

Executive Summary

The mission of the 2017-2021 Houston Area Comprehensive HIV Prevention & Care Services Plan (2017 Comprehensive 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 living with, affected by, or at risk for HIV.

The purpose of the 2017 Comprehensive Plan is to: (1) identify HIV prevention and care needs, existing resources, barriers, and gaps within the Houston Area; (2) outline a specific, measurable, achievable, realistic and time-phased (SMART) Integrated HIV Prevention and Care Plan designed to leverage existing and/or new resources and partnerships to meet HIV prevention and care needs, remove barriers, and bridge gaps; and (3) describe the process by which implementation of the Integrated HIV Prevention and Care Plan will be measured, evaluated, and adjusted to best meet the needs of people living with or at-risk for HIV in the Houston Area.

The 2017 Comprehensive Plan for HIV Prevention and Care Services is a collaborative project of Houston Health Department - Bureau of HIV/STD & Viral Hepatitis Prevention, the Houston HIV Prevention Community Planning Group, the Ryan White Planning Council & Office of Support, Harris County Public Health - Ryan White Grant Administration, and the Houston Regional HIV/AIDS Resource Group, Inc.

The plan is intended for use by local HIV planning bodies, Administrative Agents and grantees, providers of HIV prevention and care services, both new and established community partners, and other decision makers as they respond to the needs of people living with or at-risk for HIV over the next five years. The plan is organized into three sections summarized below.

Section I: Statewide Coordinated Statement of Need/Needs Assessment - HIV

prevention and care services are provided in the Houston Area throughout three distinctly defined service areas:

- *The Houston Metropolitan Statistical Area (MSA)* includes Harris County and the cities of Houston, Baytown, and Sugarland, TX. The Centers for Disease Control and Prevention's (CDC) HIV prevention funding and activities are administered in in the MSA.
- *The Houston Eligible Metropolitan Area (EMA)* is the geographic service area defined by the Health Resources and Services Administration (HRSA) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (MAI). It includes Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller Counties.
- *The Houston Health Services Delivery Area (HSDA)* includes the six counties of the Houston EMA plus four additional counties: Austin, Colorado, Walker, and Wharton. The Houston Regional HIV/AIDS Resource Group (TRG) administers TDSHS Ryan White HIV/AIDS Program Part B and State of Texas HIV care services funding and activities in the HSDA. Epidemiologic data for the HSDA are provided by TDSHS.

Together, the Houston MSA, EMA, and HSDA cover 9,415 square miles of southeast Texas, or 3.5 percent of the entire state, and are home to more than 6.1 million residents, the vast majority of whom (74%) reside in Houston/Harris County (U.S. Census Bureau, 2015).

There were 22,551 people living with HIV (PLWH) in Houston/Harris County by the end of 2013, and 26,041 PLWH in the Houston EMA by the end of 2015. In 2014, 1,288 new HIV diagnoses were reported among people aged 15 or older in Houston/Harris County. Since 2004, the rate of *new* HIV diagnoses in the Houston Area has remained relatively constant, though in 2014, 4 out of 5 new HIV diagnoses were among males, and 43% of the newly reported male cases were African American. The rate of new HIV diagnoses in African American men was 4.6 times the rate of white men, and 2.8 times that of Hispanic men. African American women were newly diagnosed with HIV at a rate 21.1 times that of white women and 5.8 times that of Hispanic women. Among males, men who have sex with men (MSM) was the largest risk category, with 90% of all newly diagnosed cases among whites and Hispanics and approximately 80% among African Americans being categorized as MSM. The two age groups with the highest rate of new HIV diagnoses were the age groups 15-24 and 25-34. African Americans 15-24 years of age had an HIV diagnosis rate 7.6 times that of whites. Similarly, the rate in African Americans 55 years or older was 7.7 times that of their white counterparts. It is further estimated that an additional 5,448 people in the Houston EMA are currently HIV-positive but unaware of their status, and that 6,333 individuals *are* aware of their HIV-positive status, but are not in HIV care.

The **Houston EMA HIV Care Continuum** (HCC) describes community-wide access and service gaps in HIV medical care. In 2014, 75% of all diagnosed PLWH had evidence of HIV medical care (met need), 61% were retained in care, and 55% reached viral suppression by their last viral load test of the year. Among new diagnoses, 80% were linked to HIV medical care within 3 months. Younger adults had lower percentages of retention and viral suppression compared to older adult age groups, and youth and young adults (13-24 years old) had the lowest proportion of newly diagnosed PLWH who were linked within three months of diagnosis, compared to older adults. Females had a higher proportion of individuals with met need and retention in care than males, but had a lower proportion who were virally suppressed. The proportion of newly diagnosed female PLWH linked to care within the first three months after diagnosis was higher than that for males. When birth sex and race/ethnicity groups were evaluated together, Hispanic and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need, retention in care, and viral suppression among males. Among females, White (non-Hispanic) and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of retention in care and viral suppression. Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals in each HCC stage across all birth sex and race/ethnicity groups.

Although MSM had higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV show met need and retention in care similar to those observed for all risk groups. MSM had a higher proportion of diagnosed PLWH who reached viral suppression, but a lower proportion of newly diagnosed PLWH who were successfully linked to care within three months of initial diagnosis. Injection drug users (IDU) exhibited the lowest proportions of both met need and viral suppression compared to other risk factor categories.

The Houston Health Department, Harris County Public Health, and The Houston Regional HIV/AIDS Resource Group designed and conducted a survey of the **financial and human resource capacity** of agencies in the Houston Area. Across the 17 agencies surveyed, the total

amount of current fiscal year HIV funding reported was approximately \$55.7 million. Of the total HIV funding received within the Houston Area, the highest percentages were Ryan White Part A, CDC, and urban HOPWA funding, while the lowest percentages were rural HOPWA, Ryan White Part F and AETC sub-contracted from another agency, and Community Development Block Grant.

The Houston Area maintains approximately 486 full-time employees (FTEs) to direct HIV care and prevention services. The service with the most FTEs was administration, with about 80 FTEs, followed by HIV medical care (72 FTEs), linkage to HIV medical care (67 FTEs), and HIV testing (51 FTEs). The latter three services also contain the most diverse portfolio of workforce categories, with numerous personnel representing the wide range of skills needed to manage these services and maximize their delivery to the communities in need. Despite the large number of FTEs representing the total workforce capacity, it requires a significant amount of dedication and support to execute the extensive HIV services available in the Houston Area, each of which require regular monitoring and evaluation to ensure the community's needs are being met. Furthermore, new services are being introduced as former ones are being adapted to best serve the targeted populations most at-risk or in-need of assistance, necessitating a dynamic workforce that is flexible and capable of expansion.

The HIV services with the fewest FTEs, with 1 FTE or less, total, were capacity building for HIV services, condom distribution, health insurance premium and cost sharing assistance for HIV-positive individuals, HIV advocacy, insurance navigation for HIV-positive individuals, linkage to substance abuse/mental health services, patient navigation to any service regardless of HIV status, program promotion, research projects for HIV-positive persons, and translation services for HIV-positive persons. The workforce categories with the fewest FTEs, with 1 FTE or less, total, were patient advocate, physical therapist, physician assistant, psychiatrist, public affairs specialist and translator.

As the service needs, gaps, and barriers among people living with HIV (PLWH) and high-risk individuals who are HIV-negative or status unaware can vary greatly, two separate but aligned **needs assessment** surveys are conducted in the Houston Area sampling 1) all people who live in Houston/Harris County, and 2) all PLWH in the Houston EMA or HSDA. Among all people living in Houston/Harris County, HIV prevention service needs and gaps included but were not limited to:

1. Additional HIV testing and social marketing activities to increase awareness of the importance of testing and that reduce stigma, including social meeting marketing;
2. Availability of free or reduced-cost HIV testing and formatting of HIV testing messages for easier and widespread promotion
3. Testing services provided in multiple languages;
4. Substance abuse and risk reduction services provided concurrently with HIV prevention and care services, particularly to address the prevention needs of people with anonymous sex partners; and
5. Increased PrEP promotion and education.

Barriers to HIV prevention services included but were not limited to:

1. Social, structural and client-specific barriers like stigma and discrimination, cultural resistance to sexual and gender related topics, low educational attainment, poverty, and lack of health care coverage, and the geographic size of the Houston Area;
2. Texas policy barriers like sexual and reproductive health policies, the ban on syringe exchange programs, and the non-expansion of Medicaid;
3. Health department barriers like need that has outpaced dedicated HIV funding, no general city revenues dedicated to HIV services, incomplete surveillance reporting for clinical trials, and lack of informatics funding;
4. Program barriers such as multiple data systems managed by varied entities and lack of HIV screening for Harris County Jail inmate released prior to the 14 day intake medical assessment or upon release; and
5. Provider barriers and increased stakeholder representation due to the size and complexity of the Houston medical system.

Among PLWH in the Houston EMA or HSDA, the most needed HIV care services were primary care, followed by case management, local medication assistance, and oral health care. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Needed services that are currently not funded through Ryan White in the Houston Area included food bank, emergency financial assistance, housing-related services and support groups. PLWH in the Houston EMA also indicated that they needed employment assistance and job training, vision hardware/glasses, and services for partner Prevention needs for PLWH identified were increased screening for other sexually transmitted infections, PrEP and PrEP resource awareness, and consistent condom use education and promotion that address HIV reinfection/superinfection.

Barrier to HIV care services most often related to:

1. Service education and awareness issues;
2. Wait-related issues (particularly for oral health care and housing services)
3. Interactions with staff;
4. Eligibility issues; and
5. Administrative issues.

General system and social barriers to HIV care services included:

1. Experiencing stigma, violence, and poverty;
2. Health care coverage issues, including the absence of Medicaid expansion in the State of Texas and coverage gaps;
3. Substance use, co-morbid health conditions, diagnosed and undiagnosed co-morbid mental health conditions; and
4. Housing instability and lack of transportation.

Primary data systems used in the Houston Area are the Enhanced HIV/AIDS Reporting System (eHARS) the Sexually Transmitted Disease Management Information System (STD*MIS), Evaluation Web, the Electronic Client-Level Integrated Prevention System (ECLIPS), the Houston Electronic Disease Surveillance System (HEDSS), the AIDS Regional Information and Evaluation System (ARIES), and the Centralized Patient Care Data Management System (CPCDMS). The Houston Area is uniquely challenged in that HIV prevention and HIV care

services are not administered by the same government agency and, as such, data for care and prevention are managed by separate entities, limiting the ability of any agency to access and analyze data across systems.

Section II: Integrated HIV Prevention and Care Plan – Since creation of the last Houston Area Comprehensive HIV & Care Services Plan (2012-14, extended through 2016), changes in local initiatives like End New Diagnoses Houston, advances such as Treatment as Prevention (TasP) and pre-exposure prophylaxis (PrEP), and implementation of the Affordable Care Act (ACA) have necessitate creation of a new plan to identify specific strategies to *sustain, scale-up, shift* (in terms of new priorities or needs), or *shore-up* the HIV prevention and care services system.

The vision for this process is that the “*greater Houston area will become a community with an enhanced system of HIV prevention and care. New HIV infections will be reduced to zero. Should new HIV infections occur, every person, regardless of sex, race, color, ethnicity, national origin, age, familial status, marital status, military status, religion, disability, sexual orientation, genetic information, gender identity, pregnancy, or socio-economic circumstance, will have unfettered access to high-quality, life-extending care, free of stigma and discrimination.*”

To make progress toward this vision, several influences must be addressed including: resources or resource distribution that do not meet need, continued disparities in HIV infection, the presence of co-occurring conditions and behavioral health concerns among PLWH, and overall community education, awareness, and mobilization around Houston Area HIV-related issues.

In light of these factors, the Houston Area has identified six NHAS-aligned six overall goals for the HIV prevention and care services system over the next five years:

1. Increase community mobilization around HIV in the greater Houston Area (aligned with NHAS 2020 Goal 1: Reducing New HIV Infections and Goal 4: Achieving a More Coordinated National [and Local] Response to the HIV Epidemic);
2. Prevent and reduce new HIV infections (aligned with NHAS 2020 Goal 1: Reducing New HIV Infections);
3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services; (aligned with NHAS 2020 Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV);
4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care (aligned with NHAS 2020 Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV and Goal 3: Reducing HIV-related Disparities and Health Inequities);
5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations (aligned with NHAS 2020 Goal 3: Reducing HIV-related Disparities and Health Inequities); and
6. Increase community knowledge around HIV in the greater Houston area (aligned with NHAS 2020 Goal 1: Reducing New HIV Infections, Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV, and Goal 4: Achieving a More Coordinated National [and Local] Response to the HIV Epidemic).

There are several high impact solutions for achieving system wide improvements in HIV prevention and care services in the Houston Area, including structural interventions such as policy change, HIV testing, engagement and retention in continuous HIV care, technology, and improved coordination of effort among current and new partners. These solutions and others have been incorporated into four strategies:

1. *Strategy for HIV Prevention and Early Identification*
2. *Strategy to Bridge Gaps in Care and Reach the Out of Care*
3. *Strategy to Address the Needs of Special Populations*
4. *Strategy to Improve Coordination of Effort*

Each strategy includes goals, solutions aligned with NHAS goal steps, benchmarks, and SMART activities to be conducted over the next five years to make progress toward long-range goals.

Section III: Monitoring and Improvement – Regular communication between responsible parties, local HIV planning bodies, and the Houston HIV community on progress toward the vision and goals of the 2017 Comprehensive Plan will be accomplished through real-time quarterly activities monitoring and annual benchmark and activities evaluation of 2017 Comprehensive Plan. Long-range progress will be measured by the extent to which the following System Objectives are accomplished the following by 2021:

1. Reduce the number of new HIV infections diagnosed in the Houston Area by at least 25% from 1,386 (2014) to $\leq 1,004$;
2. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through targeted HIV testing who are informed of their positive HIV status, beginning at 93.8% (2014);
3. Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within one month of their HIV diagnosis to at least 85% from 66% (2015);
- 4.1 Decrease the percentage of new HIV diagnoses with an HIV stage 3 (AIDS) diagnosis within one year by 25% from 25.9% (2014) to 19.4% ;
- 4.2 Decrease the percentage of new HIV diagnoses with an HIV stage 3 (AIDS) diagnosis within one year among Hispanic and Latino men age 35 and up by 25% from 36.0% (2014) to 27.0%;
5. Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) from 75.0 % (2014) to at least 90.0%;
6. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are retained in HIV medical care (at least two documented HIV medical care visits, viral load or CD4 tests in a 12 month period) from 60.0% (2015) to at least 90.0%;
7. Maintain, and if possible, increase the proportion of Ryan White HIV/AIDS Program clients who are virally suppressed from 80.4% (2014) to at least 90.0%;
8. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed from 57.0% (2015) to at least 80.0% (NHAS 2020 Indicator 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%); and
9. Increase the number of gay and bisexual men of color and women of color receiving pre-exposure prophylaxis (PrEP) education each year (baseline to be developed) to at least 2,000.