

**Houston Area HIV Services Ryan White Planning Council**

**2012 Houston Area Comprehensive HIV Services Plan  
COORDINATION OF EFFORT WORKGROUP**

1:00 p.m., Monday, October 24, 2011

Meeting Location: 2223 W. Loop South, Room #240

**AGENDA**

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| I. Call to Order   | Pam Green and Bruce<br>Turner, Co-Chairs               |
| A. Welcome and Introductions   |  |
| B. Moment of Reflection  |  |
| C. Adoption of the Agenda  |  |
| D. Approval of the Minutes   |  |
|  |  |
| II. Update on the Planning Process   | Jennifer Hadayia, Health<br>Planner, Office of Support |
| A. Key Findings from the Evaluation of the 2009<br>Comprehensive Plan                    |  |
|  |  |
| III. Discussion and Identification of Goals and Solutions<br>for Coordination of Effort  | Jennifer Hadayia, Health<br>Planner, Office of Support |
| A. Review of Results from the “Gaps Analysis for Priority<br>Sectors/Groups”             |  |
| B. Review of Overarching Themes on Coordination and<br>the Continuum of Care             |  |
| C. Identification of <i>Goals</i> for Coordinating Efforts                               |  |
| D. Identification of <i>Approaches</i> to Coordinating Efforts<br>(if time allows)       |  |
| E. Determination of <i>Scope</i> for Coordination of Effort Planning<br>(if time allows) |  |
|  |  |
| IV. Next Steps   | Pam Green and Bruce<br>Turner, Co-Chairs               |
| A. Review Meeting Schedule   |  |
| B. Items for Next Meeting  |  |
| C. Feedback on Process to Date   |  |
|  |  |
| V. Announcements   |  |
|  |  |
| VI. Adjourn  |  |

## Houston Area HIV Services Ryan White Planning Council

### 2012 Houston Area Comprehensive HIV Services Plan COORDINATION OF EFFORT WORKGROUP

1:00 p.m., Monday, September 26, 2011

Meeting Location: 2223 West Loop South, Room 416, Houston, TX 77027

#### Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Pam Green RN, Co-Chair	Ray Andrews, excused	Jen Hadayia, Office of Support
Bruce Turner, Co-Chair	Melody Barr, excused	Anna Langford, The Resource Group
Sherifat Akorede	Carin Martin	Tori Williams, Office of Support
Gayle Alstot, MD		
Dr. Roberto Andrade		
Ron Cookston		
Lisa Marie Hayes		
Monica James		
Tam Kiehnhoff		
Aundrea Matthews		
Ryan Rushing		
Robert Smith		

**Call to Order:** Co-chairs Green and Turner called the meeting to order at 1:05 p.m. and asked for a moment of reflection. Members introduced themselves and, as an ice-breaker, shared their perspectives on why it is important for AIDS Service Organizations (ASO) to work with non-ASOs and vice versa. Common themes from the ice-breaker activity included:

- Collaboration utilizes resources more efficiently;
- Collaboration can facilitate underserved and uninsured populations into care;
- Changes in HIV/AIDS necessitates new partners such as chronic disease management and aging;
- Non-traditional partners can serve as gatekeepers for PLWHA entering the HIV care system;
- Health care reform and the National HIV/AIDS Strategy are encouraging health-related agencies in the direction of coordination.

**Adoption of Agenda: Motion:** *it was moved and seconded (Alstot, Matthews) to adopt the agenda. Motion carried.*

**Workgroup Expectations:** The workgroup reviewed the following documents: Membership Requirements, Voting Rules and Quorum, 2012 Houston Area Comprehensive HIV Services Plan Organizational Structure, Ad Hoc Workgroup Role Description, Milestones Timeline, Ensuring Synergy and Core Planning Binder Table of Contents. See attached.

**Coordination of Effort in the 2012 Plan:** Workgroup members reviewed key data trends in HIV/AIDS epidemiology and the needs of people living with HIV/AIDS; as well as a summary of guidance from HRSA for the 2012 Comprehensive Plan regarding coordination of effort. The workgroup reviewed the program areas for which coordinating efforts are expected to be proposed in the 2012 Comprehensive Plan:

1. Within the Ryan White HIV/AIDS Programs, Parts A-F
2. Between Ryan White HIV/AIDS Programs and:
  - a) Other Public Providers (e.g., Medicare, Medicaid, CHIP, FQHCs, etc.)
  - b) Private Providers (e.g., Hospital Systems, Private Practice, Third-Party Payers, etc.)
  - c) HIV and STD Prevention
  - d) Substance Abuse Treatment
  - e) Other

Turner asked if the workgroup would be making changes to the current Houston Area Continuum of Care. Williams provided a copy of the current document for the group's reference. Hadayia stated that the workgroup and/or the Leadership Team could elect to recommend changes to the current continuum. Cookston asked which counties the 2012 Comprehensive Plan was meant to address; Hadayia noted that the plan would apply to the Houston Area EMA and HSDA, which is a 10-county area. Cookston noted that 95% of people living with HIV/AIDS reside within the City of Houston; therefore, he would be hesitant to recommend creating services in areas outside of Houston with a small number of possible consumers. Hayes recommended assessing services as urban/Harris County vs. rural/non-Harris County.

Members completed a modified "Gaps Analysis for Priority Sectors/Groups" worksheet outlining Strengths (or current efforts) and Opportunities (or needs for coordination) for each of the areas listed above. Matthews, Smith, and Cookston volunteered to share the results of their worksheets with the group. Hadayia will consolidate the worksheets for review by the group before the next meeting.

**Next Meeting:** 1:00 p.m., Monday, October 24, 2011

**Announcements:** None.

**Adjournment:** *It was moved and seconded (Matthews, Kiehnhoff) to adjourn the meeting at 3:30 p.m..* **Motion Carried.**

**Houston Area HIV Services Ryan White Planning Council**  
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**2012 Houston Area Comprehensive HIV Services Plan**  
**MEMBERSHIP ROSTER**  
**Last Updated 13-Oct-11**

**LEADERSHIP TEAM**

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*Next Meeting: October 24, 2011, 2:00 p.m., Room #416*

**Co-Chairs:**

- Sherifat Akorede, representing Ryan White Planning Council (Ryan White Program Part A)
- Tam Kiehnhoff, representing Ryan White Program Part B
- Cristan Williams, representing HIV Prevention Community Planning Group (CPG)

**Members:**

1. Gayle Alstot, MD, Manager of Operations, The Center for AIDS Information and Advocacy
2. Roberto A. Andrade, MD, Thomas Street Health Center; Assistant Professor-Infectious Diseases, Baylor College of Medicine-Houston; and Medical Director, AETC-Houston
3. Ray Andrews, Houston Crackdown
4. Melody Barr, Administration Manager, City of Houston Housing and Community Development, Housing Opportunities for People with AIDS (HOPWA)
5. Jeffrey Benavides, Latino HIV Task Force; and Harris County Hospital District
6. David Benson, Aid to County Commissioner El Franco Lee
7. Francis Bueno, Montrose Counseling Center, representing Serving the Incarcerated and Recently Released (SIRR) Coalition
8. Ron Cookston, Gateway to Care
9. Amber David, Disease Investigation Specialist, Houston Department of Health and Human Services; *Gaps in Care and Out of Care Workgroup Co-Chair*
10. Roy Delesbore, Texas Department of State Health Services, Region 6
11. Carie D. Fletcher, LCDC, CPS, Director of CORE Services, BACODA-Bay Area Council on Drugs and Alcohol, Inc.
12. David Garner, Member, Ryan White Planning Council; *Gaps in Care and Out of Care Workgroup Co-Chair*
13. Rodney Goodie, St. Hope Foundation
14. Pam Green, RN, Memorial Hermann Hospital System; *Coordination of Effort Workgroup Co-Chair*
15. Lisa Marie Hayes, MBA, Managing Local Ombudsman, Access and Assistance Coordinator, Area Agency on Aging, Houston-Galveston Area Council
16. Charles Henley, Manager, Ryan White Grant Administration, Harris County Public Health Services
17. Monica James, Gateway to Care
18. Florida Kweekkeh, Youth HIV Task Force
19. John LaFleur, External Member-Ryan White Planning Council; *Special Populations Workgroup Co-Chair*
20. Anna Langford, Planner, The Houston Regional HIV/AIDS Resource Group
21. Michael Lawson, External Member-Ryan White Planning Council

22. Amy Leonard, Legacy Community Health Services; *Prevention and Early Identification Workgroup Co-Chair*
23. Sam Lopez, Medical Lead Care Coordinator, Harris County Jail, representing Serving the Incarcerated and Recently Released (SIRR) Coalition
24. Nike Lukan, Chair, African American State of Emergency Task Force; and AIDS Foundation Houston
25. Ken Malone, HIV Testing Services Coordinator, Harris County Hospital District; *Prevention and Early Identification Workgroup Co-Chair*
26. Aundrea Matthews, PhDc, Assistant Project Coordinator, Houston Enriches Rice Education Project, Rice University
27. Mary Jo May, Chair, Board of Directors, Partners for Community Health
28. Scot More, Coalition for the Homeless of Houston/Harris County
29. M. Sandra Scurria, MD in private practice, Member, Harris County Medical Society
30. Nicholas Sloop, Public Health Advisor, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention; *Evaluation Workgroup Co-Chair*
31. Cecilia Smith-Ross, Chair, Ryan White Planning Council; and Founder, Living Without Limits Living Large Inc.
32. Bruce Turner, Member, Ryan White Planning Council, CPG, and M-PACT
33. Steven Vargas, Case Manager, MAP Program, Association for the Advancement of Mexican-Americans; *Evaluation Workgroup Co-Chair*
34. David Watson, Jail Team and Special Populations Coordinator, Houston Department of Health and Human Services; *Special Populations Workgroup Co-Chair*
35. Maggie White, BSN, RN, Research Coordinator, AIDS Vaccine Project, Baylor College of Medicine.

## **WORKGROUPS**

### **COORDINATION OF EFFORT WORKGROUP**

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*Next Meeting: October 24, 2011, 1:00 p.m., Room #240*

#### **Co-Chairs:**

- Pam Green, RN, Memorial Hermann Hospital System
- Bruce Turner, Member, Ryan White Planning Council, CPG, and M-PACT

#### **Members:**

1. Sherifat Akorede, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention
2. Gayle Alstot, MD, Manager of Operations, The Center for AIDS Information and Advocacy
3. Roberto A. Andrade, MD, Thomas Street Health Center; Assistant Professor-Infectious Diseases, Baylor College of Medicine-Houston; and Medical Director, AETC-Houston
4. Ray Andrews, Houston Crackdown
5. Melody Barr, Administration Manager, City of Houston Housing and Community Development, Housing Opportunities for People with AIDS (HOPWA)
6. Ron Cookston, Gateway to Care
7. Carie D. Fletcher, LCDC, CPS, Director of CORE Services, BACODA-Bay Area Council on Drugs and Alcohol, Inc.
8. Lisa Marie Hayes, MBA, Managing Local Ombudsman, Access & Assistance Coordinator, Area Agency on Aging, Houston-Galveston Area Council

9. Monica James, Gateway to Care
10. Tam Kiehnhoff, Triangle AIDS Network
11. Carin Martin, Ryan White Grant Administration, Harris County Public Health Services
12. Aundrea Matthews, PhDc, Assistant Project Coordinator, Houston Enriches Rice Education Project, Rice University
13. Ryan Rushing, Walgreens
14. M. Sandra Scurria, MD in private practice, Member, Harris County Medical Society
15. Robert Smith, External Member-Ryan White Planning Council

## **EVALUATION WORKGROUP**

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*Next Meeting: November 1, 2011, 1:00 p.m., Room #532*

### Co-Chairs

- Nicholas Sloop, Public Health Advisor, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention
- Steven Vargas, Case Manager, MAP Program, Association for the Advancement of Mexican-Americans; Member, Ryan White Planning Council, CPG, and Latino HIV Task Force

### Members:

1. Ben Barnett, MD, Associate Professor of Medicine, University of Texas Health Science Center; Member, Ryan White Planning Council
2. Hickmon Friday, MPH, MPA, Senior Health Planner, Houston Department of Health and Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention
3. Camden Hallmark, MPH, Data Analyst, Houston Department of Health and Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention; Member, Syphilis Elimination Advisory Council and Community Planning Group (CPG)
4. Judy Hung, MPH, Epidemiologist, Ryan White Grant Administration, Harris County Public Health Services
5. Ken Malone, HIV Testing Project Coordinator, Harris County Hospital District
6. Aundrea Matthews, PhDc, Assistant Project Coordinator, Houston Enriches Rice Education Project, Rice University; External Member, Ryan White Planning Council
7. Osaro Mgbere, PhD, MPH, Epidemiologist-Biostatistician, Houston Department of Health and Human Services, Bureau of Epidemiology; Member, Ryan White Planning Council
8. Erik Soliz, Senior Health Planner, Houston Department of Health & Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention; M-PACT
9. Bruce Turner, Member, Ryan White Planning Council, CPG, and M-PACT
10. Lena Williams, Project LEAP Student

## **GAPS IN CARE AND OUT-OF-CARE WORKGROUP**

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*Next Meeting: October 21, 2011, 12:00 p.m., Room #240*

### Co-Chairs:

- Amber David, Houston Department of Health and Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention
- David Garner, Member, Ryan White Planning Council

### Members:

1. Jeff Benavides, Latino HIV Task Force; and Harris County Hospital District

2. Linda Hollins, Texas Department of State Health Services
3. Januari Leo, Legacy Community Health Services
4. Ken Malone, HIV Testing Project Coordinator, Harris County Hospital District
5. Charolyn Mosley, Goodwill – Project Hope
6. Robert Smith, External Member-Ryan White Planning Council
7. Cecilia Smith-Ross, Chair, Ryan White Planning Council; and Founder, Living Without Limits Living Large Inc.
8. Barbara Walker, Legacy Community Health Services
9. Cristan Williams, Transgender Foundation of America

## **PREVENTION AND EARLY IDENTIFICATION WORKGROUP**

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*Next Meeting: November 9, 2011, 2:00 p.m., Room #240*

### Co-Chairs:

- Amy Leonard, Legacy Community Health Services
- Ken Malone, HIV Testing Project Coordinator, Harris County Hospital District

### Members:

1. Sherifat Akorede, Houston Department of Health and Human Services
2. Roy Delesbore, Texas Department of State Health Services, Region 6
3. Pam Green, RN, Memorial Hermann Hospital System
4. Brenda Harrison, Planned Parenthood Gulf Coast
5. Kevin Jackson, Community Member
10. Michael Lawson, External Member-Ryan White Planning Council
11. Januari Leo, Legacy Community Health Services
12. Nike Lukan, Chair, African American State of Emergency Task Force; and AIDS Foundation Houston
13. Jonathan Post, MPH Student, University of Texas, School of Public Health
14. Susan Rokes, Planned Parenthood
15. Roslyn Rose, Pink Rose-Saving Our Community Kids...Seniors (SOCKS)
16. Robert Smith, External Member-Ryan White Planning Council
17. Erik Soliz, Senior Health Planner, Houston Department of Health & Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention; Member, M-PACT
18. Amana Turner, Change Happens!
19. Ray E. Watts, DD, ThD, MEd, MCC, Urban AIDS Ministry
20. Maggie White, BSN, RN, Research Coordinator, AIDS Vaccine Project, Baylor College of Medicine
21. Simone Woodage, Sex Education for Parents of Teenagers and Preteens (SEFPOT)

## **SPECIAL POPULATIONS WORKGROUP**

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*Next Meeting: October 19, 2011, 10:00 a.m., Room #240*

### Co-Chairs:

- John La Fleur, Ryan White Planning Council-External Member
- David Watson, Jail Team and Special Populations Coordinator, Houston Department of Health and Human Services

Members:

1. Ray Andrews, Houston Crackdown
2. Kristina Arscott, Healthcare for the Homeless
3. Michael Bass, AIDS Foundation Houston
4. Jeff Benavides, Latino HIV Task Force; and Harris County Hospital District
5. Antoinette Boone, Housing Opportunities for People with AIDS (HOPWA)
6. Francis Bueno, Montrose Counseling Center, representing Serving the Incarcerated and Recently Released (SIRR)
7. Jackie Eaton, Montrose Counseling Center-IDU Outreach Team
8. Kendrick Kaie Falk, Part D C.A.B.
9. Carie D. Fletcher, LCDC, CPS, Director of CORE Services, BACODA-Bay Area Council on Drugs and Alcohol, Inc.
10. Morénike Giwa, Positive Playdates
11. Rose Haggerty, Houston Independent School District
12. Kevin Jackson, Community Member
13. Florida Kweekah, Youth HIV Task Force
14. Sam Lopez, Medical Lead Care Coordinator, Harris County Jail, representing Serving the Incarcerated and Recently Released (SIRR) Coalition
15. Scot More, Coalition for the Homeless of Houston/Harris County
16. Maggie White, BSN, RN, Research Coordinator, AIDS Vaccine Project, Baylor College of Medicine.
17. Cristan Williams, Transgender Foundation of America
18. Maxine Young, AIDS Foundation Houston

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**2012 Houston Area Comprehensive HIV Services Plan**  
**SEPTEMBER UPDATE {Steering Committee}**

**OVERALL PARTICIPATION**

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- 65 individuals are participating in the process, including at least 12 consumers.
- 52 agencies and coalitions are involved, including the Ryan White Planning Council, Houston HIV Prevention Community Planning Group (CPG), several CPG Task Forces, Houston Department of Health and Human Services, Ryan White HIV/AIDS Program (Part A, B, C, D, and F), HOPWA, multiple AIDS-service organizations, and non-traditional partners such as the Area Agency on Aging, Gateway to Care, and HISD.

**LEADERSHIP TEAM**

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- The Leadership Team met for the first time on September 26, 2011 with 23 members present.
- The focus of the meeting was to orient all members to the 2012 planning structure and to begin the process of developing the vision, mission, and values for the 2012 Comprehensive Plan.
- Attendees reviewed the 2009 Comprehensive Plan mission, vision, values, guiding principles, and goals as well as national HIV/AIDS priorities, including the National HIV/AIDS Strategy and Healthy People 2020. The meeting concluded with a group brainstorming session entitled: “Your Vision of an Ideal HIV System.”
- The next Leadership Team meeting is October 24, 2011 at 2:00 PM. Agenda items include: (1) reviewing the results of the evaluation of the 2009 Comprehensive Plan; (2) beginning to draft vision, mission, values, and overarching principles for the 2012 Comprehensive Plan.

**WORKGROUPS**

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**Coordination of Effort**

- The Workgroup met for the first time on September 24, 2011 with 12 members present.
- The focus of the meeting was to orient all members to the 2012 planning structure and to complete a modified *Gaps Analysis* for collaborative efforts occurring in each of the five areas identified by HRSA as coordination of effort priorities.
- The next Workgroup meeting is October 24, 2011 at 1:00 PM. Agenda items include: (1) identification of long-term goals for coordination of effort.

**Evaluation**

- The Workgroup met for the first time on September 6, 2011 with nine members present.
- The focus of the meeting was to review HRSA’s expectations for evaluation in the 2012 Comprehensive Plan and to adopt a methodology for evaluating the 2009 Comprehensive Plan.
- The adopted *Methodology for the Evaluation of the 2009 Comprehensive Plan* includes methods for measuring impact/community indicators, outcome/goals, and process/activities.

- Two smaller sub-groups of the Workgroup also met in September to conduct the impact and outcome evaluations. They identified quantitative measures on which to evaluate the 2009 plan, including unmet need trends, HIV/AIDS incidence, viral load, and retention in care metrics.
- The next Workgroup meeting is October 4, 2011 at 1:00 PM. Agenda items include: (1) conducting the process evaluation of the 2009 Comprehensive Plan; (2) reviewing the impact and outcome evaluation results; and (3) identifying recommendations for the evaluation report.

### **Gaps in Care and Out-of-Care**

- The Workgroup met for the first time on September 14, 2011 with eight members present.
- The focus of the meeting was to orient all members to the planning process, review HRSA's expectations for addressing gaps and the out-of-care in the 2012 Comprehensive Plan, and brainstorm key issues related to this topic. The group identified the following issues to explore:
  1. Eligibility
  2. Navigating the system
  3. Service linkage
  4. Previous positives
  5. Education to PLWHA
  6. Mental health services
  7. Social supports
- The next Workgroup meeting is Friday, October 21<sup>st</sup> at 12:00 PM. Agenda items include: (1) review of data collection on key issues; and (2) identification of long-term goals and solutions.

### **Prevention and Early Identification**

- The Workgroup met for the first time on September 14, 2011 with six members present
- The focus of the meeting was to orient all members to the planning process, review HRSA's expectations for addressing prevention/early identification in the 2012 Comprehensive Plan, and brainstorm key issues related to this topic. The group identified the following issues to explore:
  1. Needs of "non-Traditional" populations
  2. Increasing HIV testing overall, in the private sector, and routine
  3. Use of PrEP and PEP
  4. Recommendations in other national initiatives
- The next Workgroup meeting is October 12<sup>th</sup> at 2:00 PM. Agenda items include: (1) review of data collection on key issues; and (2) identification of long-term goals and solutions.

### **Special Populations**

- The Workgroup met for the first time on September 14, 2011 with eight members present.
- The focus of the meeting was to orient all members to the planning process, review HRSA's expectations for addressing special populations in the 2012 Comprehensive Plan, and brainstorm key issues related to this topic.
- Members also determined the scope of the Workgroup by reviewing an inventory of special populations identified in local, regional, state, and national initiatives. The group elected to focus on the required HRSA populations:
  1. Adolescents
  2. Homeless
  3. Incarcerated and Recently Released
  4. IDU
  5. Transgender

- The next Workgroup meeting is October 19<sup>th</sup> at 10:00 AM. Agenda items include: (1) review of data collection on key issues; and (2) identification of long-term goals and solutions.

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**REPORT ON THE EVALUATION OF**  
**THE 2009 COMPREHENSIVE HIV SERVICES PLAN**  
*for Use in Designing the 2012 Comprehensive HIV Services Plan for the Houston Area*

**I. INTRODUCTION**

Jurisdictions funded by the Health Resources and Services Administration (HRSA) to provide HIV-related services (a.k.a., the Ryan White HIV/AIDS Program) must have a Comprehensive HIV Services Plan in place for their area. The current Houston area plan expires December 2011, and a new plan will be submitted to HRSA by May 2012. Per guidance from HRSA, the new 2012 plan must include an evaluation of the expiring 2009 plan. The purpose of the evaluation is to identify: (1) major successes in the implementation of the 2009 plan; and (2) continued areas of challenge from the 2009 plan that may then be addressed in the goals and strategies outlined in the new plan. This report summarizes key findings in both areas as well as provides an overview of the 2009 plan, the process used for the evaluation, and proposed uses of data.

**II. OVERVIEW OF THE 2009 COMPREHENSIVE PLAN**

The 2009 Comprehensive HIV Services Plan for the Houston Area became effective on January 1, 2009. Its vision and mission are as follows:

*Vision:* From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for communities affected by HIV and AIDS.

*Mission:* Provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient, and culturally affirming until the end of the epidemic is realized.

2009 planners identified 10 goals, 56 objectives, and 94 action steps for achieving the vision and mission. Overall, the focus of the 2009 plan was as follows:

Types of activities

43% - Direct service (HIV prevention and care)  
23% - Education (public and provider)  
21% - Research, needs assessment, or other data collection  
9% - Collaboration between agencies  
4% - Other

Populations for activities

27% - General population and/or all PLWHA  
16% - Multiple subpopulations of PLWHA  
16% - Recently incarcerated  
13% - Youth  
11% - Women  
11% - Substance abusers  
7% - Out of care

Within the goals, objectives, and action steps in the 2009 plan were included three quantitative targets for assessing change in HIV service delivery between 2009 and 2011:

- Reduce by 10% annually the number [of PLWHA] not in care.
- [By 2011] reduce the impact of stigma and increase retention in care by 10%.
- [By 2011] increase the provision of education and advocacy events by 25%.

**III. METHODS**

The Evaluation Workgroup of the 2012 Comprehensive HIV Services Plan was formed in August 2011. Among other tasks, the Evaluation Workgroup was responsible for the evaluation of the 2009 plan, including design, implementation,

and identification of findings. Due to time and resource constraints, the methodology adopted by the workgroup for this process was highly expedited, relying on secondary data and pre-existing data sources. Workgroup members also conducted the data analysis, identified key findings, and served as key informants. The following methods were applied:

- *Impact evaluation.* Five community-level indicators were selected by the workgroup to serve as measures of the extent of achievement of the vision and mission of the 2009 plan. Special attention was paid to any goals in the plan that included a directional outcome (e.g., Goal 8: Prevent youth from becoming HIV+).
- *Outcome evaluation.* Two outcome-level indicators were included in the 2009 plan (listed above). These were assessed by the workgroup using available data points/sources at both baseline and actual.
- *Process evaluation.* One process-level indicator was included in the 2009 plan (listed above). Each action step in the 2009 plan was assessed by the workgroup for completion/non-completion to serve as a measure of the extent of achievement of this target.

Evaluation activities were conducted in September 2011. Areas of success and continued challenge were summarized at the Evaluation Workgroup meeting on October 4, 2011. Data sources and analysis tools were coordinated by support staff.

#### IV. FINDINGS

Below are key findings from the evaluation of the 2009 Comprehensive HIV Services Plan for the Houston Area. They reflect the results of data analysis on impact, outcome, and process indicators as well as conclusions drawn by members of the Evaluation Workgroup.

##### A. MAJOR SUCCESSES

- **Health outcomes for PLWHA are improving.** An important measure of HIV-related health status for PLWHA is viral load. According to two data sources reviewed for this evaluation, viral load among many PLWHA in the Houston area has improved since implementation of the 2009 plan. Between 2008 and 2011, average viral load of Ryan White Part A clients decreased 12%; and the percent of Part A clients with an undetectable viral load increased 24%. Noteworthy is that the increase in undetectable viral load seen in Houston Part A clients exceeds comparable targets set by the National HIV/AIDS Strategy.
- **PLWHA are entering care earlier.** Reducing the time between HIV diagnosis and entry into care contributes to earlier treatment and, ultimately, improved health outcomes. According to two data sources reviewed for this evaluation, PLWHA in the Houston area appear to be entering care at an earlier rate. This was measured using self-reported data from PLWHA on the time between diagnosis and first medical visit and their initial CD4 count. For the former, the percent of PLWHA reporting having their first medical visit within six months of diagnosis increased 2% between 2008 and 2011; for the latter measure, the percent of PLWHA reporting an initial CD4 count of 200 or above decreased 8% during this time.
- **HIV testing has become increasingly widespread.** During the time of plan implementation, multiple efforts were launched to increase HIV testing in non-traditional settings (i.e., non-HIV-specific locations) and using a routine, opt-out screening model. For example, the number of publicly-funded HIV tests in the Houston area increased 61% between 2009 and 2010 with an average of 151, 870 tests provided each year. Of that, approximately 85,000 tests each year were conducted routinely. In addition, an average of 12,300 tests was provided each year of plan implementation at the mass multi-site testing event, *Hip Hop for HIV Awareness*.
- **More PLWHA are becoming aware of their status.** HIV/AIDS incidence is a measure of new cases diagnosed in a specific time period. The following are HIV/AIDS incidence rates for the Houston EMA for each year of plan implementation:

	<u>2008</u>	<u>2009</u>	<u>2010</u>
HIV/AIDS Incidence	20.0 per 100,000	25.4 per 100,000	24.7 per 100,000

As described above, HIV testing experienced a significant scale-up in the Houston area during this time. The anticipated epidemiological outcome of a scale-up in testing is a sharp increase in incidence followed by gradual decreases over time. This is due to the increase in the number of previously unaware positives found through

increased testing followed by declines in new positives as testing becomes more normalized. Taken together, HIV testing and incidence data suggest that the Houston area has experienced this epidemiological trend.

- **The community has responded well to the needs of the recently incarcerated.** The 2009 plan included 11 action steps specific to the population of recently incarcerated PLWHA. During the three-year timeframe of the plan, significant community mobilization occurred to meet the needs of this subpopulation. As a result, all but one of the action steps was completed, including the formation of a new community coalition focused on this group.

## B. CONTINUED AREAS OF CHALLENGE

- **The HIV system of care still needs additional capacity to accommodate new positives.** As described above, the impact of a large scale-up in HIV testing is an increase in the number of positives diagnosed in a community. The Houston area was successful in identifying significantly more positives during the time of plan implementation. However, the HIV care system continues to need capacity to serve new positives. According to data analyzed for this evaluation, the percent of diagnosed PLWHA who were out of care (i.e., Unmet Need) increased 4% between 2008 and 2011 with the greatest increase occurring between 2008 and 2009, the year that routine HIV testing began. The number out of care then dropped between 2009 and 2010 by about 1%. Like incidence, the impact of increased testing on unmet need may be a sharp increase followed by gradual decreases as system capacity is adjusted to meet need.
- **Retention in care is steady, but not increasing.** Retaining individuals in continuous HIV care contributes to improved disease management and, ultimately, better health outcomes. According to data generated for this evaluation, PLWHA in the Ryan White Part A system are being retained in primary medical care at a steady, but not increasing, rate. The percent of PLWHA retained in care using a HRSA-defined metric was 76% for the first defined time period in 2008 compared to 75% for the most recent defined time period in 2011. In the interim, the percentage fluctuated down as low as 52% retained in care; however, beginning in late 2010, the rate began and has continued to rise.
- **Incidence in youth continues to increase.** As described above, the anticipated epidemiological outcome of a large scale-up in HIV testing is a sharp increase in incidence followed by gradual decreases over time. This trend has not yet been observed for youth aged 13 – 24 in the Houston EMA as 2009 planners had desired. Instead, as shown below, youth incidence experienced a sharp increase between 2008 and 2009, the year that routine HIV testing began, followed by another, albeit slight, rise between 2009 and 2010:

	<u>2008</u>	<u>2009</u>	<u>2010</u>
HIV/AIDS Incidence	25.8 per 100,000	31.3 per 100,000	31.4 per 100,000
Youth Aged 13 – 24			

- **Actions are needed to address the needs of specific subpopulations.** The 2009 plan included action steps specific to several subpopulations of PLWHA. A large proportion of these activities were completed or at least started during plan implementation. However, activities identified for some groups were not completed in full. These include: bisexually-identified individuals, substance abusers, and some activities targeting youth and women. The 2009 plan also lacked activities specific to: college-aged youth (vs. minors), the transgender community, and international/recently-immigrated populations.
- **Information is needed about non-traditional HIV service providers.** The majority of action steps in the 2009 plan were known to be undertaken by “traditional” HIV prevention and care providers, i.e., Ryan White HIV/AIDS Program providers, CDC-prevention funded grantees, etc. Little was known about the HIV activities of: non-Ryan White, non-CDC, and other public, private, or faith-based providers in the Houston area.
- **Future HIV planning goals and objectives need greater specificity.** Evaluation Workgroup members encountered difficulty conducting the evaluation of the 2009 plan due to the lack of specificity and measurability in its goals, objectives, and action steps. It is recommended that future planning follow the principles below:

Each proposed goal is coupled with at least one measurable and reasonably-attainable benchmark.

Each proposed objective and action step is SMART and includes specifics in regards to anticipated outputs and timeframes.

Terminology used in goals, objectives, action steps, and benchmarks is standardized and/or defined.

Only benchmarks with verifiable baseline data are used. Moreover, benchmarks are aligned with other local, state, and national targets.

## **V. USE OF FINDINGS**

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Multiple areas of major successes and continued areas of challenge from the 2009 Comprehensive HIV Services Plan were identified through the evaluation process. Due to the use of expedited methodology and the reliance on secondary and anecdotal data, findings cannot be interpreted as causative; however, they can be used by current planners as guidance for the development of goals, objectives, and action steps for the 2012 plan. Recommended uses of findings are as follows:

- Planners may elect to re-adopt goals, objectives, and action steps related to major successes to ensure continued attainment of the vision and mission of the 2009 plan.
- Planners may elect to identify new goals, objectives, and action steps related to continued areas of challenge to ensure improved progress toward the vision and mission of the 2009 plan.
- Continued areas of challenge may be related to inappropriate benchmarking at the time of 2009 plan development. Therefore, planners may use findings as a guide for future selection of targets.
- Continued areas of challenge may be related to lack of information about the HIV activities of “non-traditional” providers. Therefore, planners may use findings as a guide for improved evaluation and monitoring methods.

## **DATA SOURCES**

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The following data sources were used for the evaluation of the 2009 Comprehensive HIV Services Plan:

1. CPCDMS, Community Viral Load, Undetectable Viral Load, and Retention in Care Metrics, 2011
2. Houston Area HIV/AIDS Needs Assessment, 2008 and 2011
3. Houston Department of Health and Human Services, Enhanced Comprehensive HIV Prevention Planning (ECHPP) for Houston-Baytown-Sugarland, Texas, 2011
4. Integrated Epidemiological Profile for HIV Prevention and Care Planning, 2011
5. Texas Department of State Health Services, Unmet Need Trend Analysis and HIV/AIDS Incidence Rates, 2011

Information supplied by Evaluation Workgroup members was also considered key informant data. Workgroup meetings were held on September 16, September 20, and October 4, 2011.

## **EVALUATION WORKGROUP MEMBERS**

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Lena Williams, Project LEAP Student

**2012 Houston Area Comprehensive HIV Services Plan**  
**COORDINATION OF EFFORT WORKGROUP**  
Gaps Analysis for Priority Sectors/Groups

	STRENGTHS (Current Efforts)	OPPORTUNITIES (Needs for Coordination)
<b>Within the Ryan White HIV/AIDS Programs, Parts A-F</b>	Major organizations are well connected Joint planning process Joint data collection system	Smaller agencies (“mom & pops”) not well connected ADAP enhancements Greater prevention and care integration Use of social networking/technology and social marketing Increased access in the rural counties, including transportation Increased education to the public about RW services
<i>Between HSOs and:</i>		
<b>Other Public Providers</b> Medicare Medicaid CHIP FQHCs	Providing care to the uninsured Gateway to Care and other access to care collaboratives New alliances forming with FQHCs (“mainstreaming” of services) Availability of benefits counseling services	Ensuring coverage for non-covered services Transportation issues Geographical coordination of services Interfacing with 1115 waiver and ACA implementation Application of system navigators model Care Connection Addressing gaps in Medicaid Managed Care Need for training on HIV-related triage Education to social workers and advocates on benefits coverage Medication co-pays
<b>Private Providers</b> Hospital Systems Private Practice Third-Party Payers	Providing care to the insured Higher quality/quantity facilities Large medical infrastructure Access to medication Routine testing initiatives	Ensuring coverage for the uninsured Training on HIV; AETC resources Health information exchange; and applications of EHR Inclusion of infectious disease physicians in system of care Outreach to additional private hospital systems for testing Role of pharmacies as gatekeepers
<b>HIV and STD Prevention</b>	HIP HOP for HIV Awareness Integrated outreach Prevention with Positives	Youth involvement Cultural competency Needs of high-risk groups, e.g., substance abusers, victims of domestic violence, victims of human trafficking Expanding education beyond traditionally-affected groups
<b>Substance Abuse Treatment</b>		Coordination with smaller agencies (“mom & pops”) Treatment facilities acceptance of PLWHA Training and education for caregivers/home health
<b>Others?</b>		Revising the Continuum of Care to include all partners “New” needs of PLWHA, e.g., aging, chronic disease, respite Colleges and universities, research, conferences Needs of the undocumented Philanthropic organizations Faith-based organizations Barriers for minority communities; continued stigma



# NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES

JULY 2010





# Achieving a More Coordinated National Response to the HIV Epidemic

## **Plan to Achieve a More Coordinated National Response to the HIV Epidemic in the United States At-A-Glance**

In order for the *National HIV/AIDS Strategy* to be successful, emphasis must be placed on coordination of activities among agencies and across all levels of government.

- Increase the coordination of HIV programs across the Federal Government and between Federal agencies and State, territorial, local, and tribal governments.
- Develop improved mechanisms to monitor and report on progress toward achieving national goals.

## **The Opportunity**

The United States does many things right in how it responds to HIV. Persistent advocacy, research accomplishments, and observable successes in preventing HIV and providing health care and social supports to people with HIV have left us with a legacy of global leadership. We have also learned important lessons about how to engage affected communities and how to mobilize broad sectors of society to care about a condition that is highly stigmatized, associated with sexuality, drug use, and other issues that magnify our cultural divides. The United States investment in responding to the domestic HIV epidemic has risen to more than \$19 billion per year.<sup>159</sup> This number alone says nothing about whether it is sufficient to meet existing needs or if these resources are used most effectively—and we believe that evaluation of existing funds along with increased investments in certain key areas are warranted. Nonetheless, it is clear that the Nation has devoted significant financial resources to mount a serious and sustained response to ending the HIV epidemic.

What has been missing and what is needed at this time is an enhanced focus on coordinating our efforts across Federal agencies, across all levels of government, with external partners, and throughout the health care system. Further, with dispersed responsibility for responding to HIV, there is a need for a clearer understanding of roles and increased accountability. Since our ultimate success at ending the HIV epidemic depends on the American people understanding the urgency of the challenge and remaining supportive of the important investments we are making in research, care, and prevention, a greater priority should be placed on communicating to the public the challenges we face and the progress we are making.

The many Federal agencies that operate critical HIV programs operate under their own statutory authority as established by Congress. It is not possible or desirable to merge all HIV programs under one roof. At the same time, improved coordination is possible and we can improve the Federal response by insisting that agencies work in closer collaboration with each other.

<sup>159</sup> FY 2010 Appropriations.

In our Federal system, the role of the Federal Government is not to direct all activities by all entities. Indeed, in our diverse country, the most effective responses are often those that originate at the State or local level, or even at the level of individual neighborhoods. In this environment, Federal leadership is critical in identifying overarching national priorities, as well as supporting research to evaluate which activities are most effective and then ensuring that Federal resources are deployed to maximal effect. Many Federal HIV prevention and care programs operate largely by providing resources to State, local and tribal governments to provide services within Federal rules and guidelines. While flexibility is critical to respond to varied needs, our three decades of experience of fighting HIV has given the Nation a greater sense of what is effective. Therefore, it is appropriate for the Federal Government to focus the use of its resources on tools that have been shown to work effectively in addressing the Administration's *National HIV/AIDS Strategy* goals and to prioritize the utilization of epidemiological data in the policy-making process.

Much can be achieved by prioritizing enhanced collaboration and accountability.

## Steps to be Taken

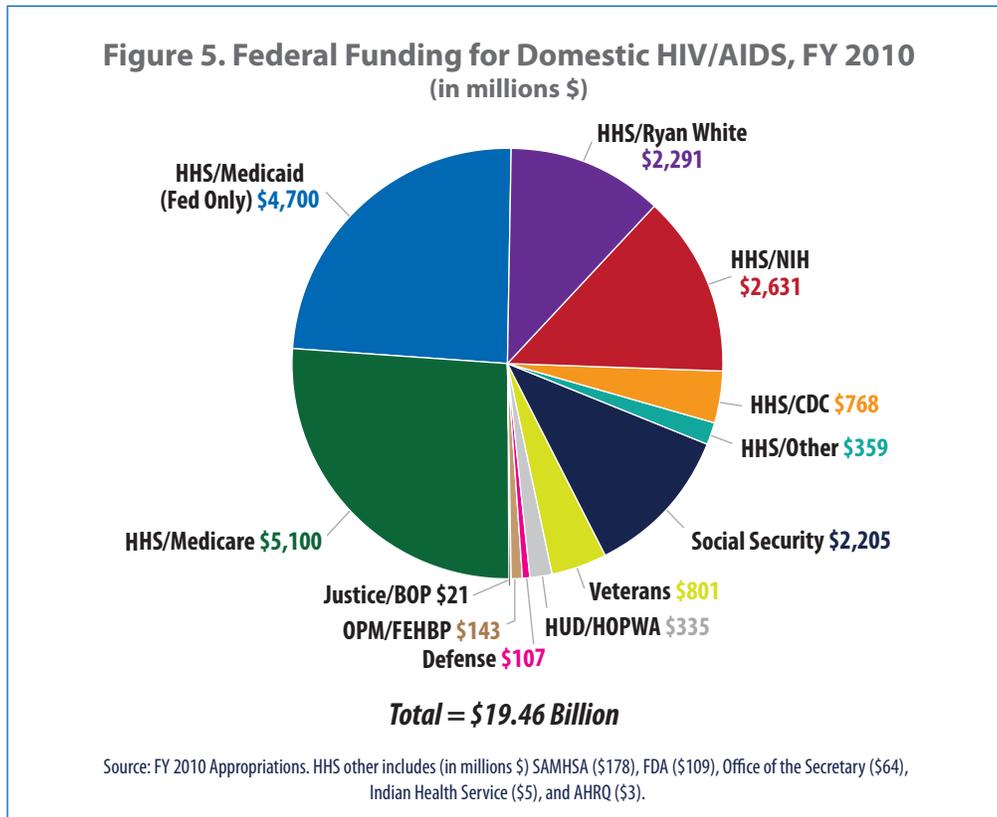
The following steps are critical to achieving a more coordinated response to HIV:

1. Increase the coordination of HIV programs across the Federal government and between federal agencies and state, territorial, tribal, and local governments.
2. Develop improved mechanisms to monitor and report on progress toward achieving national goals.

## Recommended Actions

### ***Step 1: Increase the coordination of HIV programs across the Federal Government and between Federal agencies and State, territorial, tribal, and local governments.***

Funding for HIV services is spread across multiple departments, including Health and Human Services (HHS), Housing and Urban Development (HUD), Justice, Veterans Affairs (VA), and Defense (Figure 5). Within HHS, in particular, responsibility for HIV programs is spread across multiple agencies including the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), CDC, the Indian Health Service (IHS), the Food and Drug Administration, the Office of HIV/AIDS Policy, the Office of Minority Health, and others. Responsibility for HIV research is primarily carried by NIH, but CDC, VA, Department of Defense, and USAID also support research initiatives. This dispersion of responsibility is appropriate, as each agency has its own expertise, and different agencies operate different programs with varying purposes and with unique histories. Spreading the response to HIV across the Federal Government has helped our response to HIV. At the same time, it imposes costs and challenges us in getting the greatest results.



Roughly half of Federal funding for domestic HIV services flows through Medicaid and Medicare, two programs that are administered by the Centers for Medicare & Medicaid Services (CMS) (Figure 5). These programs provide essential guarantees of access to lifesaving medical care for all eligible beneficiaries, but the structure of the programs makes it difficult to adapt to HIV policy goals. Most services must be provided to all beneficiaries, and this limits the ability to target prevention and care services to high-risk populations. Moreover, data limitations make it hard to monitor people living with HIV as a distinct group. Other programs are more flexible, but competing rules, data collection requirements, and purposes create administrative burdens for the government, grantees and other external partners.

Laws governing HIV programs have changed over time, but have not all evolved in a way that places resources where they are most needed. For instance, some localities receive more funding for HIV prevention and care services than others despite having fewer persons living with HIV/AIDS. A recent analysis found that States with a low number of existing HIV/AIDS cases received the highest HIV prevention funding per case from CDC. The five States with 50 percent of the persons living with AIDS receive only 43 percent of CDC prevention funds for the Health Department Prevention, Expanded Testing Initiative, and Core Surveillance cooperative agreements, whereas the twenty jurisdictions that account for the last two percent of AIDS cases received nearly seven percent of the budget for these cooperative agreements.<sup>160</sup> If we are to target our efforts to more effectively address the epidemic, then resources to prevent HIV infection should be proportionate to disease burden. To achieve this, HIV prevention

160. CDC analysis. Please refer to [www.cdc.gov/hiv](http://www.cdc.gov/hiv) for the budget information and <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/> for surveillance data.

funding should be based upon more current HIV surveillance data rather than historical AIDS data. CDC is moving toward this goal and will be able to provide HIV in addition to AIDS data from all localities by the 2012 HIV surveillance report.

Another issue with Federal HIV funding programs is that few are designed to encourage efficient coordination across programs. As a result, HIV services providers often receive funding from multiple sources with different grant application processes and funding schedules, and varied reporting requirements. These issues are not unique at the Federal level, and overlapping and competing programs also hinder efforts at the State and local levels.

We need to integrate services and reduce redundancy, encourage collaboration across different levels of government and with nongovernment partners, and ensure accountability for achieving positive results. In this regard, the President's Emergency Plan for AIDS Relief (PEPFAR) has taught us valuable lessons about fighting HIV and scaling up efforts around the world that can be applied to the domestic epidemic.

### *Recommended Actions*

To increase coordination across programs, the following are needed:

- 1.1 Ensure coordinated program administration:** The Federal Government should increase its focus on coordinated planning for HIV programs and services across agencies.
- 1.2 Promote equitable resource allocation:** The Federal Government should review the methods used to distribute Federal funds and take steps to ensure that resources go to the States and localities with the greatest need.
- 1.3 Streamline and standardize data collection:** The Federal Government should take short and longer-term efforts to simplify grant administration activities, including work to standardize data collection, consolidating grant announcements, and grantee reporting requirements for Federal HIV programs.

### ***Step 2: Develop improved mechanisms to monitor and report on progress toward achieving national goals.***

The HIV epidemic in America requires a bold public health response. Annual AIDS deaths have declined, but the number of new infections has been static and the number of people living with HIV is growing. We need to be able to critically evaluate our current efforts to gauge the extent to which an impact is being made. Moreover, because of budget shortfalls at the state level, it is increasingly important that existing State and local efforts are concentrated and aligned with the Strategy goals. We need to measure the results of our efforts to reduce incidence and improve health outcomes to chart our progress in fighting HIV and AIDS nationally, and refine our response to this public health problem over time. This requires a monitoring system that evaluates the implementation of the Strategy, its progress, and the impact of the Strategy efforts. A system of regular public reporting will help to sustain public attention and support.

### *Recommended Actions*

To monitor and communicate our progress, the following are needed:

- 2.1 Provide rigorous evaluation of current programs and redirect resources to the most effective programs:** Prioritize programs that are 1) scientifically proven to reduce HIV infection, increase access to care, or reduce HIV-related disparities, 2) able to demonstrate sustained and long lasting (>1 year) outcomes toward achieving any of these goals, 3) scalable to produce desired outcomes at the community level, and 4) cost efficient.
- 2.2 Provide regular public reporting:** Progress in reaching Strategy goals will be reported by the Federal Government through an annual report at the end of each year.
- 2.3 Encourage States to provide regular progress reports:** The Federal Government will encourage States to provide annual reports to ONAP and HHS OS on progress made implementing their comprehensive HIV/AIDS plans. ONAP will incorporate the State reports into the national progress report at the end of each year.



# Continuum of Care Administrative Overview Ryan White Part A

June 14, 2011

CDR Beth Henson  
Project Officer, Western Services Branch  
Department of Health and Human Services  
Health Resources and Services Administration  
HIV/AIDS Bureau



# What is an HIV Continuum of Care?

An integrated service network that guides and tracks HIV clients over time through a comprehensive array of clinical, mental, and social services in order to maximize access and effectiveness.



# Changing Systems of Care

## HIV/AIDS as a chronic disease:

- Increase in number of PLWH needing care (~56,000 new cases, ~15,000 deaths annually)
- Changes necessary in system of care -- emphasis on:
  - "Front-loaded" services
  - Peer navigators/community health workers
  - Disease self-management
- Less intensive services for many consumers after first few years

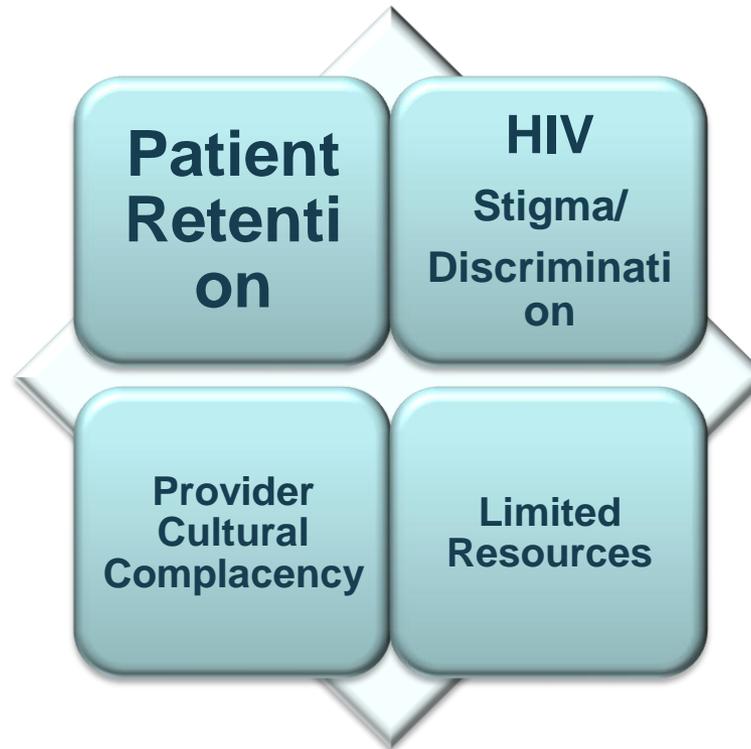
# Characteristics of a Continuum

**Coordination  
Among Provider  
Treatment  
Activities**

**Seamless  
Transitions  
Across Levels  
of Care**

**Coordination of  
Present and  
Past Treatment**

# Common CoC Barriers/Challenges





# CoC Strategy & Implementation

- There is no right or wrong way to implement the Continuum of Care in any given location.
- The local context will strongly influence the approach in design and implementation.



# Partnerships and Collaboration

- In a continuum of care, HRSA expects to see collaboration, partnering and coordination between multiple sources of treatment, care and prevention service providers.
- In a mature continuum of care, collaboration between HIV testing sites, non-Ryan White Program providers, all Ryan White Program Parts (A, B, C, D, and F), Medicaid, and VA should be established and maintained in the planning and implementation of services.



# Coordination of Services

- **Shared responsibility of grantee and Planning Council**
- Focus on ensuring that Part A funds fill gaps, do not duplicate other services, and make Ryan White the payer of last resort
- Involves coordination in planning, funding, and service delivery
- Council reviews other funding streams as input to resource allocation
- **Grantee ensures that providers have linkage agreements and use other funding where possible – for example, help clients apply for entitlements like Medicaid**



**The 2009  
Comprehensive HIV Services Plan  
for the Houston Area**

*Through December 31, 2011*

*Effective January 1, 2009*

### ***Mission Statement***

We, the Houston Comprehensive Planning Committee, have come together to update the Comprehensive HIV Services Plan for the Houston EMA/HSDA guided by the following mission:

*We will provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient and culturally affirming until the end of the epidemic is realized.*

### ***Vision Statement***

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for communities affected by HIV and AIDS.

### ***Shared Values***

The following Shared Values outline the GUIDING PRINCIPLES that planners, service providers, consumers and community leaders agree will guide the development and delivery of HIV Services within the geographic area. The guiding principles are informed by the Health Resources and Services Administration's (HRSA) focus on uninsured, underserved and special needs populations, as defined by the following goals:

- Goal 1: Improve Access to Health Care**
- Goal 2: Improve Health Outcomes**
- Goal 3: Improve the Quality of Health Care**
- Goal 4: Eliminate Health Disparities**
- Goal 5: Improve the Public Health and Health Care Systems**
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies**
- Goal 7: Achieve Excellence in Management Practices**

## **Section II**

# **WHERE DO WE NEED TO GO?**

## **CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES**

### **A Shared Vision**

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for infected and affected communities. The realization of this vision is informed by the Houston area Continuum of Care.

### **Operational Definition of Continuum of Care**

The ideal continuum of care represents a comprehensive range of services needed by individuals and families at-risk infected and affected by HIV/AIDS. The Houston Area Continuum of Care model describes an ideal system of care that bridges prevention services with care and treatment, and responds to dynamic community needs in a holistic, coordinated, and timely manner.

The Continuum of Care model is a framework for decision-making, and can be used to inform and guide planning bodies, providers, community leaders and consumers in setting priorities and allocating funds for HIV/AIDS services. The Continuum can also guide the Houston area HIV community toward the following objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.
2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.
3. Facilitate services while not overburdening the staff and capacity of the system.
4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

### **Elements of the Continuum of Care**

The Houston area Continuum of Care takes into account several factors: 1) the mission and vision statements of the various planning bodies; 2) the goals and objectives of the planning bodies; 3) the services available in the delivery system; 4) the linkages necessary to ensure efficiency and effectiveness; and 5) the coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained.

The Continuum of Care is characterized by a range of elements that inform the development and delivery of services in the Houston area. These elements include:

- Identifying and addressing needs of unserved/underserved populations
- Including prevention and care services
- Providing services in an efficient and effective manner
- Providing services in a seamless manner as a person moves among the different levels of care
- Providing high quality and culturally appropriate services
- Advocating for PLWHA service needs
- Encouraging cooperation in the coordination/delivery of services
- Assuring that the community in need is aware of available prevention and care resources
- Promoting the dissemination of information to all constituencies
- Identifying needs, gaps and barriers
- Planning capacity to meet needs
- Improving the quality of life
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age
- Assuring that PLWHA, the general public, and providers are included in the process

The Houston area Continuum of Care encourages service linkages as the mechanism for creating a seamless system of services that enables clients to easily navigate within different levels of care. The Continuum model illustrates how services can be linked among the wide range of service providers in Houston.

**Table 9: Continuum of Care Tracks**

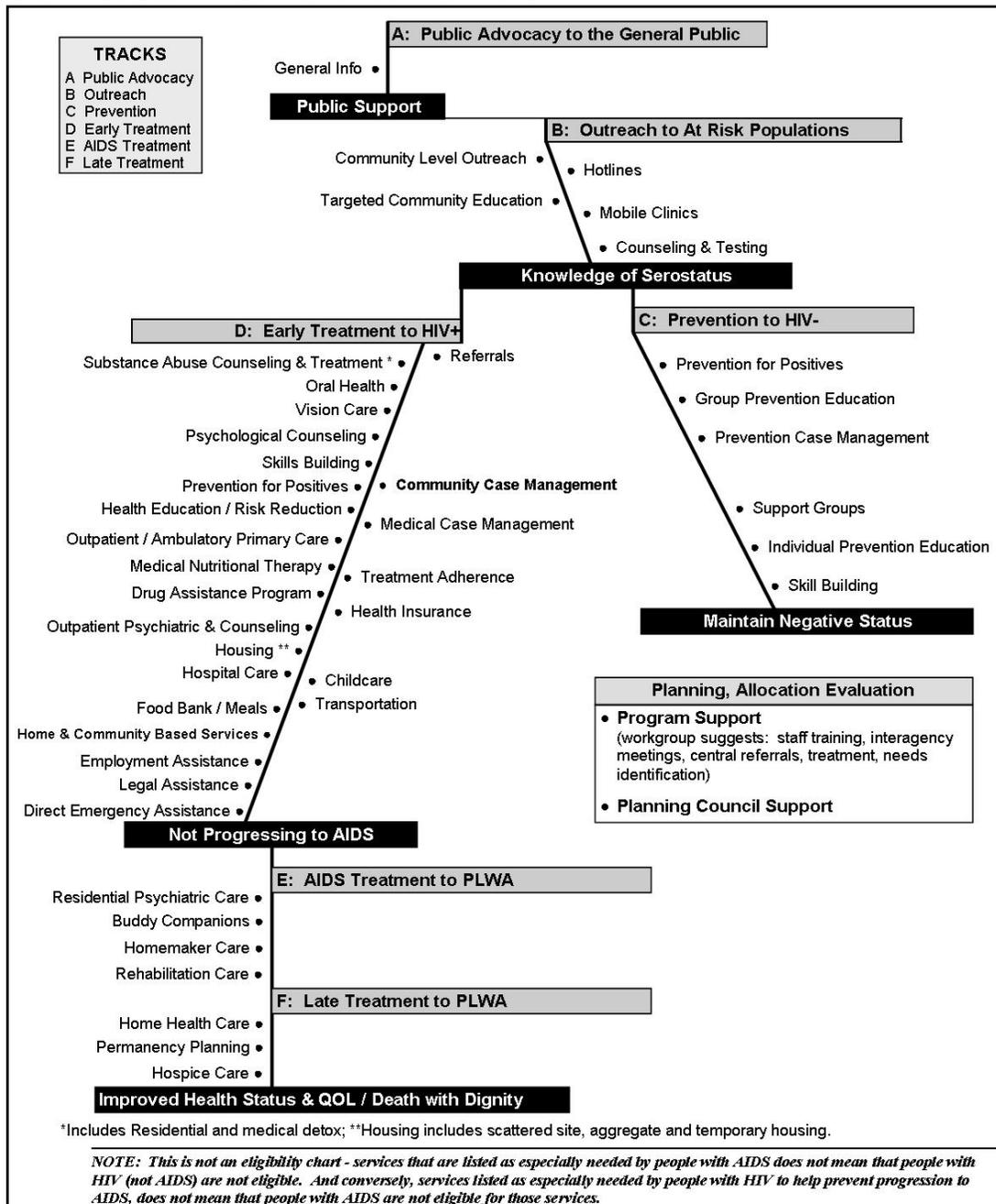
<b>TRACK</b>	<b>START</b>	<b>DESTINATION</b>
A. Public Advocacy to the General Public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach to at Risk Populations	No awareness of serostatus	Awareness of serostatus
C. Prevention to HIV-	Aware of negative status	Maintenance of negative status
D. Early Treatment to HIV+	Awareness of infection	No progression to AIDS
E. AIDS Treatment to PLWA	AIDS diagnosis	Improved health status and quality of life or death with dignity

The Houston Area Continuum of Care is shown on the following page (Figure 5). The Houston area Continuum of Care is characterized by three main features. First, it has several tracks, each of which is defined by its outcomes. Second, consumers can enter the system at any point on the track. Third, each track runs both ways – consumers can travel up or down each track.

Five attributes can be applied to the Continuum. Referred to as the “5 A’s”, the delivery system is designed to be:

- Available to meet the needs of the PLWHA and their caregivers
- Accessible to all populations infected or affected by HIV/AIDS
- Affordable to all populations infected or affected by HIV/AIDS
- Appropriate for different cultural and socio-economic populations and care needs
- Accountable to the funders and clients for providing contracted services at high quality

Figure 5: Houston Area Continuum of Care



### **Operational Definition of Core Medical Services**

Core Medical Services refer to those services deemed by the Ryan White HIV/AIDS Treatment Modernization Act as most necessary to ensure good medical outcomes for people with HIV / AIDS. The Core Medical Services are defined as:

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Congress wants to ensure that Ryan White Federal funds are used to pay for essential medical care; thus, areas receiving Ryan White funds under Parts A, B, and C must spend at least 75% of funds on core medical services.

The remaining 25% of funds may be spent on support services. Support services are defined as services that improve access to the core medical services, and directly contribute to achieving positive clinical outcomes for persons with HIV/AIDS. Support services are defined as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

### **A Shared Set of Values**

The Houston area HIV/AIDS community shares a set of values that guide the development and delivery of HIV Services within the geographic area. These values, as informed by HRSA guidelines, address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities; establish and support an HIV care continuum; coordinate resources among other Federal and local programs; and address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

## **Guiding Principles**

The guiding principles for the Houston Area HIV/AIDS Comprehensive Plan are informed by the Ryan White reauthorization principles which are intended to strengthen federal HIV treatment programs. The reauthorization principles include a focus on primary care and treatment, efforts to increase flexibility to target resources and ensuring accountability using sound fiscal management and tools to evaluate program effectiveness

As such, the guiding principles used by the Houston HIV/AIDS community are as follows:

1. Better serve the underserved in response to the HIV epidemic's growing and widespread impact among minority and hard-to-reach populations.
2. Ensure access to effective HIV/AIDS prevention and care services to make a difference in the lives of people infected and affected by HIV and AIDS.
3. Adapt to changes in the health care delivery system and the role of the Ryan White Treatment Modernization Act in filling service gaps.
4. Accurately document service outcomes and demonstrate the effectiveness of treatment, care and prevention strategies.
5. Respond to and advocate for consumer needs.
6. Provide services that are sensitive to the cultural and linguistic needs of specific communities.

*The*  
**Comprehensive Services Plan**  
*for the*  
**East Texas HIV Administrative  
Services Area**  
*2010 - 2012*  
**2011 Update**



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## Section 2: Where Do We Need To Go?

The first section of this document gave us a picture of the East Texas HASA. The demographics of the area, the course of the local HIV epidemic, and the characteristics of the existing service delivery system inform the development of a continuum of care that will meet the needs of people living with HIV. The ideal continuum of care offers a range of services, from prevention services for people at risk for HIV infection, to medical care and essential support services to those who are living with HIV. But there must be more than just a set of services. The continuum of care must be comprehensive to meet the multiple needs that accompany successful management of HIV disease; coordinated to ensure an efficient flow of resources without duplicating services; and flexible to match the changing dynamic interactions of people, resources, and needs. HRSA has established that the basic structure of a continuum of care – core medical services and essential support services – must serve to improve health outcomes. Table 15 identifies those services as they exist in the East Texas HASA.

**Table 15. Ryan White Services Available in the East Texas HASA**

<i>Core Medical Services</i>	<i>Essential Support Services</i>	
HIV/AIDS Medications	Adult Day/Respite Care	Nutritional Counseling
Home Health Care	Child Care Services	Permanency Planning
Medical Care	Child Welfare Services	Referrals to Clinical Research
Medical Case Management	Development Assessments	Referrals to Services
Oral Health Care	Emergency Financial Assistance	Rental Assistance/Shelter Vouchers
Psychiatric Services	Employment Assistance	Support Groups
Psychological Counseling	Food Bank	Translation/Interpretation
Rehabilitation Treatment	HIV Education for HIV+	Transportation
Substance Abuse Treatment	Household Items	
	Housing-Related Services	
	Legal Services	

The Administrative Agency in the East Texas HASA and the local community adhere to the principle that these services must be:

- 1) Available to meet the needs of all people and families living with HIV and those at risk
- 2) Accessible to all people and families living with HIV and those at risk
- 3) Affordable to all people and families living with HIV and those at risk
- 4) Appropriate for diverse cultural and socioeconomic populations and care needs
- 5) Accountable to consumers and funders as high quality services

As such, the local continuum of care was developed with consumers at the center, surrounded by appropriate, accessible services whose multiple access points are connected through the flow of outcomes from one service group to the next, all of which are supported through coordination, collaboration, and evaluation to reach the goal of improved health outcomes. The figure on the following page presents the continuum of care model for the East Texas HASA.

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# EAST TEXAS CONTINUUM of CARE MODEL

*Goal: To Improve Health Outcomes*

