DRAFT

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee Meeting

2:00 p.m., Thursday, September 13, 2018
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

AGENDA

I. Call to Order
   - A. Welcome and Introductions
   - B. Moment of Reflection
   - C. Adoption of the Agenda
   - D. Approval of the Minutes

Ted Artiaga and
Steven Vargas, Co-Chairs

II. Public Comment and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Overview - *Achieving Together: A Community Plan to End the HIV Epidemic in Texas*

Amber Harbolt, Health Planner
Office of Support

IV. Projects Updates:
   - A. Social Determinants of Health and Out of Care Special Studies
   - B. Epidemiological Profile
   - C. Comprehensive Plan Evaluation
   - D. African American MSM Needs Assessment Profile
   - E. Preparing for 2019 Needs Assessment process

V. Announcements

Ted Artiaga and
Steven Vargas, Co-Chairs

VI. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee
12:00 p.m., Monday, July 30, 2018
Meeting Location: 2223 West Loop South, Room 532; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Steven Vargas, Co-Chair	Dawn Jenkins	Sha'Terra Johnson-Fairley, TRG
Ted Artiaga, Co-Chair	Denis Kelly, excused	Amber Harbolt, Office of Support
Herman Finley	Osaro Mgbere, excused	Diane Beck, Office of Support
Rodney Mills	Robert Noble	
Faye Robinson	Shital Patel	
Isis Torrente	Cristina Martinez	
Ryan Clark	Oluseyi Orija	
Cynthia Deverson	Larry Woods	
Nancy Miertschin		
Esther Ogunjimi		
Crystal Starr		
Amana Turner		

Call to Order: Steven Vargas, Co-Chair, called the meeting to order at 12:10 p.m. and asked for a moment of reflection.

Adoption of Agenda: ***Motion #1:*** *it was moved and seconded (Starr, Clark) to adopt the agenda.* **Motion carried.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Clark, Ogunjimi) to approve the June 28, 2018 minutes.* **Motion carried.** Abstentions: Robinson, Starr, Torrente.

Public Comment: None.

FY 2019 EIIHA Plan: Harbolt reviewed the Target Populations Selection Matrix, Development Timeline, EIIHA Trends Data and FY 2019 EIIHA Target Populations that were selected by the EIIHA workgroup, see attached. There were no comments received regarding the populations that were selected although there was one compliment regarding the workgroup and committee very thoroughly looking at the data. ***Motion #4:*** *it was moved and seconded (Artiaga, Clark) to approve the following target populations for the FY 2019 EIIHA Plan:*

1. *African Americans*
2. *Hispanics/Latinos age 25 and over*
3. *Men who have Sex with Men (MSM)*

Motion carried. Abstention: Deverson

Motion #5: *it was moved and seconded (Starr, Artiaga) to have the Office of Support include information on HIV and aging and the uptick in late diagnosis in our area in the EIIHA section*

of the HRSA application and also include a statement recognizing that currently available epidemiologic data is not sufficient to access the need for testing, referral, and linkage in at-risk populations such as among those who are transgender, intersex, homeless, those released from incarceration or among adolescents ages 13 to 17 and young adults ages 18 to 24. ***Motion carried unanimously.***

Quarterly Committee Report: See attached. Harbolt said that the Steering Committee suggested that this committee may want to define community as stated in Goal #3. The committee agreed by consensus that they wanted to leave community open so as not to exclude anyone.

Announcements: See the attached flyer for the Road 2 Success class on August 20th and the Sharing Science Symposium on September 5th. There is a Committee Cross-Training at noon tomorrow - all Council and External members are welcome to attend. Turner said that next Wednesday she will retire from Change Happens after 20 years. She will continue to participate in Ryan White Planning Council activities until she moves to be closer to her family.

Adjournment: The meeting was adjourned at 12:35 p.m.

Submitted by: Approved by:

_____ _____

Amber Harbolt, Office of Support Date Chair of Committee Date

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

2018 Voting Record for Meeting Date July 30, 2018

MEMBERS	**Motion #1:** Agenda **Motion Carried**				**Motion #2:** Minutes **Motion Carried**				**Motion #3:** FY19 EIIHA Plan **Motion Carried**				**Motion #4:** Additional Info for the EIIHA Section **Motion Carried**			
	ABSENT	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**	**ABSENT**	**YES**	**NO**	**ABSTAIN**
Steven Vargas, Co-Chair				**C**				**C**				**C**				**C**
Ted Artiaga, Co-Chair ja 12:14 pm	**X**				**X**					**X**				**X**		
Herman Finley ja 12:21 pm	**X**				**X**					**X**				**X**		
Dawn Jenkins	**X**				**X**				**X**				**X**			
Denis Kelly	**X**				**X**				**X**				**X**			
Osaro Mgbere	**X**				**X**				**X**				**X**			
Rodney Mills		**X**				**X**				**X**				**X**		
Robert Noble	**X**				**X**				**X**				**X**			
Shital Patel	**X**				**X**				**X**				**X**			
Faye Robinson		**X**				**X**			**X**				**X**			
Isis Torrente		**X**						**X**	**X**				**X**			
Ryan Clark		**X**				**X**				**X**				**X**		
Cynthia Deverson		**X**				**X**						**X**		**X**		
Cristina Martinez	**X**				**X**				**X**				**X**			
Nancy Miertschin		**X**			**X**					**X**				**X**		
Esther Ogunjimi		**X**				**X**				**X**				**X**		
Oluseyi Orija	**X**				**X**				**X**				**X**			
Crystal Starr		**X**				**X**				**X**				**X**		
Amana Turner		**X**				**X**				**X**				**X**		
Larry Woods	**X**				**X**				**X**				**X**			

Achieving Together
A Community Plan to End the HIV Epidemic in Texas

Start where you are.
Use what you have.
Do what you can.
~ Arthur Ashe

Ending HIV as an epidemic…

…is about supporting people
who are living with HIV
and
preventing others from getting it.

Texas will become a state where HIV is rare & EVERYONE will have access

4 Goals:

- Reduce HIV transmission and acquisition
- Increase viral suppression
- Cultivate a stigma-free climate
- Eliminate health disparities

90/90/90/50 by 2030

- Priority populations receive combination prevention
- 90% of people living with HIV know their status
- 90% of PLWH are retained in care
- 90% of those retained in care are virally suppressed
- 50% decrease in HIV incidence

We have the experience

We have the tools

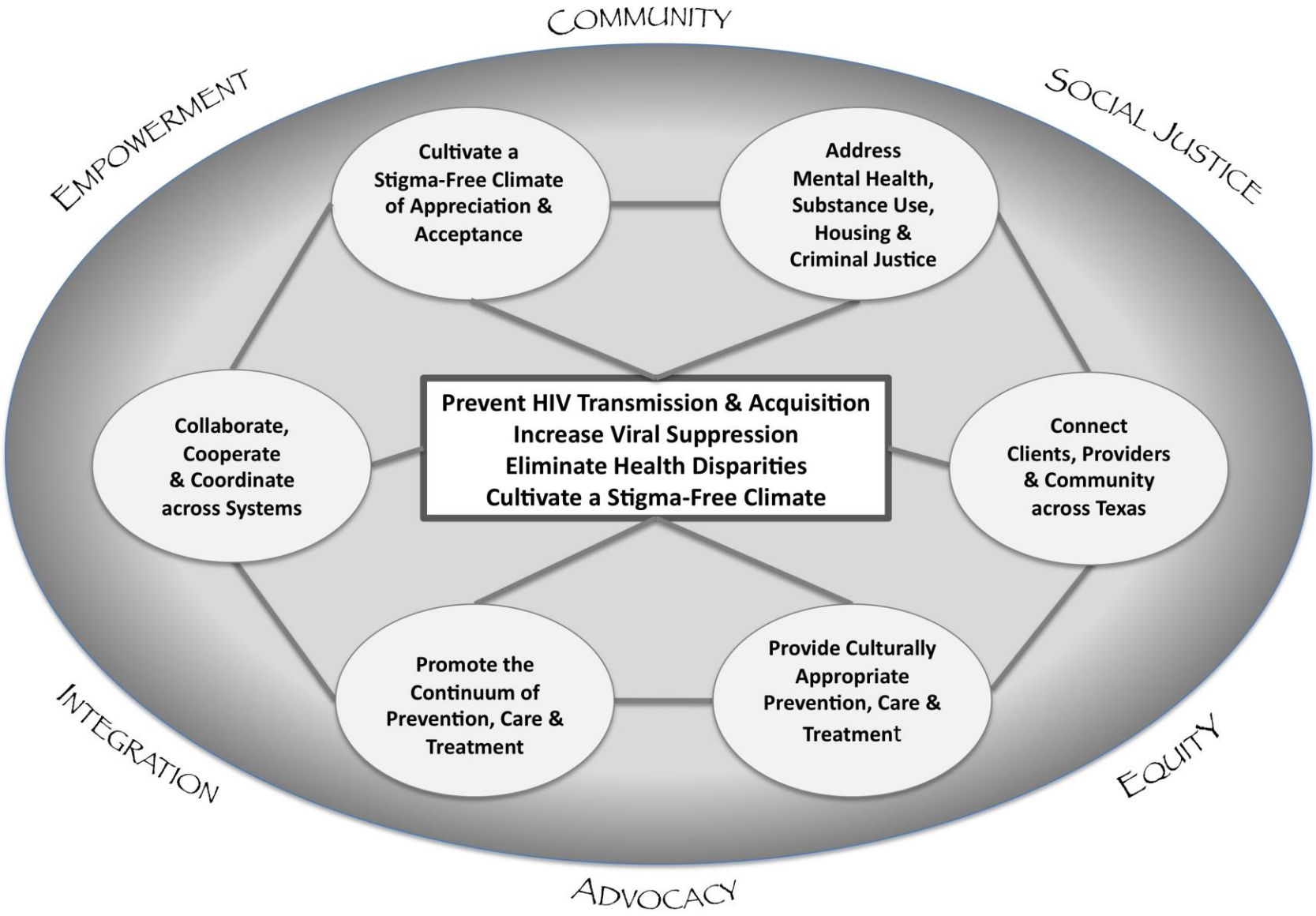
- Testing
- PrEP (pre-exposure prophylaxis)
- nPEP
- Anti-retroviral therapy (ART)
- Treatment as Prevention (TasP)
- More on the horizon…

We have the technology

- Communication
- Networking
- Data
- Electronic health records
- Others on the horizon…

We have the people & passion

How can you connect to the movement?



What matters to you?
How do you connect to the plan?

Reflection:

- What is something you heard today that concerns you?
- What is something you heard today that excites you?

Creating a movement with a plan

- https://youtu.be/RXMnDG3QzxE

Achieving Together
A Community Plan to End the HIV Epidemic in Texas

This plan reflects the ideas, recommendations, and guidance of the Texas HIV Syndicate as well as statewide community engagement efforts with people impacted by HIV, people living with HIV, clinicians, and researchers. The Texas HIV Syndicate is the Texas integrated HIV prevention and care planning group. The Texas HIV Syndicate includes representation from people living with HIV, community stakeholders, and HIV prevention and care organizational leaders.

Texas Has a Clear Vision

Texas will become a state where HIV is rare, and every person will have access to high-quality prevention, care, and treatment regardless of age, race/ethnicity, sexual orientation, gender identity, and socio-economic status.

The Time is Now

We are living at a turning point in history. More than three decades of dedicated work and research have given us the experience, tools, technology, people, and passion to end the HIV epidemic. We know that reducing HIV viral load is a powerful tool both for enhancing the health of individuals and preventing transmission of the disease. We have a better understanding of how the environment creates health inequities and continues to allow inequities to persist. This increased understanding provides us with an opportunity to engage in conversations that can influence action. It also reinforces our commitment to create systems for all people to thrive. Our knowledge and understanding continues to grow and the possibility of ending the HIV epidemic is a reality on the horizon.

Now is the time to create the will and the environment to end the HIV epidemic.

We must combine strategies.

We must go beyond the focus on individual behavior to actions that will influence systems, communities, and social norms.

We must adapt systems and structures to make it easier for all people to access the HIV prevention, care, and treatment they need in order to thrive.

We will create a Texas that supports people and makes it easy for them to be their healthiest selves, to have healthy sex lives, and to achieve personal wellbeing.

We have the experience:

Combination prevention is a framework for HIV prevention. It includes behavioral, biomedical, and structural interventions that are appropriate for an individual or community. Years of research and dedicated work have resulted in HIV prevention tools that work, including[1]:

- HIV testing and linkage to care
- HIV medications
- Access to condoms
- Behavioral interventions for people living with HIV and their partners
- Behavioral interventions for people vulnerable to HIV
- Treatment of substance use disorders and access to sterile syringes
- Sexually Transmitted Infection (STI) screening and treatment

We have the biomedical tools:

- **Testing:** Testing is often the first step for people to access HIV prevention, care, or treatment services. With support in place:
    - People who test negative for HIV can be counseled on their risk and be offered resources to prevent it.
    - People who test positive can stay healthy by accessing care and prevent transmitting HIV to others by taking medications and using condoms.

- **Pre-exposure prophylaxis (PrEP)** is a medication protocol that prevents HIV acquisition when used correctly.

- **Non-occupational post-exposure prophylaxis (nPEP)** is a protocol for taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent acquiring the virus. nPEP must be started within 72 hours after a recent possible exposure to HIV.

- **Anti-retroviral therapy (ART)** is the combination of medications used to control HIV. The goal is to reduce the viral load and lead to viral suppression. When the virus is suppressed, people have better health outcomes and the chance of transmitting HIV is greatly reduced.

1 Centers for Disease Control and Prevention. https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/hiv-proven-prevention-methods-508.pdf

* **Treatment as Prevention (TasP):** People living with HIV who are on ART and whose viral load has remained suppressed for at least 6 months have effectively no risk of transmitting HIV.

* **Viral load** is the number of HIV particles in a milliliter sample of blood. **Community Viral Load** is a way of measuring viral load across a population and is a useful way to measure disparities. As community viral load goes down, the virus is less likely to spread and we will be closer to ending the HIV epidemic.

We have the people:

The Texas HIV Syndicate and the people working in the field are passionate, motivated, and bring years of experience to this movement. Every person who reads this plan and takes action based on our guiding principles creates momentum toward our goals.

We have the technology:

Technology and other innovations are changing the way people connect, learn, make decisions, and take action. They expand networks and the roles that everyone plays in the healthcare process. Technology doesn't replace face-to-face human interaction; it increases the ways that people can navigate wellness and create community. We must use technology effectively for prevention, care, and treatment. We must start by understanding the ways technology is changing the social and healthcare landscapes. Then we can leverage it to help people thrive.

A foundation has been created through years of experience, research, and dedicated work. This foundation, along with many more advances on the horizon, does something profound. It allow us to imagine what was once unimaginable: the possibility of an AIDS-free generation, the ability to live freely and without fear of transmitting or acquiring HIV.

There are many ways to reach the goals of the plan, just like there are many pathways for individuals to meet their health and wellness goals. The purpose of this plan is to inspire and guide people, organizations, and communities to take action in ways that will move Texas in the direction of ending the HIV epidemic.

Is HIV an epidemic in Texas?

HIV is considered an epidemic in Texas because of the large numbers of cases involved. Even as tools for preventing and treating HIV have grown, the rates of new HIV cases have stayed the same between 2008-2017 and disparities have increased in communities that have been historically marginalized.

What Does Ending the HIV Epidemic Mean?

Ending HIV as an epidemic is about supporting people who are living with HIV and preventing others from acquiring it. It involves using a combination of the behavioral and biomedical tools available, creating a stigma-free climate, and reducing barriers in systems that keep people from accessing services and achieving their health and wellness goals. It continues the work and honors the accomplishments of those who came before us and of the long-term HIV survivors still among us.

We need a plan that works for everyone, no matter their race, ethnicity, sexual orientation, gender identity, age, geographic location, socio-economic status, or life circumstances.

Populations Most Impacted by HIV

Data show that the five populations in Texas most impacted by HIV are Latino, Black, and White gay, bisexual and other men who have sex with men; Black women; and Transgender individuals. Many of these communities face barriers affecting their access and ability to focus on HIV prevention and care. We will not achieve our goals without working with and addressing the needs of these communities.

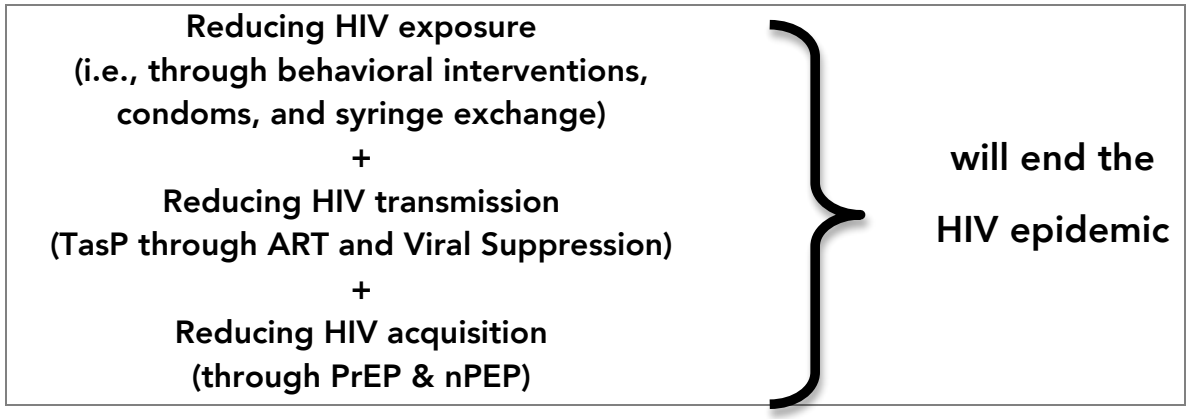
There is often an intersection of factors that increases risk for acquiring HIV and different populations are affected in each part of the state. To find out more about who is affected in your community, go to AIDSvu.org.

Data sidebar to include:

- Basic data visual on where we are now, perhaps highlighting disparities
- Potential cost-savings of prevention and viral suppression (over 10, 20, 30 years?)
- Reference to DSHS dashboard for additional data

Four Goals Will Make Our Vision a Reality

1. Reduce HIV transmission and acquisition



2. Increase viral suppression

Achieving and maintaining a suppressed viral load (less than 200 copies per ml of blood) prevents HIV transmission. This is Treatment as Prevention (TasP). For people living with HIV (PLWH), this changes what it means to live with HIV and can remove the fear that many PLWH have about transmitting HIV to others.

3. Eliminate health disparities

Some people are more likely to be affected by HIV because they are part of a group that does not have access to the same resources as others. No one should be denied the possibility of being healthy because of their identity. Ending the HIV epidemic involves creating new pathways for people who historically have been disenfranchised because of systemic racism, sexism, homophobia, and transphobia.

4. Cultivate a stigma-free climate

Stigma is a social norm that is reinforced by societal messages, the language we use, and the way we interact. We can cultivate a stigma-free climate through awareness and understanding of specific issues, empowering communities, promoting inclusive language and messages, and creating equitable systems.

Measuring Success:

By 2030, we aim to achieve…

- An increase in the proportion of people from priority populations who receive combination prevention[2]
- 90% of people living with HIV (PWLH) know their status
- 90% of PLWH are on treatment.
- 90% of those on treatment are virally suppressed
- 50% decrease in HIV incidence

…while striving for equity among priority populations across all measures and indicators.

The 90/90/90/50 targets align with the Fast-Track Cities initiative led by the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat).

We want to create forward momentum on the things we can measure directly, and we also recognize that those are not the only things that matter. We cannot end the HIV epidemic without increasing awareness, addressing stigma, and working to end institutionalized racism, sexism, homophobia, and transphobia.

[2] A baseline measure will be established.

[SIDEBAR TEXT]
Complex Questions

The work to end the HIV epidemic in Texas requires us to explore questions that do not have an immediate or simple answer. We will continue to listen and learn from different perspectives. Some of the questions to consider include:

* **Where are we ending the epidemic and where are we maintaining the status quo?**
  Small changes can have a big impact when they are strategically chosen. At every stage of planning, we must ask whether an action will move us toward ending the epidemic or hold things in place.

* **How can we honor individuals by creating systems that work for them?**
  Health equity is about creating systems that allow all people to be able to achieve the best health possible. All systems (political, social, religious, educational, transportation, justice, etc.) must work together to meet people where they are.

* **Are we cultivating acceptance or stigma?**
  Language, messages, and strategies can unintentionally stigmatize a group of people. If we are aware of our own biases and address them, then we can be more open to different perspectives. Language is evolving constantly. When we know the historical context of language, we can be more intentional in cultivating a climate where people feel accepted.

* **How can we prioritize communities without further stigmatizing them?**
  Data without context does not tell the whole story. We must share data and highlight inequities while also providing insight into the environment and conditions that created these inequities.

* **How can understanding our history help us move forward?**
  We must learn from our past to ensure we do not repeat injustices in the future. Our history contains answers to how inequities were created and can provide insight into what needs to be done in order to address injustices. Laws were created that prevented specific populations from accessing resources that were available to others. People of color and the LGBTQ community have a history of being discriminated against within systems; the stigma and discrimination associated with these systems affects how individuals operate within them. We must understand generational trauma and the impact this has had on health-seeking behaviors. We must recognize that there are cycles of learned mistrust of the medical system that contribute to why these communities seek health care less frequently even if they have access to insurance.

Guiding Principles

A plan for ending the HIV epidemic in Texas must be flexible, adaptable, and actionable in order to fit the needs of communities across the state. At the same time, the plan must also chart the course for everyone to be moving in the same direction. Guiding principles offer a tool for planning in complex and fast-changing times.

* **Social Justice:** Aim to remove barriers, eliminate oppressive systems, and provide opportunities and freedoms so that people from all communities - including Black, Latino, and LGBTQ communities - can thrive and achieve optimal health and wellness.

* **Equity:** Focus on strategies that will create access to resources and services for all people, eliminate inequities, and increase people's capacity to make decisions that affect themselves, their families, and their communities. Focus especially on those communities that face the biggest barriers affecting their access and ability to focus on HIV prevention, treatment, and care services.

* **Integration:** Create an integrated system of HIV prevention, treatment, care, and advocacy across the state. Allow space for ideas and innovation to emerge and for each part of the system to function individually and collectively to their greatest capacity. Build bridges to connect people, groups, organizations, and systems in order to share data, resources, knowledge, funding, and support.

* **Empowerment:** Support shared decision-making between people affected by HIV and providers and across systems. Recognize that people are experts in their own lives. Provide people with the skills, tools, and health literacy needed to navigate their health and wellbeing. Build capacity in the people and organizations working in the field so that they can be leaders and role models for the communities they serve.

* **Advocacy:** Promote and implement policies that will support the work in all areas of the plan. We need supportive policies at the federal, state, local, and organizational levels. In addition to policy work by people who work within health and legislative systems, there is a role for advocates and grassroots efforts outside of these established systems.

* **Community:** Lasting change happens at the local level among people who are working together, without a partisan frame, to create a healthy community. To create movement around this plan, start by strengthening existing relationships among people and organizations and reaching out to new ones. Listen and learn from multiple perspectives and build bridges with non-traditional partners and with people who have been left out of the conversation in the past. This creates opportunities to hear their stories and questions and to learn about what matters to them. Then, the work of this plan will reflect all people who are affected by HIV.

[SIDEBAR}

Vision and Principles-Based Planning

To create a "Texas-sized plan," we developed a vision-based plan rather than a monitoring or metric-based plan. That does not mean that we do not have clearly defined outcomes. Instead we start with a vision and then think about what support we need to move toward that vision.

Complexity science has identified strategies needed to thrive in complex systems, including using vision-based planning. G.U.I.D.E. is a framework developed by Michael Quinn Patton, for effective, vision-based planning and evaluation.[3] The acronym defines criteria for effective planning that is flexible, adaptable, and actionable.

Guiding – Defines areas to focus attention and specifies a direction or priorities for action.

Useful – Describes how to be effective, points toward desired results, and allows people to see their role in moving forward.

Inspiring – Based on shared vision and values and brings people together around a shared purpose.

Developmental – Flexible and adaptable to specific contexts so it can be applied in multiple situations and it stays relevant even with changes in the social, political or biomedical environment.

Evaluable – Provides pathways to measure what is happening and whether the actions are moving us in the direction we want to go.

[3] Patton, MQ. 2018. Principles Focused Evaluation. Guilford Press.

Focus Areas

The Texas HIV Syndicate identified six areas to focus attention in order to reach the goals of the plan. We believe that specific and bold action and advocacy across all of areas will have a high impact on our goals. These areas are outlined below and described in depth on the following pages.

These focus areas are interconnected and we must address **all of them** if we are going to reach our goals. None of this can be accomplished in isolation, just like no single person or entity can end the HIV epidemic. It will take the synergy of people, organizations, and communities each identifying where they can contribute and taking action. Find your place in this work.

Start where you are.
Use what you have.
Do what you can.
~ Arthur Ashe

Cultivate a stigma-free climate of appreciation and inclusion. Stigma is a negative social norm that is based on beliefs and perceptions. Change the language, the messages, and the story to promote sexual health and wellness for all people. Normalize HIV testing, prevention, care, and treatment within the healthcare system to help change perceptions and beliefs.

Address mental health, substance use, housing, and criminal justice. Addressing the interplay of mental health and substance use disorders, criminal justice, and housing is essential to creating supportive and stable environments in which people can achieve their health and wellness goals.

Collaborate, cooperate, and coordinate across systems. Create systems and processes to share data and resources and to build collaborative partnerships. Build connections with other systems that impact HIV prevention, care, and treatment such as education, housing, transportation, employment, mental health, substance use, and criminal justice. Coordinate funding opportunities to promote coordination of services across the continuum.

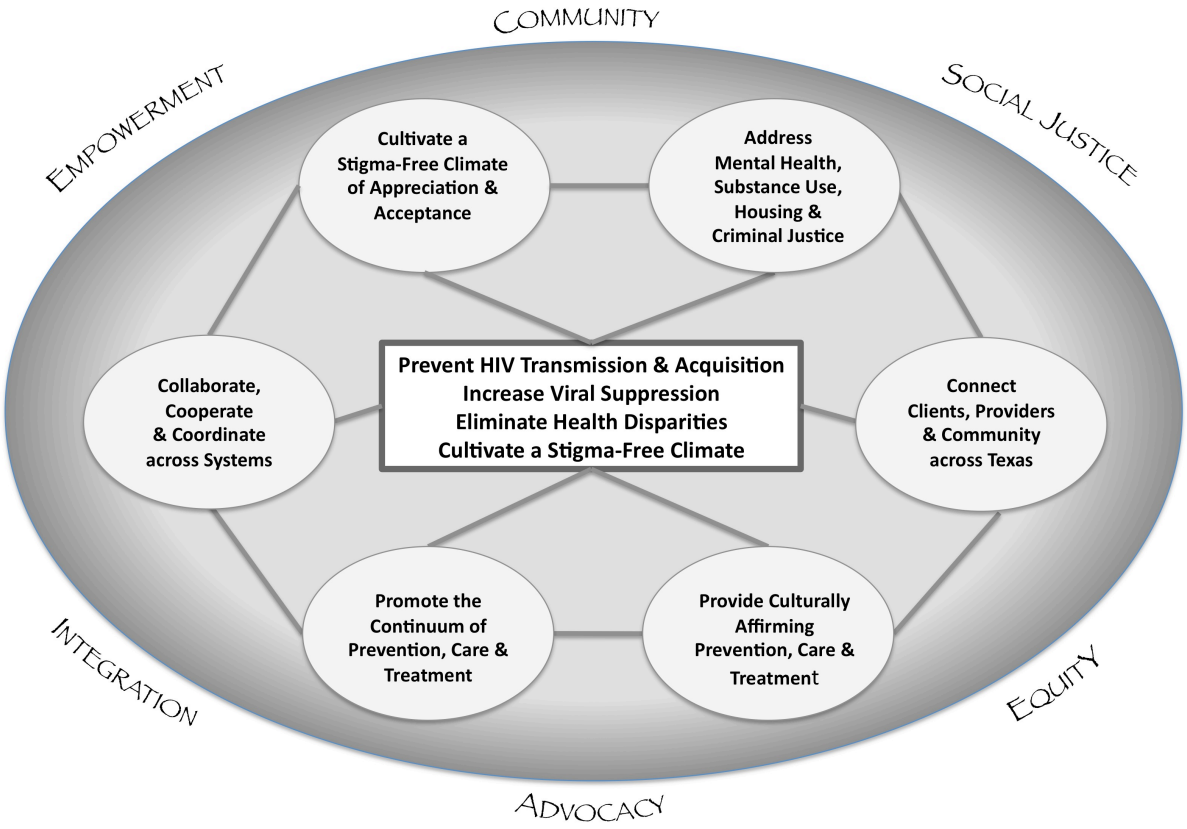
Connect clients, providers, and communities across Texas. Strong networks create multiple pathways for people to connect with HIV prevention, care, and treatment. This can increase access and actively involve communities in outreach and advocacy. In-person efforts like community mobilization and peer networks are proven methods of building support for involvement in HIV prevention, care, and treatment. New and emerging technology, including mobile apps, telehealth, at-home testing, and web-based provider education, create options for people to access services and information.

Provide culturally appropriate HIV prevention, care, and treatment. Providers and people who are planning programs must create relationships with people and communities affected by HIV based on mutual respect and an understanding of cultural humility in practice. Community-guided planning and data that is inclusive of all population groups will support programs and interventions that are culturally appropriate.

Promote the continuum of HIV prevention, care, and treatment. Biomedical tools, supported by behavioral interventions, continue to change the way we think about HIV prevention and treatment. The continuum of prevention, care, and treatment starts with testing and continues with systems of care that are in place to promote these interventions.

Plan Framework:

**Texas will become a state where HIV is rare,
and every person will have access to high-quality prevention and care services
regardless of age, race/ethnicity, sexual orientation,
gender identity, and socio-economic status.**



Focus Area:

Cultivate a stigma-free climate of appreciation and acceptance.

Addressing the language, messages, and story around HIV, sexual health, mental health, substance use, ethnicity, and race will help to create a safe, life-affirming environment that will promote health and wellness for all people. Normalizing HIV testing, prevention, care, and treatment within the healthcare system will help change perceptions and beliefs.

Aspirations[4]

1. Recognize that language evolves over time and create shared language that promotes appreciation and inclusion of all people.
2. Offer messages that promote overall health and wellness without stigma attached to mental health, substance use, and sexuality.
3. Understand and educate communities about the impact the intersectionality of race, sex, and gender has on health and wellness.
4. Create opportunities for conversations about healthy sexuality.
5. Normalize HIV testing into all clinical and non-clinical settings by making it routine.
6. Incorporate HIV treatment and care into primary medical care.

Take Action[5]

Shared language

- Work with communities to develop and adopt language that is person-first and de-stigmatizing, and promote life-affirming language in written materials, policy, and face-to-face interactions.
- Translate and interpret into other languages, especially Spanish.
- Develop original culturally and linguistically appropriate materials and messages in languages other than English.

Accurate messages

- Normalize the conversations about HIV with providers and communities.

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[4] An aspiration is a hopeful desire to achieve something.

[5] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

- Normalize conversations about sex and sexual health within the health care and broader environment.
- Work with communities of faith to promote messages of acceptance and inclusion.
- Educate about the impact of stigma on: people living with HIV; communities of color; LGBTQ communities; people with mental health and substance use disorders; and people living in poverty.
- Replace fear-based safer sex messages with opportunities for conversations on healthy sexuality and relationships.

Normalized HIV testing, prevention, treatment, and care within the healthcare system

- Implement opt-out, routine screening in all clinical settings (e.g. hospital emergency departments, inpatient services and outpatient clinics, primary care clinics, urgent care clinics, store-based health clinics, substance use treatment centers, STD clinics, etc.).
- Expand provider education to include HIV education for all health care providers.
- Incorporate HIV prevention and care into primary and emergency care settings, including combination prevention, PrEP, nPEP, and ART.
- Routinize conversations about combination prevention and healthy sexuality and wellness in all healthcare settings.

Policy and advocacy to support this area:

- Use appropriate community-driven language in all local and state policy, planning, and communication. Work with funders and federal partners to promote appropriate language.
- Promote comprehensive sexual health education through schools.
- Integrate HIV and sexual health education into curricula at medical schools, nursing schools, and other schools that train healthcare professionals.
- Advocate for opt-out, routine testing.
- Model economic impact of integrating HIV testing and care into routine care.
- Advocate for policies that support syringe exchange and overdose prevention.
- Advocate to remove policies that discriminate against people based on their race, gender identity, sexual orientation.

[SIDEBAR]

What is stigma?

Stigma is a negative social norm that is based on learned beliefs and perceptions about people or communities who are perceived as different in some way. Discrimination occurs when people and societies deprive certain groups of individuals of the rights and life opportunities that are afforded to other people, such as housing, healthcare, employment, education, and opportunities for civic life[6].

[6] http://www.saludhealthinfo.com/health/TheRootsofStigmaandDiscrimination.html

Focus Area:
Address mental health, substance use, housing, and criminal justice.

Addressing mental health, substance use disorders, criminal justice, and housing is essential to creating supportive and stable environments in which people can achieve their health and wellness goals.

Aspirations[7]

1. Recognize and understand the intersections of mental health, substance use, housing, and criminal justice and the impact these have on people's ability to access HIV services.
2. Increase access to mental health services and substance use disorder treatment.
3. Create access to housing opportunities for people living with HIV, especially those who have been incarcerated.
4. Remove policies that perpetuate stigma and limit access for people with mental health and substance use disorders or who have been incarcerated.
5. Address the impact of mass incarceration on racial and economic disparities that contribute to the HIV epidemic.
6. Address the barriers to HIV prevention, care, and treatment created by the fear of deportation and by the inadequate services offered in immigration detention centers.
7. Create a seamless flow of HIV prevention, treatment, and care services for people who transition in and out of the criminal justice system.

Take Action[8]

Mental Health

- Promote a recovery model for mental health disorders, including broadening the base of trained mental health recovery coaches.
- Establish collaborations between HIV organizations and mental health providers.
- Adopt models for co-location of services.

[7] An aspiration is a hopeful desire to achieve something.

[8] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

Substance Use

- Promote a harm reduction approach to substance use disorders.
- Promote a recovery model for substance use disorders, including broadening the base of trained substance use recovery coaches.
- Develop relationships between local law enforcement, mental health authorities, and substance use communities to promote treatment rather than incarceration for substance use.
- Promote access to long-term treatment and mental health services for people who are under- or uninsured or living in poverty.

Housing

- Pilot the use of HOPWA (Housing Opportunities for Persons with AIDS[9]) funds for post-incarceration housing assistance and develop outcome measures and best practice models for adoption of successful models.
- Adopt the Housing First evidence-based model for helping people with mental health and substance use disorders get housing[10].
- Collaborate and coordinate with housing authorities to create synergy of ideas, strategies, and advocacy.

Criminal Justice

- Ensure continued, consistent HIV prevention, care, and treatment in the correctional health system.
- Provide access to HIV prevention, care, and treatment in immigration detention centers.
- Operationalize post-incarceration service flow in order to provide comprehensive medical and supportive services for people who have been released from prisons and jails.
- Implement the Healthy Person initiative to improve HIV/AIDS literacy in the correctional system.
- Work with criminal justice advocates to address the inequities and disparities in the criminal justice system. Collaborate and coordinate with criminal justice professionals and advocates to bring improvements to the current systems.
- Work with immigration advocates to address the impacts that immigration policies are having on HIV prevention, treatment, and care.

[9] The Housing Opportunities for Persons With AIDS (HOPWA) Program is the only Federal program dedicated to the housing needs of people living with HIV/AIDS.
https://www.hudexchange.info/programs/hopwa/

[10] https://www.usich.gov/solutions/housing/housing-first

Policy and advocacy to support this area:

- Highlight data to support syringe exchange programs in Texas.
- Advocate for changes in federal laws that restrict housing.
- Remove barriers to hiring people based on criminal history.
- Advocate for condom access in the correctional system by researching the success of condom distribution programs in correctional-settings and promoting findings with Texas Department of Criminal Justice (TDCJ) and county jail officials.
- Promote and educate providers in the correctional, housing, mental health and substance use treatment settings on the advances in HIV prevention and treatment and how they can help.
- Advocate for safe and legal injection sites.

Focus Area:

Connect clients, providers, and communities across Texas.

Strong networks create multiple pathways for people to connect with HIV prevention, care, and treatment. This can increase access and actively involve communities in outreach and advocacy. In-person efforts like community mobilization and peer networks are proven methods of building support for involvement in HIV prevention, care, and treatment. New and emerging technology, including mobile apps, telehealth, at-home testing, and web-based provider education, create options for people to access services and information.

Aspirations[11]

1. Expand access to testing, prevention, treatment, and care.
2. Same day test to treatment time.
3. Adopt wide use of current technology across testing, prevention, treatment, and care.
4. Expand provider base across Texas.
5. Expand peer navigation networks across Texas.
6. Increase collaboration between primary care and specialty HIV providers.

Take Action[12]

Technology across testing, prevention, treatment, and care

- Expand the use of telehealth for case management, mental health care, risk reduction, and prevention in addition to medical care.
- Explore the use of mobile apps for consumers and providers.
- Use technology to streamline the enrollment process.
- Expand the availability of at-home testing.
- Embrace and adopt new and emerging technologies.
- Expand the use of electronic medical records (EMRs) (e.g., screening algorithms, laboratory ordering, linkage to care tracking) to increase health outcomes for patients, efficiency for clinicians, and coordination across systems.

[11] An aspiration is a hopeful desire to achieve something.

[12] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

Peer networks

- Develop and adopt a peer navigation training program.
- Develop inclusive policies for hiring and training peer navigators that reflect the people affected by HIV in the community.
- Expand the role of and support for peer navigators across communities.
- Develop support structures to build advocacy and leadership skills for peer networks to engage the HIV community and to be advocates in other systems.

Community mobilization

- Implement community engagement strategies to identify and involve people affected by HIV in disenfranchised communities.
- Build capacity for leadership and advocacy, especially in communities that have been historically disenfranchised.
- Highlight and implement best practices.

Accessible testing, prevention, treatment, and care

- Address health literacy needs by considering ways to ease the burden on consumers.
- Offer non-traditional hours that meet the needs of the community.
- Create models for co-location of services and "one-stop-shop" regardless of HIV status.
- Redesign health-care roles to utilize medical assistants and other licensed professionals in HIV prevention, treatment, and care.
- Expand the uses of mobile care: intake, healthcare, appointments, labs, testing, and syringe exchange.
- Develop approaches to engage and retain youth in HIV prevention, treatment, and care.
- Create environments where people feel safe accessing prevention, treatment, and care services regardless of their gender, sexual identity, race, ethnicity, or immigration status.

Provider base and collaboration between primary care and specialty HIV providers

- Work with medical schools to expand HIV education into primary care curriculum.
- Improve data sharing to improve communication between providers.
- Strengthen the provider base through peer-to-peer networks and web-based distance education for providers.

- Build capacity and proficiencies of HIV care providers throughout the state through the use of web-based peer-to-peer training.

Policy and advocacy to support this area:

- Develop agency policies that provide support for people to remain in care.
- Increase access by advocating for Medicaid expansion and universal health coverage.
- Understand the minimum requirements and barriers to the adoption of technology, including EMR, social media, texting, mobile apps, and other emerging technologies.
- Advocate to develop policies at the local and state level that will facilitate the adoption of technologies that will increase access.
- Understand the minimum requirements and barriers to adoption of technology, including social media, texting, mobile apps, and emerging technologies. Advocate to develop policies at the local and state level that will facilitate the adoption of technologies that will increase access.
- Adjust policies to support hiring and training peers navigators.
- Advocate for the reimbursement of peer-delivered interventions.
- Remove barriers to hiring people based on criminal history.
- Increase the availability/access of at-home testing and connection to providers.

[SIDEBAR TEXT]

Health Literacy

There are many literacy-related tasks involved with understanding, preventing, and managing a disease like HIV, as well as navigating the systems involved. Health literacy is a function of both individual skills and the structure of the healthcare system.[13] Research on health literacy highlights the gap between the demands and expectations of health systems and individuals' skills.[14] The shift in focus from the individual to the health care system also shifts the burden of responsibility from patients to the communicators of health information. All members of a health care system or

13 1. Paasche-Orlow, MK.Wolf, MS. The causal pathways linking health literacy to health outcomes. *American Journal of Health Behavior*. 2007;31(Suppl 1):S19-S26(8).

14 1. Institute of Medicine. Committee on Health Literacy. Health Literacy: A Prescription to End Confusion. Washington DC: The National Academies Press. 2004.

organization must communicate clearly so that people can effectively participate in health care services and medical treatment.

As technology becomes more widely used in health care, people need to be able to access, understand, and use electronic health information. Digital health literacy involves more than the ability to read and understand written language. People need to know how to use a computer, smartphone, or other device. People also need to be able to understand health terms, identify credible sources of health information, and know the limitations and applicability of information they find. They need to be able to navigate online portals and understand how their personal health information is used online.

People and organizations involved in planning and providing health-related information and services must rethink their assumptions about what people can easily understand and do. Consider ways to ease the burden on the people who use materials or services when developing communication materials, reviewing operating procedures or systems, or working directly with consumers. For more information, visit https://hivhealthliteracy.careacttarget.org/iit/resources.

Focus Area:

Provide culturally affirming prevention, care, and treatment.

Providers and people who plan programs must create relationships with people and communities affected by HIV based on mutual respect and an understanding of cultural humility in practice. Community-guided planning and data that is inclusive of all population groups will support programs and interventions that are culturally appropriate and will help people find the right pathway to meet their health and wellness goals.

Aspirations[15]

1. Increase equity in opportunities for Latino, Black, and White gay, bisexual and other men who have sex with men, Black women, and Transgender individuals to achieve positive health outcomes, especially viral suppression.
2. Increase the possible pathways through which people can achieve viral suppression.
3. Institutionalize consumer-centered healthcare and shared decision-making.

Take Action[16]

A. Cultural humility, sensitivity, competency, and equity

- Review eligibility processes, standards of care, and documentation requirements to ensure they are equitable to the populations being served.
- Make access to PrEP, prevention, and treatment equally available and accessible.
- Expand the positive messaging to all the systems that people seeking HIV prevention, treatment, and care come in contact with.
- Work with communities to develop and adopt language that is person-first, de-stigmatizing, and life affirming in written materials, policy, and face-to-face interactions.
- Provide materials and services in Spanish and other languages where it is appropriate.
    - Identify or create and implement effective cultural humility and equity training for providers and people working in systems that impact HIV.

i. Develop cultural humility accountability standards for providers.

[15] An aspiration is a hopeful desire to achieve something.

[16] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

Community-guided planning

- Create ongoing pathways for meaningful community engagement in local and statewide planning with a focus on participation from:
    - Latino, Black, and White gay, bisexual and other men who have sex with men; Black women; and Transgender individuals
    - Young people within the priority populations
    - Aging population of people living with HIV
- Collaborate and coordinate with other systems that are also involved in community planning.

Data-informed planning and services

- Improve data collection on under-reported populations, including transgender individuals, uninsured, youth in priority populations, youth living with HIV transitioning from pediatric to adult care, and aging populations transitioning from private insurance to public insurance.
- Use asset mapping in addition to needs assessments at the state and local levels in order to build on strengths and resources of communities.
- Use data to inform decisions about services.

Policy and advocacy to support this area:

- Advocate to remove policies that discriminate against people based on their race, gender identity, or sexual orientation.
- Advocate for training that supports organizations to provide culturally affirming services.
- Adapt systems to meet the needs of the changing epidemic and diverse cultures.
- Provide more flexibility in funding organizations and groups that work specifically with and are led by gay, bisexual and other men who have sex with men, communities of color and gender non-conforming communities.
- Advocate for providing additional technical assistance to organizations and groups that work specifically with and are led by gay, bisexual and other men who have sex with men, communities of color and gender non-conforming communities to build capacity within these communities.
- Advocate for flexibility in the eligibility process to remove barriers and meet the needs of people from diverse communities.
- Advocate for flexibility in the documentation requirements that might present barriers to people experiencing homelessness and immigration issues.

[SIDEBAR TEXT]

Cultural sensitivity, humility, and competence have often been used in place of one another depending on the context being used. More recently, they have developed distinct meanings and represent a spectrum of cultural knowledge and awareness.

Cultural sensitivity[17]*:*

- Cultural sensitivity begins with a *recognition* that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another, and they carry over into interactions with healthcare providers.

Cultural humility[18]*:*

- Cultural humility refers to *respecting* the validity of another person's culture and *accepting* the creative tension of holding two different perspectives simultaneously.

Cultural competence[19]*:*

- Cultural competence refers to the capacity of an individual or organization to *communicate and interact effectively* with people of similar and dissimilar cultures. It is a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables *effective work in cross-cultural situations*.

Cultural equity[20]*:*

- Cultural equity is an emerging concept that all cultures be equally represented, respected, and honored as an overall part of a community. It takes the approach

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[17] **B. Chandler, The Gale Encyclopedia of Nursing and Allied Health, 3rd ed., vol. 2, Detroit: Gale, 2013, pp. 921-23.**

[18] A. Guskin, "Cultural humility," in *The SAGE encyclopedia of intercultural competence*, Bennett, J. ed., Thousand Oaks, CA: SAGE Publications, 2015, pp. 163-4.

[19] D. Frederick, N. Ng and S. Yousefinejad, "Cultural competence," in *Multicultural America: A Multimedia Encyclopedia*, C. E. Cortez, Ed., Thousand Oaks, CA: SAGE Publications, 2013, pp. 638-40.

[20] Add citation.

that diversity should be valued, embraced, and preserved.

[SIDEBAR]

Talking About My Generation

It is important to pay attention to generational differences when planning culturally appropriate prevention, care, and treatment. For example, long-term survivors of HIV have unique needs as they age, including managing co-morbidities, long-term effects of medication, and aging in place. Youth within priority populations may have different perspectives on HIV compared with older generations. Many view HIV as a treatable chronic disease and this impacts their perception of risk. Many young people also choose to connect with each other, with information, and with systems in different ways than people in other generations.

Shared Decision-Making

Shared decision-making is a collaborative process that allows patients and their providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patients' needs, values, and preferences.

Focus Area:
Promote the continuum of prevention, care, and treatment.

Biomedical tools, supported by behavioral interventions, change the way we think about HIV prevention and treatment. The continuum of prevention, care, and treatment starts with awareness and continues with testing and systems of care that are in place to promote these interventions.

Aspirations[21]

1. Integrate the prevention and care continuum through a status neutral lens – care should happen regardless of status.
2. Increase medication adherence and retention in care among people living with HIV.
3. Increase viral suppression among people living with HIV.

Take Action[22]

Integrated prevention and care continuums

- Re-envision the system as person-centered rather than provider-centered
- Provide supportive care services (e.g., housing, nutrition, mental health) across the continuum based on need.

Biomedical interventions

- Increase the awareness, availability, and accessibility of pre-exposure prophylaxis (PrEP) as a biomedical prevention option for people vulnerable to HIV.
- Increase the awareness, availability, and accessibility of non-occupational post-exposure prophylaxis (nPEP) as a biomedical prevention option.
- Increase provider understanding of and willingness to prescribe PrEP and nPEP.
- Provide anti-retroviral therapy (ART) to all people living with HIV, regardless of viral load and CD4+ T-cell counts, to promote viral suppression.
- Improve access to care to optimize treatment as prevention.

[21] An aspiration is a hopeful desire to achieve something.

[22] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

- Increase the availability and accessibility of systems that use test and treat models that get people from diagnosis into care and on treatment within 72 hours.

Behavioral interventions

- Continue to adopt and use behavioral interventions.
- Pilot, evaluate, and increase scalability of effective behavioral interventions that increase healthy outcomes and wellness.
- Incorporate biomedical interventions into behavioral intervention models.

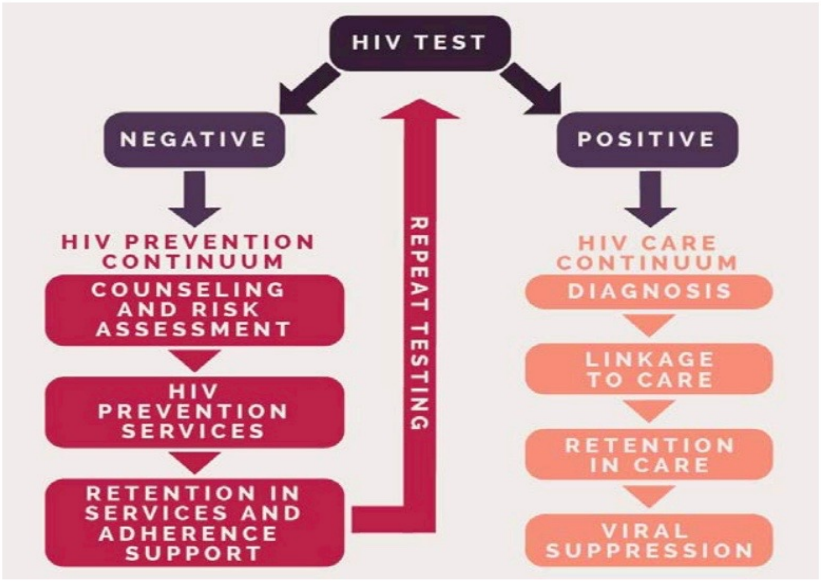
Policy and advocacy to support this area:

- Advocate for continued funding for HIV research toward a cure and a vaccine.
- Advocate for Medicaid expansion.
- Leverage existing campaigns to promote treatment as prevention.
- Advocate for policies that support condom distribution.
- Advocate for covering related medical costs associated with PrEP and nPEP.
- Advocate for continued access to 340B drug discount program for ART & PrEP.
- Advocate for PrEP assistance programs.

[SIDEBAR]

Status Neutral Visual of Pathways

Where is says HIV Prevention Services, change to "Combination Prevention"
Where it says Retention, change to "Retention in Combination Prevention Services"



Adapted from Horn et al. J Int AIDS Soc. 2016 Nov 17;19(1):21263.

Definitions

Viral load is the number of HIV particles in a milliliter sample of blood.

Viral Suppression is defined as suppressing or reducing the function and replication of a virus. The term "viral load" refers to the number of copies of HIV per millileter of blood. In other words, it is the amount of virus in the blood.

CD4+ T-cells are immune cells that can be destroyed by the HIV. A CD4+ cell count measures how many CD4 cells are in the blood. The higher the CD4 count, the healthier the immune system.

Anti-retroviral therapy (ART) is the combination of medications used to treat HIV. The goal is to reduce the viral load and lead to viral suppression.

Treatment as Prevention – Research shows that people living with HIV whose viral loads are suppressed (under 200 copies per mL of blood) for at least 6 months cannot transmit HIV.

Test and Treat is an intervention strategy in which the population at risk is screened for HIV and people diagnosed with HIV receive early treatment with anti-retroviral therapy (ART), reducing potential transmission to other people.

Pre-exposure prophylaxis (PrEP) is a medical protocol that prevents HIV acquisition when used correctly.

Non-occupational post-exposure prophylaxis (nPEP) is a protocol of taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent acquiring the virus. PEP must be started within 72 hours after a recent possible exposure to HIV.

Focus Area:
Collaborate, cooperate, and coordinate across systems.

Create systems and processes to share data and resources and to build collaborative partnerships. Build connections with other systems that impact HIV prevention, care, and treatment such as education, housing, transportation, employment, mental health, substance use, and criminal justice. Coordinate funding opportunities to promote coordination of services across the continuum.

Aspirations[23]

1. Build leadership, networking, and evaluation capacity within the Texas HIV Syndicate membership as change agents within their regions.
2. Strengthen existing relationships with current allies and build bridges to work with new partners.
3. Cultivate cooperative and collaborative environments at all levels across the state.
4. Create a statewide data system that meets the needs of all stakeholders.
5. Create platforms and increase efficiencies for statewide communication and centralized data and resource sharing.

Take Action[24]

Data sharing

- Centralize eligibility and records at the state level.
- Integrate data systems across electronic medical record software (EMRS) that communicate with each other.
- Restructure data collection and dissemination processes to create a streamlined system for collecting and providing access to timely, accurate, and comprehensive data that reflects the current reality.

Resource sharing

- Develop an online peer-to-peer resource and information-sharing network for everyone who works in and with the HIV field in Texas.
- Create mechanisms for streamlined communication between levels of government.

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[23] An aspiration is a hopeful desire to achieve something.

[24] The actions in each section reflect potential high-impact recommendations from the EtE planning group. A longer list of ideas and strategies is available on the website.

Funding Structures

- Re-structure funding processes to encourage collaboration rather than competition at the local level.
- Coordinate funding across co-morbidities.
- Create collaborative grant models that encourage seamless services.
- Provide funding based on integrated models, funding coalitions that demonstrate that they collaboratively provide services across the continuum.
- Provide funding for organizations led by communities most impacted by health disparities.
- Move from a memorandum of understanding (MOU) model to a truly collaborative model.

Engage people in other systems, including transportation, education, faith-based communities, employment, housing, mental health, substance use, and criminal justice

- Use community-engagement strategies to build partnerships across communities.
- Invite people from other disciplines to training and educational programs on harm reduction, trauma, informed disclosure laws, and cultural humility.
- Engage faith-based and education communities in partnerships to promote understanding and acceptance.

Policy and advocacy to support this area:

- Conduct economic modeling for lifetime HIV treatment.
- Advocate for Texas government support of an Ending the Epidemic plan.
- Implement non-discrimination policies.
- Evaluate and update administrative systems and structures at the State level and with funders and federal partners to ensure that they support the implementation of this plan, including Notice of Funding Opportunities, Requests for Proposals, standards of care, outcome measures, monitoring tools, and reporting requirements.
- Create joint policies/mandates for agencies who serve the same population.
- Advocate for multiple systems to work together to holistically address the needs of communities and issues that affect HIV outcomes.

[PLAN DEVELOPMENT AND ACKNOWLEDGEMENTS]

The [EtE plan] was developed by community leaders from across Texas through a process that began at the October 2017 Texas HIV Syndicate meeting. The planning group included 111 TEXAS HIV Syndicate members and a 35-member Steering Committee consisting of TEXAS HIV Syndicate Regional Co-Chairs and other community leaders. Between November 2017 and February 2018, five workgroups and the Steering Committee met monthly via internet-based conference calls to develop the plan framework. Through a generative process, the group developed goals, guiding principles, areas of focus, aspirations, and recommended actions. A planning summit was held in Austin in January 2018 to share perspectives and create consensus around the developing concepts and vision of the plan. The UT-Austin Health Innovation and Evaluation Team facilitated all of the workgroup and Summit meetings. Representatives from the Texas Department of State Health Services HIV/STD Branch attended all meetings to listen to what the community representatives discussed. Over the course of six months, community leaders contributed over 1,000 person-hours in the development of this plan. UT-Austin drafted the plan to reflect the ideas, recommendations, and guidance of the workgroups and Steering Committee.

A Community Engagement Toolkit was created to guide the planning group members in reaching out to traditional and non-traditional stakeholders to gain additional input from the communities in which they live and work. The planning group reported feedback from individuals and groups around the state.

For more information or to get involved, visit www.achievingtogethertx.org

More information about the Texas HIV Syndicate is available at www.txhivsyndicate.org.

[Back Cover]: How can Texas achieve together?

Talk to people in your community about HIV [link to community engagement guide].

Talk to co-workers about how equity, racism, sexism, homophobia, and transphobia impact health and wellness.

Affirm people's experiences.

Ask people what pronouns they prefer.

Vote from your heart.

Talk to medical providers about mental health.

Promote healthy sex lives.

Get tested.

Talk to a health care provider about PrEP.

Ask people what matters to them.

For more information or to get involved, visit www.achievingtogethertx.org

Proposed Needs Assessment Group Activities Timeline
November 2018 – October 2019

Draft
Updated 09-06-18

Nov 2018	Dec 2019	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019
Needs Assessment Group (**NAG**) meets to design Needs Assessment (**NA**) process	Survey Workgroup creates survey tool	NAG approves survey tool and sampling plan	Analysis Workgroup adopts of principles for data analysis	NA data collection and entry continues	NA data collection and entry continues	NA data collection and entry continues
	Epi Workgroup convenes to create sampling plan	NA data collection and entry begins	NA data collection and entry continues	**Focus Group:** Case Management Staff		**Focus Group:** Prevention / Linkage / Outreach Staff

Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
NA data collection and entry ends, cleaning and analysis begins	Analysis WG convenes to review preliminary findings	No activities [HRSA Grant Application / EIIHA Process]	Analysis concludes, staff write report	**Committee approve NA report**	**Council approves NA report**	No activities
Focus Group: HSDA/Rural consumers	**Focus Group:** EMA/Urban consumers		NAG reviews/approves NA report			

You are invited to a *consumer-only* workgroup to discuss

Standards of Care and Performance Measures

for Ryan White funded HIV services

Examples of services to be discussed:

- ✓ ***Primary Medical Care***
- ✓ ***Case Management***
- ✓ ***Dental Care***
- ✓ ***Local Pharmacy Assistance***
- ✓ ***Professional Counseling***
- ✓ ***Transportation***
- ✓ ***Medical Nutritional Therapy & Supplements***

Standards of Care are the minimal acceptable levels of quality in service delivery based upon accepted industry guidelines and practices. Houston area standards relate to issues such as staff training and supervision, client rights and confidentiality, timeliness of service delivery, allowable activities, the minimum services each client should receive, and more.

Monday, September 17, 2018

12:00 p.m. – Consumer Workgroup

Harris County Annex 83
2223 West Loop South, Room 416
Houston, Texas 77027

Performance Measures indicate to what extent a service has achieved its desired outcomes. Examples of Houston area performance measures include: health status (such as viral load and CD4 increases and decreases), quality of life, cost-effectiveness, adherence to treatment and more.

To review the current Standards of Care and Performance Measures, please go to:
http://rwpchouston.org/Publications/SOCandPM.htm

For more information contact:
Tori Williams
Ryan White Planning Council Office of Support
713 572-3724 or victoria.williams@cjo.hctx.net

FOR THOSE NEEDING TRANSLATION SERVICES: If you need an ASL or Spanish interpreter, please call to request an interpreter at least two days in advance: 713 572-2813 (TTY) or 832 927-7926 (Main)

Usted está invitado/a a un *grupo de trabajo orientado al consumidor* a dialogar sobre

Normas del Cuidado y Medidas de Resultados

Para los Servicios del VIH financiados por Ryan White

Ejemplos de Servicios a ser discutidos:

- ✓ Cuidado médico primario
- ✓ Administración de Casos
- ✓ Cuidado Dental
- ✓ Asistencia en Farmacia
- ✓ Servicios de salud mental
- ✓ Transporte
- ✓ Suplementos nutricionales

***Normas del Cuidado*:** es el mínimo nivel de calidad aceptable en la entrega de los servicios, basados en reconocidas prácticas y directrices industriales. Las Normas del Cuidado en el área de Houston se relacionan a temas como: entrenamiento y supervisión del personal, derechos y confidencialidad del cliente; exactitud en la entrega de servicios, actividades aprobadas; servicios mínimos que el cliente pueda recibir y otros temas.

Lunes, Septiembre 17, 2018
12:00 p.m. – Consumer Workgroup

Harris County Annex 83
2223 West Loop South, Room 416
Houston, Texas 77027

***Medidas de Rendimiento*:** indica a qué extensión un servicio ha logrado el resultado deseado. Ejemplos en el área de Houston incluyen: estado de salud (tales como carga viral e incremento o disminución del CD4); calidad de vida; eficacia de costo; adhesión al tratamiento y otros temas.

Para revisar la actual Normas del Cuidado y Medidas de Rendimiento, favor de ir a:
http://rwpchouston.org/Publications/SOCandPM.htm

Para mayor información llame:
Ryan White Planning Council Office of Support
713 572-3724

PARA PERSONAS QUE NECESITEN INTERPRETACIÓN: Si necesita un intérprete, por favor llame al 832 927-7926 por lo menos 48 horas antes.

Understanding the HIV Care Continuum

Overview

Recent scientific advances have shown that antiretroviral therapy (ART) not only preserves the health, quality of life, and life expectancy of people living with HIV, but people living with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners.

These developments have transformed the nation's approach to HIV prevention. By ensuring that everyone with HIV is aware of their infection, receives the treatment they need, and achieves sustained viral suppression, we can sharply reduce new infections in the United States.

This vision is a core focus of CDC's high-impact HIV prevention strategy, which aims to achieve the greatest possible reductions in HIV infections by making sure that resources go to the regions, populations, and prevention strategies where they will have the greatest impact.

To help gauge progress towards national goals (see sidebar) and direct HIV prevention resources most effectively, CDC tracks the "HIV care continuum." The continuum is the series of steps from the time a person receives a diagnosis of HIV through the successful treatment of their infection with HIV medications. This fact sheet explains the various approaches and data used to develop the HIV care continuum, how it is used to improve outcomes for people living with HIV in the United States, and how it helps guide the nation's response to HIV.

National HIV Prevention Objectives on HIV Diagnosis and Care

At the national level several specific goals related to early HIV diagnosis and effective care include:

- 90% — Increasing the proportion of HIV-positive **individuals aware of their status** to 90%.
- 85% — Increasing the proportion of **persons with newly diagnosed HIV who are linked to care** within one month to 85%.
- 80% — Increasing the proportion **of HIV-diagnosed individuals whose virus is effectively suppressed to 80%,** with an emphasis youth and persons who inject drugs.

What is the HIV Care Continuum?

The ultimate goal of HIV treatment is to achieve viral suppression, which means the amount of HIV in the body is very low or undetectable. This is important for people with HIV to stay healthy, have improved quality of life, and live longer. People living with HIV who maintain viral suppression have effectively no risk of passing HIV to others.

The HIV care continuum consists of several steps required to achieve viral suppression. Specifically, CDC tracks:

Diagnosed

receives a diagnosis of HIV

Linked to care*

visited a heath care provider within 30 days after HIV diagnosis

Received or were retained in care*

received medical care for HIV infection once or continuously

Viral suppression

amount of HIV in the blood was at a very low level.

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

*Linked to care is calculated differently from other steps in the continuum, and cannot be directly compared to other steps. See Table 1 on page 5 for details.** Note. Receipt of medical care was defined as ≥1 test (CD4 or VL) in 2015. Retained in continuous medical care was defined as ≥2 tests (CD4 or VL) ≥3 months apart in 2015. Viral suppression was defined as <200 copies/mL on the most recent VL test in 2015. See Table 1 on page 5 for details.

Two Ways to Monitor the Continuum

CDC currently uses two different approaches to monitor the HIV care continuum. The two approaches are used for different purposes, and both are essential to monitor the nation's progress and identify key HIV prevention and care needs.

The major difference between the two approaches is that they have **different denominators.** That is, they measure progress among different groups of people living with HIV:

The prevalence-based HIV care continuum describes the number of people who are at each step of the continuum as a percentage of the ***total* number of people living with HIV** (known as HIV prevalence). Prevalence includes both people whose infection has been diagnosed and those who are infected but don't know it.

This approach allows us to monitor elements of the care continuum by measuring the care outcomes among all Americans living with HIV. It can also monitor outcomes for broad populations, such as African Americans or men who have sex with men (MSM). However, because of certain statistical limitations, this approach does not allow more segmented analyses within those populations, such as young black MSM. See Figure 1 for the 2015 Prevalence-based HIV Care Continuum.

The diagnosis-based HIV care continuum shows each step as a percentage of **the number of people living with diagnosed HIV.**

This approach gives us more detailed information about persons who are living with diagnosed HIV and provides a way to look at the continuum within subgroups of affected populations, for example young black MSM. For the 2015 diagnosis-based continuum, see Figure 2.

The difference is in the denominators • All people living with HIV (includes persons with diagnosed and undiagnosed infection) is used as the denominator for the prevalence-based continuum. People living with ***diagnosed*** HIV is the denominator used for the diagnosis-based continuum.

Figure 1: Prevalence-based HIV Care Continuum, 2015

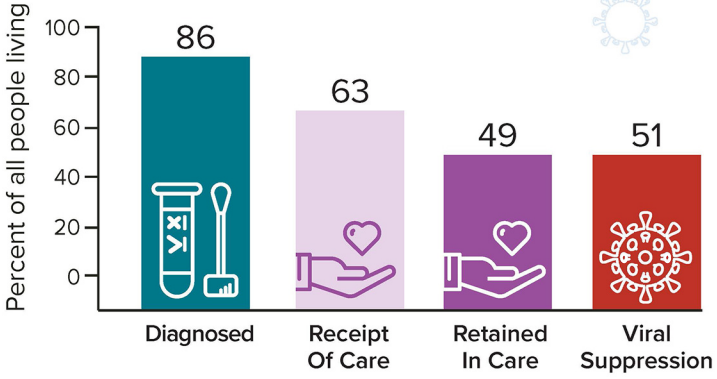
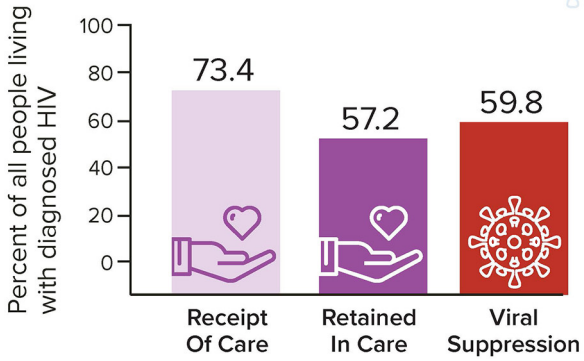
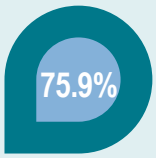


Figure 2: Diagnosis-based HIV Care Continuum, 2015



Linked to Care

- In 2016, 75.9% of persons receiving a diagnosis of HIV were linked to care within 1 month.
- Defined as linked to care within 1 month of HIV diagnosis.



- Denominator is persons receiving a diagnosis of HIV in a measurement year; numerator is the number of persons who were linked to care within 1 month of HIV diagnosis.
- Because it has a different denominator, it cannot be directly compared to other steps.

See Table 1 on page 4 for additional details

Different Approaches for Different Needs

CDC's current approaches draw on the best data available.

It is **important to know how the continuum will be used.** Some uses of the **prevalence-based continuum** include:

- Monitoring testing efforts in the U.S. and demonstrating the importance of diagnosing HIV infections to achieve viral suppression.
- Monitoring how the U.S. is doing among **all** persons living with HIV
- Comparing U.S. data to other countries who monitor the continuum among all persons living with HIV

Some uses of the **diagnosis-based continuum** include:

- Monitoring U.S. progress in comparison to national level 2020 goals
- Monitoring U.S. progress in comparison to the UNAIDS 90-90-90 goals
- Monitoring disparities by examining data among sub-groups of the population
- Monitoring data at a local level to understand local progress and identify additional action steps to meet national level goals

Ways of presenting the continuum will also continue to evolve over time, as better and more complete data become available.

How CDC Develops the Continuum

The data for both the prevalence- and diagnosis-based continua of care approaches come from **The National HIV Surveillance System (NHSS),** which provides a range of information on people who have diagnosed HIV or have died with HIV. Data are from every U.S. state and territory and the District of Columbia and include race/ethnicity, route of transmission, and age. The data are reported to CDC by state and local health departments. This is the source of data for both the prevalence and diagnosis denominators. Data from the states and D.C. that have complete laboratory reporting are used to calculate some measures of the continuum.

For more information, details on the two continuum approaches are found in Table 1 below. Some of these indicators are also used to monitor progress toward the national goals. For more information on national indicators, please see [insert link to Fact Sheet on Selected National HIV Prevention and Care Outcomes].

What is CDC doing to improve the outcomes at every step of the HIV Care Continuum?

CDC is undertaking many initiatives including:

- **Directly funding health departments to implement a comprehensive HIV surveillance and prevention program** – to prevent new HIV infections and achieve viral suppression among persons living with HIV. The integrated approach promotes and supports improving health outcomes for persons living with HIV through achieving and sustaining viral suppression, and reducing health-related disparities by using quality, timely, and complete surveillance and program data to guide HIV prevention efforts. Priority activities include HIV testing; linkage to, re-engagement in, and retention in care and support for achieving viral suppression; support for pre-exposure prophylaxis (PrEP); community-level HIV prevention activities; and HIV transmission cluster investigations and outbreak response efforts.
- **Directly funding community-based organizations (CBOs)** – to increase HIV testing, improve linkages to care and support improvement of viral suppression for persons living with HIV, and improve linkages to PrEP and other prevention services for persons who are at risk for HIV.
- **Providing technical assistance** – to help health departments and CBOs develop the tools and skills to successfully implement effective HIV prevention activities for people living with HIV in their communities.
- **Improving surveillance capability and technology –** to assist states in outbreak response and improving completeness of laboratory data that are needed to assess many of the steps in the HIV care continuum and the selected national HIV care outcomes.
- **Researching new approaches** – to include studies of clinical, behavioral and structural interventions to help people with HIV stay in care, get back in care if they fall out of care, and adhere to their medications.
- **Developing guidelines** – to assist health care providers with HIV testing, care, treatment, and prevention.
- **Launching educational campaigns and a HIV Risk Reduction Tool** – to help health care providers integrate simple prevention approaches into routine care for people living with HIV and to help all audiences understand risks for HIV and the benefits of HIV testing.

Table 1: Calculating the Continuum: Step by Step

Continuum Step	
Diagnosed	Measures the percentage of the total number of people living with HIV whose infection has been diagnosed. The denominator for this continuum step is HIV prevalence, which is the total number of people living with HIV (includes both those with diagnosed infection and those with undiagnosed infection). HIV prevalence is estimated through statistical modeling using NHSS data from all U.S. states and the District of Columbia.
Receipt of Care	NHSS data from states and DC with complete reporting of CD4 and viral load test results are used to estimate "receipt of care" and "retained in care." Receipt of care is measured as the percentage of persons with diagnosed HIV who had at least 1 CD4+ or viral load test. The denominator for the prevalence-based continuum is all persons living with HIV (HIV prevalence) The denominator for the diagnosis-based continuum is all persons living with diagnosed HIV (diagnosed prevalence*).
Retained in Care	NHSS data from states and DC with complete reporting of CD4 and viral load test results are used to estimate "receipt of care" and "retained in care." Retained in care is measured as the percentage of persons with diagnosed HIV who had two or more viral load or CD4+ tests, performed at least three months apart. The denominator for the prevalence-based continuum is all persons living with HIV (HIV prevalence). The denominator for the diagnosis-based continuum is all persons living with diagnosed HIV (diagnosed prevalence*).
Viral Suppression	NHSS data from states and D.C. that have complete laboratory reporting are used to determine viral suppression. Viral suppression is measured as a viral load test result of <200 copies/mL at the most recent viral load test during measurement year.
Linked to Care	NHSS data from states and DC with complete reporting of CD4 and viral load test results are used to determine "linked to care." Linked to care measures the percentage of people receiving a diagnosis of HIV in a given calendar year who had one or more documented viral load or CD4+ test within 30 days (1 month) of diagnosis. Because this measure is limited to people with HIV diagnosed in a single year only, it cannot be directly compared to other steps in the continuum. This means that the denominator for linkage to care is different from the denominators used to calculate the other steps in the continuum. It is also important to note that an individual who enters care more than 30 days after diagnosis may still be included in subsequent steps of the continuum, but would not be counted as "linked to care."

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

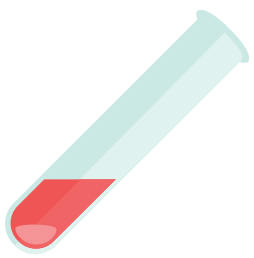
*Diagnosed prevalence is defined as the number of persons with HIV diagnosed through the end of 1 year and are living through the end of the next year (e.g. diagnosed prevalence for 2015 is defined as persons receiving a diagnosis of HIV by end of 2014 and living through the end of 2015).

Prescribing nPEP

(non-occupational HIV post-exposure prophylaxis)

Key concepts for providers:

1. **Early initiation of nPEP is essential!** Evaluate persons rapidly for nPEP when care is sought **≤72 hours after a potential exposure - the first dose needs to be given ASAP**



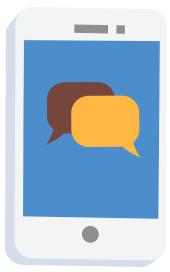
2. **Do an HIV test before initiating nPEP** (if rapid testing is not possible, send blood to lab and initiate nPEP immediately – follow-up with results and patient asap – stopping nPEP only if test result is confirmed positive)

3. **All persons offered nPEP should be prescribed a 28-day course** of a 3-drug antiretroviral regimen, and given the first dose **ON SITE ASAP** after the exposure

4. **Adherence** to recommended dosing for 28 days without interruption **is essential**

5. **Emphasize that severe adverse effects from nPEP are rare**, but review possible side effects and reinforce the limitedness of such effects

6. **Follow-up is important** for additional counseling and monitoring



For clinician-to-clinician assistance with nPEP-related questions contact:

AETC National Clinician Consultation Center's Post-Exposure Prophylaxis Hotline (PEPline):
888-HIV-4911 (888-448-4911)
9:00 AM - 9:00 PM ET, 7 days/week

AETC AIDS Education & Training Center Program
National Coordinating Resource Center