**DRAFT**

# Houston Area HIV Services Ryan White Planning Council

## Comprehensive HIV Planning Committee

2:00 p.m., Thursday, March 9, 2017
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

## AGENDA

*** = handout to be distributed at meeting**

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I. Call to Order
   - A. Welcome and Introductions — Isis Torrente and
   - B. Moment of Reflection — Steven Vargas, Co-Chairs
   - C. Adoption of the Agenda
   - D. Approval of the Minutes (February 9, 2017)

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/AIDS 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/AIDS 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 with HIV/AIDS", 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. Report from the Speaker's Bureau Workgroup — John Lazo, Workgroup Chair
   - A. Upcoming Meetings:
     1. Thursday, April 20th at 2 p.m.
     2. Thursday, August 17th at 2 p.m.
     3. Wednesday, December 13th at 2 p.m.

IV. Old Business — Amber Harbolt, Health Planner, Office of Support
   - A. Committee Description
   - B. Elect a Committee Vice Chair

V. Approve Y4 (2015) Comprehensive Plan Evaluation Report

VI. Determine and Plan Special Studies for 2017

VII. Announcements — Isis Torrente and Steven Vargas
   - A. No Committee Meeting in April
   - B. EIIHA Workgroup Meeting: Thursday, March 23 at 9 a.m.
   - C. Transgender & Gender Non-Conforming Profile*
   - D. KFF Data Note "Insurance Coverage Changes for People with HIV Under the ACA"
   - E. POWER 2016 Annual Report

VIII. Adjourn

# Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee
2:00 p.m., Thursday, February 9, 2017
Meeting Location: 2223 West Loop South, Room 532; Houston, Texas 77027

## Minutes

| MEMBERS PRESENT | MEMBERS ABSENT | OTHERS PRESENT |
|---|---|---|
| Isis Torrente, Co-Chair | Denny Delgado, excused | John Lazo |
| Steven Vargas, Co-Chair | Shital Patel | Esther Ogunjimi |
| Ted Artiaga | Taneisha Broaddus, excused | Gloria Sierra |
| Evelio Salinas Escamilla | | Charles Sydnor |
| Tracy Gorden | | Sha'Terra Johnson-Fairley |
| Herman Finley | | Nicole Booker |
| Osaro Mgbere | | Sharon Rhames |
| Allen Murray | | Lashunda Robinson |
| Larry Woods | | Amber Harbolt, Office of Support |
| Oluyesi Orija | | Diane Beck, Office of Support |
| Amana Turner | | |
| David Watson | | |
| Maggie White | | |

**Call to Order:** Isis Torrente, co-chair, called the meeting to order at 2:12 p.m. and asked for a moment of reflection. She then asked everyone to introduce themselves.

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

**Approval of the Minutes:** ***Motion #2:*** *it was moved and seconded (Vargas, Murray) to approve the November 10, 2016 minutes.* **Motion carried.** Abstentions: Gorden, Mgbere, Orija, Turner, Vargas, Watson, White.

**Public Comment:** None.

**Nuts and Bolts for Committee Members:** Harbolt reviewed the following documents: Nuts and Bolts for Committee Members, Timeline of Critical 2017 Council Activities, Committee Meeting Schedule, memo re Petty Cash, Open Meetings Act Training and the 2017 Committee Goals.

**Report from the Speaker's Bureau Workgroup:** Lazo reported that the speaker's bureau can present information to rotary clubs, chambers of commerce and other business-related organizations in the area. The workgroup meets quarterly (April, August and December). There are currently six speakers who can present on a wide variety of topics. The first presentation for 2017 is scheduled for March 21st to the case managers and social workers Methodist Hospital Willowbrook; Nancy Miertschin will be the speaker. We need suggestions for speaking opportunities in the business community. Orija asked to be added to the workgroup.

**2017 Committee Timetable:** Harbolt reviewed the attached timetable. Escamilla suggested

including the Medical Monitoring Project's data in the special studies.

**Announcements:** Kelly said that the HIV and Aging Coalition will meet this Saturday. See the attached flyer.

**Adjournment:** The meeting was adjourned at 3:27 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**

# 2017 Voting Record for Meeting Date February 9, 2017

| MEMBERS | Motion #1: **Agenda** | | | | Motion #2: **Minutes** | | | |
|---|---|---|---|---|---|---|---|---|
| | ABSENT | YES | NO | ABSTAIN | ABSENT | YES | NO | ABSTAIN |
| Isis Torrente, Co-Chair | | | | **C** | | | | **C** |
| Steven Vargas, Co-Chair | | **X** | | | | | | **X** |
| Ted Artiaga | | **X** | | | | **X** | | |
| Denny Delgado | **X** | | | | | | | |
| Evelio Salinas Escamilla | | **X** | | | | **X** | | |
| Tracy Gorden | | **X** | | | | | | **X** |
| Herman Finley lm 3:02 pm | | **X** | | | | **X** | | |
| Osaro Mgbere | | **X** | | | | | | **X** |
| Allen Murray | | **X** | | | | **X** | | |
| Shital Patel | **X** | | | | | | | |
| Larry Woods lm 3:02 pm | | **X** | | | | **X** | | |
| Taneisha Broaddus | **X** | | | | | | | |
| Oluyesi Orija | | **X** | | | | | | **X** |
| Kris Sveska | **X** | | | | | | | |
| Amana Turner | | **X** | | | | | | **X** |
| David Watson | | **X** | | | | | | **X** |
| Maggie White | | **X** | | | | | | **X** |

# Houston Area HIV Services Ryan White Planning Council
# Standing Committee Structure

**(Reviewed 07-15-15)**

## 1. Affected Community Committee

This committee is designed to acknowledge the collective importance of consumer participation in Planning Council (PC) strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee).

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a presentation where all HIV/AIDS-related drug representatives are invited.

The committee will consist of HIV+ individuals, their caregivers (friends or family members) and others. All members of the PC who self-disclose as HIV+ are requested to be a member of the Affected Community Committee; however membership on a committee for HIV+ individuals will not be restricted to the Affected Community Committee.

## 2. Comprehensive HIV Planning Committee

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from external membership and expertise.

## 3. Operations Committee

This committee combines four areas where compliance with Planning Council operations is the focus. The committee develops and facilitates the management of Planning Council operating procedures, guidelines, and inquiries into members' compliance with these procedures and guidelines. It also implements the Open Nominations Process, which requires a continuous focus on recruitment and orientation. This committee is also the place where the Planning Council self-evaluations are initiated and conducted.

This committee will not benefit from external member participation except where resolve of grievances are concerned.

## 4. Priority and Allocations Committee

This committee gives attention to the comprehensive process of establishing priorities and allocations for each Planning Council year. Membership on this committee does include external members and must be guided by skills appropriate to priority setting and allocations, not by interests in priority setting and allocations. All Ryan White Planning Council committees, but especially this committee, regularly review and monitor member participation in upholding the Conflict of Interest standards.

**5. Quality Improvement Committee**

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Performance Measures/Outcome Evaluation, which must be looked at within each year, are monitored from this committee. Whenever possible, this committee should collaborate with the other Ryan White planning groups, especially within the service categories that are also funded by the other Ryan White Parts, to create shared Standards of Care.

In addition to these responsibilities, this committee is also designed to implement the Planning Council's third legislative requirement, assessing the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, or assessing how well the grantee manages to get funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the Planning Council and whether all the funds are spent. This Committee may benefit from the utilization of external members.

# 2017 Ryan White Planning Council

## STANDING COMMITTEE LIST

(Updated 02-21-17)

**Red Text = Committee Mentor**

| STEERING | |
|---|---|
| Cecilia Ross, RWPC Chair | Curtis Bellard, Co-Chair, Operations |
| John Lazo, Vice Chair | Nancy Miertschin, Co-Chair, Operations |
| Carol Suazo, Secretary | Ella Collins-Nelson, Co-Chair, Priority and Allocations |
| Rodney Mills, Co-Chair, Affected Community | Paul Grunenwald, Co-Chair, Priority and Allocations |
| Tana Pradia, Co-Chair, Affected Community | Robert Noble, Co-Chair, Quality Improvement |
| Isis Torrente, Co-Chair, Comprehensive HIV Planning | Gloria Sierra, Co-Chair, Quality Improvement |
| Steven Vargas, Co-Chair, Comprehensive HIV Planning | |

| AFFECTED COMMUNITY | | | |
|---|---|---|---|
| 1. Rodney Mills, Co-Chair | 7. Arlene Johnson | ***External Members:*** | |
| 2. Tana Pradia, Co-Chair | 8. Denis Kelly | *1. Alex Moses* | |
| 3. Curtis Bellard | 9. Allen Murray | *2. Jacob Sandler* | |
| 4. Skeet Boyle, **Vice Chair** | 10. John Poole | | |
| 5. Amber David | 11. Teresa Pruitt | | |
| 6. Herman Finley | 12. Isis Torrente | | |

| COMPREHENSIVE HIV PLANNING | | | |
|---|---|---|---|
| 1. Isis Torrente, Co-Chair | 8. Osaro Mgbere | ***External Members:*** | |
| 2. Steven Vargas , Co-Chair | 9. Allen Murray | *1. Taneisha Broaddus* | |
| 3. Ted Artiaga | 10. Shital Patel | *2. Kris Sveska* | |
| 4. Denny Delgado | 11. Larry Woods | *3. Amana Turner* | |
| 5. Evelio Salinas Escamilla | | *4. David Watson* | |
| 6. Herman Finley | | *5. Maggie White* | |
| 7. Tracy Gorden | | | |

| OPERATIONS | | | |
|---|---|---|---|
| 1. Curtis Bellard, Co-Chair | 4. Denis Kelly | | |
| 2. Nancy Miertschin, Co-Chair | 5. Carol Suazo, **Vice Chair** | | |
| 3. Ardry "Skeet" Boyle | 6. Isis Torrente | | |

| PRIORITY AND ALLOCATIONS | | | |
|---|---|---|---|
| 1. Ella Collins-Nelson, Co-Chair | 4. J. Hoxi Jones | 7. Krystal Shultz | ***External Members:*** |
| 2. Paul Grunenwald, Co-Chair | 5. Peta-gay Ledbetter | | *1. Bruce Turner* |
| 3. Angela F. Hawkins | 6. John Lazo | | |

| QUALITY IMPROVEMENT | | | |
|---|---|---|---|
| 1. Robert Noble, Co-Chair | 8. Amber David | ***External Members:*** | |
| 2. Gloria Sierra, Co- Chair | 9. Johnny Deal | *1. Kevin Aloysius* | *7. Angelica Williams* |
| 3. Ted Artiaga | 10. Tom Lindstrom | *2. Billy Ray Grant, Jr.* | |
| 4. Connie Barnes | 11. John Poole | *3. Shamra Hodge* | |
| 5. Curtis Bellard, **Vice Chair** | 12. Teresa Pruitt | *4. Esther Ogunjimi* | |
| 6. Bianca Burley | 13. Venita Ray | *5. Samantha Robinson* | |
| 7. David Benson | 14. Viviana Santibanez | *6. Amana Turner* | |

**(Over)**

| PROJECT LEAP ADVISORY COMMITTEE | | | |
|---|---|---|---|
| 1. Tracy Gorden, Co-Chair | 9. Rodney Mills | ***External Members:*** | |
| 2. Teresa Pruitt, Co-Chair | 10. Allen Murray | *1. Alex Moses* | |
| 3. Curtis Bellard | 11. Robert Noble | | |
| 4. Johnny Deal | 12. John Poole | | |
| 5. Denny Delgado | 13. Tana Pradia | | |
| 6. Herman Finley | 14. Venita Ray | | |
| 7. Angela F. Hawkins | 15. Isis Torrente | | |
| 8. Denis Kelly | 16. Steven Vargas | | |

| SPEAKERS BUREAU WORKGROUP | | | |
|---|---|---|---|
| 1. John Lazo, Co-Chair | 9. Robert Noble | ***External Members:*** | |
| 2. Ardry "Skeet" Boyle, Co-Chair | 10. Tana Pradia | | |
| 3. Curtis Bellard | 11. Teresa Pruitt | | |
| 4. Bianca Burley | 12. Gloria Sierra | | |
| 5. Johnny Deal | 13. Carol Suazo | | |
| 6. Arlene Johnson | 14. Isis Torrente | | |
| 7. Denis Kelly | 15. Steven Vargas | | |
| 8. Rodney Mills | | | |
| | | | |

# The Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2016

Capturing the community's vision for an ideal system of HIV prevention and care for the Houston Area

## Year 4 Evaluation Report

# Table of Contents

# Vision of the Houston Area Plan

"The greater Houston Area will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination."

# Mission of the Houston Area Plan

"The mission of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the needs of populations infected with, affected by, or at risk for HIV."

# Contributors

## Members of the 2012 Houston Area Comprehensive HIV Plan Evaluation Workgroup

*The following individuals serve as members of the 2012 Houston Area Comprehensive HIV Plan Evaluation Workgroup, which met December 2016 to evaluate Year 4 implementation. This report summarizes their findings and recommendations*

Nicholas Sloop, Co-Chair
Nancy Miertschin, Co-Chair
Ted Artiaga
David Benson
Nike Blue
Evelio Escamilla
Herman Finley
Morénike Giwa
Tracy Gorden
Camden Hallmark
John Humphries
Judy Hung
Amy Leonard
Ken Malone
Aundrea Matthews
Osaro Mgbere
Nancy Miertschin
Allen Murray
Shital Patel
Tasha Traylor
Amana Turner
C. Bruce Turner
Steven Vargas
Cristan Williams
Larry Woods

## Others

*The following individuals provided data, analysis, and other information used during the evaluation process and in this report*

### Ryan White Planning Council Office of Support

Tori Williams
Diane Beck
Amber Harbolt
Rodriga Avila

### Harris County Public Health Services Ryan White Grant Administration

Carin Martin
Tasha Traylor
Heather Keizman
Dawn Meade

### The Houston Regional HIV/AIDS Resource Group, Inc.

Patrick Martin
Sha'Terra Johnson-Fairley

### Houston Health Department Bureau of HIV/STD & Viral Hepatitis Prevention

Marlene McNeese
Camden Hallmark
Cathy Wiley
Nick Sloop
Amber David
Kellie Watkins
Truc Pham

### Houston Department of Health and Human Services Office of Surveillance and Public Health Preparedness

Jeffrey Meyer
Weilin Zhou

### Texas Department of State Health Services HIV Prevention and Care Branch

Janina Vazquez

**Suggested citation:**
The Houston Area Ryan White Planning Council and the Houston HIV Prevention Community Planning Group. Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 through 2016. Evaluation Report for Year 4 Implementation (covering the period of January 2015 to December 2015). Conducted December, 2016.

# Introduction

The Houston Area Comprehensive HIV Prevention and Care Services Plan for 2012 – 2016 (also referred to as the 2012 Comprehensive Plan) was revealed to the public on July 2, 2012, following a ten-month planning process that involved 111 individuals and 61 agencies. The final plan included 75 specific activities to be conducted over the next three years in order to make progress toward an ideal system of HIV prevention and care in the Houston Area. The plan was later extended to five years to bridge the gap to implementation of the 2017-2021 Comprehensive Plan. Sixty (60) benchmarks were originally included for use in measuring change over time. The 2012 Comprehensive Plan also included an *Evaluation and Monitoring Plan*, which set forth the annual assessment of the plan's activities and progress made in achieving the plan's objectives and benchmarks. This report summarizes the findings of the evaluation and monitoring process for Year 4 of plan implementation, including highlights from the year.

# Purpose

The 2012 Comprehensive Plan's *Evaluation and Monitoring Plan* (Section IV) outlines specific goals and methods for assessing progress in both the short- and long-term aims of the plan:

> *"**The goal of the evaluation plan is** to determine the impact of the Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 as measured by the extent of achievement of [system-wide] objectives (Section II)…*
>
> ***The goal of the monitoring plan** is to monitor the implementation of the Plan as measured by (1) the extent of achievement of stated activities and efforts (Section III); and (2) the extent of achievement of stated benchmarks (Section III)."*

Assessment of the status of proposed activities measures the extent of the community's implementation of the 2012 Comprehensive Plan each calendar year. Over time, assessment of the progression of objectives and benchmarks reveals the plan's larger impact on attaining stated goals, filling gaps in the HIV prevention and care system in the Houston Area, and, ultimately, alleviating the local HIV epidemic.

# Methods

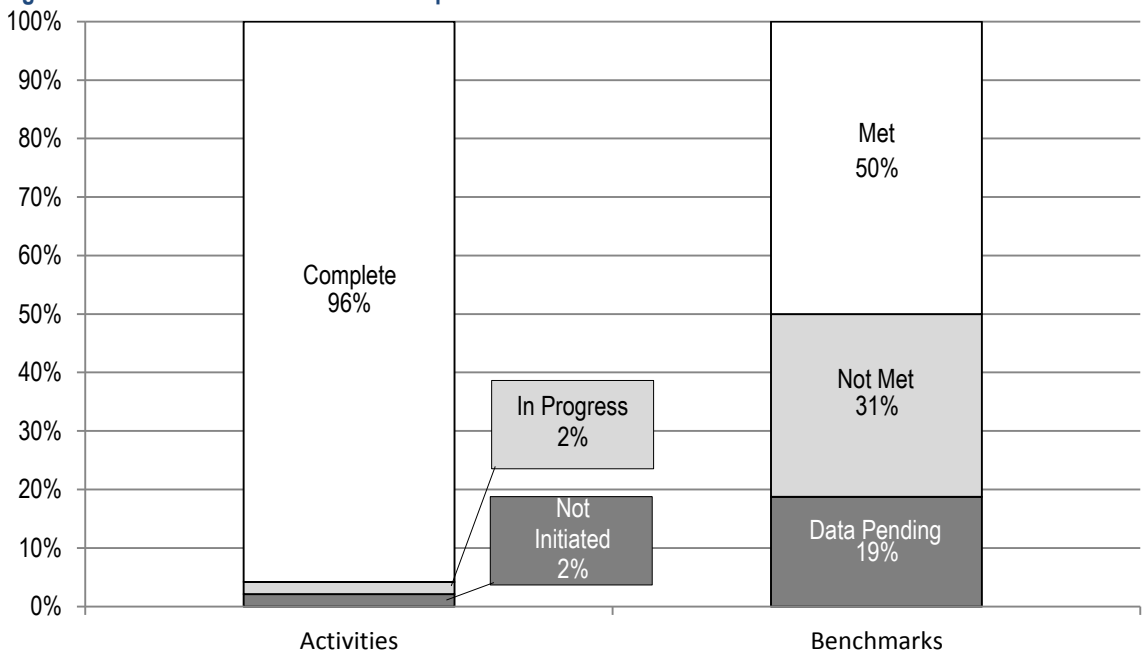
The methods used for evaluating Year 4 implementation are consistent with the *Evaluation and Monitoring Plan* (Section IV). In December 2016, each Responsible Party (**RP**) named in the 2012 Comprehensive Plan (Section III) completed a series of written checklists of assigned activities and benchmarks. For the former, the RP was asked to indicate the extent of achievement of each assigned activity for the time period of January – December 2015 using a standard key [C = Complete, C4 = Complete for Year 4 (for annual activities), P = In Progress, NI = Not Initiated, NA = N/A for Time Period, NA/C = N/A Complete] and to provide process notes or other updates to support and provide context for their conclusions. For the latter, the RP supplied the most current and complete year-end data point for each benchmark using approved data sources. All checklists and supporting documentation were cross-referenced and consolidated by support staff. Staff also gathered data on system-wide objectives and any benchmarks not assigned to a RP. The 2012 Comprehensive Plan's standing *Evaluation Workgroup* convened in December 2016 to review consolidated checklists and identify key findings.

# Summary of Year 4 Implementation

- **The Houston Area Report Card: Overall Status of Year 4 Activities and Benchmarks**

  The 2012 Comprehensive Plan is organized into four topic-specific Strategies, each containing activities and benchmarks. While initially slated for completion by the end of 2014, outstanding activities and benchmarks were retained into 2015 and 2016. Across the four Strategies, a total of 48 distinct activities were designated for completion in Year 4, including activities to be conducted annually; and 37 benchmarks were measured for Year 4. Overall, 47 of the activities designated for Year 4 (98%) were completed or had progress made (**Figure 1**). Only one activity (2%) that was designated for completion in Year 4 was not initiated: the *Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes* activity 16i. "Target philanthropic organizations for coordination of effort activities." Sixteen benchmarks measured in Year 4 (46%) met or exceeded targets originally set for Year 3. Data were not available or are still pending for 14 Year 4 benchmarks (38%).

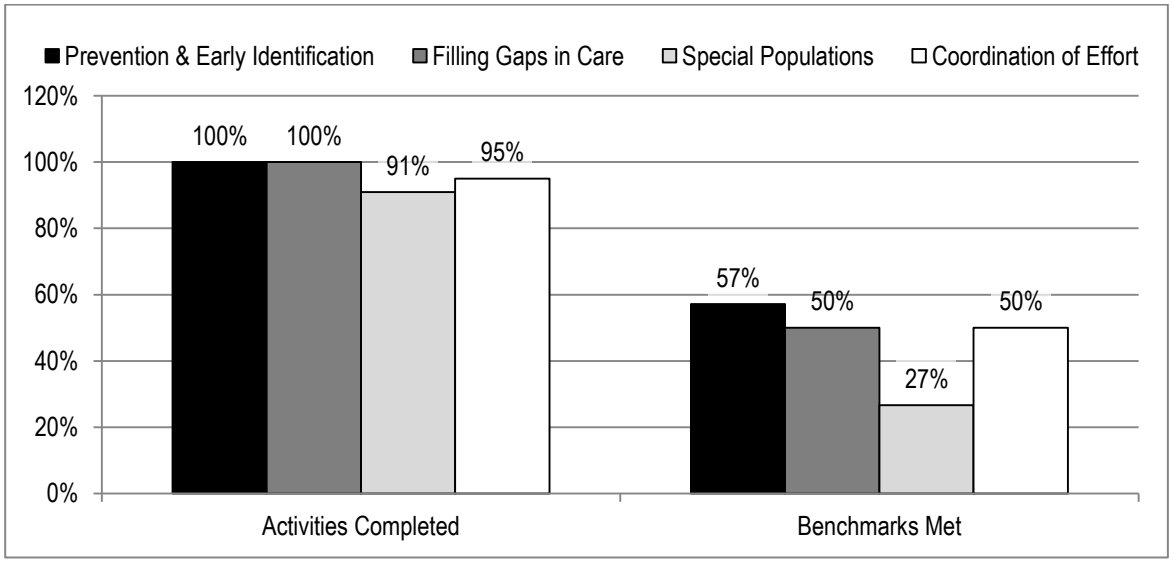
**Figure 1: Activities and Benchmarks Completion for Year 4**




Overall, the *Strategy for Prevention and Early Identification* and the *Strategy to Fill Gaps in Care and Reach the Out-Of-Care* saw the most activity progress with 100% of its activities completed (**Figure 2**). The *Strategy to Address the Needs of Special Populations* saw the least overall activity progress with 91% of its activities completed by the end of Year 4. The *Strategy for Prevention and Early Identification* had the most benchmark progress with 57% of benchmarks met or exceeded. The *Strategy to Address the Needs of Special Populations* saw the least benchmark progress with 27% of benchmarks measures met[1].

[1] The *Strategy to Address the Needs of Special Populations* had four (4) Year 3 benchmarks, three (3) of which had benchmark indicator measures for special population groups, resulting in a total of 22 benchmark measures.

**Figure 2: Percent of Activities and Benchmarks Completed/Met for Year 4, by Strategy**




- **The Houston Area Objectives: Progress Made in Year 4**

The 2012 Comprehensive Plan includes nine objectives intended to serve as measures of overall improvements in the Houston Area of HIV prevention and care system. The objectives include core epidemiological indicators of HIV infection, nationally defined benchmarks for HIV prevention and care services, and locally defined goals for the Houston Area Ryan White HIV/AIDS Program (**Figure 3**). Of the seven objectives measured for Year 4, four had most current measurements that met or exceeded the 2012 Comprehensive Plan targets originally set for Year 3.

**Figure 3: Status of System-Wide Objectives for the Houston Area, 2015**

| Objective | Baseline | Y4 Actual | Y3 Target | Status |
|---|---|---|---|---|
| 1.) Number of new HIV infections diagnosed | 1,335 | 1,345 | ↓25% = 1,001 | ✗ |
| 2.) Percent of PLWH* informed of status through *targeted* testing | 92.9% | 93.8% | Maintain = 93.0% | ✓ |
| 3.) Proportion of newly diagnosed PLWH linked to clinical care within three months | 65.1% | 81.0% | 85% | ✗ |
| 4.) Percent of new HIV diagnoses with an Stage 3 HIV diagnosis within one year | 34.5% | 20.0% | ↓25% = 27.0% | ✓ |
| 5.) Percent of RW Program clients who are in continuous HIV care | 78.0% | 73% | 80% | ✗ |
| 6.) Proportion of PLWH not in care | 34.2% | 24.0% | ↓0.8% = 27.3% | ✓ |
| 7.) Proportion of RW Program clients with suppressed viral load | 57.0% | 75%+ | ↑10% = 62.7% | ✓ |
| 8.1) Reports of barriers to RW Program-funded Substance Abuse Services** | - | - | - | - |
| 8.2) Reports of barriers to RW Program-funded Mental Health Services** | - | - | - | - |

*People Living with HIV
** There are no Year 4 actual measurements for Objectives 8.1 and 8.2 as these data are reported in the Year 3 Evaluation Report.
+Y4 actual measure is the proportion of RW Part A suppressed viral load (undetectable viral load unavailable).

# Highlights of Year 4 Implementation

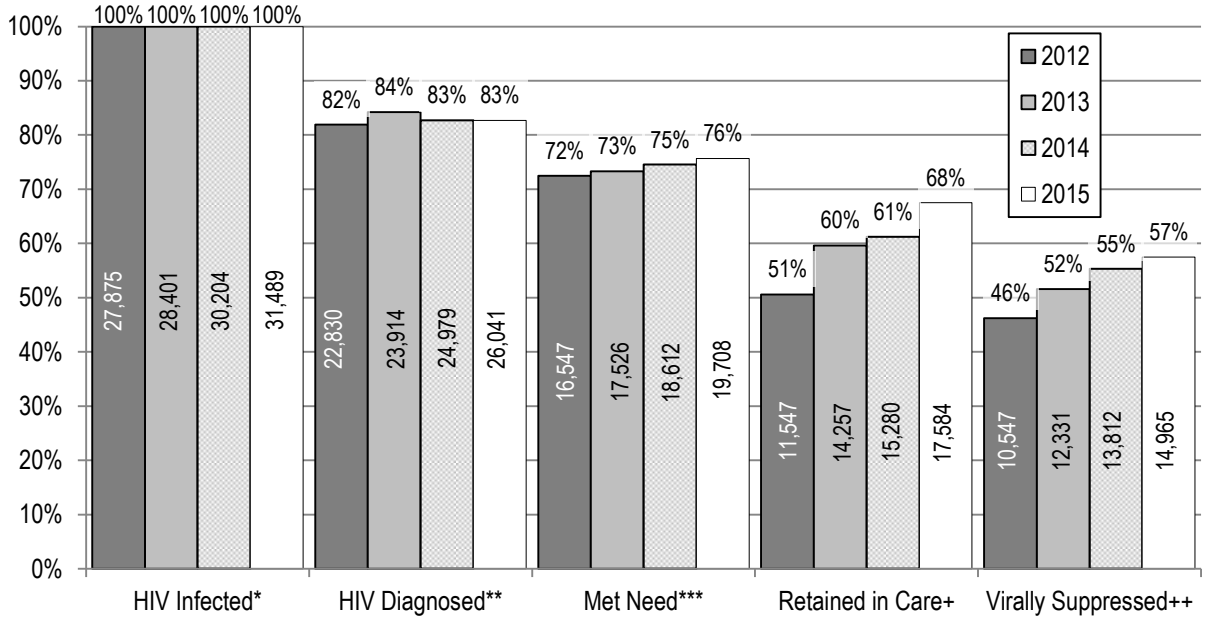
- **Four Core HIV Indicators Met or Exceeded Year 3 Targets in Year 4**
  As in all previous years of implementation, the 2012 Comprehensive Plan's outcome objectives measuring the overall improvement in the Houston HIV prevention and care system made progress in Year 4. Four objectives had measures that met or exceeded targets originally set for Year 4. The percent of PLWH informed of their positive HIV status through targeted testing exceeded its 2014 target maintenance target of 93.0% at 93.8% in 2015. The percentage of new HIV diagnoses with an HIV Stage 3 diagnosis (formerly AIDS) within one year also surpassed the 2014 target of 27.0% to 20.0% in 2015, though changes in Texas Department of State Health Service (**TDSHS**) methodology likely account for a portion of this decrease. The estimated proportion of PLWH not in care (Unmet Need) fell from 34.2% at baseline (2010) to 24.0% for the 2015 actual measurement, surpassing the 2014 target. Finally, though the proportion of Ryan White Program clients with undetectable viral loads was not available, the proportion of clients with suppressed viral loads was 75%. One additional objective made progress toward its Year 3 target from the baseline measurements in Year 4. The proportion of newly diagnosed PLWH linked to HIV clinical care within three months of diagnosis increased from 65.1% at the baseline to a 2015 actual measurement of 81%, the highest of any measurement year. Though it is not possible to determine whether the 2012 Comprehensive Plan is the sole source of this progress, the improvements observed in the plan's system objectives indicate that the Houston Area community has progressed toward the plan's goals since 2012.

- **Sixteen Benchmarks Met or Exceeded Year 3 Targets in Year 4**
  Of the 37 benchmarks measured in Year 4, 16 had actual 2015 measurements that met or exceeded 2014 targets. The 2012 Comprehensive Plan's *Strategy for Prevention and Early Identification* benchmarks for the number of HIV/STD brochures distributed, the positivity rate for publicly-funded traditional HIV testing and opt-out/routine HIV testing, the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their HIV-positive status, the percentage of new HIV diagnoses with an HIV Stage 3 diagnosis within one year, the proportion of Ryan White HIV/AIDS Program clients with suppressed viral loads, the number of high-risk individuals receiving information on HIV risk reduction through community outreach, and the number of high-risk individuals that completed an evidence-based behavioral intervention to reduce risk for HIV all met or surpassed their 2014 targets in 2015. The *Strategy to Fill Gaps in Care and Reach the Out-Of-Care* benchmarks for the proportion of individuals who have tested positive for HIV but who are not in HIV care as determined by the Ryan White HIV/AIDS Program Unmet Need Framework and the proportion of Ryan White HIV/AIDS Program clients with suppressed viral loads exceeded their 2014 targets in 2015. Four benchmark measurements exceeded 2014 targets for the *Strategy to Address the Needs of Special Populations in* 2015: the proportion of newly diagnosed men who have sex with men (**MSM**) linked to clinical care within three months of diagnosis beyond the 2014 target, the proportions of newly diagnosed injection drug using (**IDU**) individual and MSM who have tested positive for HIV but who are not in HIV care, and the percentage of HIV prevention and care frontline staff receiving annual cultural competence training. Under the *Strategy to Improve Coordination of Effort and Prepare for Health Care System Changes*, the numbers of non-AIDS Service Organizations (**ASO**) serving as members of the Ryan White Planning Council and requesting information about HIV services exceeded Year 3 targets in Year 4.

- **Year 4 Progress in the Houston EMA HIV Care Continuum**

In addition to monitoring the system objectives in the Plan Objectives, the Evaluation Workgroup recommended during the Year 1 evaluation process to include monitoring of the local HIV Care Continuum (**HCC**). Though the 2012 Comprehensive Plan cites and uses the cascade as a secondary data source in the *Strategy to Fill Gaps in Care and Reach the Out-of-Care*, a local iteration of the cascade was not incorporated into the plan itself as the plan was four months into development when the Centers for Disease Control and Prevention released *Vital Signs: HIV Prevention Through Care and Treatment — United States,* which included estimates of the numbers of PLWH in selected stages of the continuum of HIV care. While the 2012 Comprehensive Plan includes the Houston Health Services Delivery Area (**HSDA**) served through Ryan White Part B and States Services funds, and through CDC HIV prevention funding in the Houston Metropolitan Statistical Area (**MSA**), the data reflected in the local treatment cascade are derived only from data collected for the counties that comprise the Houston Eligible Metropolitan Area (**EMA**) (**Figure 4**).

**Figure 4: The Houston EMA HIV Care Continuum, 2012-2015**




*No. person who are HIV positive in 2012, 2013, 2014, and 2015 in the Houston EMA (diagnosed + undiagnosed estimate).
**No. diagnosed persons who are HIV positive in 2012, 2013, 2014, and 2015 in the Houston EMA.
***No. diagnosed persons with met need in 2012, 2013, 2014, and 2015 in the Houston EMA.
+No. diagnosed persons with retained in care (PLWH with at least 2 visits, labs, or ARVs in 12 months, at least 3 months apart) in 2012, 2013, 2014, and 2015 in the Houston EMA.
++No. diagnosed persons whose last viral load test of 2012, 2013, 2014, 2015<=200 (among persons with >=1 VL test) in the Houston EMA.

The HCC reflects within the Houston EMA: the estimated total number of PLWH (diagnosed and estimated status unaware); the number of PLWHA in who have been diagnosed; and, among the diagnosed, the numbers of PLWHA with records of met need, retention in care, and viral suppression within the 2012, 2013, 2014, and 2015 calendar years. The proportions of the diagnosed PLWH with met need, who were retained in care, and who had suppressed viral loads at the end of the calendar year has increased consistently since 2012.

**For more information, contact:**
Houston Area Ryan White Planning Council
2223 West Loop South, #240
Houston, Texas 77027
Tel: (713) 572-3724
Fax: (713) 572-3740
Web: www.rwpchouston.org

**Special Study Prospectus**: Out of Care (**OOC**) Needs Assessment

| | |
|---|---|
| Why is this special study of interest/importance to the Houston HIV Community? | • OOC people living with HIV (**PLWH**) have historically been under sampled needs assessments.<br>• The most recent unmet need estimate suggests that OOC PLWH comprise 27% of all PLWH in the Houston EMA. Only 4 (0.8%) of participants in the 2016 Needs Assessment met HRSA unmet need criteria.<br>• Houston Health Department's (**HHD**) Re-linkage Program and Texas Department of State Health Services (**TDSHS**) Region 6-5 South contact individuals meeting HRSA OOC criteria, and work to connect those individuals back into care. |
| Where is the gap in our knowledge about this topic? | • In the Houston EMA, we do not know enough about the core medical and support service needs of OOC PLWH, what factors lead to currently OOC PLWH falling out of care, and what service system changes could improve retention in care. |
| What do we ultimately want to learn? What are our research questions? | • What are the needs of OOC PLWH in the Houston EMA?<br>• How have OOC PLWH met their other needs outside the Ryan White system?<br>• What proportions of OOC PLWH are truly OCC (vs. being OOC "on record")?<br>• Are there any barriers to care in the Houston EMA that contribute to PLWH falling out of care?<br>• What service system improvements would be necessary to reduce the number of PLWH who are OOC? |
| What methodology/methodologies will be used in this special study? | • Snowball/chain referral sampling & convenience sampling through HHD and TDSHS if amenable; surveys/phone interviews/in-person interviews with OOC |
| Are there any risks for special study participants? | • No, standard informed consent and confidentiality practices will be applied<br>• A benefit to special study participants may be referral to re-linkage resources |
| What are the potential limitations of this study? | • Lack of generalizability due to potentially small size and sampling strategies |
| What is our data analysis process for this special study? | • Collect, clean, and analyze survey data in SPSS, using similar protocol to the 2016 Needs Assessment |
| Who are the responsible parties and potential community partners who can assist in this special study? | • Comprehensive HIV Planning Committee & Ryan White Planning Council<br>• RWPC Office of Support & Interns<br>• HHD's Bureau of HIV/STD & Viral Hepatitis Prevention Re-Linkage Program<br>• TDSHS Region 6-5 South<br>• TRG |
| What is a rough timeline for this special study? | • Duration of study will be partially determined by availability of participants.<br>• Adapt 2016 Needs Assessment survey tool, design sampling strategy, and adjust data analysis protocol<br>• Collect and enter surveys; clean dataset<br>• Analyze survey findings<br>• Develop services system improvement recommendations<br>• Draft report |
| How will the findings of this special study be used? | • The findings of this special study will inform HIV re-linkage and care services design, allocations, provision, and potentially standards of care should findings warrant. |

**Special Study Prospectus**: Social Determinants of Health Supplement

| | |
|---|---|
| Why is this special study of interest/importance to the Houston HIV Community? | • Several questions related to social determinants of health were trimmed from the 2016 Needs Assessment survey tool, such as question regarding employment, current transportation resources, public assistance, current substance abuse and needle use practices, disability, etc.<br>• Houston Health Department's (**HHD**) Bureau of Epidemiology collects similar data from a large sample for the Houston Medical Monitoring Project (**HMMP**) |
| Where is the gap in our knowledge about this topic? | • Since several questions related to social determinants of health were trimmed from the 2016 Needs Assessment survey tool, the most recent collection of these data was 2013.<br>• Epidemiological / Surveillance data does not probe most social determinants of health |
| What do we ultimately want to learn? What are our research questions? | • How do social determinants of health affect PLWH in the Houston area?<br>• How can services be designed to improve HIV care in light of social determinants? |
| What methodology/methodologies will be used in this special study? | • Data mining HMMP database(s) if HHD Bureau of Epidemiology is amenable |
| Are there any risks for special study participants? | • No, HMMP data collection and de-identification would fall under the purview of HHD Bureau of Epidemiology |
| What are the potential limitations of this study? | • Depending on the roles of potential community partners, RWPC Office of Support staff & interns may need to learn / re-learn data mining methodologies.<br>• Data likely limited to Houston/Harris County |
| What is our data analysis process for this special study? | • TBD |
| Who are the responsible parties and potential community partners who can assist in this special study? | • Comprehensive HIV Planning Committee & Ryan White Planning Council<br>• RWPC Office of Support & Interns<br>• HHD Bureau of Epidemiology (HMMP) |
| What is a rough timeline for this special study? | • Duration of study will be greatly determined by HHD Bureau of Epidemiology, content of HMMP data, and data mining resources. |
| How will the findings of this special study be used? | • The findings of this special study supplement the findings of the 2016 Needs Assessment and potentially enrich the HMMP |

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February 2017 | Data Note

# Insurance Coverage Changes for People with HIV Under the ACA

Jennifer Kates, Lindsey Dawson

Prior to the Affordable Care Act (ACA), people with HIV faced limited access to insurance coverage due to several barriers, including pre-existing condition exclusions, high costs, Medicaid eligibility limitations, and other challenges. Several key provisions of the ACA removed these barriers. With discussion underway about the future of the ACA, including repealing it in full or in part, it is important to understand how the ACA has changed coverage for people with HIV.

This brief provides the first national estimates of changes in insurance coverage among people with HIV since the implementation of the ACA.[1,2] It is based on analysis of data from the Centers for Disease Control and Prevention (CDC). We find that coverage increased significantly for people with HIV due to the ACA's Medicaid expansion; indeed, increased Medicaid coverage in expansion states drove a nationwide increase in coverage for people with HIV. In addition, the share relying on the Ryan White HIV/AIDS Program also increased. To the extent that ACA repeal efforts include elimination of the Medicaid expansion option for states, most people with HIV who gained this type of insurance could be at risk for losing coverage. In addition, elimination of private market protections- such as bans on preexisting condition exclusions and rate setting tied to health status- would also limit access for this population.

## Background

Prior to the ACA, many people with HIV faced limited access to insurance coverage due primarily to three types of barriers:

- Pre-existing conditions exclusions: Insurance issuers were able to deny individuals coverage based on pre-existing conditions (or perceived future conditions) including but not limited to being HIV positive, and HIV was generally considered an uninsurable condition.[3] As a result, in most cases people with HIV were effectively barred from the individual market.
- Cost barriers: Even if someone with HIV could obtain private insurance, it was often prohibitively expensive, as rates varied by health status and other factors. In addition, in both the individual and group markets, annual and lifetime limits on coverage posed a particular challenge for people with HIV given the high cost of HIV treatment.
- Medicaid eligibility limitations: Prior to the ACA, to qualify for Medicaid in most states, an enrollee had to be both low income and "categorically eligible," such as being disabled or pregnant, which excluded many low-income adults from coverage. This presented a "catch-22" for many low-income people with HIV who could not qualify for Medicaid until they were already quite sick and

disabled, often as a result of advanced HIV and developing AIDS, despite the fact that early access to treatment could help stave off disability and prevent further transmission.[4]

Several key provisions of the ACA removed these barriers. These include: eliminating pre-existing conditions exclusions; prohibiting private insurers from denying coverage or charging higher premiums to individuals based on their health status; eliminating annual and lifetime benefits limits; and providing subsidies to assist with purchasing private coverage through the Marketplaces for those between 100% and 400% of the federal poverty level (FPL). In addition, the law required states to expand their Medicaid programs to cover eligible individuals below 138% of FPL, basing eligibility on income and residency status alone and addressing the catch-22 described above. Although a June 2012 US Supreme Court decision effectively made Medicaid expansion a state option, to date, 32 states (including DC) have expanded their programs (where an estimated 60% of people with HIV live).[5] Still, the ruling meant that individuals who live in non-expansion states and are below 100% FPL fall into what is known as the "coverage gap" – neither eligible for the Medicaid program nor subsidies to make purchasing coverage through the Marketplaces more affordable. It is estimated that there are over 2.5 million individuals in the coverage gap, including thousands with HIV.[6]

To better understand how the ACA has affected coverage for people with HIV, we analyzed data from the CDC's Medical Monitoring Project (MMP), a surveillance system that produces nationally representative information about people with HIV who are in care.[7] Since the MMP currently surveys only individuals in care, data in this report is not representative of all people with HIV in the United States. We compared insurance coverage of people with HIV in care in 2012, before the implementation of major ACA expansion reforms, to 2014 (full methodology in Appendix B). In this analysis we looked at nationwide changes as well as changes within states that expanded Medicaid and those that did not expand. We also looked at whether the role of the Ryan White Program changed over this period. Since the major coverage reforms under the ACA were implemented in 2014, this data note provides an early glimpse of the insurance changes that have taken place among people with HIV in the ACA era. As was seen across the nation as a whole, it is likely that coverage gains have been greater in the subsequent years.[8]

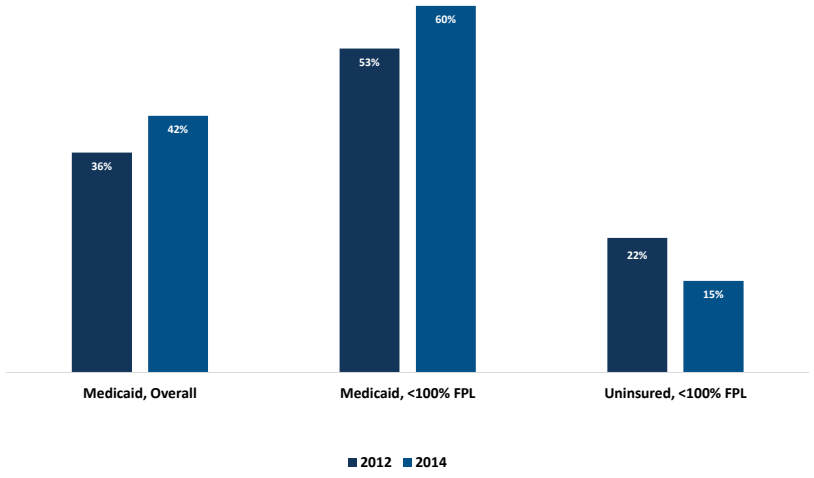
# Findings

Nationwide. Medicaid coverage of people with HIV in care increased significantly nationwide, rising from 36% in 2012 to 42% in 2014. The gains in Medicaid coverage were driven by those in Medicaid expansion states in the sample (where the uninsurance rate also dropped – see below). A similar increase in Medicaid coverage was not seen in non-expansion states. The share who were uninsured or with private coverage did not change significantly overall.

There were also changes for some subgroups, including by income level, race/ethnicity, and gender (detail available in Appendix A). For example, those below 100% FPL saw Medicaid coverage rates rise from 53% in 2012 to 60% in 2014, a group that also saw a decrease in uninsurance rates (falling from 22% in 2012 to 15% in 2014).

Figure 1

## Coverage Changes Among People with HIV in Care, Nationwide, 2012-2014

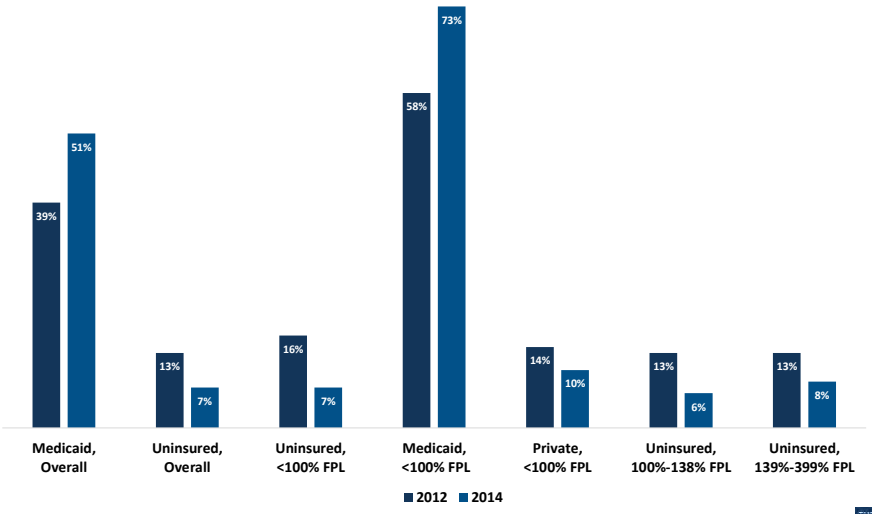



*Note: statistically significant at p<.05.*
Source: CDC/KFF analysis of MMP, 2012 and 2014.

Medicaid Expansion States. In the Medicaid expansion states sampled, Medicaid coverage rose significantly, from 39% in 2012 to 51% in 2014 and the share uninsured decreased from 13% to 7%.[9] Significant differences were also observed among subgroups (see Figure 2, additional detail available in Appendix A).

Figure 2

## Coverage Changes Among People with HIV in Care, Medicaid Expansion States Sampled, 2012-2014



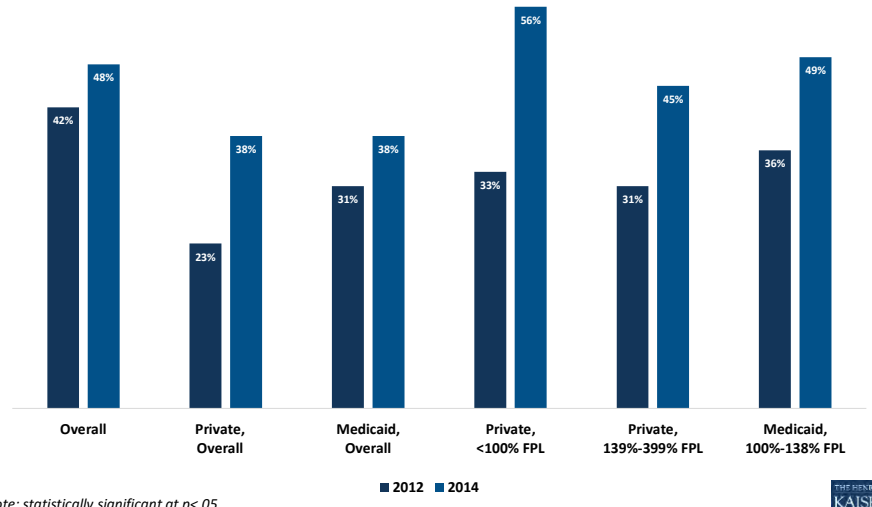

*Note: statistically significant at p<.05.*
Source: CDC/KFF analysis of MMP, 2012 and 2014.

Non-expansion States. Among the non-expansion states sampled,[10] no significant gains in coverage or drops in the share of the uninsured occurred between 2012 and 2014, though those below 100% FPL saw gains in private insurance, rising from 5% in 2012 to 13% in 2014 (additional detail available in Appendix A).

Ryan White. The role of the Ryan White Program has increased since implementation of the major coverage reforms under the ACA. Nationwide, the share of people with HIV in care relying on Ryan White rose from 42% in 2012 to 48% in 2014. In particular, the share of those with private insurance relying on the program rose from 23% in 2012 to 38% in 2014. Those with Medicaid also increased their reliance on Ryan White (from 31% in 2012 to 38% in 2014). While the uninsured did not see a significant change in reliance on Ryan White during this period, about 9 in 10 HIV positive uninsured individuals in care were already supported by the program in 2012. Additional coverage changes were observed among some subgroups (see Figure 3, additional detail available in Appendix A).

Figure 3

**Changes in Ryan White Reliance Among People with HIV in Care, Nationwide, 2012-2014**




*Note: statistically significant at p<.05.*
Source: CDC/KFF analysis of MMP, 2012 and 2014.

People with HIV in non-expansion also states saw a significant overall increase in reliance on Ryan White (rising from 42% in 2012 to 55% in 2014) and those with private insurance saw a particularly sharp increase in Ryan White support (rising from 17% to 38% over the same period). In the expansion states sampled, although there was no overall change in reliance on Ryan White, those with private insurance experienced increased reliance on Ryan White support, rising from 27% in 2012 to 39% in 2014.

# Discussion

The ACA has played a significant role in increasing insurance coverage for people with HIV through Medicaid expansion. Even though not all states have expanded Medicaid, coverage increases for people with HIV in expansion states drove a nationwide increase. At the same time, there was no significant decrease overall in the share who were uninsured, although this drop was significant in expansion states. This is likely due to the fact that in 2014 53% of people with HIV in non-expansion states had incomes below 100% FPL and fell into the coverage gap[11]. Of note, the share relying on Ryan White with Medicaid and private coverage increased, reflecting the program's significant and growing role in assisting people with HIV who have insurance afford that coverage and providing services that may not be covered such as case management, transportation assistance, and longer more complex provider visits.[12]

Overall, this analysis suggests that the ACA has had a significant impact on coverage for people with HIV in the U.S., due to Medicaid expansion. To the extent that ACA repeal efforts include elimination of the Medicaid expansion option for states, most people with HIV who gained coverage would likely lose it unless states adopt alternative approaches to retaining the newly covered population in the program.

# Appendix A: Tables

| Table 1. Insurance Coverage Changes Among People with HIV, 2012–2014 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Coverage Type | Nationwide | | Medicaid Expansion | | Non-Medicaid Expansion | |
| | | 2012 | 2014 | 2012 | 2014 | 2012 | 2014 |
| **Coverage Type, Overall** | | | | | | | |
| | **Uninsured** | 18% | 14% | 13%* | 7%* | 26% | 23% |
| | **Private** | 31% | 30% | 34% | 29% | 26% | 32% |
| | **Medicaid** | 36%* | 42%* | 39%* | 51%* | 31% | 28% |
| **Coverage Type, by Gender** | | | | | | | |
| **Male** | **Uninsured** | 19% | 14% | 14%* | 7%* | 27% | 24% |
| | **Private** | 35% | 34% | 37% | 32% | 31% | 36% |
| | **Medicaid** | 30%* | 37%* | 34%* | 47%* | 24% | 23% |
| | | | | | | | |
| **Female** | **Uninsured** | 17%* | 12%* | 11%* | 6%* | 23% | 17% |
| | **Private** | 19% | 20% | 23% | 18% | 15%* | 23%* |
| | **Medicaid** | 52% | 54% | 57% | 65% | 47% | 41% |
| **Coverage Type, by Income** | | | | | | | |
| **<100% FPL** | **Uninsured** | 22%* | 15%* | 16%* | 7%* | 30% | 26% |
| | **Private** | 10% | 11% | 14%* | 10%* | 5%* | 13%* |
| | **Medicaid** | 53%* | 60%* | 58%* | 72%* | 47% | 43% |
| | | | | | | | |
| **100–138% FPL** | **Uninsured** | 17% | 13% | 13%* | 6%* | 23% | 24% |
| | **Private** | 17% | 22% | 18% | 18% | 16% | 26% |
| | **Medicaid** | 45% | 43% | 51% | 56% | 37%* | 24%* |
| | | | | | | | |
| **139–399% FPL** | **Uninsured** | 17% | 13% | 13%* | 8%* | 23% | 20% |
| | **Private** | 46% | 48% | 48% | 46% | 43% | 51% |
| | **Medicaid** | 19% | 21% | 22% | 28% | 15% | 11% |
| | | | | | | | |
| **400%+ FPL** | **Uninsured** | 4% | - | - | - | 7% | - |
| | **Private** | 87% | 90% | 87% | 91% | 86% | 89% |
| | **Medicaid** | - | 4% | - | 5% | - | - |
| **Coverage Type, by Race/Ethnicity** | | | | | | | |
| **White** | **Uninsured** | 12%* | 7%* | 8%* | 2%* | 19% | 16% |
| | **Private** | 47% | 44% | 49% | 45% | 44% | 44% |
| | **Medicaid** | 25%* | 34%* | 26%* | 39%* | 22% | 24% |
| | | | | | | | |
| **Black** | **Uninsured** | 21%* | 14%* | 13%* | 5%* | 29%* | 22%* |
| | **Private** | 21% | 25% | 24% | 19% | 18%* | 29%* |
| | **Medicaid** | 47% | 48% | 52%* | 63%* | 42% | 35% |
| | | | | | | | |
| **Hispanic** | **Uninsured** | 25% | 22% | 24%* | 17%* | 26% | 30% |
| | **Private** | 22% | 21% | 23% | 19% | 20% | 24% |
| | **Medicaid** | 32% | 39% | 41%* | 52%* | 17% | 17% |

* Indicates coverage changes statistically significant at p<.05

Note: Medicaid expansion and non-Medicaid expansion data only representative of states sampled and are not generalizable to all states with that expansion decision. Medicaid expansion states sampled are DE, IL, IN, MI, NJ, NY, OR, PA, WA, and CA. The non-expansion states sampled are FL, GA, MS, NC, VA, and TX.

| Table 2. Ryan White Coverage Changes Among People with HIV, 2012-2014 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Coverage Type | Nationwide | | Medicaid Expansion | | Non-Medicaid Expansion | |
| | | 2012 | 2014 | 2012 | 2014 | 2012 | 2014 |
| **Coverage Type, Overall** | | | | | | | |
| | Uninsured | 88% | 91% | 90% | 88% | 87% | 92% |
| | Private | 23%* | 38%* | 27%* | 39%* | 17%* | 38%* |
| | Medicaid | 31%* | 38%* | 32% | 36% | 30% | 42% |
| | Total | 42%* | 48%* | 42% | 43% | 42%* | 55%* |
| **Coverage Type, by Gender** | | | | | | | |
| Male | Uninsured | 89% | 90% | 91% | 88% | 87% | 91% |
| | Private | 23%* | 38%* | 28%* | 38%* | 15%* | 38%* |
| | Medicaid | 36%* | 43%* | 37% | 42% | 33% | 47% |
| | | | | | | | |
| Female | Uninsured | 89% | 91% | 85% | 86% | 91% | 93% |
| | Private | 23%* | 39%* | 23%* | 46%* | 23% | 34% |
| | Medicaid | 24% | 27% | 23% | 23% | 25% | 34% |
| **Coverage Type, by Income** | | | | | | | |
| <100% FPL | Uninsured | 88% | 92% | 88% | 87% | 89% | 93% |
| | Private | 33%* | 56%* | 31%* | 52%* | 40%* | 60%* |
| | Medicaid | 28% | 34% | 29% | 31% | 26%* | 42%* |
| | | | | | | | |
| 100-138% FPL | Uninsured | 87% | 87% | 86% | 84% | 87% | 88% |
| | Private | 44% | 61% | 45%* | 75%* | 43% | 47% |
| | Medicaid | 36%* | 49%* | 36%* | 51%* | 35% | 41% |
| | | | | | | | |
| 139-399% FPL | Uninsured | 92% | 89% | 94% | 88% | 89% | 90% |
| | Private | 31%* | 45%* | 37%* | 49%* | 21%* | 41%* |
| | Medicaid | 44% | 50% | 46% | 53% | - | 42% |
| | | | | | | | |
| 400%+ FPL | Uninsured | 83% | 100% | 100% | 100% | 73% | 100% |
| | Private | 8% | 9% | 12% | 11% | - | - |
| | Medicaid | 44% | - | 50% | - | - | - |
| **Coverage Type, by Race/Ethnicity** | | | | | | | |
| White | Uninsured | 91% | 90% | 91%* | 70%* | 91%* | 96%* |
| | Private | 21%* | 35%* | 26%* | 36%* | - | 33% |
| | Medicaid | 40%* | 54%* | 41% | 53% | - | 58% |
| | | | | | | | |
| Black | Uninsured | 87% | 87% | 87% | 79% | 88% | 89% |
| | Private | 25%* | 41%* | 28%* | 40%* | 21%* | 42%* |
| | Medicaid | 29% | 33% | 30% | 29% | 27% | 39% |
| | | | | | | | |
| Hispanic | Uninsured | 87%* | 95%* | 93% | 94% | 79%* | 95%* |
| | Private | 24%* | 40%* | 25%* | 45%* | 23% | 34% |
| | Medicaid | 27% | 30% | 26% | 29% | - | 38% |

* Indicates coverage changes statistically significant at p<.05

Note: Medicaid expansion and non-Medicaid expansion data only representative of states sampled and are not generalizable to all states with that expansion decision. Medicaid expansion and non-Medicaid expansion data only representative of states sampled and are not generalizable to all states with that expansion decision. Medicaid expansion states sampled are DE, IL, IN, MI, NJ, NY, OR, PA, WA, and CA. The non-expansion states sampled are FL, GA, MS, NC, VA, and TX.

# Appendix B: Methods

## DATA SOURCE:

This analysis relies on data from the Medical Monitoring Project (MMP), a CDC surveillance system designed to produce nationally representative estimates of behavioral and clinical characteristics of HIV-infected adults (those aged 18 and older) in the United States.[13] During 2009–2014, MMP employed a three-stage, complex sampling design in which US states and territories were sampled, followed by facilities providing outpatient HIV clinical care in those jurisdictions, and then HIV-infected adults (aged 18 years and older) receiving care in those facilities. We used MMP data collected from adults with at least one HIV clinical care visit to participating facilities during January to April of 2013 and 2014. Findings describe adults receiving HIV clinical care during these time periods.

Data used in this analysis were collected via face-to-face interviews and medical record abstractions between June 1, 2012 and May 31, 2013 for the 2012 cycle and June 1, 2014 and May 31, 2015 for the 2014 cycle. All sampled states and territories participated in MMP. In 2012, of 548 sampled facilities within these states or territories, 467 participated in MMP (facility response rate 85%), and of 9,394 sampled persons, 4,901 completed both an interview and a linked medical record abstraction (adjusted patient-level response rate 53%)%.[14] In 2014, of 561 sampled facilities within these states or territories, 485 participated in MMP (facility response rate 86%), and of 9,400 sampled persons, 5,154 completed both an interview and a linked medical record abstraction (adjusted patient-level response rate 56%).[15] Data were weighted based on known probabilities of selection at state or territory, facility, and patient levels. In addition, data were weighted to adjust for non-response using predictors of patient-level response. Although characteristics associated with nonresponse varied over time, the following characteristics were generally associated with nonresponse and informed weighting classes: facility size, private practice, younger age, black and Hispanic race, and shorter time since HIV diagnosis. This analysis includes information on 4,901 participants in 2012 and 5,154 in 2014 who represent all HIV positive individuals receiving care in the United States and Puerto Rico during the time in which they were sampled.

## ANALYSIS:

For all respondents in MMP, we examined self-reported insurance coverage as well as payment source for antiretroviral medicines using responses to the following questions “During the past 12 months, what were all the kinds of health insurance or health coverage you had?” and “During the past 12 months, what were the ways your antiretroviral medicines were paid for?” Response options included insurance programs (Medicaid, Medicare, private insurance, Veteran’s Administration, Tricare or CHAMPUS coverage, other public insurance, and other unspecified insurance) as well as medical care, medications and other services paid for by the Ryan White HIV/AIDS Program (Ryan White or the AIDS Drug Assistance Program). “Other specify” responses were extensively recoded to reflect the most accurate coverage type when possible. It is important to note that patients may not be aware of all the services they receive that are paid for by the Ryan White HIV/AIDS Program (the program provides funding directly to service organizations in many cases) and therefore, the estimates of the number of individuals who receive Ryan White HIV/AIDS Program services is likely an underestimate.

We estimated weighted percentages of individuals with the following types of health care coverage: no coverage (uninsured), private insurance, Medicaid, Medicare, and other (specified). Because respondents in MMP may indicate more than one type of coverage, we relied on a hierarchy to group people into mutually-exclusive coverage categories. Specifically, the hierarchy groups people into coverage types in the following order:

- Private coverage
- Medicaid coverage, including those dually eligible for Medicare
- Medicare coverage only
- Other public coverage, including Tricare/CHAMPUS, Veteran's Administration, or city/county coverage

In most cases, this hierarchy classifies individuals according to the coverage source that serves as their primary payer. People who do not report any of the sources of insurance coverage above are classified as uninsured. As noted above, we separately assess weighted percentages of persons receiving assistance through the Ryan White HIV/AIDS Program by health coverage type. This analysis depicts coverage for those who are uninsured, covered by private insurance, or covered by Medicaid. Findings related to those with other coverage or Medicare were excluded from this analysis given that insurance changes within those categories would not have been impacted by the ACA provisions examined for this work.

We assessed distributions of health coverage type in 2012 compared to 2014, overall and by whether the participant lived in a Medicaid expansion or non-Medicaid expansion state (as of 2014). We further stratified the analysis to examine health coverage types by income, race/ethnicity, and gender. Income is presented as a share of the federal poverty level (FPL); race/ethnicity, and gender was self-reported. Statistical comparisons between the percentage of the population with a particular health coverage type and the percentage receiving Ryan White HIV/AIDS Program assistance in 2012 compared to 2014 were made using chi-square tests.

## LIMITATIONS:

MMP is nationally representative only of those with HIV who are in care and does not include those who are diagnosed but not in care or those not yet diagnosed. (MMP is now including those who are diagnosed but not in care in the sample and that data will be available in the future).

MMP only allows for extrapolation to the national level when using the full sample. However, similar extrapolation is not possible when examining coverage changes in and contrasting Medicaid expansion states and non-expansion states. The Medicaid expansion and non-expansion coverage data presented here are representative only of the subset of states sampled that fell into each group.[16]

It is also important to note that these data reflect only the first two open enrollment periods of the ACA and therefore it is possible that coverage has continued to increase (as it has for the U.S. population overall).

The MMP categorized gender as male, female, or transgender based on self-identification. Participants are also classified as transgender if reported sex at birth and current reported gender differ. Findings by gender are

presented only by male and female categories in this analysis due to the limited sample size of transgender individuals and the fact that no coverage changes among this population met statistical significance.

# Endnotes

[1] CDC, special data request, October 16, 2013 and Bradley H, Prejean J, Dawson L, Kates, J, Shouse RL. Health care coverage and viral suppression pre- and post-ACA implementation. Poster (#1012) presented at: the Conference on Retroviruses and Opportunistic Infections (CROI) 2017; February 14, 2017; Seattle, WA.

[2] A subset of the data presented here was also released at the 2017 annual Conference on Retroviruses and Opportunistic Infections (CROI) in February 2017.

[3] Claxton, G., et al. Kaiser Family Foundation. *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA.* December 2016. Available at: http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/

[4] Department of Health and Human Services, Panel on Antiretroviral Guidelines for Adults and Adolescents (2013). Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents, July 14, 2016. Available at: http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/.

[5] Kaiser Family Foundation analysis of CDC surveillance data.

6 Kaiser Family foundation. State Health Facts. *Characteristics of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap.* Available at: http://kff.org/health-reform/state-indicator/characteristics-of-poor-uninsured-nonelderly-adults-in-the-aca-coverage-gap/?currentTimeframe=0 and Dept. of Health and Human Service. ASPE Issue Brief. *Health Insurance Marketplace Enrollment Projections for 2017.* October 2016. Available at: https://aspe.hhs.gov/sites/default/files/pdf/211056/EnrollmentProjections.pdf

[7] For the 2014 data, MMP only collected information on those in care. The MMP is now including those who are diagnosed but not in care in the sample and that data will be available in the future

[8] See for example: Kaiser Family Foundation. State Health Facts. *Health Insurance Coverage of the Total Population, 2013-2015.* http://kff.org/other/state-indicator/total-population/?currentTimeframe=0

[9] The Medicaid expansion states sampled by the MMP are Delaware, Illinois, Indiana, Michigan, New Jersey, New York, Oregon, Pennsylvania, Washington and California.

10 The non-expansion states sampled by the MMP are Florida, Georgia, Mississippi, North Carolina, Virginia and Texas.

11 Kates, J., et al. Kaiser Family Foundation. *Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV.* January 2014. http://kff.org/hivaids/issue-brief/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv/view/footnotes/#footnote-97557-6

12 See for example: Dawson, L. and Kates, J. Kaiser Family Foundation. *The Ryan White Program and Insurance Purchasing in the ACA Era: An Early Look at Five States.* April 2015. Available at: http://kff.org/hivaids/issue-brief/the-ryan-white-program-and-insurance-purchasing-in-the-aca-era/

13 An Institute of Medicine report commissioned by the White House recommended MMP to help identify data sources for monitoring the effects of the Affordable Care Act (ACA) on HIV care and coverage in the United States. See: IOM (Institute of Medicine). 2012. Monitoring HIV care in the United States: A strategy for generating national estimates of HIV care and coverage. Washington, DC: The National Academies Press.

[14] Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, 2014 Cycle (June 2014–May 2015). HIV Surveillance Special Report 17. December 2016. Available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2014.pdf.

[15] Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, 2012. HIV Surveillance Special Report 12. August 2015. Available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2014.pdf

16 The Medicaid expansion states sampled by the MMP are Delaware, Illinois, Indiana, Michigan, New Jersey, New York, Oregon, Pennsylvania, Washington and California. The non-expansion states sampled by the MMP are Florida, Georgia, Mississippi, North Carolina, Virginia and Texas.

# Promoting Our Worth, Equality, and Resilence


## 2016 ANNUAL REPORT

https://www.lgbthlres.pitt.edu/
http://centerforblackequity.org/

# Acknowledgements

## COMMUNITY PARTNER ORGANIZATIONS

**Thank you to all community based organizations (CBOs) who partnered with POWER to offer confidential HIV testing, without whom this project would not be possible!**

ACCESSMATTERS

AID ATLANTA

AIDS FOUNDATION HOUSTON

AHF AIDS HEALTHCARE FOUNDATION

CHAG

DC BLACK PRIDE

HOTTER THAN July

THE HORIZONS PROJECT

HACS

HS

ITIA

NAESM

Philadelphia BLACK PRIDE

PHILADELPHIA FIGHT COMMUNITY HEALTH CENTERS

POSITIVE EFFORTS

"Changing Risky Behavior"

UNIFIED

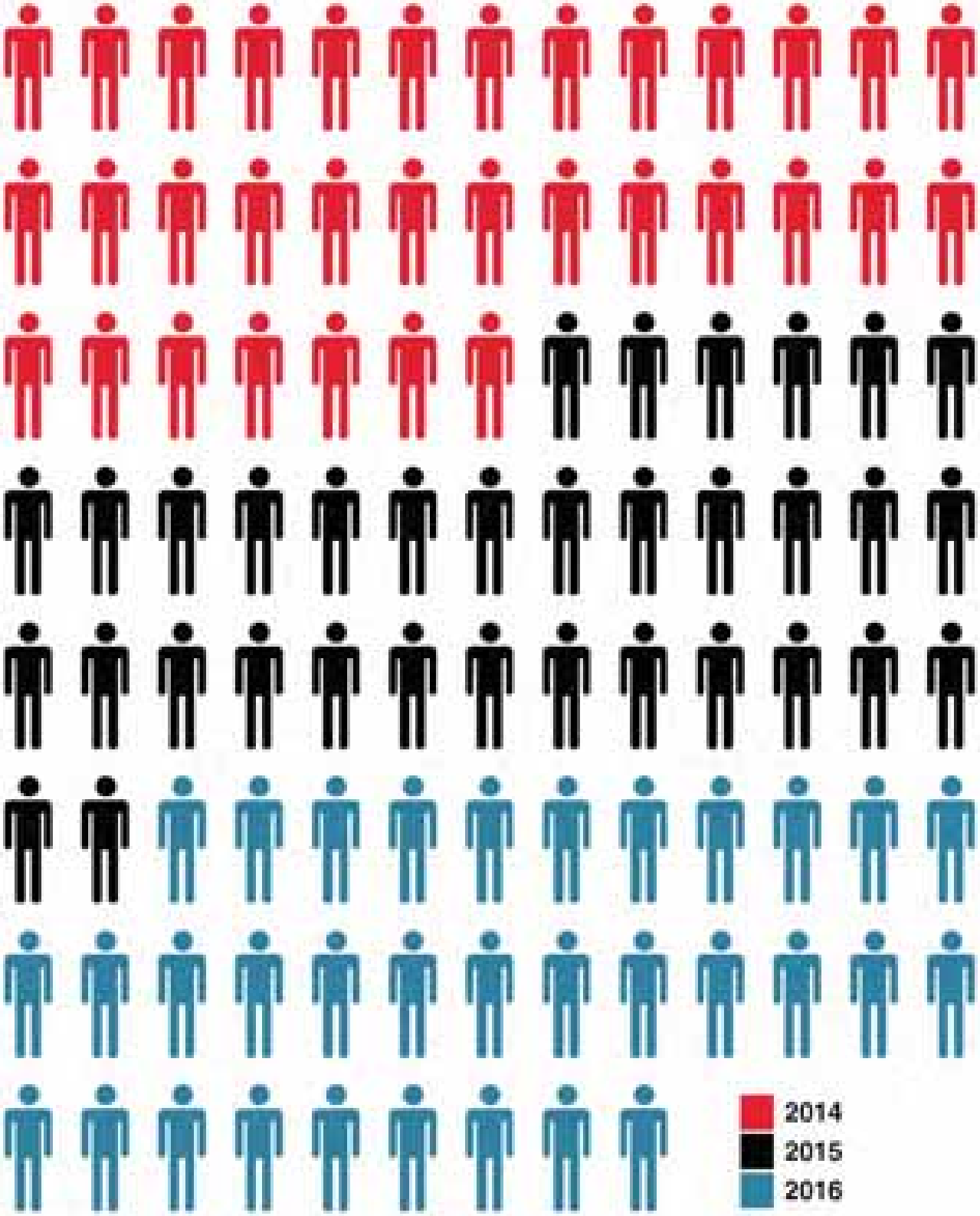
No health and beyond

US HELPING US

PEOPLE INTO LIVING

# STUDY PARTICIPANTS

**Thank you to all the individuals who took the time to participate in the POWER study!**



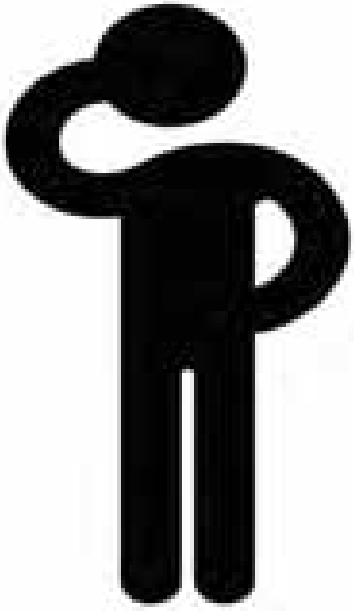
# SUPPORT & FUNDING





# Study Overview

## RATIONALE

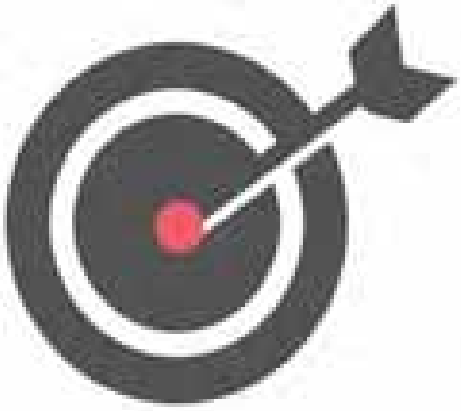


1. HIV prevalence and incidence are higher among Black men who have sex with men (BMSM) than for any other other group of US citizens
2. Delayed HIV testing, unknown HIV status, and lower rates of antiretroviral therapy (ART) uptake among diagnosed HIV-positive individuals drive this disparity among BMSM
3. We know little regarding what is associated with delayed HIV testing, unknown HIV status, and lower rates of ART uptake among BMSM

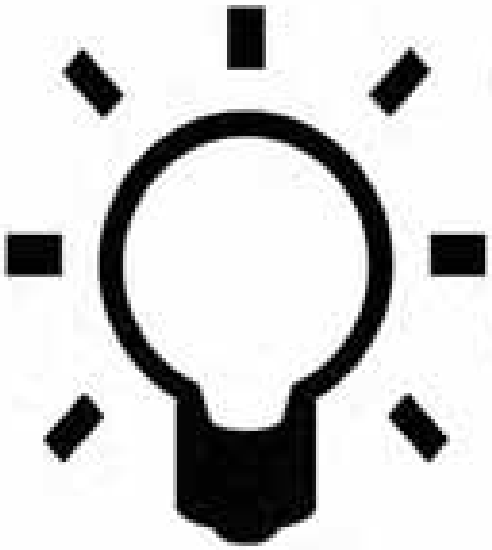
---

## SPECIFIC AIMS

1. Measure HIV testing rates and identify the factors associated with HIV testing among BMSM
2. Measure the prevalence of undiagnosed HIV-positive BMSM and identify the factors associated with an undiagnosed HIV-positive status
3. Measure the prevalence of HIV Care Continuum outcomes and identify syndemic associations of HIV Care Continuum outcomes among BMSM



# INNOVATION

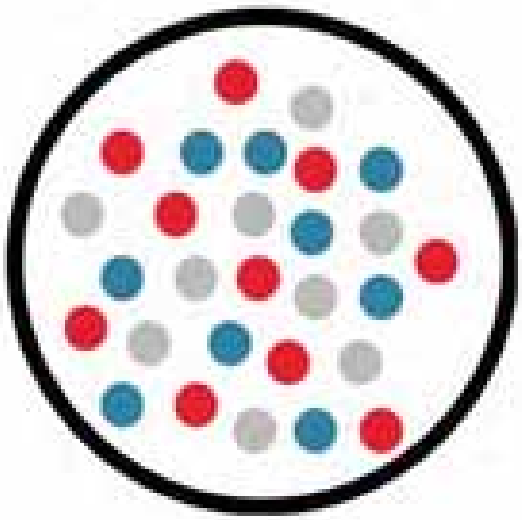


1. Collect data from ~6,000 BMSM over the course of 3 years in order to assemble the largest sample of BMSM in any study to date
2. Recruit BMSM where they already gather: at Black Pride events
3. Partner with local community-based HIV testing organizations (CBOs) to aid in study implementation and data dissemination

---

# INCLUSION CRITERIA

1. Assigned male sex at birth
2. Currently identify as male, female, or transgender
3. Reported having at least one male sexual partner in their lifetime
4. 18 years of age or older



# RECRUITMENT AT BLACK PRIDE EVENTS

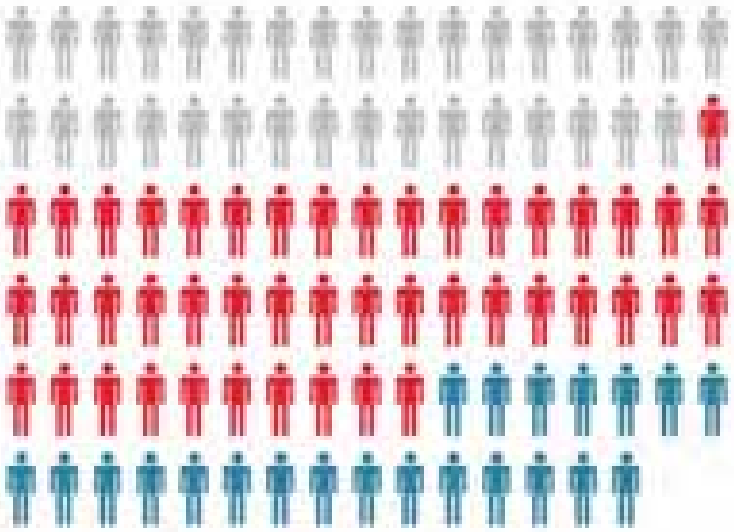
**88 Events in 6 Cities over 3 Years**

Atlanta, GA; Detroit, MI; Houston, TX; Memphis, TN*; Philadelphia, PA; Washington, D.C.

*Only in 2015

# 44, 925

**Potential Participants Encountered**

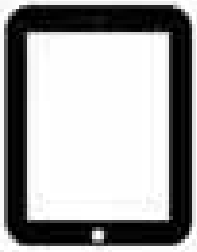


2014 2015 2015

# METHODS

## Time Location Sampling

- Randomly select recruitment times in 2-hour increments from all possible Black Pride events in a city
- Set-up an intercept zone at events and count every potential participant who enters this zone
- Approach and recruit potential participants who have entered the intercept zone

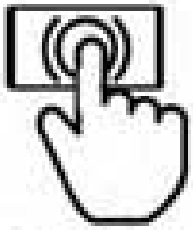


## Behavioral Health Survey

- Self administered using QDS software on Dell Venue Pro tablets
- Takes approximately 20 minutes to complete
- Participants compenstated $10

## Onsite HIV Testing

- Confidential HIV testing performed by local CBOs; participants receive their test result
- If participants decline confidential testing, they are offered anonymous HIV testing via the study; participants do not receive their test result
- Participants are compensated $10 for completing either testing option; CBOs are compensated $20 for each test they perform on behalf of the study



## Dry Blood Spot Sample Collection*

- Participants provide a few drops of blood by pressing their pricked finger on a small card
- Participants are compensated $10 for providing a sample
- Dry blood spot samples are destroyed after analysis and allow us to characterize the HIV care continuum with biological markers

# SURVEY DOMAINS*

1. **Demographics**
   Age; education; income; employment status; race; incarceration; homelessness; ethnicity; country of origin; presence of and access to health care; homelessness; incarceration

2. **Sexual Behavior**
   Male life-time history and most recent partner; female life-time history and most recent partner

3. **Psychsocoial**
   Depression; substance use; internalized homophobia; internalized transphobia

4. **Experiences of Violence and Discrimination**
   Intimate partner violence (IPV); physical assault; childhood sexual abuse; discrimination based on race; sexual orientation; transgender status; HIV-status; and socioeconomic status; HIV related stigma**

5. **HIV Testing**
   Lifetime HIV testing history; past 6-month HIV testing history

6. **HIV Care**
   HIV care continuum outcomes; biological confirmation of HIV care continuum outcomes**

7. **PEP and PrEP**
   PrEP awareness and uptakes; biological confirmation of PrEP uptake**

8. **Resilience**
   Social support among family, friends, work, church, LGBT community, Black community); level of outness with family, friends, work, church, LGBT community, Black community; community tolerance

9. **Religiosity and Spirituality**

*For more information regarding what is measured within the survey, please contact Leigh Bukowski at lab108@pitt.edu
** Year 3 (2016) only

# Data Overview

## TIME-LOCATION SAMPLING

At 88 Events in 6 Cities over 3 Years

10,810 Were Approached

8,851 Agreed to hear about POWER

5,399 Agreed to take the survey

5,135 Completed the survey

## STUDY POPULATION

**5,135**
Completed the Survey

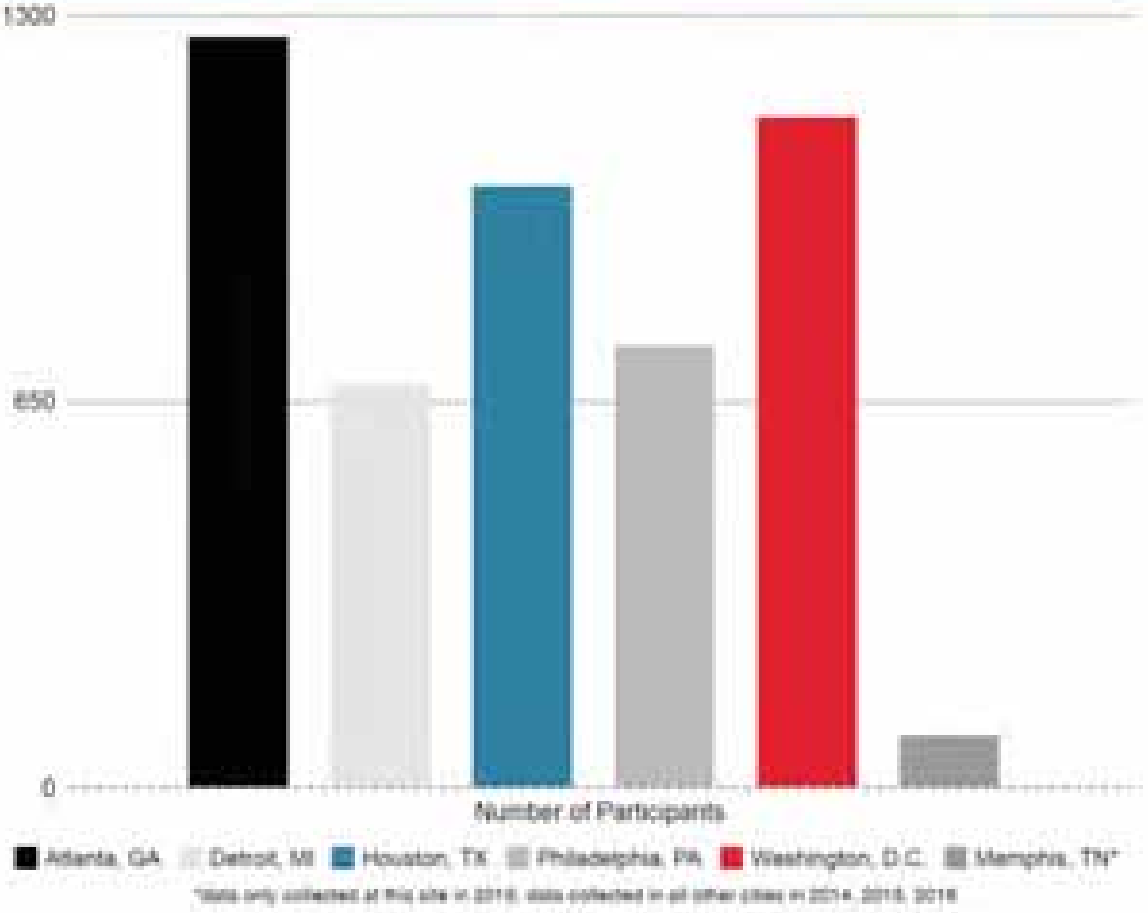
**4,908**
Identified as Black or African-American

**4,763**
Identified as Male

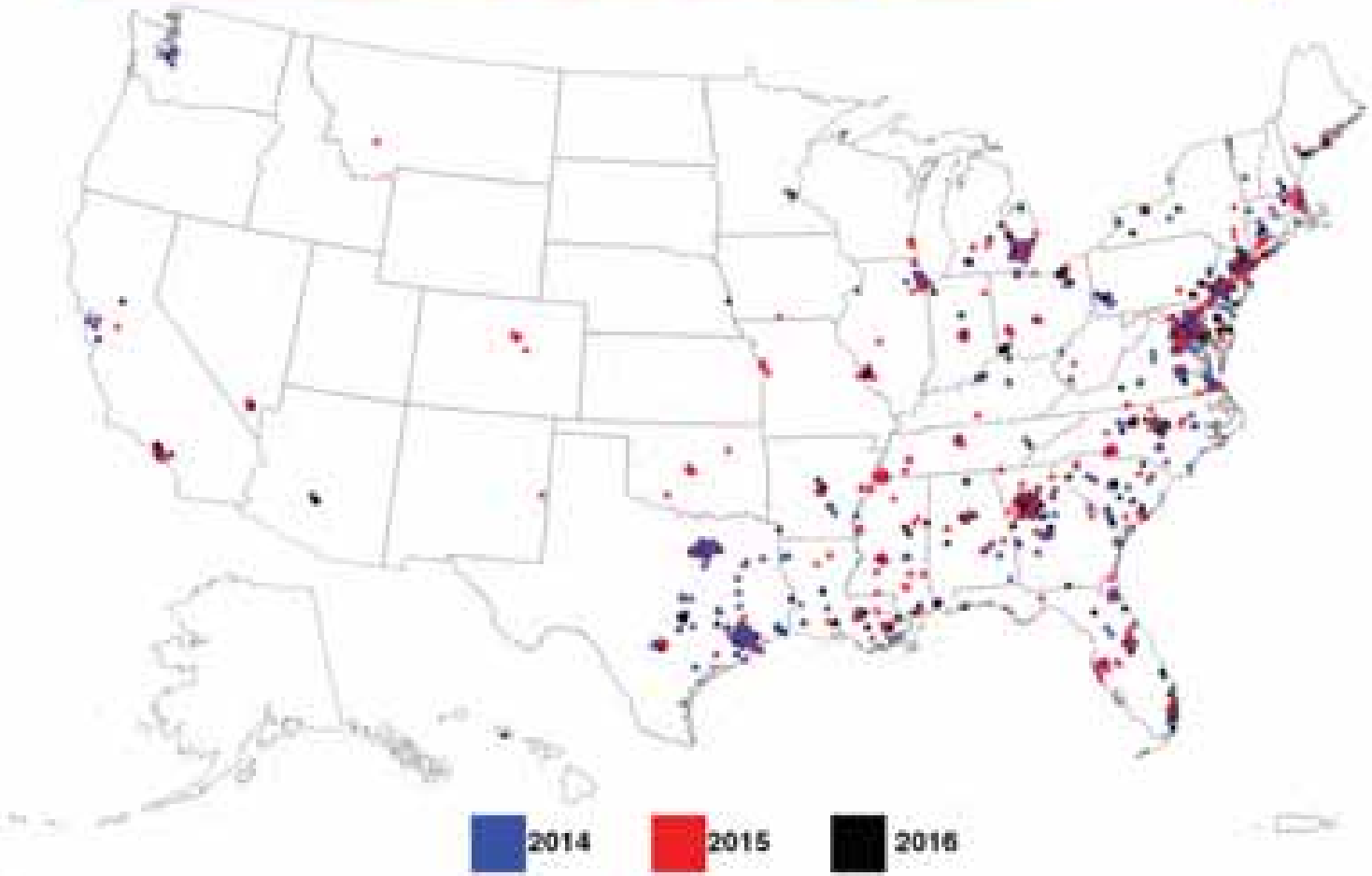
**145***
Identified as Female or Transgender

*For more information regarding the sample of Black transgender women, please contact lab108@pitt.edu

## WHERE WERE PARTICIPANTS RECRUITED?




## WHERE ARE PARTICIPANTS FROM?



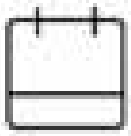
# Study Findings

**Results from Sample of 4,763 BMSM**

# Characteristics of BMSM*

**Education**
37% of BMSM had achieved a college diploma or more

**Housing**
11% of BMSM reported having been homeless in the past-year

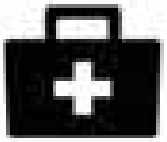


**Age**
BMSM were on average 31 years old

**Physical Assault**
14% of BMSM reported experiencing past-year physical assault

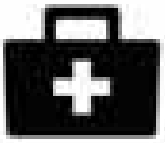
**US Born**
97% of BMSM were born in the U.S.

**Intimate Partner Violence**
16% of BMSM reported experiencing past-year intimate partner violence

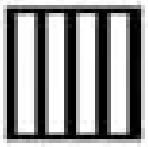


**Health Insurance Coverage**
85% of BMSM reported having some form of health insurance coverage

**Childhood Sexual Abuse**
25% of BMSM reported having experienced childhood sexual abuse



**Access to Medical Care**
20% of BMSM reported being unable to access medical care



**Incarceration**
10% of BMSM reported having been incarcerated in the past 2-years

**Depression**
23% of BMSM reported past week symptomology of depression

**Family Support**
46% of BMSM reported receiving a lot of support from their family

**Poly-Substance Use**
5% of BMSM reported past-year poly-substance use

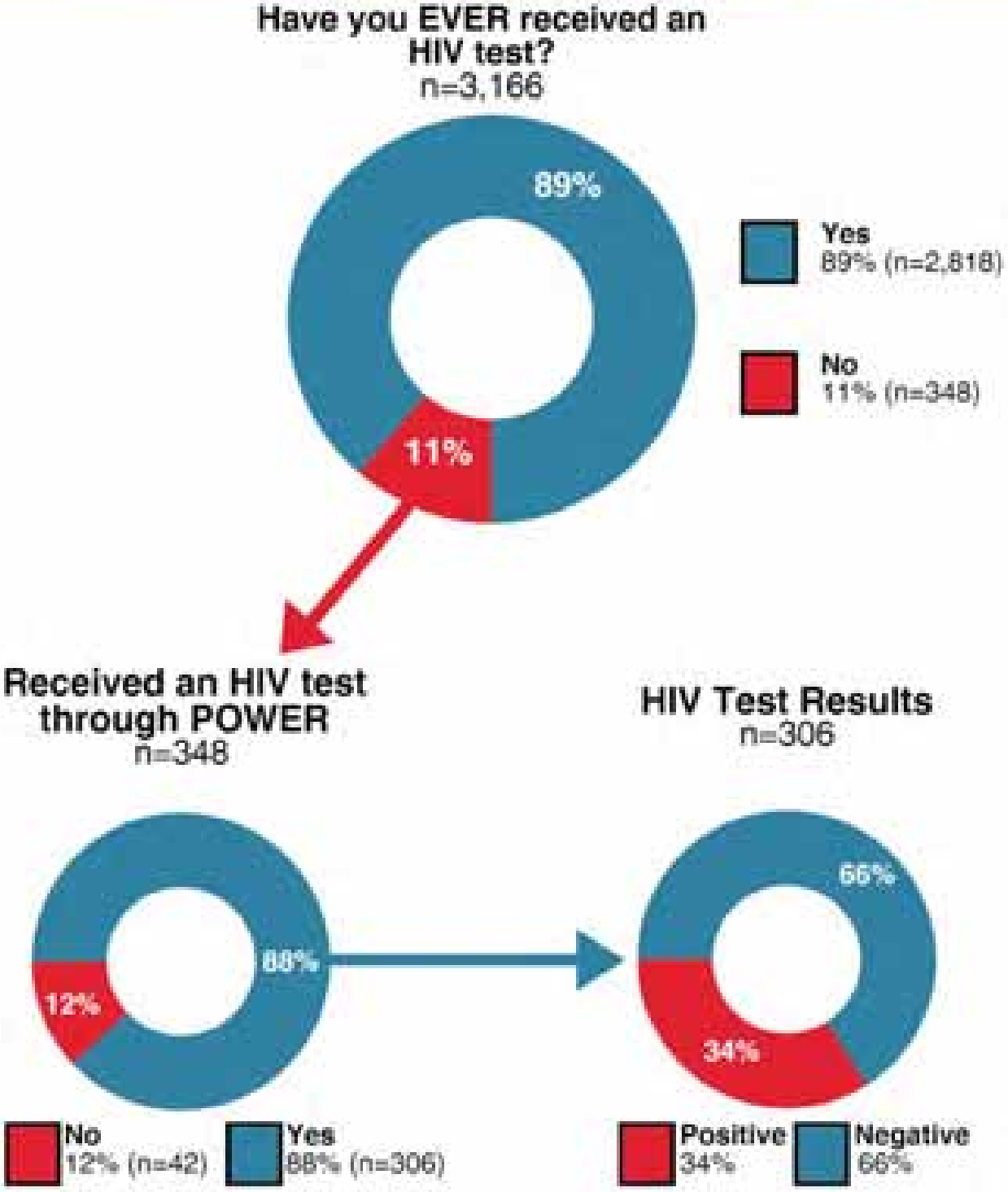
**Friend Support**
62% of BMSM reported receiving a lot of support from their friends

*For more information related to the characteristics of BMSM in our sample, please refer to Appendix I

# Aim 1

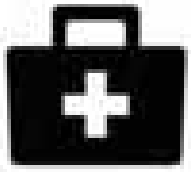
**a) Measure the rates of HIV testing among BMSM**
**b) Identify factors associated with testing among BMSM**

## a) Rates of lifetime HIV testing history among BMSM who did not report a prior HIV diagnosis



## b) What is associated with having never received an HIV test when controlling for age, education, and city?

**Bisexual Identity**
Individuals who identified as bisexual were 50% more likely to have never received an HIV test compared to those who identified as gay.



**Ability to Access Medical Care**
Individuals unable to access medical were 40% more likely to have never received an HIV test compared to those able to access medical care.

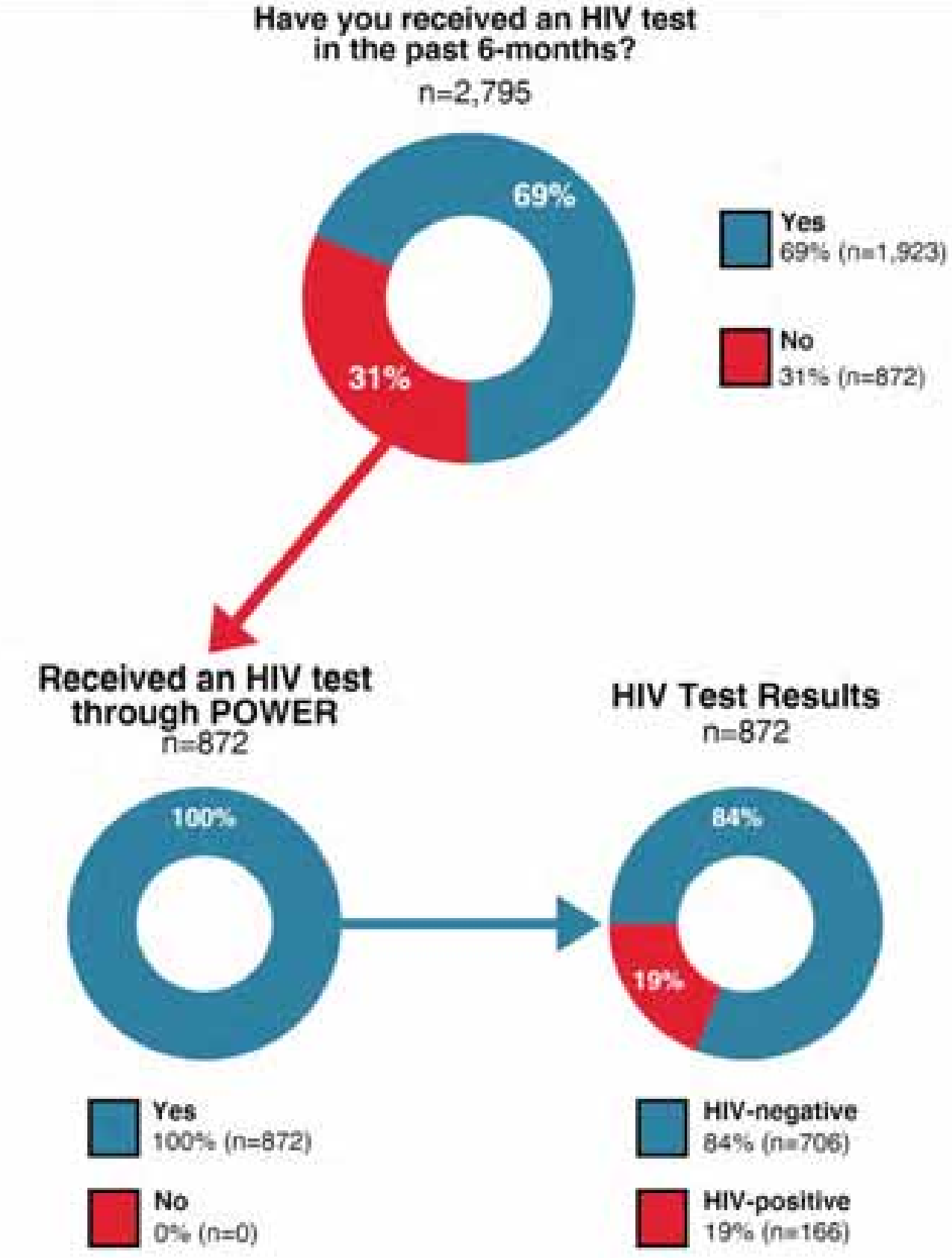
**Depression**
Individuals who reported past-week depression symptomology were 70% more likely to have never received an HIV test compared to those who did not report past week depression symptomology.

**Physical Assault**
Individuals who experienced past-year physical assault were 37% more likely to have never received an HIV test compared to those who did not experience past-year physical assault.

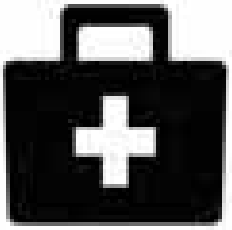
**Family Support**
Individuals who reported no family support were 184% more likely to have never received an HIV test compared to those who reported a lot of family support.

**Friend Support**
Individuals who reported no family support and little family support were 226% and 95% more likely to have never received an HIV test respectively compared to those who reported a lot of family support.

## a) Rates of past 6-month HIV testing history among BMSM who did not report a prior HIV diagnosis, excluding indiviuals who reported having never received an HIV test



## b) What is associated with having received an HIV test in the past 6 months when controlling for age, education, and city?



### Health Insurance Coverage

Individuals who had health insurance coverage were 34% more likely to have received an HIV test in the past-6 months than individuals without health insurance coverage.

### Intimate Partner Violence

Individuals who had been victims of IPV in the past year were 41% more likely to have received an HIV test in the past 6-months than individuals who had not been victims of past-year IPV.

### Physical Assault

Individuals who had been victims of past-year physical assault were 46% more likely to have received an HIV test in the past 6-months than individuals who had not been victims of past-year physical assault.

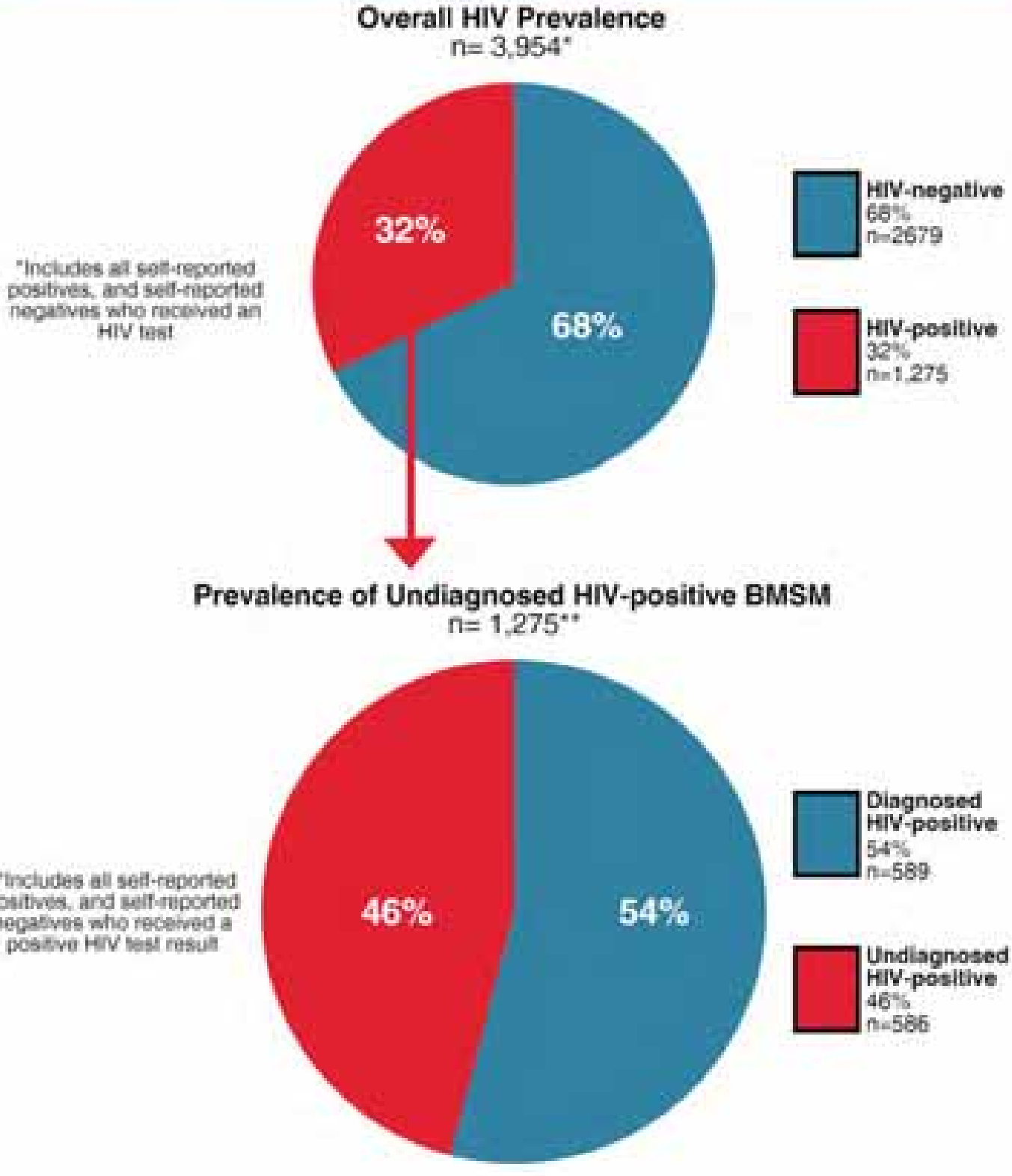
### Homelessness

Individuals who had been homeless in the past year were 54% more likely to have received an HIV test in the past 6-months than individuals who had not been homeless in the past-year.

# Aim 2

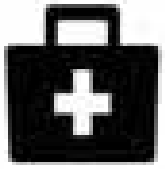
**a) Measure the prevalence of undiagnosed HIV-positive BMSM; and b) Identify the factors associated with a undiagnosed HIV-positive status**

## a) Measure the prevalence of undiagnosed HIV-positive BMSM



## b) What is associated with an undiagnosed HIV-positive status when controlling for age, education, and city?

*Comparing undiagnosed HIV-positive BMSM and HIV-negative BMSM* n=3,265*



### Ability to Access Medical Care

Individuals unable to access medical care were 82% more likely to be undiagnosed HIV-positive compared to those able to access medical care.

### Problematic Drug Use

Individuals who abused illicit substances were 52% more likely to be undiagnosed HIV-positive compared to those who did not abuse illicit substances.

### Intimate Partner Violence

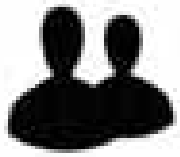
Individuals who experienced past-year intimate partner violence (IPV) were 50% more likely to be undiagnosed HIV-positive compared to those who did not experienced past-year IPV.

### Physical Assault

Individuals who experienced past-year physical assault were 54% more likely to be undiagnosed HIV-positive compared to those who did not experienced past-year physical assault.

### Childhood Sexual Abuse

Individuals who experienced childhood sexual abuse were 37% more likely to be unaware of their HIV-positive status compared to those who did not experience childhood sexual abuse.



### Friend Support

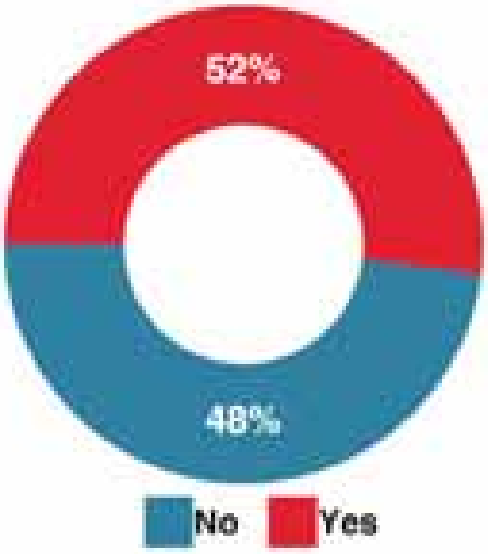
Individuals who reported no friend support were 57% more likely to be unaware of their HIV-positive status compared to those who reported a lot of friend support.

*These are all individuals who report a negative HIV status at the time of survey. Understanding demographic and psychosocial differences between undiagnosed, HIV-positive BMSM and HIV-negative BMSM my help elucidate a means by which to advance HIV diagnosis in this population.

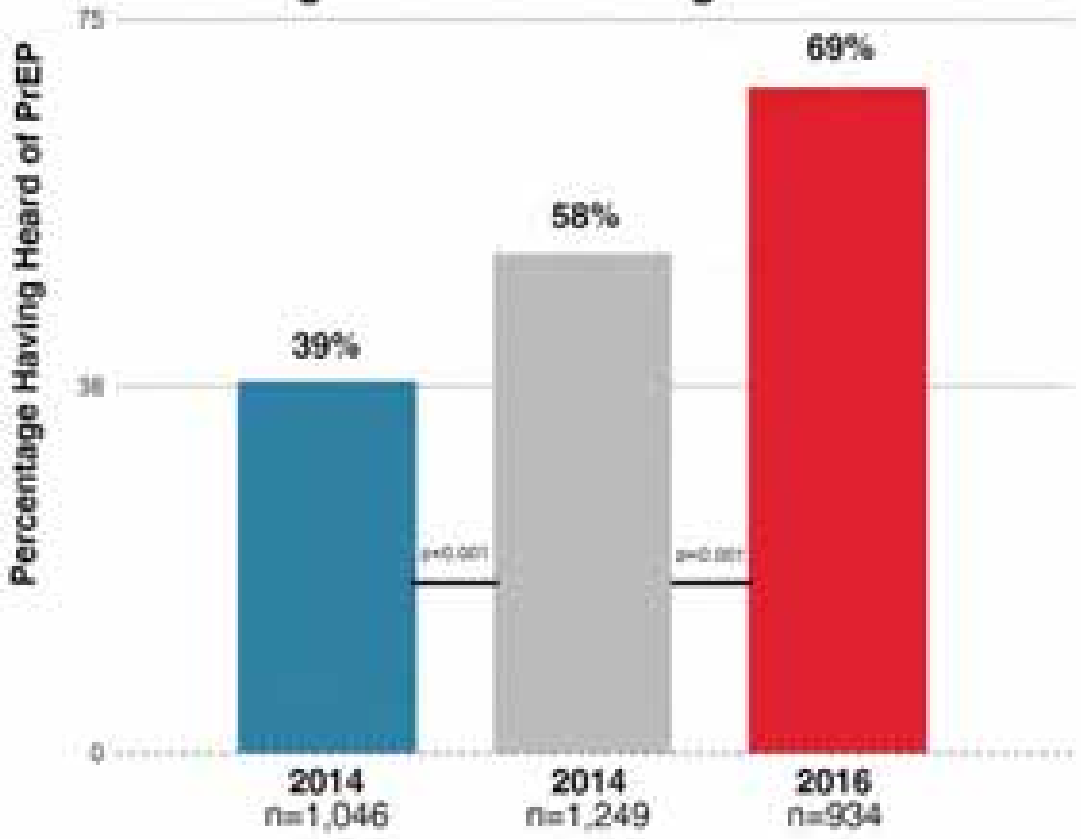
# PrEP Knowledge & Uptake

## PrEP Knowledge
n=3,181*

### Have you ever heard of PrEP?



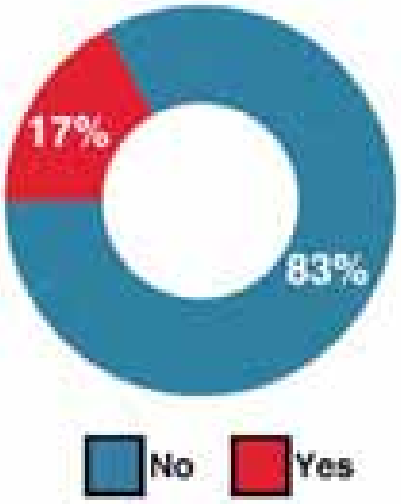

### Change in PrEP Knowledge Over Time



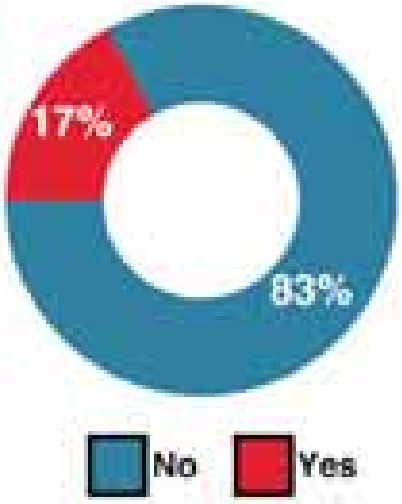

*Includes individuals (1) who reported >0 past-year male sexual partners; and (2) individuals who reported an HIV-negative status at the time of survey

# PrEP Uptake
n=1,666*

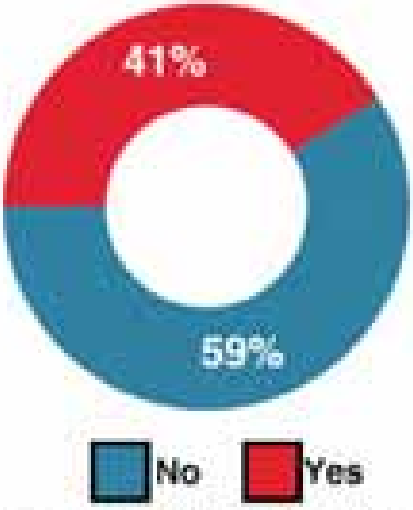
## Are you currently taking PrEP?




## Have you ever taken PrEP?




## Do you know anyone taking PrEP?




*Includes individuals (1) who reported >0 past-year male sexual partners; (2) individuals who

# Grant Productivity

## CONFERENCE PRESENTATIONS

7

### AIDS 2016, 21st International AIDS Conference
Durban, South Africa, July 18-22, 2016

- Physical assault partially mediates the impact of transgender status on depression and poly-substance use among Black men who have sex with men and Black transgender women in the United States. Oral presentation.
- Differences between unknown HIV-positive and HIV-negative Black transgender women in the United Stated. Oral presentation.
- Identifying unaware HIV-positive status among HIV-positive Black men who have sex with men in the United States. Poster presentation.
- Bi behavior, bi identity, or both? Interpreting disparities among bisexual Black men in the U.S. across the HIV prevention and care continuum. Poster presentation.
- The Prevalence of HIV Infection in Large, Time-Location Sample of Black MSM who attend Black Pride Events in the United States. Poster presentation.
- Characterizing Black men who have sex with men in the United States who have never received an HIV test. Poster presentation.
- Characterizing Black men who have sex with men in the United States who have never received an HIV test. Poster presentation.

1

### International Academy of Sex Research (IASR)
Malmö, Sweden, June 2016

- Who you are, or what you do? Associations between psychosocial health disparities, bisexual behavior, and bisexual identity among Black men in the United States. Poster presentation.

2

### National HIV Prevention Conference (NHPC)
Atlanta, GA, December 6-9, 2015

- PrEP and PEP Awareness and Uptake, and Correlates of Use among a Large Sample of Black Men Who Have Sex with Men. Oral presentation.
- Characterizing the HIV care continuum among Black transgender women (BTW) and correlates of undetectable viral load. Poster presentation.

1

### National AIDS & Education Service for Minorities (NAESM) Annual MSM Leadership Conference,
Atlanta, GA, January 15-18, 2015

- "Promoting Our Worth, Equality, and Resilience (POWER): Using a community-engaged multi-city study to understand the HIV care continuum among Black MSM – Year 1," Oral presentation.

# PAPERS

## 2 Published

- Matthews, D. D., Herrick, A. L., Coulter, R. W. S., Friedman, M. R., Mills, T. C., Eaton, L. A., Wilson, P. A., Stall, R. D., & POWER study team. (2016). Running Backwards: Consequences of HIV Incidence Rates for the Next Generation of Black MSM in the United States. AIDS and Behavior, 20, 7-16. doi: 10.1007/s10461-015-1158-z
- Eaton, L. A., Matthews, D. D., Driffin, D. D., Bukowski, L., Wilson, P. A., & Stall, R. D. (2017). A Multi-US City Assessment of Awareness and Uptake of Pre-exposure Prophylaxis (PrEP) for HIV Prevention Among Black Men and Transgender Women Who Have Sex with Men. Prevention Science, 1-12. doi: 10.1007/s11121-017-0756-6

## 2 Under Review

- Bukowski, L. A., Riley, N. C., Buehler, S. P., Hoffmann, C. S., Gehri-Seloover, A. A., Herrick, A. L., and Coulter, R. W. S. (Resubmission under Review). Physical assault partially mediates the impact of transgender status on depression and poly-substance use: Results from a study of Black MSM and Black transgender women in the United States.
- Friedman, M.R., Bukowski, L.A., Dyer, T.V., Eaton, L.A., Matthews, D.D., Siconolfi, D.E., and Stall, R.D. (2017) Psychosocial Health Disparities among Black Bisexual Men: The Effects of Sexuality disclosure and community support.

## 8 in Progress

- Characterizing BMSM who have never received an HIV test
- Factors associated with awareness of HIV-positive status among BMSM
- Temporal trends of PrEP awareness and uptake among BMSM
- Prevalence and correlates of HIV Care Continuum outcomes among BTW.
- Identifying differences related to correlates of HIV testing and care between BMSM and BTW
- Prevalence and correlates of HIV Care Continuum outcomes among BMSMW.
- HIV testing behaviors and discrimination among BTW
- HIV testing typologies among BMSM

# INVITED PRESENTATIONS

THE DEAN'S GRAND ROUNDS ON THE FUTURE OF PUBLIC HEALTH

TEAM SCIENCE FOR THE PUBLIC'S HEALTH

CENTER FOR LGBT Health Research

Philadelphia BLACK PRIDE

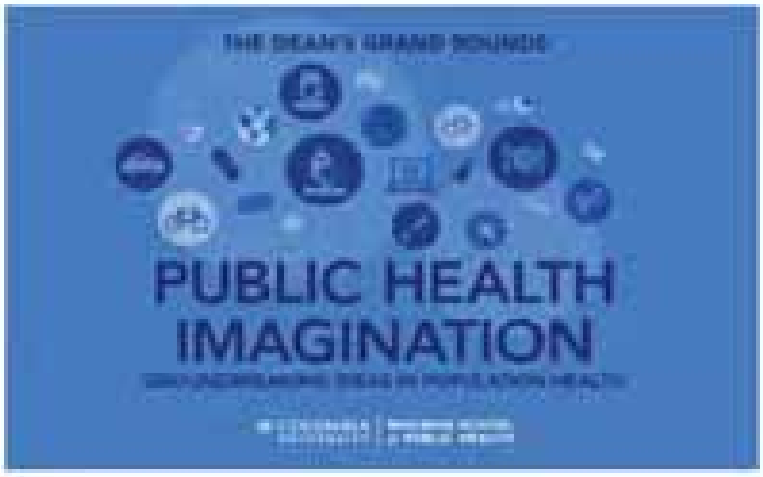
DC BLACK PRIDE

FRIDAY NIGHT YOUTH

Open-Open

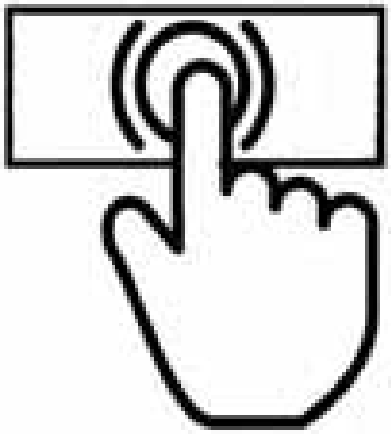
Hang Out, Eat Pizza, Play Games

THE BLACK AIDS INSTITUTE



# Dry Blood Spotting (DBS)

## 2016 DBS Collection



1. **Acceptability**
   85% of the 1,538 participants who completed a behavioral health survey provided a DBS sample which is nearly 100% of participants who opted to complete either HIV testing option.

2. **What's Next?**
   DBS samples collected at Black Pride events in 2016 have been processed, and we are currently adding this data to the POWER dataset.

## DBS data will allow us to:

1. Examine differences in operationalizing HIV care continuum position using self-report and biological data

2. Explore HIV care continuum position and associated factors using a combination of behavioral and biological outcome data

3. Maximize intervention success for BMSM by allowing for the confident identification, and consequently the ability to target, sources of HIV disparities.

# Community Feedback

Please contact Leigh Bukowski in the Center for LGBT Health Research at the University of Pittsburgh via phone (412-624-6174) or email (lab108@pitt.edu) if you have any questions, comments or concerns regarding the 2016 POWER Annual Report.

We want to know how we can use POWER data to help you leverage the work you're doing in your communities. Please contact Leigh Bukowski via phone (412-624-6174) or email (lab108@pitt.edu) if there are any analyses we could perform to achieve this goal.

What would you like to see next from the POWER study? Your feedback is highly valued and allows us to do our best work!

**We look forward to hearing from you!**

## Appendix I

**Table 1: Characteristics of Black men who have sex with men in the POWER sample**

| | n=4,414<br>*% (n)* |
|---|---|
| Education | |
| Less than high school | 7.1 (314) |
| High School diploma | 19.7 (869) |
| Some college | 36.0 (1588) |
| College diploma or more | 37.2 (1643) |
| Age mean (standard deviation) | 30.8 (9.8) |
| Health care | |
| Presence of health coverage | 85.3 (3764) |
| Unable to access care | 20.0 (882) |
| US Born | 96.7 (4266) |
| Depression | 23.2 (1023) |
| Alcohol | |
| Alcohol Consumption (past year) | 80.8 (3564) |
| Problematic Alcohol Consumption | 19.2 (848) |
| Drug Use | |
| Poly-Substance Use | 5.3 (234) |
| Problematic Substance Use | 8.6 (380) |
| Violence | |
| Intimate Partner Violence | 16.2 (713) |
| Physical Assault | 13.7 (605) |
| Childhood Sexual Abuse | 24.4 (1077) |
| Perceived Discrimination | |
| Race | 20.8 (919) |
| Sexuality | 20.4 (900) |
| HIV Status | 8.0 (353) |
| Incarceration (past 2-years) | 10.3 (455) |
| Homeless (past-year) | 11.4 (504) |
| Family Support | |
| None | 15.6 (704) |
| A little | 16.8 (741) |
| Somewhat | 21.1(933) |
| A lot | 46.1 (2036) |
| Friend Support | |
| None | 11.0 (485) |
| A little | 468 (10.6) |
| Somewhat | 691(15.7) |
| A lot | 67.8 (2770) |

## POWER Study 2016 Report Back
## Houston, TX Specific Data

**Table 1: Characteristics of Black men who have sex with men (BMSM) in the POWER sample recruited in Houston**

| | n= 935<br>*% (n)* |
|---|---|
| **Education** | |
| Less than high school | 7.1 (66) |
| High School diploma | 21.0 (195) |
| Some college | 38.3 (356) |
| College diploma or more | 33.6 (312) |
| **Age mean (standard deviation)** | 29.3 |
| **Health care** | |
| Presence of health coverage | 80.2 (750) |
| Unable to access care | 21.2 (195) |
| US Born | 97.7 (910) |
| **Depression** | 24.6 (229) |
| **Alcohol** | |
| Alcohol Consumption (past year) | 77.4 (723) |
| Problematic Alcohol Consumption | 17.3 (162) |
| **Drug Use** | |
| Poly-Substance Use | 5.5 (51) |
| Problematic Substance Use | 6.5 (61) |
| **Violence** | |
| Intimate Partner Violence | 18.7 (174) |
| Physical Assault | 15.0 (140) |
| Childhood Sexual Abuse | 25.3 (236) |
| **Perceived Discrimination** | |
| Race | 20.8 (194) |
| Sexuality | 21.1 (197) |
| HIV Status | 10.3 (96) |
| **Incarceration (past 2-years)** | 11.8 (110) |
| **Homeless (past-year)** | 10.8 (100) |
| **Family Support** | |
| None | 18.9 (176) |
| A little | 15.4 (144) |
| Somewhat | 20.4 (190) |
| A lot | 45.3 (423) |
| **Friend Support** | |
| None | 14.4 (134) |
| A little | 9.0 (84) |
| Somewhat | 14.2 (132) |
| A lot | 62.5 (582) |

**Table 2: Seroprevalence by Age Group among BMSM in the POWER sample recruited in Houston**

| Age Group | % of Age Group HIV+ |
|---|---|
| 18-19 | 10.3 |
| 20-24 | 36.8 |
| 25-29 | 37.4 |
| 30-34 | 43.7 |
| 35-39 | 60.0 |
| ≥ 40 | 58.33 |

**Figure 1: HIV Care Continuum among BMSM in the POWER sample recruited in Houston**

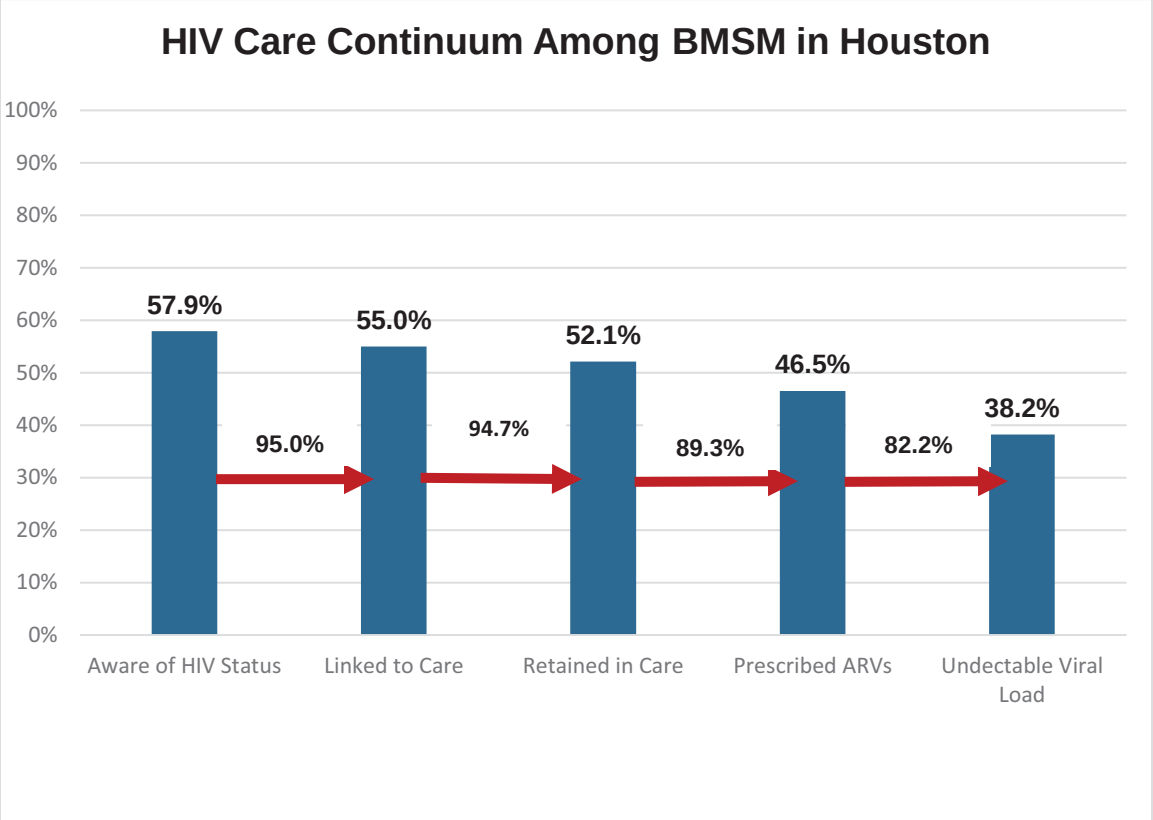



**Table 3: HIV Testing among BMSM in the POWER sample recruited in Houston**

| | n=935<br>% (n) |
|---|---|
| **Received an HIV test through POWER** | 87.2 (815) |
| Tested With POWER | 54.4 (443) |
| Tested with CBO | 45.6 (372) |
| **Never Received HIV Test** | 7.2 (67) |
| Never Received HIV test, tested with study | 6.4 (60) |
| Tested with POWER | 41.7 (25) |
| Tested with CBO | 58.3 (35) |
| **Received an HIV test, past 6-month** | 66.4 (618) |
| **Did not receive HIV test, past 6-month** | 33.6 (313) |
| No past 6-month test, tested with study | 92.3 (289) |
| Tested with POWER | 48.8 (141) |
| Tested with CBO | 51.2 (148) |