Data and Info for Workgroup #3

2020 Houston HIV Care Services Needs Assessment

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

Approval: Pending

INTRODUCTION

What is an HIV needs assessment?

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

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

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

How are HIV needs assessment data used?

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

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

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

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

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

Sources:

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

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

METHODOLOGY

Needs Assessment Planning

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

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

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

Survey Sampling Plan

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

Survey Tool

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

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

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

Data Collection

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

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

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

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

Data Management

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

Limitations

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

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

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

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

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

Sources:

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

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

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

BACKGROUND

The Houston Area

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

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

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

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

HIV in the Houston Area

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

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

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

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

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

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

HIV Services in the Houston Area

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

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

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

Sources:

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

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

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

Chapter 1: Demographics

PARTICIPANT COMPOSITION

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

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

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

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

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

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

The results of these efforts are summarized in Table 2.

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

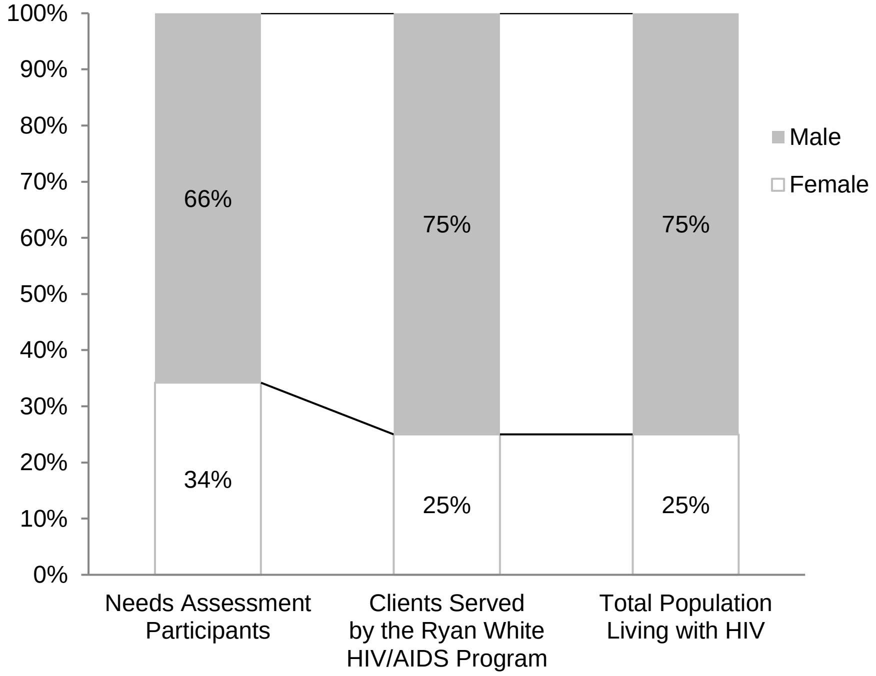
	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County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

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

COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

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

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



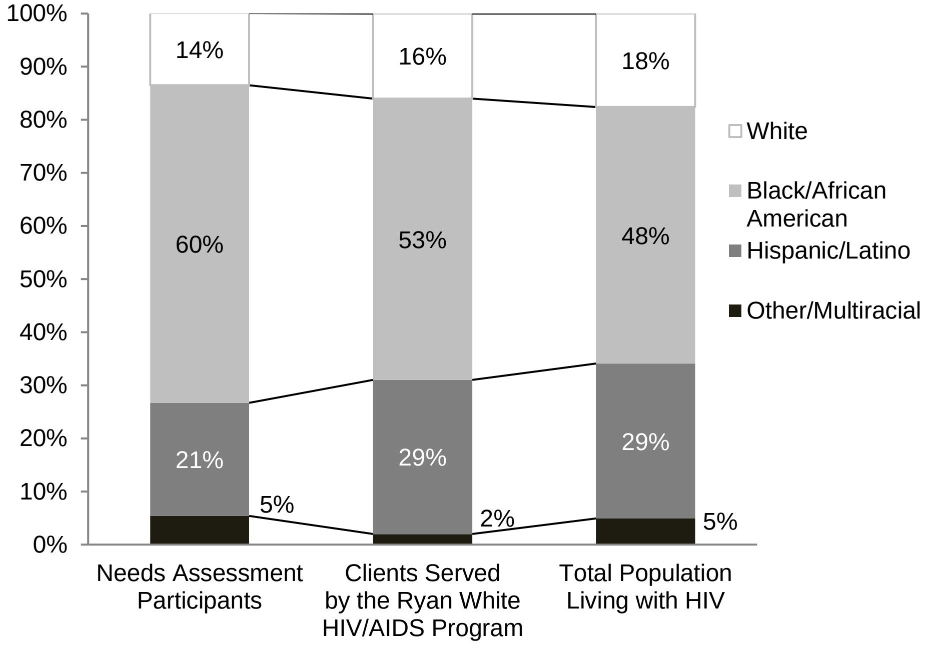
[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

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

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

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

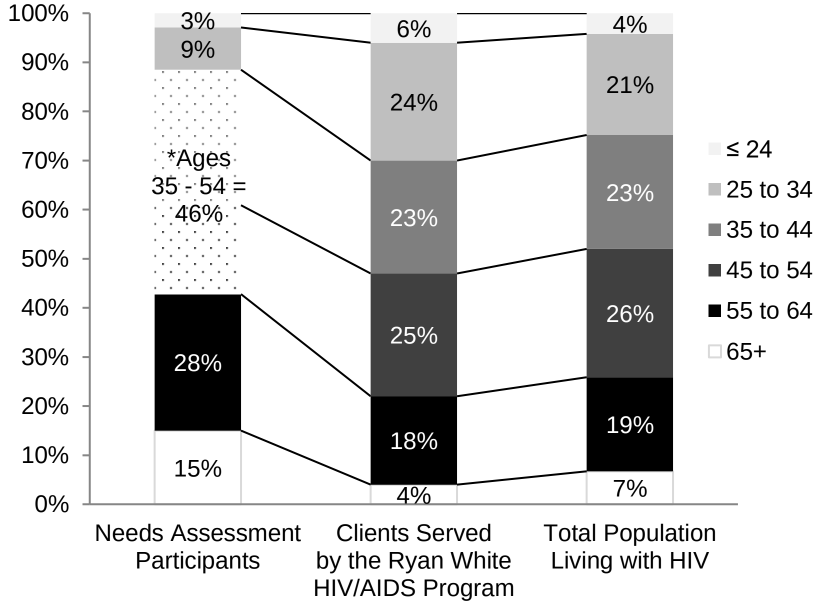
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients^a and Total HIV Diagnosed Population^b in the Houston EMA, by Race/Ethnicity, 2018



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

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

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



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

Weighting the Sample

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

Sources:

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

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

Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

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

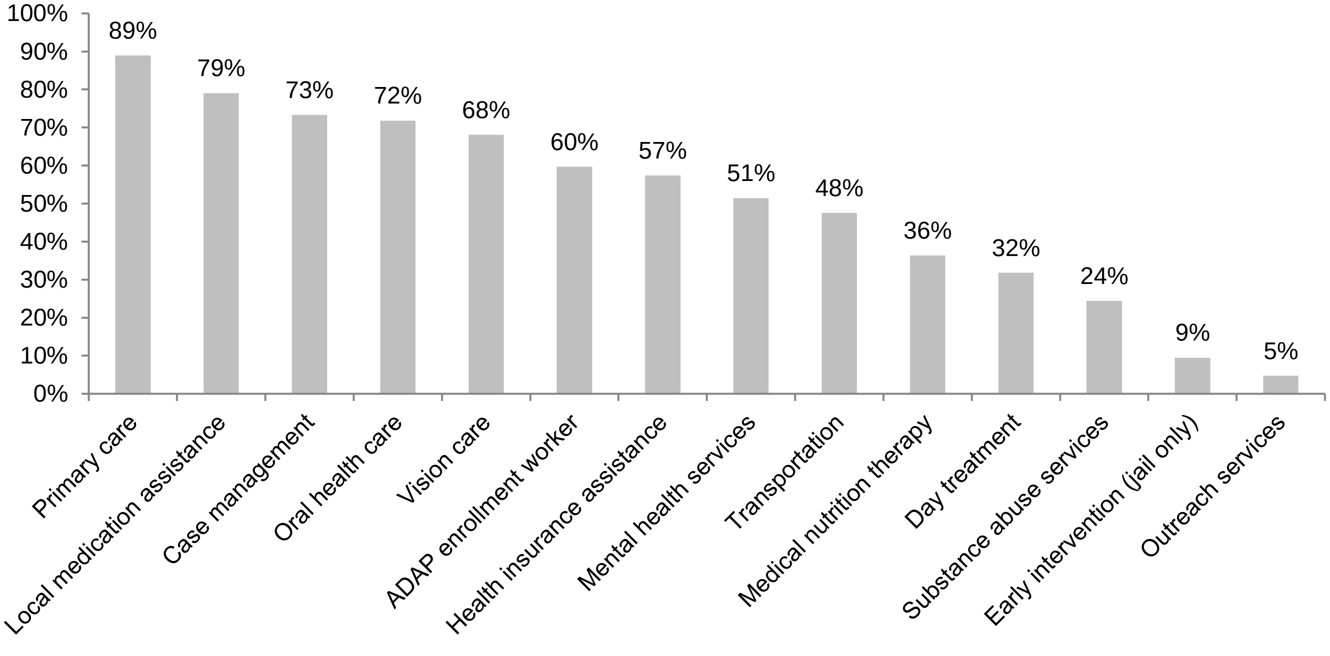
Overall Ranking of Funded Services, by Need

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

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

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

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



Overall Ranking of Funded Services, by Accessibility

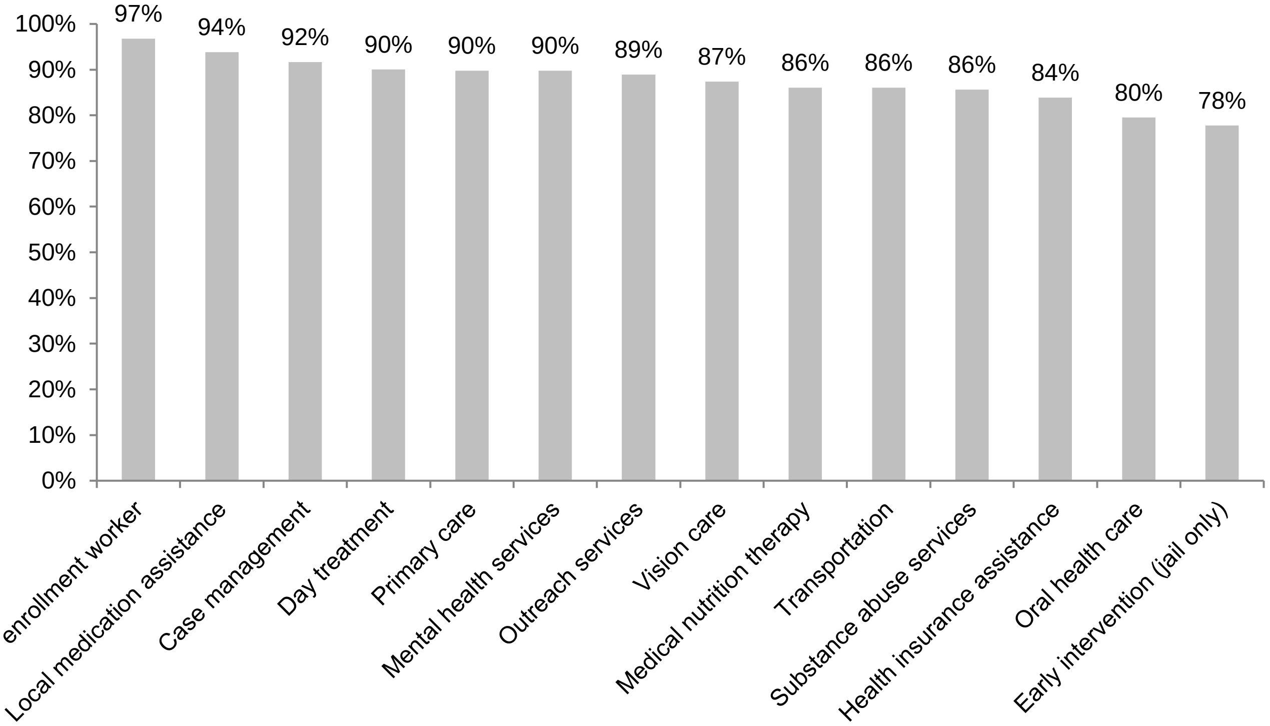
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both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

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

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

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

Denominator: 569-573 participants, varying between service categories



Overall Ranking of Barriers Types Experienced by Consumers

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

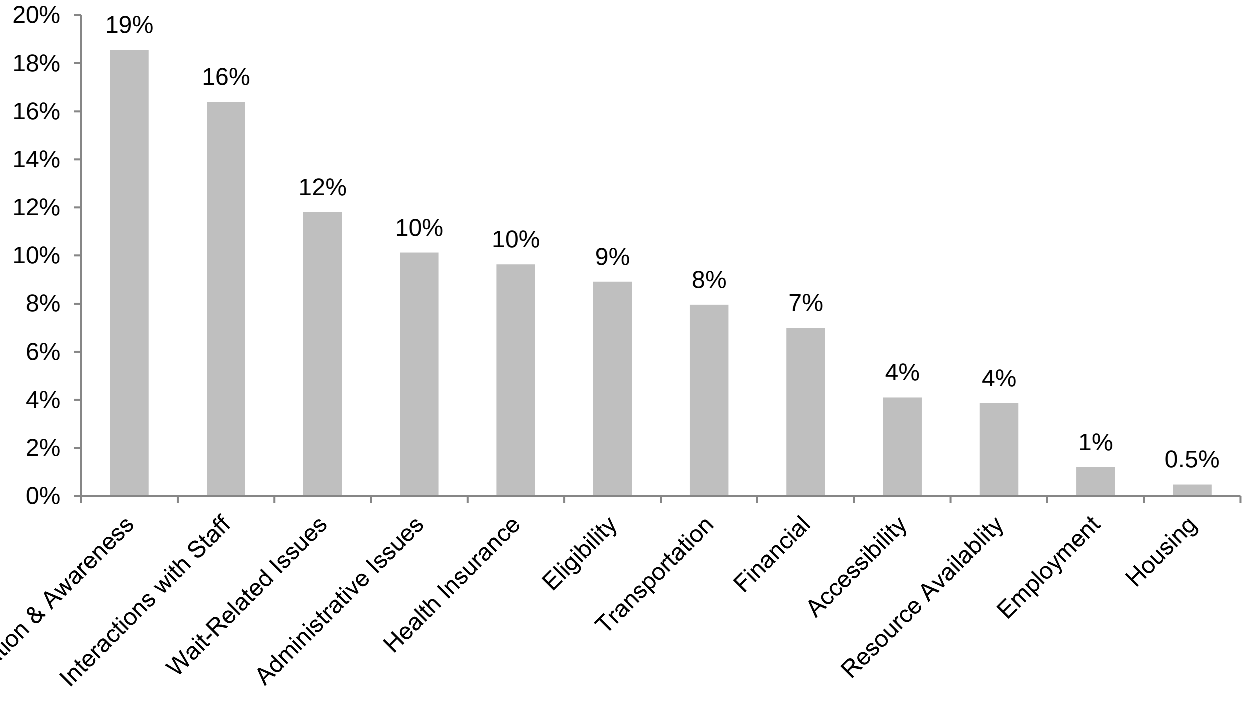
(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues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

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

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

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

Denominator: 415 barrier reports



Descriptions of Barriers Encountered

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

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

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

TABLE 1-Barrier Proportions within Each Barrier Type, 2020

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

NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

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

Overall Ranking of Unfunded Services, by Need

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

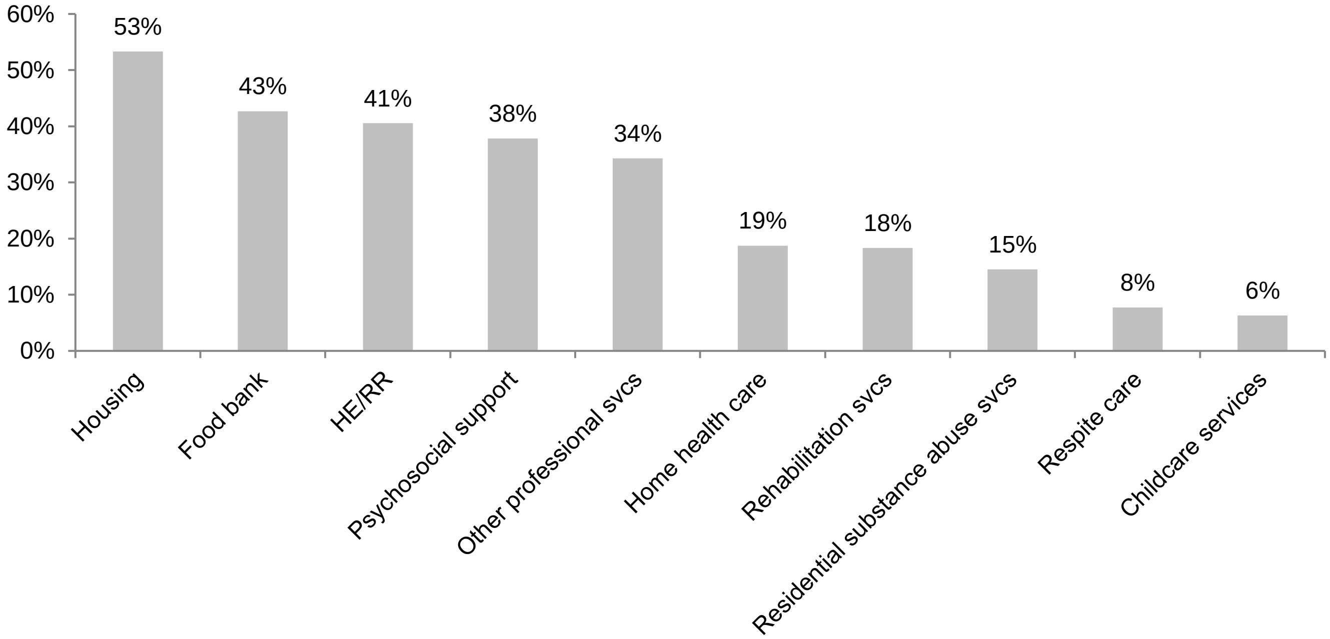
(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing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

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

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

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

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

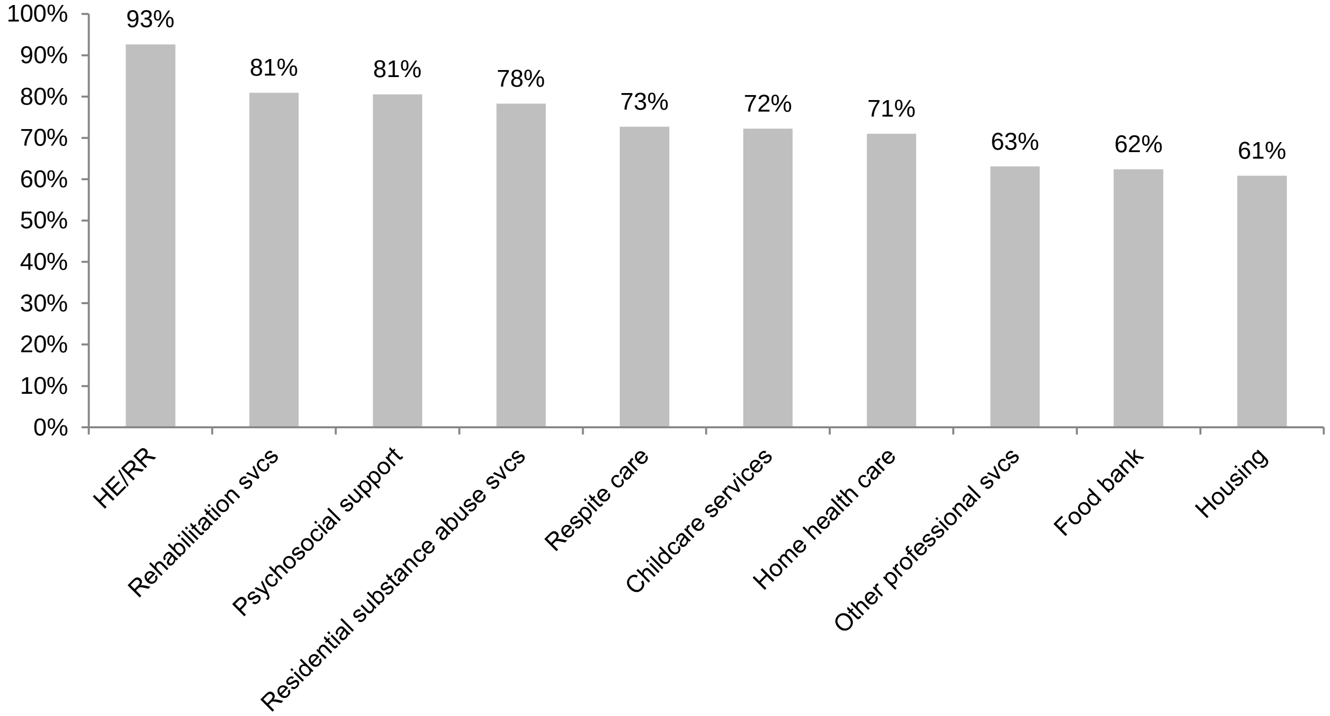
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

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

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

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

Denominator: 569-572 participants, varying between service categories



Other Identified Needs

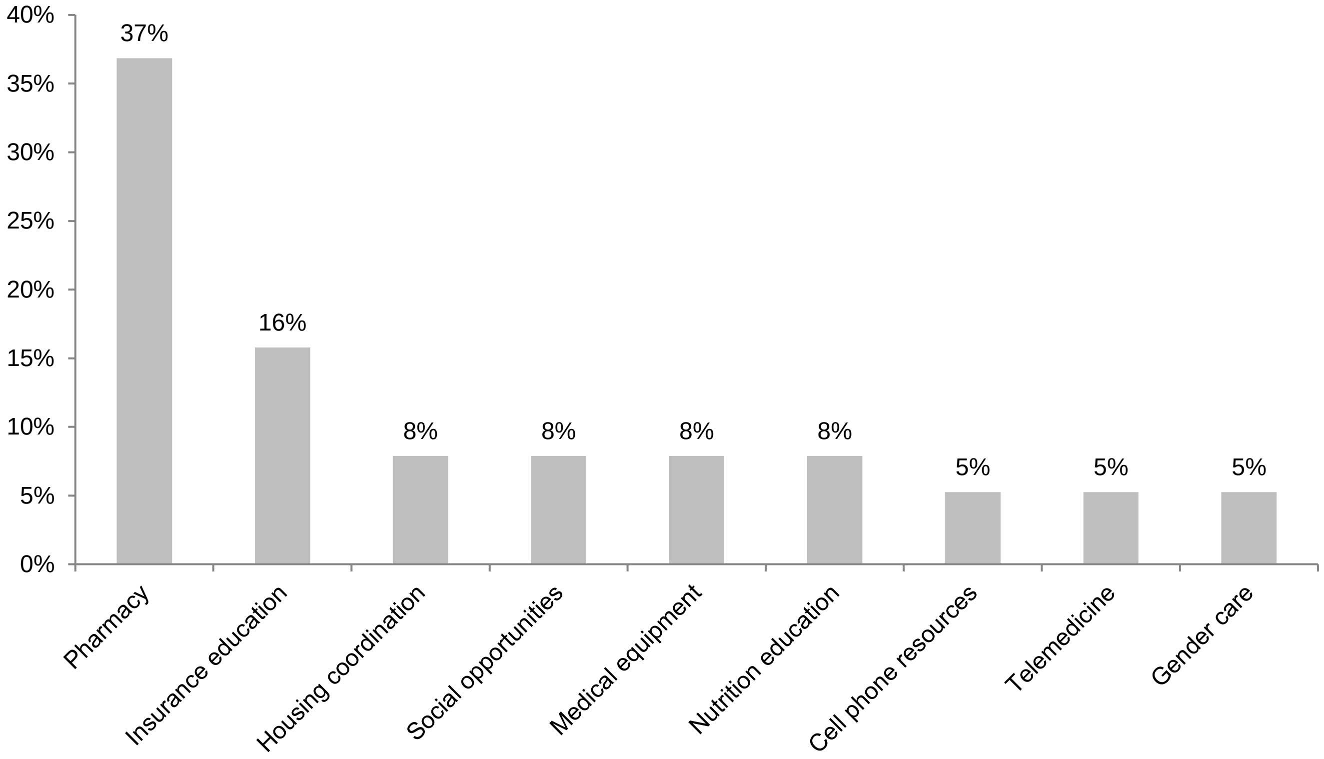
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

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

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

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

Denominator: 38 write-in responses



Service-Specific Fact Sheets

DAY TREATMENT

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

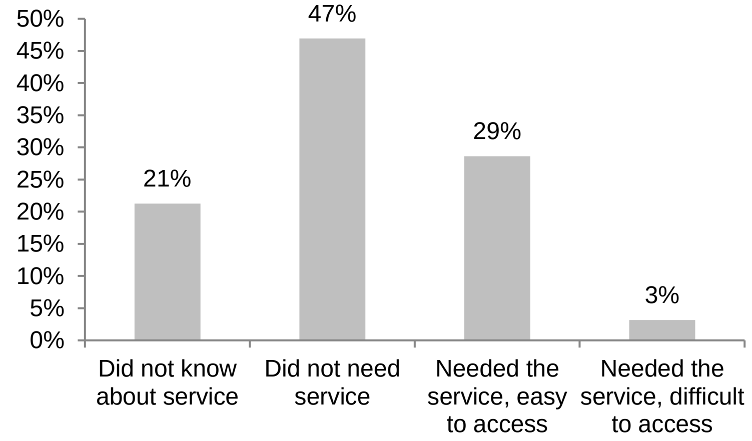
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 32% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 3% reported difficulty. 21% stated that they did not know the service was available.

(**Table 1**) When barriers to *day treatment* were reported, the most common barrier type was education and awareness (25%). Education and awareness barriers reported include lack of knowledge about service availability and where to access the service.

TABLE 1-Top 3 Reported Barrier Types for Day Treatment, 2020

		No.	%
1.	Education and Awareness (EA)	3	25%
2.	Administrative (AD)	2	17%
3.	Wait (W)	2	17%

GRAPH 1-Day Treatment, 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 *day treatment*, this analysis shows the following:

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

TABLE 2- Day Treatment, 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%	18%	18%	24%	20%	19%	14%	26%	15%
Did not need service	46%	50%	69%	49%	40%	42%	38%	45%	51%
Needed, easy to access	28%	29%	12%	24%	38%	31%	52%	25%	32%
Needed, difficult to access	3%	2%	1%	3%	2%	4%	0%	4%	1%

TABLE 3- Day Treatment, 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	27%	24%	23%	31%	26%	28%
Did not need service	29%	49%	52%	30%	66%	36%
Needed, easy to access	35%	24%	26%	38%	9%	20%
Needed, difficult to access	8%	3%	0%	2%	0%	16%

[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

EARLY INTERVENTION (JAIL ONLY)

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

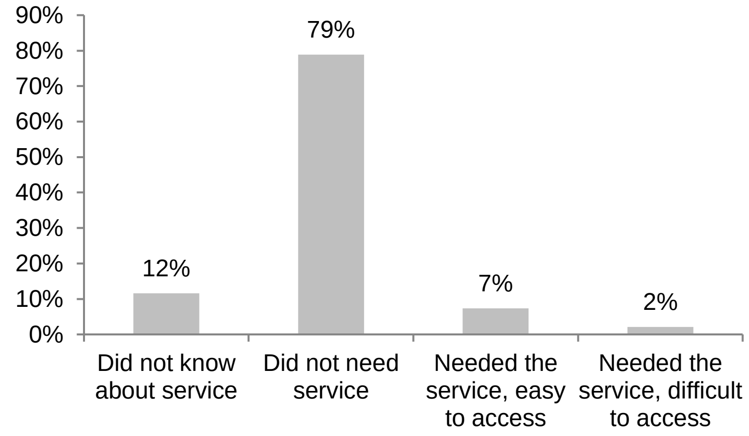
(**Graph 1**) In the 2020 Houston Area HIV needs assessment, 9% of participants indicated a need for *early intervention services* in the past 12 months. 7% reported the service was easy to access, and 2% reported difficulty. 12% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was interactions with staff (67%). Interactions with staff barriers reported include poor correspondence or follow up, poor treatment, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2020

	No.	%
1. Interactions with Staff (S)	6	67%
2. Education and Awareness (EA)	3	33%

GRAPH 1-Early Intervention (Jail Only), 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 *early intervention services*, 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 recently released, homeless, transgender, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), 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	13%	8%	5%	12%	12%	12%	5%	12%	11%
Did not need service	77%	84%	83%	78%	81%	31%	86%	77%	82%
Needed, easy to access	8%	7%	8%	9%	5%	38%	5%	9%	6%
Needed, difficult to access	2%	1%	4%	2%	1%	19%	0%	3%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	13%	14%	6%	15%	14%	4%
Did not need service	66%	79%	87%	43%	80%	83%
Needed, easy to access	16%	5%	6%	31%	6%	8%
Needed, difficult to access	5%	3%	0%	11%	0%	4%

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

HOSPICE

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

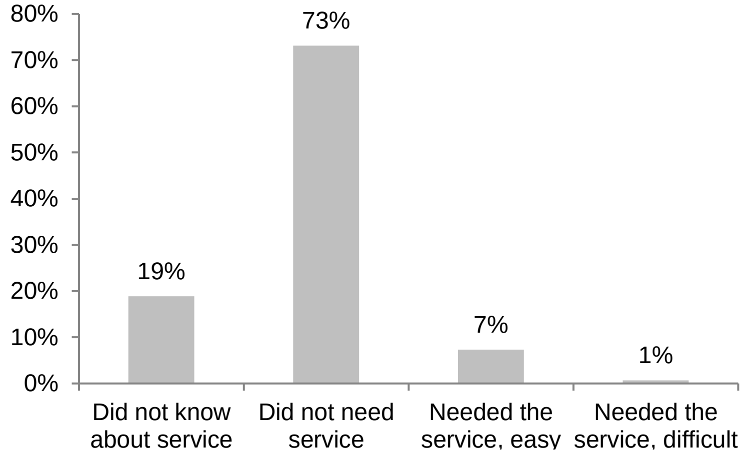
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 8% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 1% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) Only two barriers were reported for hospice. This number is too small to detect any pattern in service barriers for hospice.

TABLE 1- Reported Barrier Types for Hospice, 2020

	No.	%
1. Health Insurance Coverage (I)	1	50%
2. Transportation (T)	1	50%

GRAPH 1-Hospice, 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 *hospice*, this analysis shows the following:

- More females than males found the service accessible.
- More White, Hispanic/Latino, and other/multiracial PLWH found the service accessible than Black/African American PLWH.
- More PLWH age 50+ found the service accessible than other PLWH age 25 to 49.
- In addition, more MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Hospice, 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	20%	15%	10%	18%	23%	23%	10%	23%	13%
Did not need service	72%	78%	87%	76%	65%	65%	95%	67%	80%
Needed, easy to access	8%	5%	3%	5%	11%	12%	0%	9%	6%
Needed, difficult to access	0%	1%	0%	1%	0%	0%	0%	1%	0%

TABLE 3- Hospice, 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	19%	8%	26%	27%	11%	36%
Did not need service	68%	54%	61%	63%	83%	64%
Needed, easy to access	13%	33%	13%	11%	6%	0%
Needed, difficult to access	0%	1/%	0%	0%	0%	0%

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

TRANSPORTATION

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

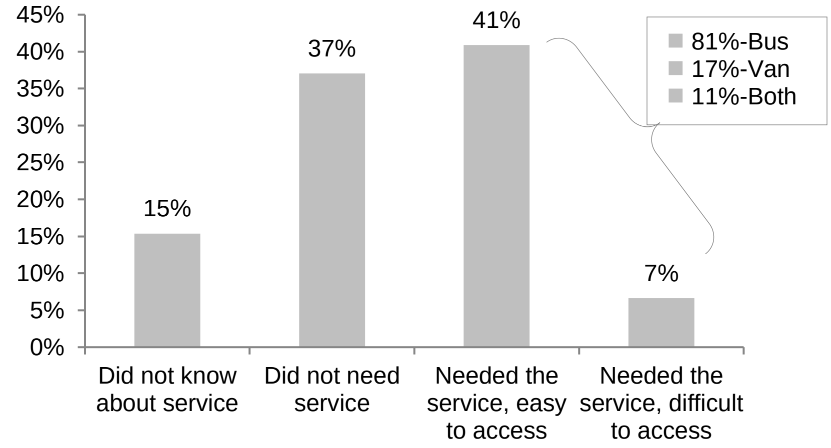
(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 48% of participants indicated a need for *transportation services* in the past 12 months. 41% reported the service was easy to access, and 7% reported difficulty. 15% stated they did not know the service was available. When analyzed by type transportation assistance sought, 81% of participants needed bus passes, 17% needed van services, and 11% needed both forms of assistance.

(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was education and awareness (24%). Transportation barriers reported include lack of knowledge about service availability and where to go to access the service.

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

	No.	%
1. Education and Awareness (EA)	7	24%
2. Resource Availability (R)	5	17%
3. Transportation (T)	5	17%
4. Eligibility (EL)	3	10%
5. Financial (F)	3	10%

GRAPH 1-Transportation Services, 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 *transportation services,* this analysis shows the following:

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

TABLE 2-Transportation Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	5%	14%	8%	12%	43%	20%	7%
Did not need service	38%	35%	51%	32%	81%	31%	14%	38%	37%
Needed, easy to access	39%	47%	36%	49%	9%	38%	43%	35%	50%
Needed, difficult to access	6%	8%	8%	5%	1%	19%	5%	7%	7%

TABLE 3-Transportation 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	7%	19%	30%	12%	14%	8%
Did not need service	28%	38%	17%	21%	71%	32%
Needed, easy to access	51%	37%	40%	59%	14%	16%
Needed, difficult to access	15%	6%	13%	8%	0%	4%

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

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

TABLE OF CONTENTS

Access to Care

ACCESS TO CARE

The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.

Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

Ending the epidemic will require a more coordinated and focused response.

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q® Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children's Health Insurance Program (CHIP), and health literacy resources in medical settings.

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

Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the "care" back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant's familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

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.

Increase the availability of mental health services and substance abuse treatment.

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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Contents

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

SERO

THRIVE SS

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

US PLHIV CAUCUS

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.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
HOME AND COMMUNITY-BASED HEALTH SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Home and Community-Based Health Services are provided to an eligible PLWH in an integrated setting appropriate to a PLWH's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services,
- Day treatment or other partial hospitalization services,
- Durable medical equipment,
- Home health aide services and personal care services in the home,
- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy),
- Routine diagnostic testing, and
- Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities.

Program Guidance: Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing Home and Community-Based Health Services.

DSHS Definition:
Services: Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a licensed/certified home or community-based setting (e.g. adult daycare center) in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following:

- Para–professional care is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help PLWH remain in their homes.
- Professional care is the provision of services in the home by licensed providers for mental health, development health care, and/or rehabilitation services.

Home and Community-Based Health Providers work closely with the multidisciplinary care team that includes the case manager, primary care provider, and other appropriate health care professionals.

Local Definition:
Home and Community-based Health Services (facility-based) is defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are not included.

Scope of Services:

Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of PLWH through the provision of treatment and activities of daily living. Services will be available at least Monday through Friday for a minimum of 10 hours/day. Services must include:

- **Skilled Nursing** including medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physician(s), personal care, and diagnostics testing,
- **Other Therapeutic Services** including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation,
- **Nutrition** including evaluation and counseling, supplemental nutrition, and daily nutritious meals, and
- **Education** including instructional workshops of HIV related topics and life skills.

Standard	Evidence
Program	
1.1 Doctor's Orders Community-based Health Services must be provided in accordance with doctor's orders. As part of the intake process, doctor's orders must be obtained to guide service provision to the PLWH.	• Doctor's order documented in the primary service record.
1.2 Refusal of Referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the PLWH's condition, the PLWH requires a higher level of care than would be considered reasonable in a home/community setting. • The agency has attempted to complete an initial assessment and the referred PLWH has been away from home on three occasions. • The home or current residence is determined to not be physically safe (if not residing in a community facility) before services can be offered or continued. The agency must document the situation in writing and immediately contact the PLWH's primary medical care provider.	• Refusal of referral documented in the primary service record. • Reason for refusal meets established criteria. • Primary medical care provider notification documented.
1.3 Initial Assessment A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. PLWH will be contacted within one (1) business day of the referral, and services should be initiated at the	• Initial contact documented in the primary service record. • Initial contact attempted within established timeframe. • Completed initial assessment documented in the primary service record.

time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	
1.4 Comprehensive Assessment A comprehensive PLWH assessment, including nursing, therapeutic, and educational is completed for each PLWH within seven (7) days of intake and every six (6) months thereafter. A measure of PLWH acuity will be incorporated into the assessment tool to track PLWH's increased functioning. A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of PLWH's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine PLWH's ability to perform activities of daily living and the level of attendant care assistance the PLWH needs to maintain living independently.	• Completed comprehensive assessment documented in the primary service record. • Comprehensive assessment completed within established timeframe. • Acuity level documented in comprehensive assessment.
1.5 Nutritional Evaluation Each PLWH shall receive a nutritional evaluation within fifteen (15) days of initiation of care. Nutritional evaluation updated as necessary.	• Nutritional evaluation documented in primary services record. • Nutritional evaluation updates documented in the primary service record. • Nutritional evaluation completed within established timeframes.
1.6 Meal Plans Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
1.7 Care Plan A written care plan is completed for each PLWH within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of care plan incorporates a multidisciplinary team approach. The care plan will include: • Current assessment and needs of the PLWH, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services • Types, quantity, and length of time services are to be provided.	• Completed care plan documented in the primary service record. • Care plans updated documented in primary service record. • Care plan completed and updated within established timeframes.
1.8 Implementation of Care Plan	• Service provision consistent with the care plan documented in the primary service record.

In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the PLWH's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the PLWH and revising it as necessary based on any changes in the PLWH's situation. • Advocate for the PLWH when necessary (e.g., advocating for the PLWH with a service agency to assist the PLWH in receiving necessary services). • Monitor changes in PLWH's physical and mental health, and level of functionality. • Work closely with PLWH's other health care providers and other members of the care team in order to effectively communicate and address PLWH service-related needs, challenges, and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with PLWH's self-administration of medication. • Promptly report any problems or questions regarding the PLWH's adherence to medication. • Report any changes in the PLWH's condition and needs.	
<u>1.9 Provision of Service/Progress Notes</u> Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services. • Progress notes will be kept in the primary service record and must be written the day services are rendered. • Progress notes will then be entered into the PLWH record within (14) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines.	• Completed progress notes documented in the primary service record. • Ongoing communication with primary medical care provider and care coordination team documented in the primary service record.

The Home and Community-Based Provider will document in the primary service record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.	
<u>1.10 Coordination of Services/Referrals</u> If referrals are appropriate or deemed necessary, the agency will: • Ensure that service for PLWH will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging PLWH access to integrated health care. • Consistently report referral and coordination updates to the multidisciplinary medical care team. • Assist PLWH in making informed decisions on choices of available service providers and resources.	• Referrals to other services (as applicable) documented in the primary service record. • Referral follow-up documented in the primary service record. • Multidisciplinary team coordination documented in the primary service record.
<u>1.11 Completion of Services/Discharge</u> Services will end when one or more of the following takes place: • PLWH acuity indicates self-sufficiency and care plan goals completed, • PLWH expresses desire to discontinue/transfer services, • PLWH is not seen for ninety (90) days or more, • PLWH has been referred on to a higher level of care (such as assisted living or skilled nursing facility), • PLWH is unable or unwilling to adhere to agency policies, • PLWH relocates out of the service delivery area, and • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances (if applicable) must be accompanied by a referral to an appropriate service provider agency.	• Discharge documented in the primary service record. • Discharge/Transfer plan developed with PLWH documented in the primary service record, if applicable.

Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the HCBHS service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures
2.2 Facility Licensure Agency must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider. Agency maintains other certification for facilities and personnel, if applicable. Services are provided in accordance with Texas State regulations.	• License and/or certification available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.3 Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by Registered Nurses/Licensed Vocational Nurses or appropriate licensed personnel in accordance with State of Texas regulations. Other Therapeutic Services are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, LMFTA). Nutritional Services are provided by a Registered Dietician and food managers. Education Services are provided by a health educator.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working knowledge of: ➢ HIV and its diverse manifestations ➢ HIV transmission and effective methods of reducing transmission ➢ current treatment modalities for HIV and co-morbidities ➢ HIV/AIDS continuum of care ➢ diverse learning and teaching styles ➢ the impacts of mental illness and substance use on behaviors and adherence to treatment ➢ crisis intervention skills	• Assessment of staff qualifications documented in personnel file. • Exceptions documented in personnel file. • Training to increase staff qualifications documented in personnel file.

➢ the use of individualized plans of care in the provision of services and achievement of goals • Effective crisis management skills • Effective assessment skills	
<u>2.5 Billing Requirement/Payment of Last Resort</u> Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payer sources.	• Third-Party payer screening documented in the primary service record. • Evidence of third-party billing

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
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- Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009
- San Francisco EMA Home-Based Home Health Care Standards of Care February 2004
- Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters Accessed on October 16, 2020.

RYAN WHITE PART B/DSHS STATE SERVICES
22 -23 QUALITY ASSURANCE MEASURES
HOME AND COMMUNITY-BASED HEALTH SERVICES

1. Percentage of PLWH with documented evidence of agency refusal of services with detail on refusal in the primary service record **and** if applicable, documented evidence that a referral is provided for another home or community-based health agency.
2. Percentage of PLWH with documented evidence of needs assessment completed in the primary service record.
3. Percentage of PLWH with documented evidence of a comprehensive evaluation completed by the Home and Community-Based Health Agency Provider in the primary service record.
4. Percentage of PLWH with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the primary service record.
5. Percentage of PLWH with documented evidence of care plans reviewed and/or updated as necessary based on changes in the PLWH's situation at least every sixty (60) calendar days as evidenced in the primary service record.
6. Percentage of PLWH with documented evidence of completed progress notes in the primary service record.
7. Percentage of PLWH with documented evidence of ongoing communication with the primary medical care provider and care coordination team as indicated in the primary service record.
8. Percentage of PLWH accessing Home and Community-Based Health Services with documented evidence of referrals, as applicable, to other services as indicated in the primary service record.
9. Percentage of PLWH accessing Home and Community-Based Health Services have follow up documentation to the referral offered in the primary service record.
10. Percentage of PLWH with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the primary service record.
11. Percentage of PLWH with documented evidence of a discharge plan developed with PLWH, as applicable, as indicated in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
HOSPICE SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Hospice Services are end-of-life care services provided to PLWH in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling,
- Nursing care,
- Palliative therapeutics,
- Physician services, and
- Room and board.

Program Guidance: Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the state of Texas. Services must be provided with appropriate and valid licensure of provider as required by the State of Texas, as applicable. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under Texas Medicaid.

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

Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are:

- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Hospice services must have physician certification of the PLWH’s terminally ill status as defined by Texas Medicaid documented in the primary service record.

<u>Limitations</u>: Ryan White Part B/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services. Services cannot be provided in skilled nursing facilities or nursing homes.

Local Definition:

Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Scope of Services:

Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Allowable services are:

- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics

Services not allowed under this service:

- HIV medications under hospice care unless paid for by the PLWH.
- Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.

- Funeral, burial, cremation, or related expenses.
- Nutritional services,
- Durable medical equipment and medical supplies.
- Case management services
- Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the PLWH's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services per legislation.

Standard	Evidence
Program	
<u>1.1 Physician Certification</u> • The attending physician must certify that a PLWH is terminal, defined under Texas Medicaid hospice regulations as having a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification must specify that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course. • The certification statement must be based on record review or consultation with the referring physician. • The referring provider must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Provider orders are transcribed and noted by attending nurse. • Must be reassessed by a physician every six (6) months. • Must first seek care from other facilities and denial must be documented in the resident's chart.	• Physician certification documented in the primary service record. • Reassessment documented in the primary service record.
<u>1.2 Denial of Service</u> The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations • Patient is aggressive and a danger to the staff • Patient is a "no show" Agency must develop and maintain s system to inform Administrative Agency regarding issue of long-term care facilities denying admission for PLWH based on	• Denial of Services documented in the primary service record. • Notification of the Administrative Agency regarding issue of denying admission for PLWH based on inability to provide appropriate level of skilled nursing care documented.

inability to provide appropriate level of skilled nursing care	
<u>1.3 Intake Information</u> Information will be obtained at intake (from the referral source, PLWH or other source) and will include, but is not limited to: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (PLWH self-report) • Demographics • Emergency contact • Household members • Pertinent releases of information	• Intake information documented in the primary service record.
<u>1.4 Comprehensive Health Assessment</u> A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components: • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. • A review of current goals of care Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.	• Completed comprehensive health assessment document in the primary service record and dated within 48 hours of admission. • Required elements are included in the comprehensive health assessment.

Hospice provider documents each PLWH's scheduled medications, including dosage and frequency. • HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects. • Hospice provider documents as needed medications for PLWH and includes PLWH's name, dose, route, reason, and outcome.	
1.5 Care Plan Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities. A written Plan of Care is completed for each patient within seven (7) calendar days of admission and reviewed monthly. Care Plans will be updated once every six (6) months thereafter or more frequently as clinically indicated. Hospice care should be based on the professional guidelines for supportive and palliative care. Hospice provider will maintain a consistent plan of care and communicate changes from the initial plan to the referring provider.	• Completed care plan based on physician's orders documented in the primary service record within 7 calendar days of admission. • Monthly care plan reviews documented in the primary service record. • Care Plan updates documented in the primary service record at least every 6 months.
1.6 Palliative Therapy Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure. Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider	• Palliative therapy as ordered by the referring provider documented on the care plan in the primary service record. • Provision of palliative therapy documented in the primary service record.
1.7 Counseling Services for Family The need for counseling services for family members must be assessed and a referral made if requested. The need for ~~bereavement~~ ~~and~~ counseling services for family members must be consistent with definition of mental health counseling.	• Assessment and referrals documented in the primary service record.
1.8 Bereavement Counseling The need for bereavement counseling services for family members must be consistent with the definition of mental health counseling. Bereavement counseling must be provided. Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief,	• Discussion of bereavement counseling with family members upon admission to Hospice services documented in the primary service record. • Bereavement care plan documented in the primary services record. • Provision of bereavement counseling documented in the primary services record.

loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery, • Make bereavement services available to a patient's family and other persons in the bereavement plan of care for up to one year following the death of the patient, • Ensure that bereavement services reflect the needs of the bereaved. Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding cannot pay for these services in a skilled nursing facility or nursing home per legislation.	
1.9 Mental Health Counseling Mental health counseling should be solution focused; outcomes oriented and time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's assessment • The patient's acceptance of these services	• Provision of mental health counseling documented in the primary service record. • Qualifications of mental health professional documented in personnel file.
1.10 Dietary Counseling Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a	• Dietary counseling documented on the care plan in the primary service record. • Provision of dietary counseling documented in primary service record.

hospice patient's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. A qualified person includes a dietitian, nutritionist, or registered nurse. A person that provides dietary counseling must be appropriately trained and qualified to address and assure that the specific dietary needs of a PLWH are met.	
<u>1.11 Spiritual Counseling</u> A hospice must provide spiritual counseling that meets the PLWH's and the family's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the PLWH's and family's spiritual needs, • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a PLWH's spiritual needs, and • Advise the PLWH and family of the availability of spiritual counseling services.	• Discussion of spiritual counseling with PLWH and family members upon admission to Hospice services documented in the primary service record. • Provision of spiritual counseling documented in the primary service record. • Referral to spiritual counseling documented.
<u>1.12 Medical Social Services</u> Medical social services must be provided by a qualified social worker. and is based on: • The PLWH's and family's needs as identified in the patient's assessment • The PLWH's and family's acceptance of these services	• Medical social services documented on the care plan in the primary service record. • Provision of medical social services documented in the primary service record.
<u>1.13 Multidisciplinary Team Approach</u> Program must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.	• Multidisciplinary team documented in the primary service record. • Provision of multidisciplinary coordination documented in the primary service record.

1.14 Medication Administration Record Staff documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects.	• Medication administration documented in the primary service record.
1.15 PRN Medication Record Staff documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, outcome, and signature and title of staff.	• PRN medication administration documented in the primary service record.
1.16 Referrals and Tracking Program receives referrals from a broad range of HIV service providers, community stakeholders and clinical providers. Program makes appropriate referrals out when necessary.	• Referral source documented in the primary service record. • Referrals made documented in the primary service record
1.17 Discharge An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires. • Patient's medical condition improves, and hospice care is no longer necessary, based on attending physician's plan of care and a referral to Medical Case Management or OAHS must be documented Patient elects to be discharged. • Patient is discharged for cause. • Patient is transferred out of provider's facility	• Discharge documented in primary service record. • One or more discharge criteria met.
Administrative	

Program Policies and/or Procedures
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing Hospice services. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG Contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

2.1 Facility Licensure	• License and/or certification available at the site(s) where services are provided.

Agency is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation	• License and/or certification posted in a highly visible place at site(s) where services are provided.
<u>2.2 Services Requiring Licensed Personnel</u> All services requiring licensed personnel shall be provided by appropriate licensed personnel in accordance with State of Texas regulations. Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• License documented in the personnel file. • Staff interviews document compliance.
<u>2.3 Staff Education</u> Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of PLWH. Agency provides access to training activities, including but not limited to: • Updated HIV information, including current treatment methodologies and promising practices • In-service education • DSHS-sponsored trainings	• Agency documents the dissemination of HIV information and training activities relevant to the needs of PLWH to paid staff and volunteers. • Agency documents attendance at training activities. • Materials for training activities (agendas, handouts, etc.) are on file.
<u>2.4 Ongoing Staff Training</u> • Eight (8) hours of training in HIV and clinically related issues is required annually for licensed staff • One (1) hour of training in HIV/AIDS is required annually for all other staff.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
<u>2.5 Staff Experience</u> A minimum of one-year documented hospice and/or HIV work experience is preferred	• Work experience documented in personnel file with exceptions to work experience noted.
<u>2.6 Staff Supervision</u> Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years' experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory,	• Work experience for professional supervisory providers documented in personnel file. • Supervision consistent with licensure documented. • Supervision of other staff members by supervisory provider or advanced practice registered nurse documented.

provider or advanced practice registered nurses will document supervision over other staff members	
2.7 Volunteer Assistance Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Policy and/or procedure documents duties and activities conducted by volunteers and oversight. • Signed job descriptions documented in volunteer file. • Service provision by volunteers are documented in the primary service record.
2.8 Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV. For volunteers who are licensed practitioners, training addresses documentation practices	• Trainings and education documented in volunteer file.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 15-17. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services located at: https://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook/mhps- title-40-texas-administrative-code-chapter-30
- Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook. Located at http://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 QUALITY ASSURANCE MEASURES
HOSPICE SERVICES

1. Percentage of PLWH receiving Hospice services with attending physician certification of PLWH's terminal illness documented in the primary service record.
2. Percentage of PLWH receiving Hospice care with documentation in the primary record of all physician orders for initiation of care.
3. Percentage of PLWH in Hospice care with a documented comprehensive health assessment completed within 48 hours of admission in the primary service record.
4. Percentage of PLWH in Hospice care with documentation of all scheduled and as needed medications, including dosage and frequency, noted in the primary service record.
5. Percentage of PLWH in Hospice care with a written care plan based on physician's orders completed within seven calendar days of admission documented in the primary service record.
6. Percentage of PLWH in Hospice care with documented evidence of monthly care plan reviews completed in the primary service record.
7. Percentage of PLWH in Hospice care with a written care plan that documents palliative therapy as ordered by the referring provider documented in the primary service record.
8. Percentage of PLWH accessing Hospice care with documented evidence of bereavement counseling offered to family members upon admission to Hospice services in the primary service record.
9. Percentage of PLWH in Hospice care with documented evidence of dietary counseling provided, when identified in the written care plan, in the primary service record.
10. Percentage of PLWH in Hospice care that are offered spiritual counseling, as appropriate, documented in the written care plan in the primary service record.
11. Percentage of PLWH in Hospice care with documented evidence of mental health counseling offered, as medically indicated, in the primary service record.
12. Percentage of PLWH with documented evidence in the primary record of all refusals of attending physician referrals by hospice providers with evidence indicating an allowable reason for the refusal.
13. Percentage of PLWH in Hospice care with documented evidence of discharge status in the primary service record.

RYAN WHITE PART B/DSHS STATE SERVICES
22-23 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC INTERPRETIVE SERVICES

Effective Date: April 1, 2022/September 1, 2022

HRSA Definition:
Linguistic Interpretive Services include interpretation and translation activities, both oral and, written, to eligible people living with HIV (PLWH). These activities must be provided by a qualified linguistic services provider as a component of HIV service delivery between the healthcare provider and the PLWH. These services are to be provided when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of HRSA Ryan White HIV/AIDS Program (RWHAP) eligible services.

Program Guidance: Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Linguistic services include sign language linguistics

DSHS Definition:
Linguistic services are provided as a component of HIV service delivery to facilitate communication between the PLWH and provider, as well as support service delivery in both group and individual settings. These standards ensure that language is not a barrier to any PLWH seeking HIV-related medical care and support, and that linguistic services are provided in a culturally appropriate manner.

Services are intended to be inclusive of all individuals and not limited to any population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations living with HIV receive quality, unbiased services.

Limitations: Linguistic services, including interpretation (oral) and translation (written) services, must be provided by a qualified linguistic provider.

Telehealth and Telemedicine is an alternative modality to provide most Ryan White Part B and State Services funded services. For the Ryan White Part B/SS funded providers and Administrative Agencies, telehealth & telemedicine services are to be provided in real-time via audio and video communication technology which can include videoconferencing software.

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between PLWH and providers. RW Providers must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Local Definition:
Support for Linguistic Interpretive Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the PLWH, when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Types of service include, but are not limited to, sign language for deaf and/or hard of hearing PLWH and native language interpretation for monolingual PLWH.

Scope of Services:
The agency will provide interpreter services including, but not limited to, sign language for deaf and/or hard of hearing and native language interpretation for monolingual PLWH. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.

<u>Limitation</u>: Eligible languages exclude Spanish as it is an expectation that all funded providers have the internal capacity to communicate with PLWH in English and Spanish.

<u>Subcontractor Exclusion</u>:
Due to the nature of service delivery, the staff training outlined in the Houston General Standards is not required for interpreters at subcontracted linguistic service agencies.

Standard	Evidence
Program	
<u>1.1 Provision of Services</u> Service referral will document assessment of need for linguistic services for interpretation and/or translation needs to communicate with the healthcare provider and/or receive appropriate services. Program shall provide translation and/or interpretation services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the primary service record. Linguistic services may be provided in person or via telephonic or other electronic means (see telehealth/telemedicine information above). Program will offer services to the PLWH only in connection with other HRSA approved services (such as clinic visits).	• Referral for service documents need of linguistic services for interpretation and/or translation • Provision of linguistic services for interpretation and/or translation documented in primary service record.

Program will deliver services to the PLWH only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the PLWH. Based on need, agency shall provide the following types of linguistic services in the PLWH's preferred language: • Oral interpretation • Written translation • Sign language	
<u>1.2 Timeliness of Scheduling</u> Program will schedule service within one (1) business day of the request.	• Request date documented. • Scheduling of service documented.
Administrative	

<u>2.1 Program Policies and/or Procedures</u>
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders, the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
Agency should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the PLWH seeking assistance
Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area.
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

<u>2.2 Staff Qualifications and Training</u> To ensure highest quality of communication: • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of	• Program Policies and Procedures will ensure the contracted agency complies with Legislation and Regulations: • (Americans with Disabilities Act (ADA), Section 504 of the

Certification for Medical Interpreters (NBCMI). Where CCHI and NBCMI certification for a specific language do not exist, an equivalent certification (MasterWord, etc.) may be substituted for the CCHI and NBCMI certification. • Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), the National Interpreter Certification (NIC), or the State of Texas at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting.	Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency scheduling documents appropriate levels of interpreters are requested.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 37-38. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). Located at: http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- National Culturally and Linguistically Appropriate Services (CLAS) Standards: https://thinkculturalhealth.hhs.gov/clas/standards

RYAN WHITE PART B/DSHS STATE SERVICES
22 -23 QUALITY ASSURANCE MEASURES
LINGUISTIC INTERPRETIVE SERVICES

1. Percentage of PLWH with documented evidence of need of linguistic services as indicated in the service assessment.
2. Percentage of primary service records with documented evidence of interpretive/translation services provided for the date of service requested.

Harris County
Public Health
Building a Healthy Community

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)

TABLE OF CONTENTS

Service Specific Standards

Introduction

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

Purpose

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

Scope

The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2021-2022:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Medical Nutrition Supplement*
- *Outreach*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services
- *Emergency Financial Assistance*
- *Emergency Financial Assistance (Other)*
- Referral for Healthcare & Support Services

Part A funded services

Combination of Parts A, B, and/or Services funding

Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make 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	<u>Staff education on eligibility determination and fee schedule</u> Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	<u>Service Evaluation</u> Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	<u>Subcontractor Monitoring</u> Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	<u>Staff Guidelines</u> Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and 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	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency • Fraudulent claims or documentation about HIV diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit). • Client service plan is completed, and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System • A copy of written notice and a certified mail receipt for involuntary termination
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure • Summary of all services received by the client and the client's response to services • Referrals made and/or • Instructions given to the individual at discharge (when applicable)	• Documentation in client record and in the Centralized Patient Care Data Management System
3.8	<u>Client Feedback</u> 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	<u>Patient Safety (Core Services Only)</u> 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	<u>Client Records</u> Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	<u>Cultural Competence</u> 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	<u>Proof of HIV Diagnosis</u> 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	<u>Provision of Services Regardless of Current or Past Health Condition</u> 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	<u>Client Eligibility</u> 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	<u>Re-certification of Client Eligibility</u> 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	<u>Linkage Into Core Services</u> 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	<u>Wait Lists</u> 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	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: -IS-100.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	Emergency Preparedness Plan 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. (www.jointcommission.org)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

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

SERVICE SPECIFIC STANDARDS OF CARE

Emergency Financial Assistance Program (OTHER)

Emergency Financial Assistance (EFA) is to provide one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, food (including groceries, and food vouchers), and transportation. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

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	EFA funds may be used on the following essential items or services: • Utilities (may include household utilities including gas, electricity, propane, water, and all required fees). • Telephone • Food (groceries or food vouchers) Other RWHAP allowable costs needed to improve health outcomes.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in the client chart
1.2	Client Eligibility Applicants must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. Demonstrated need is made by the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • The cost of their shelter is more than 30% of the household income • The cost of their utility consumption is more than 10% of the household income • They are unable to obtain credit necessary to provide for basic needs and shelter • A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children	• Documentation of client assessment • Copy of invoice/bill paid. • Copy of check for payment

	- Other emergency needs as deemed appropriate by the agency The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client.	
1.3	Client Confidentiality Payment for assistance made to service providers will protect client confidentiality through use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	- Agency financial records indicate compliance - Documentation in the client chart
1.4	Assessment - An assessment must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. - Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. - Emergent need must be documented each time funds are used.	- Documentation in the client chart
1.5	Documentation - Plans are developed jointly with the client and must include an approach to mitigate the need in the future. - Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided.	- Documentation in the client chart
1.6	Timeliness of Service Provision All completed requests for assistance shall be approved or denied within three (3) business days following the completed request.	- Documentation in the client chart

2.0	**Agency requirements**	
2.1	Budget Requirements or Restrictions - Direct cash payments to clients are not permitted. - RWHAP funds will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. - At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. - The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary.	- Documentation includes copies of checks paid and vouchers purchased - Review of agency's Policies & Procedures Manual indicates compliance - Documentation that at least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements.
2.2	Agency providing emergency financial assistance shall have procedures in place to ensure that funds are distributed fairly and consistently.	- Agency written procedure
2.3	Agency must be dually awarded as HOWPA sub-recipient and work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. Agency must document procedures.	- Agency written procedure

Transportation Services

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

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

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

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

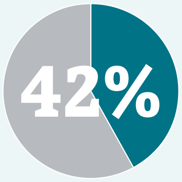
		• Client interviews and client satisfaction survey
3.3	Future Service Delays Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review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

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

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

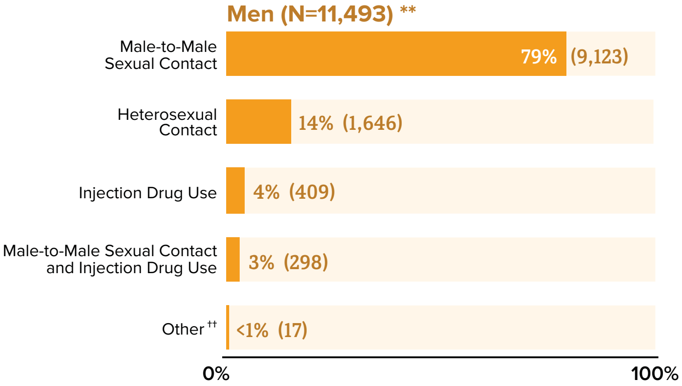
		- Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	Mileage Documentation Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service) per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

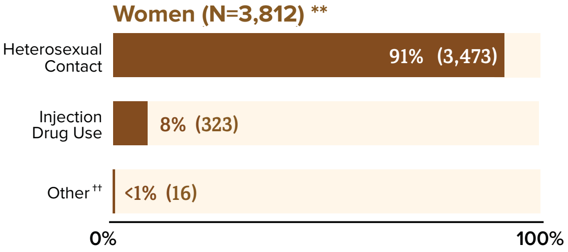
HIV and African American People



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

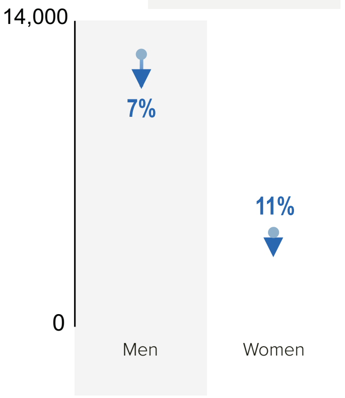
Among Black/African American people, most new HIV diagnoses were among men.



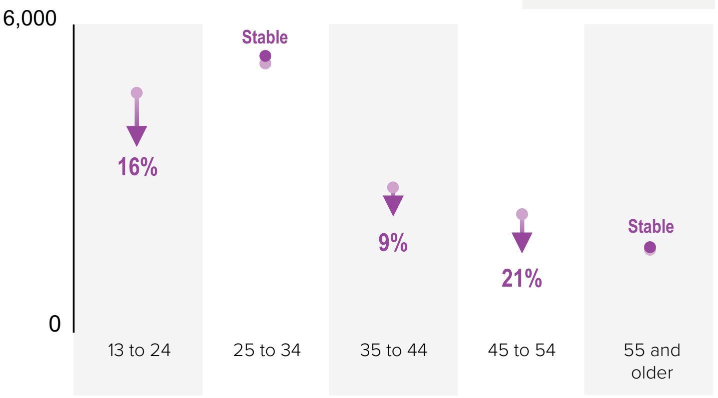


Progress has been made with reducing HIV diagnoses among most age groups, with HIV diagnoses decreasing 8% among Black/African American people overall from 2015 to 2019.

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.

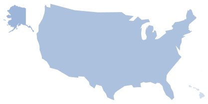
‡ American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** 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.

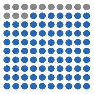


In 2019, an estimated **1.2 MILLION PEOPLE** had HIV. **Of those, 479,300 were Black/ African American people.*****

For every 100 people with HIV

87 knew their HIV status.

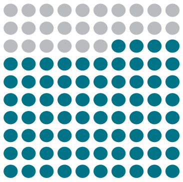
For every 100 Black/African American people with HIV



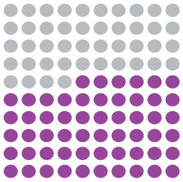
87 knew their HIV status.

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.

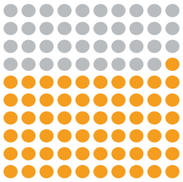
Compared to all people with diagnosed HIV, Black/African American people have lower viral suppression rates. More work is needed to increase these rates. For every **100 Black/African American people with diagnosed HIV** in 2019:†††



74 received some HIV care



56 were retained in care

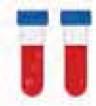


61 were virally suppressed

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.

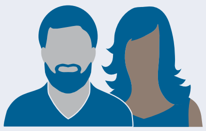
Ryan White HIV/AIDS Program Fast Facts: Black/African American Clients

46.6%

of All RWHAP Clients

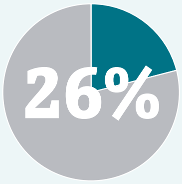
65.9%
Live at or Below
100%
of the Federal
Poverty Level

85.2%
2019
Are
Virally
Suppressed



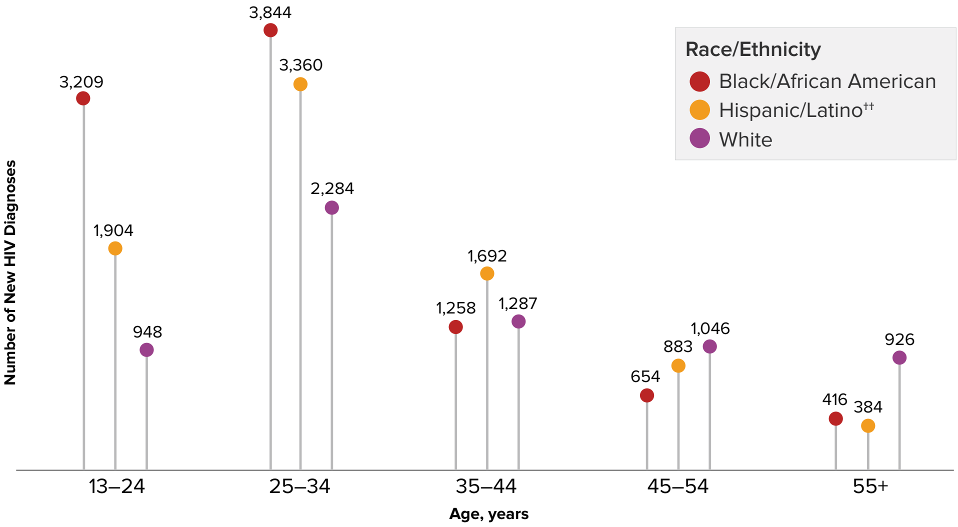
44.5% Are
Aged 50+

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.[‡] [**]

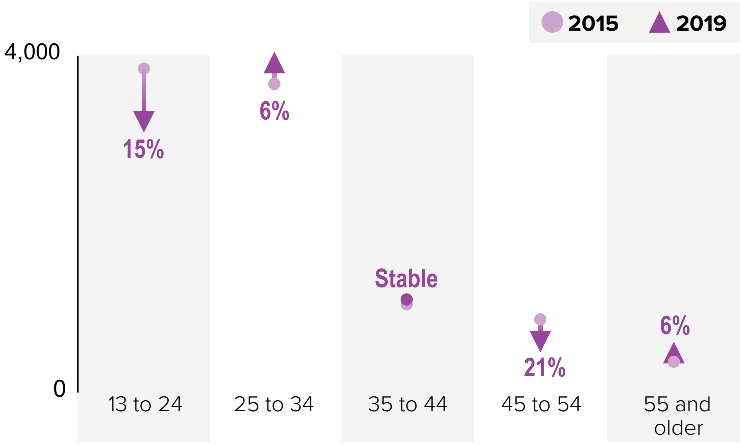
About 3 out of 4 Black/African American gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



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.

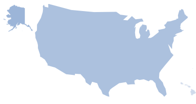
[‡] This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact.

[**] 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.

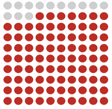
[‡‡] In 50 states and the District of Columbia.

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.



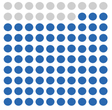
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV. **Of those, 235,400 were Black/African American gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

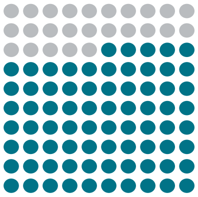
For every 100 Black/African American gay and bisexual men



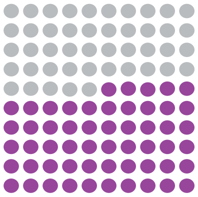
83 knew their HIV status.

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.

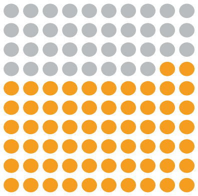
Compared to all people with diagnosed HIV, Black/African American gay and bisexual men have lower viral suppression rates. For every **100 Black/African American gay and bisexual man with diagnosed HIV in 2019:**[†††]



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

STIGMA

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.

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.

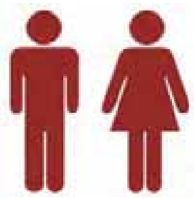
*** Includes infections attributed male-to-male sexual contact only. Among Black/African American men with HIV attributed to male-to-male sexual contact and injection drug use, 94% knew they had HIV.

††† In 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

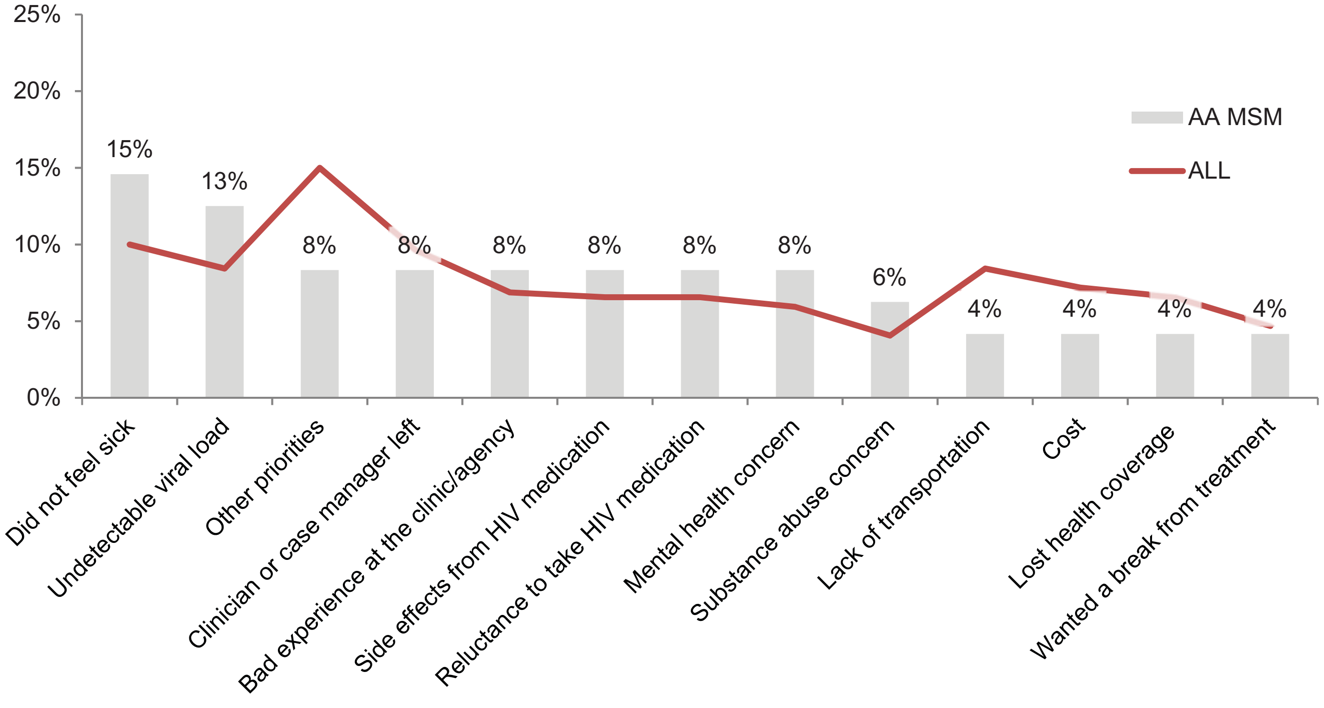
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

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.



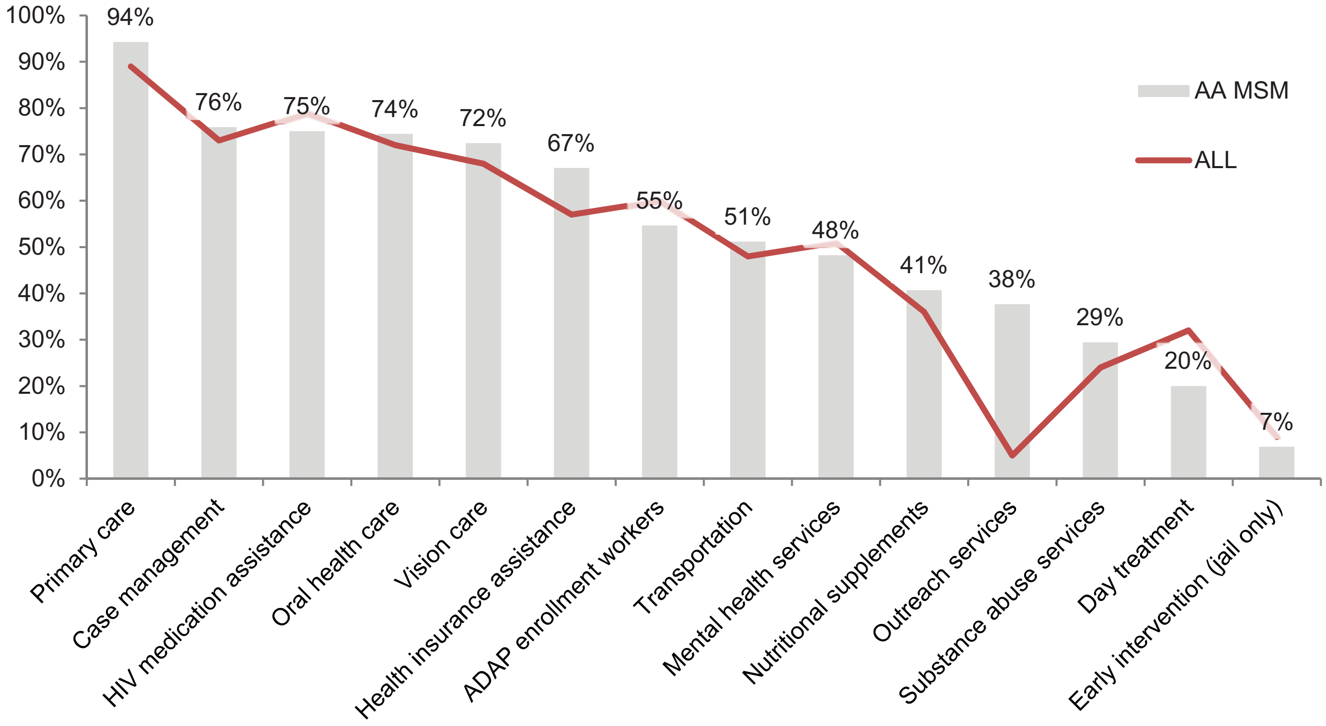
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.



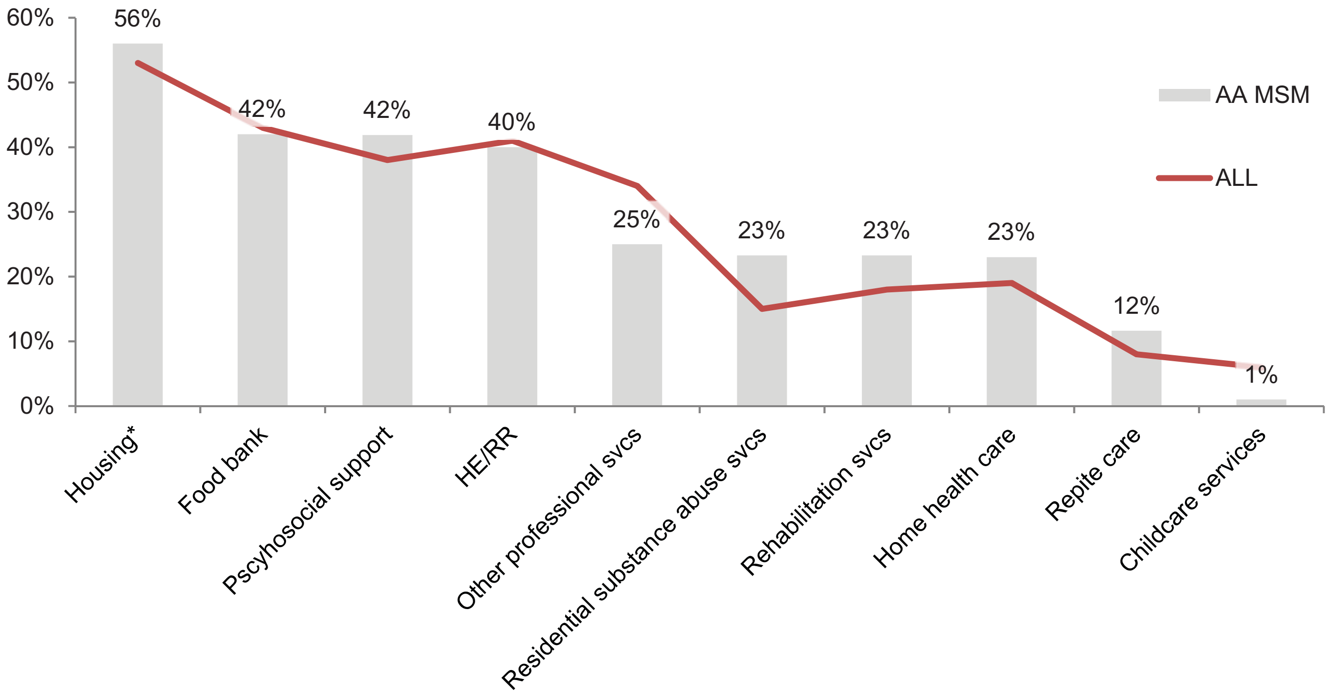
OTHER IDENTIFIED NEEDS

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.

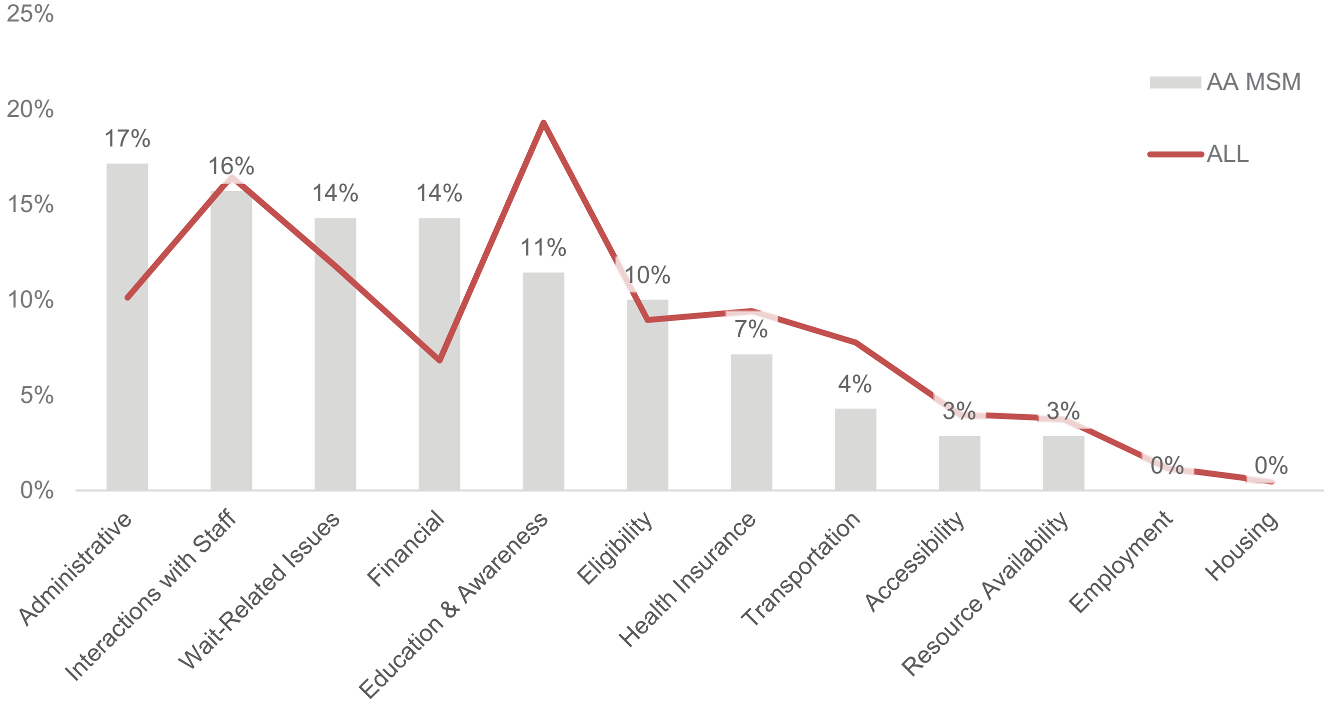
(**Graph 4**) Eighty-six (86) African American MSM participants cited barriers to Ryan White funded HIV care services. African American MSM participants most often cited barriers related to administrative issues (17%), interactions with staff (16%), wait related issues (14%), and financial barriers (14%).

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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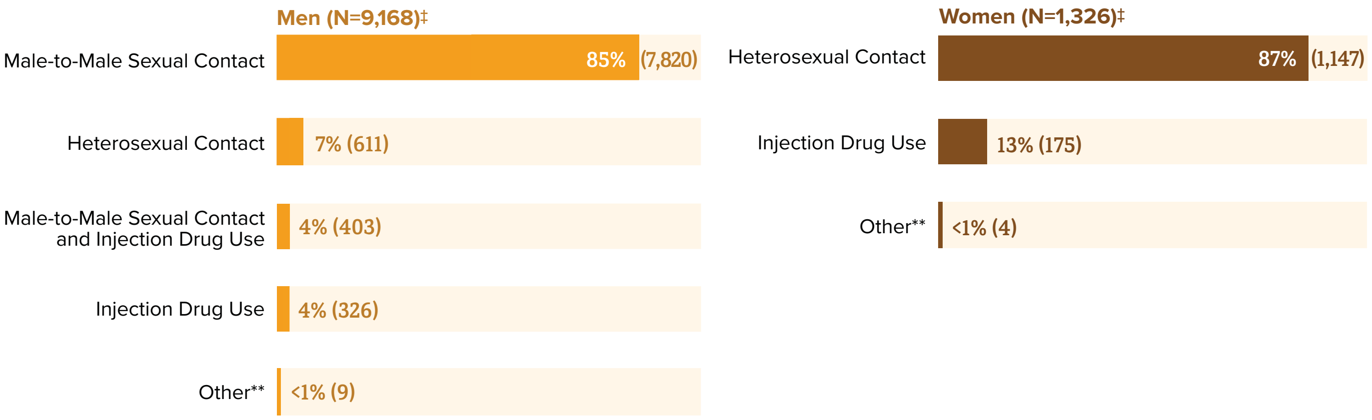
Fax: (713) 572-3740
Web: rwpchouston.org

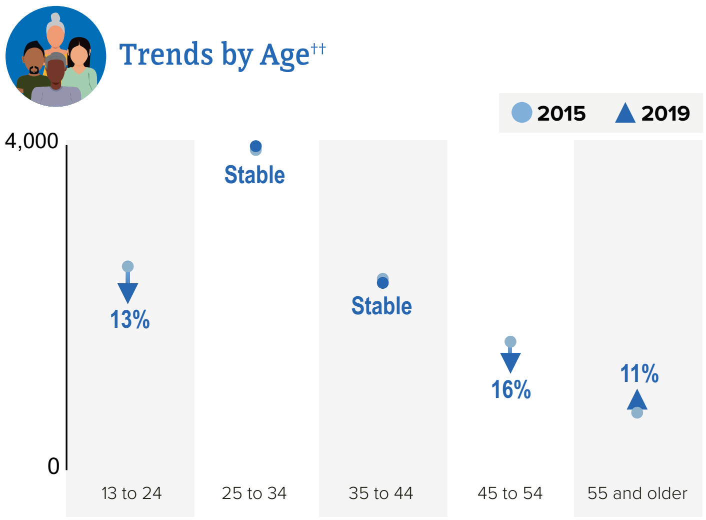
HIV and Hispanic/Latino People

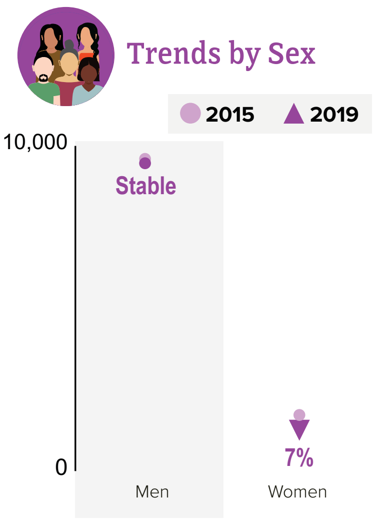
Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2019, 29% (10,494) were among Hispanic/Latino people.[†]

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.





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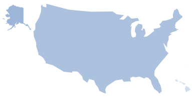
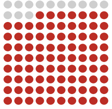
[*] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
[†] Hispanic/Latino people can be of any race.
[‡] Based on sex assigned at birth and includes transgender people.
[**] Includes perinatal exposure, blood transfusion, hemophilia, and 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.



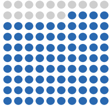
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.[#] **Of those, 294,200 were Hispanic/Latino people.**

For every 100 people with HIV



87 knew their HIV status.

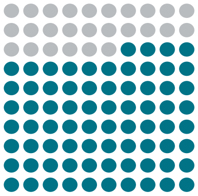
For every 100 Hispanic/Latino people with HIV



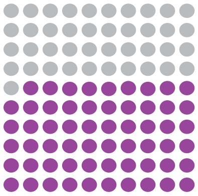
84 knew their HIV status.

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.

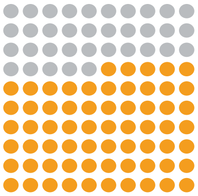
Compared to all people with diagnosed HIV, Hispanic/Latino people have about the same viral suppression rates. For every **100 Hispanic/Latino people with diagnosed HIV in 2019**:***



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

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.

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.

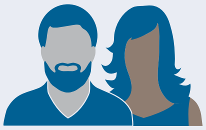
Ryan White HIV/AIDS Program Fast Facts: Hispanic/Latino Clients

23.3%

of All RWHAP Clients

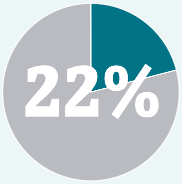
62.8% Live at or Below **100%** of the Federal Poverty Level

90.1% 2019 Are Virally Suppressed



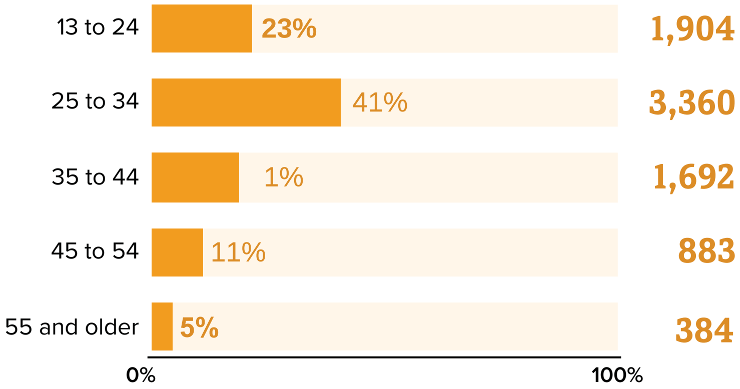
42.0% Are Aged 50+

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.[‡][**]

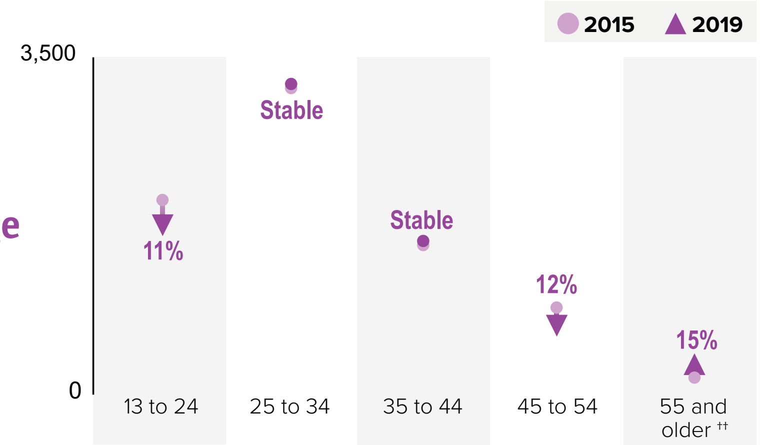
About 2 out of 3 Hispanic/Latino gay and bisexual men who received an HIV diagnosis were aged 13 to 34.



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.

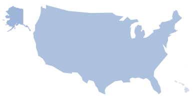
[‡] This fact sheet uses the term *gay and bisexual men* to represent gay, bisexual, and other men who reported male-to-male sexual contact aged 13 and older.

[**] 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.

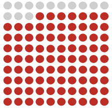
[‡‡] In 50 states and the District of Columbia.

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.



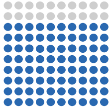
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.[‡‡] **Of those, 202,000 were Hispanic/Latino gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

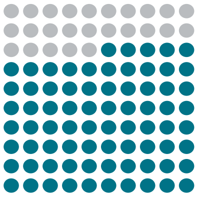
For every 100 Hispanic/Latino gay and bisexual men with HIV



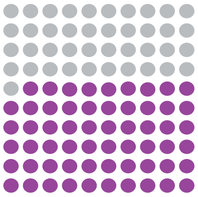
80 knew their HIV status.[***]

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.

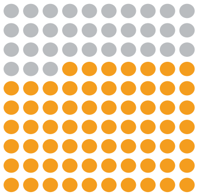
Compared to all people with diagnosed HIV, Hispanic/Latino gay and bisexual men have about the same viral suppression rates. For every **100 Hispanic/Latino gay and bisexual men with diagnosed HIV in 2019**:[†††]



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).

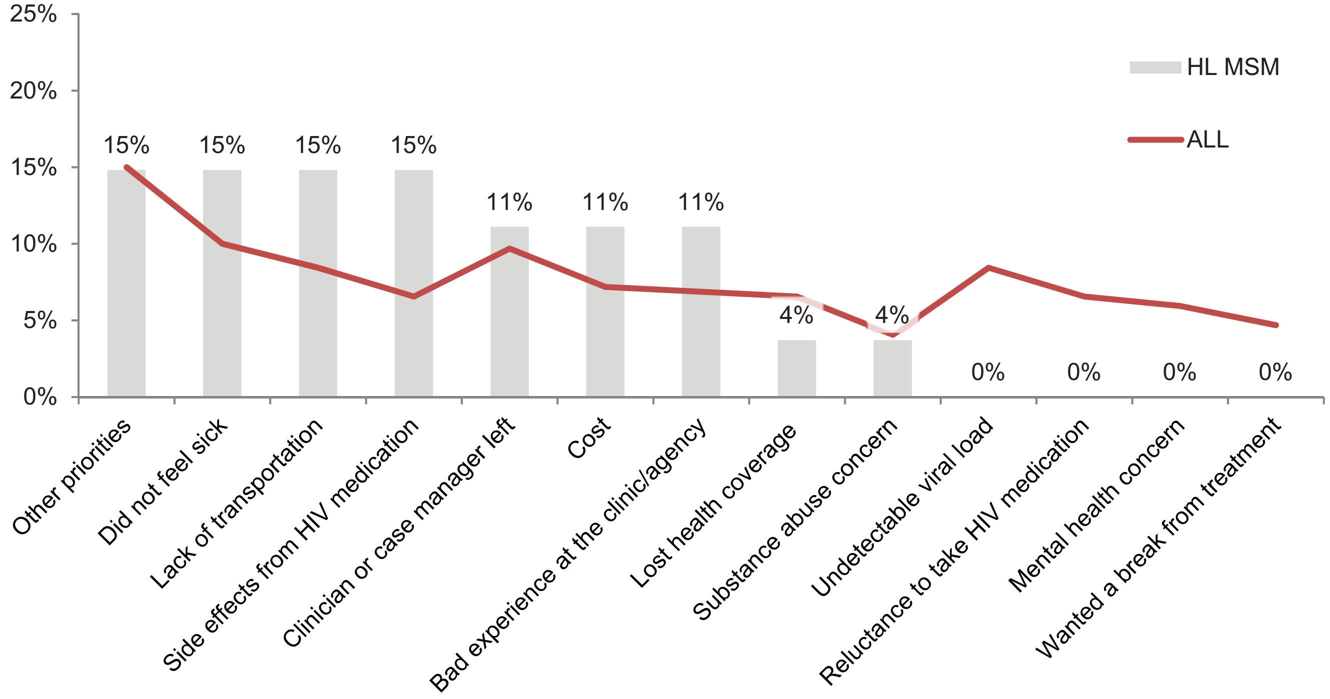
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months of more since their diagnosis, 81% of Hispanic/Latino MSM needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering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

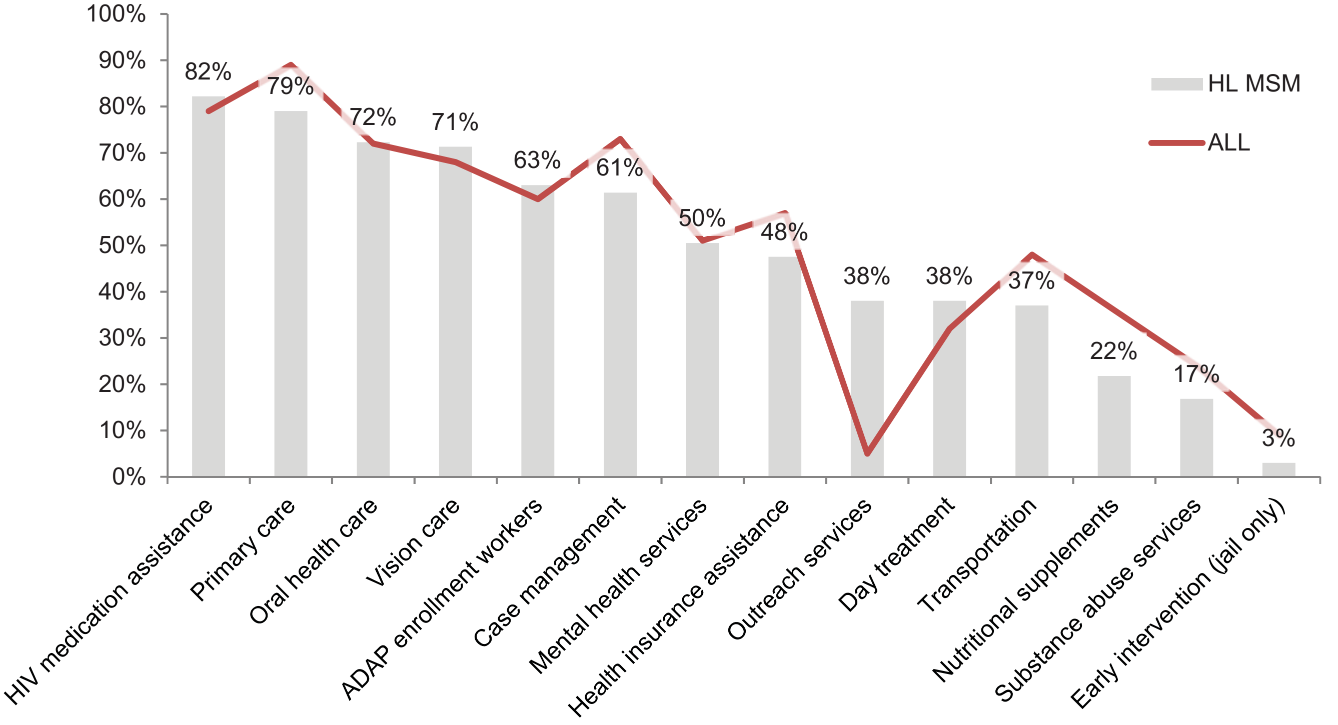
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

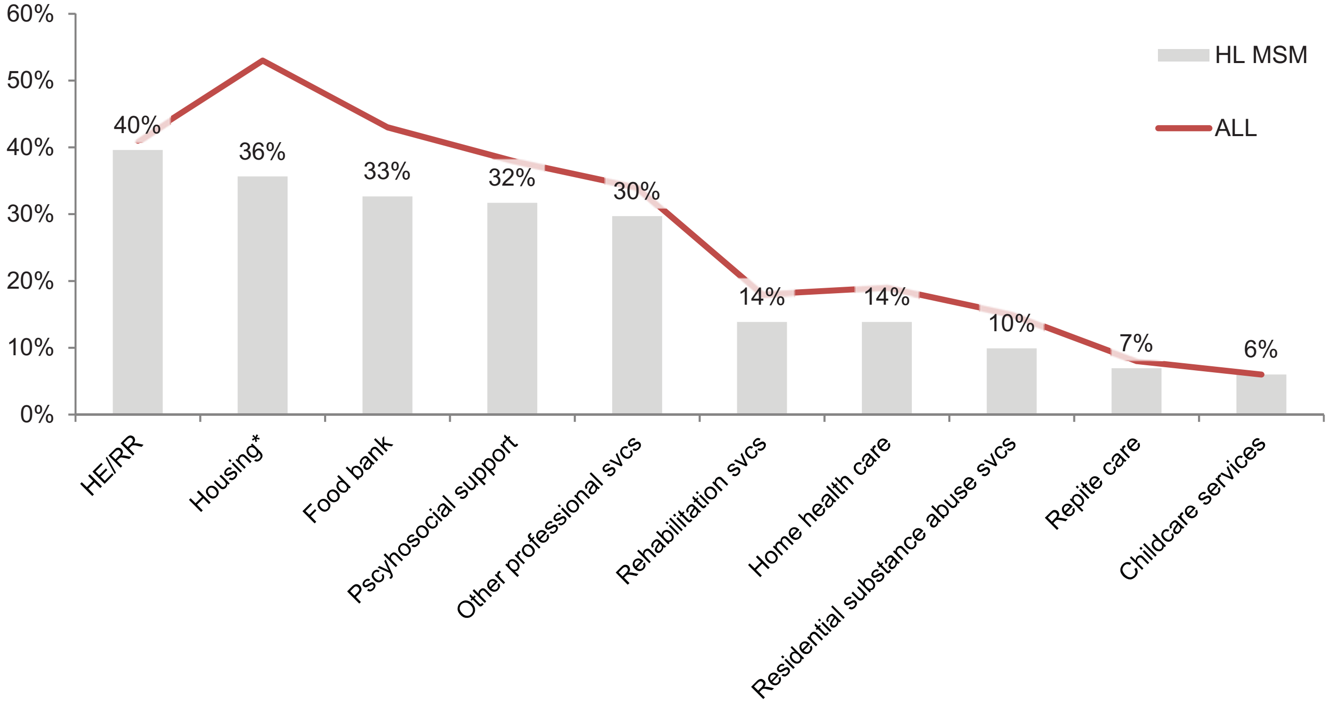
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, 40% of Hispanic/Latino MSM reported need for health education & risk reduction services as the most needed. Additionally, Hispanic/Latino MSM reported a need for housing (36%), food bank (33%), and psychosocial support services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

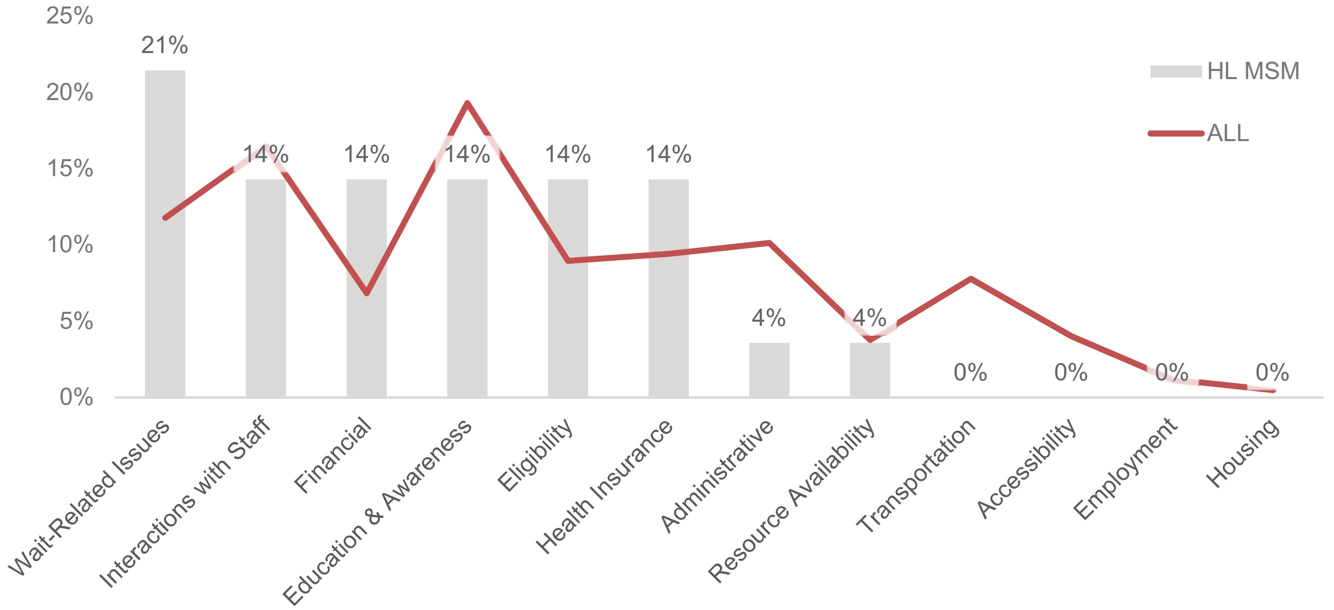
(**Graph 4**) Sixteen (16) Hispanic/Latino MSM participants cited barriers to Ryan White funded HIV care services. Hispanic/Latino MSM participants most often cited barriers related to wait issues (21%), interactions with staff at the agency or clinic, financial barriers, and education and awareness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

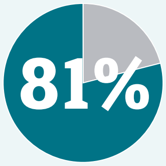


Works Cited

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.

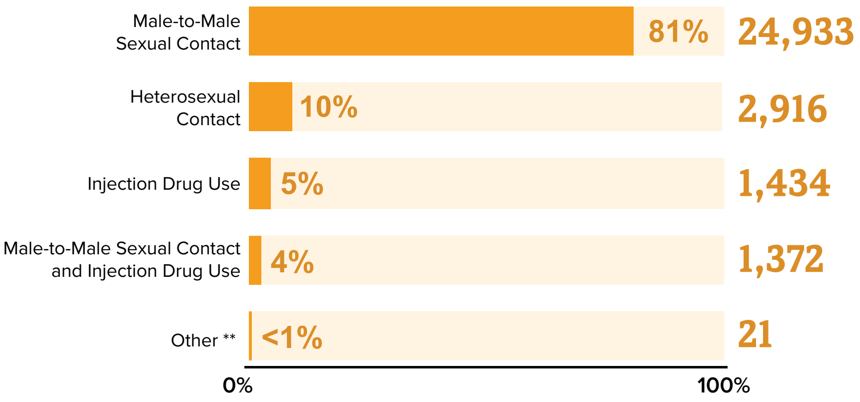
For more information or a copy of the full 2020 Houston HIV Care Services Needs Assessment contact:
Houston Area Ryan White Planning Council
2223 West Loop South #240
Houston, TX 77027
Tel: (832) 927-7926
Fax: (713) 572-3740
Web: rwpchouston.org

HIV and Men



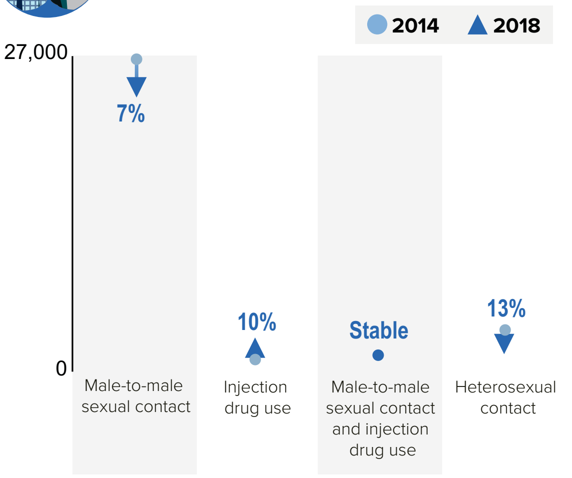
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 81% were among men.†‡

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

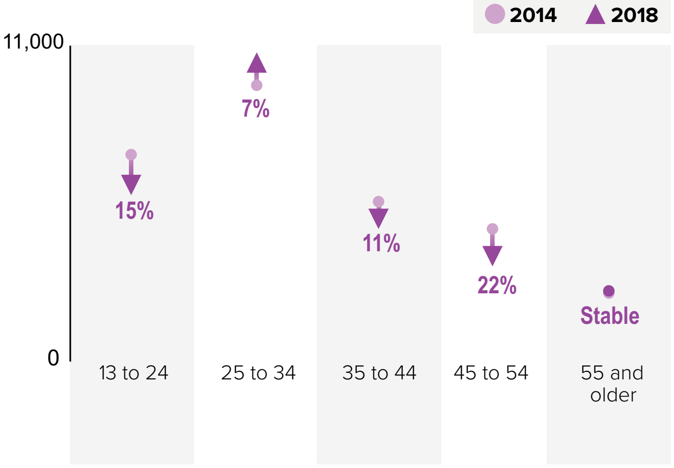


From 2014 to 2018, HIV diagnoses decreased 7% among men overall, but trends varied for different groups of men.

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.

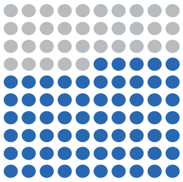
Men who don’t know they have HIV cannot get the care and treatment they need to stay healthy.

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

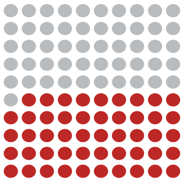
6 in 7 men knew they had the virus.

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.

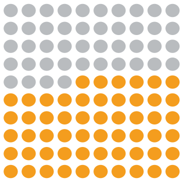
When compared to people overall with HIV, men have the same viral suppression rates. But more work is needed to increase these rates. In 2018, for every **100 men with HIV**:††



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.

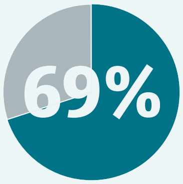
How is CDC making a difference for men?

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

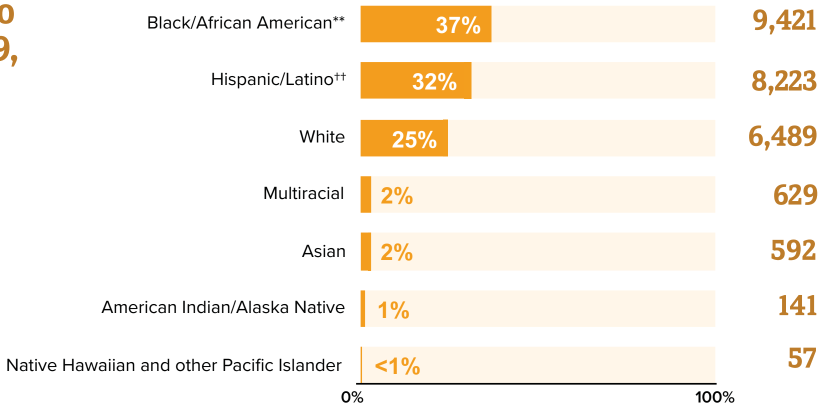
For more information visit www.cdc.gov/hiv

HIV and Gay and Bisexual Men



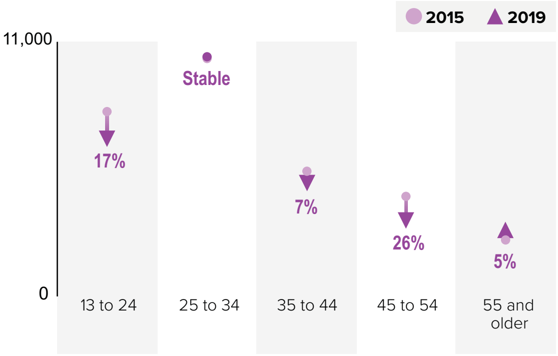
Of the **36,801 NEW HIV DIAGNOSES** in the US and dependent areas[*] in 2019, 69% (25,552) were among gay and bisexual men.[†‡]

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

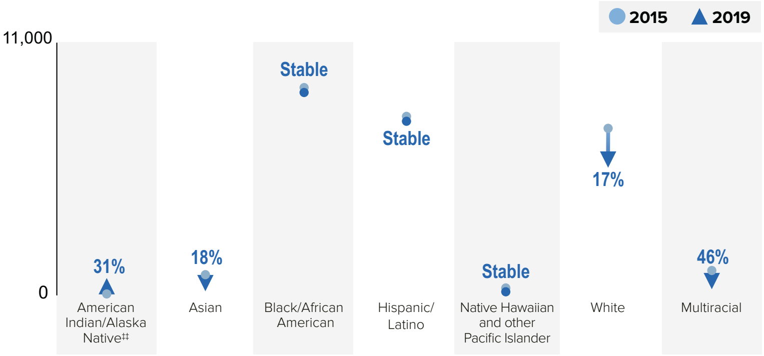


From 2015 to 2019, HIV diagnoses decreased 9% among gay and bisexual men overall.

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).

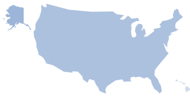
[**] *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

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

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

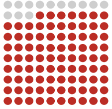
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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



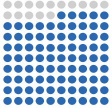
In 2019, an estimated **1.2 MILLION PEOPLE** had HIV.[***] **Of those, 754,700 were gay and bisexual men.**

For every 100 people with HIV



87 knew their HIV status.

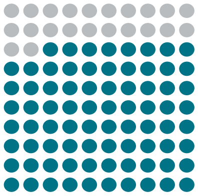
For every 100 gay and bisexual men with HIV



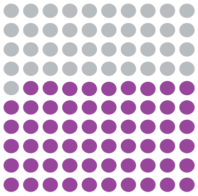
85 knew their HIV status.[†††]

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.

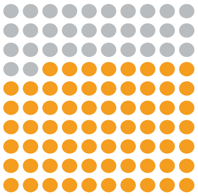
Compared to all people with diagnosed HIV, gay and bisexual men have higher viral suppression rates. For every **100 gay and bisexual men with diagnosed HIV in 2019:**[‡‡‡]



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.

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

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

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

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

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

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

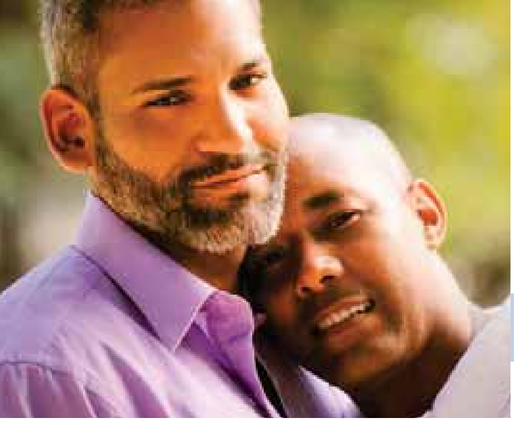
[†††] Includes infections attributed to male-to-male sexual contact *only*. Among men with HIV attributed to male-to-male sexual contact *and* injection drug use, 92% knew they had HIV.

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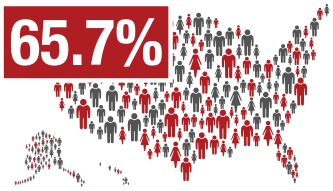
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year.

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



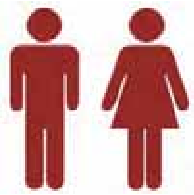
65.7% of All Male RWHAP Clients

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

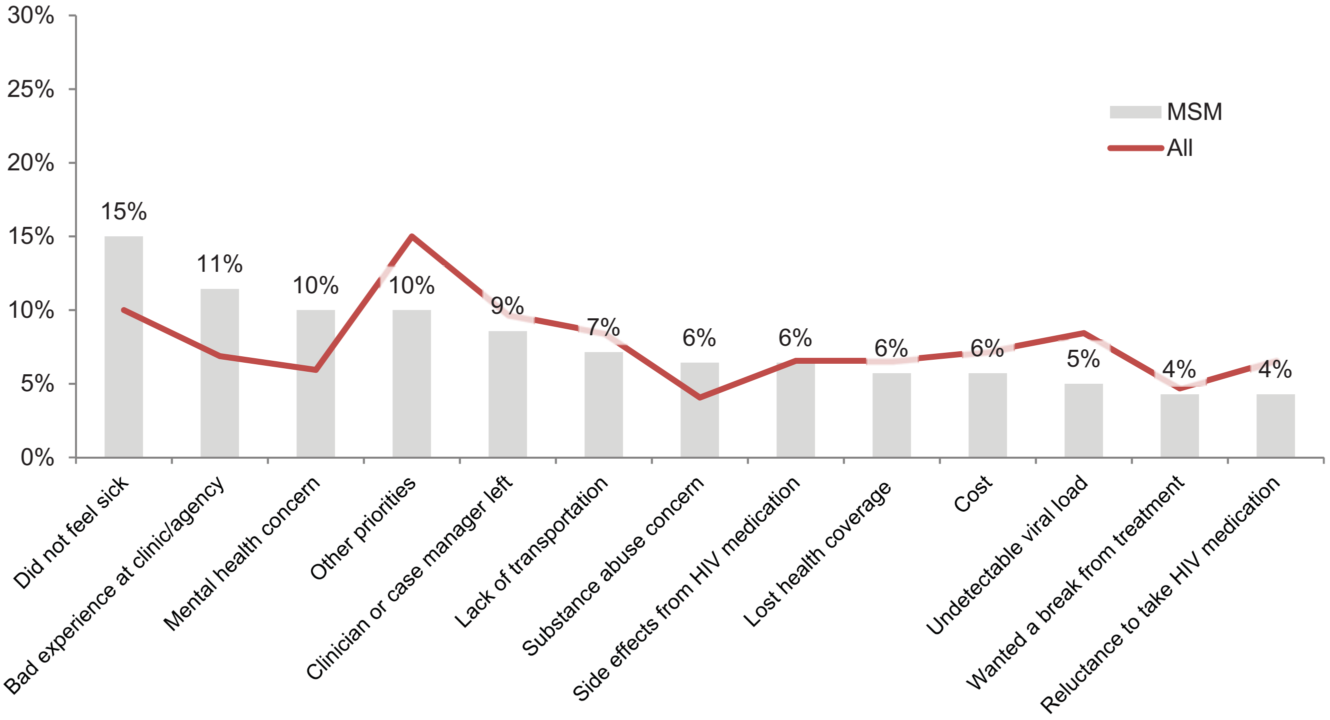
As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2018) in order to produce proportional results (See: *Methodology*, full document).

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.



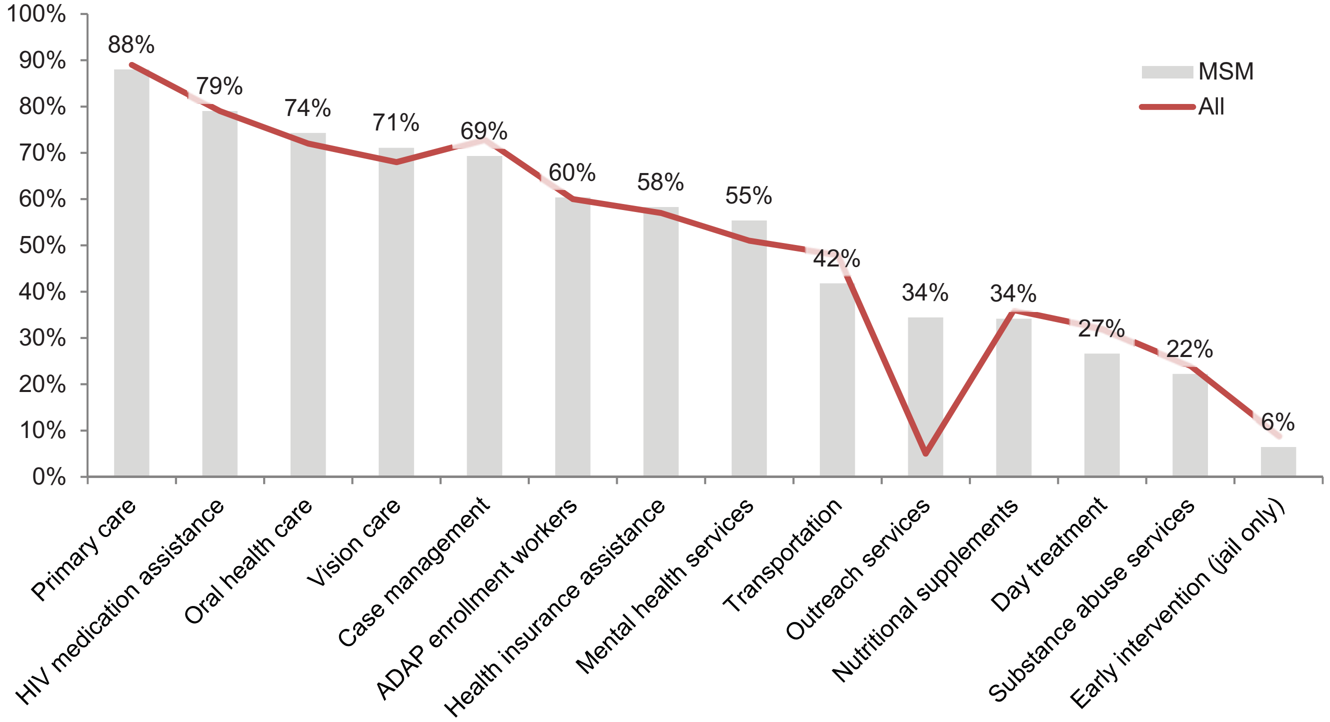
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.

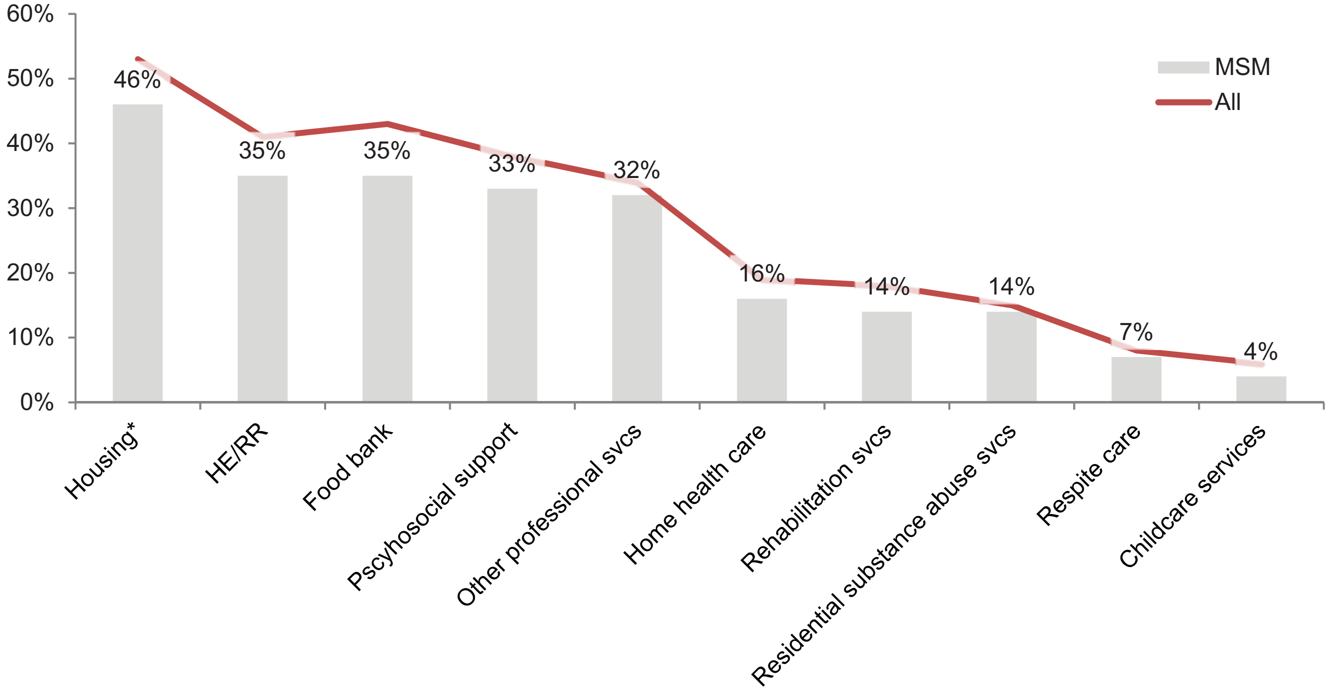
(**Graph 3**) Among the 10 other/non-Ryan White funded HIV-related services, forty-six percent (46%) of MSM participants reported housing as the most needed. Additionally, MSM participants reported a need for health education & risk reduction (HE/RR) (35%), food bank (35%), and psychosocial support (33%).

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

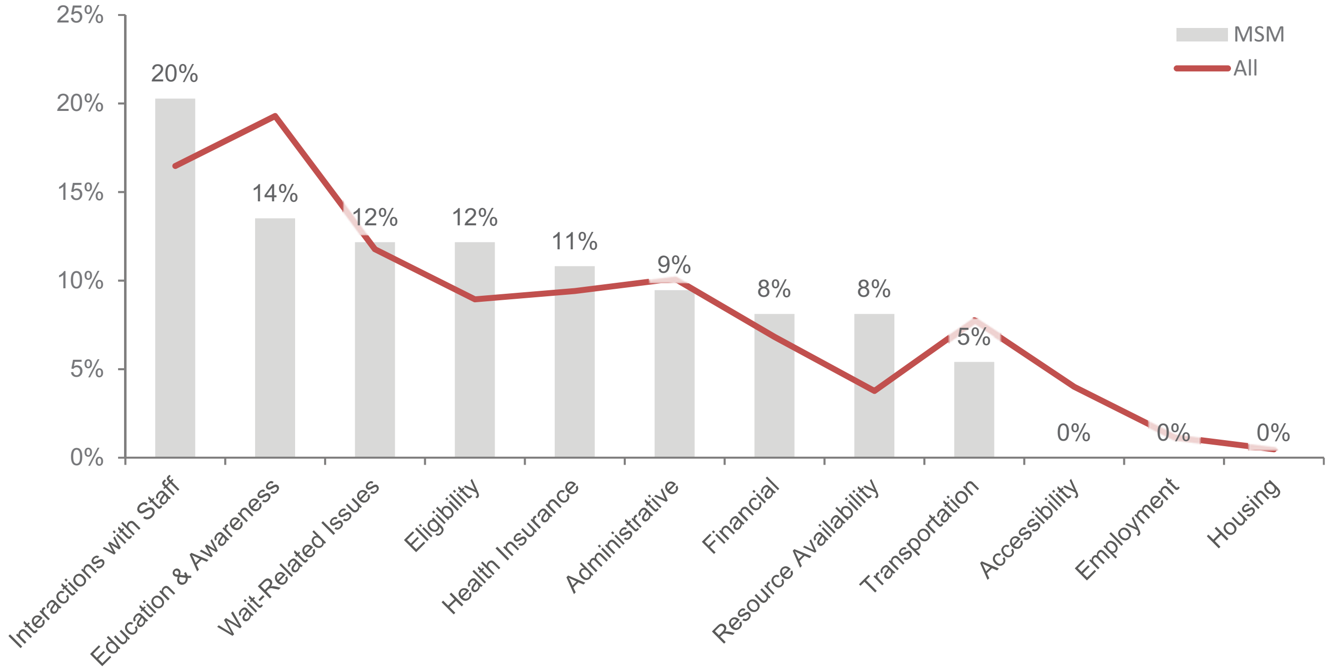
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant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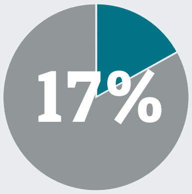
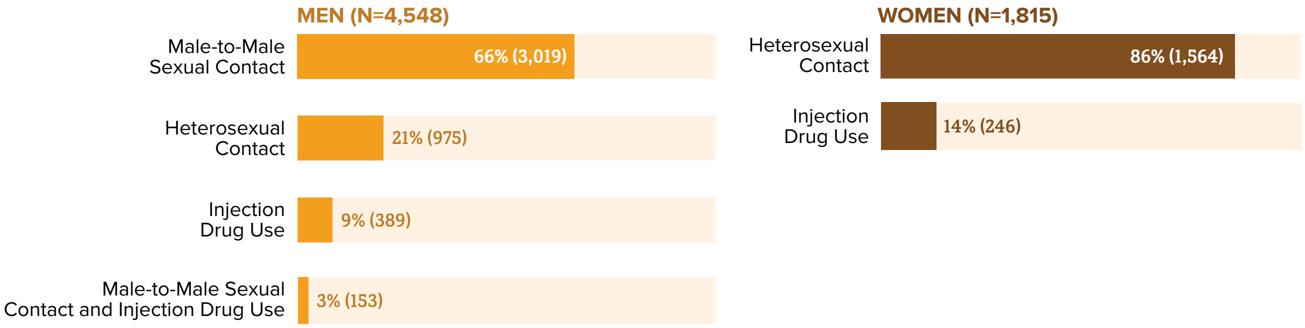
HIV and Older Americans



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

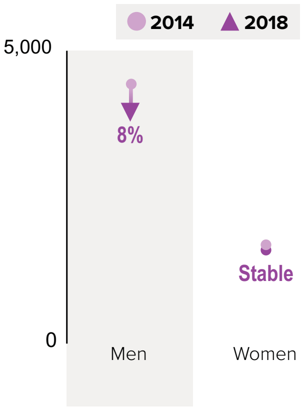
Among people aged 50 and older, most new HIV diagnoses were among men.[†]



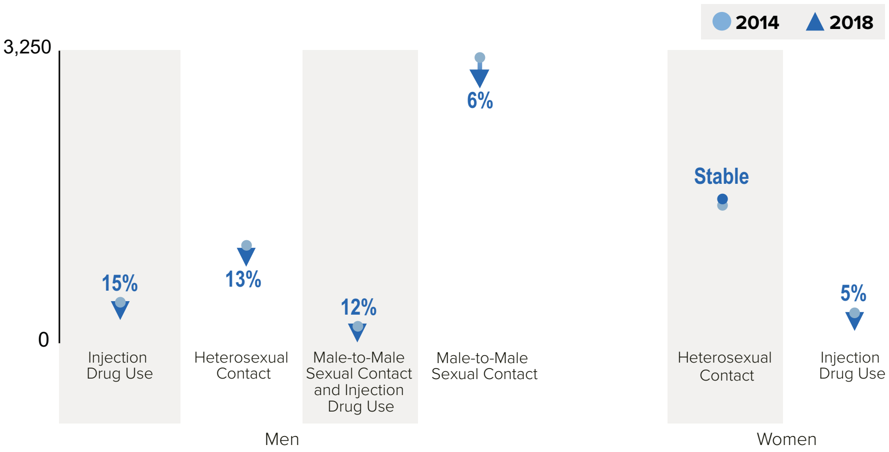
Totals may not equal 100% due to rounding.

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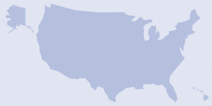
[*] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

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

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

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

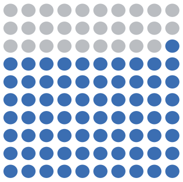


At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV.[‡] Of those, 379,000 were aged 55 and older.

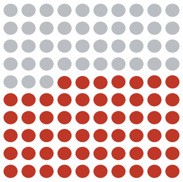
9 in 10
people aged 55 and older knew they had the virus.

It is important for people aged 50 and older to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

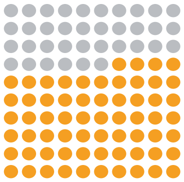
Compared to all people with HIV, people aged 55 and older have higher viral suppression rates. In 2018, for every **100 people aged 55 and older with HIV**: [‡]



71 received some HIV care



57 were retained in care



64 were virally suppressed

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

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

Fewer Discussions with Doctors

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

Knowledge of HIV Prevention

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

Delayed Treatment

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

Stigma

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

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

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

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

For more information visit www.cdc.gov/hiv

Older 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.

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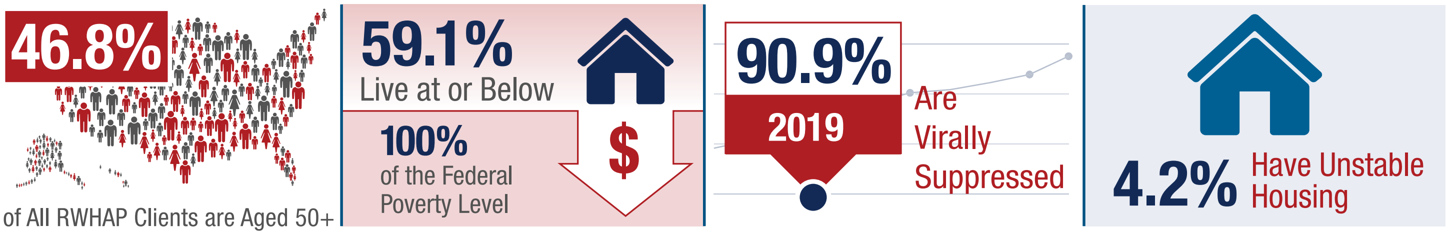
* Viral suppression is defined as a viral load result of less than 200 copies/mL at most recent test, among people with HIV who had at least one outpatient ambulatory health services visit and one viral load test during the measurement year

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

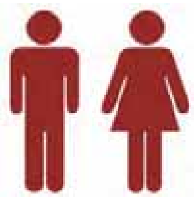


46.8% of All RWHAP Clients are Aged 50+

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

90.9% **2019** Are Virally Suppressed

4.2% Have Unstable Housing



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

	Youth %	Aging %	Total %		Youth %	Aging %	Total %		Youth %	Aging %	Total %
County of residence				**Sex at birth**				**Primary race/ethnicity**			
Harris	89%	94%	95%	Male	84%	66%	66%	White	11%	17%	14%
Montgomery	5%	1%	1%	Female	16%	34%	34%	African American/Black	53%	62%	60%
Walker	5%	0%	1%	Intesex	0%	0%	0%	Hispanic/Latino	5%	14%	21%
Fort Bend	0%	2%	2%	Other	0%	0%	0%	Asian American	5%	1%	1%
Other	0%	3%	1.6%	Transgender/Gender Non-Conforming	17%	2%	4%	Native American or Native Alaskan	0%	1%	1%
				Currently pregnant	0%	0%	2%				
Sexual orientation				**Health insurance (multiple response)**				**Immigration status**			
Heterosexual	22%	61%	57%	Private insurance	0%	7%	9%	Born in the U.S.	100%	89%	88%
Gay/Lesbian	44%	28%	30%	Medicaid/Medicare	21%	56%	67%	Citizen > 5 years	0%	10%	10%
Bisexual/Pansexual	28%	9%	9%	Harris Health System	17%	21%	29%	Citizen < 5 years	0%	1%	1%
Other	6%	2%	3.8%	Ryan White Only	50%	10%	24%	Visa (student, work, tourist, etc.)	0%	0%	0.2%
				VA	0%	3%	3%	Prefer not to answer	0%	3%	0.7%
MSM	77%	37%	43%								

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).

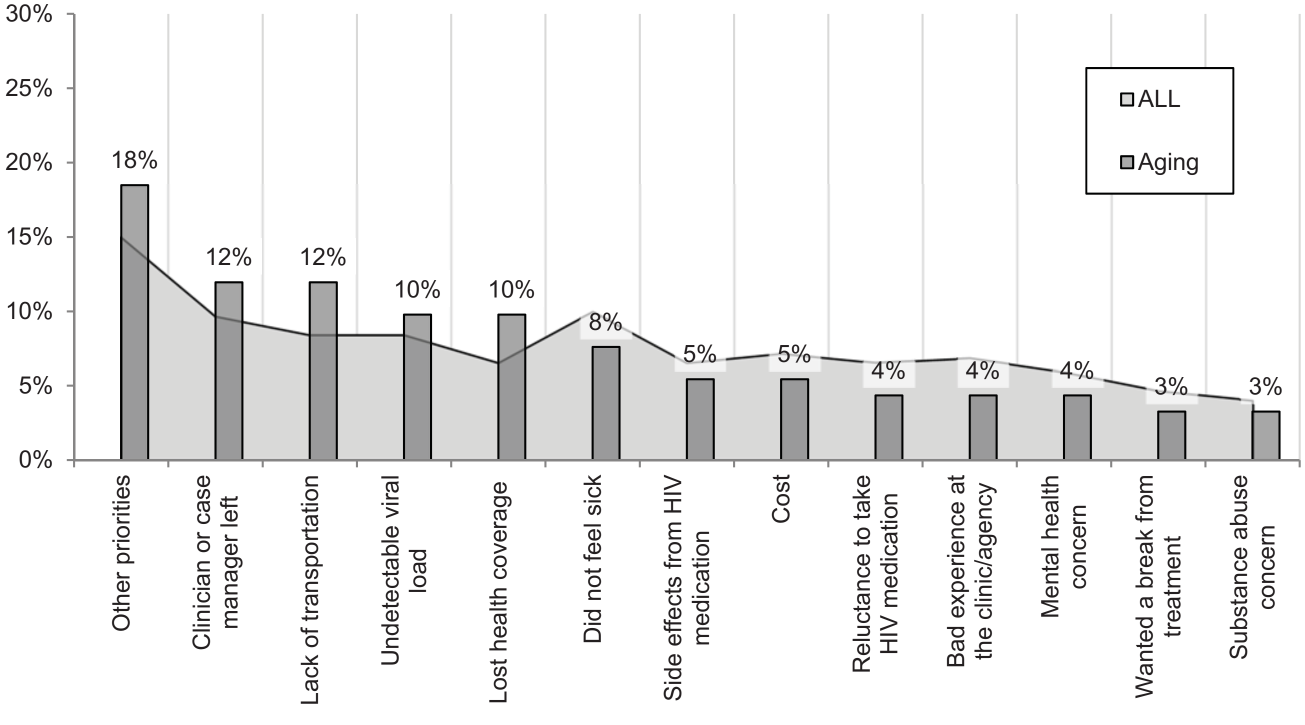
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 81% of youth and 70% of aging needs assessment participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first 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

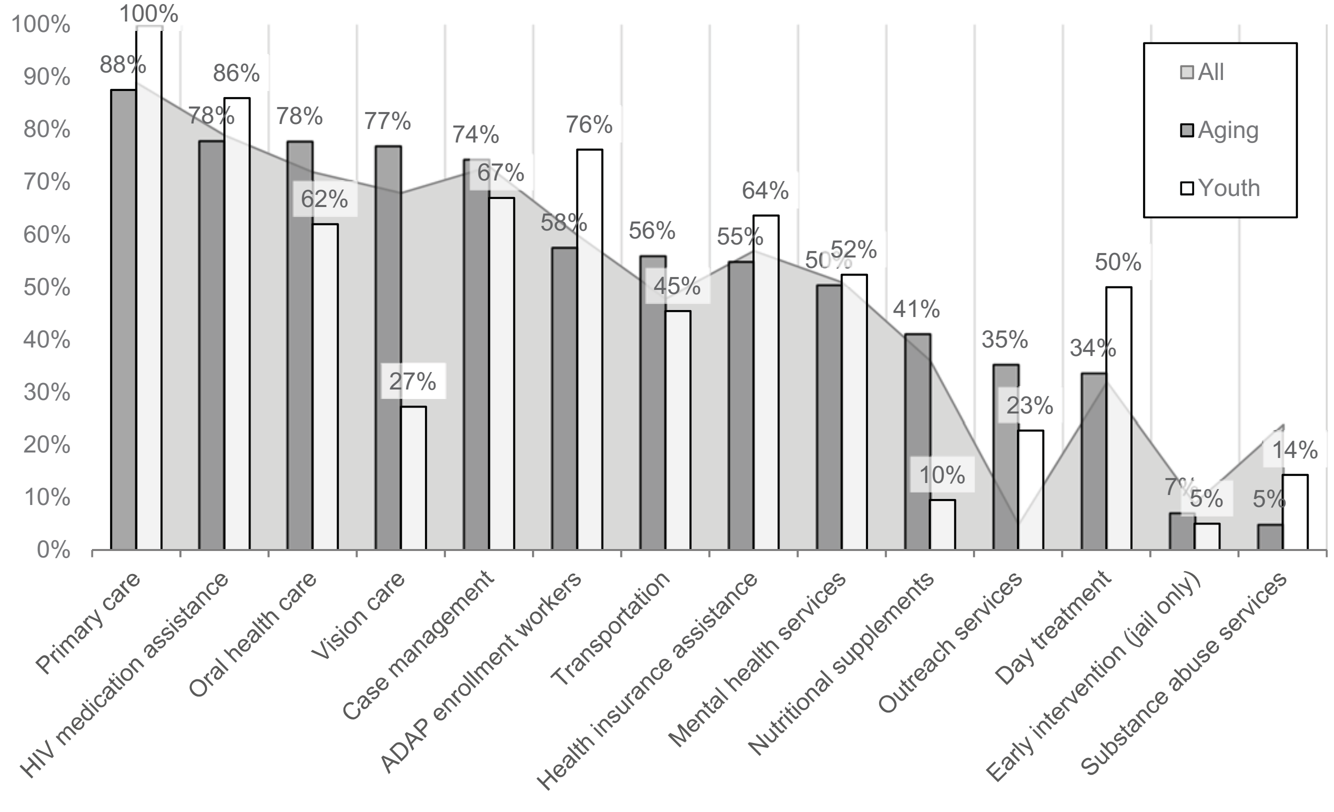
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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



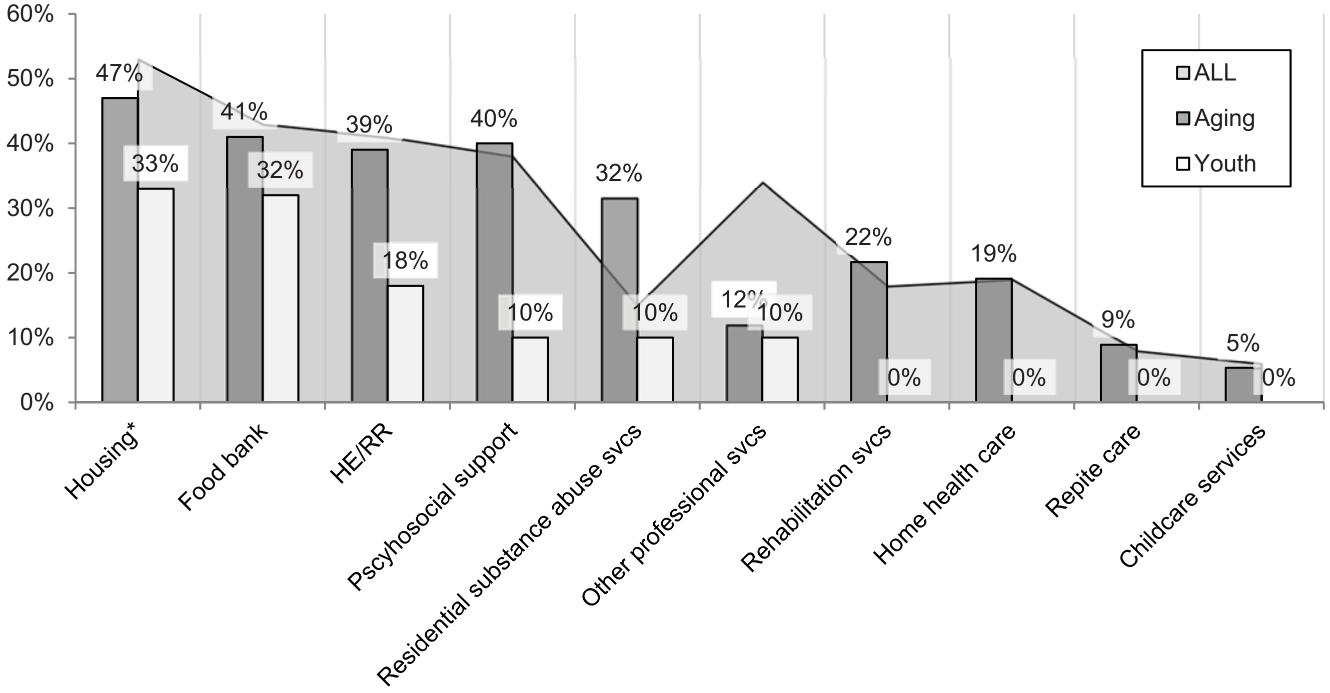
Other Identified Needs

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

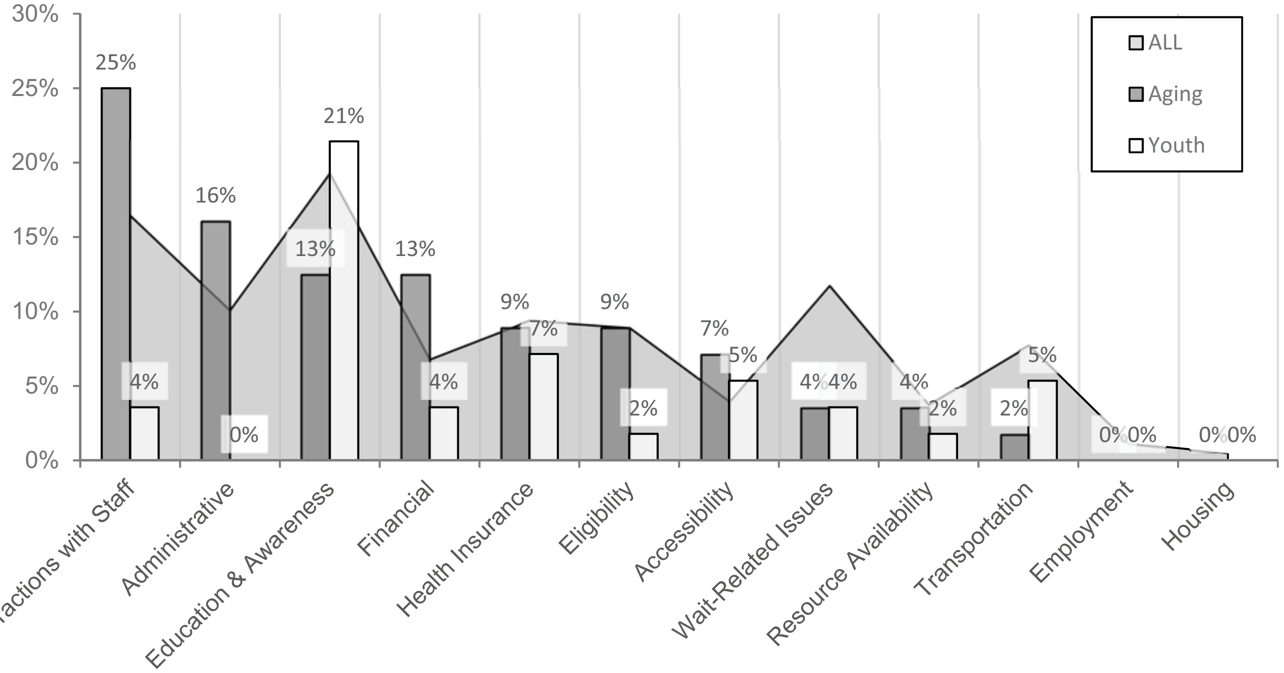
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant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

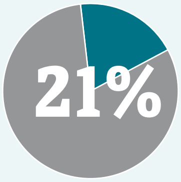
Definition: Percent of times each barrier type was reported by youth and aging needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



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

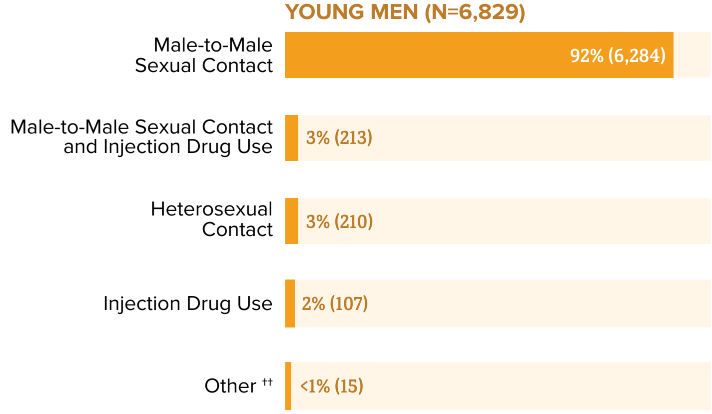
Houston Area Ryan White Planning Council
2223 West Loop South #240
Houston, TX 77027
Tel: (832) 927-7926
Fax: (713) 572-3740
Web: rwpchouston.org

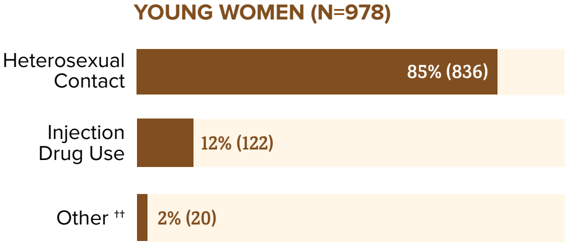
HIV and Youth



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. ‡ **

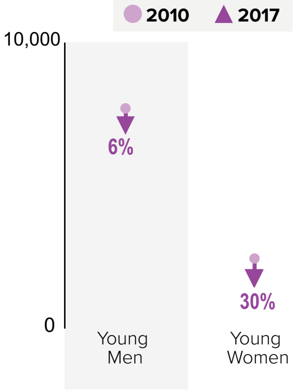




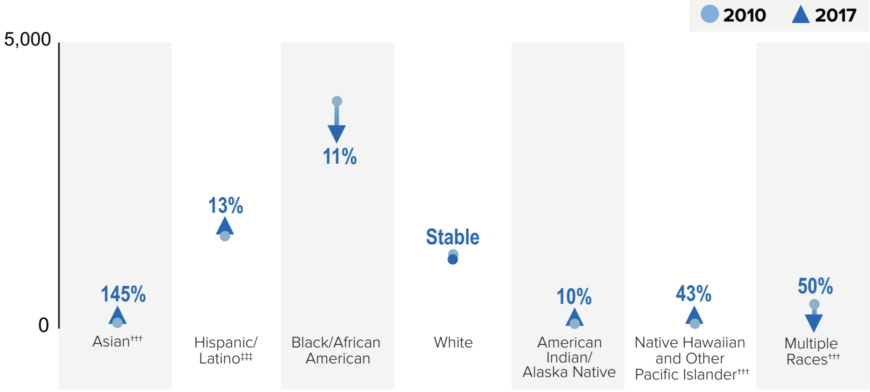
Totals may not equal 100% due to rounding.

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

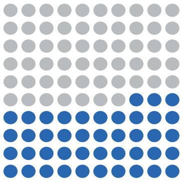
Youth who don't know they have HIV cannot get the care and treatment they need to stay healthy.

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

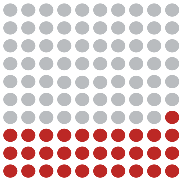
Nearly 4 in 7
youth knew they had the virus.

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.

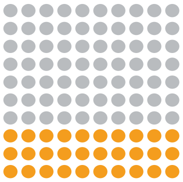
Compared to all people with HIV, youth have the lowest rates of viral suppression. **For every 100 youth with HIV:** ‡



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.

LET'S STOP HIV TOGETHER

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

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

Ending the HIV Epidemic

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

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

For more information visit www.cdc.gov/hiv

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

Youth and Young 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.

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

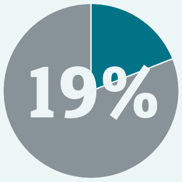
68.9%
Live at or Below
100%
of the Federal
Poverty Level

79.4%
2019
Are
Virally
Suppressed

5.8% Have Unstable
Housing

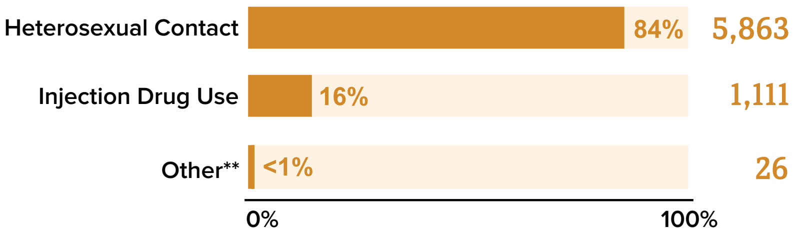
For more information on HRSA's Ryan White HIV/AIDS Program, visit: hab.hrsa.gov.

HIV and Women



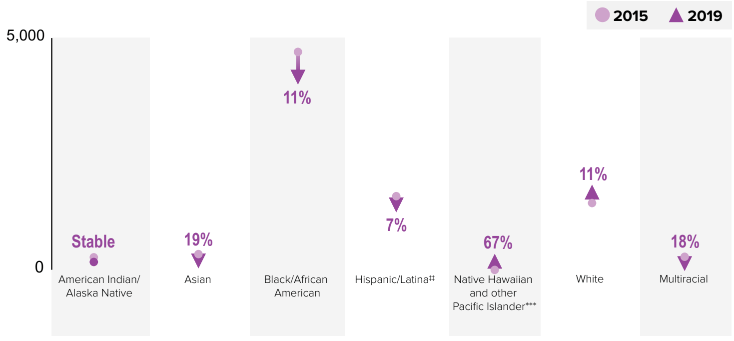
There were **36,801 new HIV diagnoses** in the US and dependent areas in 2019.* Of those, 19% (6,999) were among women.†‡

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

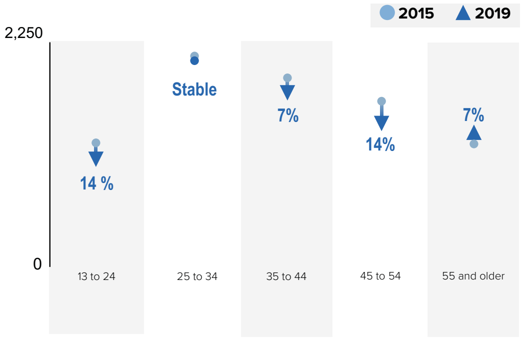


HIV diagnoses decreased 6% among women overall from 2015 to 2019. Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including Black/African American†† women and women aged 13 to 24.

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.

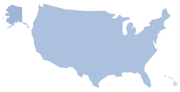
** Includes perinatal exposure, blood transfusion, hemophilia, and risk factors not reported or not identified.

†† *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.

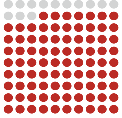
*** Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.

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



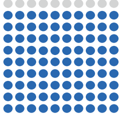
In 2019, an estimated **1.2 million PEOPLE** had HIV.††† **Of those, 263,900 were women.**‡‡‡

For every 100 people with HIV



87 knew their HIV status.

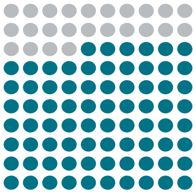
For every 100 women with HIV



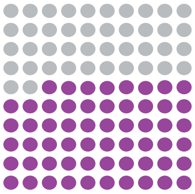
90 knew their HIV status.

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.

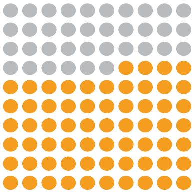
Compared to all people with diagnosed HIV, women have lower viral suppression rates. More work is needed to increase these rates. For every **100 women with diagnosed HIV** in 2019: ****



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.

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.

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.

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.
- 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.

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††† 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.

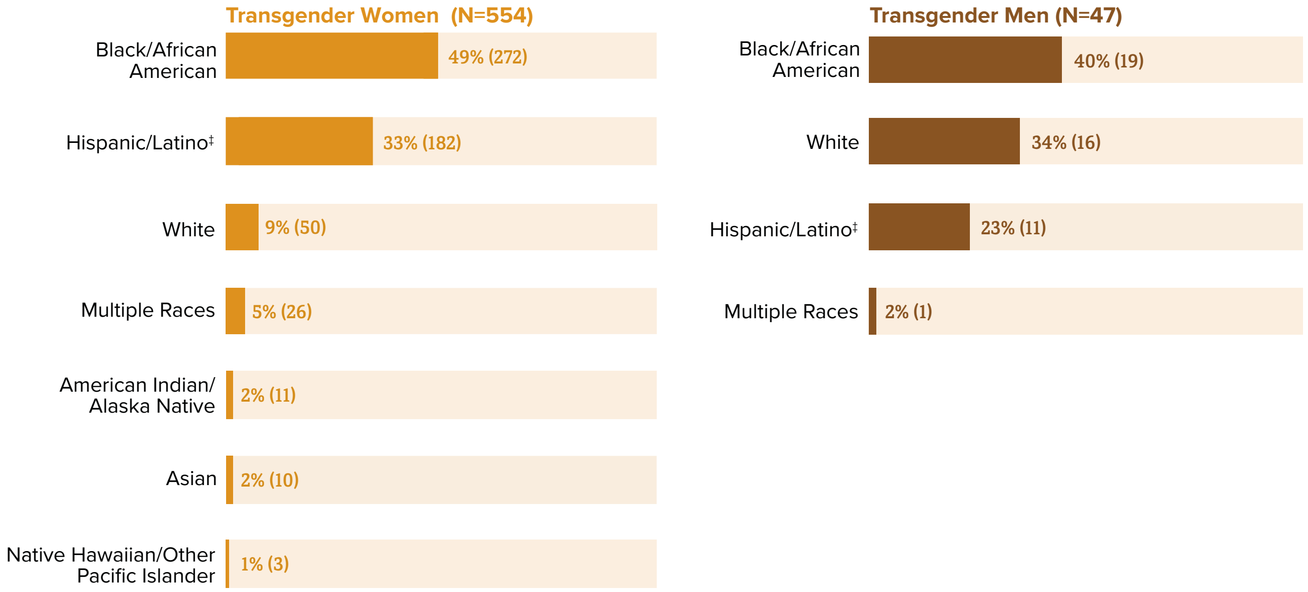
Cisgender: A person whose sex assigned at birth is the same as their gender identity or expression.

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.

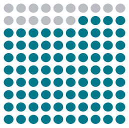
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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

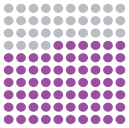
It is important for transgender people to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or remain virally suppressed) can stay healthy for many 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.

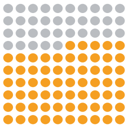
For every 100 transgender women with diagnosed HIV in 2018: **



84 received some HIV care

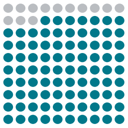


66 were retained in care

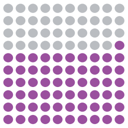


65 were virally supressed

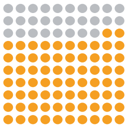
For every 100 transgender men with diagnosed HIV in 2018: **



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.

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.

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.

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.

LET'S STOP HIV TOGETHER

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

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

Ending the HIV Epidemic

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

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

For more information visit www.cdc.gov/hiv

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

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

Population Fact Sheet | June 2021

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.

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.

Ryan White HIV/AIDS Program Fast Facts: Transgender Clients

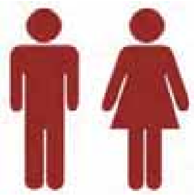
2.3%
of All RWHAP Clients

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).

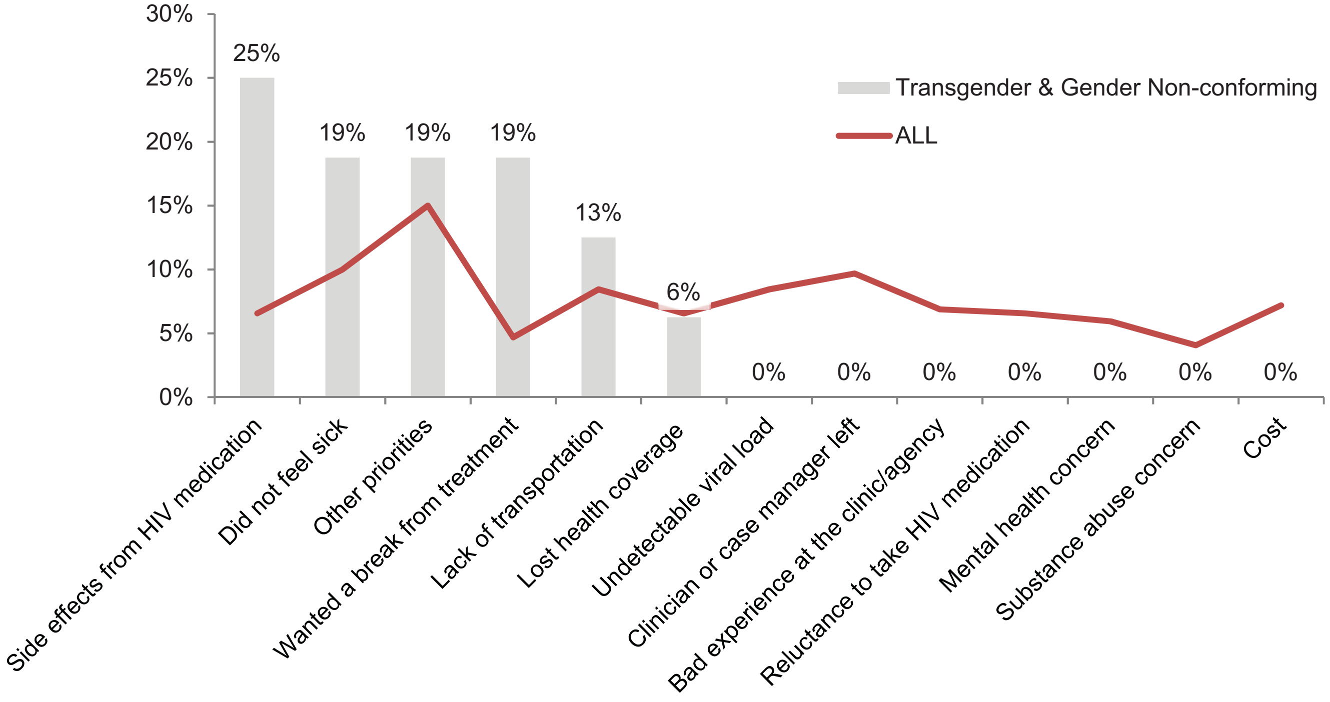
Though representing a very small overall number, the proportion of transgender and gender non-conforming participants reported a higher proportion of at least one interruption in their HIV medical care for 12 months or more since their diagnosis (42% vs 32%). Those who reported a break in HIV care for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

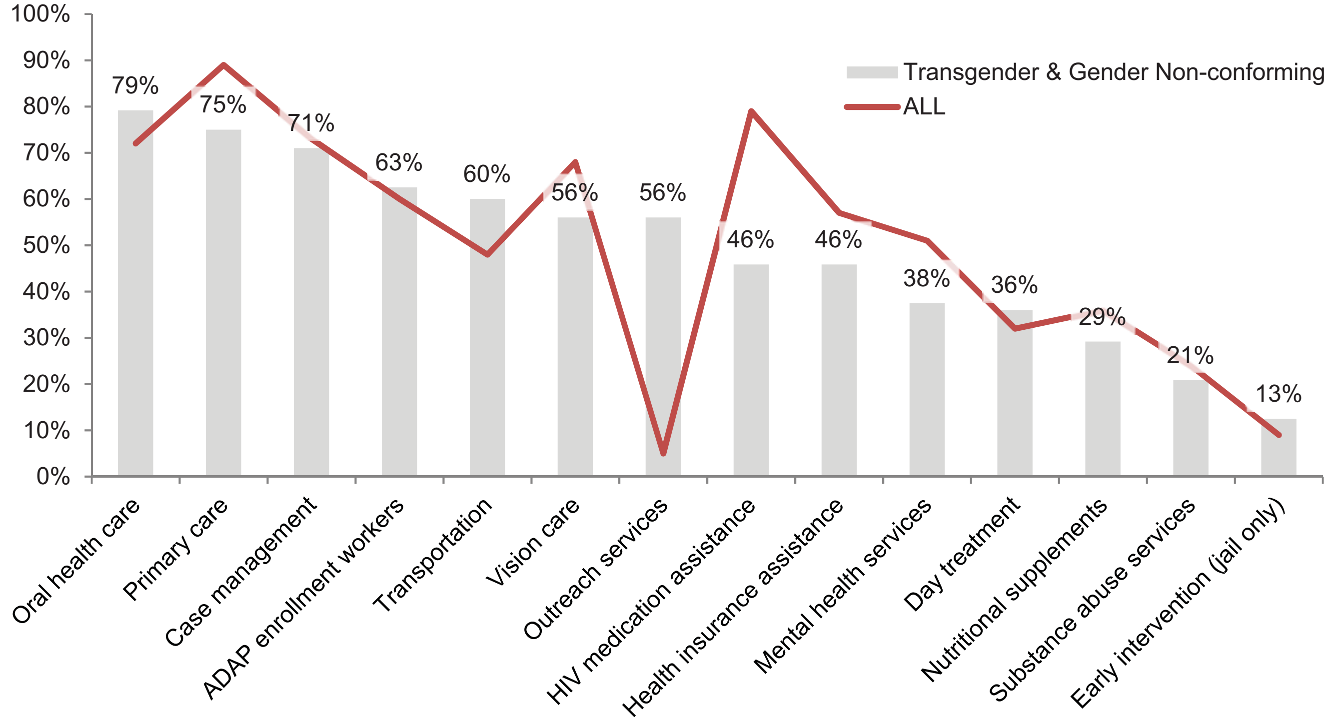
In 2020, 16 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

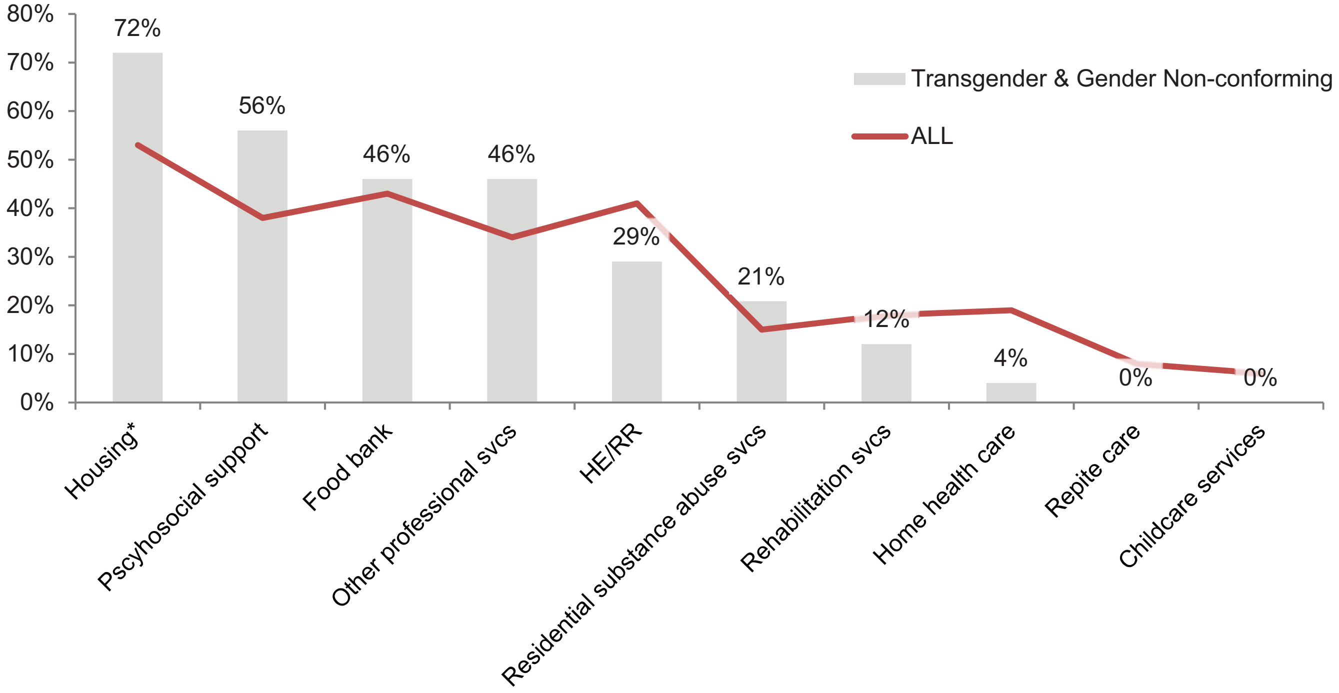
In 2020, 10 other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for PLWH in the Houston area. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these other/non-Ryan White funded HIV-related services they needed in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

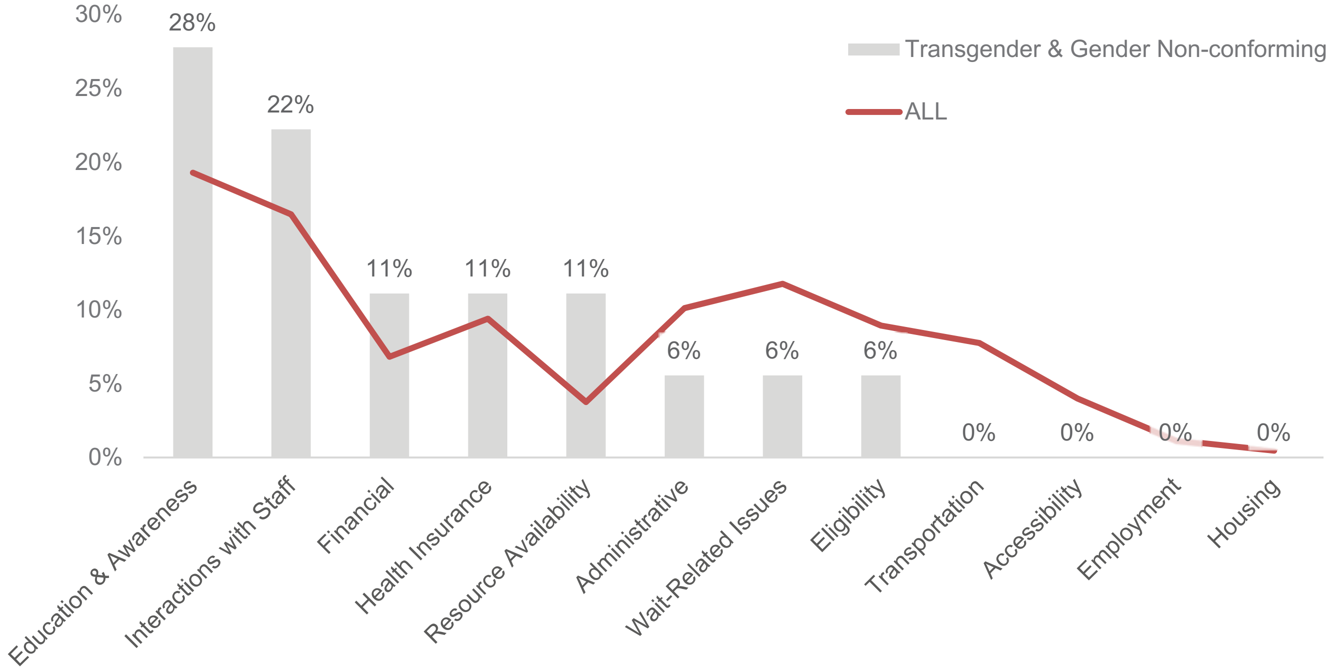
(**Graph 4**) Only 12 transgender and gender non-conforming participants cited barriers to HIV care services. As this group comprises only 50% of all transgender and gender non-conforming participants and 3.9% of the total sample, great care should be taken in applying data and conclusions from Graph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

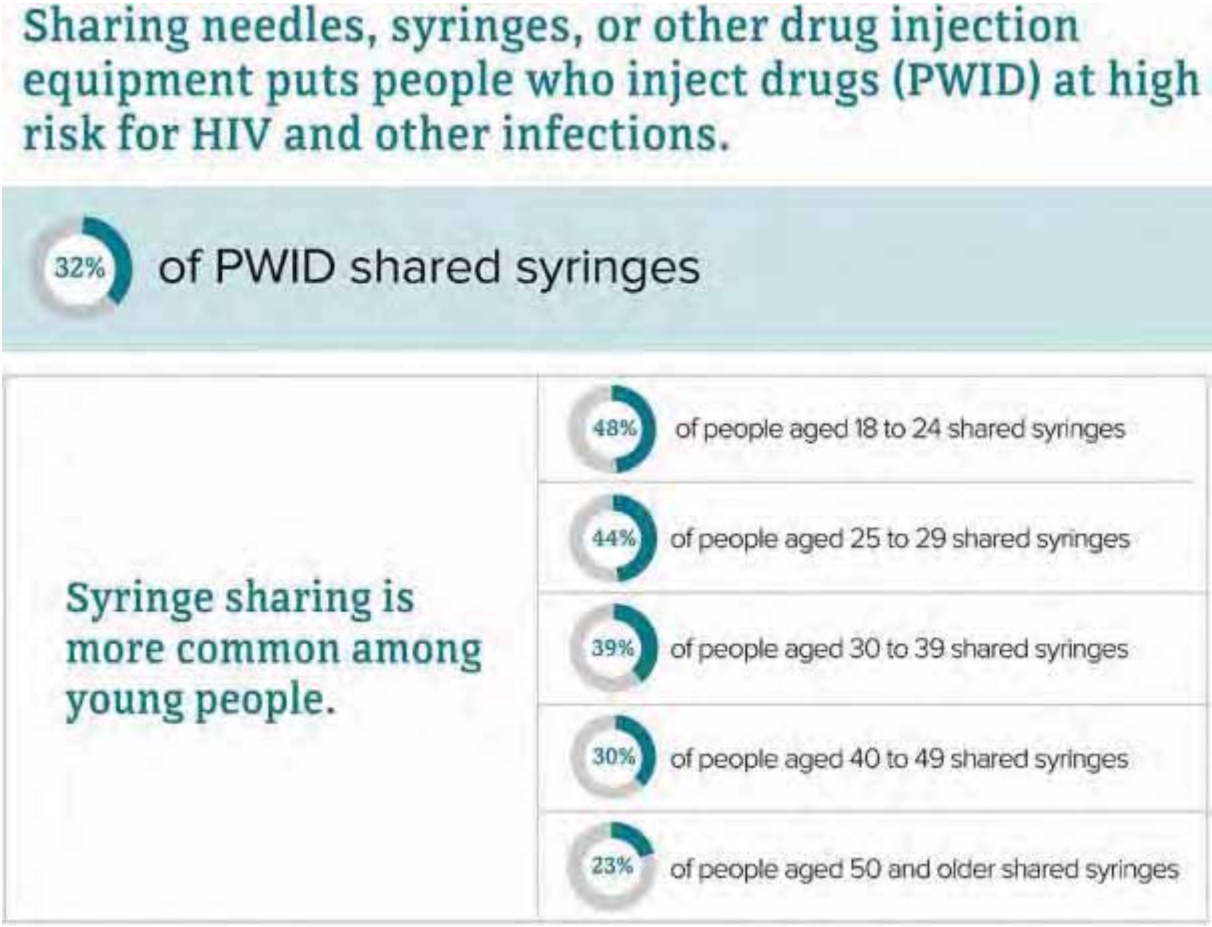
Although HIV diagnoses among PWID have remained stable in recent years, injection drug use in some areas of the United States have created prevention challenges and placed new populations at risk for HIV. This highlights the need for strengthened HIV prevention efforts for PWID, such as expanding coverage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

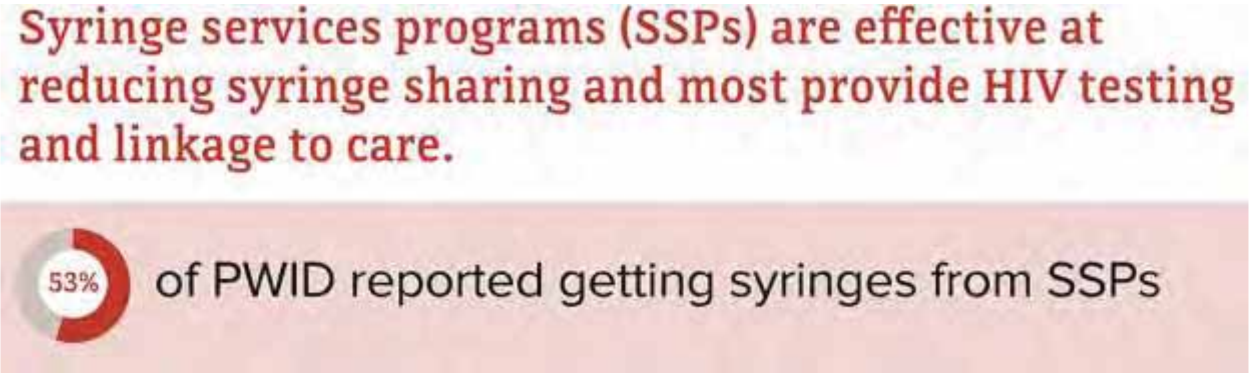
30% of people aged 40 to 49 shared syringes

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.

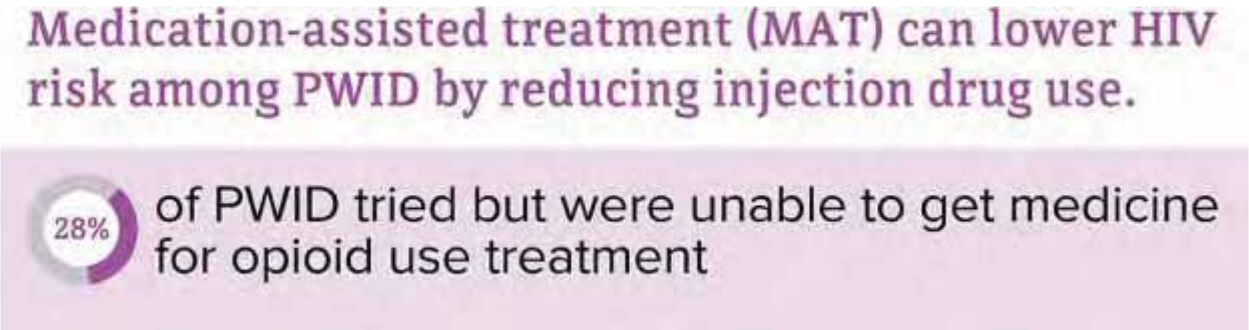


Syringe services programs (SSPs) are effective at reducing syringe sharing and most provide HIV testing and linkage to care.

53% 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.

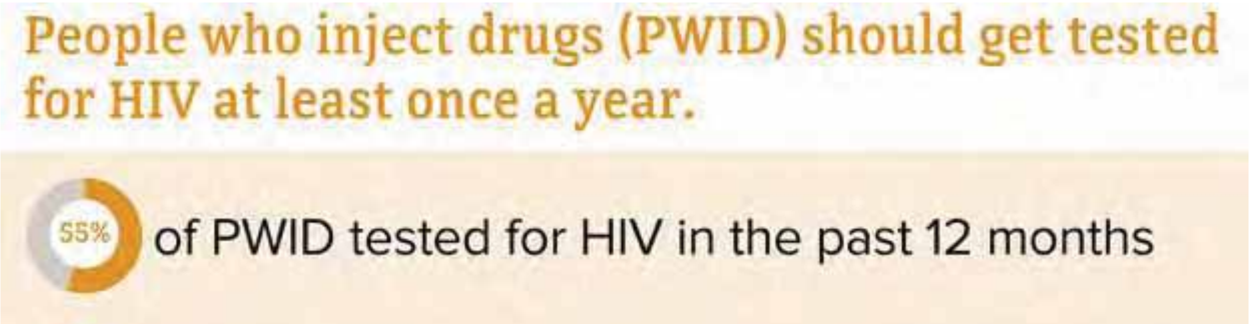


Medication-assisted treatment (MAT) can lower HIV risk among PWID by reducing injection drug use.

28% 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.



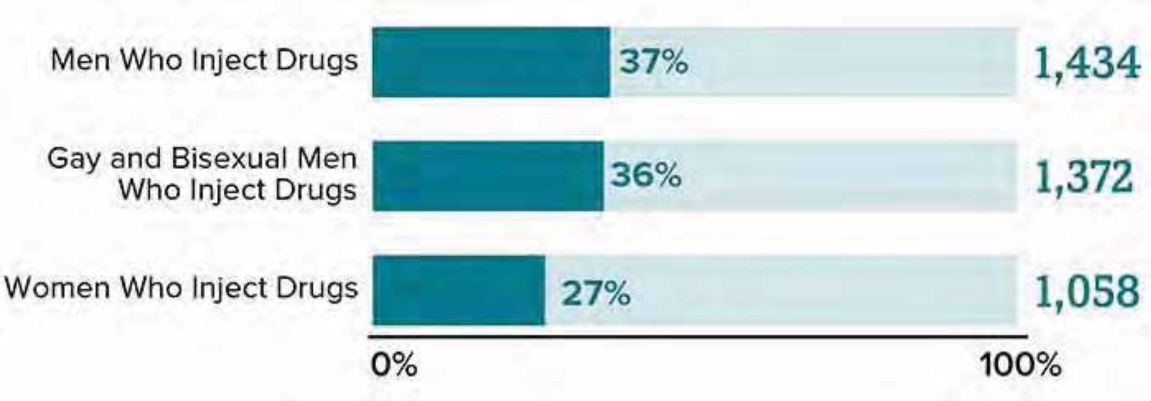
People who inject drugs (PWID) should get tested for HIV at least once a year.

55% of PWID tested for HIV in the past 12 months

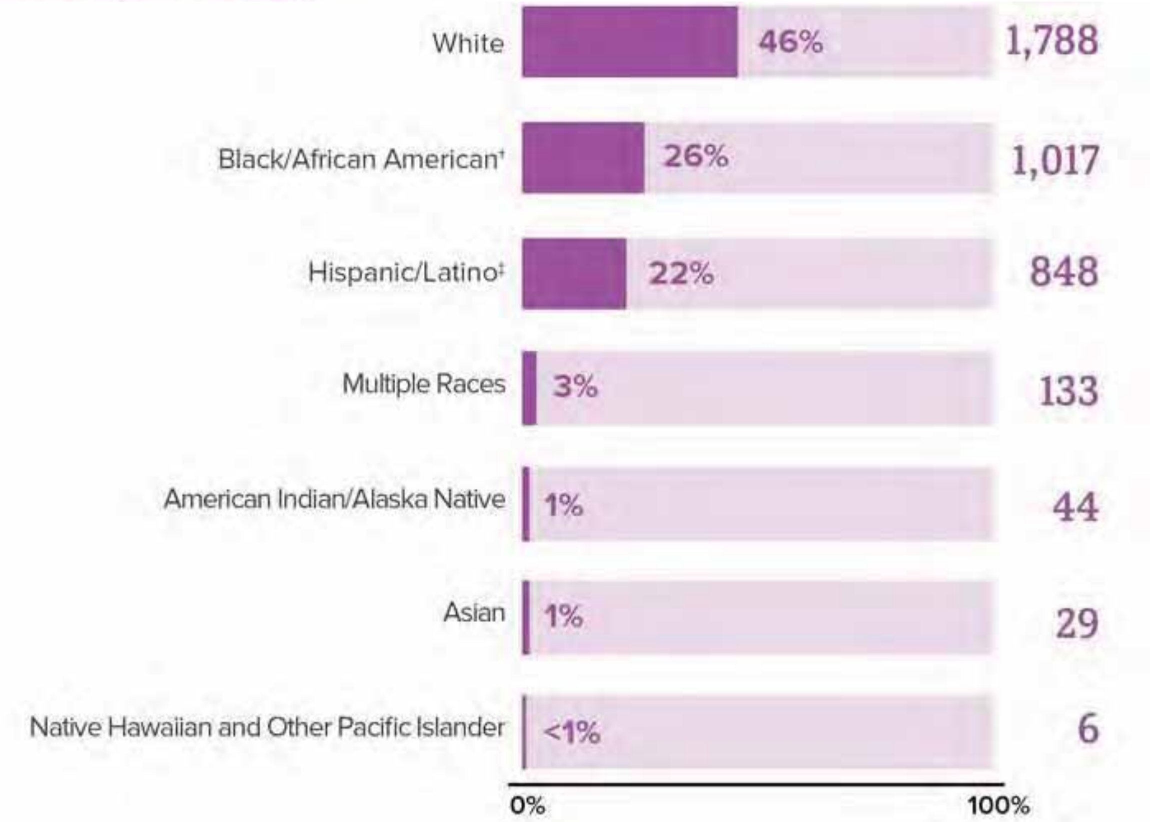
HIV Diagnoses

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.



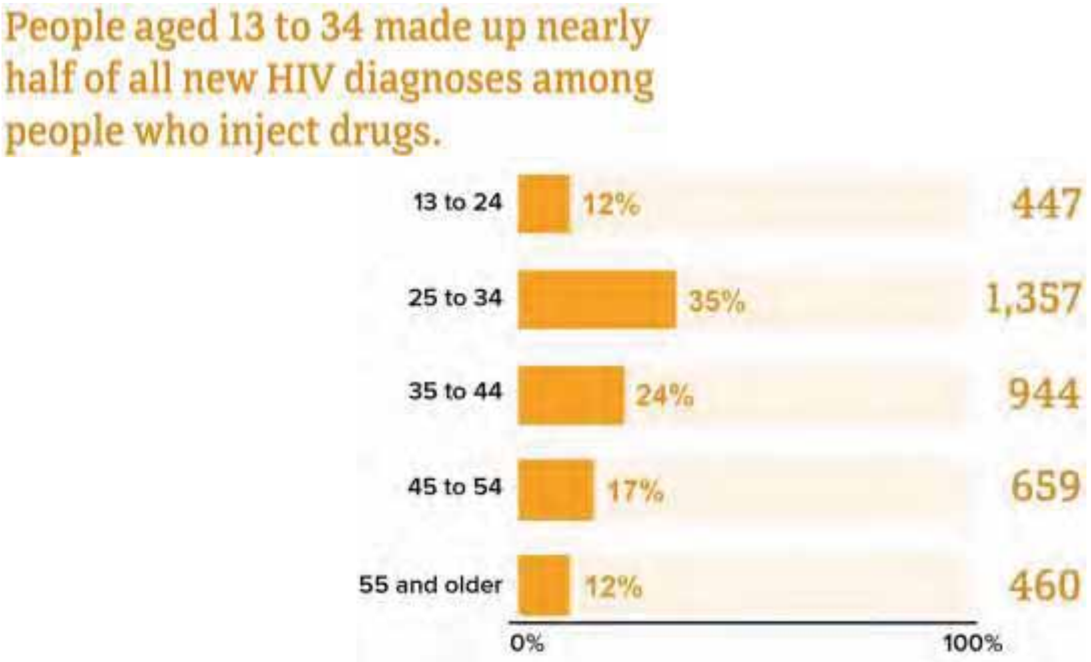
White people accounted for the highest number of new HIV diagnoses among people who inject drugs.



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

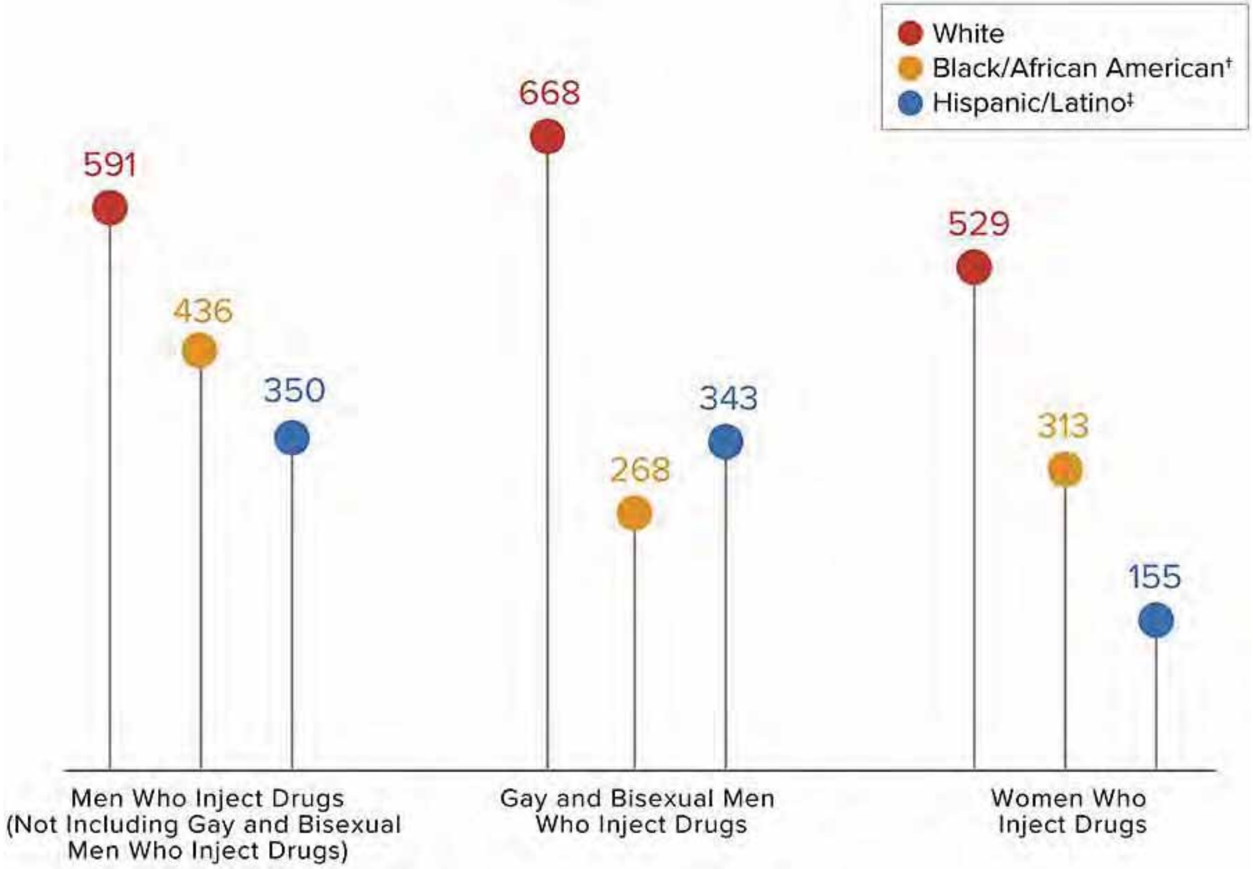
† *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

‡ Hispanic/Latino people can be of any race.



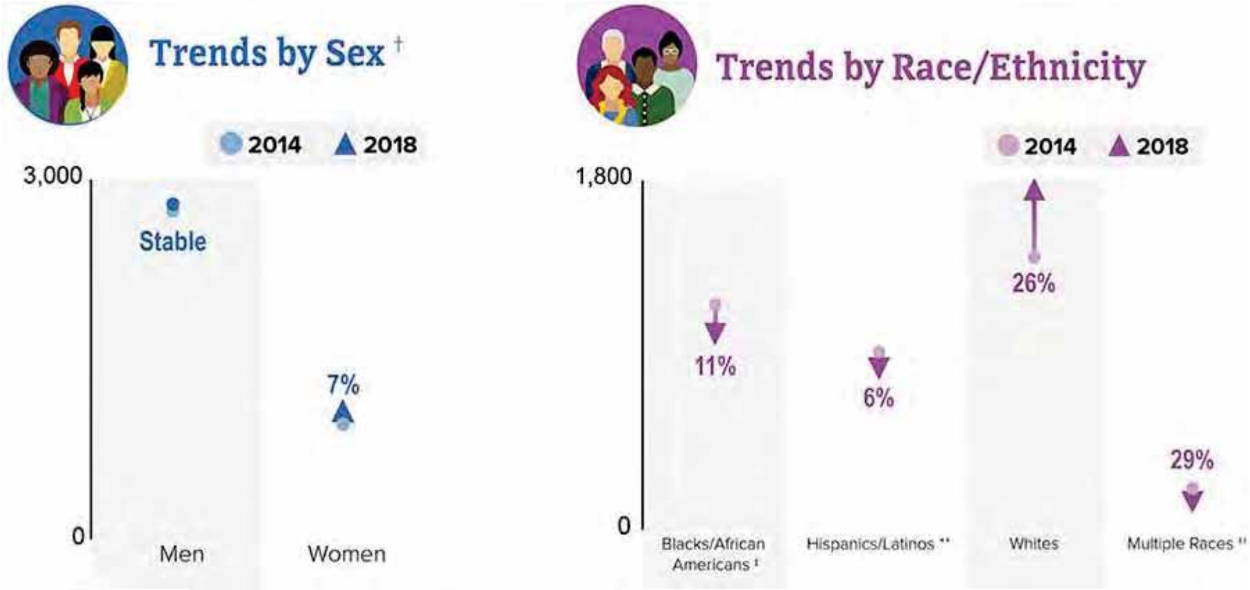
The numbers have been statistically adjusted to account for missing transmission categories. Values may not equal the total number of PWID who received an HIV diagnosis in 2018.
* Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

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.

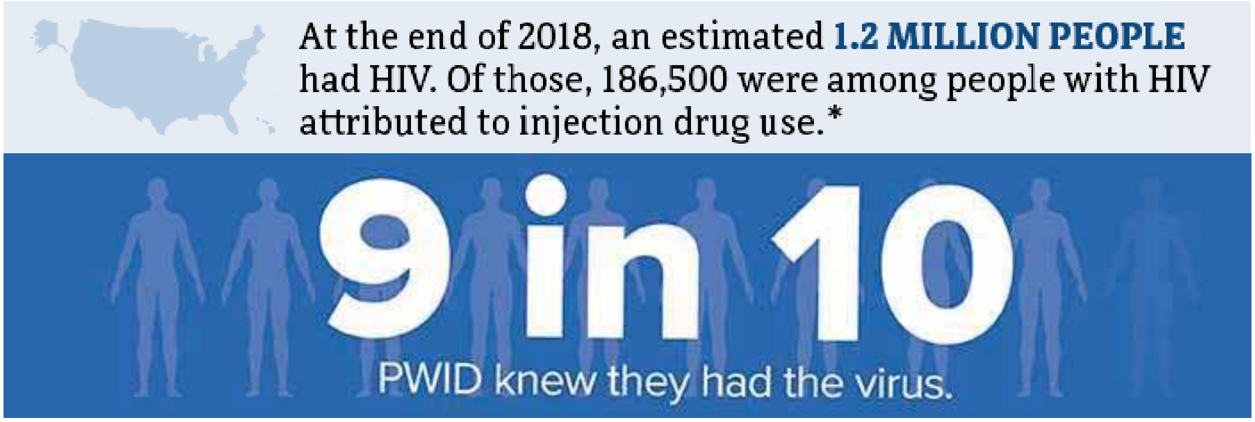
‡ *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.

** 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.*

9 in 10 PWID knew they had the virus.

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

Keeping an undetectable viral load also likely reduces the risk of transmitting HIV through shared needles, syringes, or other drug injection equipment, though we don't know by how much.

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

For 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.

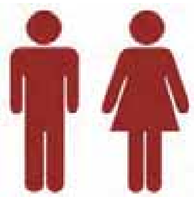
DATA CONSIDERATIONS

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).

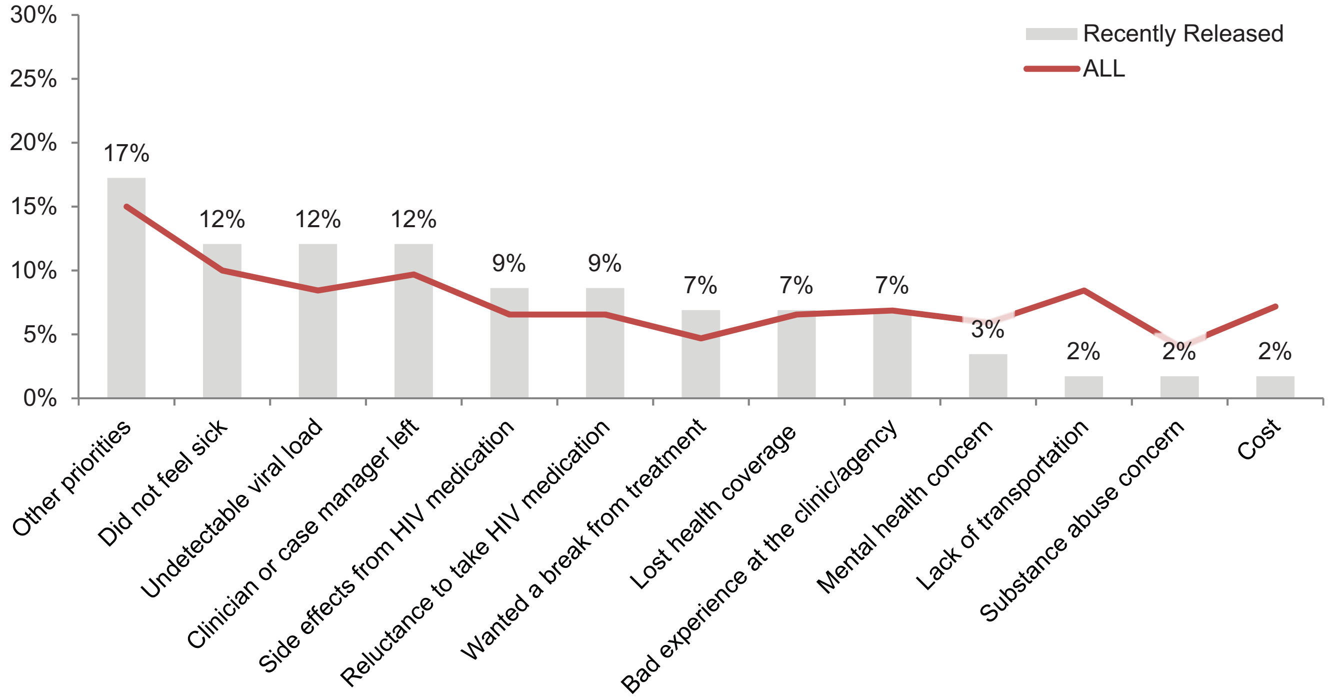
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 58% of recently released participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked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

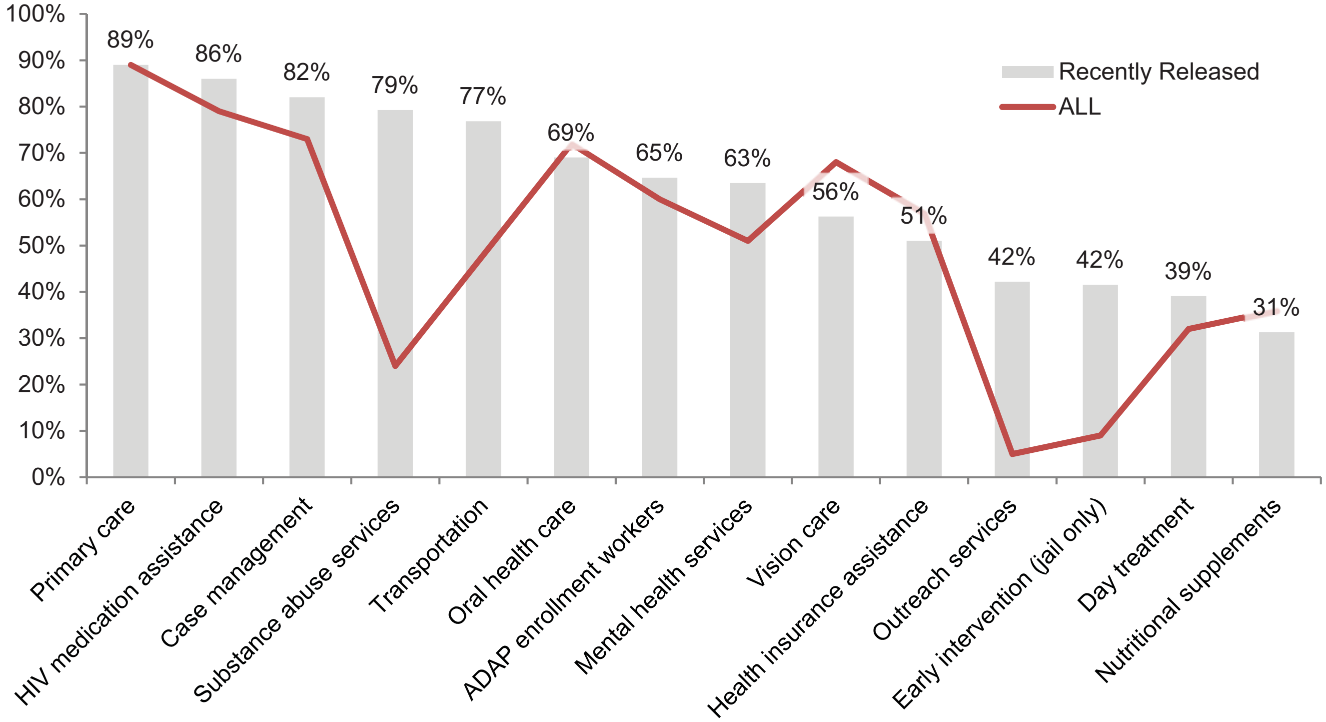
In 2020, 16 HIV care medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services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

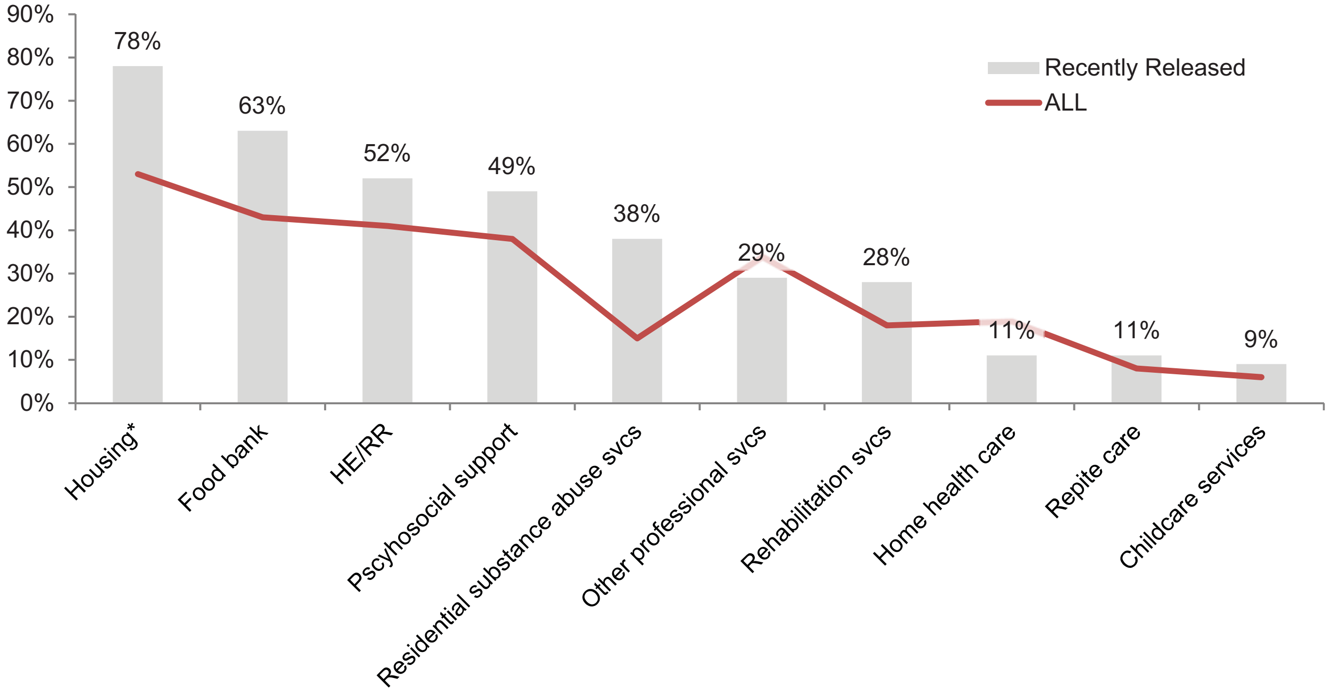
(**Graph 3**) From the 10 services options provided, the greatest proportion of recently released participants reported housing (78%) as the most needed service. This was followed by food bank (63%) and health education and risk reduction services (52%).

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

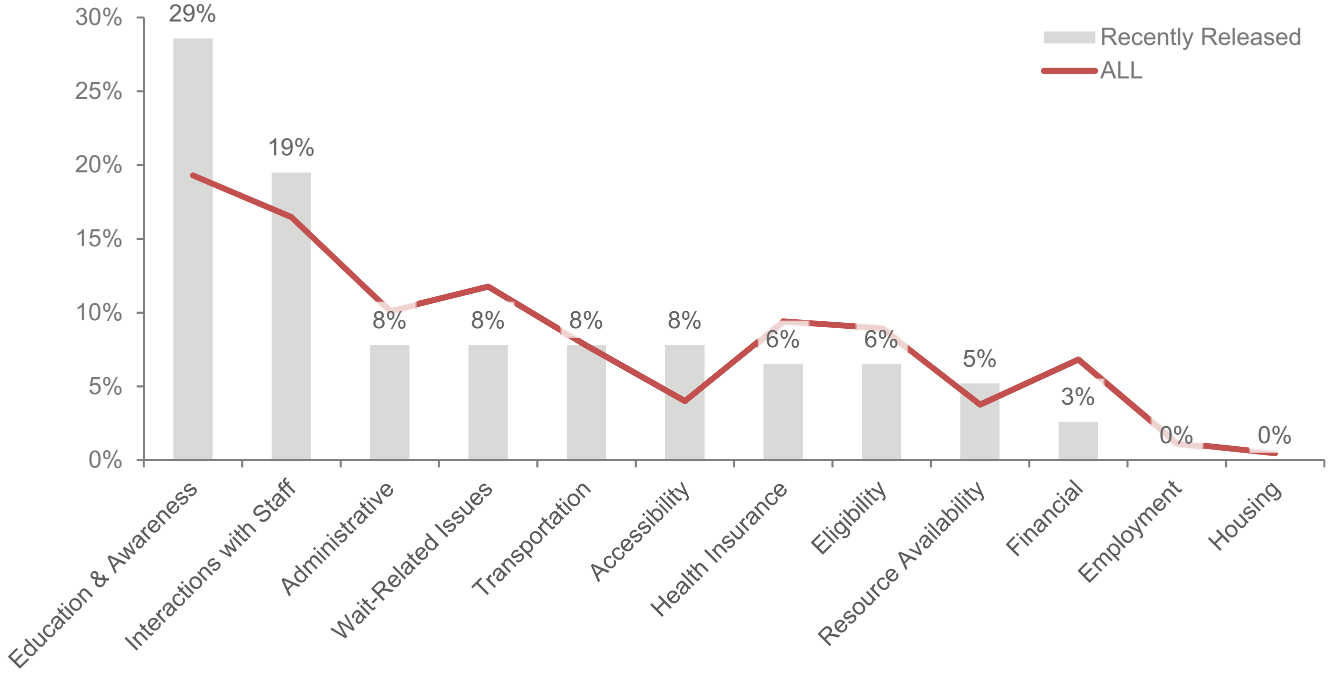
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant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

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.

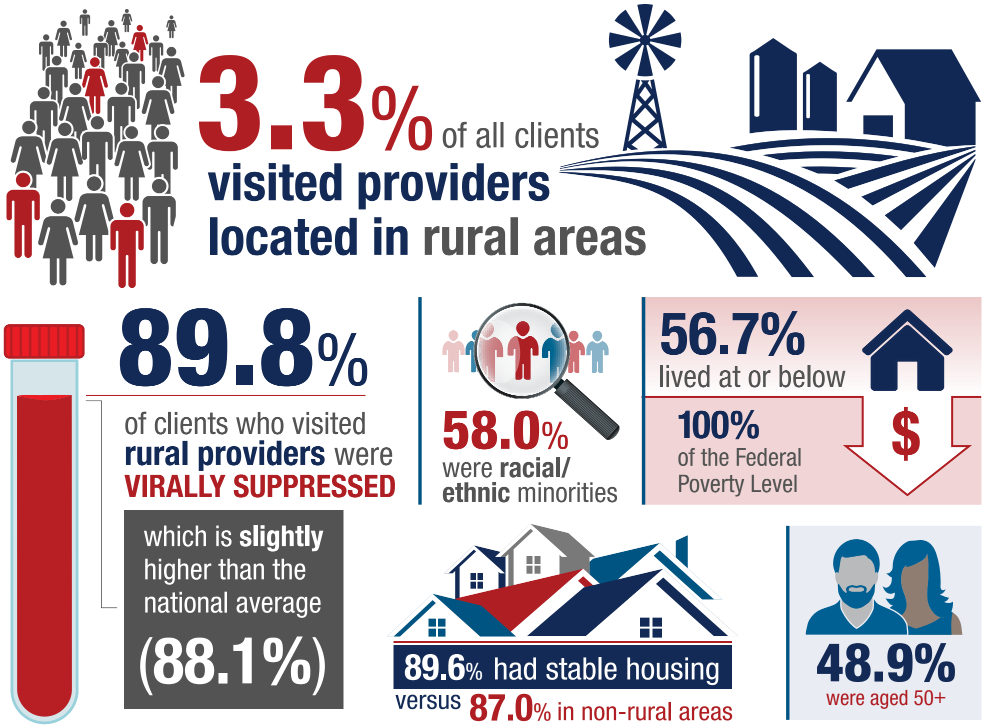
Among RWHAP providers in rural areas in 2019—

- 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).

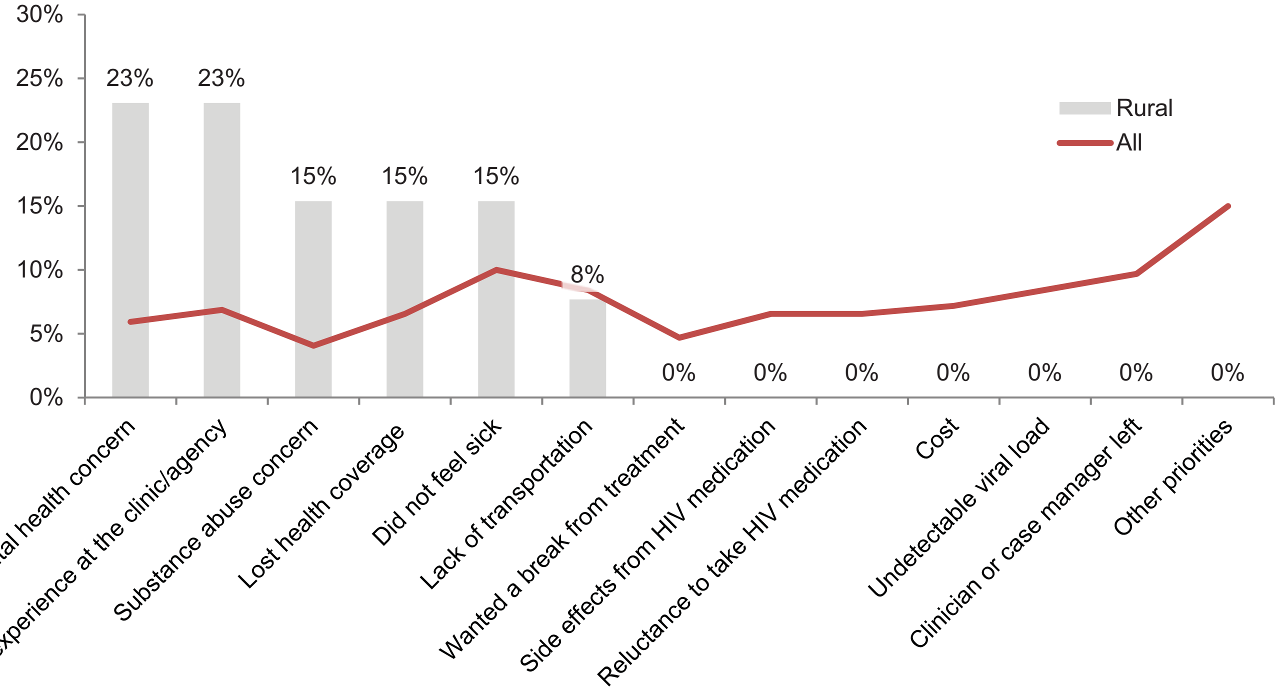
While 67% of all needs assessment participants reported no interruptions in their HIV care for 12 months or more since their diagnosis, 80% of rural participants reported no interruptions in their HIV care for 12 months or more since their diagnosis. Those who reported a break in HIV care for 12 months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



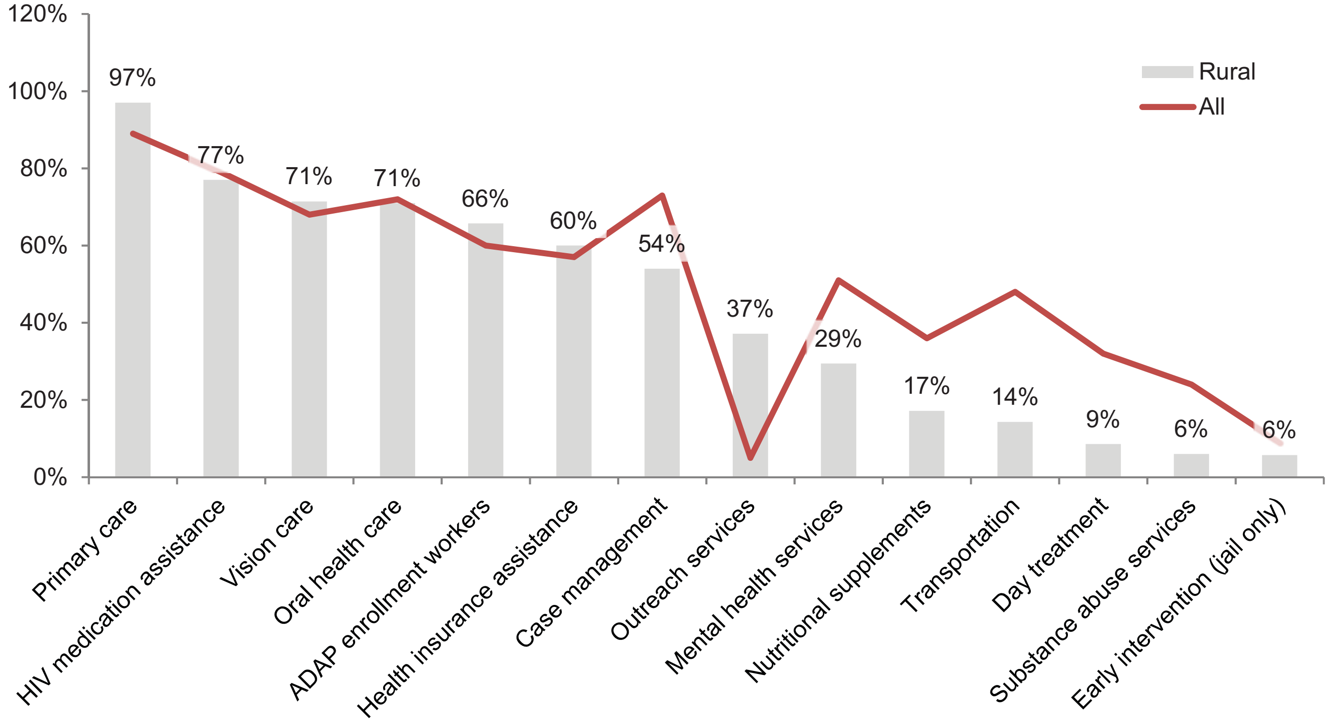
OVERALL RANKING OF FUNDED SERVICES, BY NEED

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.

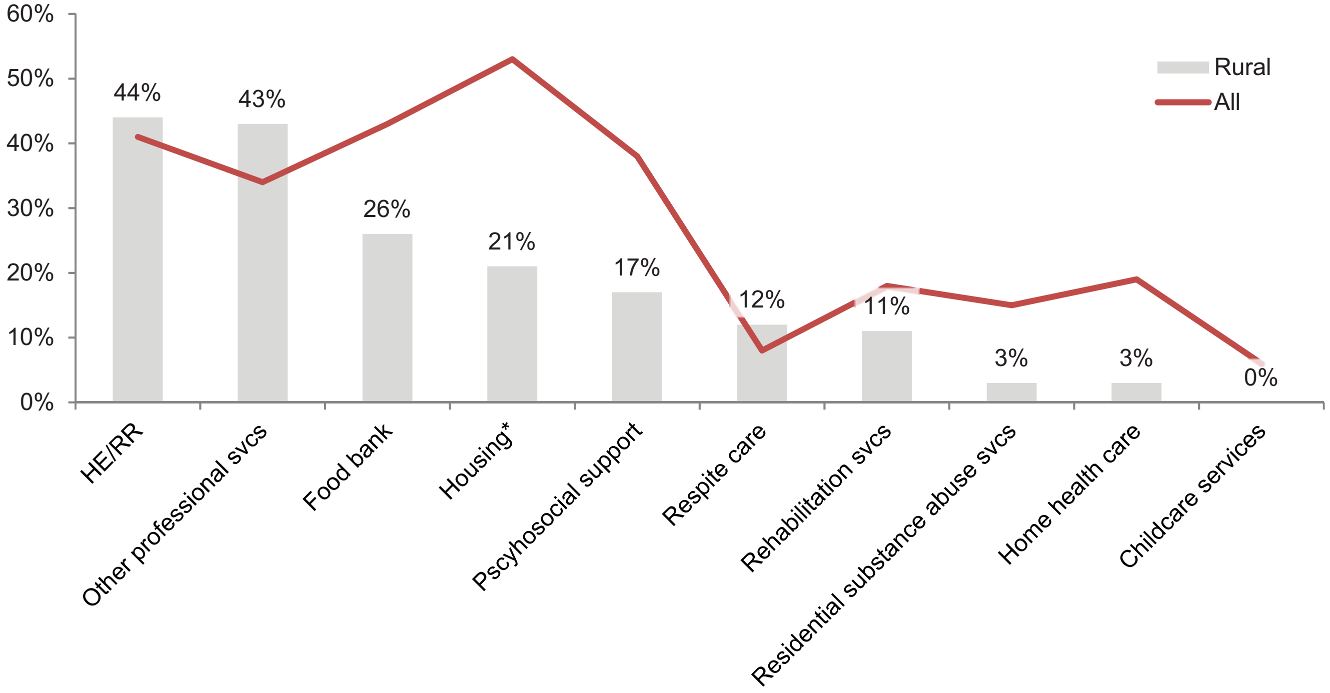
(**Graph 5**) From the 10 service options provided, rural needs assessment participants reported health education & risk reduction services (44%) as the most needed other/non-Ryan White Funded HIV-related service. Rural needs assessment participants also cited other professional services (43%), and food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

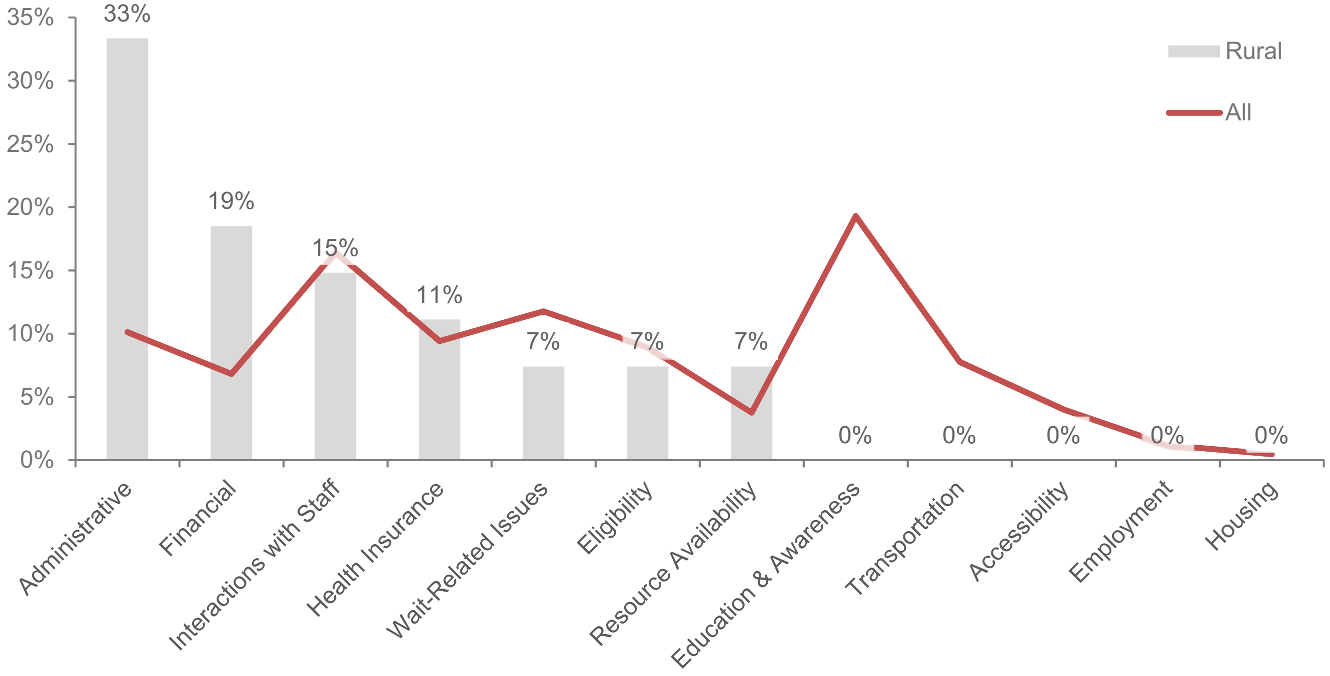
The 2020 Houston Area HIV Needs Assessment process continued the practice of reporting difficulty accessing needed services to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Staff used recursive abstraction to categorize participant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



Works Cited

Centers for Disease Control and Prevention. (2019, September). *Diagnoses of HIV Infection in the United States and Dependent Areas, 2019*. Retrieved from https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf

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