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Early Identification of Individuals with HIV/AIDS

Where Care Meets Prevention

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Agenda

- Introductions
- Legislative References
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Legislative References

■ Part A Grant

- *“...shall determine size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status”*
- *“determine the needs of...individuals with HIV/AIDS who do not know their HIV status”*
- *“develop a comprehensive plan...that includes – “*
 - *“a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services”*



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Legislative References

■ Part B Grant

- *“develop a comprehensive plan – ”*
 - *“describing the estimated number of individuals within the State with HIV/AIDS who do not know their status”*
 - *“describing activities undertaken by the State to find the individuals described in subparagraph (A) and to make such individuals aware of their status”*
 - *“describing the manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS”*
 - *“describing efforts to remove legal barriers, including State laws and regulations, to routine testing”*



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National Strategy Relevancy

■ Factors Contributing to the Current Epidemic:

1. **Too Many People Living with HIV Are Unaware of Their Status**
2. **Access to HIV Prevention is Too Limited**
3. **Insufficient Access to Care**
4. **Diminished Public Attention**

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Definitions

□ Early Identification of Individuals with HIV/AIDS (EIIHA):

- **Identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to care.**

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Definitions

Unaware of HIV Status:

- Any individual who has **NOT** been tested for HIV in the past 12-months, any individual who has **NOT** been informed of their HIV result (HIV positive or HIV negative), and any HIV positive individual who has **NOT** been informed of their confirmatory HIV result.

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Definitions

Identification of Individuals Unaware of Their HIV Status:

- The categorical breakdown of the overall unaware population into subgroups, which allow for the overall EIIHA strategy to be customized based on the needs of each subgroup, for the purposes of identifying, counseling, testing, informing, referring, and linking these individuals into care.

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Definitions

- **Informing individuals of their HIV status:**
 - **Informing an HIV negative individual, post-test, of their appropriate HIV screening result.**
 - **Informing an HIV positive individual, post-test, of their confirmatory HIV result.**

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Definitions

- **Referral to care/services:**
 - **The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific care/service provider for the purpose of accessing care/services after the individual has been informed of their HIV status (positive or negative).**

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Definitions

□ Linkage to care:

- The post-referral verification that care/services were accessed by an HIV positive individual being referred into care.

- Example: Confirmation first scheduled care appointment occurred.

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EIHA: 3 Basic Components



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Strategy

- **“Blueprint” for Implementation:**
 - **Goals**
 - **Coordination with other RW Parts**
 - **Coordination with Prevention Programs**
 - **Coordination with other Community Efforts**
 - **Incorporation in to RFP’s**
 - **Consideration of ADAP Services**
 - **Role of Early Intervention Services (EIS)**
 - **Addressing Disparities in Access**



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Plan

- **Activities, Methods & Means:**
 - **Identify**
 - **Inform**
 - **Refer**
 - **Link**



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Plan

□ Identifying Unaware by Groups:

- “Within the overall unaware population that encompasses any individual who is unaware of their HIV status, develop a matrix listing the subgroups, which will allow the applicant’s overall strategy to be customized to meet the needs of each subgroup.”



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Plan

□ Strategy/Plan Customization:

- “For each subgroup in the EIIHA Matrix, describe how the strategy will be customized to address their respective needs specific to identifying, informing, and referring HIV positive individuals who are unaware of their status.”



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Plan

Informing Unaware:
 "...educate providers regarding resources available whenever a client does not return for their HIV results..."

Individuals Not Post-Test Counseled <i>(HIV positive & HIV negative)</i>		Received Preliminary HIV Positive Result Only – No Confirmatory Test	High Risk Individuals			Moderate & Low Risk Individuals		
Tested Confidentially	Tested Anonymously		I V D U	M S M	Infants Of Infected Mothers	Partners of HIV+ Individuals	Not Tested in Past 24 Month	Not Tested in Past 48 Month



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Plan

□ Challenges:

- **“For each subgroup in the EIIHA Matrix, describe the respective challenges (including any local legislation or policies) associated with identifying, informing, and referring individuals who are unaware of their HIV status.”**



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Plan

□ Activities:

- “For each subgroup in the EIIHA Matrix, describe the respective activities essential for identifying, informing, and referring HIV positive individuals who are unaware of their status.”
- Establishing a Baseline
 - Activities implemented immediately
 - Activities not implemented immediately

Plan

□ Linkage To Care:

- “Describe the activities essential to ensuring access to care regardless of where any newly identified HIV positive individual enters into the continuum of care.”

2) EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

2) A. Strategy (*Blueprint for implementation*)

(1) Strategy to identify individuals who are unaware of their HIV status. The Houston EMA EIIHA Strategy reflects a combination of proven approaches from HIV prevention, surveillance, and care targeted to communities where HIV is most heavily concentrated and where linkage to care rates fall below the statewide average. It consists of a three-part strategy of HIV testing, disease investigation, and service linkage conducted through collaboration with the local health jurisdiction, RW/B, and planning bodies.

(a) Specific goals strategy is intended to achieve. The *goals* of the EIIHA Strategy are: 1) increase the proportion of PLWH who know their status (baseline=21%); 2) increase the proportion of newly-aware PLWHA linked to care within three months (baseline=65%); and 3) address disparities among populations disproportionately impacted by HIV. The *objectives* of the EIIHA Strategy are: 1) PROVIDE routine HIV counseling and testing in the medical setting and targeted HIV counseling and testing in non-traditional settings in high-risk communities; 2) CONDUCT disease investigation of newly-diagnosed PLWHA and their sex- and needle-sharing partners through contact tracing; and 3) CONNECT the newly-diagnosed into HIV care and supportive services through Point of Entry (POE) agreements, strategic placement of Service Linkage Workers (SLW), and Case Management (CM), including non-medical, medical, and clinical service definitions.

i) Consistency of each goal with the National HIV/AIDS Strategy (NHAS) goals.

Each Houston EMA EIIHA Strategy goal links directly to NHAS:

Houston EMA EIIHA Strategy	NHAS Goals
Goal 1) increase the proportion of people living with HIV who know their status	Replicates target for the NHAS goal of “Reducing New HIV Infections”
Goal 2) increase the proportion of newly-diagnosed PLWHA linked to care	Replicates target for the NHAS goal of “Increasing Access to Care and Improving Health Outcomes for People Living with HIV”
Goal 3) address disparities among populations disproportionately impacted	Reflects NHAS goal of “Reducing HIV-Related Disparities and Health Inequities”
Objective 1) PROVIDE routine and targeted HIV testing and post-test counseling	Recommended activity to achieve the NHAS goal of “Reducing New HIV Infections”
Objective 2) CONDUCT disease investigation of newly-diagnosed PLWHA and partners	Recommended activity to achieve the NHAS goal of “Reducing New HIV Infections”
Objective 3) CONNECT people to care through Point of Entry (POE) agreements, Service Linkage Workers (SLW), and Case Management (CM)	Recommended activity to achieve the NHAS goal of “Increasing Access to Care and Improving Health Outcomes for People Living with HIV”

In addition, by implementing these activities through collaboration with partners, the EIIHA Strategy is also consistent with the last NHAS goal of “Achieving a More Coordinated National Response to the HIV Epidemic.”

ii) Consistency of each goal in making unaware individuals aware of their HIV status. Each objective of the Houston EMA EIIHA Strategy is consistent with transitioning unaware individuals into being aware:

Houston EMA EIIHA Strategy	Making Individuals Who Are Unaware of Their HIV Status Aware of Their Status
Objective 1) PROVIDE routine and targeted HIV testing and post-test counseling	Ensures the availability of multiple and diverse convenient opportunities for status-unaware individuals to test for HIV, receive post-test counseling, and become aware of their status
Objective 2) CONDUCT disease investigation of newly-diagnosed PLWHA and their partners	Ensures that individuals who have tested for HIV are informed of their status and that their sex- and needle-sharing partners are also notified, tested, and informed
Objective 3) CONNECT people to care through Point of Entry (POE) agreements, Service Linkage Workers (SLW), and Case Management (CM)	Ensures additional “safety nets” for informing the newly-diagnosed of their status as POE sites must refer a minimum number of clients annually and all SLW are cross-trained as disease investigators

(b) Coordination of strategy with other programs/facilities and community efforts. Houston’s EIIHA Strategy is a consolidation of multiple agencies’ efforts to identify PLWHA. Core partners in the Strategy are: RW/A, RW/B, the HDHHS (the City, which is the CDC HIV Prevention directly-funded grantee), the PC, the Houston HIV Prevention Planning Group (PPG), and the PPG’s Community Task Forces. Design and implementation of the Strategy is overseen by a joint prevention and care committee convened by the PC. The EIIHA Ad Hoc Committee (or EAHC) is comprised of prevention stakeholders (routine HIV testing sites, community-based HIV testing sites, PPG committee chairs, members of the Statewide PPG, and correctional facilities), care stakeholders (RW/A-funded Primary Medical Care providers, PC members, the RW/B administrative agent, and RW/C), and consumers.

(c) Incorporation of EIIHA activities and strategies into the program’s Requests for Proposals (RFP). RW/A and MAI RFPs will continue to require applicants to comply with relevant components of the EMA’s EIIHA Strategy. For example, agencies applying for RW/A and MAI funds will be required to maintain POE agreements to ensure referral to care for the newly-aware, and specific contracts will be awarded for the SLW and CM components of the Strategy. The RFP will also outline the data collection requirements described in Sec. 2) C (3) below, and each FY 2012 contract will include the provider’s specific EIIHA responsibilities as part of their scope of work. The monitoring and quality assurance efforts described elsewhere in this application will continue to be applied to funded EIIHA activities.

(d) Consideration of ADAP and other medication resources to accommodate needs of new positives. RW/A will continue to allocate HIV medication assistance services commensurately with increases in the number of newly-identified PLWHA linked to medical care as a result of the EIIHA Strategy. For example, SLW and CM will continue to refer and verify access to medication assistance services, including ADAP, and at least one RW-Outcome Measure specific to client utilization of drug reimbursement services following SLW/CM will be monitored. RW/A will also continue to co-locate LPAP at all RW/A and MAI-funded providers of *adult* primary medical care and to place RW/A-funded CM at all *adult and pediatric* primary medical care sites to assist clients with LPAP, ADAP, and Medicaid/Medicare eligibility. Funding to LPAP will be expanded as needed during the fiscal year to accommodate the needs of new positives through the PC’s allocation process.

(e) Description of strategy addressing disparities in access and services among affected subpopulations. Goal 3) of the EMA's EIIHA Strategy is "to address disparities among populations disproportionately impacted by HIV," which is consistent with NHAS. To achieve this goal, the Strategy was segmented using both HIV epidemiological and service-utilization data to ensure activities are directed to the EMA's most highly-affected subpopulations as well as those with the greatest disparities in service access. As revealed through the 2011 NA, members of proposed Target Groups reflect some of the most disenfranchised subpopulations in the EMA, with high rates of health illiteracy, homelessness, drug addiction, mental illness and language/cultural barriers. Two of the Strategy's core activities, SLW and CM, directly address disparities in access by connecting newly-aware and highly HIV-impacted subpopulations to basic services such as food, clothing, and shelter, transportation, literacy, and vocational training. As a result, historically underserved subpopulations in the EMA are connected to needed services in addition to being linked to HIV medical care.

(f) Programmatic, systemic, and logistical challenges associated with making individuals aware of their HIV status. Most of the programmatic, systemic, and logistical challenges in the Houston EMA stem from its population size and geographic density as well as from the socio-economic barriers encountered by status-unaware individuals. For example, the EMA has a large and multi-tiered health services system administered by city, county, and state officials as well as by private and non-profit organizations, including the largest medical center in the world. The size and complexity of this system can create challenges for individuals seeking health care. In response, many AIDS-service organizations have consolidated their HIV activities both programmatically and geographically. The latter solution responds to a second example of the EMA's logistical challenges, i.e. those related to size. At over 6,000 square miles, the Houston EMA is the least densely populated metropolitan area in the nation. Relatively long distances must be travelled to seek services even within the urban center. This creates challenges for HIV service providers attempting to reach individuals for HIV results. Confounding these logistical challenges are socio-economic barriers often faced by communities at high-risk for HIV, such as lack of transportation, employment, or knowledge of services.

(g) Role of the RW Program in facilitating routine HIV testing. The City has been implementing routine HIV testing in the EMA since 2008 using both CDC and State funds. Currently, routine testing is provided in three public STD clinics, seven ERs, two FQHC locations, and three community health clinics. In 2010, these sites together provided 109,974 HIV tests and identified 1,605 new positives. Though identifying new positives is the *primary* goal of routine testing, routine testing also results in earlier diagnosis and treatment and improved health outcomes for PLWHA. These long-term aims can only be realized if the HIV care system is able to accommodate the new positives. In the EMA, the RW program provides the HIV service system capacity to accommodate new positives found through routine testing. The RW program regularly adjusts allocations to Core and Supportive services in response to trends in new positives. The RW program's capacity for new positives is evidenced by the overall decline in unmet need in the EMA described elsewhere in this application. New positives will also need assistance connecting to and navigating the HIV care system; the EIIHA Strategies of POE requirements, SLW and CM are specifically designed to address this.

(h) Coordination with RW Part C program. RW/A will continue to coordinate with RW/C for the purpose of making HIV unaware individuals aware of their status. The RW/C-funded agency in the Houston EMA (the Harris County Hospital District) is represented on the EAHC, and data sharing measures between RW/A and RW/C are described in Sec. 2)C(3) below. The RW/C-funded clinic is also integrated into several core activities of the EIIHA Strategy. For example, the RW/C-funded clinic is a POE for newly-diagnosed PLWHA, and is also listed in the EMA's HIV Resource Guide or "Blue Book" used in making referrals for newly-aware clients. Outcome Measures associated with the Strategy's core activities of SLW and CM incorporate care received at the RW/C-funded clinic as an indication of effective linkage to care. RW/C is also a provider of targeted HIV testing. Together, these efforts ensure that EMA's EIIHA Strategy is coordinated with RW/C status-unaware goals and that RW/C activities to inform the status-unaware are documented in EIIHA monitoring efforts.

(2) Matrix of Parent and Target Groups. Data on HIV incidence and prevalence, priority needs, linkage to care, and the status-unaware were utilized by the Houston EMA to effectively target its EIIHA Strategy. The result is population segmentation based on testing status and demographic characteristics (see **Attachment 9: EIIHA Matrix**).

2) B. Plan (Activities, Methods, and/or Means utilized to implement the strategy)

(1) Barriers which obstruct awareness of HIV status

(a) *Priority Needs which obstruct awareness of HIV status.* Various social, economic, and health needs can obstruct awareness of HIV status by creating barriers to HIV services. The 2011 NA and other sources provide important primary data on such needs for each Target Group:

- **African American MSM.** 164 NA respondents identified as African American MSM. Members of this group reported less educational attainment than White MSM but more than Hispanic MSM; 41% were unemployed; and 30% had been released from the correctional system within the last 12 months. Over half reported having a mental health condition, and over one-third showed an indication of alcohol abuse. Similarly, the reported need for outpatient drug or alcohol treatment services was highest among this group compared to other MSM. African American MSM also had one of the lowest proportions of the newly-diagnosed linked to care within three months as well as the highest rate of never seeking care among all MSM groups.

- **Hispanic MSM.** 85 NA respondents identified as Hispanic MSM. Of those, 38% reported Spanish as their primary language at home, and 29% reported Spanish as their primary language when seeking medical care. Over half reported being foreign-born, and as many as 28% may be undocumented. Members of this group reported less educational attainment than all other MSM groups. In addition, a majority reported having at least one mental health condition, and about one-third showed an indication of alcohol abuse.

- **African American IDU.** Of newly-diagnosed IDU in the EMA, 70% are African American; **and of IDU PLWHA, 69% are African American. In the NA, 59% of those identified as substance abusers were also African American.** Substance abusers were more likely to report falling out of HIV care than most other groups in the study; and almost 75% reported having a co-occurring mental health condition. African American IDU also had one of the lowest proportions of the newly-diagnosed linked to care within three months of diagnosis. African American IDUs also face potential health risks associated with illegal drug use, such as overdose, and/or with sharing injection equipment, such as Hepatitis.

- **Women of Childbearing Age.** 286 NA respondents were women of childbearing age. They reported far less educational attainment than men; 31% were unemployed; 21% reported unstable housing; and 10% had been released from the correctional system within the last 12 months. A majority reported having at least one mental health condition, and one-third showed an indication of alcohol abuse. It is also estimated that 1,401 women are currently unaware of their HIV status in the EMA. Of those, it is likely that the majority are African American. Currently, the HIV incidence rate for African American women is 11 times that of White women and 14 times that of Hispanic women. Moreover, African American women comprise the largest percentage of the newly-diagnosed in the EMA. In the NA, 67% of female respondents were African American.

- **Youth Aged 13-24.** An estimated 269 youth aged 13-24 are currently unaware of their HIV status in the EMA. Among youth, sexual contact is the most common transmission mode for HIV. 62% of all new HIV infections in this age group are attributed to MSM, and in the NA, 1% of White MSM, 4% of African American MSM, and 4% of Hispanic MSM were 18-24 years of age. In addition, 2% of all recently incarcerated survey respondents, 3% of substance abusers, and 2% of homeless were youth. Youth also have one of the lowest proportions of newly-diagnosed linked to care within three months of diagnosis. In the EMA, only IDUs had a lower percentage than youth aged 13-24.

(b) Cultural Challenges. “Culture” refers to a shared set of beliefs and values of a particular group. Through its history of serving high-risk populations, the EMA has identified some shared beliefs/values of Target Groups that create *cultural challenges which obstruct HIV awareness*:

- **African American MSM.** This target group faces multiple cultural challenges from the intersection of being African American, male, and MSM. Historically, HIV has not been openly discussed in the African American community nor has being gay or bisexual. As a result, many African American MSM may delay HIV awareness due to fear of rejection by family or friends for being HIV infected and/or MSM. Conversely, not all MSM identify as gay or bisexual, and, as a result, may not perceive themselves to be at risk for HIV, thereby further delaying awareness. The “down low” trend in the African American community best exemplifies this challenge. For those who are MSM-identified, cultural norms in the MSM community such as “HIV fatigue” may also obstruct awareness. Lastly, experience with discrimination related to race and/or sexual orientation can also be a barrier.

- **Hispanic MSM.** This target group faces multiple cultural challenges due to the intersection of being Hispanic, male, and MSM. Due to legal barriers, many Hispanics may not seek services due to fear of disclosure of immigration status and the consequence of deportation. Historically, the cultural value of “machismo” in the Hispanic community has deterred MSM-identified members from disclosing their orientation due to fear of rejection by family or friends. This fear can also translate into disclosure of HIV+ status. For those who are MSM-identified, these cultural norms in the MSM community may also obstruct awareness. Lastly, language barriers and discrimination due to race and/or sexual orientation can also serve as deterrents to care.

- **African American IDU.** The majority of African American IDU in the EMA are male and, as such, face many of the same cultural challenges described above for African American MSM. They also face additional challenges related to the use of injection drugs. The first is social pressure toward unsafe injection practices such as the sharing of equipment or participation in injection “parties.” Currently, sterile syringe access programs are prohibited by Texas state law. Fear of exposure as (or presumption of being) an illegal drug user and the consequence of incarceration keep many in this group from seeking health services in general, including HIV testing. Often, drug dependence overshadows all other health needs, putting IDUs at greater risk of HIV through sexual activity or the exchange of sex for drugs.

- **Women of Childbearing Age.** Though the vast majority of HIV transmission in women occurs through heterosexual contact, many patterns of belief related to heterosexual partners continue to impede HIV awareness. For example, many women believe that seeking knowledge of HIV status will be perceived by partners as a sign of distrust or betrayal; therefore, fear of rejection or retaliation from partners including violence can impede awareness. Fear of rejection or retaliation also translates into disclosure of HIV+ status. Pregnant women may also fear potential perinatal transmission and, as a result, delay prenatal care. As primary care-givers for partners, children, and even aging parents, many women delay seeking self-care in general. Overall, competing demands on time and resources may de-prioritize HIV for this target group.

- **Youth Aged 13-24.** Awareness of HIV status can be impeded by two powerful yet competing trends in current youth culture: (1) peer, media, and social pressures towards sexual risk-taking and (2) lack of perceived HIV risk. Sexual exploration and identification is a normal psychosocial developmental task in the young adult life stage. However, today's youth are also regularly exposed to media and social messages promoting sexual activity. The onset of social networking has revolutionized the way young people access sex partners; and peer pressure to engage in sexual activity remains strong. At the same time, comprehensive sexuality education in schools remains subject to political decision-makers; and it is not uncommon for parents to be reluctant to discuss sex with their teens. Furthermore, most of today's youth did not witness first-hand the toll of HIV/AIDS in its first decade. As a result, there is less urgency for awareness of HIV status, and these conditions keep HIV awareness from being a cultural norm for youth.

(2) Activities to address barriers that obstruct awareness of HIV status

(a) *Activities to address Priority Needs that obstruct awareness of HIV status.* Proven prevention, surveillance, and care activities that increase awareness of HIV status will continue to be tailored to address the social, economic, and health needs of each Target Group. ***All activities are ongoing for FY12 unless otherwise noted; responsible party is listed in parenthesis after each activity.***

Three activities will be applied to *all* Target Groups, with tailoring based on location and needs:

1. Routine and targeted HIV testing and post-test counseling will continue to focus on each Target Group by being offered at FQHCs, community-based clinics, and ERs in high-prevalence geographic areas and at other locations commonly frequented by the population. A mobile testing program will continue to bring services directly to culturally-specific communities (City).

2. Service Linkage Workers (SLW) are a unique service definition in the Houston EMA. Their purpose is to assist newly-aware and otherwise out-of-care PLWHA obtain needed medical, social, community, legal, financial, and other services as a way to eliminate barriers to HIV care. There are currently 28 SLWs in the EMA's system of care. SLW will continue to be strategically placed at HIV testing programs, public clinics, and RW/A and MAI-funded primary medical care sites that serve the Target Groups and connect individuals to priority needs services such as employment assistance, drug and alcohol treatment, and prenatal care (RW/A).

3. Case Management (CM) will also continue to be strategically located at RW/A and MAI-funded sites that serve the Target Groups. Like SLW, case managers are trained to connect individuals to priority needs services. They also coordinate medical treatment and address mental health and substance abuse co-morbidities. There are currently 30 case managers in the Houston EMA system of care (RW/A, RW/B).

Additional tailored activities per Target Group are described below:

- **African American MSM.** (1) HIV testing will continue at jails and correctional facilities to reach currently incarcerated and soon-to-be-released African American MSM. Disease investigation efforts will also be enhanced in jails and correctional facilities and through

community-based re-entry efforts (City). (2) Early Intervention Services (EIS) will continue to target the incarcerated population (RW/B). (3) Designated CM sites will continue to be targeted specifically to African Americans (RW/A). (3) An intensive HIV testing initiative launched in 2010 called the “SAFER Initiative” will also continue. SAFER focuses HIV awareness resources on the five EMA neighborhoods with the highest HIV/STD morbidity. SAFER neighborhoods include those with large populations of African Americans and MSM (City).

- **Hispanic MSM.** (1) Hispanic-service organizations will continue to meet the priority needs of this Target Group such as language interpretation, legal services for the undocumented, and in-language HIV testing (Association for the Advancement of Mexican Americans-AAMA). (2) Designated CM sites will continue to be targeted specifically to Hispanics (RW/A). (3) The SAFER initiative will also address priority needs of Hispanic MSM as neighborhoods with large populations of Hispanics and MSM are included in its geographic focus (City).

- **African American IDU.** Activities identified to meet the priority needs of African American MSM will also benefit this group. In addition, (1) The IDU Outreach Team established by a RW/A-funded AIDS-service organization will continue to reach-out to IDU with information about safe injection practices, drug treatment and overdose prevention, and “safe” HIV testing sites (Montrose Counseling Center-MCC). (3) Mobile HIV testing efforts will continue to target non-traditional locations frequented by IDU (City).

- **Women of Childbearing Age.** Activities identified to meet the priority needs of African American MSM in the jail and correctional facilities will also benefit the African American members of this group as will the SAFER initiative. In addition, (1) The RW/D programs in the Houston EMA will continue. These include the Houston WICY Project and Positive VIBE focused on priority needs of women and infants (RW/D). (2) Private sector collaborations to address women’s health needs will also continue. For example, Planned Parenthood Gulf Coast maintains representation on the PPG; and several women’s health providers, OB-GYNs, and others are included in the HIV Resource Guide or “Blue Book” for PLWHA (PC/OS).

- **Youth Aged 13-24.** Activities identified to meet the priority needs of African American MSM and Hispanic MSM will also benefit the minority and MSM members of this group. In addition, (1) RW/A will continue to fund SLW dedicated solely to the priority needs of youth (RW/A); and (2) RW/D programs targeting children and youth will be ongoing (RW/D).

(b) Activities to address cultural challenges that obstruct awareness of HIV status. Target Groups and the agencies that serve them have a central role in identifying and implementing activities to address cultural challenges. *Activities are ongoing for FY12 unless otherwise noted; responsible party is listed in parenthesis after each activity.* Two activities will be applied to *all* Target Groups, with tailoring based on unique cultural beliefs and values:

- 1. Culturally sensitive outreach to normalize awareness of HIV status.** HIV prevention funded-CBOs will continue to focus their HIV messaging, outreach, and HIV testing and counseling activities to members of Target Groups in ways that are culturally and linguistically appropriate and that address culturally-established patterns for avoidance of HIV status awareness. Activities include Effective Behavioral Interventions (EBIs) and other health education strategies (e.g., health fairs, awareness days, social marketing) (City).

- 2. Comprehensive HIV planning.** Efforts are being made to ensure that Target Group members are actively participating in the design of the 2012 Houston Area Comprehensive HIV Services Plan (Sept – May, 2012, PC/OS). This will better guarantee that the cultural challenges of Target Groups are considered during HIV services goal-setting for the next three years.

Additional tailored activities per Target Group are described below:

• **African American MSM.** (1) The mass HIV testing event, *HIP-HOP for HIV Awareness*, will continue. This is an annual event designed to de-stigmatize HIV testing in the African American, Hispanic, and youth communities. In 2009, 14471 HIV tests were conducted at the event, and 86 new positives were identified (0.6% positivity) (City). Other awareness days relevant to the Target Group are also commemorated. (2) Community collaborations that address the cultural challenges of this group will continue. These include M-Pact Houston (MSM Task Force), Urban AIDS Ministry, African American State of Emergency Task Force, and the Serving the Incarcerated and Recently Released (SIRR) coalition (RW/B).

• **Hispanic MSM.** (1) The mass HIV testing event, *HIP-HOP for HIV Awareness*, will continue for the Hispanic MSM population as well, and other relevant awareness days are commemorated (City). (2) Community collaborations focused on the needs of this group will also continue. These include the Latino Task Force and M-Pact Houston (MSM Task Force).

• **African American IDU.** Activities identified to address the cultural challenges to HIV awareness of African American MSM will also benefit members of this group. In addition, (1) Community collaborations focused on the needs of IDU will continue such as the newly-formed Harm Reduction Workgroup of the PPG's Hepatitis C Task Force. The Harm Reduction Workgroup will continue to support the de-criminalization of sterile syringe access programs such as syringe exchange as well as continue to make IDU aware of local pharmacies that sell sterile syringes without prescription (PPG). (2) The IDU Outreach Team will continue to reach-out to African American IDU to help normalize positive health-seeking behaviors (MCC).

• **Women of Childbearing Age.** Activities identified to address the cultural challenges to HIV awareness of African American MSM will also benefit the African American members of this group. In addition, (1) Beginning in 2010, Texas state law mandated additional HIV testing in the third trimester of pregnancy as well as rapid HIV testing upon delivery if the mother's HIV status is unknown. Policy changes like this help de-stigmatize HIV testing for women by making it a routine component of prenatal care and labor/delivery.

• **Youth Aged 13-24.** Activities identified to address the cultural challenges to HIV awareness of African American MSM and Hispanic MSM will also benefit the minority and MSM members of this group. In addition, (1) The City will continue to fund implementation of an evidence-based HIV prevention curriculum for middle schools developed by the UT Health Science Center at Houston called "*It's Your Game: Keep it Real.*" The curriculum uses structured lessons, journaling, and parent engagement to change youth cultural norms about sexual activity (City). (2) The Houston Independent School District (HISD), the State's largest district, will continue to implement HIV prevention curricula in grades 6-12 with funding from the CDC Department of Adolescent Health Services. Topics include media, family, and social and cultural norms about sexual activity (HISD). (3) Community collaborations focused on the needs of this group will also continue, including the PPG's Youth Task Force.

(3) Actions taken to facilitate HIV testing in the EMA/TGA

(a) Coordination with other organizations to facilitate HIV testing. Efforts by RW/A to facilitate HIV testing in the Houston EMA are described in Sec. 2) A. (1) (g) above.

(b) Role of Early Intervention Services in facilitating HIV testing. In FY 2011, the PC allocated TDSHS State Services funding to support Early Intervention Services (EIS) at the Harris County Jail HIV program. Additional EIS activities in the Houston EMA are provided by RW/C and are described in Sec. 2) A. (1) (h) above.

(4) Identifying, Informing, Referring, and Linking

• **For (a) – (d) i. a. and b.** All essential activities are able to be implemented immediately.

- ***For (a) – (d) ii)*** RW/A will continue to **coordinate with RW/B for the purpose of identifying, informing, referring, and linking individuals unaware of their HIV status.** The Statewide RW/B agency, the local RW/B administrative agency, and RW/B-funded subcontractors are all represented on the EAHC, and data sharing measures between RW/A and RW/B are described in Sec. 2) C (3) below. RW/B-funded agencies are also integrated into several core activities of the EIIHA Strategy. For example, RW/B-funded medical providers are encouraged to serve as POE for testing sites and are also listed in the EMA’s “Blue Book” used in making referrals to the newly-aware. Outcome Measures associated with the Strategy’s core activities of SLW and CM incorporate care received at RW/B-funded providers as an indication of effective linkage to care. RW/B is also a provider of targeted HIV testing. Together, these efforts ensure that the EIIHA Strategy is coordinated with RW/B status-unaware goals and that RW/B activities to inform the status-unaware are documented in EIIHA monitoring efforts.

- ***For (a) – (d) iii)*** RW/A will continue to **coordinate with prevention and disease control/intervention programs without supplanting funds for the purpose of identifying, informing, referring, and linking individuals unaware of their HIV status.** The HDHHS (City) is the CDC HIV Prevention directly-funded grantee in the EMA. The City, several of their subcontractors, and the local and Statewide HIV Prevention PPGs are all represented on the EAHC, and data sharing measures between RW/A and the City are described in Sec. 2) C (3) below. HDHHS programs are also integrated into several core activities of the EIIHA Strategy. For example, the vast majority of the Strategy’s efforts to identify the status-unaware through HIV testing are funded by HDHHS. The City’s public STD clinics are encouraged to serve as POE for RW/A-funded sites and are listed in the EMA’s HIV Resource Guide or “Blue Book.” In addition, beginning in 2009, RW/A has contracted with the City to employ four SLW at City-operated sites where PLWHA are newly-diagnosed. City-based SLW are also cross-trained in disease investigation (DIS). Though the City’s routine DIS activities are funded through non-RW/A sources, the RW/A-funded SLW have been established through a direct RW/A contract with the City as no alternate source of funds is available. As a result, there is no supplanting of funds to support collaboration between RW/A and the City on EIIHA Strategy implementation.

(a) IDENTIFYING individuals unaware of their HIV status

i) Activities essential for identifying HIV+ individuals who are unaware of their status.

- ***Routine HIV testing in the medical setting.*** The City has implemented routine HIV testing in the Houston EMA since 2008 using both CDC and State funds. Currently, the City provides routine testing in three public STD clinics and contracts for routine testing in seven emergency rooms, two FQHC locations, and three community health clinics. In 2010, these sites together provided 109,974 HIV tests and identified 1,605 new positives (1.5% positivity).

- ***Targeted HIV testing in high-risk communities and in non-traditional settings.*** The City also implements several targeted HIV counseling and testing (CTR) efforts in the EMA, including at the Harris County Jail, juvenile detention facility, and through a mobile testing van. The City also directly contracts with eight CBOs to provide CTR and other evidence-based interventions (e.g., EBI) targeting high-risk groups. Three RW/A-funded primary medical care sites are funded separately by the City to provide CTR. In 2010, the City’s targeted HIV testing efforts produced 17,046 HIV tests and identified 295 new positives (1.7% positivity). The City also supports HIV testing activities of the PPG’s six population-specific Community Task Forces, and at least eight additional CBOs in the EMA provide testing independent of the City. In 2010, the City launched a new intensive HIV testing initiative in the five EMA neighborhoods with the highest HIV/STD morbidity (the “SAFER Initiative”). Lastly, RW/B, C, and D provide targeted HIV testing to specific high risk groups such as women, youth, and rural EMA residents.

ii) and iii) See above

(b) INFORMING individuals of their HIV status

i) Activities essential for informing unaware individuals of their HIV status.

- *Disease investigation of newly-diagnosed PLWHA.* As the local health jurisdiction for the Houston EMA, HDHHS conducts routine disease investigation of all newly-reported HIV/AIDS cases, which centers on informing individuals of their HIV status. All newly identified HIV+ are reported to the City's HIV Surveillance Unit, and investigation is initiated within three days. It is also contract protocol for the City's directly-funded CBOs to conduct results notification for all newly identified HIV+ within seven days. In 2010, 29% of individuals testing positive in the EMA were informed of their status, including 93% of positives found through targeted testing, and 18% found through routine testing (See Attachment 10: HIV Testing and Awareness Data). Efforts to increase this percentage are being intensified by the EIIHA Strategy. For example, HDHHS has formed DIS Teams assigned to high volume providers, the Harris County jail and ERs. RW/A-funded SLW cross-trained as DIS serve on these teams. The City also requires funded CBOs to use structured CTR scripts that emphasize obtaining test results. HIV+ clients not counseled by the CBO within seven days must be referred to a DIS. The State RW/B agency also conducts disease investigation and results notification as part of targeted testing in the EMA.
- *Partner Counseling and Referral Services (PCRS).* As part of routine disease investigation, the City's DIS also conduct PCRS for partners of the newly-diagnosed. Of all risk categories, partners to a known PLWHA have the highest positivity; the City estimates that 10% of partners to the newly-diagnosed are also newly- positive. Through PCRS, partners are identified, located, notified, tested, and informed of their status. To further increase awareness of status, HDHHS has adopted a new policy of providing rapid HIV testing to partners of HIV+ in the field. According to recent data, DIS staff connects 60% of all partners to HIV+ index cases. RW/A-funded SLW cross-trained as DIS also provide PCRS. The State RW/B agency also conducts PCRS as part of their targeted testing efforts in the EMA.

ii) and iii) See above

(c) REFERRING to medical care and services

i) Activities essential to referring individuals recently informed of HIV+ status to care.

- *Point of Entry (POE) agreements.* The POE requirement has been in effect in the EMA since 2002; it mandates that all RW/A-funded primary medical care and case management providers maintain formal, signed agreements with a minimum of five community agencies or programs that serve as points of entry into care for the newly-aware. POE agreements define the minimum number of clients to be formally referred by each entity to the RW/A provider each year.
- *Service Linkage Workers (SLW).* Targeted, non-medical community-based case management provided by specially trained SLW is strategically embedded in locations where PLWHA are newly-informed of their status. There are currently 28 SLW in the EMA targeted as follows to:
 - Newly-diagnosed youth aged 13-24;
 - Newly diagnosed PLWHA informed at HIV testing sites, including routine HIV testing locations;
 - Newly-diagnosed PLWHA informed at public STD clinics; and
 - Newly-diagnosed PLWHA informed at RW/A Primary Medical Care locations.

Specific SLW activities include client intake and assessment, motivational interviewing and risk-reduction, and active referrals to medical, mental health, substance abuse, and psychosocial services. The SLW SOC requires that each newly-diagnosed PLWHA be transferred to a RW-funded Primary Medical Care or CM program within 120 days of intake. As noted above, four SLW are employees of HDHHS, funded by RW/A, and cross-trained as DIS.

- *Case Management (CM)*. CM in the Houston EMA is also strategically embedded in locations where PLWHA are newly-informed of their status. Like SLW, case managers connect individuals to medical, social, community, and financial needs. However, they also coordinate medical treatment as well as address mental health and substance abuse co-morbidities. There are currently 30 case managers in the Houston EMA system of care.

- *Distribution of the Houston HIV Resource Guide, or “Blue Book,” and “Mini-Blue Book.”* Biennially, the PC/OS produces the Blue Book, which contains information from 182 agencies in the EMA that can provide services to PLWHA. The book is widely distributed to individuals and service providers for use in making referrals to medical care and services. In 2011, the PC/OS began producing “mini-Blue Books” - these publications are miniature sized-versions of the full Blue Book designed specifically for incarcerated and recently-released PLWHA. Their inconspicuous size allows for easy transport and enhanced confidentiality. The PC/OS is currently collaborating with the TDCJ to print and distribute the mini-Blue Books.

ii) and iii) See above

(d) LINKING to Medical Care

i) Activities essential to ensuring access to medical care.

- *Service Linkage Workers (SLW) and Case Management (CM)*. In addition to referring the newly-aware to medical and supportive services, SLW and CM also make post-referral verification that services were accessed. Both are evaluated according to specific Outcome Measures designed to ensure access verification. These are described in detail below.

ii) and iii) See above

iv) Activities undertaken post-referral to verify that medical care/services were accessed.

- *Outcome Measures for the SLW Standard of Care*. Community-based non-medical case management in the EMA is evaluated according to four Outcome Measures. These measures serve as quantifiable verification that medical care/services are being adequately accessed by PLWHA who have been linked to care by SLW. Inability to meet stated outcomes is an indication that medical care/services are not being accessed adequately and corrective action is needed. The service linkage outcome measures are:

After accessing community-based case management,

- A minimum of 70% of clients will utilize Part A/B/C/D Primary Medical Care services two or more times at least three months apart.
- A minimum of 30% of clients will utilize Part A Local Medication Assistance services.
- A minimum of 25% of clients will utilize Part A/B Oral Health services.
- There will be an increase in the percent of clients who utilize mental health services.

- *Outcome Measures for the CM Standard of Care*. Like the SLW SOC, CM in the EMA is evaluated according to defined Outcome Measures. CM must demonstrate achievement of the SLW Outcomes Measures listed above as well as measures specific to coordination of medical treatment:

- 75% of clients will show improved or maintained CD-4 counts over time
- 75% of clients will show improved or maintained viral loads over time
- There will be an increase in the percent of clients who had hepatitis B and C screening

(v) Activities undertaken to form and maintain relationships with private HIV care providers. The process adopted by the PC to design the *2013-2015 Houston Area Comprehensive HIV Services Plan* places a high priority on identifying activities to form and maintain relationships with private HIV care providers. A workgroup has been established to develop goals and solutions for coordination of effort with private providers, and several private and non-profit service agencies are serving in leadership roles in the planning structure.

(vi) **Efforts to address legal barriers, including local and state laws and regulations, to routine testing.** There are no legal barriers to routine testing in the State or EMA.

2) C. Data

(1) **Estimated number of living HIV positive individuals who were unaware of their status as of December 31st, 2009.** Per the Estimated Back Calculation (EBC), the number of HIV+ status-unaware in the EMA for 2009 is 5,306. This is a slight increase from 2008 at 5,224.

(2) The EMA will continue to **coordinate with its RW/B counterpart with regard to data collection and sharing** through the use of CPCDMS, the EMA’s centralized client-level data system. CPCDMS contains service utilization, lab, and health outcome data for all RW/A and MAI-funded providers as well as for all RW/B, RW/C, and State Services-funded providers. CPCDMS is also being used by the HDHHS (City) to track newly-diagnosed cases identified at City-funded HIV testing sites until such time that their new client-level data system is implemented (see (3) below). CPCDMS data are exported monthly to the State’s Part B AIDS Regional Information and Evaluation System (ARIES).

(3) **Coordination with disease control and prevention/intervention with regard to data collection and sharing.** By the end of 2011, the City is scheduled to launch its Electronic Client Level Integrated Prevention System or eCLIPS, a complementary application to CPCDMS for tracking prevention activities including HIV testing. In its full iteration, eCLIPS will communicate directly with CPCDMS, and all referrals to care made by the City’s prevention and disease control/intervention staff to newly-aware PLWHA in the EMA will transmit electronically into CPCDMS. This direct connection between prevention and care data systems will further advance EIIHA goals by seamlessly tracking PLWHA from diagnosis by City prevention and disease control staff to engagement in RW care.

The total number of HIV tests conducted using federal, state, & local funds as of December 31st 2010 are included in Attachment 10: HIV Testing & Awareness Data.

2) D. Enhanced Comprehensive HIV Prevention Planning (ECHPP)

(1) **NHAS goals supported by Part A program and ECHPP initiative.** HDHHS (City) is the directly-funded CDC grantee for the *ECHPP* initiative serving the MSA of Houston-Baytown-Sugarland, Texas. The Part A program will collaborate with the City on the required ECHPP interventions listed in the chart below. How each collaborative activity supports NHAS goals is also noted:

Part A/ECHPP Collaborative Effort:	Supports the NHAS Goal of:
Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care”	“Increasing Access to Care and Improving Health Outcomes for People Living with HIV”
Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”	“Increasing Access to Care and Improving Health Outcomes for People Living with HIV”

Collaboration between the Part A program and the City to implement ECHPP also supports the NHAS goal of “Achieving a More Coordinated National Response to the HIV Epidemic.”

(2) **Planned activities of the Part A program to collaborate with the EMA’s ECHPP initiative** are described below. Timeline and responsible party are noted in parentheses.

- *Service Linkage Workers (SLW)*. The Part A program will continue to place SLW at HDHHS-funded ECHPP locations where PLWHA are newly-diagnosed, including routine HIV testing

sites and public STD clinics, for the purpose of linking these individuals to HIV care, treatment, and prevention services (ECHPP Required Intervention #6). As described elsewhere in this application, SLW provide targeted, non-medical community-based case management, including active referrals to medical care, mental health, substance abuse, supportive, and basic needs services. The SLW SOC requires each newly-diagnosed PLWHA to be transferred to RW-funded primary medical care or case management within 120 days. (FY12 Ongoing, RW/A)

- *Case Management (CM)*. The Part A program will continue to place CM in locations where newly-diagnosed or out-of-care PLWHA interact with the HIV system, including City-funded ECHPP locations, for the purpose of promoting retention in or re-engagement in care (ECHPP Required Intervention #7). In addition to making active referrals to services, CM includes coordination of medical appointments, treatment plans, and medication adherence to ensure improved health outcomes. CM is evaluated on specific RW-Outcome Measures related to CD-4, viral load, and stage of illness. (FY12 Ongoing, RW/A)

- *Data sharing*. The Part A program will continue to collaborate with the City on data collection using CPCDMS, which houses both RW- and ECHPP-related data (FY12 Ongoing, RW/A). By the end of 2011, the City will also implement a complimentary client-level data system called eCLIPS, which, in its full iteration, will bi-directionally communicate electronically with CPCDMS on service utilization, lab, and health outcome data (December 2011, City).

- *Comprehensive HIV Planning (CHP)*. The City maintains representation on the PC and its standing Comprehensive Planning Committee (FY12 Ongoing, PC); in addition, four members of the RPWC are also members of the Houston PPG and several of its Community Task Forces (FY12 Ongoing, PC). Moreover, representatives from Part A, the PC, the City and PPG are serving in leadership roles on the development of the *2013-2015 Houston Area Comprehensive HIV Services Plan* (September – May 2012, PC).

Attachment 9: EIIHA Matrix, Houston EMA

<p>P1. <u>ALL</u> Individuals in the Houston Area EMA who are Unaware of their HIV Status <i>(HIV Positive & Negative – Tested & Untested – Publically & Privately Tested)</i></p>					
<p>P2. Tested in the Past 12 Months</p>			<p>P3. Not Tested in the Past 12 Months</p>		
<p>P4. Individuals Informed of Status <i>(Not Linked to Care)</i></p>	<p>P5. Individuals Not Informed of Status <i>(HIV positive & HIV negative)</i></p>	<p>P6. Historically High Risk Populations <i>(African Americans, Hispanics, MSM, Substance Abusers/IDU)</i></p>		<p>P7. Moderate & Low Risk Populations</p>	
		<p>MSM</p>	<p>IDU</p>	<p>T4. Youth Aged 13-24</p>	<p>T5. Women of Child-Bearing Age</p>
		<p>T1. African American MSM</p>	<p>T2. Hispanic MSM</p>	<p>T3. African American IDU</p>	<p>P8. Rural</p>