

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

**2012 Houston Area Comprehensive HIV Prevention & Care Services Plan  
GAPS IN CARE AND OUT-OF-CARE WORKGROUP**

12:00 p.m., Friday, January 20, 2012

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

**AGENDA**

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- I. Call to Order Amber David and David  
Garner, 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  
Planner, Office of Support
  - A. Participation Update
  - B. Leadership Team Activities
  - C. Working Outline At-A-Glance
  
- III. Completion of Workgroup STRATEGY: *Activities, Timelines,  
and Responsible Parties*
  - A. Review of Plan Structure: *System Goals, Workgroup  
Strategies, and Implementation Plan*
  - B. Review of Final Workgroup Goals, Solutions, Activities,  
and Benchmarks
  
- IV. Discussion of Public Comment Process
  
- V. Next Steps Amber David and David  
Garner, Co-Chairs
  - A. Review of Key Milestones
  - B. Opportunities for Ongoing Involvement
  - C. Thank You Workgroup!
  
- VI. Announcements
  
- VII. Adjourn

## Houston Area HIV Services Ryan White Planning Council

### 2012 Houston Area Comprehensive HIV Prevention & Care Services Plan GAPS IN CARE AND OUT-OF-CARE WORKGROUP

12:00 p.m., Wednesday, December 16, 2011

Meeting Location: 2223 West Loop South, Suite 240; Houston, TX 77027

#### Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
David Garner, co-chair	Jeff Benavides	Diane Beck, Office of Support
Linda Hollins	Amber David, excused	Jen Hadayia, Office of Support
Sam Lopez	Januari Leo	Erik Soliz, HDHHS
Jonathan Post	Ken Malone, excused	
Cecilia Smith-Ross	Charolyn Mosley	
	Rachel Nahan	
	Robert Smith, excused	
	Barbara Walker, excused	
	Cristan Williams	

**Call to order:** On behalf of the co-chairs, Smith-Ross called the meeting to order at 12:13 p.m.; she welcomed everyone and asked for a moment of reflection. She then asked everyone to introduce themselves.

**Adoption of the Agenda:** *Motion: It was moved and seconded (Lopez, Post) to adopt the agenda. Motion Carried.*

Lopez assumed the duty of chair for the Approval of the Minutes.

**Approval of the Minutes:** *Motion: It was moved and seconded (Smith-Ross, Post) to approve the November 18, 2011 meeting minutes. Motion Carried.* Abstentions: Lopez.

Garner arrived and assumed the duty of chair for the remainder of the meeting.

**Update on the Planning Process:** Hadayia reviewed the November update; see attached. She noted the sustained level of individual and organizational participation, upcoming milestones in the planning process, and recent Leadership Team activities.

**Putting it All Together:** Hadayia reviewed the documents *Working Outline At-A-Glance* and *Putting it All Together: A Map of the Plan*; see attached.

**Workgroup Strategy Part II: Plan, Activities, and Timelines:** Hadayia noted that the *Inventory of National and Global HIV/AIDS Priorities* and the *Inventory of Local, Regional, State, National and Global Priority Populations* documents were updated to reflect the *2011 UNAIDS World AIDS Day Report*; see attached.

The workgroup reviewed and discussed comments collected by Hadayia and Camden Hallmark during their presentation at the 2011 HIV Prevention and Care Capacity-Building Conference entitled *Your Role in the Joint Comprehensive HIV Prevention and Care Plan*; see attached.

The workgroup brainstormed details for each proposed activity in the Gaps in Care and Out-of-Care Strategy; see attached *Logic Model 3: Action Planning Matrix*.

Hadayia will summarize the results and distribute them to workgroup members for their review prior to the next meeting.

**Next Meeting:** The next meeting is scheduled for January 20, 2012 at 12:00 p.m.; agenda items include review of final workgroup strategy and discussion of the public comment process.

**Adjourn:** The meeting was adjourned at 2:10 p.m.

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**2012 Houston Area Comprehensive HIV Prevention and Care Services Plan**  
**DECEMBER UPDATE**

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**OVERALL PARTICIPATION**

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- Participation remained steady in December with 76 individuals , six staff, and 59 agencies.
- At least 18 HIV+ individuals continue to participate, which represents 24% of total participation.
- Updates on the planning process are now being received by the Prevention Planning Group (PPG)'s Executive Committee at their monthly meetings. Several planning documents have been shared with the Centers for Disease Control and Prevention by the HDHHS as well.
- A Working Outline of the plan has been developed as well as "Map of the Plan" (see attached), which indicates how the planning process and the final product will integrate.
- All planning materials, including meeting packets and data collection, continue to be made available on the RWPC: [www.rwpchouston.org](http://www.rwpchouston.org). Click Calendar; and then click the meeting day.

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**LEADERSHIP TEAM**

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- The Leadership Team met on December 19, 2011. The focus of the meeting was to provide direction on Section II of the plan, "Where do we need to go?" by approving overarching community concerns, cross-cutting solutions, system goals, and overall measures of success. Approved items are as follows:

***Overarching Community Concerns***

1. Dedicated public resources for HIV prevention and care have been stagnant and yet need remains severe
2. The focus must be on high-impact solutions and ways to maximally engaging the private sector. Expanding and diversifying the HIV system through new partners and new providers will be critical especially in light of health insurance reform.
3. There continues to be a disproportionate burden of HIV disease in certain populations and communities
4. Bias, stigma, and discrimination against PLWHA, people at risk for HIV, and vulnerable and disenfranchised populations continue to impact their access to prevention and care services
5. There is a clear health benefit to continuous HIV medical care including "treatment as prevention;" at the same time, there continues to be unmet need and barriers to care
6. HIV prevention and care must continually move toward greater integration
7. Syndemic public health problems (e.g., substance abuse, mental health, underlying societal conditions, etc.) continue to impact HIV prevention and care in our community

***Cross-Cutting Solutions***

1. Structural improvements (e.g., policy change, population-based activities, norm change, etc.)
2. Targeted interventions (e.g., EBIs, service linkage, primary care, etc.)
3. Increasing community awareness of HIV
4. Increasing awareness of HIV status
5. Increasing social supports for PLWHA
6. Early linkage to care, engagement in care, and retention in care

7. A seamless system for prevention, care, and co-occurring conditions
8. Full adherence to treatment and “treatment as prevention”
9. Coordinated data collection and surveillance
10. Use of available technology
11. Expanded partnerships

### ***System Goals***

1. Mobilize the Greater Houston Area Community Around HIV
2. Prevent New HIV Infections Through Both Prevention and Treatment Strategies
3. Ensure that All People Living With or At Risk for HIV Have Access to Early and Continuous HIV Prevention and Care Services
4. Reduce the Effect of Co-Occurring Conditions that Hinder HIV Prevention Behaviors and Adherence to Care
5. Reduce Disparities in the Houston Area HIV Epidemic and Address the Needs of Vulnerable Populations
6. Achieve a More Coordinated and Expansive HIV System

### ***Measures of Success***

1. Number of new HIV infections
  2. Percentage of people living with HIV who know their status \*Through traditional/targeted HIV testing only
  3. Percentage of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis
  4. Percentage of individuals who progress to AIDS within one year of a new HIV diagnosis
  5. Percentage of HIV clients who are in continuous care ( $\geq 2$  visits for routine HIV medical care in 12 months  $\geq 3$  months apart)
  6. Percentage of HIV clients who are retained in care ( $\geq 1$  visit for HIV primary care in the 2<sup>nd</sup> half of the year after also having  $\geq 1$  visit for HIV primary care in the 1<sup>st</sup> half of the year)
  7. Percentage of PLWHA not in care (RW/A Unmet Need Analysis)
  8. Percentage of HIV clients with undetectable viral load
  9. Percentage of PLWHA reporting co-occurring public health problems that inhibit HIV prevention and care (indication of alcohol or drug abuse, mental health condition in the past 30 days, housing instability, seeking no medical care due to inability to pay)
- The next Leadership Team meeting is January 23, 2012 at 2:00 PM. Attendees will review a first draft of Sections II and III of the plan.

### **EVALUATION WORKGROUP**

- The workgroup met on December 6, 2011 with 11 members and staff. The main focus of the meeting was to discuss a methodology for determining priority populations for the plan as a whole, per the Leadership Team’s request.
- After reviewing several possible methodologies and data sources, the Evaluation Workgroup’s recommendation is to include a single joint list of priority populations for the plan; and that this list be a combination of the current population priorities from:
  1. HIV prevention community planning (as listed in the *2009 Houston HIV Prevention Plan*); and
  2. HIV care (as identified in Ryan White Parts A/B service category priorities and allocations and HRSA-required *Special Populations*).
 See attached model for a list of the populations and definitions.
- The next workgroup meeting is January 3, 2012 at 1:00 PM. Attendees will finalize all benchmarks and targets per workgroup strategy and for the plan as whole.

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## STRATEGY WORKGROUPS

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The focus of December workgroup meetings was to refine and prioritize short-term activities for the plan. Members also reviewed ideas generated by frontline HIV care and prevention staff at the *2011 Joint Capacity-Building Conference* in November. Examples of priority activities identified by each workgroup are listed below. Final workgroup meetings will take place in January; members will review complete drafts of their workgroup strategy and discuss methods for public comment on the plan.

### **Coordination of Effort (COE)**

- The COE workgroup met on December 19, 2011 with nine members and staff. Examples of prioritized activities to better coordinate efforts for the entire HIV system include:
  1. Forming a broad-based HIV coalition for the purpose of networking, education, and engagement with current HIV stakeholders and new and non-traditional partners;
  2. Developing a Houston Area HIV media and marketing plan;
  3. Scaling-up local professional education and capacity-building for funded ASOs, medical providers, and new and non-traditional partners with a focus on high-impact HIV prevention and care solutions (e.g., nPEP, treatment as prevention, etc.);
  4. Translating the Houston Area HIV/AIDS Resource Guide into a real-time web-based resource locator with accompanying mobile applications accessible by clients and providers;
- The final workgroup meeting is January 23, 2012 at 12:00 PM (please note earlier time!).

### **Gaps in Care and Out-of-Care (G&O)**

- The G&O workgroup met on December 16, 2011 with eight members and staff. Examples of prioritized activities to fill gaps in care and reach the out-of-care include:
  1. Developing a universal readiness for care screening tool and/or expanding self-administered risk assessment to include readiness;
  2. Finding ways to best meet the emotional and social support needs of clients (e.g., separation of mental health services from substance abuse services, adjusting Standards of Care to require a general counseling visit for all clients, etc.);
  3. Creating a toolkit for the private sector to help link clients to care;
  4. Piloting an online training program for the newly-diagnosed and/or the use of technology to encourage retention in care;
  5. Piloting a client reminder system; supporting the City's Re-Linkage to Care Project; and
  6. Establishing new partnerships to find the out-of-care, such as homeless counts or DIS investigation of prior positives.
- The final G&O workgroup meeting is January 20, 2012 at 12:00 PM.

### **Prevention and Early Identification (P&EI)**

- The P&EI workgroup met on December 14, 2011 with 13 members and staff. Examples of prioritized activities for prevention and early identification include:
  1. Launching a community-wide education campaign on "treatment as prevention" for HIV+ individuals;
  2. Developing a community-wide standard for linkage to care and for nPEP and PrEP;
  3. Re-examining service delivery models to encourage linkage to care earlier in the HIV system;
  4. Creating a real-time, web-based resource database that includes available behavioral interventions/EBIs and clinical trials alongside services;
  5. Developing community-wide protocols for a peer mentor/patient navigator program; and
  6. Supporting the scientific and research infrastructure through the community-wide "super-CAB" and the City's Scientific Advisory Board.
- The final P&EI workgroup meeting is January 11, 2012 at 2:00 PM.

## **Special Populations (SP)**

- The SP workgroup met on December 14, 2011 with 15 members and staff. Examples of prioritized activities for special populations include:
  1. Requiring progressive annual training for all HIV prevention and care frontline staff on how to best serve each special population;
  2. Adopting universal statements about non-discrimination and about serving the homeless, the recently released, and the undocumented;
  3. Exploring how to broaden options for proof of identity, such as a CPCDMS-generated client identification card;
  4. Altering variables in local data collection systems to collect information on special populations, particularly transgender individuals and the homeless;
  5. Piloting new service delivery models that might facilitate special populations into the HIV system of care (e.g., monetary incentives, agency-to-agency data transfers); and
  6. Supporting other community-wide efforts to address the needs of special populations, such as HISD's HIV, STD, and Unintended Pregnancy Prevention plan and EIIHA.
- The final SP workgroup meeting is January 18, 2012 at 10:00 AM.

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**2012 Houston Area Comprehensive HIV Prevention and Care Services Plan**

**FOUNDATIONAL ITEMS**

**Vision:**

“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:**

“The mission of the 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan 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.”

**Guiding Principles:**

The development of the 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan was guided by 10 core principles; that the plan and planning process would:

1. Fully integrate the perspectives, needs, and priorities of both HIV prevention and HIV care and, within the HIV care community, all Ryan White HIV/AIDS Program components.
2. Align with local, state, and national HIV prevention and care plans and initiatives, including the National HIV/AIDS Strategy, *Healthy People 2020*, the CDC’s plan for High-Impact HIV Prevention, and the local acceleration initiatives, ECHPP and EIIHA.
3. Be cognizant of changes occurring in the national health care delivery system resulting from the *Affordable Care Act* and the Ryan White Treatment Modernization Act.
4. Assess strategies, including those used internationally, that have effectively reduced HIV infections and could be implemented locally.
5. Assure that federal expectations for Houston Area comprehensive planning and the required deliverables of funded agencies are met while still allowing new or emerging critical areas of need and innovation to be considered.
6. Produce Specific, Measurable, Achievable, Realistic, and Time-phased (SMART) goals and solutions that can be used to guide priority-setting, resource allocations, scopes of work, quality assurance, and other decision-making activities of the Houston Area planning bodies and administrative agents.
7. Balance the need to be comprehensive, data-driven, and reflective of new science, theory, and models with the need for efficiency in regards to resources and timelines.
8. Recognize the importance of and provide opportunities for participation by non-AIDS-service organizations and other non-traditional partners.
9. Honor the populations most impacted by HIV, including the underserved in response to the epidemic’s impact on minority and hard-to-reach populations, and those who are uniquely vulnerable to HIV infection due to social, economic, cultural, or structural barriers.
10. Engage with and ensure that people living with and at risk for HIV as well as consumers of prevention and care services have a central voice, clear understanding, and full involvement throughout the process.

## **OVERARCHING COMMUNITY CONCERNS**

- Dedicated public resources for HIV prevention and care have been reduced or at level-funding and need remains severe.
- There is a need to expand and diversify the HIV system through new partners and new providers especially in light of health insurance reform.
- There is a disproportionate burden of HIV on certain populations and communities.
- Bias, stigma, and discrimination against PLWHA, people at risk for HIV, and vulnerable populations continues to impact their access to prevention and care services.
- There is a clear health benefit to continuous HIV medical care including “treatment as prevention:” at the same time, there continues to be unmet need and barriers to care.
- HIV prevention and care must continue to constantly move toward integration.
- Syndemic public health problems (e.g., substance abuse, mental health, underlying societal conditions, etc.) continue to impact HIV prevention and care in our community.

## **CROSS-CUTTING SOLUTIONS**

- Structural improvements (e.g., policy change, population-based activities, norm change, etc.)
- Targeted interventions (e.g., EBIs, service linkage, primary care, etc.)
- Increasing community awareness of HIV
- Increasing awareness of HIV status
- Early linkage to care, engagement in care, and retention in care
- A seamless system for prevention, care, and co-occurring conditions
- Full adherence to treatment and “treatment as prevention”
- Increasing social supports for PLWHA
- Coordinated data collection and surveillance
- Expanded partnerships
- Use of available technology

## **SYSTEM GOALS**

1. Mobilize the Greater Houston Area Community Around HIV
2. Prevent New HIV Infections Through Both Prevention and Treatment Strategies
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## PRIORITY POPULATIONS

### Methodology

A combination of the current HIV prevention and care services population priorities determined by:

1. HIV prevention community planning (Source: 2009 Houston HIV Prevention Plan)
2. HIV care service category priorities and HRSA-required *Special Populations* (Source: FY2011 Ryan White Part A “Emerging Populations” and HRSA Guidance)

(in alphabetical order)

- African-Americans
- HIV+ Individuals
- Incarcerated or Recently Released
- Injection Drug Users (IDU)/People Who Share Needles
- Hispanics
- Homeless
- Men
- Men Who Have Sex with Men (MSM)
- Rural
- Transgender
- Women
- Youth (aged 13 – 24), including Adolescents (aged 13 -17)

### SYSTEM OBJECTIVES

1. Annual number of new HIV infections
2. Percentage of people living with HIV who know their status \*Through traditional/targeted HIV testing only
3. Percentage of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis
4. Percentage of individuals who progress to AIDS within one year of a new HIV diagnosis
5. Percentage of HIV clients who are in continuous care ( $\geq 2$  visits for routine HIV medical care in 12 months  $\geq 3$  months apart)
6. Percentage of HIV clients who are retained in care ( $\geq 1$  visit for HIV primary care in the 2<sup>nd</sup> half of the year after also having  $\geq 1$  visit for HIV primary care in the 1<sup>st</sup> half of the year)
7. Percentage of PLWHA not in care (RW/A Unmet Need Analysis)
8. Percentage of HIV clients with undetectable viral load
9. Percentage of PLWHA reporting co-occurring public health problems that inhibit HIV prevention and care (indication of alcohol or drug abuse, mental health condition in the past 30 days, housing instability, seeking no medical care due to inability to pay)

### STRATEGIES

#### Topics:

1. Prevention and Early Identification
2. Closing Gaps in Care and Reaching the Out-of-Care
3. Meeting the Needs of Special Populations
4. Coordination of Effort

#### Contents per Strategy:

- Opportunities
- Goals
- Solutions
- Activities
- Benchmarks

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**2012 Houston Area Comprehensive HIV Prevention and Care Services Plan**  
**WORKING OUTLINE At-A-Glance**

- I. Opening Sections  
Acknowledgments, Letters of Concurrence, and Table of Contents. *Profiles* included throughout the document.
  
- II. Introduction  
The purpose of this section is to describe the broader social and community context in which the 2012 Comprehensive Plan was developed and will be implemented, including background on the Houston Area and various considerations made during the planning process for changes occurring at the local, state, and national levels.
  - A. Who We Are: The Greater Houston Area Community
  - B. Where We've been: Houston's Response to the HIV Epidemic
  - C. Where We're Going: The New Landscape for HIV Prevention and Care
  
- III. Engagement Plan: The Process for Developing the 2012 Comprehensive Plan  
The purpose of this section is to describe the process that was undertaken to develop the 2012 Comprehensive Plan including methods used to ensure extensive collaboration and consultation with PLWHA, consumers, and community members. It also describes the strategies used to engage and retain previous and new partnering agencies and to ensure synergy with other community planning efforts.
  - A. Design of the Process (Creating A "Plan for Planning") and Determining Who to Engage
  - B. Partner Recruitment, Engagement, and Retention in the Process
  - C. Ensuring Participation by PLWHA, Consumers, and Community Members
  - D. Plan Development and the Use of Working Groups
  - E. Synergy with HIV Prevention and HIV Care Planning Bodies
  - F. Synergy with Other Local, Regional, State, and National HIV Initiatives and Plans
  
- IV. Executive Summary
  
- V. Where Are We Now?  
The purpose of this section is to describe the current state of HIV in the Houston Area, including local trends in HIV/AIDS epidemiology and service-delivery as well as needs, gaps, and barriers to HIV prevention and care. It also provides an overview of the current system of HIV prevention and care service-delivery in the Houston Area and summarizes progress made in the time since the 2009 Comprehensive Plan.
  - A. HIV/AIDS in the Houston Area (2011 Epi Profile)
  - B. The Houston Area Continuum of HIV Prevention and Care
  - C. Needs, Gaps, and Barriers
  - D. Evaluation of the 2009 Comprehensive HIV Services Plan
  
- VI. Where Do We Need to Go?  
The purpose of this section is to describe the community's vision for an ideal, high quality, comprehensive continuum of HIV prevention and care services and to outline the overarching goals, solutions, and other elements that shape this ideal system.
  - A. Our Approach: *Sustain, Scale-Up, Shift, and Shore-Up*
  - B. "A Living Document"
  - C. The Foundation: *Vision, Mission, and Guiding Principles*

- D. Overarching Community Concerns, or the “Problem Statement”
- E. Cross Cutting Community Solutions, or the Local “Best Practices”
- F. System Goals
- G. Priority Populations
- H. System Objectives
- I. Dashboard

VII. How Will We Get There?

The purpose of this section is to describe the specific strategies, activities, and efforts needed to achieve the specified goals and solutions for an ideal system of HIV prevention and care in the Houston Area.

- A. Our Structure: *The Four Cornerstones*
- B. Strategies for Achieving an Ideal System
  1. Prevention and Early Identification
  2. Closing Gaps in Care and Reaching the Out-of-Care
  3. Meeting the Needs of Special Populations
  4. Coordination of Effort

VIII. How Will We Monitor Progress?

The purpose of this section is to describe the methods and/or means by which success will be measured and progress in achieving goals will be monitored. It also outlines plans for improved data collection and the use of data as well as for expanding the HIV prevention and care knowledge base in the community.

- A. Evaluation Plan
- B. Monitoring Plan
- C. Data Collection Goals
- D. Improved Use of Client Level Data
- E. Use of Data in Monitoring Service Utilization
- F. Measurement of Clinical Outcomes and Quality Assurance
- G. Determining Scalability

IX. How the Plan Aligns

The purpose of this section is to describe how the 2012 Comprehensive Plan responds to other local, regional, state, and national initiatives and plans.

- A. Approach to Alignment
- B. Alignment Discussions
  1. The National HIV/AIDS Strategy
  2. CDC Division of HIV/AIDS Prevention Strategic Plan & High-Impact HIV Prevention
  3. Healthy People 2020
  4. Affordable Care Act
  5. Statewide Coordinated Statement of Need/Texas Jurisdictional Plan
  6. Texas HIV/STD Prevention Plan
  7. Enhanced Comprehensive HIV Prevention Planning (ECHPP)
  8. Early Identification of Individuals with HIV/AIDS (EIIHA)

X. Attachments

- A. Executive Map of the Plan
- B. Detail of Goals, Benchmarks, and Targets
- C. Implementation Plan
- D. Pull-Out: *How to Use the Plan*
- E. References

# 2012 Houston Area Comprehensive HIV Prevention and Care Services Plan

## Compendium of Goals, Solutions, Activities, and Benchmarks, By Strategy

**STRATEGY:** **Gaps and Out-of-Care**

### GOALS:

1. Reduce Unmet Need
2. Ensure Early Entry Into Care
3. Increase Retention in Continuous Care
4. Improve Health Outcomes for People Living with HIV/AIDS (PLWHA)

### SOLUTIONS:

1. Target **linkage to care** efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit) where individuals are more likely to not seek care or to fall out of care, particularly *newly-diagnosed* PLWHA
2. Intensify **retention and engagement activities** with *currently in-care* PLWHA, focusing on community education, system enhancements, and health literacy
3. Adopt **strategies to re-engage** *out-of-care* PLWHA and other “prior positives” to return to care

### BENCHMARKS:

1. Reduce the percentage of PLWHA who are not in care by 0.8 percent each year (using the Ryan White HIV/AIDS Program Unmet Need Analysis) beginning at 30.1 percent
2. Reduce the percentage of PLWHA reporting being currently out-of-care (i.e., no evidence of HIV medications, viral load test, or CD4 test in 12 consecutive months) by 3.0 percent (from 7.1 percent to 4.1 percent)
3. Prevent the percentage of PLWHA reporting a prior history of being out-of-care from increasing above 20.6 percent
4. Increase the proportion of newly-diagnosed individuals linked to clinical care within three months of their HIV diagnosis to 85 percent (from 65.1 percent)
5. Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by 25 percent (from 36 percent to 27 percent)
6. Increase the proportion of HIV clients who are in continuous care (i.e., at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) to 80 percent (from 78 percent)
7. Prevent the proportion of HIV clients who are retained in care (i.e., at least 1 visit for HIV primary care in the 2<sup>nd</sup> half of the year after also having at least 1 visit for HIV primary care in the 1<sup>st</sup> half of the year) from falling below 75 percent
8. Increase the proportion of HIV clients with undetectable viral load by 10 percent (from 58 percent to 63.8 percent)

### ACTIVITIES:

#### **Linkage to care**

1. Implement training to Counseling, Testing, and Referral (CTR) providers about their role in service linkage beginning at post-test counseling/results notification; and establish linkage to care performance measures for CTR providers
  - a. Rationale: Early entry into HIV primary care and initiation of treatment leads to improved health outcomes; moreover, HIV-positive individuals with suppressed viral load are less likely to transmit the virus to sex partners. Initiating linkage to care activities at the earliest stages of an HIV diagnosis (i.e. at post- test counseling/results notification) can assist in earlier linkage to and initiation of care.
  - b. Timeframe: 2012
  - c. Responsible Party: Houston Department of Health and Human Services (HDHHS); Ryan White Grants Administration (RWGA)
  - d. Reference Plan: N/a
2. Expand Disease Investigation Services (DIS) activities to include a readiness for HIV care assessment at the time of DIS interview as a means of assisting with linkage to care efforts
  - a. Rationale: Early entry into HIV primary care and initiation of treatment leads to improved health outcomes; however, barriers may exist for the newly-diagnosed to enter treatment. Awareness of a client's stage of readiness for care and initial triage at the time of diagnosis can assist Service Linkage Workers (SLWs) and others to provide tailored referrals and assistance focused on preventing newly-diagnosed HIV+ clients from delaying care.

- b. Timeframe: 2012
- c. Responsible Party: Houston Department of Health and Human Services (HDHHS)
- d. Reference Plan: N/a

**3. Re-develop the Service Definition for Service Linkage (non-medical case management) so as to complete linkage to care earlier in the process of an HIV diagnosis**

- a. Rationale: Early entry into HIV primary care and initiation of treatment leads to improved health outcomes; moreover, HIV-positive individuals with suppressed viral load are less likely to transmit the virus to sex partners. Initiating linkage to care activities at the earliest possible points in the continuum can assist in earlier initiation of care.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Planning Council (RWPC)
- d. Reference Plan: ECHPP; EIIHA

**4. Identify and disseminate a model protocol for a patient/peer navigator program that will assist newly-diagnosed HIV+ individuals to enter the HIV care system**

- a. Rationale: Early initiation of treatment for HIV leads to improved outcomes; however, barriers may exist for the newly-diagnosed to enter treatment. Evidence suggests that assists such as peer mentors or navigators can help the newly-diagnosed overcome barriers to care.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Planning Council/Office of Support (RWPC/OS)
- d. Reference Plan: N/a

**2. Develop a toolkit for private medical doctors for how to link newly-diagnosed HIV+ individuals into the Houston Area HIV system**

- a. Rationale: Early initiation of treatment for HIV leads to improved outcomes; however, barriers may exist for the newly-diagnosed to enter treatment particularly when diagnoses occurs outside of the public HIV care system.
- b. Timeframe: 2013
- c. Responsible Party: Ryan White Planning Council/Office of Support (RWPC/OS)
- d. Reference Plan: N/a

***Retention and engagement activities***

**1. Launch a retention in care educational campaign targeting HIV+ individuals, their partners, and providers (e.g., in+care)**

- a. Rationale: Continuous care and viral load suppression lead to improved health outcomes for PLWHA; HIV-positive individuals who are adhering to therapy are also less likely to transmit the virus. Many PLWHA are unaware of the relationship between continuous care, viral load suppression, and risk of transmission. Moreover, the evaluation of the 2009 Comprehensive Plan showed that retention in care among Part A clients is steady, but not increasing.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Planning Council/Office of Support (RWPC/OS); Ryan White Grants Administration (RWGA); The Resource Group (TRG)
- d. Reference Plan: N/a

**2. Integrate messaging on the importance of retention in care for health outcomes and secondary prevention into evidence-based behavioral interventions (EBIs) targeting HIV+ individuals and their partners**

- a. Rationale: Continuous care and viral load suppression lead to improved health outcomes for PLWHA; HIV-positive individuals with suppressed viral load are also less likely to transmit the virus to sex partners. Many PLWHA are unaware of the relationship between continuous care, viral load suppression, and risk of transmission.
- b. Timeframe: 2014
- c. Responsible Party: Houston Department of Health and Human Services (HDHHS)
- d. Reference Plan: ECHPP

**3. Assist funded AIDS-service organizations (ASOs) to develop client reminder systems as a standard of care**

- a. Rationale: Continuous care and viral load suppression lead to improved health outcomes for PLWHA; however, the evaluation of the 2009 Comprehensive Plan showed that retention in care among Part A clients is steady, but not increasing. Additional infrastructure improvements are needed to prevent lapses in care; and examples from other sectors suggest that technology can be an effective tool for supporting compliant client behavior.
- b. Timeframe: 2013
- c. Responsible Party: Ryan White Grants Administration (RWGA)
- d. Reference Plan: Ryan White HIV/AIDS Program Part A/B Standards of Care

**4. Implement plans to expand health literacy programming for people living with and/or affected by HIV/AIDS**

- a. Rationale: A HIV diagnosis requires complex disease self-management skills that many living with or caring for those with the disease may not have. Evidence from other sectors, particularly chronic disease, shows the benefits of teaching clients health literacy skills.
- b. Timeframe: 2012
- c. Responsible Party: The Resource Group (TRG); Ryan White Planning Council/Office of Support (RWPC/OS) Project LEAP
- d. Reference Plan: Ryan White HIV/AIDS Program Part A/B Standards of Care

**5. Re-asses the Service Definition for Medical/Clinical Case Management so as to fill gaps in the mental health and emotional/social support needs of PLWHA**

- a. Rationale: Almost 20% of PLWHA in the Houston Area report no source for social support for living with HIV, which can lead to lapses in care and/or long-term mental health concerns. Mental health services are a funded service category under Ryan White Parts A/B, but may not be sufficiently addressing the emotional needs and/or situational depression experienced by PLWHA.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Planning Council (RWPC)
- d. Reference Plan: N/a

**6. Implement plans to sustain required annual training for case management staff on effective client engagement (e.g., client-centered counseling, motivational interviewing, building rapport and trust, etc.)**

- a. Rationale: Frontline HIV prevention and care staff identified the client relationship as a core factor in effective case management and retention of the client in care.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Grants Administration (RWGA); The Resource Group (TRG)
- e. Reference Plan: Ryan White HIV/AIDS Program Part A/B Standards of Care

**7. Facilitate technical assistance to funded ASOs in rural counties to transition into HIV medical homes**

- a. Rationale: Co-occurring conditions such as substance abuse or mental illness/disability can lead directly to lapses in HIV care. In addition, as many PLWHA age, they experience other health conditions as well such as chronic disease. Providing a holistic approach to HIV care can better meet the needs of clients and help retain them within the HIV system.
- b. Timeframe: 2014
- c. Responsible Party: The Resource Group (TRG)
- d. Reference Plan: N/a

**8. Establish a mechanism for tracking medication adherence among Ryan White HIV/AIDS Program Part A/B clients**

- a. Rationale: Macro-level measures are needed to monitor community-wide HIV health.
- b. Timeframe: 2013
- c. Responsible Party: Ryan White Grants Administration (RWGA)
- d. Reference Plan: ECHPP

**Strategies to re-engage**

**1. Implement plans to launch a re-linkage to care project using data matching algorithms between HIV surveillance (eHARS) and client-level care data (CPCDMS)**

- a. Rationale: Continuous care and viral load suppression lead to improved health outcomes for PLWHA. When HIV+ individuals are out-of-care, their viral loads may not remained suppressed, and they may experience opportunistic infections or other health problems. The evaluation of the 2009 Comprehensive Plan showed that the percent of PLWHA who were out of care increased 4% between 2008 and 2011. Additional efforts are needed to locate these individuals and return them to care.
- b. Timeframe: 2012
- c. Responsible Party: Houston Department of Health and Human Services (HDHHS)
- d. Reference Plan: N/a

**2. Re-develop the Service Definition for Service Linkage (non-medical case management) so as to reach “prior positives” and return them to care**

- a. Rationale: Frontline staff report that a notable proportion of HIV+ individuals identified through routine testing and mass testing events have been previously diagnosed in the jurisdiction (i.e., “prior positives”). Since they are “prior positives,” no follow-up investigation is conducted nor are there efforts in place to return them to care. The evaluation of the 2009 Comprehensive Plan showed that the percent of PLWHA who were out of care increased 4% between 2008 and 2011.
- b. Timeframe: 2012
- c. Responsible Party: Ryan White Planning Council (RWPC)
- d. Reference Plan: N/a

**4. Establish partnerships with existing community-wide outreach opportunities to locate the out-of-care particularly in vulnerable sub-populations and high-incidence communities**

- a. Rationale: PLWHA can fall out of care due to loss of housing, drug addiction, mental health/disability, or other co-occurring or underlying social or health problems. Partnering with agencies that perform outreach on these issues may serve as a venue for locating and re-engaging the out-of-care. Examples of potential partnerships include homeless enumerations, AIM, and the SAFER Initiative. The evaluation of the 2009 Comprehensive Plan showed that the percent of PLWHA who were out of care increased 4% between 2008 and 2011.
- b. Timeframe: 2014
- c. Responsible Party: Ryan White Planning Council/Office of Support (RWPC/OS)
- d. Reference Plan: N/a