DRAFT

2017 Comprehensive Plan for HIV Prevention and Care Services

Gaps in Care & Reaching the Out of Care Workgroup

1:00 p.m., Thursday, February 18, 2016
Meeting Location: 2223 W. Loop South, Room #416

AGENDA

I.	Call to Order A. Welcome B. Moment of Reflection C. Adoption of the Agenda D. Approval of the Minutes	Connie Barnes and Pam Green, Co-Chairs
II.	Review 2017 Comprehensive Plan Objectives A. Refresher on Organizational Structure	Amber Harbolt, Health Planner, Office of Support
III.	Review 2012 Gaps in Care & Reaching the Out of Care Activities Progress	
IV.	Review Integrated HIV Prevention and Care Plan Guidance on Activities	
V.	Next Steps A. Set next meeting— 3/17 or 3/24 (afternoon only) B. What to Expect at the Next Meeting 1. Review progress on the 2012 Comprehensive Plan Benchmarks 2. Begin Discussing 2017 Comprehensive Plan Activities	Connie Barnes and Pam Green, Co-Chairs
VI.	Announcements A. FYI – End of Year Petty Cash Procedures	
VII.	Adjourn	

◆ Meetings hosted by the Ryan White Planning Council 2223 W. Loop South, #240; Houston, TX 77027 ◆
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2017 Comprehensive Plan for HIV Prevention and Care Services

GAPS IN CARE & REACHING THE OUT OF CARE WORKGROUP

10:00 a.m., Thursday, January 28, 2016
Meeting Location: 2223 West Loop South, Room 416; Houston, TX 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Pam Green, co-chair	Alex Moses	Amber Harbolt, Office of Support
Connie Barnes, co-chair	Denis Kelly, excused	Diane Beck, Office of Support
Allen Murray	Gloria Sierra	Biru Yang, HHD
Angela F. Hawkins	John Lazo	
Cecilia Ross	Kris Sveska, excused	
Curtis Bellard	Nancy Miertschin, excused	
Ebony Smith	Tam Kiehnhoff	
Ella Collins-Nelson		
Gene Ethridge		
Isis Torrente		
Michael Kennedy		
Rodney Mills		
Tana Pradia		
Teresa Pruitt		

Call to order: Connie Barnes, Co-Chair, called the meeting to order at 10:03 a.m.; she welcomed everyone and asked for a moment of reflection. She then asked everyone to introduce themselves.

Adoption of the Agenda: ***Motion #1:*** *It was moved and seconded (Bellard, Pruitt) to adopt the agenda.* ***Motion Carried.***

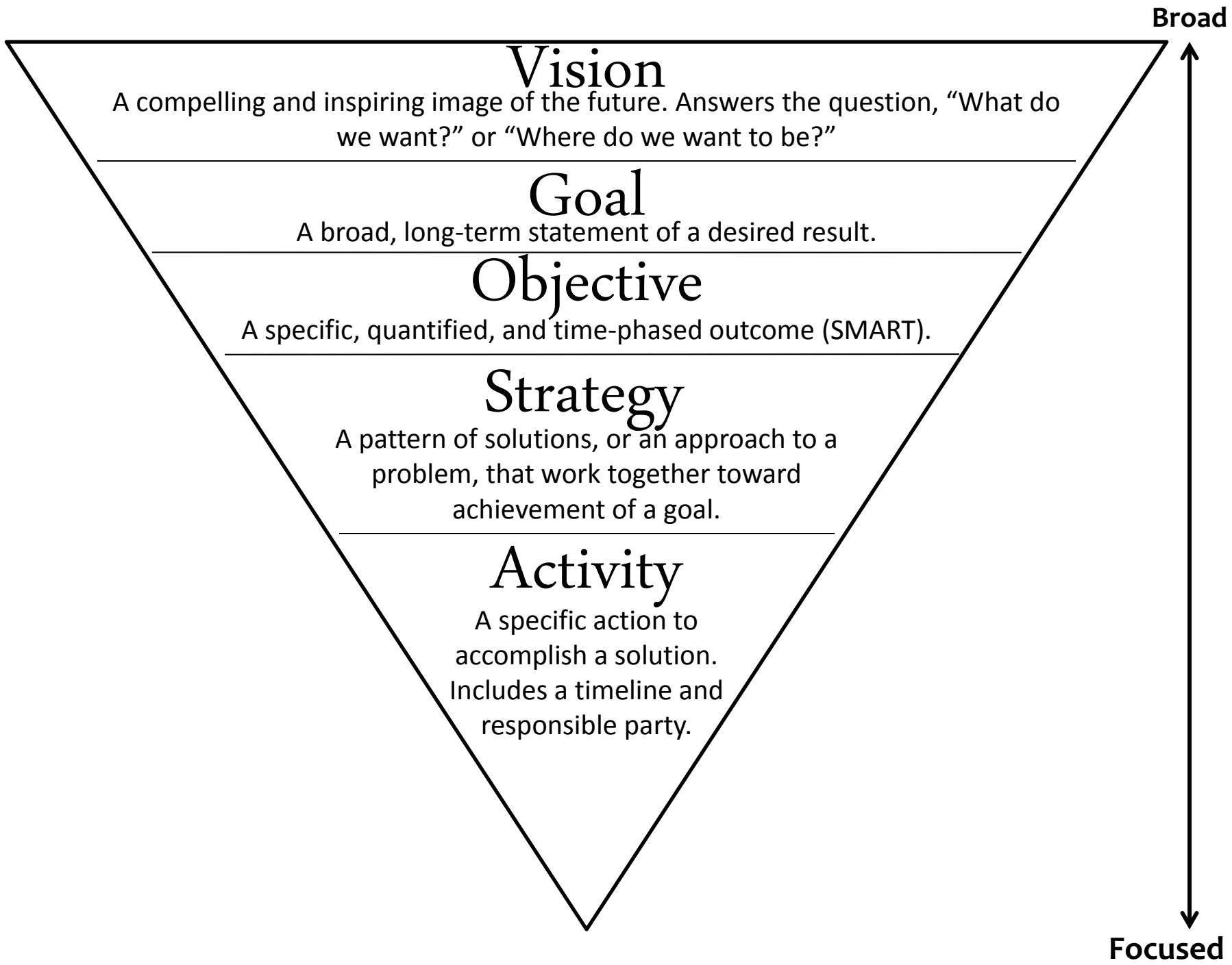
Workgroup Orientation: The workgroup reviewed the following documents: Membership Requirements, Voting Rules and Quorum, Organizational Structure, Workgroup Description, and Milestones Timeline. See attached. Harbolt said that the timeline would be updated for the next meeting.

Motion #2: *It was moved and seconded (Ross, Pruitt) to adopt quorum for the workgroup as at least 1/3 of members must be present, including one consumer and one co-chair.* ***Motion Carried.***

Review 2017 Comprehensive Plan Foundational Documents: The workgroup reviewed the 2017 Comprehensive Plan Vision and Mission Statements, Guiding Principles and Goals that were approved by the Leadership Team. See attached.

Next Meeting: February 18, 2016 at 1:00 p.m.; Agenda items include: (1) review 2017 Comprehensive Plan Objectives; and (2) review progress on the 2012 Comprehensive Plan Gaps in Care and Reaching the Out of Care Strategy Activities and Benchmarks.

Adjourn: **T**he meeting was adjourned at 10:43 a.m.


Broad
Vision
A compelling and inspiring image of the future. Answers the question, “What do we want?” or “Where do we want to be?”
Goal
A broad, long-term statement of a desired result.
Objective
A specific, quantified, and time-phased outcome (SMART).
Strategy
A pattern of solutions, or an approach to a problem, that work together toward achievement of a goal.
Activity
A specific action to accomplish a solution. Includes a timeline and responsible party.
Focused

2017-2021 Comprehensive Plan Goals & Objectives

(Approved by the Leadership Team 02-03-15)

Goals

To make progress toward an ideal system of HIV prevention and care for the Houston Area, we must:

1. Increase community mobilization around HIV in the Greater Houston Area
2. Prevent and reduce new HIV infections
3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services
4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care
5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations
6. Increase community knowledge around HIV in the Greater Houston Area.

Objectives

By 2021, we hope to accomplish the following:

1. Reduce the number of new HIV diagnoses in the Houston Area by at least 25 percent (from 1,338 to 1,004).
2. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status (beginning at 94.4 percent).
3. Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within one months of their HIV diagnosis to at least 85 percent (from X.X percent).

4.1 Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by at least 25 percent (from 25.9 percent to 19.4 percent).

4.2 Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year among Hispanic/Latino men age 35 and up by at least 25 percent (from X.X percent to X.X percent).

5. Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) to at least 90 percent (from 75 percent).
6. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are retained in HIV medical care (at least two documented HIV medical care visits, viral load or CD4 tests at least three months apart) to at least 90 percent (from 61.2 percent).
7. Maintain and, if possible, increase the proportion of Ryan White HIV/AIDS Program clients who are virally suppressed (beginning at 80.4 percent).
8. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed to at least 80 percent (from 55 percent)
9. Provide PrEP awareness education to at least 2,000 gay and bisexual men of color and females of color each year

Suggested staff revision: Increase the number of gay and bisexual men of color and women of color receiving pre-exposure prophylaxis (PrEP) education to at least 2,000 (beginning at X)

2012-2014

HOUSTON AREA COMPREHENSIVE HIV PREVENTION AND CARE SERVICES PLAN

STRATEGY 2: STRATEGY TO FILL GAPS IN CARE AND REACH THE OUT-OF-CARE

GOALS

1. Reduce Unmet Need
2. Ensure Early Entry Into Care
3. Increase Retention in Continuous Care
4. Improve Health Outcomes for People Living with HIV/AIDS (PLWHA)

SOLUTIONS

1. Target linkage to care efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit, after the initial visit, etc.) where individuals are more likely to not seek care or to fall out of care, particularly *newly-diagnosed* PLWHA
2. Intensify retention and engagement activities with *currently in-care* PLWHA, focusing on community education, system enhancements, and health literacy
3. Adopt strategies to re-engage *out-of-care* PLWHA and other "prior positives" to return to care

ACTIVITIES (RESPONSIBLE PARTY, TIMELINE)

1. Implement training to Counseling, Testing, and Referral (CTR) providers about their role in encouraging entry into care beginning at post-test counseling/results notification; and establish linkage to care performance measures for CTR providers (Houston Department of Health and Human Services; 2012)
2. Expand Disease Intervention Specialist (DIS) activities to include a readiness for HIV care assessment at the time of DIS interview as a means of assisting with linkage to care efforts (Houston Department of Health and Human Services; 2013)
3. Re-develop the Ryan White HIV/AIDS Program Service Category definition for Case Management (Non-Medical) (i.e., Service Linkage) during the *How to Best Meet the Need* process to improve linkage to care rates (Ryan White Planning Council; 2012)
4. Identify and disseminate a model protocol for a layperson system navigator program to assist newly-diagnosed HIV infected individuals to enter and be retained in HIV care (Ryan White Planning Council/Office of Support; 2013)
5. Develop a toolkit for private medical doctors for how to link newly-diagnosed HIV infected individuals into the Ryan White HIV/AIDS Program (Ryan White Planning Council/Office of Support; 2013)
6. Launch a Ryan White HIV/AIDS Program clinical quality management initiative focused on retention in care (Ryan White Grant Administration Clinical Quality Management Committee; The Resource Group; 2012)
7. Integrate messaging on the importance of retention in care for health outcomes and secondary prevention into evidence-based behavioral interventions (EBIs) targeting HIV infected individuals and their partners (Houston Department of Health and Human Services; 2012-2014)
8. Add to the Ryan White HIV/AIDS Program Standards of Care that funded primary care providers will have in place a client reminder system that reflects client preferences (Ryan White Grant Administration, The Resource Group; 2013)

ACTIVITIES (RESPONSIBLE PARTY, TIMELINE) CON'T

9. Provide educational opportunities and materials for people living with and/or affected by HIV/AIDS with attention to the impact of the *Patient Protection and Affordable Care Act* (Ryan White Grant Administration, The Resource Group, Ryan White Planning Council/Office of Support; 2012-2014)
10. Re-asses Ryan White HIV/AIDS Program Service Category definitions during the *How to Best Meet the Need* process for ways to address the emotional/social support needs of PLWHA (Ryan White Planning Council; 2012)
11. Sustain required annual training for Ryan White HIV/AIDS Program funded case managers on effective client engagement (e.g., motivational interviewing, rapport development, assessment skills, etc.) (Ryan White Grant Administration, The Resource Group; 2012-2014)
12. Establish a mechanism for tracking medication adherence among Ryan White HIV/AIDS Program clients (Ryan White Grant Administration; 2012)
13. Launch a re-linkage to care project using data matching algorithms between client-level HIV surveillance (eHARS) and client-level HIV care databases (CPCDMS) (Houston Department of Health and Human Services; 2012-2014)
14. Re-assess the Ryan White HIV/AIDS Program Standards of Care for "lost to care" clients for the purpose of increasing the number of individuals returned to HIV care (Ryan White Grant Administration, The Resource Group; 2012)
15. Establish partnerships with existing community-wide outreach opportunities to locate PLWHA who are out-of-care particularly among Priority Populations, Special Populations, and other high-risk sub-populations (Ryan White Planning Council/Office of Support; 2012-2014)

BENCHMARKS

1. Reduce the proportion of individuals who have tested positive for HIV but who are not in care by 0.8 percent each year (using the Ryan White HIV/AIDS Program Unmet Need Framework) beginning at 30.1 percent
2. Reduce the percentage of PLWHA reporting being currently out-of-care (i.e., no evidence of HIV medications, viral load test, or CD_4 test in 12 months) by 3.0 percent (from 7.1 percent to 4.1 percent)
3. Prevent the percentage of PLWHA reporting a prior history of being out-of-care from increasing above 26.0 percent
4. Increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent)
5. Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care to 80 percent (from 78.0 percent) (i.e., at least 2 visits for routine HIV medical care in 12 months at least 3 months apart)
6. Prevent the proportion of Ryan White HIV/AIDS Program clients who are retained in care from falling below 75.0 percent (i.e., at least 1 visit for HIV primary care in the 2nd half of the year after also having at least 1 visit for HIV primary care in the 1st half of the year)
7. Increase the proportion of Ryan White HIV/AIDS Program clients with undetectable viral load by 10 percent (from 57.0 percent to 62.7 percent

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The Integrated HIV Prevention and Care Plan development is a joint effort between jurisdictions and planning bodies that engages persons at higher risk for HIV infection, PLWH, service delivery providers, and other community stakeholders. It sets forth the jurisdiction's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV. The Integrated HIV Prevention and Care Plan establish the blueprint for achieving HIV prevention, care, and treatment goals. The Integrated HIV Prevention and Care Plan should include:

- **Goals:** a broad statement of purpose that describes the expected long-term effects of efforts consistent with the National HIV/AIDS Strategy and covering a period of 5 years
- **Objectives:** measurable statements that describe results to be achieved;
- **Strategies:** the approach by which the objectives will be achieved
- **Activities:** describing how the objectives will be achieved
- **Resources:** committed toward implementing the activities

In this section, grantees and planning bodies will use the National HIV/AIDS Strategy (NHAS) as the organizing framework for the Integrated HIV Prevention and Care Plan to achieve a more coordinated jurisdictional response to the local HIV epidemic. The Integrated HIV Prevention and Care Plan should respond to the needs identified in Section I of the Integrated HIV SCSN/Needs Assessment guidance and align with the three NHAS goals: (1) reducing new HIV infections; (2) increasing access to care and improving health outcomes for PLWH; and (3) reducing HIV related disparities and health inequities.

This section should:

a. Identify at least two objectives (using the SMART format – specific, measurable, achievable, realistic, and time-phased) that correspond to each NHAS goal.

b. For each objective, describe at least three strategies that correspond to each objective.

c. For each strategy, describe the activities/interventions, targeted populations, responsible parties, and time-phased, resources needed to implement the activity. Identify any activities specifically aimed at addressing gaps along the HIV Care Continuum.

d. Describe the metrics (e.g., number of HIV tests performed, medical visits, mental health screenings, HIV positivity rate, etc.) that will be used to monitor progress in achieving each goal outlined in the plan. Metrics should be consistent with the most current HHS Core Indicators and the NHAS Indicators.

e. Describe any anticipated challenges or barriers in implementing the plan.

Below is an example of a response that corresponds to an NHAS goal:

2010 – 2015 NHAS Goal: Reducing New HIV infections

2010 – 2015 SMART Objective (National): By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).

2017 – 2021 SMART Objective (Local): By 2021, lower the annual number of new infections by 10 percent (from 100 to 90).

Strategy: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Part A Early Intervention Service Providers	Deliver intensified HIV testing, referral services to eliminate barriers to care, health literacy and linkage to core medical services	Young Men who have Sex with Men (MSM)	• Number of HIV tests performed • HIV Positivity Rate • Number linked to medical care
By the end of 2021:	CDC-funded Health Department	Deliver expanded partner services and HIV testing for partners of those infected.	MSM	• Number of HIV tests performed • Number of newly diagnosed HIV positive persons

B. Collaborations, Partnerships, and Stakeholder Involvement

Collaboration among stakeholders is critical to maximizing resources and efficiencies in serving PLWH. As jurisdictions continue to develop high-quality, coordinated prevention and care and treatment for PLWH, collaboration will become even more important and will be paramount to providing services that fully address each component of the HIV care continuum.

This section should:

a. Describe the specific contributions of stakeholders and key partners to the development of the plan

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum

UPDATED:
02/02/16

All meetings subject to change. Please call in advance to confirm: 713 572-3724.

Unless otherwise noted, meetings are held at:

2223 W. Loop South,
Suite 240
Houston, TX 77027

March 2016

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	**2**	**3** 12 noon Steering Committee Room #240	**4** 5:00 pm Deadline for submitting Idea Forms	**5**
6	**7** 3:00 pm Prevention and Early Identification Wg Room #TBD	**8**	**9**	**10** 12 noon Planning Council Room #532 2:00 pm Comp HIV Planning Room #532 Nat'l Woman & Girls HIV Awareness Day	**11**	**12**
13	**14**	**15** 11:00 am Operations Room #240	**16**	**17** 11:00 am Joint Meeting and Quality Improvement Room #416	**18**	**19**
20 National Native HIV Awareness Day	**21**	**22** 12:00 pm Affected Community Room #532	**23** SIRR Conference	**24** 11:00 am Priority & Allocations Room #240	**25** **Good Friday** **Office Closed**	**26**
27	**28**	**29**	**30**			

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax

MEMORANDUM

To: Members, Ryan White Planning Council
External Members, Ryan White Committees

Copy: Modelle Brudner
Carin Martin

From: Tori Williams, Manager, Office of Support

Date: January 21, 2016

Re: End of Year Petty Cash Procedures

The fiscal year for Ryan White Part A funding ends on February 29, 2016. Due to procedures in the Harris County Auditor's Office, it is important that all volunteers are aware of the following end-of-year procedures:

1.) Council and External Committee members must turn in all requests for petty cash reimbursements **at or before 2 p.m. on Friday, February 5, 2016.**

2.) Requests for petty cash reimbursements for childcare, food and/or transportation to meetings before March 1, 2015 **will not be reimbursed at all if they are turned in after March 31, 2016.**

3.) The Office of Support may not have access to petty cash funds between March 1 and May 31, 2016. This means that volunteers can give Eric the usual reimbursement request forms for expenses incurred after March 1, 2016 (expenses such as transportation, food and childcare) but the Office may not be able to reimburse volunteers for these expenses until mid to late May 2016.

We apologize for this significant inconvenience. Please call Tori Williams at the number listed above if you have questions or concerns about how these procedures will affect you personally.

(OVER FOR TIMELINE)

March 1
2015.....
Beginning
of fiscal year 2015

Feb 5
2016.....
Turn in all
receipts

Feb 29
2016.....
End of
fiscal year 2015.
No money
available to write
checks until April
or May

March 31
2016
Turn in all receipts
or you will not be
reimbursed for any
expenses incurred
between March 1, 2015
and Feb. 29, 2016