DRAFT

2017 Comprehensive Plan for HIV Prevention and Care Services

Evaluation Workgroup

10:00 a.m., Tuesday, August 30, 2016
Meeting Location: 2223 W. Loop South, Room #416

AGENDA

Goal of Today's Meeting:
Develop Improvement and Monitoring Process for the 2017 Comprehensive Plan

I.	Call to Order A. Welcome B. Moment of Reflection C. Adoption of the Agenda	Brenda Harrison, Nick Sloop, and Steven Vargas, Co-Chairs
II.	Review Membership Requirements, Voting Rules, & Quorum A. Role of the Coordination of Effort Workgroup	Amber Harbolt, Health Planner, Office of Support
III.	Review 2017 Comprehensive Plan Objectives & Benchmarks	
IV.	Develop 2017 Comprehensive Plan Monitoring & Improvement Process	
V.	Next Meeting – Late Oct/Early Nov A. 2012 Comprehensive Plan Y4 Evaluation	Brenda Harrison, Nick Sloop, and Steven Vargas, Co-Chairs
VI.	Announcements	
VII.	Adjourn	

◆ Meetings hosted by the Ryan White Planning Council 2223 W. Loop South, #240; Houston, TX 77027 ◆
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2017 Comprehensive HIV/AIDS Service Plan

Leadership Team

Membership Requirements, Voting Rules and Quorum

(Approved by the Leadership Team 10-29-15)

Quorum for the Leadership Team is defined as:

- *1 representative from 3 of the 5 workgroups (see below*).*
- *7 additional Team members (including a Leadership Team co-chair).*
- *Of these 10, at least 2 must be PWAs (not including a chair).*
- *Of these 10, there must be a representative of:*
  - *Part A: 1 member of the Houston Ryan White Planning Council*
  - *Part B: 1 representative of a funded agency, volunteer or staff member*
  - *Community Planning Group (CPG): 1 member or staff member*

Voting Rules are as follows:

- *No voting at a member's first meeting (with the exception of the first meeting).*
- *Each agency gets one vote. This is based upon employment and applies even if a member of the Team is not representing the agency where they are employed.*
- *No more than 2 consecutive absences (either excused or unexcused)*

Members must email Diane Beck (diane.beck@hctx.net) or call the Office of Support (713-572-3724) at least one day in advance, except in an emergency. If a member does not email or call in, they are unexcused.

*The 2017 Comprehensive HIV Services Plan Workgroups are:

- Evaluation
- Coordination of Effort
- Gaps in Care and Out-of-Care
- Prevention and Early Identification
- Special Populations

2017 Comprehensive Plan for HIV Prevention and Care Services

WORKGROUP DESCRIPTIONS & MEETING SCHEDULE

Leadership Team – Next meeting: 1/13/2015 @ 3:00 p.m.

- Serve as the "steering committee" of the entire planning process.
- Guide the overall process by provide ongoing feedback on structure, timeline, outputs, etc.
- Provide the "big picture" perspective on HIV prevention and care services by reviewing mission, vision, values, guiding principles, and overall HIV prevention and care goals.
- Help identify individuals to serve on other Workgroups.
- Participate in the design of the community vetting process (e.g., community meetings, etc.).
- Review and provide feedback on draft sections of the plan.
- Facilitate review of and concurrence with the plan by agency leadership.

Evaluation Workgroup – First meeting: TBA

- Assist in the design of a process to evaluate the status of the 2017 Comprehensive HIV Services Plan; review evaluation results and make recommendations regarding continued areas of need.
- Provide guidance on data collection methods for the planning process, including identifying data sources, locating secondary and/or collecting primary data, and advising on data analysis and findings for the Leadership Team and other Workgroups.
- Review various outcome measures, targets, and other quantitative indicators for use in effectively monitoring the goals and objectives developed through the planning process.
- Assist in assuring alignment of 2017 HIV prevention and care goals, objectives, and performance measures with other local, state, and national initiatives and plans.
- Assist in the design of the Evaluation and Monitoring Plan for the 2017 plan.

Gaps in Care & Out-of-Care Workgroup – First meeting: 12/17/2015 @ 3:00 p.m.

- Identify goals regarding individuals who are *aware* of their HIV status but who are *not in care* (i.e., meeting unmet need) with an emphasis on ways to improve retention in care.
- Propose solutions for closing gaps in the current system of HIV prevention and care services in Houston.
- Propose solutions for addressing overlaps, or duplication, of services in the current system.

Prevention & Early Identification Workgroup – First meeting: 12/14/2015 @ 3:00 p.m.

- Identify goals regarding individuals who are *unaware* of their HIV status (EIIHA) with an emphasis on:
  - Identifying individuals who are HIV-positive
  - Informing individuals of their HIV status
  - Referring individuals to needed services
  - Providing linkages to HIV care
- Propose ways to better coordinate efforts between Ryan White programs and prevention programs, including:
  - HIV prevention
  - Partner notification initiatives
  - Prevention with positives
  - STD prevention
  - Hepatitis prevention

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Special Populations Workgroup – First meeting: 12/11/2015 @ 9:00 a.m.

- Identify any emerging special populations not included in the 2012 Comprehensive Plan (adolescents, injection drug users, homeless, transgender); selection of emerging special populations must be data-driven.
- Identify goals for improving HIV prevention and care for members of special populations.
- Propose solutions for meeting the HIV prevention and care services needs of each special population.

Coordination of Effort Workgroup – First meeting: 12/22/2015 @ 9:00 a.m.

- Identify goals for ensuring optimal access to prevention and care through enhanced coordination *within* the HIV Prevention Program and Ryan White Program "Parts"
- Propose ways to better coordinate efforts *between* prevention and Ryan White programs and other community service provider, including:
    - Public Providers:
        - Medicare
        - Medicaid
        - State Children's Health Insurance Program
        - Federally Qualified Health Centers
    - Private Providers
    - Substance Abuse Treatment Programs and Facilities
- As time allows, propose ways to better coordinate efforts *between* Ryan White programs and "non-traditional" partners (e.g., those agencies, organizations, or programs that are not providing direct HIV services but who may be reaching people living with HIV/AIDS for other reasons, health care services, or needs).

Expectations of Workgroup Members

- Attend Workgroup meetings on a schedule to be determined by the members.
- Participate in activities conducted during Workgroup meetings.
- Complete assignments made at Workgroup meetings according to established timelines.
- Provide feedback on Workgroup deliverables.
- Participate in the community vetting process.
- Review and provide feedback on draft sections of the plan.

In addition to the above activities, Workgroup Co-Chairs will:

- Facilitate monthly meetings in accordance with Robert's Rules of Order and Open Meeting Law.
- As needed, represent the Workgroup to the Leadership Team and others.
- As needed, fill gaps in the assignments of other Workgroup members.

2017 Houston Area Comprehensive HIV Plan
System Objective Evaluation Tool

Revised: 8-23-16

Objective to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ OBJECTIVE 1: Number of new HIV infections diagnosed in the Houston Area	DSHS eHARS	1,386 (2014)	↓ at least 25% ≤1004 (NHAS target)	Region is EMA
❖ OBJECTIVE 2: Percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status	DSHS HIV Testing & Awareness Data	94.4% (2014)	Maintain or increase ≥94.4% (local target)	Region is EMA Target exceeds NHAS 90% goal
❖ OBJECTIVE 3: Proportion of newly-diagnosed individuals linked to clinical care within one month of their HIV diagnosis	DSHS Linkage to Care Data	Pending (78% linked w/in 3 months in 2014)	↑ to at least 85% (NHAS target)	Region is EMA
❖ OBJECTIVE 4.1: Percentage of new HIV diagnoses with an HIV stage 3 diagnosis within one year	DSHS Late Diagnoses Data	25.9% (2014)	↓ at least 25% =19.4% (DHAP target)	Region is EMA
❖ OBJECTIVE 4.2: Percentage of new HIV diagnoses with an HIV stage 3 diagnosis within one year among Hispanic/Latino men age 35 and up	DSHS Late Diagnoses Data	Pending	↓ at least 25% = Pending (local target)	Region is EMA
❖ OBJECTIVE 5: 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)	CPCDMS	75.0% (2014)	↑ to at least 90% (NHAS target)	
❖ OBJECTIVE 6: 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 in a 12 month period)	DSHS Retention Data	61% (2014)	↑ to at least 90% (NHAS target)	Region is EMA
❖ OBJECTIVE 7: Proportion of Ryan White HIV/AIDS Program clients who are virally suppressed	CPCDMS	80.4% (2014)	Maintain or increase ≥80.4% (local target)	
❖ OBJECTIVE 8: Percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed	DSHS Viral Suppression Data	55% (2014)	↑ to at least 80% (NHAS target)	Region is EMA
❖ OBJECTIVE 9: Number of gay and bisexual men of color and women of color receiving pre-exposure prophylaxis (PrEP) education each year	HHD	To be developed	≥2000 (local target)	Among HIV-negative clients seen by HHD frontline staff (i.e. DIS and SLWs) and HHD-funded contractors

2017 Houston Area Comprehensive HIV Plan

Benchmark Evaluation Tool, By Strategy

STRATEGY 1: PREVENTION AND EARLY IDENTIFICATION

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ BENCHMARK 1: Number of new HIV infections diagnosed in the Houston Area	DSHS eHARS	1,386 (2014)	↓25% =1040 (NHAS target)	Region is EMA
❖ BENCHMARK 2: Number of HIV/STD brochures distributed	HDHHS	88,700 (2014)	Maintain =88,700 (local target)	Target based on current resources and planning
❖ BENCHMARK 3: Number of publicly-funded *targeted* and *routine* HIV tests				
Number of publicly-funded *targeted* HIV tests	HHD, DSHS HIV Testing & Awareness Data	10,109 (2015) Include DSHS data when available	Maintain = 10,109 (local target) Include DSHS data when available	Region is Houston/Harris County for HHD; EMA for DSHS
Number of publicly-funded *routine* HIV tests	HHD, DSHS HIV Testing & Awareness Data	117,610 (2015) Include DSHS data when available	Maintain = 117,610 (local target) Include DSHS data when available	Region is Houston/Harris County for HHD; EMA for DSHS
❖ BENCHMARK 4: Positivity rate for publicly-funded *targeted* HIV testing	HHD, DSHS HIV Testing & Awareness Data	3.01% (2015) Include DSHS data when available	Maintain = 3.01% (local target) Include DSHS data when available	Region is Houston/Harris County for HHD; EMA for DSHS

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ BENCHMARK 5: Percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status	HHD, DSHS HIV Testing & Awareness Data	93.8% (2015) Include DSHS data when available	Maintain = 93.8% (local target) Include DSHS data when available	Region is Houston/Harris County for HHD; EMA for DSHS
❖ BENCHMARK 6: Percentage of new HIV diagnoses with an HIV stage 3 diagnosis within one year	DSHS Late Diagnoses Data	25.9% (2014)	↓25% =19.4% (DHAP target)	Region is EMA
❖ BENCHMARK 7: Proportion of newly-diagnosed individuals linked to clinical care within one months of their HIV diagnosis	DSHS Linkage to Care Data	Pending from DSHS	85% (NHAS Updated target)	Region is EMA
❖ BENCHMARK 8: Proportion of Ryan White HIV/AIDS Program clients with suppressed viral load	CPCDMS Report	80.4%* (2014)	Maintain =80.4% (local target)	Part A clients only
❖ BENCHMARK 9: Percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed	DSHS Viral Suppression Data	55.5%* (2014)	80% (NHAS Updated target)	Region is EMA
❖ BENCHMARK 10: Number of new HIV infections in high HIV/STD morbidity zip codes targeted for intervention				
Sharpstown (77036 and 77074)	HHD, eHARS	= 56 (2014)	↓25% =42 (NHAS target)	
Sunnyside/South Park (77033 and 77051)	HHD, eHARS	=34 (2014)	↓25% =26 (NHAS target)	
Greater 5th Ward (77020 and 77026)	HHD, eHARS	=28 (2014)	↓25% =21 (NHAS target)	
Acres Home (77088 and 77091)	HHD, eHARS	=32 (2014)	↓25% =24 (NHAS target)	

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
Montrose (77006)	HHD, eHARS	=26 (2014)	↓25% =20 (NHAS target)	
❖ BENCHMARK 11: Rate of STD infection per 100,000 population (Chlamydia, gonorrhea, and primary and secondary syphilis)	HHD, STDMIS	CT: 563.7 GC: 162.5 P&S: 8.2 (2014) Update with 2015 when available	CT: Maintain =510.3 (local target) GC: ↓0.6%/ year =157.0 (local target) P&S: 6.7 (HP 2020 males target)	Region is Houston/Harris County CT/GC targets based on available historical data
❖ BENCHMARK 12: Number of condoms distributed	HHD	450,000 (2014)	Maintain =450,000 (local target)	Includes mass and targeted condom distribution efforts
❖ BENCHMARK 13: Number of high-risk individuals that completes an evidence-based behavioral intervention to reduce risk for HIV	HHD	4,944 (2015)	Maintain =4,944 (local target)	Includes completion of ILI or GLI intervention only (not CLI)
❖ BENCHMARK 14: Percentage of prevention and care staff receiving standardized pre-exposure prophylaxis (PrEP) training	HHD, RWGA, TRG	Baseline to be developed	100% (local target)	
❖ BENCHMARK 15: Number of MSM and transgender persons of color receiving pre-exposure prophylaxis (PrEP) education	HHD Project PrIDE	Baseline to be developed	2,000 annually (local target)	
❖ BENCHMARK 16: Percentage of HIV-negative clients screened for PrEP eligibility	HHD Project PrIDE, ECLIPS, Maven	Baseline to be developed	10% increase	Among HIV-negative clients seen by HHD frontline staff (i.e., DIS and SLWs) and HHD-funded contractors

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

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ BENCHMARK 1: Proportion of PLWH with Unmet Need	DSHS Unmet Need Data	25.0% (2014)	↓1.6% annually =17.0% (local target)	Region is EMA Target based on available historic data (2010= 33.1%)
❖ BENCHMARK 2: Proportion of newly-diagnosed individuals linked to clinical care within one month of their HIV diagnosis	DSHS Linkage to Care Data	Pending (78% linked w/in 3 months in 2014)	↑ to at least 85% (NHAS target)	Region is EMA
❖ BENCHMARK 3: 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)	CPCDMS	75.0% (2014)	↑ to at least 90% (NHAS target)	
❖ BENCHMARK 4: 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 in a 12 month period)	DSHS Retention Data	61% (2014)	↑ to at least 90% (NHAS target)	Region is EMA
❖ BENCHMARK 5: Proportion of Ryan White HIV/AIDS Program clients who are virally suppressed	CPCDMS	80.4% (2014)	Maintain or increase ≥80.4% (local target)	
❖ BENCHMARK 6: Percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed	DSHS Viral Suppression Data	55% (2014)	↑ to at least 80% (NHAS target)	Region is EMA

STRATEGY 3: TO ADDRESS THE NEEDS OF SPECIAL POPULATIONS

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ BENCHMARK 1: Number of new HIV infections diagnosed among each special population:				
Youth (13-24)	DSHS eHARS	360 (2014)	↓25% =70 (NHAS target)	Region is EMA
Homeless	HMIS (potential)	54 (2014)	↓25% =41 (NHAS target)	Region is Harris/Fort Bend County Baseline: 3.9%- National Alliance to End Homelessness, 2009. http://www.nationalhomeless.org/factsheets/hiv.html applied to local 2014 new Dx
Incarcerated in Jail	The Resource Group	Pending	↓25% = Pending (NHAS target)	
Incarcerated in Prison	TDCJ	Pending	↓25% = Pending (NHAS target)	
IDU	DSHS eHARS	66 (2014)	↓25% =50 (NHAS target)	Region is EMA
MSM	DSHS eHARS	930 (2014)	↓25% =698 (NHAS target)	Region is EMA
Transgender and Gender Non-conforming	HHD, HIV Surveillance System	Pending	↓25% =Pending (NHAS target)	Region is Houston/Harris County
Women of Color	DSHS eHARS	Pending	↓25% =Pending (NHAS target)	Region is EMA
Aging (50 and up)	DSHS eHARS	264 (2014)	↓25% =198 (NHAS target)	Region is EMA Baseline: Placeholder, reflects 45+

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2021 Target	Notes
❖ BENCHMARK 2: Proportion of newly-diagnosed individuals within each special population linked to clinical care within one month of their HIV diagnosis:				
Youth (13-24)	DSHS Linkage to Care Data	74.0% (2014)	85% (NHAS target)	Region is EMA Baseline: Reflects 3 month linkage window
Homeless	Needs Assessment	53.9% (2016)	85% (NHAS target)	Region is HSDA Baseline: Unstable housing
Recently Released from Jail (*linked within 1 month of release)	The Resource Group	Pending	85% (NHAS target)	Region is HSDA Harris County Jail only.
Recently Released from Prison (*linked within 1 months of release)	The Resource Group	Pending	85% (NHAS target)	
IDU	DSHS Linkage to Care Data	85.0% (2014)	85% (NHAS target)	Region is EMA
MSM	DSHS Linkage to Care Data	78.0% (2014)	85% (NHAS target)	Region is EMA
Transgender and Gender Non-conforming	Needs Assessment	54.1% (2016)	85% (NHAS target)	Region is HSDA
Women of Color	DSHS eHARS	Pending	85% (NHAS target)	Region is EMA
Aging (50 and up)	DSHS eHARS	84% (2014)	85% (NHAS target)	Region is EMA Baseline: Placeholder, reflects 45+

STRATEGY 3: TO ADDRESS THE NEEDS OF SPECIAL POPULATIONS – *CONTINUED*

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2014 Target	Notes
❖ BENCHMARK 3: Proportion of PLWH with unmet need within each Special Population				
Youth (13-24)	DSHS Unmet Need Analysis	24.0% (2014)	10% (NHAS 90% retention target)	Region is EMA
Homeless	Needs Assessment – Out of Care Assessment	To be established	10% (NHAS 90% retention target)	Region is HSDA 2014 NA = 16.3%
Recently Released from Jail/Prison	Needs Assessment – Out of Care Assessment	To be established	10% (NHAS 90% retention target)	Region is HSDA 2014 NA = 11.9%
IDU	DSHS Unmet Need Analysis	27.0% (2014)	10% (NHAS 90% retention target)	Region is EMA
MSM	DSHS Unmet Need Analysis	25.0% (2014)	10% (NHAS 90% retention target)	Region is EMA
Transgender and Gender Non-conforming	Needs Assessment – Out of Care Assessment	To be established	10% (NHAS 90% retention target)	Region is HSDA 2014 NA = 7.4%
Women of Color	DSHS Unmet Need Analysis	Pending	10% (NHAS 90% retention target))	Region is EMA
Aging (50 and up)	DSHS Unmet Need Analysis	25% (2014)	10% (NHAS 90% retention target)	Region is EMA Baseline: Placeholder, reflects 45+
❖ BENCHMARK 4: Percentage of grievances relating to cultural and linguistic competence received through the Ryan White grievance lines and the HHD prevention "warmline" and website	Ryan White Grants Administration; TRG; HHD	To be established	Track only	Region is EMA

STRATEGY 4: TO IMPROVE COORDINATION OF EFFORT AND ADAPT TO HEALTHCARE SYSTEM CHANGES

Benchmark to Be Measured	Recommended Data Source (Reference)	Baseline (year)	2014 Target	Notes
❖ BENCHMARK 1: Number of Ryan White Planning Council members who are not employed at HIV care or prevention service providers	RWPC/OS	29 total 4 non-infected/ affected (2014)	Maintain (local target)	Baseline includes Council and External members who do not bring HIV expertise because of their place of employment. 2014 measure is placeholder for 2016 data.
❖ BENCHMARK 2: Number of non-HIV prevention and care service providers requesting information about HIV services	RWPC/OS	110 (2015)	Increase (local target)	Actual numbers tallied using office tracking sheets and website requests. Defined as an entity that does not state HIV prevention or care in its mission.
❖ BENCHMARK 3: Proportion of PLWH reporting barriers to using Ryan White HIV/AIDS Program Core Medical	Needs Assessment	40.5% (2016)	↓ = Pending SPSS run (local target)	Baseline: Numerator = 203; Denominator = 501 Target to be based on available historical data (2014)
❖ BENCHMARK 4: Proportion of PLWH reporting barriers to using Ryan White HIV/AIDS Program Support Services	Needs Assessment	20.2% (2016)	↓ = Pending SPSS run (local target)	Baseline: Numerator = 93 Denominator = 461 Target to be based on available historical data (2014)
❖ BENCHMARK 5: Proportion of PLWH reporting barriers to outpatient alcohol or drug abuse treatment services	Needs Assessment	8.2% (2016)	↓ = Pending SPSS run (local target)	Baseline: Numerator = 10 Denominator = 122 Target to be based on available historical data (2014)
❖ BENCHMARK 6: Proportion of PLWH reporting barriers to professional mental health counseling	Needs Assessment	12.1% (2016)	↓ = Pending SPSS run (local target)	Baseline: Numerator = 32 Denominator = 265 Target to be based on available historical data (2014)
❖ BENCHMARK 7: Proportion of PLWH reporting housing instability	Needs Assessment	25.6% (2016)	Maintain =25.6% (local target)	Target based on current resources and planning
❖ BENCHMARK 8: Percentage of Ryan White HIV/AIDS Program clients with Medicaid or Medicare enrollment	CPCDMS	27% (2014)	Increase (local target)	Baseline to be updated
❖ BENCHMARK 9: Proportion of Ryan White HIV/AIDS Program clients who may qualify for Medicaid or Medicare, but who are not enrolled in either program	CPCDMS	Pending	Decrease (local target)	
❖ BENCHMARK 10: Percentage of Ryan White HIV/AIDS Program clients with private health insurance	CPCDMS	10% (2014)	Increase (local target)	Baseline to be updated
❖ BENCHMARK 11: Proportion of Ryan White HIV/AIDS Program who may qualify for an Advanced Premium Tax Credit, but who are not enrolled in an ACA Marketplace QHP.	CPCDMS	Pending	Decrease (local target)	6.3% of RW enrolled in QHP in 2015

Section III: Monitoring and Improvement

Monitoring the Integrated HIV Prevention and Care Plan will assist grantees and planning bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information; and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

This section should:

a. Describe the process for regularly updating planning bodies and stakeholders on the progress of plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvements.

b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan.

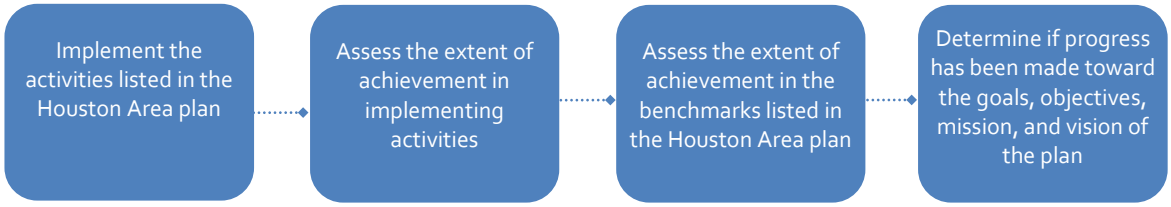
c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum which will be used to impact the quality of the HIV service delivery system, including strategic long-range planning.

Plans for the Implementation and Evaluation of the Houston Area Plan

How progress toward an ideal system of HIV prevention and care will be measured

The Houston Area plan includes over 75 activities designed to improve the system of HIV prevention and care over the next three years. The Houston Area plan also includes close to 50 benchmarks for measuring the impact of these activities. In the short-term, assessing the status of proposed activities will reveal the extent of the community's implementation of the plan from year-to-year. In the long-term, assessing the status of benchmarks will reveal the extent of the community's impact on attaining the goals of the plan, on filling gaps in the HIV prevention and care system in the Houston Area, and, ultimately, on improving the local HIV epidemic. A flow chart of this process is illustrated below:

Flow Chart for Evaluating the Impact of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2014



There will be several sources for information about activities and benchmarks throughout implementation. For example, the responsible parties from both HIV prevention and care that are listed in this document generate progress reports, service utilization reports, and reports on outcomes and performance measures on a regular basis. The local HIV Planning Bodies also produce documents about the HIV prevention and care system as a whole: an Epidemiological Profile on HIV/AIDS is developed annually, a community-wide Needs Assessment of People Living with HIV/AIDS is conducted every three years, and Special Studies are initiated throughout the year to fill gaps in data.

The following steps will take place in order to evaluate and monitor the Houston Area plan in light of these various data sources:

1. Convene a community workgroup to oversee the evaluation of the implementation process
2. Develop tools that will help track progress made on activities and benchmarks
3. Conduct periodic reviews of progress reports and other documents produced by responsible parties containing information about activities and benchmarks
4. On an *annual* basis, review benchmark data, assess the direction of benchmarks compared to baseline, provide an explanation of results, and report findings to the community
5. On a *biannual* basis, review data on the status of activities, provide an explanation of results, identify new direction and revise activities if needed, and report findings to the community
6. Update a Houston Area dashboard of goals and objectives

The goal of the evaluation of the Houston Area plan is to determine the extent of achievement of goals and objectives

The goal of monitoring the Houston Area plan is to determine the extent of achievement of strategies and activities