

Houston Area HIV Services Ryan White Planning Council
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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

SUMMARY OF KEY FINDINGS

MAJOR SUCCESSES

- Health outcomes for PLWHA are improving
- PLWHA are entering care sooner after diagnosis
- HIV testing has become increasingly widespread
- More PLWHA are becoming aware of their status
- The community has responded well to the needs of the recently incarcerated

CONTINUED AREAS OF CHALLENGE

- The HIV system of care still needs additional capacity to accommodate new positives
- Retention in care is steady, but not increasing
- Incidence in youth continues to increase
- Actions are needed to address the needs of specific subpopulations
- Information is needed about non-traditional HIV service providers
- Future HIV planning goals and objectives need greater specificity

USE OF REPORT

Planners may:

- Re-adopt goals, objectives, and action steps related to major successes to ensure continuation
- Identify new goals, objectives, and action steps related to challenge areas to ensure progress
- Use findings as a guide for future selection of targets, as challenge areas may be related to inappropriate benchmarking at the time of plan development
- Use findings as a guide for improved evaluation and monitoring methods, as challenge areas may be related to lack of information about the HIV activities of non-traditional providers

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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. Reviews of key findings were conducted with members of all Workgroups in October 2011 with subsequent editing. A final report was approved at the November 1, 2011 Evaluation Workgroup meeting. Data sources, analysis tools, and draft documents 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 and other key stakeholders in the planning process.

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 PLWHA in the Houston area has significantly improved since implementation of the 2009 plan. Between 2008 and 2011, the percent of Ryan White Part A clients with an undetectable viral load increased 71% (from 34% with an undetectable viral load in 2008 to 58% at the time of this evaluation in 2011). In addition, the average viral load of Part A clients (including those with undetectable viral load) also decreased 12%. Noteworthy is that the increase in undetectable viral load seen in Houston Part A clients far exceeds comparable targets set by the National HIV/AIDS Strategy.
- **PLWHA are entering care sooner after diagnosis.** Reducing the time between HIV diagnosis and entry into care contributes to earlier treatment and, ultimately, improved health outcomes. According to data sources reviewed for this evaluation, PLWHA in the Houston area appear to be entering care sooner after diagnosis. This was measured using self-reported data from PLWHA on the time between diagnosis and first medical visit. Between 2008 and 2011, the percent of PLWHA reporting their first medical visit *less than one* month after diagnosis increased 1%, and the percent reporting their first medical visit *one to six* months after diagnosis increased 2%. It is noteworthy, however, that self-reported initial CD4 count at first medical visit did not show comparable improvements, suggesting that PLWHA may be being diagnosed later in their disease.
- **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

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.

VI. DATA SOURCES

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 to conduct the evaluation were held on September 16, September 20, and October 4, 2011.

VII. EVALUATION WORKGROUP MEMBERS

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