

**Houston Department of Health and Human Services
Bureau of HIV/STD and Viral Hepatitis Prevention**



**Enhanced Comprehensive HIV Prevention Planning and
Implementation for Metropolitan Statistical Areas Most Affected by
HIV/AIDS (ECHPP) for
Houston-Baytown-Sugarland, Texas**

March 15, 2011



Houston Department of Health and Human Services
Bureau of HIV/STD and Viral Hepatitis Prevention
CDC PS10-10181 - ECHPP

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Enhanced Comprehensive HIV Prevention Planning

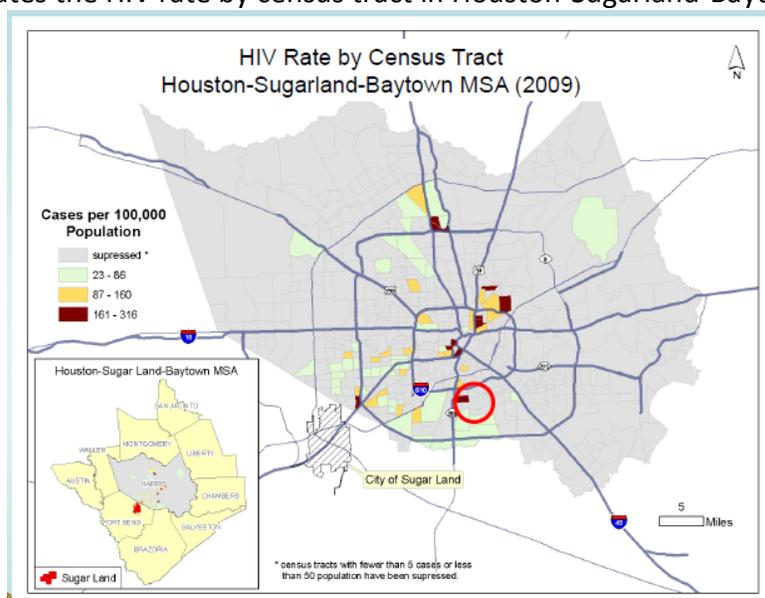
Introduction

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with and measurable targets to be achieved by 2015. The NHAS is intended to refocus our existing efforts and deliver better results within current funding levels, as well as demonstrate the need for new investments. It is also a new attempt to set clear priorities and provide leadership for all public and private stake-holders to align their efforts toward a common purpose. There are three primary goals outlined in the strategy:

1. Reducing the number of people who become infected with HIV;
2. Increasing access to care and optimizing health outcomes; and,
3. Reducing HIV-related health disparities.

Through the Centers for Disease Prevention and Control's (CDC) funding announcement PS10-10181, the Houston Department of Health and Human Services (HDHHS) received funding support to develop an Enhanced Comprehensive HIV Prevention Plan that would outline local strategies to achieve the goals outlined in the National HIV/AIDS Strategy. The development of a localized enhanced plan should call for effective planning and implementation of HIV prevention and care services. Information about who is infected, their backgrounds and risk factors should lay the foundation for local and regional prevention and care planning, and would cover the Houston Metropolitan Statistical Area (MSA) which includes the cities of Houston, Baytown and Sugarland. Baytown and Houston are located within Harris County, and Sugarland and some parts of Houston are located within Fort Bend County.

The map below illustrates the HIV rate by census tract in Houston-Sugarland-Baytown MSA in 2009:



At the lower left corner is an area map that includes Houston and surrounding counties. The gray area is Houston/Harris County and it has the most HIV morbidity. The red circle indicates the Sunnyside/South Park area of Houston, where the S.A.F.E.R. Initiative (Innovative Intervention #26) has already begun.

Historically, all local and regional planning for HIV prevention and treatment services encompasses a larger area to include the Houston Eligible Metropolitan Statistical Area or (EMA), a six county area with Harris County/Houston at the center. Other counties comprising the EMA include: Chambers, Fort Bend, Liberty, Montgomery and Waller.

Spanning more than 1,700 square miles with nearly 3.7 million residents, Harris County is the most populous county in Texas and the third most populous county in the United States. Harris County remains the eighth most HIV/AIDS impacted local jurisdiction in the United States. Within Harris County, the City of Houston covers more than 600 square miles with over 2 million residents, making it the fourth most populous city in the United States. The City of Houston accounts for more than 95% of HIV and AIDS cases within Harris County. The number of AIDS cases as of June 30, 2010 is 26,599. The number of reported HIV cases (regardless of AIDS status) among adult and adolescent residents is 17,907.

Using new technology developed by CDC ¹, HDHHS estimated 1,700 people were newly infected with HIV in 2006 in Harris County (HIV incidence =1,700). Based upon the CDC nationwide prevalence estimates ², HDHHS estimated 26,500 people were living with HIV in Harris County in 2006 (HIV prevalence=26,500). As a result, the HIV transmission rate is 6.4% ($1700/26500 \times 100\% = 6.4\%$). Reducing the annual number of new HIV infections has a correlation on reducing the number of opportunities HIV can be transmitted. ***In order to meet the goals outlined in the NHAS of reducing the annual number of new HIV infections by 25% and reducing the HIV transmission rate by 30% locally, by 2015 the HDHHS will seek to reduce the annual number of new infections to 1,275 and realize a reduced transmission rate of 3.7%(1275/33810)*.***

Based on the CDC estimates that 25% of those infected with HIV are unaware of their status, there are an estimated additional 4,000 to 6,000 people who are HIV infected in Harris County. These persons are not accessing HIV specific medical care, can benefit from such care and may be unknowingly transmitting HIV to sexual and drug using partners. Between 2000 and 2007 in Houston/ Harris County, 37% of those diagnosed with HIV (regardless of AIDS diagnosis) were diagnosed with HIV and AIDS within the same year. This indicates that, for over a third of Houstonians living with HIV and AIDS, HIV is being detected late in the progression of the disease. Concurrent HIV/AIDS diagnoses can be attributed to many factors, including lack of access to care, lack of health insurance, stigma, and lower self-perceived risk of HIV infection.

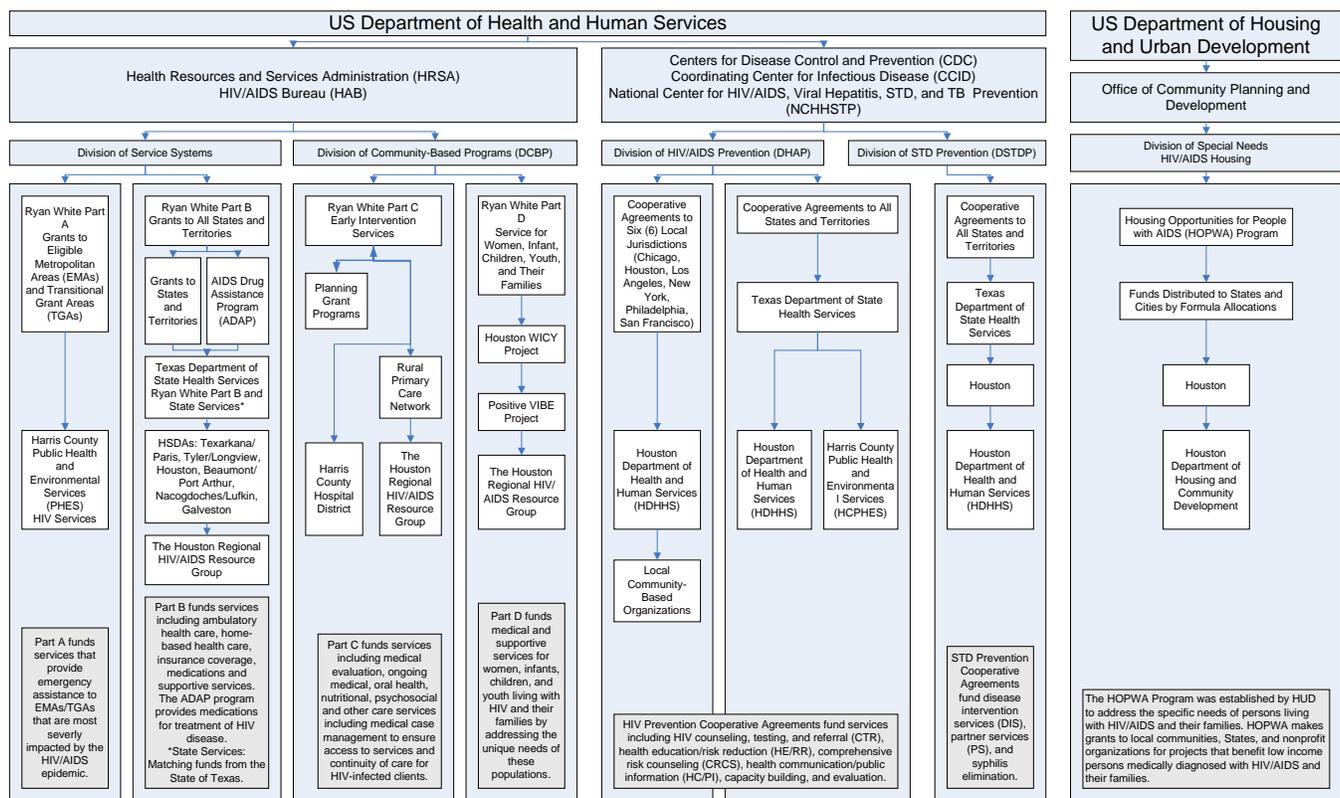
In addition and conversely, many new HIV infections involve persons without the appropriate level of knowledge, skills, resiliency or support to avoid or reduce risk behavior – hence our emphasis on broad sets of interventions for high-risk HIV-negative persons. Finally, some infections involve persons who face multiple and complex life challenges, including substance abuse, childhood abuse and mental illness, among others, that demand intensive and ongoing interventions (e.g., comprehensive risk counseling services) to keep persons either HIV infection risk free or HIV transmission risk free.

A closer look at HIV/AIDS prevalence in Harris County shows that the epidemic continues to be predominantly among males (74%), specifically among men who have sex with men (43%) and among people of color (70%). The most striking change in the local epidemic over the past decade has been a

shift to communities of color. The proportion of HIV-infected Latinos in Harris County is slightly higher than in the United States as a whole, and the new HIV diagnosis rate among African-Americans in Harris County remains much higher than in other racial/ethnic groups.

HIV Resource Allocation and Planning

The following chart documents the flow of federal funding streams originating from various government agencies responsible for the administration and allocation of HIV/AIDS prevention, treatment and other related care services. These funding resources are locally overseen by different fiscal organizations, or administrative agencies and planning bodies. Consequently, the planning and service provision areas are also different. This ECHPP document also seeks to present a brief geographic description of the different HIV planning areas that would be expected to benefit from and utilize this Comprehensive Plan.



There are three primary planning groups in Houston/Harris County that provide guidance to HIV/AIDS prevention and care services. The three planning bodies implement HIV/AIDS policy initiatives set by federal, state, and local governments that ensure that HIV prevention and care services are provided to the community in the most efficient, comprehensive, culturally appropriate manner possible. Each of the three planning bodies develops planning documents; conducts needs assessments, and collaborate with each other. The three planning bodies include:

Ryan White Planning Council (RWPC): The RWPC is a 40-member volunteer group of community members who help determine which services are most needed by people living with HIV in the Houston EMA. The RWPC prioritizes the services and decides the best way to allocate funds received under Part A (emergency aid to cities) and Part B (aid to states and territories) of the Ryan White HIV/AIDS Treatment Modernization Act as well as State Services dollars. The RWPC does not directly fund or

contract with agencies to provide client services. The Harris County Public Health & Environmental Services (HCPHES), Grants Management Section of Ryan White Grant Administration oversees the administration of Ryan White Part A grant funding to providers of HIV/AIDS services in the Houston EMA. The RWPC evaluates how well the Grants Management Section performs in contracting the provision of services.

Houston HIV Prevention Community Planning Group (CPG): The CPG is a Comprehensive Planning group that works toward improving the effectiveness of services at local health departments and community-based organizations as they develop and implement HIV prevention programs. Representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention providers and health department staff work together to create an HIV prevention plan for Harris/County that will be responsive to the local epidemic.

History of the Comprehensive Planning Committee

In 1999, the RWPC led local planning groups and many others in the community in the creation of the first Comprehensive Planning Committee (CPC). The CPC served as an *ad hoc* committee of the RWPC, but was composed of the people who plan for, administer, provide, and use HIV care and prevention services in all ten counties of the HSDA (see Section I for a map of the area). The first meeting took place in March 1999, with over 100 people in attendance, to discuss the reasons for a Comprehensive Plan and the structure of the process. The CPC then developed a mission so that the members could clarify the purpose of the CPC and provide a framework for making decisions, a vision that described how the plan was to work, and shared values that were to be the guiding principles that shaped the system of care.

Members of the workgroups developed and prioritized critical issues based on what are called the “Five A’s”: affordable, accessible, appropriate, available, and accountable. The idea was to develop a system in which services were *affordable* to all people at risk for or living with HIV and their families, *accessible* to all people, *appropriate* for different cultural and socioeconomic populations, *available* to meet the needs of all people, and *accountable* to the funding sources and consumers for providing services at high quality. For many years, representatives from all of the participating planning bodies met quarterly through membership on the Joint Comprehensive Planning Committee (JCPC). The goal of this free-standing committee was to monitor the progress being made by the different planning bodies in meeting the goals outlined in the plan. In 2003, with the consent of the other planning bodies, the function of the JCPC was folded into the HIV Planning Committee, a standing committee of the Ryan White Planning Council. Membership on the standing committee continues to include representation from the other planning bodies of both the RWPC and the CPG.

Under the Ryan White Treatment Extension Act for FY 2011, there were new responsibilities outlined for Ryan White Part A programs. The Houston MSA with its unique in Texas situation of having a directly-funded CDC grantee, the City of Houston, will further collaborate locally with the local Ryan White and State of Texas grantees. An Ad-Hoc Committee (AHC), convened by the Houston RWPC and Houston CPG, will serve as the planning vehicle for developing a long term and sustainable ECHPP to identify and bring the status unaware into care. The HDHHS will assist in guiding the process of transitioning the efforts of the Ad-Hoc Committee into ongoing CPG and RWPC activities. The RWPC and CPG planning bodies have each appointed a representative to serve as co-chairs for the AHC. AHC membership consists of key stakeholders from both care and prevention who can contribute to the planning and implementation of the new testing initiative. Stakeholders representing HIV care include Part A-funded

primary medical clinics and other points of entry for newly-diagnosed PLWHA, RWPC committee members and the local administrative agency for RW Part B and State funds. HIV Prevention stakeholders include the Harris County Hospital District's Opt-Out routine HIV/AIDS Testing Program, the HDHHS Bureau of HIV/STD Prevention, the Texas Department of State Health Services HIV/STD Program, community-based HIV, Hepatitis C, STD and TB testing sites, CPG committee chairs, the TDSHS Statewide CPG and local perinatal testing providers.

Executive Summary

The purpose of this ECHPP is to, a) to provide a road map for developing a system of care; b) to present a detailed picture of the local HIV/AIDS epidemic, and; c) to guide decisions about HIV-related services and resources in our area that are consistent with the goals of the National HIV/AIDS Strategy. This plans also outlines goals, objectives, and strategies for delivering the optimal combination of prevention, care and treatment services to maximally reduce new infections. By reviewing needs assessment and other data (evaluation, contract monitoring), the plan will seek to identify existing resources to meet those needs, and barriers to care. It also reflects the community's vision and values about how to best deliver HIV/AIDS care, particularly in light of limited resources.

The ECHPP will serve as a more focused, results-oriented supplement to both the Houston Area HIV/STD Prevention Comprehensive Plan developed by the Houston Area Community Planning Group, and the Houston Area Ryan White Comprehensive Plan developed by the Houston Area Ryan White Planning Council. This supplemental plan focus intensive strategy not currently developed in either existing jurisdictional plan.

The enhanced plan will:

1. Review the current distribution of HIV prevention, care and treatment resources, and evaluate the extent to which these current resources are distributed to maximally reduce HIV incidence. This will include an examination of:
 - a. current services (the extent to which persons at greatest risk for acquisition or transmission are being appropriately targeted with a a combination of services that are appropriate for that community);
 - b. intervention effectiveness (extent to which interventions are evidence-based and effective in reducing HIV at the population-level and
 - c. resource distribution (extent to which resource-intensive interventions are targeted for people and communities at highest risk of HIV acquisition or transmission).
2. Address gaps in coverage and/or realign resources to maximally reduce HIV incidence in the jurisdiction. This will include a plan to coordinate services at different points along the continuum of HIV prevention, care and treatment.

Meeting the goals and objectives that will outlined in the plan will entail leveraging existing strengths within the Houston area MSA, including well established, productive relationships between both the prevention and care planning councils, the administrative agencies of both prevention and care funding, as well as with the State of Texas HIV administration branch and statewide planning groups.

This ECHPP will be used by community-based planning bodies in order to:

- Utilize resources so that they have the biggest impact on HIV incidence
- Identifying and addressing gaps in scope and reach of prevention activities among priority populations

- Enhancing coordination between prevention, care and treatment
- Provide supporting documentation for annual federal, state and local grant applications including, but not limited to, the Centers for Disease Prevention and Control (CDC), Health Resources and Services Administration (HRSA) and the Texas Department of State Health Services (DSHS).

Methodology

This ECHPP was developed and assembled from existing area comprehensive and strategic plans related to HIV/AIDS prevention, care, and support administrations. These existing plans were developed and or updated using several mechanisms for community input. Various approaches – mailed surveys, community meetings and provider interviews – ensured that the update process incorporated a wide range of input from HIV and non-HIV segments of the Houston community. By making deliberate efforts to include providers outside of the traditional CDC and Ryan White funded networks, the reach of the ECHPP extends beyond the “usual players” and brings fresh voices to the planning table.

Staff from the Bureau of HIV/STD Prevention, RWPC Office of Council Support and Ryan White Grant Administration worked collaboratively over the course of three months to assemble this ECHPP. Specifically the Sr. Health Planners, and IT Programmer from the HDHHS, public health analysts, all provided technical expertise in support of this effort.

Workbook #1: SITUATIONAL ANALYSIS & GOAL SETTING

Required Intervention #1: “Routine, opt-out screening for HIV in clinical settings”

A: Situational Analysis

HDHHS STD Clinics

In 2009, routine, opt-out HIV testing was offered in five HDHHS STD clinics using a conventional laboratory test. In 2009, the HD spent approximately \$222,222.00 in general revenue on overall services for HIV/STD clinic staff and services. In 2010, HIV testing was decreased to only three clinics, including Lyons, Sharpstown and Sunnyside clinics due to budget cuts and staffing reductions in City of Houston general tax revenue support for clinical health services.

Emergency Rooms

In 2009, HDHHS continued to work with collaborators on the CDC CTR Expansion project (PS07-768) to continue implementation of routine, opt-out HIV screening in three (3) high-volume emergency departments and two **Federally Qualified Health Centers (FQHC)**. Currently, HDHHS continues to guide implementation of routine, opt-out HIV screening in clinical settings within the Harris County Hospital District (HCHD) through Lyndon B. Johnson (73,000 annual visits), Ben Taub General Hospital(94,000 annual visits), and Thomas Street Health Center; within the Memorial Hermann Healthcare System emergency rooms via Clinical Innovation & Research and the University of Texas Medical School; within the two FQHC, Legacy Community Health Center on Westheimer and Lyons Avenue Health Center.

Baytown

There are two clinics in the Baytown area that offer HIV testing. Both clinics are provided by Harris County Public Health and Environmental Services and they include, Baytown Health Clinic and the LaPorte Health Clinic. Texas Department of Health Services also offers HIV testing at their Baytown Health Clinic location.

Other HIV testing is offered on a payment basis by “Same Day Testing Centers.” They have two locations; West Baker Road and Garth Road.

Sugarland

Testing offered by the [Fort Bend County Department of Health and Human Services](#) is done through partner services by the state regional STD program and through collaborations upon referral with local nonprofit organizations that includes, St. Hope Foundation and Planned Parenthood. Many residents of Fort Bend County access services in Harris County due to the lack of HIV routine opt out testing offered in the region.

Additional testing is provided by [Planned Parenthood of Houston and Southeast Texas Incorporated](#) located in the Rosenberg and Stafford areas.

The tables below summarize all HDHHS supported testing for years 2009 & 2010. Annual numbers of HIV tests is expected to increase annually throughout the ECHPP Project Period.

2009

| Venue Type | # of Tests | # Positive | Pos Rate | Funding Amount | Funding Source |
|--|---------------|-------------|--------------|------------------------|---------------------|
| Emergency Departments | | | | | |
| Memorial Hermann-TMC | 13841 | 126 | 0.91% | \$ 130,000.00 | CDC Expanded |
| Memorial Hermann-SW | 2831 | 49 | 1.73% | \$ 21,000.00 | DSHS |
| HCHD-Ben Taub | 34298 | 623 | 1.82% | \$ 183,720.00 | CDC Expanded |
| HCHD-LBJ | 12227 | 226 | 1.85% | \$ 61,240.00 | CDC Expanded |
| FQHCs & Community Based Clinics | | | | | |
| Legacy-215 | 1455 | 40 | 2.75% | \$ 93,569.00 | CDC Expanded |
| Legacy-Lyons | 970 | 27 | 2.78% | \$ 93,569.00 | CDC Expanded |
| Corrections | | | | | |
| Harris County Jail | 8330 | 130 | 1.56% | N/A | DSHS |
| Juvenile Detention Facility | 2108 | 0 | 0.00% | N/A | DSHS |
| HDHHS Clinics | | | | | |
| Sunnyside | 3681 | 62 | 1.68% | | COH GF |
| Lyons | 3956 | 82 | 2.07% | | COH GF |
| Sharpstown | 5047 | 103 | 2.04% | | COH GF |
| Riverside | 2434 | 52 | 2.14% | | COH GF |
| Casa | 1238 | 18 | 1.45% | | COH GF |
| STD Mobile | 1838 | 56 | 2.99% | \$ 19,363.00 | COH GF/DSHS |
| Community Based CTR Agencies | | | | | |
| Legacy | 500 | 24 | 4.80% | \$ 337,138.00 | CDC |
| AFH | 333 | 3 | 0.90% | \$ 56,500.00 | CDC |
| St. Hope | 540 | 23 | 4.26% | \$ 158,900.00 | CDC |
| Career & Recovery Resources | 1502 | 35 | 2.33% | \$ 156,959.00 | CDC |
| HACS | 250 | 2 | 0.80% | \$ 75,000.00 | CDC |
| NAACP | 390 | 2 | 0.51% | \$ 127,981.00 | CDC |
| Positive Efforts | 632 | 7 | 1.11% | \$ 150,000.00 | CDC |
| Bee Busy | 1070 | 22 | 2.06% | \$ 88,507.00 | CDC |
| Mass Screening | | | | | |
| Hip Hop | 14471 | 86 | 0.59% | \$ 331,666.00 | CDC/DSHS/Private |
| Task Forces | | | | \$ 300,000.00 | GF/Private |
| CTR Agencies w/ CDC Directly-funded contracts | | | | | |
| CDC Directly-Funded | 2637 | 99 | 3.75% | | CDC Directly-Funded |
| Totals | 116576 | 1896 | 1.63% | \$ 2,384,112.00 | |

2010

| Venue Type | # of Tests | # Positive | Pos Rate | Funding Amount | Funding Source |
|--|---------------|-------------|--------------|------------------------|---------------------|
| Emergency Departments | | | | | |
| Memorial Hermann-TMC | 12775 | 107 | 0.84% | \$ 145,752.00 | CDC Expanded |
| Memorial Hermann-SW* | 11774 | 173 | 1.47% | \$ 105,000.00 | DSHS |
| Memorial Hermann-NE* | 1247 | 7 | 0.56% | \$ 105,000.00 | DSHS |
| Memorial Hermann-NW* | 667 | 11 | 1.65% | \$ 105,000.00 | DSHS |
| Memorial Hermann-MC* | 499 | 1 | 0.20% | \$ 105,000.00 | DSHS |
| HCHD-Ben Taub | 36398 | 712 | 1.96% | \$ 142,103.00 | CDC Expanded |
| HCHD-LBJ | 18124 | 267 | 1.47% | \$ 72,789.00 | CDC Expanded |
| HCHD-Ben Taub* | 36398 | 712 | 1.96% | \$ 254,058.00 | DSHS |
| HCHD-LBJ* | 18124 | 267 | 1.47% | \$ 130,145.00 | DSHS |
| FQHCs & Community Based Clinics | | | | | |
| Legacy-215 | 2155 | 55.8 | 2.59% | \$ 152,138.00 | CDC Expanded |
| Legacy-Lyons | 1437 | 37.2 | 2.59% | \$ 35,000.00 | CDC Expanded |
| HCHD-Acres Homes | 3252 | 10 | 0.31% | \$ 13,861.00 | CDC Expanded |
| HCHD-Strawberry | 3152 | 7 | 0.22% | \$ 14,007.00 | CDC Expanded |
| HCHD-Acres Homes* | 3252 | 10 | 0.31% | \$ 24,782.00 | DSHS |
| HCHD-Strawberry* | 3152 | 7 | 0.22% | \$ 25,043.00 | DSHS |
| HCHD-Peoples* | 0 | | | \$ - | DSHS |
| Corrections | | | | | |
| Harris County Jail | 8844 | 156 | 1.76% | N/A | DSHS |
| Juvenile Detention Facility | 2239 | 0 | 0.00% | N/A | DSHS |
| HDHHS Clinics | | | | | |
| Sunnyside | 3356 | 53 | 1.58% | | COH GF |
| Lyons | 3844 | 87 | 2.26% | | COH GF |
| Sharpstown | 5294 | 94 | 1.78% | | COH GF |
| Riverside | 1903 | 14 | 0.74% | | COH GF |
| Casa | 829 | 18 | 2.17% | | COH GF |
| STD Mobile | 1500 | 59 | 3.93% | \$ 5,053.00 | COH GF/DSHS |
| NSD Mobile | | | | | COH GF |
| Community Based CTR Agencies | | | | | |
| Legacy | 480 | 20 | 4.17% | \$ 337,138.00 | CDC |
| AFH | 257 | 4 | 1.56% | \$ 40,500.00 | CDC |
| St. Hope | 770 | 12 | 1.56% | \$ 150,000.00 | CDC |
| Career & Recovery Resources | 952 | 7 | 0.74% | \$ 156,959.00 | CDC |
| HACS | 302 | 7 | 2.32% | \$ 75,000.00 | CDC |
| NAACP | 338 | 1 | 0.30% | \$ 77,543.00 | CDC |
| Positive Efforts | 757 | 10 | 1.32% | \$ 47,760.00 | CDC |
| Bee Busy | 607 | 19 | 3.13% | \$ 15,000.00 | CDC |
| Mass Screening | | | | | |
| Hip Hop | | | | \$ 402,145.00 | CDC/DSHS/Private |
| Task Forces | | | | \$ 300,000.00 | GF/Private |
| CTR Agencies w/ CDC Directly-funded contracts | | | | | |
| CDC Directly-Funded | 2475 | 90 | 3.64% | | CDC Directly-Funded |
| Totals | 187163 | 3096 | 1.62% | \$ 3,038,878.00 | |

SAFER Initiative

To reduce the number of new HIV infections, the HDHHS will implement a combination of

activities to include intensifying HIV and STD prevention efforts in five geographic areas within the MSA with high HIV and STD morbidity, which includes; 1) Sunnyside/South Park, 2) Greater Fifth Ward, 3) Acres Homes, 4) Sharpstown/Southwest, and the 5) Montrose. This targeted public health and community mobilization effort will be branded as the SAFER Initiative. Activities will include:

The HDHHS will allocate all of its new and existing HIV/STD and related funding support to these high morbidity areas.

The HDHHS will initiate consultations with administrative agencies within the MSA to determine current distribution of HIV resources

...Increase access to HIV testing

...Increase social marketing campaigns

...Increase service linkage capacity within the MSA

...Increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks.

B: Rationale:

HIV screening programs in health care settings help to minimize the complexity and stigma of such programs, and they take advantage of the fact that 81% of U.S. adults see a health care provider at least annually. Routinely screening patients, ages 13- 64, for HIV after being notified that testing will be performed unless the patient declines (opt-out testing). HIV screening programs in health care settings help to minimize the complexity and stigma of such programs, and they take advantage of the fact that 81% of U.S. adults see a health care provider at least annually. This intervention will continue to be scaled up in the Houston MSA and will receive an increases in funding as it becomes available.

C: Goal Setting

- To increase the number of persons who know their serostatus by 25% in the Houston MSA annually.
- To link 85% of HIV+ individuals diagnosed in the existing eight (8) clinical routine opt-out HIV screening settings to primary medical care.
- To decrease transmission rates 25% by 2015.

Required Intervention #2: “HIV testing in non-clinical settings to identify undiagnosed HIV infection”

A: Situational Analysis

HDHHS currently coordinates with local businesses, social and civic organizations, including faith-based organizations, to promote or link to HIV testing activities targeting populations disproportionately affected by HIV, primarily African Americans. Additionally, HDHHS continues to collaborate with correctional facilities to initiate or enhance HIV testing for incoming and soon to be released inmates.

The Bureau continues to support the use of both rapid and conventional HIV testing by contractors or CBO's funded by the Bureau for Counseling, Testing, & Referral Services (CTRS). Currently, HDHHS contracts with eight community-based organizations (listed below) to provide CTRS in both clinic and outreach settings. Agencies providing CTRS continued to use Protocol-Based Counseling (PBC—implemented in 2006). In addition to ongoing CTRS services provided by contract CBOs, the Bureau is involved in many other activities that contribute to the identification of new HIV positive clients.

Community Based Organizations

- Legacy Community Health Services
- Houston Area Community Services
- St. Hope Foundation – Fusion, Bellaire,
- Change Happens
- AIDS Foundation of Houston
- Career & Recovery Resources Incorporated
- Bee Busy Learning Academy Incorporated
- National Association for the Advancement of Colored People, Inc. – Houston Branch (NAACP)
- DIS test partners in field

HIP HOP for HIV: Community-Based Service Integration Testing

2009 & 2010 marked the third and fourth annual public/private partnership providing free and confidential testing to 15,000 youth and young adults in Houston. HIV/STD educational groups were conducted and all individuals fully participating in the entire intervention received a free HIP HOP concert ticket. Community organizations, advocacy groups, skilled staff and volunteers, along with support provided through the local health department and other private entities coordinated testing events in high prevalence zip codes throughout the city.

STD Clinic Rapid Testing

In 2009, the Bureau piloted a program providing rapid HIV testing in HDHHS STD clinics for individuals at highest risk for acquiring HIV and/or other STDs. The Bureau currently continues to offer conventional as well as rapid testing.

DIS Rapid Testing

HDHHS Disease Intervention Specialists (DIS) currently provide rapid testing to HIV partners in the field. Of all risk groups, partners to a known HIV case have the highest positivity rates. Nearly 10% of HIV partners tested by HDHHS DIS are newly identified positives. This policy will greatly increase the proportion of HIV contacts who learn their status, and they will have a much greater likelihood of being successfully referred into care and prevention services.

Assessment, Intervention, and Mobilization (AIM)

HDHHS conducts a recurring project called Assessment, Intervention and Mobilization (AIM). Employees visit each resident in a designated neighborhood to provide information on services available through the City and make referrals. Selected neighborhoods represent those that are underserved and at high risk for multiple health issues, including HIV. The Bureau's Mobile

Clinic participates in each AIM event providing easy access for rapid HIV testing, as well as other STD services.

African American State of Emergency Task Force (SOETF)

The Bureau sponsors the African American State of Emergency Task Force (AASOETF), which works with the African-American community in support of HIV prevention activities. The AASOETF continues to strive to increase the participation of non-medical; non-HIV affiliated community-based organizations and community stakeholders in HIV prevention efforts targeted to African-Americans. In addition, the AASOETF takes the lead role in sponsoring special testing events, such as National HIV Testing Day, World AIDS Day, and National Black HIV/AIDS Awareness Day. These events make HIV testing readily available in high prevalence areas. HDHHS also sponsors the Syphilis Elimination Advisory Committee, which encourages HIV screening in addition to its syphilis elimination efforts.

In addition to the AASOETF, HDHHS provides support for community-based HIV testing efforts to the following Community Task Forces:

| | |
|--|--|
| Latino HIV Task Force – LHTF | Houston Hepatitis C Task Force - HHCTF |
| Youth Task Force – YTF | Urban AIDS Ministry - UAM |
| Syphilis Elimination Advisory Committee – SEAC | M-Pact Houston (MSM Task Force) |

The following is a listing of the days HDHHS Task Forces hold HIV testing events:

[National Black HIV/AIDS Awareness Day](#)
[National Women and Girls HIV/AIDS Awareness Day](#)
[National Native HIV/AIDS Awareness Day](#)
[National Asian & Pacific Islander HIV/AIDS Awareness Day](#)
[World Hepatitis Day](#)
[National Caribbean American HIV/AIDS Awareness Day](#)
[National HIV Testing Day](#)
[National Latino AIDS Awareness Day](#)
[World AIDS Day](#)

CBO's

- Covenant House Texas
- [Association for Advancement of Mexican Americans, Incorporated \(AAMA\)](#)
- Pink Rose SOCKS
- Diversified Medical Practices
- Motherland Incorporated
- Positive Efforts Incorporated
- [Fundacion Latino Americana Contra el SIDA Incorporated \(FLAS\)](#)
- [Nursing Bridges Healthcare](#)

Surveillance Program

Houston's Behavioral Surveillance Program

This program is funded by the Centers for Disease Control and Prevention (CDC). The National HIV Behavioral Surveillance System (NHBS) was established to monitor behaviors that put people at risk for HIV infection. Houston is one of more than twenty U.S. metropolitan areas with high HIV/AIDS prevalence rates selected as NHBS sites. NHBS consists of a repeated, cross-sectional survey of men who have sex with men (MSM), injecting drug users (IDU), and heterosexuals at risk for HIV infection (HET).

In 2006, MSM accounted for 50 % of the reported male HIV cases (regardless of AIDS status) in Houston. In addition, 3% of all reported HIV infections among men were classified into the MSM/IDU risk category. IDUs are at high risk of becoming infected with HIV and other blood borne pathogens through sharing injection-drug equipment with HIV-infected persons. HIV cases attributed to injection drug use accounted for 5% of Houston's total male cases in 2006; an additional 3% of the total male cases were among men who have sex with men and inject drugs. HIV cases attributed to injection drug use accounted for 7% of Houston's total female cases in 2006. HIV cases attributed to heterosexual contact accounted for 17% of Houston's total male cases and 50% of the Houston's total female cases in 2006.

Houston's Behavioral Surveillance Program Goals

NHBS aims to gain a deeper understanding of the high risk behavior related to HIV infection. The goals of the project are: 1) Develop an ongoing behavioral surveillance program to ascertain the prevalence of, and trends in HIV risk behaviors among selected populations of high-risk MSMs, IDUs and HETs. 2) Develop an ongoing program to evaluate changes over time in behaviors among the selected populations of MSMs, IDUs and HETs. 3) Develop a mechanism to incorporate and utilize the behavioral data gathered during this project and other sources of HIV-related behavioral risk data, to effectively summarize what is currently known about HIV risk taking behaviors in Houston.

Procedures

NHBS activities are implemented in cycles so that data are collected from each risk group every three years; these study cycles are referred to as NHBS-MSM, NHBS-IDU, and NHBS-HET. The project seeks to identify the prevalence and trends of sexual and drug-use risk behaviors among each risk group, as well as their exposure to and utilization of HIV testing and other prevention services funded by the CDC and state and local health departments. The overarching goal of NHBS is to help evaluate and direct local and national prevention efforts. The Bureau of Epidemiology is collaborating with the CDC and the University of Texas School of Public Health to conduct NHBS activities in Houston MSA. Individuals who agree to participate undergo an anonymous interview and anonymous HIV Testing. In addition to the standard NHBS questionnaire, participants are asked questions tailored to Houston/Harris County.

Cycles

- During the first cycle of data collection (January 2004 - August 2004), surveillance activities focused on men who have sex with men (MSM).
- The second cycle of data collection (May 2005 - November 2005) focused on injection drug users (IDU).

- The third cycle of data collection (October 2006 - June 2007) focused on heterosexuals (one who is resident of or has a social connection to a geographic area characterized by higher rates of poverty and HIV/AIDS).
- The Partner study was also a part of HET cycle where high risk females along with their male partners were recruited and interviewed.
- NHBS-MSM2 was again a survey of men who attend MSM-identified venues within locally defined geographic areas.
- During first year of the second round of Behavioral Surveillance (July 2008 - December 2008), surveillance activities focused on MSM.
- During second year of the second round of Behavioral surveillance (July 2009 - November 2009), data collection focused on injection drug users (IDU). In the year 2009, the crude HIV positivity rate was 7.69% (41 positives out of 533 tests).
- The formative research activities are being carried out for the HET2 Cycle of the second round of Behavioral Surveillance in Houston. The data collection began in June 2010.

(Source: <http://www.houstontx.gov/health/Epidemiology/NHBS.html>)

SAFER Initiative

To reduce the number of new HIV infections, the HDHHS will implement a combination of activities to include intensifying HIV and STD prevention efforts in five geographic areas within the MSA with high HIV and STD morbidity, which includes; 1) Sunnyside/South Park, 2) Greater Fifth Ward, 3) Acres Homes, 4) Sharpstown/Southwest, and the 5) Montrose. This targeted public health and community mobilization effort will be branded as the SAFER Initiative. Activities will include:

The HDHHS will allocate all of its new and existing HIV/STD and related funding support to these high morbidity areas.

The HDHHS will initiate consultations with administrative agencies within the MSA to determine current distribution of HIV resources

...Increase access to HIV testing

...Increase social marketing campaigns

...Increase service linkage capacity within the MSA

...Increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks.

Houston HIV Prevention Community Planning Group (HHPCPG)

In its 2003-2008 HIV Prevention Community Planning Guidance, the CDC outlined three goals and eight implementation objectives for local community planning efforts. The second goal charged by the CDC speaks to setting priority target populations and interventions for each identified target populations as follows:

- Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

As a result, the 2009-2013 Comprehensive Plan includes the following target populations: The population receiving the highest total score ranked 1st to the lowest scoring population, which ranked 6th. The results are as follows:

1. Men
2. Women
3. HIV +
4. Youth
5. People who share needles/works
6. Transgender Individuals

B: Rationale:

The use of more aggressive screening programs outside the clinical setting is justifiable for subpopulations affected by health disparities and with limited access to or utilization of medical care or those highest risk groups with high rates of new infections. This intervention will receive an increase in funding as it becomes available.

C: Goal Setting

- To increase the proportion of HIV-infected persons who are aware of their status by 25% in the Houston MSA annually.
- To expand HIV testing in non-clinical settings to populations that have been prioritized as high risk for acquiring or transmitting HIV; to include Men, Women, Youth, People who Share Needles/Works, and Transgender Individuals.

Required Intervention #3: “Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection”

A: Situational Analysis

Condom distribution within the community is a critical component of prevention efforts. The Houston Department of Health and Human Services (HDHHS) participates in various events throughout the city that offers opportunities for the distribution of condoms along with educational information and in some instances, testing and counseling services. The Texas Department of State Health Services (DSHS) provides HDHHS with 250,000 condoms annually for distribution throughout the Houston MSA. Additionally, HDHHS purchases latex dental dams, female condoms (FC2), Strapped condoms and magnum condoms as specialty condoms particularly for populations that have been prioritized as highest risk for acquiring or transmitting HIV to include (Men {MSM & HIV+}, Women {HIV+}, People Who Share Needles/Works {HIV+}, and Transgender Individuals) as described in the HDHHS 2009

Comprehensive Plan. Condom distribution is not considered an intervention that is funded by HDHHS to its subcontractors. The distribution of condoms in a community is a part of an agency's overall intervention; therefore the purchase is included in general supplies and may vary depending on the targeted population.

Female Condom Distribution

Female (Reality), oral (Kiss of Mint), extra strength condoms and dental dams are distributed during HE/RR, PBC, EIP and PCM sessions by staff and CBOs to reinforce prevention and risk reduction behavior among the priority populations, and when working with HIV-infected population.

Houston Gay, Lesbian, Bisexual, and Transgender Pride Parade

2009 "Social Justice" Pride

On the evening of Saturday, June 27th, approximately forty (40) HDHHS staff members and community volunteers participated in Pride Houston's 31st Annual GLBT Pride Parade. The design of the HDHHS float, "Be Free From HIV," played on the theme of the Houston Pride Committee, "Social Justice." All volunteers wore t-shirts that further illustrated the "Be Free" theme. Each T-shirt was printed with different messages such as, "Be Free from...Stereotypes," "...Labels," "...Expectations," "Doubt," "Stigma," "Denial," & "Ignorance." The parade participants distributed approximately 5,000 condom packets (10,000 condoms) along with 2,500 gavels marked with the "Be Free from HIV" logo ". Parade officials estimate crowd attendance at around 200,000 this year, which was the highest attendance in the history of the GLBT pride parade. The HDHHS, along with other City of Houston departments and officials, participated in the Houston GLBT for the past ten years.

2010 "Pride Not Prejudice" Pride

Based on the Houston Pride Committee's theme of "Pride not Prejudice," "Hippies of the New Millennium," was the theme of the HDHHS float. On the evening of June 26th, approximately 35 staff members, including the HDHHS Director, the Bureau Chief of HIV/STD & Viral Hepatitis Prevention, and several volunteers from HDHHS Community Task Forces, participated in Houston's 32nd Annual GLBT Pride Parade. Parade participants distributed approximately 20,000 condoms, half of which were the Houston-branded condom, via condom packets. Parade officials estimated crowd attendance close to 300,000, due to the election of Houston's first openly gay Mayor, Annise Parker.

MSM Task Force

In 2009, M-Pact Houston, the city's first MSM Task Force was established with the purpose to address the increase in HIV and other STD infections in men who have sex with men through education, awareness, and prevention. M-Pact Houston participated in the 2009 and 2010 GLBT Pride Festivals as one of the exhibitors. M-Pact Houston Task Force members also participated in the GLBT Pride Parades for both years, assisting in the distribution of over 10,000 Houston condom packets, doubling the amount from 2009.

HIP HOP for HIV

The HIP HOP for HIV Testing Campaign took place in the summer of 2009 with a focus on African American youth and young adults. The campaign included HIV, syphilis, gonorrhea, and Chlamydia screening, condom distribution, educational sessions, treatment and partner



services throughout the city for 30 days leading up to HIP HOP Concert. Condoms and other prevention tools were distributed to participants. In 2009, 50,000 condoms packets were distributed over the month long testing campaign.

In 2010, HIP HOP For HIV increased its number of HIV and STD screenings as well as increased the number of condoms from 50,000 to 80,000 during the month long campaign. AIDS Foundation Houston, a local nonprofit organization provided specialty condoms such as Magnum and Strapped Condoms as well as dental dams, flavored lubricants and female condoms.

Annual Los Magnificos Car Show

In 2009, this collaboration with Radio One, HDHHS and private partners targets urban youth and young adults, primarily Latino and African American. This one day event saw a distribution of 12,000 Magnum condoms, 10,000 Strapped Condoms, a local condom manufacturer and 25,000 Durex condoms.

In 2010, HDHHS continued to partner with Radio One and the annual Car Show to outreach to 30,000 people. HDHHS contribution of 60,000 condoms including female, Magnum, Durex Condoms. This was the first year that the Houston branded condom was introduced to the car show community on a mass level.

B. Rationale

The Houston MSA will maintain our current activities related to this intervention based on the current distribution level (adequate to meeting those at highest risk) throughout the MSA and the lack of additional funding to support a more robust distribution. The overall landscape of the Houston MSA is somewhat conservative and many faith and school based facilities do not allow condom distribution. This intervention will receive any additional funding. TO INCREASE THE ACCEPTABILITY OF CONDOMS AND CONDOM DISTRIBUTION (BY CHANGING NORMS), AND MAKING CONDOMS MORE EASILY ACCESSED AND READILY AVAILABLE THROUGH A VARIETY OF VENUES WHERE VERY HIGH RISK TARGET POPULATIONS CAN BE REACHED TO PREVENT HIV TRANSMISSION BY HIV-POSITIVE PERSONS AND ACQUISITION BY HIGHEST RISK.

C: Goal Setting

- Maintain the current distribution of 300,000 condoms targeted to populations that have been prioritized as highest risk for acquiring or transmitting HIV to include (Men {MSM & HIV+}, Women {HIV+}, People Who Share Needles/Works {HIV+}, and Transgender Individuals) as described in the HDHHS 2009 Comprehensive Plan.

Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”

A: Situational Analysis

Post-exposure prophylaxis (PEP) is any prophylactic treatment started immediately after

exposure to a pathogen (such as a disease-causing virus), in order to prevent infection by the pathogen and the development of disease. In the case of HIV infection, post-exposure prophylaxis is a course of antiretroviral drugs which is thought to reduce the risk of seroconversion after events with high risk of exposure to HIV (e.g., unprotected anal or vaginal sex, needlestick injuries, or sharing needles).

The Houston Department of Health and Human Services (HDHHS) does not provide PEP. However, according to the 2008 Houston HIV Prevention Community Planning Group Community Services Assessment Resource Inventory, PEP is provided by some organizations in Houston/Harris County. PEP- Rape/ Sexual Assault/Occupational Exposure are provided by Harris County Hospital District, Legacy Community Health Services, and St. Hope Foundation. PEP-Upon Request is offered by Harris County Hospital District, Harris County Public Health and Environmental Services, Houston Area Community Services (HACS), Legacy Community Health Services, and St. Hope Foundation. These organizations that provide PEP are either HDHHS HIV prevention contractors or have a collaborative relationship with HDHHS.

The Center for AIDS Information & Advocacy (The CFA) has opened the city's first post-exposure prophylaxis (PEP) clinic in collaboration with the University of Texas Health Science Center at Houston. This clinic is part of a public, private and academic effort to provide comprehensive HIV prevention and treatment services in Houston.

When given within 72 hours of exposure to the virus, PEP may stop an HIV infection before it takes root. The treatment plan requires 28 days of anti-HIV drugs plus appropriate blood tests. This treatment has been proven successful, is endorsed by the Centers for Disease Control and Prevention, and has long been used in hospitals to stop the spread of the virus to healthcare workers.

The PEP clinic will provide treatment to Houstonians who've had a non-occupational exposure to HIV. In addition to offering PEP, the clinic will also provide regular medical care to patients already living with HIV. Like other communities, Houston is faced with a shortage of HIV-treating physicians. This clinic will help to alleviate that shortage.

While it is known that some organizations in the Houston MSA offer occupational (oPEP) and/or non-occupational (nPEP), it is not clear at this time how often PEP is used and how effective PEP is at preventing HIV infection after exposure to the virus. Because of this gap in information regarding PEP, HDHHS will conduct a PEP resource inventory, in 2011, to determine a baseline for coverage level of PEP in the Houston MSA. HDHHS will also conduct an ECHPP workshop for representatives from HIV prevention, care, and treatment that will include presentation and discussion concerning PEP to determine the role of emergency departments, standardized treatment guidelines, and regimen selection. HDHHS through information sharing will encourage scaling up access to PEP, with priority given to individuals at high-risk of exposure to HIV (e.g., unprotected anal or vaginal sex, needlestick injuries, or sharing needles). As a result of information sharing concerning PEP, HDHHS expects a five percent increase (based on newly determined baseline, using 2009 data) in PEP use by local HIV prevention, care, and treatment providers.

B: Rationale

This intervention concerns appropriate scale and targeting of nPEP for maximum impact at reasonable cost. Data suggests that nPEP is more cost effective when focused on people with known recent exposures to HIV (within the previous 72 hours). This intervention can be incorporated into existing interventions or settings (e.g., behavioral interventions, partner services, self referral to providers or agencies) that identify recent exposure events between susceptible persons and known HIV-positive persons. THIS INTERVENTION WILL BE MAINTAINED.

C: Goal Setting

- HDHHS will determine a baseline for coverage level of post-exposure prophylaxis (PEP) in the Houston MSA.

Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”

A: Situational Analysis

Advocacy plays a strong role in HIV prevention and care services in the Houston EMA. Through advocacy groups, such as HDHHS HIV Prevention Community Planning Group, the Ryan White Planning Council and The Texas HIV/AIDS Coalition, involved citizens, community leaders, public health providers and the HIV community work together with local and state officials to educate on issues related to HIV prevention, care and treatment. One of the goals of coalitions such as the Texas HIV/AIDS Coalition, is to include both prevention and care providers and community members who can educate/advocate on behalf of relevant concerns to the community, funding and service provision. A key issue facing the Texas HIV/AIDS Coalition in 2011 is efforts to increase funding for the AIDS Drug Assistance Program for the 2013 fiscal year. Coalition members plan scheduled visits to the state capital to discuss concerns with representatives and health services committee members. In February 2011, over 100 individuals representing provide agencies, community organizations, churches and the HIV community participated in HIV Advocacy Day in Austin, Texas. Representatives had as their common objective a demand to increase ADAP funding for 2013 by \$22 million dollars.

Critical to the maintenance of highly effective advocacy in the HIV community are three elements; parity, inclusion and representation. By ensuring that there is an equality amongst participating member advocacy organization, the inclusion of all parties including the HIV positive community and those most impacted by the disease and the representation of all individuals are risk, the ability to secure fair and responsive legislation is more readily offered and available.

Syringe Exchange Policy:

Syringe exchange is currently prohibited by Texas state law (cut and paste). The Hepatitis C Task Force has established a Harm Reduction Workgroup, which has been meeting to discuss how to

best meet the needs of those who continue to be at risk for contracting HCV and HIV through unsafe injection practices (illegal drugs, hormones, and silicone). One area of interest for this group is how best to support those who advocate for the legalization of syringe exchange in Texas.

Routine Opt Out Testing

The city of Houston is one of few cities nationwide that offers routine opt-out testing in its emergency room centers. HDHHS partners with three hospitals to provide routine, opt-out HIV screening in their emergency departments, Ben Taub General Hospital (BTGH) and Memorial Hermann Hospital in the Texas Medical Center and Lyndon B. Johnson General Hospital (LBJ) in the Northside Area. HDHHS also partners with Legacy Community Health Services (Legacy), which operates two clinics in Houston: a community healthcare clinic and a Federally Qualified Health Center (FQHC). Legacy will not only be able to offer routine HIV screening to their clinic patients, but will also offer screening activities for syphilis, hepatitis B, and hepatitis C. Through this project, HDHHS will be able to reach approximately 73,600 Houstonians and identify 610 new HIV positive persons who are unaware of their status and who do not present for risk-based HIV screening.

Routine, opt-out screening in medical settings is an ideal alternative because it does not require patients to self select for testing. It also has the potential of finding patients earlier in their infections, as they could be presenting to the emergency department for illnesses or injuries unrelated to HIV infection. Routine, opt-out HIV screening has been shown to be cost-effective, even in relatively low prevalence populations while also being acceptable to patients as evidenced by low refusal rates

In the Texas state legislature, there are current bills proposed by both House Representative Yvonne Davis and State Senator Rodney Ellis to make routine opt-out testing mandatory throughout the state. In addition, legislation is calling for the mandatory payment of routine testing through Medicaid and private insurers.

City/County Policy Collaboration

There is not a combined jurisdiction-wide prevention/care planning group operating that focuses on policy or regulations guiding prevention and care; however, The Houston HIV Prevention Community Planning Group & The Ryan White Planning Council share representation, planning process, data and resources, as well as combined goals and objectives when seeking additional support from the federal, state or local levels of government. The City of Houston is a directly funded jurisdiction which develops the Comprehensive Plan for the geographic area that it represents. Elements of the Community Planning Group process works closely with the Ryan White Planning Council and the State CPG structure for ongoing discussions regarding issues affecting prevention and care services. As ad hoc committees are created to address specific objective such as the development and implementation of EIIHA, members representing the various groups are called on to add input through representation from within their organizations. There are specific occurrences that have made the need for collaboration among the two planning bodies a necessity, including the loss in capacity of trained and skilled prevention and treatment providers; businesses that focus on the provision of direct or supplemental care services closing; and medical providers limiting number of patients that they see, moving away from Medicaid and Medicare/private only. The combined efforts of the city and county expedite the need for data collection, service delivery and

resource availability. Additionally, the collaboration between the city and county go beyond the planning bodies. Joint initiatives are signed off on by local government representatives including the Harris County Judge and the Mayor for the city of Houston.

B. Rationale

The goals set forth under this intervention are long-term goals established by the various planning bodies and advocacy organizations in the city of Houston. Most goals were developed as a response to the growing concern and/or need for revised interventions and strategies to address gaps in services or to pursue more effective models for reaching a greater number of individuals at risk.

Policy or regulatory change can be accomplished through advocacy (subject to lobbying restrictions under federal law) and community mobilization, especially when arguments are based on evidence that illustrate negative effects on HIV prevention, care, and treatment. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE.

C: Goal Setting

- Increase broad-based community participation in HIV prevention and care planning with an emphasis on parity, inclusion and representation among membership.
- Support the adoption of lawful sanction syringe exchange programs
- Implement a client-level HIV prevention data management system (ECLIPS) that will interface and exchange information with other databases to capture referral linkage.
- Support efforts and encourage the adoption of federal regulations that promote routine testing in clinical settings in Texas.
- Work with legislative efforts that support the re-imbursement of core services provided through the state, including routine testing, funding ADAP and other prevention services.

Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care”

A: Situational Analysis

Partner Services

Partner Services (PS) in Houston is conducted by HDHHS Disease Intervention Specialists (DIS) and CBO risk-reduction specialists. In the state of Texas, only DIS may perform partner notification. Newly reported HIV positives are reported to the HIV surveillance unit of the Bureau of Epidemiology. Provider follow-up is conducted by surveillance staff and field investigation records are initiated within three days of receipt of test result for DIS follow-up.

Newly reported individuals screened through HDHHS clinics are initiated to DIS for field follow-up. During the 1st half of 2008, HDHHS staff successfully provided PS to 78% (398/513) of newly reported HIV infected individuals assigned for public health follow-up.

Although controversial, using surveillance data to initiate PS in an integrated HIV/STD program is effective and efficient. Traditional PS techniques in conjunction with innovative strategies such as DIS liaisons and internet partner services create opportunities for success while an intensive quality improvement process ensures that success is achieved.

CBOs are under contract to conduct result notification and partner elicitation for all HIV positives newly identified by their agency. PS conducted by CBO staff was strengthened in 2006 with the implementation of Protocol-Based Counseling (PBC), described earlier in the CTR section. CBO staff members are required to conduct structured counseling sessions using a prescribed script of questions. Within seven days of receiving a positive test result, CBO staff must notify clients of their results and conduct partner elicitation. Clients not counseled within seven days must be referred by the CBO to HDHHS for DIS follow-up.

Partner notification is conducted by DIS in accordance with guidelines established by the Texas Department of State Health Services (DSHS). During the first half of 2008, HDHHS DIS located and notified 60% (223/370) of partners initiated from an HIV index case. First-line supervisors provide oversight of partner notification through audits of investigative activities to ensure that all disease intervention opportunities have been exhausted.

Service Linkage

The HDHHS is in a unique situation to provide service linkage to individuals newly diagnosed with HIV due to the process already in place for identifying these individuals for Partner Services, i.e. public health follow-up. The HDHHS is tasked with the responsibility of interviewing every new HIV diagnosis in Houston/Harris County to provide education and elicit partner information in order to conduct partner notification. Often, individuals are just learning of their HIV diagnosis for the first time and it has proven to be beneficial to have the resource of a service linkage worker to connect them with right at this time.

The HDHHS receives funding from the Harris County Public Health and Environmental Services (PHES) Department (via the Ryan White Treatment Modernization Act) to implement a comprehensive community case management program providing service linkage to HIV-positive individuals, both those newly diagnosed and those who are out of care. The service linkage program consists of five staff: one supervisor and four service linkage workers. The service linkage workers function in conjunction with the HIV/STD Disease Intervention Specialists (DIS), who identify and interview individuals with new syphilis and HIV diagnoses. Once interviewed, the DIS refers new HIV clients to the service linkage workers, who then facilitate entry into the Ryan White primary care system. This linkage is one of the most important parts of the HIV care continuum, and a point where many individuals are lost to care. The service linkage workers fill this vital role in the continuum of care.

A Harris County Interlocal Agreement regarding Ryan White Part A (formerly Title I) was first established in April of 2001 to fill a gap in linkage services determined to exist between clients receiving notification of their HIV status through post-test counseling and the clients receiving HIV services, more importantly, primary care and case management.

In the first quarter of 2009, HDHHS had two service linkage workers funded through the Ryan White Part A grant. By the end of the year, the Bureau employed a total of four (4) SLW FTEs and served a total of 128 unduplicated HIV positive persons. Special Project of National Significance (SPNS) was funded through Ryan White Part F to meet the needs of Houston's young MSM of color population. This project was designed to engage and retain HIV positive men in medical care. The program ended in September 2009.

In 2010, HDHHS had four SLW and one (1) supervisor that respond to positive clients located through the Disease Intervention Specialists. SLW program support and enhance efforts to locate and re-link to medical services those patients who have been lost to follow-up. These SLW conduct outreach targeted to patients who do not return for follow-up appointments. Further, all RW/A- and MAI-funded primary medical care and case management programs must maintain a minimum of five points of entry (POE) agreements. According to HDHHS data, 236 unduplicated clients were served within the 2010 contract year, from March 2010 to February 2011.

The following reflects allocations (not expenditures) under Ryan White Part A for Service Linkage Workers (SLW):

- FY2009: \$957,000
- FY2010: \$957,000
- FY2011: \$1,163,000

Early Treatment of HIV Infection

Service linkage is a critical piece of the continuum of care ensuring early treatment of HIV infection to those who are newly diagnosed. The amount of time that elapses between HIV infection and HIV diagnosis determines the severity of disease progression and the level of care that is needed at the time of diagnosis. Linkage into care at the time of diagnosis is critical in the early treatment of HIV infection. There are times when a client is diagnosed with AIDS simultaneously as being diagnosed with HIV. The average concurrent diagnosis rate in Houston/Harris County ranges between 35% and 40% of all new HIV diagnoses. Existing processes regarding public health follow-up by a DIS requires that an individual be re-interviewed by a DIS if he/she is known to be HIV positive and has a new diagnosis of another sexually transmitted disease (STD). This opportunity allows HDHHS service linkage workers the opportunity to provide prevention services to HIV-positive individuals who may know their status but be considered "out of care".

The HDHHS will continue to utilize current relationships with the following HIV primary care providers: 1) Harris County Hospital District, 2) Legacy Community Health Services, 3) St. Hope Foundation, and 4) Houston Area Community Services. HDHHS service linkage workers (SLW) currently have relationships with service linkage workers at each of these primary care providers, which is a critical component of successful outcomes. Equally important are the personal relationships that are developed and fostered between the SLW and the client. Experience has shown that many clients require multiple interactions prior to deciding to enter HIV primary care services. In the current HDHHS release of information, clients allow SLWs to verify whether or not they have shown up for the primary care appointment. Often this is not

needed since the SLW will either transport or accompany the client to the first primary care appointment.

The HDHHS has a very strong collaboration with several health care providers and primary care clinics within the Houston Metropolitan Area. All of the Ryan White community- based primary care facilities are also funded through the HDHHS for prevention activities. By which, we are able to give clients options regarding linkage to primary care.

Public Health Follow-up

For the months of January through April 2009, the Houston Department of Health and Human Services (HDHHS) HIV/AIDS Surveillance Program received approximately 1,800 positive HIV reports. There were 986 cases new to the HIV/AIDS reporting system (HARS). Upon investigation, 466 (47%) were found to be new HIV positives with no record in HARS. In addition, 103 previously HIV positive persons were reported with evidence of unsafe sex (e.g., new STD diagnosis, pregnancy). This group, plus the new positives, constituted the number (569) eligible for public health follow-up.

Of the 569 eligible for follow-up, 161 (28%) were from STD clinics, PCPE contractors or other facilities (such as correctional institutions and the Harris County Hospital District) that offered Partner Counseling and Referral System (PCRS) services. The remaining 408 (72%) were from providers that did not offer PCRS. Of the 408 persons from non-PCRS providers, 391 (96%) were referred to Disease Intervention Specialists for follow-up. 11 (3%) were unable to be referred for public health follow-up because patients were deceased, critically ill, mentally ill or without sufficient locating information. Providers opted out of follow-up for the remaining six (1%). In summary, of 569 persons eligible for public health follow-up, 552 (97%) were targeted for public health follow-up services of some kind.

For the months July through December 2009, the Houston Department of Health and Human Services (HDHHS) HIV Surveillance Program received approximately 2,700 positive HIV reports. There were 1,383 cases new to HARS. Upon investigation, 377 (27%) were found to be new HIV positives with no record in the HIV/AIDS reporting system (HARS). In addition, 137 previously HIV positive persons were reported with evidence of unsafe sex (e.g., new STD diagnosis, pregnancy). This group, plus the new positives, constituted the number (514) eligible for public health follow-up. Of the 514 eligible for follow-up, 166 (32%) were from STD clinics, PCPE contractors or other facilities (such as correctional institutions and the Harris County Hospital District) that offered Partner Counseling and Referral System (PCRS) services. The remaining 348 (68%) were from providers that did not offer PCRS. Of the 348 persons from non-PCRS providers, 338 (97%) were referred to Disease Intervention Specialists for follow-up. Four (1%) were unable to be referred for public health follow-up because patients were deceased, critically ill, mentally ill or without sufficient locating information. Providers opted out of follow-up for the remaining six (2%). In summary, of 514 persons eligible for public health follow-up, 504 (98%) were targeted for public health follow-up services of some kind.

Data Systems

In order to improve the ability of HDHHS to track referrals for positive clients, counseling and testing contractors began using the new CDC PEMS CTR data collection form in June of 2006. This captures more detailed information on referrals and provides a method for tracking

referral outcomes. In addition to the data being collected in PEMS, HDHHS is developing a data collection system (ECLIPS) that will interface with Harris County's data collection system (CPCDMS), which is used to track Ryan White-funded care services. Once the software is developed, a system for linking positive client's CTR services to their primary care follow-up will be in place. The vendor developing the software is the same vendor who developed the data collection system used by Harris County in their HIV care system. The goal is for the two systems to be able to interact, providing the ability for HIV prevention workers to make electronic referrals directly into the HIV care data system, and to be able to electronically verify the client's entry into care. Using a secure web-based interface, HDHHS HIV prevention contractors will be able to make these referrals and receive confirmations from any site with Internet access, replacing the need for multiple phone calls and paper forms.

HDHHS currently uses a tracking system called the SPNS list to track HIV-positive persons not currently in care, treatment and prevention services. This data is uploaded into a password-protected database for the HIV Service Linkage Supervisor to access and utilize for linkage into all identified service needs.

The new prevention data collection system will update and consolidate all of the current databases in use by the Houston HIV Prevention Section, which include an intervention database for health education/risk reduction (HE/RR) activities, a counseling, testing and referral (CTR) database for HIV/STD CTR services, a training database for capacity building activities, an approved materials database, and a financial tracking database. By consolidating all of these activities into one data collection system, the HDHHS will increase its ability to monitor and evaluate contractor activities as well as to provide better oversight of our contractors, both fiscally and programmatically.

The ECLIPS will also allow the HDHHS to accurately ensure that all individuals newly-diagnosed with HIV are referred and retained into HIV primary care services; significantly reducing the number of individuals who are lost to follow-up and/or lost to care. Ensuring that individuals diagnosed with HIV are engaged in primary care services has been shown to decrease those individuals' risk-taking behaviors, serving as a secondary HIV prevention strategy and reducing the amount of HIV transmission within the community.

In summary, the ECLIPS will improve contract management for HIV prevention services; enhance CTR services and related lab and linked referral activities; bring the HDHHS HIV prevention data into compliance with CDC's PEMS requirements, and contribute to the improvement and expansion of a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for those infected and affected in the greater Houston area.

HDHHS has written policy and procedures on linkage to HIV care, treatment, and prevention for those testing positive and not currently in care. This document, regularly updated, is available in the Policy and Procedure Manual located at our 8000 North Stadium Drive office.

Grantees in the jurisdiction receive training on the policy and procedure. The most current training was conducted on December 8th, 2010 during the Joint HIV Prevention and Care Meeting.

HIV Care and Treatment

- The Houston RWPC manages written standards of care and service definitions that address the policies and procedures on linkage to care. Ryan White-funded DHHS Service Linkage Workers (SLW) receive training on standards of care, service definitions and other policies/procedures and are cross-trained as DIS workers.
- HDHHS uses CPCDMS Service Utilization Data, Surveillance Data, and HRSA Unmet Need Estimates to track HIV-positive persons not currently in care, treatment and prevention services.
- As of December 31, 2009, there were 20,945 People Living with HIV/AIDS (PLWHA) residing in the Houston MSA.
- Using the HRSA unmet need framework, there are an estimated 8,101 PLWHA who are aware of their HIV status but are not in care and in need of treatment. [Source: Texas DSHS]. Additionally, using the CDC back estimate regarding the HIV+ unaware, there were an estimated 5,224 individuals who were not aware of their HIV infection during 2008. [Source: Texas DSHS]
- Under Ryan White Part A, there are at least 6 publicly funded HIV/Infectious Disease treatment facilities and/or agencies providing some form of direct medical care. [Source: RWPC]
- Funding outside of CDC for care and HIV prevention for PLWHA
 Ryan White Part A 2009 award: \$18,551,623 + \$1,525,669 MAI funds.
 Ryan White Part B 2009: \$2,916,728
 State 2009: \$1,945,381
- All four of the Ryan White funded primary care CBOs and clinics are also funded by the HDHHS for HIV/STD Prevention Services. The HDHHS CPG is also working closely with the Ryan White Planning Council to consolidate planning activities and create one jurisdictional comprehensive plan for prevention and care.

B: Rationale

This intervention focuses on linkage strategies on the initial entry into HIV primary care. Linkage strategies may involve linkage workers, counselors, nurses, and social workers and require cooperative efforts from agencies including public health departments, county hospitals, emergency departments, and HIV counseling and testing programs. . In FY 2011, the allocation for community-base primary care was expanded and the goal for medical case management targeted to African American and Hispanic PLWHA was maintained. Non-medical case management services targeted to newly diagnosed and not-in-care PLWHA were expanded in support of the EIIHA Strategy. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE.

C: Goal Setting

Ensure that 85 percent of persons who receive their HIV positive test result are referred to medical care and have a confirmed first visit for care.

Maintain a Partner Counseling and Referral Services system to conduct interviews and field investigations for new HIV and syphilis cases.

To provide HIV prevention services to inmates in the County Jail System.

Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals.

Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”

A: Situational Analysis

RETENTION and RE-ENGAGEMENT IN CARE

Through the Ryan White Planning Council, the Houston Department of Health and Human Services and other collaborative supportive service partners, HIV positive individuals who are either newly diagnosed or not in care have the opportunity to re-enter the care system through various avenues. Ryan White reaches newly diagnosed and not-in-care PLWHA’s through targeted, non-medical community-based case management services. HDHHS reaches works closely with private providers and HIV positive individuals to ensure that once diagnosed and in care, they are able to successfully attend at least two primary medical care visits. Many of the staff assigned to Service Linkage are co-located at sites where individuals learn their HIV status, including testing sites, hospital emergency rooms, substance abuse treatment programs and programs that provide outreach to recently released offenders. This relationship ensures a clients initial linkage to care and the provision of information about additional HIV services, such as eligibility requirements, transportation assistance and other services designed to reduce barriers and maximize health outcomes. This linkage directly connects RW/A efforts to locate and engage not-in-care and newly diagnosed PLWHA with the City’s comprehensive HIV testing efforts conducted at numerous health clinics and several community-based agencies throughout the metropolitan area. In 2010, SLW remain embedded in all RW/A primary medical care programs to support and enhance efforts to locate and re-link to medical services those patients who have been lost to follow-up. These SLW conduct outreach targeted to patients who do not return for follow-up appointments. Further, all RW/A- and MAI-funded primary medical care and case management programs must maintain a minimum of five POE agreements.

Ryan White Part A provides funding for Medical and Non Medical Case Managers within the Primary Medical Care Services . Medical Case Managers are responsible for assisting PLWHA with retention to medical/clinical appointments. McM’s have been a standard component of primary medical care providers and have in essence replaced Community Case Managers by providing clients with more information centered on maintaining relationships with physicians and ensuring adherence to medications. In the Houston EMA, there are approximately 12

providers implementing interventions/strategies promoting retention in care. To ensure MCM's are equipped to meet the needs of clients who may have exited care and are returning or working with clients to maintain care, ongoing trainings are provided to staff members. These trainings are required sessions that are client-centered, providing MCM's with resources necessary to help maintain adherence and compliance to medical requirements.

RW Part A works closely with the administrators of the local CDC HIV Prevention Program, a directly-funded CDC prevention grantee. Two representatives from the City's prevention program are members of the RWPC – throughout the P&A processes, these representatives provide invaluable information regarding trends in the local epidemic. The Co-Chair of the City's Community Planning Group (CPG) is a member of the Planning Council. Additionally, RW/A-funded case management programs are co-located at sites where clients learn their HIV status.

Additionally, the Ryan White Planning Council works diligently to ensure that the HIV positive community has multiple access points into medical care. Living Healthy With HIV was established in 2010 by various community partners to provide HIV positive individuals with a host of resources and workshops designed to empower, educate and assist individuals with getting back into care and services. Living Healthy 2010 has over 200 clients participating in various sessions on dating, medication adherence and advocacy.

B. Rationale

Care Services are client centered and rely upon the active participation of the client to remain engaged in care. In order to ensure clients remain engaged in or return to care, there needs to be an increase in the number of access points available to the client for additional information and support. By increasing the number of clients that stay engaged in care, HIV transmission will be reduced and individuals will be able to achieve and maintain positive health outcomes.

Retention and engagement in care also provide multiple opportunities for preventive health care interventions and the promotion of health behavior changes that may minimize transmission and improve community health. This intervention will receive an increase in funding as it becomes available.

C: Goal Setting

- Increase the number of reported diagnosed HIV infected persons linked to care who are still in care after initial medical appointments.
- Identify individuals who know their HIV status but are not engaged in primary medical care.

Required Intervention #8: “Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons”

A: Situational Analysis

The Ryan White Grants Administration is responsible for the provision of antiretroviral treatment for HIV positive clients. Imperative for the maintenance of healthy outcomes, management of the provision of treatment is followed in accordance with federal and state regulations. Information and data on the treatment regimens of persons living with HIV are prescribed and the treatment they receive is kept in client medical records. The database, CPCDMS only collects whether or not a PLWHA is receiving ART, but not the specific drugs they are on.

The Ryan White Part A service definition for primary medical care discusses delivery of medical care (including ART) in accordance with current U.S. Public Health Service Treatment Guidelines. There are approximately 12 providers under Ryan White Part A.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as “a range of client-centered services that link clients with health care, psychosocial, and other services” including coordination and follow-up of medical treatment and “adherence counseling to ensure readiness for and adherence to HIV complex treatments. Through the medical case management system, clients receive the information necessary, medical support and additional counseling to ensure compliance to medication regimens designed to reduce illness related to HIV disease.

Other services offered through Medical Case Management include HAART readiness assessment, referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support. During 2009 for Ryan White Part A , 6,399 unduplicated PLWHA were served under primary medical care and 5,019 were served under Medical Case Management services.

Ryan White Part A standards of care include expectations regarding medical adherence services. The Patient Medication Education program under Ryan White Part A must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in all areas of HIV/AIDS care, to provide the educational services. Licensed social workers may also provide adherence education/counseling. Public clinics and community-based primary care sites, including 2 Federally Qualified Health Clinics. There are approximately 12 providers under Ryan White Part A.

Medical case managers must complete readiness assessments for any clients who will be prescribed ongoing medication regimens (i.e. ART). This includes clients who are beginning an initial regimen, who have a change in regimen, who have an existing regimen on admission, or who are restarting a regimen. Clients who have positive readiness in all five assessment areas (mental health, substance use/abuse, environmental, cognition and attitudes and belief system) do not require a service plan. When the assessment shows negative readiness in one or more assessment areas, the medical case manager and the client should complete the

readiness assessment summary sheet goals and plan section if the client wishes to improve his/her readiness for ART. All medical case management contacts and interventions should be documented in the medical case management progress notes as well.

B. Rationale

Accessing ART therapies is critical to the health outcomes of HIV positive individuals. A significant number of HIV positive individuals receive medication and treatment through the Ryan White funded primary medical care providers. It is mandated that all recipients of federal funding follow guidelines set and approved by HRSA and the US Department of Health and Human Services. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE.

C: Goal Setting

- To ensure individuals understand the need for antiretroviral treatment and adhere to standards of care set for HIV positive individuals.

Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”

A: Situational Analysis

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines medical case management as “a range of client-centered services that link clients with health care, psychosocial, and other services” including coordination and follow-up of medical treatment and “adherence counseling to ensure readiness for and adherence to HIV complex treatments. Through the medical case management system, clients receive the information necessary, medical support and additional counseling to ensure compliance to medication regimens designed to reduce illness related to HIV disease.

Other services offered through Medical Case Management include HAART readiness assessment, referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support. During 2009 for Ryan White Part A , 6,399 unduplicated PLWHA were served under primary medical care and 5,019 were served under Medical Case Management services.

Ryan White Part A standards of care include expectations regarding medical adherence services. The Patient Medication Education program under Ryan White Part A must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in all areas of HIV/AIDS care, to provide the educational services. Licensed social workers may also provide adherence education/counseling. Public clinics and community-based primary care sites, including 2 Federally Qualified Health Clinics. There are approximately 12 providers under Ryan White Part A.

Medical case managers must complete readiness assessments for any clients who will be prescribed ongoing medication regimens (i.e. ART). This includes clients who are beginning an initial regimen, who have a change in regimen, who have an existing regimen on admission, or who are restarting a regimen. Clients who have positive readiness in all five assessment areas (mental health, substance use/abuse, environmental, cognition and attitudes and belief system) do not require a service plan. When the assessment shows negative readiness in one or more assessment areas, the medical case manager and the client should complete the readiness assessment summary sheet goals and plan section if the client wishes to improve his/her readiness for ART. All medical case management contacts and interventions should be documented in the medical case management progress notes as well.

B. Rationale

Incomplete adherence to ART, however, is common in all groups of treated individuals. Among persons on ART, the average rate of adherence is approximately 70%, despite the fact that long-term viral suppression requires near-perfect adherence. . This intervention will receive an increase in funding as it becomes available.

C: Goal Setting

- Develop and implement a comprehensive course of action for primary medical care providers to follow for maximum health outcomes for HIV positive clients.

Required Intervention #10: “Implement STD screening according to current guidelines for HIV-positive persons”

A: Situational Analysis

Clinic Based Screening

Active integration of HIV and STD services is a hallmark of the HDHHS-Bureau of HIV/STD and Viral Hepatitis Prevention. All HDHHS STD clinics in Houston continue to provide HIV testing as part of a routine, opt-out screening program that includes testing for syphilis, gonorrhea, and Chlamydia, HBV and HCV.

Linkage

Referrals are done for previous positives that test for insurance purposes and access medical services. When an individual has been released from criminal justice and previously tested positive then there will be connection to a medical provider. Services are linked and integrated so that a previous positive or newly diagnosed individual will receive STD screening regardless of whether it’s a clinic or non-clinic based settings.

Non-Clinic Based Screening

Once the STD clinic has conducted notification and referral to service linkage and clinical care another STD screening will be conducted. This is targeted more towards outreach activities where HIV testing is the only service offered. HIP HOP for HIV started initially as a screen for HIV and later moved to screening HIV and other STDs in 2010.

The majority of the persons discovered to be positive through this project has been referred to Ryan White Part A care providers, and as a standard component of intake to receiving services includes assessment for STD, TB, HAV, HBV, and HCV. Although funding for these activities was not sought for all sites through this project, HDHHS will continue to provide STD, maternity and family planning services in its four (4) integrated clinic sites throughout the City of Houston. These sites currently offer routine HIV opt-out screening for all patients. In addition, HDHHS currently operates Medical Mobile Clinic with stat laboratory testing capability for syphilis, and also conducts testing for HIV, gonorrhea, Chlamydia and vaccines for hepatitis A and B. Case related screenings occur in areas of the City where new cases of disease are reported. The unit is deployed directly to those communities in order to provide enhanced disease intervention. One project partner, Legacy Community Health Services has conducted syphilis screenings in addition to HIV screenings at both of their clinical locations.

HIV and STD prevention services are now offered at all HDHHS clinics allowing for expanded geographic access to HIV/STD prevention services for all residents of the City of Houston. All CTR sub contractual agencies are required to provide syphilis testing along with their HIV

testing. Disease Intervention Specialists (DIS) conduct public health follow-up activities (PCRS) for all primary and secondary syphilis cases and most new HIV diagnoses in Harris County.

HDHHS integrates HIV/STD prevention services into ALL of its eight (8) community health centers. HIV/STD prevention services are offered alongside other HDHHS services including family planning services, WIC services, immunization services, and TB services.

HCV testing is conducted concurrently with HIV testing in some settings serving populations with high numbers of current or past injection drug users. Pre-vaccination testing for HAV and HBV is also conducted as indicated for MSM and injection drug users. HIV funds are used for viral hepatitis testing. Additional standard testing is provided as indicated by current treatment guidelines for HIV infected patients, including STD, HBV, HCV and TB testing.

HIV/STD surveillance, administratively in the HDHHS Bureau of Epidemiology, ensures that suspected cases are reported in a timely manner and initiated for client follow-up when appropriate. Virtually all data collected for surveillance and program evaluation is input into existing systems such as HIV/AIDS Reporting System (HARS) or Sexually Transmitted Diseases Management Information System (STD*MIS). Surveillance staff enters morbidity and reactors for processing, perform assessments and make assignments to DIS at the time of case report.

The Recalcitrant Policy addresses previous positives and those individuals who have a reoccurrence of STDs. Individuals are brought in for special counseling to review behavior and what puts them at risk. A plan is developed to assist clients in reducing risk through education and risk reduction methodology with progressive steps.

In 2009, 137 previously HIV positive persons were reported with evidence of unsafe sex (e.g., new STD diagnosis, pregnancy). Individuals who fall into this risk group undergo Public Health Follow-up.

HIV Treatment & Care

The 2006 CARE Act defines Primary Medical Services as the “provision of professional diagnostic and therapeutic services rendered by a physician, physician’s assistant, clinical nurse specialist, nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting..... Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history tasking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provisions of specialty care”.

The RW Part A primary care visit consist of a client examination by a qualified Medical Doctor, Nurse Practitioner and/or Physician Assistant and includes all ancillary services such as eligibility screening, patient medication/treatment education, adherence education, counseling and support; medication access/linkage; and as clinically indicated, OB/GYN specialty procedures, nutritional counseling, routine laboratory and radiology. All primary care services must be provided in accordance with the current US public Health Services guidelines

Primary Care Guidelines

Primary medical care must be provided in accordance with the most current published U.S. Public Health Service treatment guidelines (www.hivatis.org).

The current Ryan White Care Act Part A/B Standards of Care for HIV Services for the Houston EMA lists the following under *Primary Medical Care Standard 1.7*:

- STD testing including syphilis, gonorrhea and Chlamydia as clinically indicated.

B. Rationale

To focus on STDs among this population is important because; 1) an STD may indicate recent risky behavior that could lead to HIV transmission, 2) presence of some STDs increases the likelihood of both transmitting and acquiring HIV, and 3) identification and treatment of STDs can reduce their spread among high risk groups, including HIV-positive persons. Funding at present levels and scale for STD screening for HIV positive persons will be maintained as the Houston MSA currently complies with U.S. treatment guidelines.

C: Goal Setting

- To collaborate with the Ryan White Planning Council (RWPC) and the Standards of Care Administration to ensure that all HIV-positive persons receive an initial STD screening.
- Continue operation of the HDHHS Medical Mobile Clinic with stat laboratory testing capability for syphilis, and also conducts testing for HIV, gonorrhea, Chlamydia and vaccines for hepatitis A and B.

Required Intervention #11: “Implement prevention of perinatal transmission for HIV-positive persons”

A: Situational Analysis

The HDHHS will continue to encourage and support routine HIV screening through the task forces and advisory groups sponsored. The Perinatal Advisory Group is focusing on assisting hospitals in providing rapid HIV testing in Labor and Delivery units throughout the city.

In 2006, CDC published “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings”. To further reduce the number of children who are infected with HIV perinatally, these recommendations called for routine opt-out screening for all pregnant women, with repeat HIV screening in the third trimester for women who meet 1 or more of 4 criteria (for example, women at high risk and women who receive health care in jurisdictions with elevated rates of HIV infection among women). Women whose HIV status is unknown at the time of labor should be offered opt-out screening with a rapid test.

Perinatal HIV transmission prevention activities implemented for January through June 2008 included the HDHHS perinatal program three component approach: 1) expanded HIV rapid



testing to Houston area L&Ds through capacity building and technical assistance; 2) expanded existing community involvement through the HDHHS clinics and mobile unit to pregnant women who are at high risk and have received little or no prenatal care. Additionally, pregnancy testing will be offered to all women of childbearing age; and 3) the HDHHS began to expand its social marketing campaign to ensure that women who are pregnant and of childbearing age are aware of services that are available to them. These services include maternal care and family planning. The expected outcome is to locate and provide services to high-risk pregnant women that are not receiving prenatal care. The achieved outcomes will be determined by the number of childbearing women that received prenatal care, HIV prevention services; as well as the number of women identified who have traditionally never received HIV testing and prevention, prenatal care or family planning services. Also in 2008, the HDHHS provided our perinatal social marketing campaign materials electronically, as well as minimal technical assistance, to Triangle AIDS Network in Beaumont, TX. The HDHHS will ensure that women who are pregnant; who are of childbearing age and identified as meeting the CDC's definition of high-risk will receive HIV screening in HDHHS clinics. The outcome will be determined by the number of pregnant women that received HIV testing during the first and third trimesters.

The HDHHS' Perinatal Program Liaison continues to establish rapport and fosters linkages to hospitals in the Houston area to help facilitate the use of the rapid HIV test in Labor and Delivery Units. The expected outcome is to increase the number of at-risk pregnant women that become aware of their status prior to delivery. The outcome will be determined by the increased number of hospitals giving the rapid HIV test in Labor & Delivery as well as increasing their participation and the development of protocols and training of hospital staff. (p.

HIV CARE AND TREATMENT

Ryan White Part A Standards of Care for primary medical care include policy & procedure regarding perinatal services.

In 2009, the Houston EMA jurisdiction, non-CDC funded activities specific to Perinatal Prevention included obstetrical care for HIV infected pregnant women was funded within primary medical care services under Ryan White Part A. The agencies funded for primary medical care targeting women included the Harris County Hospital District (HCHD), Legacy Community Health Services, and Houston Area Community Services. The funding allocated under Part A allocated \$542,179 to these agencies.

In July, 2009, the Legislature of the State of Texas enacted House Bill No. 1795 , effective January 1, 2010, which requires any health care provider allowed to care for a pregnant woman to test her for human immunodeficiency virus (HIV), syphilis and hepatitis B virus (HBV), unless she objects.

| Stage of Pregnancy | Perinatal HIV/STD Tests Required by Texas Law |
|--------------------|---|
| First Trimester | <ul style="list-style-type: none"> HIV, HBV and syphilis test required |
| Third Trimester | <ul style="list-style-type: none"> HIV test required |

| | |
|---|---|
| Delivery | <ul style="list-style-type: none"> Expedited HIV test¹ required if no record of third trimester result HBV and Syphilis tests required |
| Newborn Tests | <ul style="list-style-type: none"> Expedited HIV test¹ required if no record of third trimester result |
| <p>1Expedited test. Test must be expedited and result obtained < 6 hours. For newborn test, blood must be drawn <2 hours after birth.</p> | |

| Stage of Pregnancy | Recommended Perinatal Tests and Precautions ¹ |
|---------------------------|---|
| First Trimester | <ul style="list-style-type: none"> Chlamydia and gonorrhea screening, especially for populations at risk² Retest 3-4 weeks after treatment for gonorrhea or Chlamydia |
| Third Trimester | <ul style="list-style-type: none"> Syphilis test recommended between 28-32 weeks for high risk populations³ and where syphilis prevalence is high Chlamydia test for high-risk populations² |
| Delivery | <ul style="list-style-type: none"> Any woman delivering a stillborn infant should be tested for syphilis Testing for HBV for women not previously tested or at high risk for HBV⁴ |
| Newborn Tests | <ul style="list-style-type: none"> First of three HBV vaccinations is given Required prophylaxis to prevent ophthalmia neonatorum (conjunctivitis sometimes caused by gonorrhea or Chlamydia bacteria) |

¹ Recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecology (ACOG).
² High risk for Chlamydia includes women under age 25 and those with a new or more than one sex partner.
³ High risk for syphilis may include women who previously test positive for syphilis, multiple sex partners, and low access to healthcare.
⁴ High risk for HBV includes more than one sex partner in the previous six months, evaluation or treatment for an STD, recent or current injecting-drug use, HBsAg-positive sex partner, and those with clinical hepatitis should be retested at the time of admission to the hospital for delivery.

- Does the HD have written policies and procedures for perinatal prevention and treatment?
 The Bureau of Epidemiology does not have funding specifically for prevention activities besides enhanced perinatal surveillance. This grant states that the HIV pediatric epidemiologists will participate in community prevention groups including the Community Planning Group, the Texas Consortium for Perinatal HIV Prevention, and the TRIAD Perinatal Task Force.
- What specific activities were funded by the HD for Perinatal prevention in Houston in 2009?
 The Bureau of Epidemiology does not have funding specifically for prevention activities

besides enhanced perinatal surveillance. This grant states that the HIV pediatric epidemiologists will participate in community prevention groups including the Community Planning Group, the Texas Consortium for Perinatal HIV Prevention, and the TRIAD Perinatal Task Force.

- What was the HD's 2009 budget for the jurisdiction for the activity?
The Bureau of Epidemiology does not have funding specifically for prevention activities besides enhanced perinatal surveillance.
- How many agencies in the jurisdiction carried out perinatal prevention activities in 2009?
This specific number is not known by the Bureau of Epidemiology.
- How many pregnant women in the jurisdiction were tested for HIV during 2009?
In 2009, 99% of the pregnant women were tested for HIV in Harris County.
- How many were newly diagnosed with HIV?
There were 53 infants born in 2008 who had mothers that were diagnosed during pregnancy.
- How many HIV exposed infants were born in 2008?
There were 179 exposed infants born in 2008 in addition to 5 infants that are possible exposures currently under investigation.
- How many infants were born with HIV in 2008?
There were a total of 2 confirmed HIV positive infants born in 2008. There were a total of 5 confirmed HIV positive infants born in 2009. There are 2 confirmed cases born in 2010 with several cases pending HIV DNA PCR tests after 4 months of birth.

B. Rationale

HIV testing early during pregnancy to identify unrecognized maternal infections should continue to be conducted consistent with CDC recommendations and Texas statutes. Among women with known HIV infection, preventing unplanned and planning desired pregnancy, scheduling cesarean delivery, avoiding breastfeeding, and linkage to HIV care for mother and infant are examples of strategies that have been successful at preventing perinatal transmission and leading to a near elimination of this transmission route in the Houston MSA. Continued support for implementation of these successful strategies will be maintained and will allow for transmission rates to remain low.

C: Goal Setting

- The City of Houston Department of Health and Human Services (HDHHS) will follow progress towards maximal reduction of perinatal HIV transmission among 100% of HIV exposed infants in the Houston/Harris County HIV Surveillance Jurisdiction.
- The City of Houston Department of Health and Human Services will analyze and disseminate perinatal HIV transmission prevention data quarterly to community

partners within the Houston MSA.

Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”

A: Situational Analysis

Partner Services:

PCRS in Houston is conducted by HDHHS Disease Intervention Specialists (DIS) and CBO risk-reduction specialists. In the state of Texas, only health department DIS may perform partner notification.

The Bureau also provides Partner Services (PCRS) to all individuals newly-diagnosed with HIV in Houston/Harris County. This is an instrumental service to intervene in the spread of HIV by contacting partners and contacts to newly diagnosed individuals and getting them tested so that they too can know their HIV status. The HDHHS developed a service linkage protocol to ensure that newly diagnosed individuals are interviewed for PCRS and linked into primary care services

Partner Services is currently offered through HDHHS and has stringently enforced standards and QA procedures for implementing disease intervention activities. The HDHHS employs entry-level Public Health Investigators to serve as Disease Intervention Specialists (DIS). These DIS staff members improve the HDHHS capacity to continue increasing HIV Partner Services, which has been a priority of the Bureau of HIV/STD and Viral Hepatitis Prevention.

Patients are notified that HIV testing will be conducted as a part of their visit, that HIV testing is confidential and that they may opt-out of testing. In the State of Texas, partner services include routine elicitation of other persons at high risk within the original patient’s social-sexual network. From 2004 to 2008, the number of individuals newly diagnosed with HIV in the Houston/Harris County jurisdiction remained stable at approximately 1,200 new diagnoses each year. However, the number of HIV clients interviewed by DIS staff has more than doubled (from 285 to 811), and the total number of partners elicited has increased proportionally (from 349 to 855).

Internet Partner Notification:

The HDHHS Bureau of HIV/STD and Viral Hepatitis Prevention has been actively conducting internet partner notification services utilizing Disease Intervention Specialists (DIS). In 2009, 197 requests were conducted and 146 requests were conducted during 2010. In 2009 and 2010, HDHHS employed 22 DIS workers to conduct partner services for HIV positive persons. It is a standard practice that all partners of infected STD patients are routinely tested for HIV. The process of receiving an HIV test allows for the clients to voluntarily opt-out. It is estimated that less than 1% voluntarily opt-out. STD-MIS is the only data system used to track and monitor STD partner services information.

Newly reported HIV positives are reported to the HIV surveillance unit of the Bureau of Epidemiology within HDHHS. Provider follow-up is conducted by surveillance staff and field

investigation records are initiated within three days of receipt of test result receipt for DIS follow-up. Newly reported individuals screened through HDHHS clinics are initiated to DIS for field follow-up.

PENSHouston

The web-based self-interview (WBI), known as PENSHouston, was expanded to selected private providers after completion of a successful pilot phase. This secure, Internet-based system has proven to be an acceptable option for clients who may initially decline a face-to-face interview, particularly men who have sex with men (MSM). Expansion of the WBI in 2009 provided DIS staff with an additional tool for successfully conducting PCRS.

The Bureau conducts internet partner notification services for other prevention programs in Texas including Dallas County Health Department, San Antonio Metro Health Department, and Austin/Travis County Health Department. Profiles on several websites are currently maintained by the Bureau including: 1) Manhunt.net, 2) Gay.com, 3) Adam4Adam.com, 4) BlackGayChat.com, 5) m4m-usa.net, 6) SilverDaddies.com, and 7) MySpace.com. In FY 2009 and FY 2010, one DIS was dedicated solely to Internet Partner Services.

CBOs are under contract to conduct partner elicitation for all newly identified HIV positives that they identify. PCRS conducted by CBO staff was strengthened in 2006 with the implementation of Protocol-Based Counseling (PBC). CBO staff members are required to conduct structured counseling sessions using a prescribed script of questions. Within seven days of receiving a positive test result, CBO staff must notify clients of their results and conduct partner elicitation. Clients not counseled within seven days must be referred by the CBO to HDHHS for DIS follow-up. Partners elicited by CBO staff are either notified by the client or referred to HDHHS for DIS partner notification. The HDHHS also recently entered into a Memorandum of Agreement with Planned Parenthood of Houston and Southeast Texas to provide PCRS services to all individuals newly diagnosed with HIV.

Partner notification is conducted by DIS in accordance with guidelines established by the Texas Department of State Health Services (DSHS). HIV/STD surveillance, administratively in the HDHHS Bureau of Epidemiology, ensures that suspected cases are reported in a timely manner and initiated for client follow-up when appropriate. Virtually all data collected for surveillance and program evaluation is input into existing systems such as HIV/AIDS Reporting System (HARS) or Sexually Transmitted Diseases Management Information System (STD*MIS). Surveillance staff enters morbidity and reactors for processing, perform assessments and make assignments to DIS at the time of case report.

All interviews conducted by DIS are entered in STD*MIS. The HDHHS-Bureau of HIV/STD and Viral Hepatitis Prevention program goal is to interview 85% of cases within 72 hours of report to

the health department. DIS are required to initiate follow-up within 24 hours of receipt to arrange an in-person interview. Interviews are conducted in the field or in the clinic to expedite follow-up. DIS are expected to achieve a contact index of 2.0 and a cluster index of 1.0 for each case interviewed. Partner notification is expected to be successfully conducted for 70% of patients pursued. Supervisors and DIS are encouraged to flex working hours as needed to ensure that our notification services reach the patients on their turf in a timely manner. DIS are evaluated in part on the percent of contacts referred for examination and treatment within 7 days.

The program strongly emphasizes the cluster interview to identify suspects and associates. The program also places emphasis on case related outreach screening. The Bureau's mobile medical clinic will continue to be an important component of our plan to examine case related high risk clusters in the client's social network. For this proposal, HDHHS is supporting HIV testing only while encouraging and/or providing referral for all other related services.

B. Rationale

Implementation of partner services, including the expansion of PENSHouston in the Houston MSA has proven to be highly effective in facilitating timely linkages to care for both patients and their previously status unaware partners and contacts. Support for this highly cost effective, high impact intervention will continue to receive increases as funding becomes available in order to identify and link more undiagnosed infections to treatment, facilitate positive behavior change, decrease HIV/STD transmission and incidence, and improve overall individual health. outcomes.

C: Goal Setting

- To increase the proportion of HIV-infected persons in Houston EMA who are linked to prevention counseling, medical care, partner services and HIV prevention services.
- To continue to offer the web-based self interview process through PENS Houston and expand utilization of PENSHouston to HDHHS STD clinics, thereby streamlining DIS activities.

Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"

A: Situational Analysis

Healthy Relationships

Healthy Relationships, a small-group, skills-based behavioral intervention for men and women living with HIV. The intervention focuses on skills building, self-efficacy, and positive expectations about new behaviors. Through group discussions, role plays, videos and skill-

building exercises, the intervention helps persons living with HIV develop skills to cope with HIV-related stressors and risky sexual situations. Intervention sessions also enhance decision-making skills for self-disclosing HIV-serostatus to sex partners, and help participants develop and maintain safer sex practices. Participants receive personalized feedback about their own risk practices, and with the help of the intervention group, develop strategies to maintain satisfying relationships while protecting both themselves and their partners. Intervention sessions are conducted separately for men and women in groups of 6-10 participants.

Community Promise

Community PROMISE is an effective, community-level HIV/STD prevention intervention that relies on role model stories and peer advocates from the community. The intervention is based on behavioral theories including Stages of Change.

Members of the target population who have made positive HIV/STD behavior change are interviewed and role model stories are written based upon the interviews. The stories are personal accounts about how and why they took steps to practice HIV/STD prevention behaviors and the resulting positive effects on their lives. Peer advocates from the target populations are recruited and trained to distribute the role model stories and prevention materials within their social networks. New role model stories are written based on continuous formative research that reflects behavior change within the target population

Protocol Based Counseling

The Bureau decided, through many conversations with the Texas Department of State Health Services (DSHS) and research of the protocol, to institute Protocol Based Counseling (PBC) to replace Prevention Counseling Partner Elicitation. DSHS had already developed and began implementing the protocol to their directly-funded contractors. PBC is consistent with the prevention risk reduction intervention found to be effective in Project RESPECT. It has been adapted to incorporate additional elements in the DSHS “Prevention Quality Assurance Standards” and “HIV and STD Program Operating Standards.”⁷ This protocol was developed jointly with the CDC, DSHS and organizational representatives from around Texas. This intervention focuses on protocol-based risk reduction sessions. The protocol for this intervention is very closely aligned to the Project RESPECT protocol that was implemented in Denver, Long Beach and Newark. It is a client-centered prevention counseling model that was proven effective at reducing high-risk behaviors and new STDs. A few adaptations have been made and forms designed to assist Risk Reduction Specialists (RRS) in carrying out the intervention and for quality assurance purposes.

B. Rationale

Risk assessments to identify behavioral risk of HIV transmission could include a risk self-assessment or risk screening interview and are recommended by the CDC’s PWP guidelines. Behavioral interventions for HIV-positive persons have been found to work well in conjunction with interventions that promote linkage to and engagement in care, medication and

appointment adherence, STD screening, and partner services. Current funding levels for this intervention will be maintained.

C: Goal Setting

- Maintain existing and increase interventions including Healthy Relationships and Community Promise as tools utilized by agency contractors to track behavior screening and risk reduction models for HIV positive persons.
- Continue utilization of Protocol Based Counseling as an effective counseling and testing tool to determine risk for HIV/STD transmission and reduction methodology for client participation.

Required Intervention #14: **“Implement linkage to other medical and social services for HIV-positive persons”**

A: Situational Analysis

Local Standards of Care (SOC) from the Ryan White Planning Council mandate that Point of Entry (POE) sites must transfer clients to a primary medical care or clinical case management program within 120 days of initial contact. This process ensures timely linkage to care and the provision of information about additional services in the local Continuum of Care (COC), such as eligibility requirements, transportation assistance and other services designed to reduce financial constraints. Ryan White/A funded Service Linkage Workers (SLW) are placed with the Houston Department of Health and Human Services (HDHHS) Bureau of HIV/STD and Viral Hepatitis Prevention, a directly-funded CDC prevention grantee. This linkage directly connects RW/A- and Minority AIDS Initiative (MAI)-funded efforts to locate and engage not-in-care and newly diagnosed people living with HIV/AIDS (PLWHA) with the City’s comprehensive HIV testing efforts conducted at numerous health clinics and community-based agencies throughout the metropolitan area.

In order to not supplant funds, the Houston EMA did not allocate FY 2011 RW/A funds under Early Intervention Services (EIS) for EIIHA activities as the RWPC determined the existing public funding for HIV Testing and EIS was adequate. However, the EMA had included EIS referral and linkage activities as a component of Non-medical case Management, or Service Linkage. SLW are embedded in programs that conduct HIV testing, and target newly diagnosed PLWH who have learned their HIV status within the previous 12 months but are not yet linked to care. Specific SLW activities include providing the newly diagnosed with “hands-on” information, referrals and linkage to medical, mental health, substance abuse and psychosocial services. SLW must transfer previously unaware PLWH who choose to access primary medical care from a non-RW source or private physician must be transferred to a Clinical Case Management or Medical Case Management site per client need and preference.

In addition to delivering test results, the SLWs embedded at HIV testing sites ensure that newly diagnosed individuals are referred to services that are appropriate to their needs, culture, language, sex, sexual orientation and age. Referral services include medical



evaluation and care, partner counseling, reproductive health services, drug or alcohol treatment, mental health services, legal services and screening for STDs and viral hepatitis. The newly diagnosed might also have multiple needs that can be addressed through support services such as housing assistance, food, employment, transportation and child care. Each year, the Houston RWPC publishes a resource guide known as the Blue Book. The Blue Book lists over 182 agencies that offer services to PLWHA. The Blue Book, distributed to service providers in Houston, assists HIV prevention and disease control programs make appropriate referrals for newly diagnosed PLWHA.

In FY 2011, the allocation for community-base primary care was expanded and the goal for medical case management targeted to African American and Hispanic PLWHA was maintained. Non-medical case management services targeted to newly diagnosed and not-in-care PLWHA were expanded in support of the EMS's EIIHA Strategy.

Key linkage to care for Demonstrated Need populations is maintained by expanding non-medical case management services co-located at HIV testing sites and primary medical care treatment sites. These programs, co-located at HDHHS clinics, other community-based HIV testing sites and RW-funded primary medical care programs will link at least 750 previously unaware, newly diagnosed individuals and out-of-care PLWHA into the EMA's COC.

Of note is that the EMS's three (3) Part A-funded community-based primary care providers are all funded for HIV testing and prevention interventions by the HDHHS and are among the most productive in terms of identifying new cases among demonstrated need populations.

HDHHS is currently collaborating with the RW_A program in the development and implementation of the Electronic Client-Level Integrated Prevention System (ECLIPS), a complementary application for tracking prevention activities including testing. This direct connection between the prevention and care data systems enhances linkage by seamlessly tracking referrals from initial HIV test to engagement in primary medical care for positive individuals, thus improving data collection and analysis.

Substance Abuse Programs

Through Legacy's Enhanced Syringe Access Program (ESAP), they have contact with many patients at very high risk for HIV and Hepatitis C Virus (HCV). The Bureau of HIV/STD and Viral Hepatitis Prevention sub contracts with one agency, Career and Recovery Resources that routinely provides CTR services in several substance abuse treatment facilities. Career and Recovery Resources specializes in programs to help those newly released from prison and those in recovery to secure employment. They serve a clientele at very high risk for HCV infection (injection and non-injection illegal drug use, high risk heterosexual contacts, and those recently released from incarceration).

Mental Health Departments and Community Mental Health Centers

The HDHHS currently collaborates with the Mental Health and Mental Retardation



Authority of Harris County (MHMRA) to ensure that the needs of this population are met.

Family Planning and Women's Health Agencies

In 2006, the HDHHS also began the process of integrating HIV/STD prevention services into ALL of its eight (8) community health centers. HIV/STD prevention services are now offered alongside other HDHHS services including family planning services, WIC services, immunization services, and TB services. The HDHHS also recently entered into a Memorandum of Agreement with Planned Parenthood of Houston and Southeast Texas to provide PCRS services to all individuals newly diagnosed with HIV.

Private Medical Doctors

In addition to primary care clinics, the HDHHS has developed and fostered relationships with several private medical doctors (PMDs) that primarily serve men who have sex with men. This has been a successful effort to improve partner services with this difficult-to-engage population. A few select disease intervention specialists (DIS) are assigned as liaisons to these PMDs and have created great working relationships with the staff in these medical offices. The DIS is notified by the PMD's office when a newly diagnosed client is scheduled to be seen, and the DIS conducts the partner services interview directly in the PMD's office. These successful relationships in the past have been with Dr. Shannon Schrader's office and Dr. Gordon Crofoot's office, and these liaison relationships are planned to be expanded to other PMDs. The web-based self interview mentioned earlier in the PCRS section is also a key tool for the clients of these PMDs.

Corrections

Voluntary HIV screening is offered in Harris County Jail under a contract with TDSHS. Inmates who test positive are counseled and offered partner services by HDHHS DIS assigned to the jail. HDHHS is working with the Texas DSHS to encourage Harris County Jail to adopt routine, opt-out HIV screening as a part of the standard medical assessment performed on each inmate on their 14th day in the jail.

The Harris County Juvenile Detention Center screens all detainees for gonorrhea and Chlamydia, and provides HIV testing to all individuals who test positive for one or both of these STDs. HDHHS DIS staff members provide counseling and partner services to persons who test HIV positive.

Two Texas Department of Criminal Justice state jails are located within the jurisdiction of HDHHS. All inmates are screened for HIV upon intake and at release. Inmates who test positive are reported to HDHHS and receive partner services from HDHHS DIS.

Additionally, the HDHHS is playing a key role in assisting individuals upon re-entry to the City of Houston/Harris County from incarceration. In 2007, City of Houston Mayor Bill White launched plans to initiate a pilot project entitled City of Houston Ex-Offender Reentry Initiative. The three-phased program began implementation in 2008 and is designed to provide the participants with the necessary training, support, and services needed for successful long term integration into responsible living. Program staff also

assists participants with money management, job readiness and retention, and the acquisition of vital statistic documents and identifications. Staff from the Bureau of HIV/STD and Viral Hepatitis Prevention have been an active part of this program plan, design, and implementation and assists with the provision of screening and education to prevent the spread of communicable diseases.

In January 2011, the Houston Community Reentry Network Works Program (CRN); the HDHHS offender reentry program joined the Bureau of HIV, STD, and Viral hepatitis Prevention. Houston's CRN has proven successful in (1) reducing ex-offender recidivism rates, (2) connecting program participants with much needed community employment , and (3) linking services to address issues impacting recovery.

B: Rationale

Linkage of HIV-positive persons with medical and social services involves ongoing processes by which they are assisted in obtaining necessary emergent and ongoing support services have shown to be highly effective within the Houston MSA. With strong coordination and joint strategic planning among the local service linkage network of providers and organizations, this intervention has consistently demonstrated client level benefits including the decreased likelihood of HIV transmission risk behavior and funding support for this strategy will continue to be expanded and increased as it becomes available.

C: Goal Setting

- To ensure appropriate linkage to primary medical care and other healthcare services, mental health therapy, substance abuse treatment and other essential support services for HIV-positive individuals, both those newly diagnosed and those who are out of care in the Houston MSA.
- Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals.

Recommended Intervention #15: “Condom distribution for the general population”

A: Situational Analysis

Community Based Organization and City-Wide Condom Distribution

Non-profit organizations distribute condoms throughout the Houston MSA. All condoms are provided free of charge. In 2009, a total of 60,000 condoms and 32,500 personal lubrication packets were distributed throughout the year to a minimum of 25 venues such as popular bars and clubs, bath houses, adult bookstores, barber shops, beauty salons, health fairs and retail stores. Condoms are also made available upon request from the general public.

The Texas Department of State Health Services (DSHS) provides HDHHS with 250,000 condoms annually for distribution throughout the Houston MSA. We receive a variety of Durex condoms, including: Maximum Love, Performax, Extra Sensitive, Enhanced Pleasure, Extra and Natural Feeling.

The Houston condom distribution program also made condoms available to individuals through the City of Houston 3-1-1 Helpline.

Youth specific condom promotion and distribution is limited based on the social climate within the State of Texas. State legislation prohibits the distribution of condoms within primary and secondary educational institutions.

Condom distribution remains a key strategy of HIV prevention services regardless of intervention or collaborative partnership.

B. Rationale

Because of the potential condom distribution provides as a structural-level intervention focused on increasing the acceptability (norms) for condom use within the general population funding and support for this intervention will be maintained at current levels. Structural-level condom distribution interventions have also been found to increase the amount of condom use and general access to them.

C: Goal Setting

- Maintain the distribution of 80,000 condoms provided throughout Houston MSA.

Recommended Intervention #16: “HIV and sexual health communication or social marketing campaigns targeted to relevant audiences”

A: Situational Analysis

HDHHS defines “social marketing” as the use of modern marketing principles and methodologies to affect in some way knowledge, attitudes, beliefs and/or practices regarding HIV/AIDS risk, associated behavior change and risk reduction and access to services and treatment education.

The Houston/Harris County EMA has seen and heard its share of Social Marketing efforts throughout the last decade. The following is a reflection of the current and most recent social marketing campaigns broadcast in this jurisdiction:

Greater Than AIDS

Through a national media campaign and community outreach, Greater Than AIDS targeting, Black Americans, aims to elevate the public’s knowledge and understanding of HIV/AIDS and confront the stigma surrounding the disease. Although national in scope, the effort is targeting communities most heavily affected, based on HIV/AIDS incidence and prevalence data.

By stressing unity, hope, and empowerment Greater Than AIDS seeks to inspire each and every one of us – in our relationships, families, and communities -- to do our part to stem HIV/AIDS by:

- > Being informed
- > Speaking openly
- > Getting involved
- > Acting with respect
- > Using condoms
- > Getting tested – and treated as needed

Greater Than AIDS aims to elevate the public’s knowledge and understanding of HIV/AIDS and confront the stigma surrounding the disease. A focus is on reaching and engaging Black Americans, who represent half of people living with HIV/AIDS in the U.S. and a majority of new infections. Priority groups include: youth, men who have sex with men and women.

This effort continues in the Houston/Harris County EMA with a partnership with the Houston Rockets. The NBA has partnered with Greater Than AIDS to mobilize fans, teams and local communities in response to AIDS in the United States and reduce the stigma associated with the disease.

The Houston Rockets has already proclaimed their March 18, 2011 match against the Boston Celtics as their Greater Than AIDS day.

Deciding Moments

“Deciding Moments,” every day opportunities to do something to stem the spread of HIV. The concept grew from focus groups conducted with more than 100 Black Americans, ages 18 to 50, across the nation in which participants described transformative moments when they were confronted with a decision related to HIV/AIDS and felt empowered by their response. The idea of “*Deciding Moments*” may also be considered on a higher, societal level, representing a moment in time when our community can make a collective decision to change the course of this epidemic.

Local Business/Labor Responds to AIDS Project

Business and labor remain two of the most significant and yet underutilized sectors of society in addressing the HIV/AIDS pandemic. The Centers for Disease Control and Prevention (CDC) launched the Business Responds to AIDS/Labor Responds to AIDS (BRTA/LRTA) program to engage and support the private sector (business and labor) in promoting HIV education and policy development in the workplace and to increase the utilization of these very important sectors in the fight against HIV/AIDS. BRTA/LRTA activities are designed to assist business and labor in improving HIV/AIDS awareness, prevention, testing, and care in their sectors, organizations, and surrounding communities.

The Local Business/Labor Responds to AIDS Project Lifecycle provides guidelines to help ensure and measure successful capacity building of local health departments to engage the business and labor sectors, including their ability to:

- Increase awareness of the Local Business/Labor Responds to AIDS Project among local merchants and citywide leaders
- Increase awareness of HIV in communities of high prevalence
- Increase number of persons motivated to get tested within the project city
- Increase number of people who actually get tested within the project city
- Increase number of people linked to care within the project city

Expanded Syringe Access Program (ESAP)

The Bureau of HIV/STD and Viral Hepatitis Prevention funded Legacy Community Health Services to implement a program entitled the Expanded Syringe Access Program (ESAP). As syringe exchange programs are presently considered illegal in the State of Texas, Legacy will continue this innovative project that targets pharmacies in Houston/Harris County. Project goals are to educate pharmacists on Texas Law and hepatitis disease and encourage them to allow the purchase of syringes to persons over 18 who do not have a prescription.

GYT: Get Yourself Tested

MTV and the Kaiser Family Foundation, working with Planned Parenthood Federation of America and other partners nationwide, bring you **GYT ("Get Yourself Tested")**, a special promotion of IYSL to inform young people about STDs and normalize testing.

The campaign takes a multi-platform approach to providing information, using online and mobile technologies as well as MTV's core on-air assets. Messaging is integrated across programming genres including public service advertisements (PSAs), long-form documentary and entertainment programming, and news segments. The campaign engages MTV audiences through social networking, user generated content, and high-profile contests. It's Your (Sex) Life

(IYSL) also provides young people with extensive free informational resources including a dedicated Web site and cell phone text messaging service providing access to HIV testing site locations.

2009 Houston Gay, Lesbian, Bisexual, and Transgender Pride Parade

Following along with the theme of the float, a radio spot, “Be Free From HIV...” was launched during GLBT Pride Month in June 2009. The radio spot directed to the Gay, Lesbian, Bisexual, and Transgender community played on “Social Justice” by focusing on psychological factors that the GLBT community deal with on a day-to-day basis that lead to placing oneself at risk.

Perinatal HIV Prevention

HDHHS expanded its social marketing campaign to include women who are pregnant and of childbearing age and ensure their awareness of services that are available to them. These services include maternal care and family planning. With its attempt to be more “green” HDHHS provides perinatal social marketing materials electronically to Triangle AIDS Network in Beaumont, TX. HDHHS will target the Vital Statistics, Women, Infant and Children (WIC) and Epidemiology/Surveillance areas, which averages approximately 1,050 clients per month. Targeted social marketing postcards, pamphlets and videos/DVDs will be used for this population including the dissemination of social marketing materials to the following targeted department areas: Vital Statistics, Women, Infant and Children (WIC) Programs, and Epidemiology/Surveillance areas.

Condom Distribution

Female (Reality), oral (Kiss of Mint), extra strength condoms and dental dams will be distributed during HE/RR, PCPE, EIP and PCM sessions by staff and CBOs to reinforce prevention and risk reduction behavior among the priority populations, and when working with HIV-infected population. Funds support Community-Level Interventions social marketing projects that make condoms accessible in different communities.

The “HIV...It’s Real” social marketing campaign utilized mainstream marketing principles and techniques to influence the target audience to voluntarily accept, reject, modify or abandon a behavior. This campaign adhered to components of well-tested theories such as social learning theory, theory of reasoned action/planned behavior, the trans-theoretical model, and the Health Belief model. Campaign materials included brochures, posters and billboards that were distributed throughout zip codes with the highest rates of HIV infection, transit advertisements, radio spots on targeted African American radio stations, a website (www.itsrealhouston.org), and interactive text messaging. Materials continue to be distributed throughout the community including bars, primary care clinics, beauty salons, and during the GLBT Pride Festival & Parade as they occur annually.

In addition, along with other non-profit organizations, businesses, and churches, HDHHS actively recognizes and participates in the following events designed to promote HIV

prevention and sexual health communication:

- National HIV/AIDS Women and Girls Awareness Day
- National Latino HIV/AIDS Awareness Day
- National Black HIV/AIDS Awareness Day
- National HIV/AIDS Testing Day
- World AIDS Day
- National Condom Day
- Splash (African American Gay Pride Weekend)

Legacy Community Health Services – HDHHS Contractor

The following is an example of the social marketing campaigns produced by one of HDHHS contractors Legacy Community Health Services funded to implement social marketing campaigns.

In 2008 through 2009, Legacy Community Health Services developed a social marketing campaign targeting urban youth. The program was funded by the City of Houston Department of Health & Human Services to target men of color who have sex with men, with a focus on ages 15-30. During the formative evaluation process, it was determined that this population would better respond to a campaign that uses technology rather than a traditional print campaign. The population was interested in websites, blogs, videos and social media. They also suggested that they were more likely to visit an internet-based product that did not single them out as gay or bisexual, but instead was a place for all youth to visit. Legacy developed www.lifestylez.org, which is a website that incorporates information on HIV/STDs and recreational drugs, community resources, along with videos developed by Legacy. The premiere video, shot in a documentary style similar to reality TV, followed a young African-American gay man living with HIV in his day-to-day life as a hairdresser. The video showed the highs and lows of real life living with HIV. Subsequent videos featured local hip-hop/rap stars delivering messages about safer sex and the importance of getting tested. The website also featured several HIV/STD prevention PSAs created by Legacy.

Legacy has also produced a syphilis awareness campaign called Don't Sleep On It (2007-present). The campaign uses print media, print collateral, radio and a website to deliver a syphilis prevention message targeted to young African-American men and women. The campaign also hosted events and participated at other large scale events to deliver the syphilis prevention message to the target populations.

B. Rationale

Health communication and social marketing campaigns are part of strategic communication planning. These campaigns are designed to inform and influence behavioral change within individuals and communities. Efforts that integrate multiple behavioral and social learning theories and models in identifying steps to influence audience attitudes and behavior helps create effective public health campaigns. This intervention will receive an increase in funding as it becomes available.

C: Goal Setting

- To alter HIV testing and risk reduction behaviors; correct misperceptions and misinformation, and create a supportive environment for communication about what it means to be HIV-positive or HIV-negative.

Recommended Intervention #17: “Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV”

A: Situational Analysis

VOICES/VOCES

VOICES/VOCES, a single-session, culturally specific, video-based intervention for STD clinic patients. The small group session (3-8 patients) is gender and ethnic matched and is conducted by a gender-matched facilitator in either English or Spanish. Groups of participants first review one of the culturally appropriate STD prevention videos, “*Let’s Do Something Different*” for African Americans and “*Porque Si*” for Latinos/Hispanics. Both videos provide accurate risk information and corrected misinformation, portray positive attitudes about condom use, and model gender- and culturally-specific strategies for encouraging condom use. Interactive group discussions following the video reinforce the STD and HIV prevention message. Participants are encouraged to talk about problems they have experienced when trying to use condoms and discuss strategies to increase condom use. All participants are offered a selection of free condoms at the clinic and a coupon for free condoms at an area pharmacy.

Safe in the City

Safe in the City (SITC), a 23-minute HIV/STD prevention video for STD clinic waiting rooms. This video has been shown to be effective in reducing sexually transmitted diseases (STDs) among diverse groups of STD clinic patients. Safe in the City aims to increase condom use and other safer sex behaviors, and thereby reduce infections among patients who view the video in the clinic waiting room.

Service Linkage Options for HIV Positive Community through HCHD and CBO

In 2009, Immediately following the post-test counseling session, individuals who test HIV positive and meet the criteria for the SPNS Program will provided materials/information about the program to include:

- program description,
- eligibility requirement
- contact information

If client consents, post-test counselor will contact SPNS staff (HCHD Social Worker Case Manager or COH Service Linkage Worker) to meet the client immediately, schedule an appointment to meet with client on the same day, or within 3 days. If for any reason contact cannot be made, and client prefers to be contacted by SPNS staff, a linked referral must be signed by the client before his information can be given to a SPNS staff member. Individuals

who express an interest in participating in the program will be assisted in scheduling an appointment to meet with the Social Worker Case Manager (SWCM) or Service Linkage Worker (SLW) within three (3) business days. They will be given a choice of meeting with the SWCM / SLW at the HDHHS, HCHD Thomas Street site or an alternate site of their choosing.

Educational Materials for HIV Positive Community (2009, 2010)

These supplies include culturally appropriate educational brochures, pamphlets, booklets, flip charts, videos, slides, and posters targeting HIV-positive persons to provide self-instruction or enhance counseling sessions for sessions conducted by staff and CBOs.

Healthy Relationships

Healthy Relationships, a small-group, skills-based behavioral intervention for men and women living with HIV. The intervention focuses on skills building, self-efficacy, and positive expectations about new behaviors. Through group discussions, role plays, videos and skill-building exercises, the intervention helps persons living with HIV develop skills to cope with HIV-related stressors and risky sexual situations. Intervention sessions also enhance decision-making skills for self-disclosing HIV-serostatus to sex partners, and help participants develop and maintain safer sex practices. Participants receive personalized feedback about their own risk practices, and with the help of the intervention group, develop strategies to maintain satisfying relationships while protecting both themselves and their partners. Intervention sessions are conducted separately for men and women in groups of 6-10 participants.

Data Collection and Management for HIV Positives

Newly reported HIV positives are reported to the HIV surveillance unit of the Bureau of Epidemiology within HDHHS. Provider follow-up is conducted by surveillance staff and field investigation records are initiated within three days of receipt of test result receipt for DIS follow-up. Newly reported individuals screened through HDHHS clinics are initiated to DIS for field follow-up.

CBO Client Notification and Referral for HIV Positives

CBOs are under contract to conduct notification and partner elicitation for all newly identified HIV positives that they identify. PCRS conducted by CBO staff was strengthened in 2006 with the implementation of Protocol-Based Counseling (PBC), described earlier in the CTR section. CBO staff members are required to conduct structured counseling sessions using a prescribed script of questions. Within seven days of receiving a positive test result, CBO staff must notify clients of their results and conduct partner elicitation. Clients not counseled within seven days must be referred by the CBO to HDHHS for DIS follow-up. Partners elicited by CBO staff are either notified by the client or referred to HDHHS for DIS partner notification.

DIS Utilization for HIV Positives

One change in strategy moving forward with the project is a realignment of DIS workload to assign one sole DIS liaison for each site specific investigations on newly reported positives. All participating sites have established policies and procedures for providing appropriate counseling and referrals to persons diagnosed with HIV in their facilities. The five HDHHS Senior Public Health Investigators will assist clients testing positive with linkages to medical care, crisis-intervention, referral to HIV primary care services, and other referrals as needed. Legacy will continue with their standard operating procedures for HIV positives identified in their clinic and



will continue to provide clients who test positive with active referrals to HIV case management and care providers, as well as existing community-based HIV prevention services.

B: Rationale

HIV clinics and other medical facilities are ideal settings for delivering sustainable behavioral interventions to HIV-positive persons and those at highest risk of acquiring HIV. The HDHHS has continued to seek new and innovative strategies to integrate evidenced-based prevention into these settings. This intervention will be increased as funds become available.

C: Goal Setting

- Ensure that at least 50% of HIV-positive patients diagnosed at HDHHS Clinic locations and 25% of individuals at highest risk of acquiring HIV testing at HDHHS Clinic locations actively receive or participate in evidence-based HIV prevention interventions
- To ensure that VOICES/VOCES, Safe in the City and/or Healthy Relationships are implemented at HDHHS Clinic locations with high HIV/STD prevalence.

Recommended Intervention #18: “Community interventions that reduce HIV risk”

A: Situational Analysis

Based upon the CDC nationwide prevalence estimates², HDHHS estimated 26,500 people were living with HIV in Harris County in 2006 (HIV prevalence=26,500). As a result, the HIV transmission rate is 6.4% ($1700/26500 \times 100\% = 6.4\%$). Reducing the annual number of new HIV infections has a correlation on reducing the number of opportunities HIV can be transmitted. ***The HDHHS will seek to reduce the annual number of new infections to 1275 and realize a reduced transmission rate of 3.7% (1275/33810)*.***

To reduce the number of new HIV infections, the HDHHS will implement a combination of activities to include intensifying HIV and STD prevention efforts in five geographic areas within the MSA with high HIV and STD morbidity, which includes; 1) Sunnyside/South Park, 2) Greater Fifth Ward, 3) Acres Homes, 4) Sharpstown/Southwest, and the 5) Montrose. This targeted public health and community mobilization effort will be branded as the SAFER Initiative.

Intensifying activities will include:

- The allocation of new and existing HIV/STD and related funding support to these five (5) high morbidity areas.
- The initiation of local consultations with administrative agencies within the MSA to determine current distribution of HIV resources.
- Maintaining and increasing existing capacity to screen, test, treat and vaccinate HIV-positive persons, injection drug users and HIV-negative persons at highest HIV risk for

acquiring HIV, Hepatitis, STDs and TB.

A fundamental premise of the SAFER Initiative is that effective and sustainable community-level HIV prevention programs need to involve many and diverse community residents, businesses, and institutions. In order to implement this premise community residents and organizations that commit to the prevention effort early will have an opportunity to identify and invite additional community members, groups, organizations, and agencies to be part of the community mobilization group that will partner with the HDHHS.

Once community partners are identified HDHHS staff and community leaders will share in the design and implementation of comprehensive strategies for HIV prevention services. The SAFER Initiative will borrow President Obama's framework from the National HIV/AIDS Strategy, to empower the Sunnyside and South Park communities to take ownership of preventing HIV/STIs in their communities and promote the need for ongoing medical care and services for people living with HIV/AIDS. This large-scale public health initiative will be replicated throughout Houston communities using different program names unique to each community participating in the initiative.

B. Rationale

Community level interventions (CLIs) seek to improve the HIV risk conditions and behaviors in a community by changing social norms regarding risk behaviors, and increasing the social acceptability and support for safer behaviors. CLI are directed at entire communities with the aim of creating widespread and durable behavior change throughout the target population. This intervention will increase as funding becomes available.

C: Goal Setting

- Through the SAFER (Strategic AIDS/HIV Focused Emergency Response) Initiative, community mobilization models targeted to five high morbidity areas within the Houston MSA will be utilized in order to coordinate community-based responses for HIV prevention.

Recommended Intervention #19: “Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship”

A: Situational Analysis

Prioritized Risk Groups

In 2004, based on a comprehensive review of local HIV epidemiology, the CPG developed and

recommended for adoption the use of a behavioral risk group (BRG) model to allocate HIV prevention resources. This recommendation was a departure from the previous target population model that did not significantly factor in the behavioral HIV risk of targeted groups.

In past years (2005-2006), the CPG reviewed numerous secondary data sources to assess met and unmet HIV prevention needs and evaluate the appropriateness of the current BRG model. Recently, the CPG re-affirmed the existing BRG model for the purposes of priority setting, resource allocation and prevention program planning with some minor adjustments. The CPG recommended that transgenders, incarcerated individuals, and individuals recently released from incarceration be considered populations of special need. Additionally, the CPG recognized the continued importance of placing the highest priority for prevention resources on people of color, youth and persons living with HIV within each BRG and special population and forwarded recommendations accordingly.

The six prioritized BRGs include:

- Males who have sex with males (MSM);
- Females who have sex with males (FSM);
- Males who have sex with females (MSF);
- Male injection drug users (M/IDU);
- Female injection drug users (F/IDU), and;
- Males who have sex with males and use injection drugs (MSM/IDU).

Additional priority populations include:

- Persons living with HIV/AIDS, and;
- Youth (persons ages 13 – 24).

Additional populations of special need include:

- Transgenders;
- Incarcerated individuals, and;
- Individuals recently released from incarceration.

BRG categories are mutually exclusive and persons at risk for HIV are counted in only one BRG category. HIV-positive individuals are a high priority in every behavioral risk group, in addition to high-risk HIV-negative individuals and those who do not know their serostatus. In order to bring about a reduction in new infections, it is of primary importance that programs reach HIV-positive individuals. Interventions for HIV-positive individuals (both those who know their serostatus and those who are unaware that they are positive) should be designed to address their risk behavior as well as meet their specific needs.

The HDHHS recognizes that a select number of group-, individual-, and community-level interventions that have demonstrated some level of efficacy have been identified by our

federal partners for **adaptation or tailoring** throughout the country. These include Street Smart, SISTA, Safety Counts, Popular Opinion Leader, and Community PROMISE, among others.

Individual-Level Interventions (ILI)

Health education and risk-reduction (HE/RR) counseling is provided to one individual at a time and either face-to-face or via the Internet. Individual-level interventions assist clients in making plans for individual behavior change, provide ongoing appraisals of the client's own behavior, and include skills-building activities. These interventions also facilitate linkages to services in both clinic and community-based settings (e.g., substance abuse treatment settings, HIV counseling, testing and referral services) and are intended to support behaviors and practices that prevent transmission of HIV.

HIV counseling, testing and referral (CTR) services constitute an individual-level intervention designed to inform persons of their HIV status. It is the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, an explanation of testing procedures and test results, an assessment of the individual's risk for HIV transmission, a review of strategies to prevent HIV infection or transmission, a review and offering of partner counseling and referral services and the delivery of client-centered referrals.

CTR Interventions

HIV screening has been recommended in traditional, health-care settings; however, it may be beneficial in non-traditional settings when targeted in high-prevalence venues and geographic areas.

Protocol-Based Counseling (PBC) is an individual-level intervention involving a pre-defined set of standards for multiple interventions delivered as a set and includes the following CTR components:

Partner Counseling and Referral Services (PCRS)

PCRS is a systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can learn their HIV status, avoid infection or, if infected, prevent HIV transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Partner Elicitation is the process of eliciting or obtaining names, locating information and identifying information of the client's sex and/or needle-sharing partners as well as social networks of an HIV-positive individual. Due to the very sensitive nature of PCRS, CBO staff must be well trained in order to conduct partner elicitation. In Texas, this activity may be conducted by health department staff and/or CBO staff.

Partner Notification is the process of informing an HIV-positive individual's sexual or needle sharing partner of his or her possible exposure to HIV. Partner notification is traditionally a function of the health department and, in Texas, may only be conducted by health department staff or through contract referral with the client.

Group-Level Intervention (GLI)

Health education and risk-reduction counseling that shifts the delivery of services from the individual to groups of varying sizes. Group-level interventions include peer and non-peer models involving a wide range of skills, information, education, and support. Group level interventions must have a multiple session component thereby including at least three (3) sessions in its design with a follow-up component.

Education, Planning, and Evaluation Unit

The Education, Planning, and Evaluation Unit is responsible for the overall training and health planning needs for the Bureau. They coordinate an active training calendar that incorporates all training and refresher courses needed by staff within the Bureau, the health department, the Community Planning Group, and other interested community stakeholders. Courses are facilitated by trainers within this unit or by other external subject matter experts. This group, as part of a larger quality management effort within the Bureau, is charged with ensuring that each Bureau employee is fully trained in best practice models for HIV and STD Prevention and Care, and local, state, and federal required trainings for staff and sub-contractual vendors performing HIV/STD prevention work such as, Protocol Based Counseling, HIV/AIDS Facts and Fallacies (HIV 101), and behavioral interventions part of the CDC recognized DEBI Project. All Bureau related training is identified and scheduled in accordance with the national effort to define “Core Competencies for Public Health Professionals” and the national goals of Healthy People 2010.

Partner Services Unit

Direct partner services are provided by DIS as directed by State of Texas Law governing partner notification of infectious communicable disease. DIS personnel conduct field investigations on all HIV and other STDs infected individuals and their partners who do not follow up for treatment services. DIS also work with each sub-contractual vendor providing HIV/STD testing and screening services to provide partner elicitation of individuals testing positive for disease. This ensures that standardized methodologies are used across all testing venues for ultimately improving partner counseling and referral services (PCRS) within the City of Houston.

Program Unit

Sub-contractual vendors for the Bureau providing direct HIV/STD prevention services are monitored by program analyst staff housed in this unit. These staff members serve as the primary point of contact for all programmatic/quality assurance matters for these vendors. Special projects of national significance and research projects related to HIV/STD surveillance are operated within this unit, including planning and deployment of mobile testing and treatment unit to “hot spot” areas of the city with evidence of high morbidity and disease outbreak.

Screening Procedure for HCHD

At the initial screening appointment, the prospective client will be assessed by the Screening Nurse. All needs identified will be addressed by referring the client for subsequent appointments with clinicians such as the Physician, Nutritionist, Substance Abuse Counselor,



SWCM etc. The Screening Team will input all scheduled appointments in the appointment data base and also notify the SWCM. The client will ultimately be assigned to the Youth Primary Care Program. If available, a TSHC volunteer will be assigned to assist patient with the screening process. Unless otherwise indicated, SWCM will remain with patient throughout the process.

Houston Re-Entry Program Collaboration

Additionally, the HDHHS is playing a key role in assisting individuals upon re-entry to the City of Houston/Harris County from incarceration. In 2007, City of Houston Mayor Bill White launched plans to initiate a pilot project entitled City of Houston Ex-Offender Reentry Initiative. The three-phased program began implementation in 2008 and is designed to provide the participants with the necessary training, support, and services needed for successful long term integration into responsible living. Program staff also assists participants with money management, job readiness and retention, and the acquisition of vital statistic documents and identifications. Staff from the Bureau of HIV/STD and Viral Hepatitis Prevention has been an active part of this program plan, design, and implementation and assists with the provision of screening and education to prevent the spread of these communicable diseases.

Risk Reduction Services

Approximately 13 direct service community-based organizations (CBOs) are funded to provide HIV/STD Counseling, Testing, and Referral Services (CTR), Health Education/Risk Reduction (HE/RR), Social Marketing, and Comprehensive Risk Counseling Services (CRCS).

PBC Screening

Due to its structured nature, a Protocol-Based Counseling (PBC) session requires more time than a traditional counseling session. For 2007, all CTR services funded by HDHHS were PBC sessions. PBC has been successful in yielding an overall positivity rate of 1.96% (148/7,543) for 2007, but has reduced the number of clients tested. Adding HIV screening as an intervention will allow for an increase testing numbers while still offering PBC to the highest risk clients.

OPT Out Routine Screening

During 2009, the HDHHS will support routine HIV screening in three hospital emergency rooms and a Federally-Qualified Health Center with multiple sites serving a high risk population. It is anticipated that these activities will reach a significant population of high risk individuals whose only contact with a health care provider is through public hospital emergency rooms. Pilot testing in one emergency room has shown a refusal rate of only 5.43% (94/1,732), with the primary reason for refusal being that the patient was already aware of their positive status. The positivity rate to date is 0.46%. This project represents an implementation of the CDC's 2006 Testing Guidelines for Adults, Adolescents, and Pregnant Women in Health Care Settings.

The HDHHS will continue to encourage and support routine HIV screening through the task forces and advisory groups sponsored. The Perinatal Advisory Group is focusing on assisting hospitals in providing rapid HIV testing in Labor and Delivery units throughout the city. The HDHHS also sponsors the State of Emergency Task Force (SOETF), which works with the African-American community in support of HIV prevention activities. The SOETF takes the lead role in sponsoring special testing events, such as National HIV Testing Day, World AIDS Day, and

National Black HIV/AIDS Awareness Day. These events make HIV testing readily available in high prevalence areas. HDHHS also sponsors the Syphilis Elimination Advisory Committee, which encourages HIV screening in addition to its syphilis elimination efforts.

Perinatal HIV Prevention

The HDHHS will ensure that women who are pregnant; who are of childbearing age and identified as meeting the CDC's definition of high-risk will receive HIV screening in HDHHS clinics. The outcome will be determined by the number of pregnant women that received HIV testing during the first and third trimesters.

HIV/AIDS educational interventions are generally conducted by peer or paraprofessional educators either face-to-face or via the internet with high-risk individuals in neighborhoods or other areas where the agency's target population gathers. Examples of sites might include streets, bars, parks, bathhouses, shooting galleries, specific websites, etc. The primary purpose of outreach is recruitment of individuals of behavioral risk groups into more intensive prevention and/or treatment services. These interventions are conducted by program staff in person or via the internet with high- risk/hard-to-reach individuals. Condoms, bleach, safer sex kits (e.g., condoms/latex barriers with instructions, lubricants), promotional and educational materials and information may be distributed.

Key characteristics of outreach include:

- Going to places where potential clients congregate, and go at times when they are likely to be there.
- Conducting outreach in teams (for safety).
- Screening clients to determine their needs for specific prevention services such as counseling, testing, and referral services; comprehensive risk counseling services; or other prevention interventions.
- Developing and delivering tailored and appropriate messages (health promotion and prevention).
- Providing tailored and appropriate materials (describing programs and services for potential clients).
- Using peers as outreach workers, when possible.

Other aspects of outreach include that the outreach worker discusses the agencies or other HIV/AIDS programs and how the individual can benefit from these services. The outreach worker may also ask a few questions to assess risk behavior(s). If individuals are interested in the program, the outreach worker will collect the client's name, address, and phone number to set up an appointment for intake or a linked referral. A referral mechanism for measuring the use of referral services is required.

B: Rationale

Risk assessments to identify behavioral risk of HIV acquisition could include a risk self-assessment or risk screening interview in a health care or community-based setting. While these strategies and interventions have proven outcomes of effectiveness, the reach into

members of impacted populations is limited due in large part to their high implementation costs. Since many of the interventions have become cost prohibitive and therefore not feasible for wide-scale implementation, existing funds will be decreased from this intervention and reallocated to more cost effective interventions.

C: Goal Setting

- To decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV in the Houston MSA.
- To provide a broad array of Counseling, Testing, and Referral Services (CTRS), with a focus on diagnosing as many new cases of HIV infection as possible while linking infected clients to appropriate prevention, care, and treatment services.
- To increase the proportion of HIV-infected persons in the Houston MSA who are linked to care services.
- Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals.

Recommended Intervention #20: “Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines”

A: Situational Analysis

Organizationally housed within the Disease Prevention and Control Division, the Bureau of HIV/STD and Viral Hepatitis Prevention is one of only seven local jurisdictions directly-funded by the Centers for Disease Control and Prevention (CDC) for HIV Prevention Services. This Bureau is a fully integrated program. As was previously structured in 1990, the Bureau was divided into two programmatic functions; the HIV Prevention Program, and the STD Prevention Program, and primarily received its funding from the Centers for Disease Control and Prevention and the Texas Department of State Health Services. Beginning in the year 2000, the Bureau began viral hepatitis prevention services and officially changed its name in 2003 to reflect these integrated hepatitis activities. In 2008, the Bureau received additional CDC funding for the provision of an Adult Viral Hepatitis Program Coordinator (AVHPC) and has continued its commitment to integrating viral hepatitis prevention into established HIV and STD prevention activities.

HIV testing is offered in the integrated HDHHS Family Planning, Maternity, and STD clinics, as well as clinical sites maintained by several of the CBOs contracted for CTRS. Outreach testing is provided by CBOs as well as two HDHHS mobile clinics. All outreach testing is targeted to areas identified as having high morbidity for HIV and other STDs.

In 2007, the Bureau required, through contractual mandate, that all HIV funded counseling and testing agencies also complete a venipuncture blood draw for syphilis. Utilizing every single

testing opportunity to screen for multiple diseases is a primary goal of the Bureau's prevention efforts and improves patient access to care, overall acceptance rates of prevention services, and ultimately improved treatment services and outcomes. When indicated, agencies are also able to offer HCV testing, and Hepatitis A and B vaccinations. These tests are processed by the HDHHS Bureau of Laboratory Services, and positive results are reported directly to the HIV/STD Surveillance Unit within the Bureau of Epidemiology. If the client has no syphilis treatment history with an appropriate serologic response, a field record is initiated and assigned to a DIS for follow-up. Most of the CTRS contract agencies have a specific DIS liaison assigned to facilitate the flow of information between the agency and the HDHHS.

The Bureau of HIV/STD and Viral Hepatitis Prevention sponsors the African American HIV/AIDS State of Emergency Task Force (SOETF), which works with the African-American community in support of HIV prevention activities. The SOETF strives to increase the participation of non-medical, non-HIV affiliated community-based organizations and community stakeholders in HIV prevention efforts targeted to African-Americans. The SOETF takes the lead role in sponsoring special testing events, such as National HIV Testing Day, World AIDS Day, and National Black HIV Testing Day. These events make HIV testing readily available in high prevalence areas. HDHHS also sponsors the Syphilis Elimination Advisory Committee, which encourages HIV screening in addition to its syphilis elimination efforts.

The HDHHS Partner Services (PS) program has also been integrated over 20 years. Since the inception of name-based HIV reporting in Texas in 1999, Disease Intervention Specialists (DIS) investigate both HIV and syphilis field records, which are initiated directly from the HIV/STD surveillance program. To enhance utilization of partner services by high volume medical providers, both public and private, DIS liaisons are assigned to conduct partner services within the medical providers' office. This approach builds rapport between the partner services program, the medical provider, and the client. According to Texas laws and statutes regarding communicable disease reporting, HIV, STD, Hepatitis and TB cases may be assigned for public health follow-up if the client is either a new report or if there is evidence of high-risk behavior (new HIV or STD co-infection, named as a partner on a new STD case, or pregnant.) All reports eligible for PS are assigned to a DIS or to a TB DOT worker.

The Bureau's Disease Intervention Specialists (DIS) are responsible for conducting partner services and achieving the partner/cluster index for newly diagnosed cases of syphilis and HIV. In 2008, DIS staff initiated 1,173 partners and 806 clusters on newly diagnosed syphilis cases, achieving a 1.43% and 1.0% index respectively. Partner services are offered during interviews that are conducted in not only clinical settings, but also in the field, which includes client homes, private medical provider offices, and correctional facilities. Clustering activities are centered on index cases to include social networks; prioritizing is stressed upon pregnancy, symptomatic clients, and anyone who may benefit from screening.

Community Mobile Clinics

Currently, the HDHHS operates two recreational vehicles (RVs) at venues facilitating high risk for acquisition of HIV and other STDs, where mobile clinical services are needed based on the HIV/STD prevalence, case related screenings, and STD outbreaks during traditional and non-traditional hours. The primary function of the Mobile Clinic operation is to accommodate the Bureau of HIV/STD and Viral Hepatitis Prevention efforts to assist with the elimination of

syphilis and the intervention and control of STDs and HIV infection.

The clinics conduct STD intervention activities through a multi-disciplined team consisting of staff from the Bureau of HIV/STD and Hepatitis Prevention, the HDHHS Neighborhood Services Division, and staff from community-based organizations (CBOs). Routine positions on the Mobile Clinic include health education technicians who coordinate patient recruitment, maintenance and logistical activities; clinical assistants who are responsible for phlebotomy and laboratory follow-up of abnormal STD results; a nurse practitioner/physician who is responsible conducting patient examinations and treatment; a DIS who conducts patient interviews; and mobile clinic coordinator who is responsible for directing mobile clinic intervention activities. The CBO staff recruit targeted populations to the Mobile Clinics and assist with rapid HIV testing and referral to Health Education and Risk Reduction (HERR) activities. Specific line staffing on each clinic is as follows:

HIV/STD Mobile Clinic:

Health Education Technician (1 FTE)
Clinical Assistant (1 FTE)
Nurse Practitioner (1 FTE)
Disease Intervention Specialist (1 FTE)
Mobile Clinic Coordinator (1 FTE)
CBO CTRS Staff (.75 FTE Volunteer)

NSD Mobile Clinic:

Health Education Technician (1 FTE)
Clinical Assistant (1 FTE)
Physician (.5 FTE)
CBO CTRS Staff (.75 FTE Volunteer)

Collaboration on screening events with community-based organizations is critical because these organizations are often the only credible face of health care in underserved and uninsured areas. Mobile Clinic outreach screenings occur during non-traditional hours, often late-night, in order to reach the targeted populations during the optimal time they frequent screening venues. These settings lend themselves well to offering anti-HCV testing, HAV vaccine, and HBV vaccine, as it has the clinical capacity and serves populations at elevated risk of also contracting viral hepatitis.

The HDHHS Third Ward Multi-Service Center houses an Adult and Travel Immunization Clinic, where adults can be immunized at reduced prices. HAV vaccine is available for \$30 per dose, HBV vaccine for \$45 per dose, and Twinrix for \$78 per dose.

HIP HOP for HIV: Community-Based Service Integration Testing

2010 marked the fourth annual public/private partnership providing free and confidential testing to youth and young adults in Houston. HIV/STD educational groups were conducted and all individuals fully participating in the entire intervention received a free HIP HOP concert ticket. Community organizations, advocacy groups, skilled staff and volunteers, along with support provided through the local health department and other private entities coordinated testing events in high prevalence zip codes throughout the city. One local radio station coordinated performance artists, promotional materials, and venue support for the concert. Integrated testing results for area youth and young adults were as follows:

- 15,460 tested for HIV...in 22 DAYS
 - 113 HIV positives (0.73%)
- 8,871 received syphilis testing, treatment, and comprehensive education
 - 77 syphilis positives (.87%)

- 5,755 received Gonorrhea and Chlamydia testing
 - 733 Chlamydia positives (12.74%)
 - 144 Gonorrhea positives (2.50%)
 - 105 dually diagnosed with Ng and Ct (1.82%)
- **429 Immunization doses**
 - 228 Hep A
 - 40 Hep B
 - 105 Twinrix (Hep A & B)
 - 232 Tdap
 - 290 HPV
 - 136 MCV4

Hepatitis Prevention and Treatment Programs

The City of Houston currently provides general funds for specific Hepatitis C interventions and an HCV task force. An Expanded Syringe Access Program (ESAP) is funded through a local community-based organization to educate pharmacies on the legal allowances governing the selling of small amounts of syringes as well as education to injection drug users on how to access clean syringes in Houston/Harris County.

The Blue Book, which is an HIV/AIDS resource directory that is published every 2 years by the Ryan White Planning Council and began including viral hepatitis information for the first time in the 2008-2009 edition. The viral hepatitis information section starts on page 55 of the Blue Book, which is available online in English and Spanish at http://www.rwpc.org/Blue_Book/08-09/08-09_blue_book_MAIN.htm.

HBV vaccine is available to Contractors with the capacity to provide HBV immunization on a sporadic basis. The main source of adult HBV immunizations in Houston is the Texas Department of State Health Services (DSHS) and whenever there is a surplus in the HBV vaccine supply for the Vaccines for Children (VFC) program, doses are made available to the HDHHS. When doses are made available, Houston's Perinatal HBV Coordinator notifies the AVHPC, who announces the available doses to community agencies with the capacity to provide immunizations.

The City of Houston currently provides general funds for specific Hepatitis C interventions and an HCV task force. An Expanded Syringe Access Program (ESAP) is funded through a local community-based organization to educate pharmacies on the legal allowances governing the selling of small amounts of syringes as well as education to injection drug users on how to access clean syringes in Houston/Harris County.

Tuberculosis Clinics and Programs

The Bureau of HIV/STD and Viral Hepatitis Prevention collaborates with the Bureau of Tuberculosis Control to ensure that individuals with these co-morbidities are identified and referred to the appropriate services. The Bureau of TB Control is also directly funded to provide services and staff members are currently in the process of being trained to conduct rapid HIV testing in the field. Current HDHHS TB control efforts are exceeding CDC's national goal of 90%, by testing 93% of all adult TB cases (age >14) identified in Houston/Harris County. Staff members from the TB Control Bureau consistently conduct educational presentations and



screenings for high risk populations, including participants of the HDHHS Ex-Offender Community Re-Entry Initiative as well as setting up booths and distributing TB literature during the annual AIDS Walk Houston.

Family Planning and Women's Health Agencies

In 2006, the HDHHS also began the process of integrating HIV/STD prevention services into ALL of its eight (8) community health centers. HIV/STD prevention services are now offered alongside other HDHHS services including family planning services, WIC services, immunization services, and TB services. The HDHHS also recently entered into a Memorandum of Agreement with Planned Parenthood of Houston and Southeast Texas to provide PCRS services to all individuals newly diagnosed with HIV.

Schools, Boards of Education, Universities, and Schools of Public Health

Four (4) community-based organizations are contracted by the HDHHS to provide HIV prevention education to several high schools, middle schools and elementary schools in the Houston Independent School District (HISD). Data indicates that annually on an average 5000 youth are reached by these activities. The HDHHS also has representation on the HISD School Health Advisory Council which consists of HISD Board members, parents and community partners that reviews and recommends for approval health related activities for their schools.

The HDHHS also provides contractual funding to the University of Texas School of Public Health (UTSPH) to implement a structural intervention that addresses influential factors of continued HIV and STD transmissions among youth. These factors include a lack of knowledge of the HIV/AIDS and STD problem in youth, a lack of awareness about effective programs that are available, continued stigma towards HIV/AIDS education in schools, and a lack of self efficacy for teaching HIV/AIDS programs. The intervention includes activities to influence the adoption and implementation by teachers, school administrators, and school medical staff of an enhanced health curriculum with integrated HIV/STI prevention. Training program includes a series of workshops, newsletters, video, and adoption contract.

Syringe Exchange

Syringe exchange is currently prohibited by Texas state law. The Hepatitis C Task Force has established a Harm Reduction Workgroup, which has been meeting to discuss how to best meet the needs of those who continue to be at risk for contracting HCV through unsafe injection practices (illegal drugs, hormones, and silicone). One area of interest for this group is how best to support those who advocate for the legalization of syringe exchange in Texas.

In addition to the activities of the Harm Reduction Workgroup, the Hepatitis C Task Force has recommended that HDHHS continue to fund the Enhanced Syringe Access Program (ESAP) through the next fiscal year. This program is a combination of provider education and outreach to those at risk for diseases transmitted by unsafe injection practices. The ESAP coordinator is an active member of the Hepatitis C Task Force and refers clients to prevention services using the Houston Viral Hepatitis Resource Guide.

It is expected that through the successful awarding of CDC's PS10-10175 in 2011, the HDHHS plans to continue and build upon each of the integration activities and collaborations listed above. Testing programs for syphilis and HCV have been incorporated into the HDHHS

standards of care for the HIV CTRS program since 2008. Through the PCSI assessment and subsequent plan to expand PCSI activities, the HDHHS will investigate the feasibility of expanding the HBV vaccination project in community-based organizations as well as the HDHHS clinics.

B: Rationale

Rationale for the need to increase and expand on existing PCSI related activities includes; maximizing opportunities to screen, test, treat and vaccinate persons most in need of these services, maximizing the health outcomes for persons receiving such services, and increasing the scale and reach, service delivery efficiency and sustainability through the leveraging of resources.

C: Goal Setting

- Maintain existing capacity to screen, test, treat and vaccinate HIV-positive persons, injection drug users and HIV-negative persons at highest HIV risk for acquiring HIV, Hepatitis, STDs and TB.
- Increase the HDHHS' capacity to expand integrated screening and prevention opportunities for persons infected with HIV, Hepatitis, STD, or TB or those at high-risk for acquiring these infections.

Recommended Intervention #21: “Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis”

A: Situational Analysis

The HIV/STD Surveillance Program receives and processes all positive HIV and STD reports from laboratories and providers. The HIV/AIDS Reporting System (HARS) is checked for each positive HIV report, and the case is assigned for follow-up if the client is either a new report or if there is evidence of high-risk behavior (e.g. new STD co-infection, named as a contact on a new STD case, or pregnant). If the report is from a private provider, the physician is contacted to determine whether the client has been notified and to inform him/her that the HDHHS will provide public health follow-up. Within three days of receipt of a newly diagnosed HIV case, the HIV/STD surveillance staff initiate a field record in the Sexually Transmitted Disease Management Information System (STD*MIS) to deploy DIS for public health follow-up services. During the first half of 2009, a total of 569 persons were eligible for public health follow-up, and 97% were referred for Prevention Counseling Referral Services within the requisite three day period.

When a report is received on a person with previous HIV or STD history in STD*MIS, the DIS

reviews the record to determine whether the patient is re-infected (for syphilis cases) or if the client is aware of their status (for HIV cases). For syphilis cases with documented previous treatment and no increase in titer the investigation is closed. HIV investigations are closed if there is documentation that the client is aware of their status and no evidence of current risk behavior. Otherwise, the field record is sent to the field for public health follow-up. The patient will be located by a DIS and informed of their tests results, referred for treatment (if needed, and provided partner services).

While HIV+ individuals are one of the top priorities for the Houston HIV Prevention Community Planning Group (CPG), the HDHHS and the CPG believe that targeting individuals based on their behavioral risk along with their HIV positive status provides a more effective approach to HIV/STD prevention services for positives. In 2010, two contractors utilized approximately \$125,000 to conduct evidence-based interventions (both those from the Diffusion of Evidence-Based Interventions (DEBI) Project and those created internally) and provide HIV/STD prevention services to individuals living with HIV.

Undetectable viral loads became reportable by Texas law starting January 2010. Viral loads of the HIV+ people who are unaware of their serostatus or out-of-care are not captured by surveillance. Not all of the HIV+ people living in Houston are in Texas eHARS. If they were first diagnosed with HIV in another state, they were not included in Texas eHARS. Starting this year, surveillance is trying to include these out of state cases in eHARS (when an HIV case becomes an AIDS case in Houston, and when the case is new to the surveillance tracking database), but the data is not complete. Also, cases diagnosed prior to 1999 who have not had a reportable test since 1999 are not in eHARS.

CDC is recommending that areas have a viral load completeness rate of 75% in order to accurately calculate community viral load. If the completeness rate is less than 75% , CDC recommends we to talk to CDC and conduct “other analysis” such as limiting to persons in care vs not in care. The Houston viral load data completeness rate will be calculated using the number of living HIV+ individuals who have a value of viral load (including undetectable viral loads) as the numerator, and the number of living HIV+ individuals as the denominator. The Houston completeness rate is currently 40%, as of February 2011. CVL will be calculated as the mean HIV viral load of people living with HIV in Houston/Harris Co. by zip code.

Houston will continue to develop community viral load rates and analysis as recommended in the National HIV/AIDS Strategy,

B: Rationale

Persons diagnosed with HIV who receive a new STD diagnosis or people with a prior STD diagnosis who receive a new STD diagnosis are at increased risk for transmitting HIV and STDs to others or acquiring hiv themselves. Therefore, it is critical to identify these very high risk

persons and prioritize prevention activities in order to prevent future infections. Using HIV and STD surveillance data to help identify these persons may be one way to streamline the work of health department staff and focus HIV prevention efforts on those mostly likely to transmit or acquire HIV in the near future. this intervention will receive increased funding as it becomes available.

C. Goal Setting

- Raise the awareness of HDHHS-funded Community Based Organizations staff who offer risk reduction counseling and partner services.
- Assure the accuracy and completeness of the HIV and STD surveillance data for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis.

Recommended Intervention #22: “For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others”

A: Situational Analysis

Substance Abuse /Mental Health

One of the Bureau’s contracting agencies, Career and Recovery Resources, Inc. specializes in programs to help those newly released from prison and those in recovery to secure employment. They serve a clientele at very high risk for HCV infection (injection and non-injection illegal drug use, high risk heterosexual contacts, and those recently released from incarceration). The agency offers HCV testing to their clients.

The HDHHS currently collaborates with the Mental Health and Mental Retardation Authority of Harris County (MHMRA) to ensure that the needs of this population are met.

Juvenile and Adult Corrections Settings

The Disease Intervention Specialists continue to offer Partner Counseling and Referral Services (PCRS) in the Harris County Jail. Additionally, the HDHHS is playing a key role in assisting individuals upon re-entry to the City of Houston/Harris County from incarceration. In 2007, City of Houston Mayor Bill White launched plans to initiate a pilot project entitled City of Houston Ex-Offender Reentry Initiative. The three-phased program began implementation in 2008 and is designed to provide the participants with the necessary training, support, and services needed for successful long term integration into responsible living. Program staff also assists participants with money management, job readiness and retention, and the acquisition of vital statistic documents and identifications. Staff from the Bureau of HIV/STD and Viral Hepatitis

Prevention has been an active part of this program plan, design, and implementation and assists with the provision of screening and education to prevent the spread of these communicable diseases.

The Bureau sub contracts with one agency, Career and Recovery Resources that routinely provides CTR services in several substance abuse treatment facilities.

B: Rationale

Because research has documented the relationship between a number of psychosocial factors and HIV risk, it is recommended that HIV prevention programs provide referrals for clients who need additional services and that staff help ensure that first appointments are kept. The established association between harmful psychosocial factors and HIV risk supports the inclusion of referrals and linkages to services in HIV prevention programs. This intervention will be maintained with no additional funding.

C: Goal Setting

- To implement linkage to medical and social services for high-risk HIV- negative individuals.

Recommended Intervention #23: “Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV”

A: Situational Analysis

While little research could be found regarding the role of alcohol use, abuse, and dependency in HIV transmission could be found, in a report released by the University of Texas - Center for Social and Behavioral Research found that in 2009, 28 percent of all clients admitted to publicly-funded treatment programs had a primary problem with alcohol. This report goes on to state that the characteristics of alcohol admissions in Texas have changed over the years. In 1988, 82 percent of the clients were male, compared with 70 percent in 2009. The proportion of White clients declined from 63 percent in 1988 to 55 percent in 2009, and the proportion of Hispanic clients increased from 28 to 30 percent. The proportion of Black clients increased from 7 to 13 percent. The average age increased from 33 to 39 years. Alcohol clients are becoming more likely to be polydrug users: the proportion reporting no secondary drug problem dropped from 67 to 54 percent, and the proportion with a problem with cocaine (powder or crack) increased from 7 to 20 percent.

The Texas Department of State Health Services administrates a program specifically designed to create improved efficiencies for patients and counselor referrals to related alcohol and drug prevention and treatment programs. These are referred to as Outreach, Screening, Assessment, and Referral Programs (OSAR). In summary, program activities are designed to provide outreach activities directed towards finding individuals who may need substance abuse services, screening as a process to identify indicators for further assessment and needs for

referral to services, assessment to gain sufficient information to identify the patient strengths, problems, and needs as they relate to substance abuse, and lastly referral appropriate services. These regionally based OSARs serve as the front door for substance abuse services within their assigned region. They manage a centralized waiting list for residential services within their assigned region and provide a single source for substance abuse information within their assigned region. They are also responsible for providing interregional referrals for residential services.

The HDHHS currently sub-contracts with one agency, Career and Recovery Resources that routinely provides CTR services in several of their substance abuse treatment programs. Career and Recovery Resources' clients who test positive for HIV are referred to the necessary HIV service providers. Currently, substance abuse counselors through alcohol screenings will refer the client to the appropriate drug intervention strategy.

B: Rationale

Alcohol abuse can place HIV-negative persons at risk of acquiring HIV. Alcohol screenings and intervention can help clients understand how alcohol use, abuse or dependency can affect their health and lead to potential disease acquisition. A greater understanding of how the existing OSAR program responsible for the Houston MSA currently conducts such screenings and which populations are currently being served needs to be assessed. Also, a greater understanding of the existing barriers, challenges or facilitators to alcohol screenings is needed.

C: Goal Setting

- Collaborate with the Texas Regional OSAR and other related drug treatment programs to assess the current scale and capacity of brief alcohol screenings within the Houston MSA.
- Implement brief alcohol screening questions in HIV prevention and care needs assessments, risk reduction curriculums and other client surveys in order to assist persons in gaining a greater understanding of alcohol use can increase acquisition of HIV infection.

Recommended Intervention #24: “Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors”

A: Situational Analysis

HDHHS will collaborate with established, targeted task forces to continue to provide the community with opportunities to become involved in education, awareness and outreach activities.

HIV Prevention Task Forces

- **Latino HIV Task Force (LHTF)**

The mission of the LHTF is to encourage collaboration between public health agencies, community-based organizations, private physicians, HIV-infected, and HIV-affected individuals, to help strengthen awareness of HIV and AIDS in the Latino community.

- **Houston Hepatitis C Task Force**

The mission of the Houston Hepatitis C Task Force is to shape policy and advocate for the needs of people at risk for and living with hepatitis C infection.

- **Youth Task Force (YTF)**

The mission of the YTF is to build a community in which families, neighbors, schools and community organizations all work together to enable young people to become competent, contributing and responsible members of the community with a feeling of hope for the future.

- **African-American State of Emergency Task Force (AASOETF)**

- **The Urban AIDS Ministry (UAM)**

The Urban AIDS Ministry is a coalition of ministers, faith and community leaders who have a vested interest in mobilizing the faith-base communities in HIV prevention and AIDS care ministries.

- **Syphilis Elimination Advisory Committee (SEAC)**

The mission of the Syphilis Elimination Advisory Committee (SEAC) is to provide community-based advice and feedback on unique, non-traditional methods for syphilis intervention and syphilis elimination in Houston/Harris County.

- **M-Pact Houston Task Force**

The mission of the M-Pact Houston is to reduce HIV and other STDs among men who have sex with men through planning and effective health strategies.

Community-Level Interventions (CLI)

Community-level interventions (CLIs) seek to reduce risk conditions and promote healthy behaviors in the broader community as a whole, rather than by intervening with individuals or small groups. CLIs attempt to alter social norms, policies, and the environment. CLIs include community mobilization efforts, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

1. Community Mobilization - This is a process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

2. Social Marketing Campaigns use modern marketing principles to affect knowledge, attitudes, behaviors, and beliefs regarding HIV/AIDS risk, associated behavior change and risk reduction, access to services, and treatment education. Social marketing is not simply advertising a service

or hotline number but is action oriented. Social marketing activities should include a planning, development, and distribution phase.

3. Community Forums provide information to and elicit information from a community.

4. Health Fairs/Community Events include special events such as street fairs, job fairs, health fairs, World AIDS Day activities, and local celebrations in communities that deliver public information to large numbers of people.

5. Structural Interventions remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Structural interventions seek to modify the social, environmental, and political structures that influence the delivery of HIV prevention services. Structural interventions may impact legislation, technology, and healthcare standards, among others, to improve the delivery and/or effectiveness of HIV prevention efforts.

Structural interventions may include, but are not limited to: (1) integrating HIV/AIDS services into faith-based activities, (2) mandating HIV-antibody testing for specific offenders, (3) modifying a standard of care to include mandatory offering of HIV-antibody testing to pregnant women, (4) establishing standards and regulations for the operation of commercial sex venues, or (6) developing broad school-based support for HIV/AIDS among stakeholders.

Measuring the success of CLIs offers unique challenges as large-scale impact or change may not be evident for years. Thus, although long-term outcome-oriented evaluation is needed to measure the success of CLI, in the immediate-term, process measures lend themselves to CLI. CBOs may be able to utilize more outcome-oriented measures for specific CLIs, such as structural interventions that produce concrete outcomes (e.g., legislative changes).

Healthy living and health fairs/affected committee

B. Rationale

Community Mobilization is an important HIV prevention strategy because it promotes community participation and support in the development and implementation of risk reduction strategies. This intervention will receive increased funding as it becomes available.

C: Goal Setting

- Increase Community Mobilization efforts to create healthy communities and environments that: support HIV prevention, raise HIV awareness, encourage involvement in HIV efforts, and motivate community members to become actively engaged in reducing the risk of HIV infection.

- Increase partnerships with Task Forces to raise HIV awareness, build support for and involvement in HIV prevention efforts, motivate individuals to work to end HIV stigma, and encourage HIV risk reduction among their family, friends, and neighbors.

Workbook #2: GOALS, STRATEGIES, AND OBJECTIVES

(DRAFT Feb 15, 2011)

Required Intervention #1: “Routine, opt-out screening for HIV in clinical settings”

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| Goal 1: To increase the number of persons who know their serostatus by 25% in the Houston MSA annually. | Funding sources: CDC, TDSHS |
| Strategy 1: Continue to provide routine opt-out screening to individuals who might not present for risk-based HIV screening at the existing eight (8) clinical settings in the Houston MSA. Objective 1: Maintain support to the existing eight (8) clinical routine opt-out HIV screening settings in the Houston MSA by October 2011. Objective 2: Provide a minimum of 79,000 tests to patients accessing the existing eight (8) clinical routine opt-out HIV screening settings by October 2011. Objective 3: Maintain an overall opt-out rate of less than 8% at the existing eight (8) clinical routine opt-out HIV screening settings in the Houston MSA by October 2011. | |
| Strategy 2: Continue to provide capacity building, program support, program evaluation and quality assurance for clinical and program staff to increase understanding and rationale for routine opt-out HIV screening. Objective 4: By October 2011, ensure the continued assessment of the Monthly Routine Opt-Out Testing Monitoring and Evaluation Report to determine progress toward increasing number of tests conducted and positivity yield. Objective 5: By October 2011, clinical staff at routine screening sites will continue to receive mandatory cultural competency training, attend technical assistance trainings and quarterly program evaluation meetings; including one ECHPP workshop for representatives from HIV prevention, care, and laboratories that will include presentations and discussions on Nucleoside Acid Amplification Test System (NAAT). | |
| Strategy 3: Increase routine opt-out HIV screening venues through the SAFER Initiative in the five (5) geographic areas within the MSA with high HIV morbidity. Objective 6: By October 2011, identify one clinical routine opt-out HIV screening venue through the SAFER Initiative in each of the five (5) geographic areas within the MSA with high HIV morbidity. | |
| Data sources: STD-MIS, eHARS, ECLIPS, PEMS, Hospital Line Listing Reports – Emergency Rooms | |

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| Goal 2: To link 85% of HIV+ individuals diagnosed in the existing eight (8) clinical routine opt-out HIV screening settings to primary medical care. |
| Strategy 1: Maintain Disease Intervention Specialists (DIS) at each of the existing eight (8) clinical routine, opt-out HIV screening settings. Objective 1: By October 2011, SLW in collaboration with DIS will continue to maintain a linkage rate of at least 85% of HIV+ individuals diagnosed in the existing eight (8) clinical routine opt-out HIV screening settings linked to Ryan White care services or a private provider of their choice. |
| Strategy 2: Provide capacity building and program support for clinical and program staff regarding the role of the DIS and other community resources. |

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| <p>Objective 2: By October 2011, DIS and Service Linkage Workers will continue to receive mandatory annual trainings to include: cultural competency, case management and motivational interviewing to ensure an appropriate and effective social service outcome.</p> |
| <p>Strategy 3: Service Linkage Workers (SLW) in collaboration with DIS will continue to link HIV+ individuals diagnosed in the existing eight (8) clinical routine opt-out HIV screening settings to Ryan White care services or a private provider of their choice.</p> |
| <p>Strategy 4: Offer partner services to HIV+ individuals who received their HIV test results through routine opt-out screening.</p> |
| <p>Objective 3: By October 2011 85% of new positives will have confirmed linkage to care.</p> |
| <p>Data sources: STD-MIS, CPCDMS and ECLIPS, Ryan White Standards of Care, Training Sign-In Sheets</p> |

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| <p>Goal 3: To decrease transmission rates 25% by 2015.</p> | <p>Funding sources: CDC, TDSHS</p> |
| <p>Strategy 1: Through the SAFER Initiative increase HIV testing community access points in these five (5) geographic areas within the MSA with high HIV and STD morbidity: 1) Sunnyside/South Park, 2) Greater Fifth Ward, 3) Acres Homes, 4) Sharpstown/Southwest, and 5) Montrose.</p> | |
| <p>Objective 1: Increase the number of HIV testing community access points to five (5) in these five (5) geographic areas within the MSA with high HIV morbidity by 2015.</p> | |
| <p>Strategy 2: Through the SAFER Initiative implement new social marketing campaigns within the five (5) geographic areas of the MSA with high HIV morbidity.</p> | |
| <p>Objective 2: By 2015, roll out two (2) new social marketing campaigns annually in each of the five (5) geographic areas within the MSA with high HIV morbidity.</p> | |
| <p>Strategy 3: Through the SAFER Initiative increase service linkage capacity within the five (5) geographic areas of the MSA with high HIV morbidity.</p> | |
| <p>Objective 3: Increase service linkage capacity to support the five (5) HIV testing community access points in each of the five (5) geographic areas within the MSA with high HIV morbidity by 2015.</p> | |
| <p>Strategy 4: Through the SAFER Initiative increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks within the five (5) geographic areas of the MSA with high HIV morbidity.</p> | |
| <p>Objective 4: By 2015, increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks in each of the five (5) geographic areas within the MSA with high HIV morbidity.</p> | |
| <p>Data sources: STD-MIS, CPCDMS, and ECLIPS, Ryan White Standards of Care</p> | |

Required Intervention #2: “HIV testing in non-clinical settings to identify undiagnosed HIV infection”

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| <p>Goal 1: To increase the proportion of HIV-infected persons who are aware of their status by 25% in the Houston MSA annually.</p> | <p>Funding sources: CDC, TDSHS</p> |
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| <p>Strategy 1: Through the SAFER Initiative increase the number of local businesses, social and civic organizations, including faith-based organizations, to promote HIV testing activities targeting populations disproportionately affected by HIV; primarily African-Americans.</p> <p>Objective 1: By October 2011, identify 200 new HIV-infected persons in non-clinical settings.</p> <p>Objective 2: By October 2011, increase the number of local businesses and organizations to promote HIV testing activities by 10.</p> |
| <p>Strategy 2: Continue supporting the use of both rapid and conventional HIV testing by contractors or CBO's funded by HDHHS for Counseling, Testing, & Referral Services (CTRS).</p> <p>Objective 3: Maintain support to eight (8) HDHHS Community Based CRT Agencies for HIV testing by October 2011.</p> <p>Objective 4: By October 2011, increase the number of HIV tests provided to HDHHS contracting agencies including testing events sponsored by HDHHS Task Forces to 5,000.</p> |
| <p>Data sources: STD-MIS, CPCDMS, and ECLIPS, Ryan White Standards of Care</p> |

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| <p>Goal 2: To expand HIV testing in non-clinical settings to populations that have been prioritized as high risk for acquiring or transmitting HIV; to include Men, Women, Youth, People who Share Needles/Works, and Transgender Individuals.</p> | <p>Funding sources: CDC, TDSHS</p> |
| <p>Strategy 1: Continue providing rapid HIV testing in community based venues for individuals at highest risk for acquiring HIV and/or other STDs.</p> <p>Objective 1: Maintain support to eight (8) HDHHS Community Based CRT Agencies for HIV testing by October 2011.</p> | |
| <p>Strategy 2: Continue holding community-based HIV testing events with public and private partners such as HIP HOP for HIV.</p> <p>Objective 2: By October 2011 provide free and confidential HIV & STD testing to 10,000 youth and young adults in the Houston MSA through HIP HOP for HIV.</p> | |
| <p>Strategy 3: Through the SAFER Initiative increase the number of community partnerships to increase HIV testing access points for those communities in geographic areas of high HIV morbidity.</p> <p>Objective 3: By October 2011 increase the number of HIV testing community access points to 10 through the SAFER Initiative.</p> | |
| <p>Strategy 4: Continue providing HDHHS Task Forces with support to continue holding community-based HIV testing events.</p> <p>Objective 4: By October 2011, continue supporting HIV testing efforts by HDHHS Task Forces at each of the nine (9) HDHHS HIV/STD Awareness Days held annually.</p> | |
| <p>Strategy 5: Continue utilizing HDHHS Disease Intervention Specialists (DIS) in the field to provide rapid testing to the sexual partners of those testing positive.</p> <p>Objective 5: By October 2011 increase the number of individuals whose sexual partners are tested and made aware of their HIV status by 20%.</p> | |
| <p>Data sources: STD-MIS, CPCDMS, and ECLIPS, Ryan White Standards of Care</p> | |

Required Intervention #3: “Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection”

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| <p>Goal 1: Maintain the current distribution of 300,000 condoms targeted to populations that have been prioritized as highest risk for acquiring or transmitting HIV to include (Men {MSM & HIV+}, Women {HIV+}, People Who Share Needles/Works {HIV+}, and Transgender Individuals) as described in the HDHHS 2009 Comprehensive Plan.</p> | <p>Funding sources: DSHS, CDC</p> |
| <p>Strategy 1: Continue coordination of condom distribution as an integrated component of HIV prevention and care interventions.</p> <p>Objective 1: By October 2011, distribute 125,000 condoms annually provided with individual and group level interventions implemented by HDHHS funded community-based organizations.</p> <p>Objective 2: By October 2011, ensure continued distribution of 2,000 condom distribution is maintained with health care services (Family Planning, Adult Immunization, Women, Infants and Children (WIC), etc) provided at 3 HDHHS clinics on a monthly basis.</p> <p>Objective 3: By October 2011, continue to distribute 3,000 condoms provided with mobile clinic health services on a monthly basis.</p> | |
| <p>Strategy 2: To continue distribution of condoms at special events targeted to populations that have been prioritized as highest risk for acquiring or transmitting HIV to include (HIV+, men – to include MSM, women, substance abusers and Transgender) as described in the HDHHS 2009 Comprehensive Plan.</p> <p>Objective 4: By October 2011, identify and educate through 3 trainings staff and partners on the laws, policies, or practices that may support or hinder a community-wide condom distribution program.</p> <p>Objective 5: By October 2011, continue to provide 100,000 condoms annually for distribution and access at Gay Pride Festival, Los Magnificos Car Show, M-Pact (Men who have sex with Men) Task Force, HIP HOP for HIV Awareness and SAFER sites within Sunnyside/South Park.</p> <p>Objective 6: By October 2011, provide 20,000 condoms to the Affected Community Committee members of the Ryan White Planning Council for distribution targeted to prioritized populations.</p> | |
| <p>Strategy 3: Continue partnership with the Texas Department of State Health Services (DSHS) regarding receiving 250,000 condoms on an annual basis.</p> <p>Objective 7: By October 2011, review current agreement with DSHS to ensure adequate condom access for the Houston MSA.</p> <p>Objective 8: By October 2011, determine the additional number of specialty condoms that need to be purchased and place order.</p> | |
| <p>Data sources: HDHHS Monthly and/or quarterly reports and STD-MIS</p> | |

Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”

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| <p>Goal 1: HDHHS will determine a baseline for coverage level of post-exposure prophylaxis (PEP) in the Houston MSA.</p> | <p>Funding sources: N/A</p> |
| <p>Strategy 1: HDHHS will develop recommendations for scaling up access to post-exposure prophylaxis (PEP), with consideration given to the role of emergency departments, standardized treatment guidelines, and regimen selection.</p> <p>Objective 1: By October 2011, HDHHS will conduct a resource inventory of HIV prevention, care, and treatment providers to determine a baseline for coverage level of post-exposure prophylaxis</p> | |

(PEP) in the Houston MSA.

Objective 2: By October 2011, HDHHS will conduct one ECHPP workshop for representatives from HIV prevention, care, and treatment that will include presentation and discussion concerning post-exposure prophylaxis (PEP) to determine the role of emergency departments, standardized treatment guidelines, and regimen.

Strategy 2: Reduce the risk of sero-conversion after events with high risk of exposure to HIV.

Objective 3: By October 2011, HDHHS will increase by 5 percent the use of post-exposure prophylaxis (PEP) based on a newly determined baseline for coverage level of PEP in the Houston MSA.

Data sources: PEP Resource Inventory, Information obtained from discussions concerning post-exposure prophylaxis (PEP), HDHHS Laboratory Data, PEP Resource Inventory, HDHHS Laboratory Data

Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”

ESAPP Language needs to be included from the 10-1001 or hep grant (provides baseline for situational analysis)

Goal 1: Increase broad-based community participation in HIV prevention and care planning with an emphasis on parity, inclusion and representation among membership.

Funding sources:
CDC – HIV
Prevention
Community
Planning Group

Strategy 1: COH will participate in community based events including town hall meetings, community forums and planning bodies that focus on comprehensive HIV prevention, care and treatment.

Objective 1: By October 2011, COH will attend at least 4 community forums and town hall meetings focused on issues relevant to prevention and care services being considered by the Texas Congress

Objective 2: By October 2011, COH, through the Service Linkage Workers program will participate in six (6) Case Management and (6) Case Management Supervision meetings designed to provide guidance and updates on current policies instituted by the grant administrator.

Strategy 2: Increase number of community and business based entities on the purpose and need and goals of the prevention and care planning bodies.

Objective 3: By October 2011, COH will recruit at least 10 individuals for membership consideration on the HDHHS Community Planning Group.

Objective 4: By October 2011, COH will provide five (3) HIV prevention education workshops through SAFER Initiative in the Sunnyside/South Park Communities.

Data sources: Ryan White Standards of Care; HDHHS HIV Prevention Community Planning Group Guidance

Goal 2: Support the adoption of lawful sanction syringe exchange programs

Funding sources:

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| | n/a |
| <p>Strategy 1: Engage community leaders in understanding the need for lawful sanctioning of syringe exchange provision in state law.</p> <p>Objective 1: By October 2011, Include educational information on lawful sanctioning of syringe exchange programs in at least two (2) community meetings.</p> <p>Objective 2: By October 2011, conduct one (1) frontline training that focuses on existing policies as well as national and local trends regarding syringe exchange for contract sub-recipients.</p> | |
| <p>Strategy 2: Engage public officials on the importance of expanding existing legislation regarding lawful sanctioning of syringe exchange programs.</p> <p>Objective 3: Contact up to 3 state legislators by October 2011 to discuss and support the need for the passage of syringe exchange legislation in Texas.</p> <p>Objective 4: By October 2011, COH will meet with at least 2 state representatives and one (1) state representative regarding implementation of expanded syringe exchange policies.</p> | |
| <p>Strategy 2: Provide resources to community leaders to justify need for needle exchange provision in state law.</p> <p>Objective 5: By October 2011, HDHHS will increase its resource database with update materials on needle exchange for community dissemination.</p> <p>Objective 6: By October 2011, HDHHS will conduct two (2) community level meetings to inform the community on the benefits and relevance of effective syringe exchange programs as a component of HIV prevention.</p> | |
| Data sources: | |

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| Goal 3: Implement a client-level HIV prevention data management system (ECLIPS) that will interface and exchange information with other databases to capture referral linkage. | Funding sources: CDC - ECHPP |
| <p>Strategy 1: Work with local administrators to implement ECLIPS.</p> <p>Objective 1: By October 2011, complete all inter-local processes to establish ECLIPS as a viable option for implementation.</p> <p>Objective 2: By October 2011, develop and train front line workers (city) on ECLIPS.</p> <p>Objective 3: By October 2011, have first draft of training manual for contractors/providers utilizing ECLIPS.</p> | |
| <p>Strategy 2: Share process/protocol of ECLIPS with providers to help them understand utilization.</p> <p>Objective 4: By October 2011, provide overview of ECLIPS to subcontractors and develop a training specific for community education.</p> | |
| Data sources: ECLIPS | |

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| Goal 4: Support efforts and encourage the adoption of federal regulations that promote routine testing in clinical settings in Texas. | Funding sources: n/a |
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| <p>Strategy 1: Collaborate with advocacy organizations to educate and inform legislators on the need for expanded policies regarding expanded routine opt-out HIV testing throughout the state of Texas.</p> <p>Objective 1: By October 2011, COH will provide requested support to initiatives proposed by legislators endorsing routine opt-out HIV testing programs and services.</p> <p>Objective 2: By October 2011, COH will meet with at least 2 state representatives and one (1) state representative regarding implementation of new routine opt-out HIV testing policies.</p> |
| <p>Data sources: 07-768 Approved CDC Grant Application for Routine Opt-Out Testing</p> |

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| <p>Goal 5: Work with legislative efforts that support the re-imbursement of core services provided through the state, including routine testing, funding ADAP and other prevention services.</p> | <p>Funding sources: n/a</p> |
| <p>Strategy 1: Collaborate with advocacy organizations to increase awareness of key legislative initiatives including the 2012 budget shortfall that could have negative implications on ADAP funding and other prevention services.</p> <p>Objective 1: By October 2011, COH will meet with at least three (3) state representatives in collaboration with other advocacy organizations to promote the increase in funding for ADAP for FY 2013.</p> <p>Objective 2: By October 2011, work with at least (3) community coalitions to update the community on resolutions determined by the state legislature on ADAP and other prevention services.</p> <p>Objective 3: By October 2011, work with state designated representatives to implement potentially new legislation related to changes in law regarding routine opt-out HIV testing.</p> | |
| <p>Data sources: Texas Department of State Health Services Annual Budget 07-768 DSHS Grant Application</p> | |

Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care”

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| <p>Goal 1: Ensure that 85 percent of persons who receive their HIV positive test result are referred to medical care and have a confirmed first visit for care.</p> | <p>Funding sources: TDSHS</p> |
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Strategy 1: Ensure a comprehensive community case management program providing service linkage to HIV-positive individuals, both those newly diagnosed and those who are out of care.

Objective 1: By October 2011, DIS will identify 750 individuals newly diagnosed with HIV in the Houston MSA eligible for service linkage.

Objective 2: By October 2011, Service Linkage Workers (SLW) will ensure that 85 percent of newly diagnosed HIV positive individuals are linked to Ryan White care services.

Objective 3: By October 2011, 75 percent of persons who receive their test results will be offered Partner Services.

Objective 4: By October 2011, 75 percent of persons who receive their HIV positive test results will receive prevention counseling or will be referred to prevention services.

Objective 5: By October 2011, Service Linkage Workers (SLW) will ensure transfer of newly infected clients to a primary medical care or medical case management provider within 120 days of initial contact.

Data sources: TDSHS FPO (Funding Period Objectives), STD-MIS, ECLIPS, CPCDMS

Goal 2: Maintain a Partner Counseling and Referral Services system to conduct interviews and field investigations for new HIV and syphilis cases.

Funding sources:
TDSHS

Strategy 1: HIV/STD Disease Intervention Specialists (DIS) will conduct interviews and field investigations in accordance with Texas Department of State Health Services (DSHS) DIS performance guidelines.

Objective 1: By October 2011, DIS will interview 85 percent of newly diagnosed HIV or syphilis cases within 72 hours of report to the HDHHS.

Objective 2: By October 2011, DIS will initiate follow-up within 24 hours of report of a new HIV or syphilis case to HDHHS to arrange an in-person interview which can be conducted in the field or in the clinic to expedite follow-up.

Objective 3: By October 2011, DIS will conduct interviews and field investigations in accordance with DIS performance guidelines and will achieve a contact index of 2.0 and a cluster index of 1.0 for each case interviewed.

Objective 4: By October 2011, DIS will conduct partner notification in accordance with DIS performance guidelines and will be successfully conducted for 70 percent of patients pursued.

Objective 5: By October 2011, 90 percent of patients testing positive and receiving post-test counseling will successfully be linked to care services.

Data Sources: TDSHS – Funding Period Objectives

Goal 3: To provide HIV prevention services to inmates in the County Jail System.

Funding sources:
TDSHS

Strategy 1: Support existing programs and establish new programs(s) to facilitate Partner Counseling and Referral Services (PCRS) in the Harris County Jail. Re-entry into the medical care system upon release from jail.

Objective 1: By October 2011, expand by 10 percent services that help HIV positive people get

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| <p>medical care after being released from jail.</p> |
| <p>Strategy 2: Support existing programs and establish new programs(s) to facilitate entry into the medical care system for positive inmates upon release from jail.</p> <p>Objective 1: By October 2011, expand by 10 percent referrals to Houston area services providing job training, transportation and other transitional services.</p> <p>Objective 2: By October 2011, expand by 10 percent referrals to Houston area services providing job training, transportation and other transitional services.</p> |
| <p>Data sources: TDSHS, STD-MIS</p> |

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| <p>Goal 4: Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals.</p> | <p>Funding sources: CDC</p> |
| <p>Strategy 1: Implement the Electronic Client-Level Integrated Prevention System (ECLIPS) that will interface and exchange information related to HIV care services.</p> <p>Objective 1: By October 2011, the Electronic Client-Level Integrated Prevention System will be fully tested and implemented for use by HDHHS Service Linkage Workers (SLW), prevention contractors, and Ryan White Care Services.</p> | |
| <p>Strategy 2: HIV prevention workers and contractors will electronically make referrals directly into ECLIPS and be able to electronically verify the client’s entry into care.</p> <p>Objective 1: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically make referrals directly into ECLIPS.</p> <p>Objective 2: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically verify the client’s entry into care.</p> <p>Objective 3: By October 2011, HDHHS Service Linkage Workers (SLW) and prevention contractors will transfer all previously unaware PLWH to a RW-funded primary medical care, clinical case management or service linkage program within 120 days of initiation of services as documented in the ECLIPS and CPCDMS.</p> | |
| <p>Data sources: Ryan White Care Services CPCDMS and HDHHS ECLIPS</p> | |

Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”

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| <p>Goal 1: Increase the number of reported diagnosed HIV infected persons linked to care who are still in care after initial medical appointments.</p> | <p>Funding sources: Ryan White – HRSA</p> |
| <p>Strategy 1: Implement ECLIPS Data Management System through HDHHS; linking the CPCDMS Data Management System for client tracking.</p> <p>Objective 1: By October 2011, HDHHS will be able to track through the ECLIPS data management program, the number of patients with HIV infection who have two or more medical visits in an HIV care setting within a given <u>measurement year</u>.</p> | |



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| <p>Strategy 2: Employ trained medical, clinical and non-medical case management staff to provide HIV positive clients with support and resources needed to stay retained in care.</p> <p>Objective 1: Non clinical case managers will re-assess clients at six (6) month intervals following the initial assessment or more often if clinically indicated.</p> <p>Objective 2: Case Management staff will review and evaluate new service plans at each six (6) month reassessment or each reassessment to ensure clients remain in care and accessing necessary services.</p> <p>Objective 3: Service linkage worker will obtain a minimum of fifteen (15) hours per year additional education and/or training, including two (2) hours review of community resources, offered by the designated RW Part A/B Provider.</p> |
| <p>Data Sources: Ryan White Standards of Care, Ryan White Part A/B Grant Application</p> |

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| <p>Goal 2: Provide access points for individuals who know their HIV status but are not engaged in primary medical care.</p> | <p>Funding sources: HRSA, CDC</p> |
| <p>Strategy 1: Maintain existing collaboration with Ryan White providers through the ENHANCED LINKAGE Program to re-engage clients into active medical care.</p> <p>Objective 1: HDHHS, through DIS staff, will conduct public health follow up among out of care HIV positive individuals using surveillance data and field activities to facilitate client re-entry into care.</p> | |
| <p>Strategy 2: Examine why out-of-care youth are not utilizing Houston’s primary medical care services that specifically target youth.</p> <p>Objective 2: Continue to collect data in order to examine factors that influence entry into care for youth.</p> | |
| <p>Strategy 3: Develop community mobilization strategies for enabling HIV positive individuals who are not in care access to primary care services.</p> <p>Objective 3: By October 2011, the Ryan White Planning Council will meet to start planning the 2012 Living Healthy with HIV. Living Healthy with HIV was cancelled due to weather in Feb. 2011.</p> <p>Objective 4: By October 2011, Ryan White Planning Council will host at least six (6) committee meetings of the Affected Community Committee.</p> <p>Objective 5: By October 2011, The Community Affected Committee will participate with the HDHHS Community Planning Group to educate members on the need to include advocacy activities for the HIV positive community.</p> | |
| <p>Data Sources: CDC – Expanded Linkage, Ryan White Part A/B Standards of Care, Ryan White Planning Council Policy and Procedure Manual</p> | |

Required Intervention #8: “Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons”

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| <p>Goal 1: Ensure that all Ryan White Care Providers adhere to the most current published Houston EMA RW Part A/B Standards of Care for the Houston EMA/HSDA for the medical treatment of HIV disease.</p> | <p>Funding sources: Ryan White – HRSA</p> |
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| <p>Strategy 1: Continue to maintain most current treatment guidelines for antiretroviral treatment adherence as established by the US Department of Health and Human Services.</p> <p>Objective 1: Ryan White primary care providers will receive annual updates on the most current treatment guidelines and adherence policies provided by the US Department of Health and Human Services.</p> <p>Objective 2: Ryan White primary care providers will include discussion of treatment adherence in all Ryan White related council meetings where decisions are made regarding operational standards.</p> <p>Objective 3: Ryan White grant administration will include review and update of guidelines in at least three (3) trainings offered by Ryan White for primary care providers, case managers and service linkage workers.</p> |
| <p>Data sources: Ryan White Part A/B Standards of Care, National Institutes of Health – 2009 Antiretroviral Treatment Adherence Guidance</p> |

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| <p>Goal 2: Ensure effective tracking mechanism is utilized to capture non-compliance of medication regimen of clients utilizing Ryan White grant services.</p> | <p>Funding sources: Ryan White – HRSA</p> |
| <p>Strategy 1: Maintain policy requiring all primary care providers to document non-compliance and treatment plan.</p> <p>Objective 1: Ryan White Grants Administration will conduct annual review of contracted primary care provider policy on documentation made regarding client noncompliance.</p> <p>Objective 2: Ryan White Grants Administration will conduct annual audits to review primary care provider’s process for intervening when there is documented non compliance with clients prescribed medication regimen.</p> | |
| <p>Strategy 2: Maintain policy requiring documentation of Stage of Illness Update.</p> <p>Objective 3: Ryan White Grants Administration Monitoring Team will conduct an annual review of primary care provider documentation detailing client’s current stage of illness form which includes medication regimen and history.</p> <p>Objective 4: Every thirty days, Primary Care provider staff will update the CPCDMS with status update on client stage of illness and medication changes, if applicable.</p> | |
| <p>Data sources: Ryan White Part A/B Standards of Care, National Institutes of Health</p> | |

Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”

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| <p>Goal 1: Develop and implement a comprehensive course of action for primary medical care providers to follow for maximum health outcomes for HIV positive clients.</p> | <p>Funding sources: Ryan White - HRSA</p> |
| <p>Strategy 1: Ensure primary medical care providers have sufficient resources to effectively track client status on their ability to adhere to established treatment guidelines.</p> | |

Objective 1: At client assessment and annual reassessment, Primary Care providers will review a central “Problems List”, separate from progress notes which clearly prioritize problems for primary care management consideration.

Objective 2: At client assessment and every six months thereafter, Primary Care providers will develop and update a plan of care for each identified problem and diagnostic, therapeutic and educational issue in accordance with the current US Public Health Service treatment guidelines.

Objective 3: Primary Care providers will conduct follow up visits and yearly surveillance and monitoring of patient status in accordance with the current US Public Health Service treatment guidelines.

Objective 4: Primary Care providers will Institute a Part C adherence team which will oversee the assessment, education, medication initiation and follow up of new starts and changes to regimen.

Strategy 2: Ensure Primary Care Providers have sufficient resources to document non-compliance with medication regimen and Stage of Illness Update on all clients utilizing primary medical care services.

Objective 5: Annually or upon client need, PCP Medical Case Managers will review with client, documentation of patient medical readiness through Medication Readiness Assessment Form and make recommendations based on client status.

Objective 6: Annually, PCP Medical Case Managers will track changes in client compliance through the CPCDMS Data System, or as needed based on client interactive, accessibility and existing medical status.

Objective 7: Annually or as needed, Medical Case Managers will document in file a client Stage of Illness with any noted justification for medical team to consider.

Strategy 3: Ensure client readiness to understand and adhere to established treatment guidelines.

Objective 8: Medical Case Managers will conduct annual medical education sessions with HIV positive client; include documentation in patient records and on the standard Patient Medication Education form.

Data Sources: Ryan White Part A/B Standards of Care, CPCDMS

Required Intervention #10: “Implement STD screening according to current guidelines for HIV-positive persons”

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| <p>Goal 1: To collaborate with the Ryan White Planning Council (RWPC) and the Standards of Care Administration to ensure that all HIV-positive persons receive an initial STD screening.</p> | <p>Funding sources: RWP/A, CDC</p> |
| <p>Strategy 1: Continue collaboration with the RWPC to ensure STD screening for HIV positive persons occurs according to current guidelines.</p> | |
| <p>Objective 1: By October 2011, the 85% of those HIV positive persons linked into care will be referred to Ryan White Part A primary care providers and will receive assessment for STD, TB, HAV, HBV, and HCV as part of the standard intake.</p> | |
| <p>Strategy 2: Continue supporting the eight (8) STD clinics in the Houston MSA to provide testing for syphilis, gonorrhea, and Chlamydia, HBV and HCV, as part of the routine, opt-out</p> | |

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| screening program. |
| Objective 2: By October 2011, HDHHS will continue to provide categorical STD, maternity and family planning services in seven integrated clinic sites throughout the Houston MSA. |
| Strategy 3: Maintain Partner Counseling and Referral Services to HIV positive persons who receive diagnosis of another STD. |
| Objective 3: By October 2011, 75% of HIV positive persons who receive positive test results of another STD will be offered Partner Services. |
| Data sources: STD-MIS, eHARS, ECLIPS, Ryan White Standards of Care |

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| Goal 2: Continue operation of the HDHHS Medical Mobile Clinic with stat laboratory testing capability for syphilis, and also conducts testing for HIV, gonorrhea, Chlamydia and vaccines for hepatitis A and B. | Funding sources: CDC |
| Strategy 1: Maintain operation of the HDHHS Medical Mobile Clinic by direct deployment to the five (5) geographic areas within the MSA with high HIV morbidity to provide enhanced disease intervention. | |
| Objective 1: By October 2011, provide monthly-based enhanced disease intervention deployments to each of the five (5) geographic areas within the MSA with high HIV morbidity utilizing the Medical Mobile Clinic. | |
| Data sources: STD-MIS, eHARS, ECLIPS | |

Required Intervention #11: “Implement prevention of perinatal transmission for HIV-positive persons”

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| Goal 1: The City of Houston Department of Health and Human Services (HDHHS) will follow progress towards maximal reduction of perinatal HIV transmission among 100% of HIV exposed infants in the Houston/Harris County HIV Surveillance Jurisdiction. | Funding sources: CDC |
| Strategy 1: Conduct medical record review of mother/infant pairs of all HIV exposed infants. | |
| Objective 1: By October 2011, HDHHS will conduct medical record review of 100% of the HIV exposed mother/infant pairs from birth year 2010. | |
| Objective 2: By October 2011, HDHHS will identify and report 100% of infected infants born in 2010. | |
| Strategy 2: Evaluate the efficacy of antiretroviral medications in preventing perinatal transmission. | |
| Objective 3: By October 2011, HDHHS will identify the missed opportunities for perinatal prevention among 100% of the HIV infected infants born in 2010 to evaluate the efficacy of antiretroviral medications. | |
| Objective 4: By October 2011, HDHHS will conduct follow-up medical record reviews on 100% of infants whose HIV status is indeterminate. | |
| Data sources: (Enhanced HIV/AIDS Reporting System) eHARS and Enhanced Perinatal Surveillance (EPS) System | |

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| Goal 2: The City of Houston Department of Health and Human Services will analyze and disseminate perinatal HIV transmission prevention data quarterly to community partners within the Houston MSA. | Funding sources: CDC |
| Strategy 1: Analyze Enhanced Perinatal Surveillance data to monitor trends, assess needs, and provide feedback to reporting sources. | |
| Objective 1: By October 2011, HDHHS will analyze enhanced perinatal data trends twice in the reporting period. | |
| Strategy 2: Disseminate Enhanced Perinatal Surveillance data to community partners for education, prevention, and health promotion of HIV infected women. | |
| Objective 2: By October 2011, HDHHS will present birth outcome trends of the HIV exposed infants in birth years 2005 to 2009 to the Texas Rapid Testing Implementation at Delivery (TRIAD) Perinatal Task Force, local HIV care providers, and The HDHHS Bureau of HIV/STD & Viral Hepatitis Prevention. | |
| Objective 3: By October 2011, HDHHS will present a public health cluster demonstrating the need for prenatal care, public health follow up, and provider reporting to the TRIAD Perinatal Task Force. | |
| Objective 4: By October 2011, HDHHS will provide 100% of the requested enhanced perinatal data to community members and will disseminate an annual perinatal surveillance report. | |
| Data sources: eHARS and Enhanced Perinatal Surveillance (EPS) System | |

Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”

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| Goal 1: To increase the proportion of HIV-infected persons in Houston EMA who are linked to prevention counseling, medical care, partner services and HIV prevention services. | Funding sources: CDC, TDSHS |
| Strategy 1: Maintain partner services through the Service Linkage Worker Program through the Ryan White Grant Non Medical Case Management Grant. | |
| Objective 1: By October 2011, ensure 80% of persons who receive their HIV positive test result are referred to medical care and have a confirmed first visit for care. | |
| Objective 2: By October 2011, ensure that at least 75% of persons who receive their test results will be offered partner services. | |
| Objective 3: By October 2011, ensure that at least 75% of persons who receive their HIV positive test results receive prevention counseling or are referred to prevention services. | |
| Strategy 2: Maintain the provision of partner services to all HIV positive persons through HDHHS DIS staff. | |
| Objective 4: By October 2011, DIS will continue to provide partner service support to the nine (9) contracted agencies and three (3) STD clinics offering HIV counseling, testing and referral (CTR) services. | |
| Strategy 3: Track partner service referrals through the ECLIPS data management system. | |
| Objective 5: By October 2011, provide operational training to SLW who will use ECLIPS to track clients, service utilization and partner services. | |
| Data Source: CDC – Service Linkage Worker Grant Application, TDSHS, ECLIPS | |

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| Goal 2: To continue to offer the web-based self interview process through PENS Houston and expand utilization of PENSHouston to HDHHS STD clinics, thereby streamlining DIS activities. | Funding sources: TDSHS |
| Strategy 1: Increase PENSHouston utilization by other community providers who identify STD's. | |
| Objective 2: By October 2011, expand PENSHouston access to all contracted local providers who offer STD services. | |
| Strategy 2: Train DIS workers on PENSHouston; updating system as necessary to reach targeted population. | |
| Objective 2: Update technology for PENSHouston website as necessary or possible. | |
| Objective 3: By October 2011; host one workshop session to review PENSHouston system and invite recommendations from DIS workers to improve functionality or program. | |
| Data Sources: PENSHouston Website, TDSHS, CDC | |

Required Intervention #13: “Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV”

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| Goal 1: Maintain existing interventions including Healthy Relationships and Community Promise as tools utilized by agency contractors to track behavior screening and risk reduction models for HIV positive persons. | Funding sources: CDC |
| Strategy 1: Maintain contract with agencies that provide risk reduction interventions including Healthy Relationships and Community Promise within targeted communities. | |
| Objective 1: By 2011, conduct at least one additional training for current contracted providers on Healthy Relationships and Community Promise. | |
| Objective 2: By October 2011, provide at least one training for non-contracted providers on Health Relationships and Community Promise. | |
| Strategy 2: Maintain social marketing campaigns that promote risk reduction interventions for individuals testing in emergency room setting. | |
| Objective 3: By October 2011, continue to provide risk reduction packages, in both English and Spanish, to individuals regarding the inclusion of HIV testing and support services in emergency room settings. | |
| Data Sources: CDC | |

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| Goal 2: Decrease transmission of HIV by continuing to utilize Protocol Based Counseling as an effective counseling and testing tool with HIV Positive individuals to determine risk for HIV/STD transmission. | Funding sources: CDC, TDSHS |
| Strategy 1: Continue to provide quarterly PBC training and education to contracted and non-contracted agencies and community members interested in providing counseling and testing services. | |
| Objective 1: By October 2011, HDHHS will continue to promote the utilization of PBC training protocol for counseling and testing among representatives within the SAFER Initiative Target Area and among all nine (9) contracted organizations that provide HIV testing and counseling. | |
| Objective 2: By October 2011, HDHHS will conduct at least three (3) PBC training workshops both in the SAFER Initiative Target Area (Sunnyside/South Park) and for all interested | |

contracted and non contracted agencies throughout the EMA.

Strategy 2: Collaborate with DSHS on certification process for PBC and ensure all qualified entities follow both city and state issued guidance.

Objective 3: By October 2011, HDHHS coordinate with DSHS on at least three (3) training workshops and ensure that individuals who apply for PBC receive both local and state certification.

Objective 4: By October 2011, HDHHS will complete the written manual outlining the steps for becoming PBC qualified for both contracted and non-contracted agencies and individuals.

Data Sources: CDC, TDSHS

Required Intervention #14: “Implement linkage to other medical and social services for HIV-positive persons”

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| Goal 1: To ensure appropriate linkage to primary medical care and other healthcare services, mental health therapy, substance abuse treatment and other essential support services for HIV-positive individuals, both those newly diagnosed and those who are out of care in the Houston MSA. | Funding sources: Ryan White Care Services |
| Strategy 1: Continue Service Linkage co-located at HDHHS Public Clinics, including SLW services that provide information and referral services to current clients and linkage to care for HIV-positive individuals, both those newly diagnosed and those who are out of care in the Houston MSA. | |
| Objective 1: By 2011, Service Linkage Workers (SLW) will offer Non-medical Case Management or Service Linkage in 12? Public and community-based program sites that serve HIV-positive individuals, both those newly diagnosed and those who are out of care in the Houston MSA. | |
| Strategy 2: Service Linkage Worker (SLW) activities will include offering all newly diagnosed individuals with “hands-on” information, referrals and linkage to medical, mental health, substance abuse and psychosocial services. | |
| Objective 2: By 2011, Service Linkage Workers (SLW) will expand non-medical case management services co-located at HIV testing sites and primary medical care treatment sites by linking 750 unduplicated HIV-positive individuals, both those newly diagnosed and those who are out of care in the Houston MSA. | |
| Strategy 3: Service Linkage Worker (SLW) will transfer newly diagnosed individual to a Ryan White-funded primary care, clinical case management or service linkage program within 120 days of initiation of services as documented in both ECLIPS and CPCDMS. | |
| Objective 3: By 2011, Service Linkage Worker (SLW) will transfer 85 percent of newly diagnosed individual to a Ryan White-funded primary care, clinical case management or service linkage program within 120 days of initiation of services. | |
| Data sources: STD-MIS, ECLIPS, CPCDMS | |

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| Goal 2: Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals. | Funding sources: CDC |
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| <p>Strategy 1: Implement the Electronic Client-Level Integrated Prevention System (ECLIPS) that will interface and exchange information related to HIV care services.</p> <p>Objective 1: By October 2011, the Electronic Client-Level Integrated Prevention System will be fully tested and implemented for use by HDHHS Service Linkage Workers (SLW), prevention contractors, and Ryan White Care Services.</p> |
| <p>Strategy 2: HIV prevention workers and contractors will electronically make referrals directly into ECLIPS and be able to electronically verify the client’s entry into care.</p> <p>Objective 2: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically make referrals directly into ECLIPS.</p> <p>Objective 3: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically verify the client’s entry into care.</p> <p>Objective 4: By October 2011, HDHHS Service Linkage Workers (SLW) and prevention contractors will transfer all previously unaware PLWH to a RW-funded primary medical care, clinical case management or service linkage program within 120 days of initiation of services as documented in the ECLIPS and CPCDMS.</p> |
| <p>Data sources: Ryan White Care Services CPCDMS and HDHHS ECLIPS</p> |

Recommended Intervention #15: “Condom distribution for the general population”

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| <p>Goal 1: Maintain the distribution of 80,000 condoms provided throughout Houston MSA.</p> | <p>Funding sources: DSHS. CDC</p> |
| <p>Strategy 1: Develop partnerships and agreements with non-traditional community-based facilities to provide condoms for distribution at no cost.</p> <p>Objective 1: By October 2011, establish organizational support for condom distribution and promotion activities in traditional and non-traditional venues. By October 2011, develop a process for identifying and engaging appropriate community partners.</p> <p>Objective 2: By October 2011, maintain distribution of condoms to 5 organizations (fraternity, sorority, non-profit, beauty/barber shop, etc).</p> | |
| <p>Strategy 2: Provide training and capacity building for community partners to establish peer-to-peer educational opportunities on the usage and types of condoms.</p> <p>Objective 3: By October 2011, define programmatic objectives and the format by which the information will be collected.</p> <p>Objective 4: By October 2011, provide 7 trainings on condom usage and types to community partners.</p> <p>Objective 5: By October 2011, include condom distribution as an agenda item for discussion at 2 community-based meetings.</p> <p>Objective 6: By October 2011, continue to distribute condoms to 1 health fair or community event per month.</p> | |
| <p>Data sources: HDHHS Monthly and/or quarterly reports.</p> | |

Recommended Intervention #16: “HIV and sexual health communication or social marketing campaigns targeted to relevant audiences”

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| <p>Goal 1: Increase by 50% social marketing campaigns and HIV sexual health communication via new prevention messages targeting Men, Women, HIV-positive persons, Youth, People who Share Needles/Works, and Transgender Individuals.</p> | <p>Funding sources: Greater Than AIDS National Campaign, Houston Rockets, NBA, Planned Parenthood, CDC, FC2</p> |
| <p>Strategy 1: Partner with the Greater Than AIDS national social media and outreach campaign targeting the African American community.</p> <p>Objective 1: By October 2011, reach the African-American community using Greater Than AIDS billboards, posters, brochures, postcards, radio spots, videos, and online banner advertisements.</p> <p>Objective 2: By October 2011, utilize the Deciding Moments videos, posters, brochures, radio spots, and online banner campaign advertisements to target the African-American community.</p> | |
| <p>Strategy 2: Partner with the NBA to feature one or more professional athletes from the Houston Rockets as part of the Greater Than AIDS campaign.</p> <p>Objective 3: By October 2011, implement new television and radio spots featuring an NBA player from the Houston Rockets.</p> | |
| <p>Strategy 3: Partner with Planned Parenthood “GYT: Get Yourself Tested” campaign targeting youth.</p> <p>Objective 4: By October 2015, using the GYT: Get Yourself Tested media campaign to reach the youth in the Houston MSA through radio spots, online information, and mobile phone messaging.</p> | |
| <p>Strategy 4: Partner with the CDC “Local Business/Labor Responds to AIDS Project” campaign targeting local merchants and leaders in the business and labor sectors to raise awareness of HIV and promote testing in communities of high prevalence.</p> <p>Objective 5: By October 2011, recruit and engage at least 90% of targeted merchants and city leaders to participate and support the Local Business/Labor Responds to AIDS Project Campaign.</p> | |
| <p>Strategy 5: Collaborate with Planned Parenthood to assist in the roll out of the Female Condom 2 (FC2) by educating and training contracting agencies and Community Based Organizations providing HIV & STD education within the Houston MSA.</p> <p>Objective 6: By October 2011, educate and train 100% of contracting agencies and community based organizations funded to provide Health Education & Risk Reduction training to those populations at highest risk for acquiring and/or transmitting HIV and other STDs.</p> | |
| <p>Strategy 6: Partner with Legacy Community Health Services by funding “Enhanced Syringe</p> | |

Access Program” (ESAP), to reduce transmission rates of hepatitis C (HCV), HIV, and other blood borne pathogens among at-risk persons.

Objective 7: By October 2011, educate and promote ESAP a network of pharmacies to sell new syringes to the public without a prescription.

Data sources: Greater Than AIDS Campaign, GYT: Get Yourself Tested Campaign, Local Business/Labor Responds to AIDS Project, Female Condom 2 Manufacturer – Women’s Health Group

Recommended Intervention #17: “Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV”

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| <p>Goal 1: Ensure HIV-positive patients diagnosed at HDHHS clinic locations and patients at highest risk of acquiring HIV at HDHHS clinic locations receive evidence-based HIV prevention interventions.</p> | <p>Funding sources: HDHHS</p> |
| <p>Strategy 1: Identify HIV-positive patients diagnosed at HDHHS clinic locations during post-test counseling.</p> | |
| <p>Objective 1: By October 2011, ensure that at least 50% of HIV-positive patients diagnosed at HDHHS clinics are identified during post-test counseling sessions and linked to evident-based HIV prevention interventions and HIV care services.</p> | |
| <p>Strategy 2: Increase HDHHS clinic staff capacity to implement evidence-based HIV prevention interventions for patients at highest risk of acquiring HIV.</p> | |
| <p>Objective 2: By October 2011, ensure that at least 25% of the discordant couples (partners to HIV-positive individuals) at HDHHS clinic locations participate in evidence-based HIV prevention interventions.</p> | |
| <p>Objective 3: By October 2011, ensure 75% of the HDHHS clinic staff are trained to provide culture competent referrals for patients at highest risk of acquiring HIV.</p> | |
| <p>Data sources: HDHHS HIV Prevention Process Evaluation Data</p> | |

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| <p>Goal 2: Ensure that VOICES/VOCES, Safe in the City and/or Healthy Relationships are implemented at HDHHS clinics with high HIV/STD positivity rates.</p> | <p>Funding sources: HDHHS HIV Prevention Program</p> |
| <p>Strategy 1: Use epidemiological data to identify HDHHS clinic locations with high HIV/STD positivity rates.</p> | |
| <p>Objective 1: By October 2011, secure data, create a geographical profile and map documents to identify HDHHS clinics with high HIV/STD positivity rates.</p> | |
| <p>Strategy 2: Increase HDHHS prevention contractors’ capacity to implement evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV.</p> | |
| <p>Objective 2: By October 2011, provide training opportunities or conference registrations for HDHHS prevention contractors’ to attend national conferences and/or to receive training on evidence-based HIV prevention interventions.</p> | |
| <p>Data sources: HDHHS HIV Prevention Process Evaluation Data</p> | |

Recommended Intervention #18: “Community interventions that reduce HIV risk”

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| <p>Goal 1: In the Houston MSA implement, The SAFER (Strategic AIDS/HIV Focused Emergency Response) Initiative, that will utilize community mobilization models to motivate its members on becoming actively engaged in reducing by 25% the number of HIV infections by 2015.</p> | <p>Funding sources: CDC</p> |
| <p>Strategy 1: To empower local communities to take ownership of reducing the incidence of HIV in their communities.</p> <p>Objective 1: By October 2011, identify 10 community members, organizations and agencies that will form a community mobilization group to partner with HDHHS.</p> <p>Objective 2: By October 2011, HDHHS staff, as well as, community leaders will share in the design and implementation of 1 comprehensive strategy to address HIV prevention needs in the community.</p> | |
| <p>Strategy 2: To increase social marketing in 1 SAFER target area (Sunnyside/South Park) that demonstrates the need for HIV prevention activities in addition to other prominent issues of concern.</p> <p>Objective 3: By October 2011, HDHHS will sponsor 3 community meetings that will provide opportunities for community members to become involved in education, awareness and outreach activities, resulting in decreased stigma associated with HIV in the community.</p> <p>Objective 4: By October 2011, HDHHS will develop appropriate social marketing material for community members to distribute within Sunnyside/South Park.</p> | |
| <p>Strategy 3: To initiate consultations with administrative agencies within the Houston MSA to determine current distribution of HIV resources.</p> <p>Objective 5: By October 2011, HDHHS will provide five opportunities for targeted HIV screening within Sunnyside/South Park.</p> <p>Objective 6: By October 2011, HDHHS will provide partner services to 75% of HIV and STD infected persons, their partners, contacts, and social networks in Sunnyside/South Park.</p> <p>Objective 7: By October 2011, HDHHS will provide service linkage services to 85% of HIV infected persons found through targeted screening.</p> | |
| <p>Data sources: Meeting Minutes, Membership Roster, Meeting Evaluation, STD-MIS, and ECLIPS</p> | |

Recommended Intervention #19: “Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship”

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| <p>Goal 1: To decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV in the Houston MSA.</p> | <p>Funding sources: CDC</p> |
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Strategy 1: Ensure that individuals at high-risk for acquiring HIV are recruited and engaged in an appropriate Health Education/Risk Reduction (HE/RR) interventions.

Objective 1: By October 2011, 2,956 individuals at high-risk for acquiring HIV will receive at least one session of a Group-Level Intervention (GLI).

Objective 2: By October 2011, 1,478 (50%) of individuals at high-risk for acquiring HIV will receive ALL required sessions of the GLI in which they are enrolled.

Objective 3: By October 2011, 910 individuals at high-risk for acquiring HIV will receive at least one Individual-Level Intervention (ILI).

Objective 4: By October 2011, 900 individuals at high-risk for acquiring HIV will receive a Community-Level Intervention (CLI).

Objective 5: By October 2011, 9000 individuals at high-risk for acquiring HIV will receive HIV/STD information through outreach and/or recruitment.

Objective 6: By October 2011, 900 (10%) individuals at high-risk for acquiring HIV will be recruited and engaged in an appropriate HE/RR intervention.

Data sources: ECLIPS

Goal 2: To provide a broad array of Counseling, Testing, and Referral Services (CTRS), with a focus on diagnosing as many new cases of HIV infection as possible while linking infected clients to appropriate prevention, care, and treatment services.

Funding sources:
CDC

Strategy 1: To provide a broad array of Counseling, Testing, and Referral Services (CTRS), with a focus on diagnosing as many new cases of HIV infection in traditional settings.

Objective 1: By October 2011, provide HIV testing to at least 1,700 individuals in traditional settings.

Objective 2: By October 2011, identify a minimum of two percent HIV-infected individuals in traditional settings who had previously tested negative or were unaware of their status.

Objective 3: By October 2011, conduct a results counseling session in traditional settings with at least 80% of the newly-identified positive clients.

Strategy 2: To provide a broad array of Counseling, Testing, and Referral Services (CTRS), with a focus on diagnosing as many new cases of HIV infection in non-traditional settings.

Objective 3: By October 2011, provide HIV testing to at least 5,700 individuals in non-traditional settings.

Objective 4: By October 2011, identify a minimum of 1.0 percent HIV-infected individuals in non-traditional settings who had previously tested negative or were unaware of their status.

Objective 5: By October 2011, conduct a results counseling session in non-traditional settings with at least 80% of the newly-identified positive clients.

Data sources: ECLIPS

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| Goal 3: To increase the proportion of HIV-infected persons in the Houston MSA who are linked to care services. | Funding sources: CDC |
| <p>Strategy 1: HDHHS will link 85 percent of individuals newly diagnosed with HIV in the Houston MSA into primary medical care services.</p> <p>Objective 1: By October 2011, ensure that 85 percent of the persons who receive a new HIV diagnosis in traditional settings have a confirmed first visit for care.</p> <p>Objective 2: By October 2011, ensure that 85 percent of the persons who receive a new HIV diagnosis in non-traditional settings have a confirmed first visit for care.</p> <p>Objective 3: By October 2011, ensure that 85 percent of the persons who receive a new HIV diagnosis through partner services have a confirmed first visit for care.</p> | |
| Data sources: ECLIPS | |
| Goal 4: Establish a seamless electronic client-level data management system that will interface with Harris County CPCDMS to track referrals from initial HIV test to engagement in primary medical care for positive individuals. | Funding sources: CDC |
| <p>Strategy 1: Implement the Electronic Client-Level Integrated Prevention System (ECLIPS) that will interface and exchange information related to HIV care services.</p> <p>Objective 1: By October 2011, the Electronic Client-Level Integrated Prevention System will be fully tested and implemented for use by HDHHS Service Linkage Workers (SLW), prevention contractors, and Ryan White Care Services.</p> | |
| <p>Strategy 2: HIV prevention workers and contractors will electronically make referrals directly into ECLIPS and be able to electronically verify the client’s entry into care.</p> <p>Objective 2: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically make referrals directly into ECLIPS.</p> <p>Objective 3: By October 2011, ensure that all HDHHS Service Linkage Workers (SLW) and prevention contractors will be able to electronically verify the client’s entry into care.</p> <p>Objective 4: By October 2011, HDHHS Service Linkage Workers (SLW) and prevention contractors will transfer all previously unaware PLWH to a RW-funded primary medical care, clinical case management or service linkage program within 120 days of initiation of services as documented in the ECLIPS and CPCDMS.</p> | |
| Data sources: HDHHS, ECLIPS, Ryan White Care Services, CPCDMS | |

Recommended Intervention #20: “Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines”

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| Goal 1: Maintain existing capacity to screen, test, treat and vaccinate HIV-positive persons, injection drug users and HIV-negative persons at highest HIV risk for acquiring HIV, Hepatitis, STDs and TB. | Funding sources: CDC, DSHS, COH |
| <p>Strategy 1: Continue providing provide STD, maternity and family planning services in its four (4) integrated clinic sites throughout the City of Houston.</p> <p>Strategy 1: Continue to provide STD screening and/or treatment in non-clinical settings through a Mobile Clinic operated by the Bureau of HIV/STD and Viral Hepatitis Prevention.</p> <p>Objective 1: Increase deployment of Mobile Clinic on case-related screenings in areas of Houston where new cases of disease are reported from three (3) days weekly to four (4).</p> <p>Strategy 3: Continue efforts through local community based organizations to offer screening</p> | |



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| <p>activities for syphilis, hepatitis B, and hepatitis C, in addition to routine HIV screening.</p> <p>Strategy 4: Continue to operate the two (2) TB clinics throughout the city of Houston providing TB screening and treatment services.</p> |
| <p>Data sources: ECLIPS, MAVEN, CPCDMS, COH Personnel Tracking Report</p> |

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| <p>Goal 2: Increase the HDHHS' capacity to expand integrated screening and prevention opportunities for persons infected with HIV, Hepatitis, STD, or TB or those at high-risk for acquiring these infections.</p> | <p>Funding sources: CDC, DSHS, COH</p> |
| <p>Strategy 1: HDHHS will identify a PCSI coordinator who will increase communication and coordinate activities between CDC and locally funded HIV, viral hepatitis, STD and TB prevention, treatment, and care programs.</p> <p>Objective 1: Manage the PCSI steering committee, which will be composed of key staff across all participating programs, as well as other stakeholders and meet once monthly.</p> <p>Objective 2: By October 2011, provide training on the use of the HIV rapid test to 100% of TB DOT workers.</p> <p>Strategy 2: Improve monitoring and evaluation of HDHHS PCSI activities</p> <p>Objective 1: By October 2011, identify additional sources of funding to support the role of data analyst.</p> <p>Objective 2: Include assessments for STD, TB, HAV, HBV, and HCV as a standard component of intake to receiving services.</p> | |
| <p>Data sources: ECLIPS, MAVEN, CPCDMS, COH Personnel Tracking Report</p> | |

Recommended Intervention #21: “Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis”

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| <p>Goal 1: Raise the awareness of HDHHS-funded Community Based Organizations staff who offer risk reduction counseling and partner services.</p> | <p>Funding sources: HDHHS</p> |
| <p>Strategy 1: Increase the knowledge of the staff at HDHHS-funded Community Based Organizations which offer risk reduction counseling and partner services.</p> <p>Objective 2: By October 2011, host one HDHHS contractor’s meeting to increase the knowledge of the staff at HDHHS-funded Community Based Organization by 20%, as identified from the pre- and post- training evaluations.</p> <p>Objective 3: By October 2011, document an increase in the provision of education and advocacy events to individuals living with HIV by 25% as stated in the 2009 Comprehensive HIV Surveillance Plan for the Houston area.</p> | |

Data sources: HDHHS HIV Prevention, Process Evaluation Data

Goal 2: Assure the accuracy and completeness of the HIV and STD surveillance data for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis.

Funding sources:
TDSHS

Strategy 1: Collect previous HIV/STD test results information from persons who receive a new STD diagnosis.

Objective 1: By October 2011, maintain the monthly performance standards set by the Texas Department of State Health Services (DSHS) on the interviewing/counseling skills demonstrated by DIS in the following areas: (1) Communication, (2) Problem Solving, (3) Analysis, (4) Partner Elicitation, and (5) Cluster Elicitation/Risk Reduction.

Objective 2: By October 2011, maintain the monthly performance standards set by the Texas Department of State Health Services (DSHS) of 85% of closed cases in STD*MIS have current or previous HIV test results.

Data sources: HIV/STD Surveillance Data

Recommended Intervention #22: “For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others”

Goal 1: To implement linkage to medical and social services for high-risk HIV- negative individuals.

Funding sources:
CDC

Strategy 1: Assess medical and social service facilities in the Houston MSA available for HIV negative individuals in need of social support services.

Objective 1: By October 2011, complete a resource inventory of medical and social service facilities.

Objective 2: By October 2011, contact facilities and solicit partnerships to provide assistance to HIV – negative individuals.

Objective 3: By October 2011, provide capacity building or technical assistance to at least 1 facility.

Data sources: HDHHS Surveillance Data

Recommended Intervention #23: “Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV”

Goal 1: Collaborate with the Texas Regional OSAR and other related drug treatment programs to assess the current scale and capacity of brief alcohol screenings within the Houston MSA.

Funding sources:
CDC, TCADA

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| <p>Strategy 1: Assess the number of drug treatment programs within the Houston MSA.</p> <p>Objective 1: By October 2011, identify or conduct resource inventory of existing alcohol and drug treatment programs in the Houston MSA.</p> <p>Objective 2: By October 2011, contact 10% of identified alcohol drug treatment programs.</p> <p>Objective 3: By October 2011, determine those that implement substance abuse screenings and provide integrative services for HIV+ persons and HIV-negative persons at highest risk of acquiring HIV.</p> | |
| <p>Data sources: SAMHSA, DSHS, TCADA, Texas Department of Criminal Justice (TDCJ), United Way</p> | |

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| <p>Goal 2: Implement brief alcohol screening questions in HIV prevention and care needs assessments, risk reduction curriculums and other client surveys in order to assist persons in gaining a greater understanding of alcohol use can increase acquisition of HIV infection.</p> | <p>Funding sources: SAMHSA, TCADA, DSHS CDC</p> |
| <p>Strategy 1: Develop a partnership with drug treatment programs within the Houston MSA.</p> <p>Objective 1: By October 2011, partner with at least 2 drug treatment programs that provide aforementioned services.</p> | |
| <p>Data sources: RWPC SOC, HDHHS HIV SOC, ECLIPS, CPCDMS, BHIPS</p> | |

Recommended Intervention #24: “Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors”

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| <p>Goal 1: To collaborate with 7 HDHHS Task Forces to continue to provide the community with opportunities to become involved in education, awareness and outreach activities.</p> | <p>Funding sources: HDHHS, CDC</p> |
| <p>Strategy 1: Sustain capacity for HDHHS Task Forces to continue actively engaging their targeted populations, resulting in decreased stigma and risk behaviors associated with HIV in the community.</p> <p>Objective 1: By October 2011, HDHHS Task Forces will provide 10 education, awareness, and outreach activities in geographic areas within the Houston MSA with high HIV and STD morbidity.</p> <p>Objective 2: By October 2011, HDHHS Task Forces will increase their membership by 10 percent above their 2009 roster.</p> | |

National Strategic Goals Tool

This tool is designed to document how the elements of the Enhanced Plan work together to achieve goals set forth in the National HIV/AIDS Strategy (NHAS). It is acknowledged that each jurisdiction is in a different position regarding their capacity to reach these goals. Nevertheless, a critical step toward ensuring that maximum effort is given to achieving these national goals is to make them a key component in the planning process.

Specific 2015 targets* have been set to help reach the three broad NHAS goals. In the space provided below, please describe how the Enhanced Plan is designed to make the most progress toward achieving each target (grouped by higher level NHAS/DHAP goals). Describe the key activities from the Enhanced Plan that will serve as the principle means for reaching the 2015 target and address how other activities included in the plan work in combination to achieve this target. Specifically, descriptions for each 2015 target should address how the combination of interventions and public health strategies used in the Enhanced Plan achieve the following:

1. Utilizes an optimal combination of cost-effective and efficacious public health approaches at the right scale
2. Work together to maximize their intended impact
3. Addresses the need within your jurisdiction based on all available information (i.e., local epidemiology, situational and gap analyses, etc.)
4. Takes advantage of opportunities for optimal resource leveraging and coordination across funding streams

*These targets are based on the National HIV AIDS Strategy and the proposed DHAP strategic plan for 2015, which will be finalized soon.

Reducing New HIV Infections

1. Reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%

Based upon the CDC nationwide prevalence estimates², HDHHS estimated 26,500 people were living with HIV in Harris County in 2006 (HIV prevalence=26,500). As a result, the HIV transmission rate is 6.4% ($1700/26500 \times 100\% = 6.4\%$). Reducing the annual number of new HIV infections has a correlation on reducing the number of opportunities HIV can be transmitted. **The HDHHS will seek to reduce the annual number of new infections to 1275 and realize a reduced transmission rate of 3.7% (1275/33810)*.**

To reduce the number of new HIV infections, the HDHHS will implement a combination of activities to include intensifying HIV and STD prevention efforts in five geographic areas within the MSA with high HIV and STD morbidity, which includes; 1) Sunnyside/South Park, 2) Greater Fifth Ward, 3) Acres Homes, 4) Sharpstown/Southwest, and the 5) Montrose. This targeted public health and community mobilization effort will be branded as the SAFER Initiative. Intensifying activities will include:

- The allocation of new and existing HIV/STD and related funding support to these five (5) high morbidity areas.
- The initiation of local consultations with administrative agencies within the MSA to determine current distribution of HIV resources. Maintain existing capacity to screen, test, treat and vaccinate HIV-positive persons, injection drug users and HIV-negative persons at highest HIV risk for acquiring HIV, Hepatitis, STDs and TB.
- Increase by 50% social marketing campaigns and HIV sexual health communication via new prevention messages targeting Men, Women, HIV-positive persons, Youth, People who Share Needles/Works, and Transgender Individuals.
- Ensure that 85 percent of persons who receive their HIV positive test result are referred to medical care and have a confirmed first visit for care.
- By 2015, increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks in each of the five (5) geographic areas within the MSA with high HIV morbidity. Increase the provision of partner services to HIV and STD infected persons, their partners, contacts, and social networks.
- Increase service linkage capacity to support the five (5) HIV testing community access points in each of the five (5) geographic areas within the MSA with high HIV morbidity by 2015.

2. Increase the percentage of people living with HIV who know their serostatus to 90%

- Prioritize the implementation of 4th generation HIV diagnostic tests and the development of new tests for incident infections.

3. Increase the percentage of people newly diagnosed with HIV infection who have a CD4 count of 200 cells/ μ l or higher by 25%

- Primary care providers will continue to provide 100% of all HIV positive clients with CD4 and viral load data within the first three months of care.

4. Reduce the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25%

- By October 2011, ensure that at least 25% of the discordant couples (partners to HIV-positive individuals) at HDHHS clinic locations participate in evidence-based HIV prevention interventions
- Decrease transmission of HIV by continuing to utilize Protocol Based Counseling as an effective counseling and testing tool with HIV Positive individuals to determine risk for HIV/STD transmission.

5. Reduce the proportion of IDU at risk for transmission/acquisition of HIV by XX% [Indicator TBD pending DHAP strategic plan]

- Decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV in the Houston MSA.

6. Decrease the number of perinatally acquired pediatric HIV cases by 25%

- The City of Houston Department of Health and Human Services (HDHHS) will follow progress towards maximal reduction of perinatal HIV transmission among 100% of HIV exposed infants in the Houston/Harris County HIV Surveillance Jurisdiction.

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

7. Reduce AIDS diagnoses by 25%

- Non clinical case managers will re-assess clients at six (6) month intervals following the initial assessment or more often if clinically indicated

8. Increase the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%

- Through the use of ECLIPS, establish a seamless system to immediately link individuals to care upon diagnosis

9. Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable

- Houston will continue to develop community viral load rates and analysis as recommended in the National HIV/AIDS Strategy,

10. Reduce the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%

- By October 2011, ensure that at least 25% of the discordant couples (partners to HIV-positive individuals) at HDHHS clinic locations participate in evidence-based HIV prevention interventions
- Decrease transmission of HIV by continuing to utilize Protocol Based Counseling as an effective counseling and testing tool with HIV Positive individuals to determine risk for HIV/STD transmission.

11. By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least two visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%

- Every thirty days, Primary Care provider staff will update the CPCDMS with status update on client stage of illness and medication changes, if applicable.

- By October 2011, HDHHS will be able to track through the ECLIPS data management program, the number of patients with HIV infection who have two or more medical visits in an HIV care setting within a given measurement year.

12. By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86%

- In calendar year 2010, 10,817 unduplicated clients received Ryan White services of any type. 421 (3.8% reported being homeless). Ryan White Grants Administration does not specifically track whether clients have “permanent” housing but track if they report being homeless

Reducing HIV-Related Disparities

13. Increase the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%

- Houston will continue to develop community viral load rates and analysis as recommended in the National HIV/AIDS Strategy.
- 75% of clients will show improved or maintained viral load and CD4 counts over time.
- By 2015, increase the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20% (2010 undetectable viral load = 22%)

14. Increase the percentage of HIV-diagnosed Blacks with undetectable viral load by 20%

- Houston will continue to develop community viral load rates and analysis as recommended in the National HIV/AIDS Strategy
- In 2015, Increase the percentage of HIV-diagnosed Blacks with undetectable viral load by 20% (2010 undetectable viral load = 12%)

15. Increase the percentage of HIV-diagnosed Latinos with undetectable viral load by 20%

- Houston will continue to develop community viral load rates and analysis as recommended in the National HIV/AIDS Strategy.
- By 2015, Increase the percentage of HIV-diagnosed Latinos with undetectable viral load by 20% (2010 undetectable viral load = 18%)

16. Reduce the disparity in HIV incidence for Blacks versus Whites (Black: White ratio of new infections) by 25%; By 2015, reduce the disparity in HIV incidence for Hispanics versus Whites (Hispanic: White ratio of new infections) by 25%

- In Houston, African Americans have nearly five times the rate of new HIV infections in 2006 (127 per 100,000) compared to other races (35 per 100,000 among Hispanics and 19 per 100,000 among White/Other races). Overall, African Americans and Hispanics accounted for 78% of new HIV infections in 2006.

- The estimated Black to White/Other rate ratio of new HIV infections is $127.2/19.2=6.63$. **By 2015, realize a 25% reduction to 4.98.**
- The estimated Hispanic to White/Other rate ratio of new infections in 2006 is $35.1/19.2=1.83$. **By 2015, realize a 25% reduction to .45.**
- The HDHHS will seek to reduce these disparities by the following ratios through the implementation of the following activities:
- Use the Greater Than AIDS social marketing campaign to increase awareness of HIV as a public health emergency in the AA community in Houston/Harris County.

17. Reduce the disparity in HIV incidence for MSM versus other adults in the United States by 25%

- Men who have sex with men accounted for 34% of new HIV infections, while persons having heterosexual contact with a person with or at high risk for HIV infection accounted for 31%. People who used intravenous drugs or had no identified risk accounted for 35% of the new HIV infections.
- Use the Greater Than AIDS social marketing campaign to increase awareness of HIV as a public health emergency in MSM communities in Houston/Harris County.

18. Ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups

- 75% of clients will show improved or maintained viral load and CD4 count over time.

ECHPP At-A-Glance Summary

This at-a-glance summary (i.e., a visual summary) of the overall plan would serve as a tool to describe gross level aspects of the plan by intervention strategy. It will also emphasize how the intervention strategies work together and how the overall plan is a coordinated effort. Please complete the table below.

| Intervention Strategy | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS/DHAP Goal Addressed | Brief Justification |
|-----------------------|--|---|-------------------------------|--|--|---|---|
| Name | Increase (I) No change (N) Decrease (D) | New (N) Existing (E) Existing but leveraged (EL) | List existing funding sources | List new sources or changes in current sources | Increase (I) No change (N) Decrease (D) | (1) Reduce New Infections (2) Reduce Health Disparities (3) Increase access to care/Improve health outcomes for PLWH | A brief justification for how the collection of activities in each intervention category will achieve the identified NHAS/DHAP goal and work in conjunction or coordination with other interventions/strategies in the plan |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|---|
| 1 | ROUTINE, OPT-OUT SCREENING FOR HIV IN CLINICAL SETTINGS | I | EL | CDC, TDSHS | N/A | I | 1, 2, 3 | HIV screening programs in health care settings help to minimize the complexity and stigma of such programs, and they take advantage of the fact that 81% of U.S. adults see a health care provider at least annually. Routinely screening patients, ages 13-64, for HIV after being notified that testing will be performed unless the patient declines (opt-out testing). HIV screening programs in health care settings help to minimize the complexity and stigma of such programs, and they take advantage of the fact that 81% of U.S. adults see a health care provider at least annually. This intervention will continue to be scaled up in the Houston MSA and will receive an increases in funding as it becomes available. |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|---|
| 2 | HIV TESTING IN NON-CLINICAL SETTINGS TO IDENTIFY UNDIAGNOSED HIV INFECTION | I | EL | CDC | N/A | I | 1, 2, 3 | THE USE OF MORE AGGRESSIVE SCREENING PROGRAMS OUTSIDE THE CLINICAL SETTING IS JUSTIFIABLE FOR SUBPOPULATIONS AFFECTED BY HEALTH DISPARITIES AND WITH LIMITED ACCESS TO OR UTILIZATION OF MEDICAL CARE OR THOSE HIGHEST RISK GROUPS WITH HIGH RATES OF NEW INFECTIONS. SUCH PROGRAMS MAY HAVE A HIGHER YIELD OF UNKNOWN HIV-POSITIVE PERSONS, BUT THEY MUST BE DESIGNED CAREFULLY TO AVOID DIFFICULTIES RELATED TO THE USE OF PROFILING, THE STIGMA OF TESTING, AND COMMUNITY ACCEPTANCE. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 3 | CONDOM DISTRIBUTION PRIORITIZED TO TARGET HIV-POSITIVE PERSONS AND PERSONS AT HIGHEST RISK OF ACQUIRING HIV INFECTION | N | EL | TDSHS, CDC | N/A | N | 1, 2, 3 | TO INCREASE THE ACCEPTABILITY OF CONDOMS AND CONDOM DISTRIBUTION (BY CHANGING NORMS), AND MAKING CONDOMS MORE EASILY ACCESSED AND READILY AVAILABLE THROUGH A VARIETY OF VENUES WHERE VERY HIGH RISK TARGET POPULATIONS CAN BE REACHED TO PREVENT HIV TRANSMISSION BY HIV-POSITIVE PERSONS AND ACQUISITION BY HIGHEST RISK. The Houston MSA will maintain our current |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | activities related to this intervention based on the current distribution level (adequate to meeting those at highest risk) throughout the MSA and the lack of additional funding to support a more robust distribution. The overall landscape of the Houston MSA is somewhat conservative and many faith and school based facilities do not allow condom distribution. This intervention will receive any additional funding. . |
| 4 | PROVISION OF POST-EXPOSURE PROPHYLAXIS (PEP) TO POPULATIONS AT GREATEST RISK | N | EL | TDSHS | N/A | N | 1, 3 | This intervention concerns appropriate scale and targeting of nPEP for maximum impact at reasonable cost. Data suggests that nPEP is more cost effective when focused on people with known recent exposures to HIV (within the previous 72 hours). This intervention can be incorporated into existing interventions or settings (e.g., behavioral interventions, partner services, self referral to providers or agencies) that identify recent exposure events between susceptible |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | persons and known HIV-positive persons. THIS INTERVENTION WILL BE MAINTAINED |
| 5 | EFFORTS TO CHANGE EXISTING STRUCTURES, POLICIES, AND REGULATIONS THAT ARE BARRIERS TO CREATING AN ENVIRONMENT FOR OPTIMAL HIV PREVENTION, CARE, AND TREATMENT | I | E | CDC | N/A | I | 2 | <p>The goals set forth under this intervention are long-term goals established by the various planning bodies and advocacy organizations in the city of Houston. Most goals were developed as a response to the growing concern and/or need for revised interventions and strategies to address gaps in services or to pursue more effective models for reaching a greater number of individuals at risk.</p> <p>Policy or regulatory change can be accomplished through advocacy (subject to lobbying restrictions under federal law) and community mobilization, especially when arguments are based on evidence that illustrate negative effects on HIV prevention, care, and treatment. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE.</p> |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-------------------|-----------------|-----------------------|-----------|--|
| 6 | IMPLEMENT LINKAGE TO HIV CARE, TREATMENT, AND PREVENTION SERVICES FOR THOSE TESTING HIV POSITIVE AND NOT CURRENTLY IN CARE | I | E | Ryan White – HRSA | N/A | I | 2, 3 | This intervention focuses on linkage strategies on the initial entry into HIV primary care. Linkage strategies may involve linkage workers, counselors, nurses, and social workers and require cooperative efforts from agencies including public health departments, county hospitals, emergency departments, and HIV counseling and testing programs. . In FY 2011, the allocation for community-base primary care was expanded and the goal for medical case management targeted to African American and Hispanic PLWHA was maintained. Non-medical case management services targeted to newly diagnosed and not-in-care PLWHA were expanded in support of the EIIHA Strategy. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 7 | IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING RETENTION IN OR RE-ENGAGEMENT IN CARE FOR HIV-POSITIVE PERSONS | I | E | Ryan White – HRSA | N/A | I | 2, 3 | Care Services are client centered and rely upon the active participation of the client to remain engaged in care. In order to ensure clients |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-------------------|-----------------|-----------------------|-----------|---|
| | | | | | | | | <p>remain engaged in or return to care, there needs to be an increase in the number of access points available to the client for additional information and support. By increasing the number of clients that stay engaged in care, HIV transmission will be reduced and individuals will be able to achieve and maintain positive health outcomes.</p> <p>Retention and engagement in care also provide multiple opportunities for preventive health care interventions and the promotion of health behavior changes that may minimize transmission and improve community health. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE.</p> |
| 8 | IMPLEMENT POLICIES AND PROCEDURES THAT WILL LEAD TO THE PROVISION OF ANTIRETROVIRAL TREATMENT IN ACCORDANCE WITH CURRENT TREATMENT GUIDELINES FOR HIV-POSITIVE PERSONS | I | E | Ryan White – HRSA | N/A | I | 2, 3 | <p>Accessing ART therapies is critical to the health outcomes of HIV positive individuals. A significant number of HIV positive individuals receive medication and treatment through the Ryan White</p> |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-------------------|-----------------|-----------------------|-----------|---|
| | | | | | | | | funded primary medical care providers. It is mandated that all recipients of federal funding follow guidelines set and approved by HRSA and the US Department of Health and Human Services. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 9 | IMPLEMENT INTERVENTIONS OR STRATEGIES PROMOTING ADHERENCE TO ANTIRETROVIRAL MEDICATIONS FOR HIV-POSITIVE PERSONS | I | E | Ryan White – HRSA | N/A | i | 2, 3 | Incomplete adherence to ART, however, is common in all groups of treated individuals. Among persons on ART, the average rate of adherence is approximately 70%, despite the fact that long-term viral suppression requires near-perfect adherence. . THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 10 | IMPLEMENT STD SCREENING ACCORDING TO CURRENT GUIDELINES FOR HIV-POSITIVE PERSONS | N | E | CDC, TDSHS | N/A | N | 1, 2 | TO FOCUS ON STDs AMONG THIS POPULATION IS IMPORTANT BECAUSE; 1) AN STD MAY INDICATE RECENT RISKY BEHAVIOR THAT COULD LEAD TO HIV TRANSMISSION, 2) PRESENCE OF SOME STDs INCREASES THE LIKELIHOOD OF BOTH TRANSMITTING AND ACQUIRING HIV, AND 3) IDENTIFICATION AND TREATMENT OF STDs CAN REDUCE |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | THEIR SPREAD AMONG HIGH RISK GROUPS, INCLUDING HIV-POSITIVE PERSONS. THIS FUNDING WILL BE MAINTAINED |
| 11 | IMPLEMENT PREVENTION OF PERINATAL TRANSMISSION FOR HIV-POSITIVE PERSONS | N | E | CDC | N/A | N | 1, 2, 3 | HIV TESTING EARLY DURING PREGNANCY TO IDENTIFY UNRECOGNIZED MATERNAL INFECTIONS SHOULD BE CONDUCTED CONSISTENT WITH CDC RECOMMENDATIONS. AMONG WOMEN WITH KNOWN HIV INFECTION, PREVENTING UNPLANNED AND PLANNING DESIRED PREGNANCY, SCHEDULING CESAREAN DELIVERY, AVOIDING BREASTFEEDING, AND LINKAGE TO HIV CARE FOR MOTHER AND INFANT ARE EXAMPLES OF STRATEGIES THAT HAVE BEEN SUCCESSFUL AT PREVENTING PERINATAL TRANSMISSION AND LEADING TO A NEAR ELIMINATION OF THIS TRANSMISSION ROUTE IN THE U.S. IMPLEMENTATION OF THESE SUCCESSFUL STRATEGIES SHOULD ALLOW TRANSMISSION RATES TO REMAIN EXTREMELY LOW. FUNDING FOR THIS INTERVENTION WILL BE MAINTAINED |
| 12 | IMPLEMENT ONGOING PARTNER SERVICES FOR HIV-POSITIVE PERSONS | I | EL | CDC, TDSHS | N/A | I | 1, 2, 3 | The rationale for implementing partner services is that it can identify unrecognized |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | infection, facilitate positive behavior change, reduce future infections, decrease HIV/STD transmission and incidence, and improve public health. TO IDENTIFY UNRECOGNIZED INFECTION, FACILITATE POSITIVE BEHAVIOR CHANGE, REDUCE FUTURE INFECTIONS, DECREASE HIV/STD TRANSMISSION AND INCIDENCE, AND IMPROVE PUBLIC HEALTH. THIS INTERVENTION (PENSHOUSTON) WILL BE INCREASED AS FUNDS BECOME AVAILABLE |
| 13 | BEHAVIORAL RISK SCREENING FOLLOWED BY RISK REDUCTION INTERVENTIONS FOR HIV-POSITIVE PERSONS (INCLUDING THOSE FOR HIV-DISCORDANT COUPLES) AT RISK OF TRANSMITTING HIV | N | EL | CDC | N/A | N | 1, 2, 3 | RISK ASSESSMENTS TO IDENTIFY BEHAVIORAL RISK OF HIV TRANSMISSION COULD INCLUDE A RISK SELF-ASSESSMENT OR RISK SCREENING INTERVIEW AND ARE RECOMMENDED BY THE CDC'S PWP GUIDELINES. BEHAVIORAL INTERVENTIONS FOR HIV-POSITIVE PERSONS HAVE BEEN FOUND TO WORK WELL IN CONJUNCTION WITH INTERVENTIONS THAT PROMOTE LINKAGE TO AND ENGAGEMENT IN CARE, MEDICATION AND APPOINTMENT ADHERENCE, STD SCREENING, AND PARTNER SERVICES. FUNDING THIS INTERVENTION WILL BE MAINTAINED. |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|---|
| 14 | IMPLEMENT LINKAGE TO OTHER MEDICAL AND SOCIAL SERVICES FOR HIV-POSITIVE PERSONS | I | EL | CDC, TDSHS | N/A | I | 1, 2, 3 | LINKAGE OF HIV-POSITIVE PERSONS WITH MEDICAL AND SOCIAL SERVICES ENTAILS A PROCESS BY WHICH SERVICE PROVIDERS AND ORGANIZATIONS ASSIST PEOPLE LIVING WITH HIV/AIDS TO OBTAIN NEEDED SOCIAL SERVICES THAT WILL BENEFIT THEIR HEALTH AND/OR DECREASE THE LIKELIHOOD OF HIV TRANSMISSION RISK BEHAVIOR. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 15 | CONDOM DISTRIBUTION FOR THE GENERAL POPULATION | N | EL | CDC, TDSHS | N/A | N | 1, 2 | BECAUSE OF THE POTENTIAL CONDOM DISTRIBUTION PROVIDES AS A STRUCTURAL-LEVEL INTERVENTION FOCUSED ON INCREASING THE ACCEPTABILITY (NORMS) FOR CONDOM USE WITHIN THE GENERAL POPULATION. A RECENT META-ANALYSIS FOUND THAT STRUCTURAL-LEVEL CONDOM DISTRIBUTION INTERVENTIONS INCREASE CONDOM USE, CONDOM ACQUISITION, AND PROMOTE DELAYED SEXUAL INITIATION OR ABSTINENCE AMONG YOUTH. FUNDING FOR THIS INTERVENTION WILL BE MAINTAINED. |
| 16 | HIV AND SEXUAL HEALTH COMMUNICATION OR SOCIAL MARKETING CAMPAIGNS TARGETED TO RELEVANT AUDIENCES | I | EL | CDC | N/A | I | 1, 2 | HEALTH COMMUNICATION AND SOCIAL MARKETING CAMPAIGNS ARE PART OF STRATEGIC |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-------------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | COMMUNICATION PLANNING. THESE CAMPAIGNS ARE DESIGNED TO INFORM AND INFLUENCE BEHAVIORAL CHANGE WITHIN INDIVIDUALS AND COMMUNITIES. EFFORTS THAT INTEGRATE MULTIPLE BEHAVIORAL AND SOCIAL LEARNING THEORIES AND MODELS IN IDENTIFYING STEPS TO INFLUENCE AUDIENCE ATTITUDES AND BEHAVIOR HELPS CREATE EFFECTIVE PUBLIC HEALTH CAMPAIGNS. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 17 | CLINIC-WIDE OR PROVIDER-DELIVERED EVIDENCE-BASED HIV PREVENTION INTERVENTIONS FOR HIV-POSITIVE PATIENTS AND PATIENTS AT HIGHEST RISK OF ACQUIRING HIV | I | EL | Ryan White – HRSA | N/A | I | 1, 2, 3 | HIV CLINICS AND OTHER MEDICAL FACILITIES ARE IDEAL SETTINGS FOR DELIVERING SUSTAINABLE BEHAVIORAL INTERVENTIONS TO HIV-POSITIVE PERSONS AND THOSE AT HIGHEST RISK OF ACQUIRING HIV. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 18 | COMMUNITY INTERVENTIONS THAT REDUCE HIV RISK | I | EL | CDC | N/A | 1 | 1, 2 | COMMUNITY LEVEL INTERVENTIONS (CLIS) SEEK TO IMPROVE THE HIV RISK CONDITIONS AND BEHAVIORS IN A COMMUNITY BY CHANGING SOCIAL NORMS REGARDING RISK BEHAVIORS, AND INCREASING THE SOCIAL ACCEPTABILITY AND SUPPORT FOR SAFER BEHAVIORS. CLI ARE |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|--|-----------------|--------------------|-------------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | DIRECTED AT ENTIRE COMMUNITIES WITH THE AIM OF CREATING WIDESPREAD AND DURABLE BEHAVIOR CHANGE THROUGHOUT THE TARGET POPULATION. THIS INTERVENTION WILL RECEIVE AN INCREASE IN FUNDING AS IT BECOMES AVAILABLE. |
| 19 | BEHAVIORAL RISK SCREENING FOLLOWED BY INDIVIDUAL AND GROUP-LEVEL EVIDENCE-BASED INTERVENTIONS FOR HIV-NEGATIVE PERSONS AT HIGHEST RISK OF ACQUIRING HIV; PARTICULARLY THOSE IN AN HIV-SERODISCORDANT RELATIONSHIP | D | EL | CDC, TDSHS | N/A | D | 1, 2, 3 | RISK ASSESSMENTS TO IDENTIFY BEHAVIORAL RISK OF HIV ACQUISITION COULD INCLUDE A RISK SELF-ASSESSMENT OR RISK SCREENING INTERVIEW IN A HEALTH CARE OR COMMUNITY-BASED SETTING. FUNDS WILL BE DECREASED FROM THIS INTERVENTION AND REALLOCATED TO MORE COST EFFECTIVE INTERVENTIONS. |
| 20 | INTEGRATED HEPATITIS, TB, AND STD TESTING, PARTNER SERVICES, VACCINATION, AND TREATMENT FOR HIV INFECTED PERSONS, HIV-NEGATIVE PERSONS AT HIGHEST RISK OF ACQUIRING HIV, AND INJECTION DRUG USERS ACCORDING TO EXISTING GUIDELINES | I | EL | CDC, TDSHS, HDHHS | N/A | I | 1, 2, 3 | TO MAXIMIZE THE HEALTH BENEFITS THAT SUCH PERSONS RECEIVE FROM PREVENTION SERVICES BY COMBINING, STREAMLINING, AND ENHANCING PREVENTION SERVICES; MAXIMIZING OPPORTUNITIES TO SCREEN, TEST, TREAT, OR VACCINATE THOSE IN NEED OF THESE SERVICES; IMPROVING THE HEALTH OF POPULATIONS NEGATIVELY AFFECTED BY MULTIPLE DISEASES; AND ENABLING SERVICE PROVIDERS TO ADAPT TO AND KEEP PACE WITH CHANGES IN DISEASE EPIDEMIOLOGY |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | | | | | | | | AND NEW TECHNOLOGIES. THIS INTERVENTION WILL RECEIVE INCREASED FUNDING AS IT BECOMES AVAILABLE. |
| 21 | TARGETED USE OF HIV AND STD SURVEILLANCE DATA TO PRIORITIZE RISK REDUCTION COUNSELING AND PARTNER SERVICES FOR PERSONS WITH PREVIOUSLY DIAGNOSED HIV INFECTION WITH A NEW STD DIAGNOSIS AND PERSONS WITH A PREVIOUS STD DIAGNOSIS WHO RECEIVE A NEW STD DIAGNOSIS | I | E | CDC, TDSHS | N/A | I | 1, 2, 3 | PERSONS DIAGNOSED WITH HIV WHO RECEIVE A NEW STD DIAGNOSIS OR PEOPLE WITH A PRIOR STD DIAGNOSIS WHO RECEIVE A NEW STD DIAGNOSIS ARE AT INCREASED RISK FOR TRANSMITTING HIV AND STDs TO OTHERS OR ACQUIRING HIV THEMSELVES. THEREFORE, IT IS CRITICAL TO IDENTIFY THESE VERY HIGH RISK PERSONS AND PRIORITIZE PREVENTION ACTIVITIES IN ORDER TO PREVENT FUTURE INFECTIONS. USING HIV AND STD SURVEILLANCE DATA TO HELP IDENTIFY THESE PERSONS MAY BE ONE WAY TO STREAMLINE THE WORK OF HEALTH DEPARTMENT STAFF AND FOCUS HIV PREVENTION EFFORTS ON THOSE MOSTLY LIKELY TO TRANSMIT OR ACQUIRE HIV IN THE NEAR FUTURE. THIS INTERVENTION WILL RECEIVE INCREASED FUNDING AS IT BECOMES AVAILABLE. |
| 22 | FOR HIV-NEGATIVE PERSONS AT HIGHEST RISK OF ACQUIRING HIV, BROADENED LINKAGES TO AND PROVISION OF SERVICES FOR SOCIAL FACTORS IMPACTING HIV INCIDENCE SUCH AS | N | EL | CDC | N/A | N | 1, 2 | BECAUSE RESEARCH HAS DOCUMENTED THE RELATIONSHIP BETWEEN A NUMBER OF PSYCHOSOCIAL FACTORS AND HIV |

| Intervention Strategy | | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|-----------------------|---|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|--|
| | MENTAL HEALTH, SUBSTANCE ABUSE, HOUSING, SAFETY/DOMESTIC VIOLENCE, CORRECTIONS, LEGAL PROTECTIONS, INCOME GENERATION, AND OTHERS | | | | | | | RISK, IT IS RECOMMENDED THAT HIV PREVENTION PROGRAMS PROVIDE REFERRALS FOR CLIENTS WHO NEED ADDITIONAL SERVICES AND THAT STAFF HELP ENSURE THAT FIRST APPOINTMENTS ARE KEPT. THE ESTABLISHED ASSOCIATION BETWEEN HARMFUL PSYCHOSOCIAL FACTORS AND HIV RISK SUPPORTS THE INCLUSION OF REFERRALS AND LINKAGES TO SERVICES IN HIV PREVENTION PROGRAMS. THIS INTERVENTION WILL BE MAINTAINED WITH NO ADDITIONAL FUNDING. |
| 23 | BRIEF ALCOHOL SCREENING AND INTERVENTIONS FOR HIV-POSITIVE PERSONS AND HIV-NEGATIVE PERSONS AT HIGHEST RISK OF ACQUIRING HIV | N | EL | CDC | N/A | N | 1, 2, 3 | THE RATE OF ALCOHOL USE AMONG PEOPLE LIVING WITH HIV IS HIGH, WITH SOME STUDIES SHOWING LEVELS OF HAZARDOUS DRINKING TO BE ALMOST TWICE THE LEVELS OF THOSE FOUND IN THE NON-HIV-INFECTED POPULATION. IN ADDITION, ALCOHOL ABUSE CAN PLACE HIV-NEGATIVE PERSONS AT RISK OF ACQUIRING HIV. THIS INTERVENTION WILL BE MAINTAINED WITH NO ADDITIONAL FUNDING. |
| 24 | COMMUNITY MOBILIZATION TO CREATE ENVIRONMENTS THAT SUPPORT HIV PREVENTION BY ACTIVELY INVOLVING COMMUNITY MEMBERS IN EFFORTS TO RAISE HIV AWARENESS, BUILDING SUPPORT FOR AND INVOLVEMENT IN HIV PREVENTION | I | EL | CDC, HDHHS | N/A | I | 1, 2 | COMMUNITY MOBILIZATION IS AN IMPORTANT HIV PREVENTION STRATEGY BECAUSE IT PROMOTES COMMUNITY PARTICIPATION AND SUPPORT IN THE DEVELOPMENT AND IMPLEMENTATION OF RISK |

| Intervention Strategy | Change in Scale | Resources Required | Current Funding | Planned Funding | Net Change in Funding | NHAS Goal | Brief Justification |
|--|-----------------|--------------------|-----------------|-----------------|-----------------------|-----------|---|
| EFFORTS, MOTIVATING INDIVIDUALS TO WORK TO END HIV STIGMA, AND ENCOURAGING HIV RISK REDUCTION AMONG THEIR FAMILY, FRIENDS, AND NEIGHBORS | | | | | | | REDUCTION STRATEGIES. THIS INTERVENTION WILL RECEIVE INCREASED FUNDING AS IT BECOMES AVAILABLE. |

APPENDIX A: GLOSSARY OF ACRONYMS

| | |
|---------|--|
| 3 MV | Many Men, Many Voices |
| AASOETF | African-American State of Emergency Task |
| AAMA | Association for Advancement of Mexican Americans |
| ACOG | American College of Obstetricians and Gynecology |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Anti Retroviral Treatment |
| CBO | Community based organizations |
| CLIs | Community-level interventions |
| COH | City of Houston |
| CPCDMS | Centralized Patient Care Data Management System |
| CPG | Community Planning Group |
| CRCS | Comprehensive Risk Counseling Services |
| CTR | Counseling, Testing, and Referral Services |
| DIS | Disease Intervention Specialists |
| ECLIPS | Electronic Client-Level Integrated Prevention System |
| EAHC | EIIHA Ad-Hoc Committee |
| EIIHA | Early Identification of Individuals with HIV/AIDS |
| EIR | Enzyme Immunoassay |
| ELR | Electronic Lab Reporting Systems |
| ELISA | Enzyme-linked immunosorbent assay |
| EMA | Eligible Metropolitan Area |
| Epi | Epidemiological |
| ESAP | Enhanced Syringe Access Program |
| FLAS | Fundacion Latino Americana Contra el SIDA |

| | |
|--------|--|
| FQHC | Federally Qualified Health Centers |
| FLS | First Line Supervisor |
| GLBT | Gay Lesbian BI-sexual Transgender |
| HAART | Highly Active Antiretroviral Therapy |
| HACS | Houston Area Community Services |
| HARS | HIV/AIDS reporting system |
| HAV | Hepatitis A Virus |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HCPHES | Harris County Public Health and Environmental Services |
| HD | Health Department |
| HDHHS | Houston Department of Health And Human Services |
| HD | Health Department |
| HCI | Harris County Jail |
| HCSO | Harris County Sheriff's Office |
| HE/RR | Health Education/Risk Reduction |
| HET | Heterosexuals at Risk for HIV infection????? |
| HIV | Human immunodeficiency virus |
| HMMP | Houston Medical Monitoring Project |
| HRSA | Health Resources and Services Administration |
| IDU | injecting drug users |
| L&D | labor & delivery |
| LHTF | Latino HIV Task Force |
| MSM | Men who have Sex with Men |
| NAAT | Nucleic Acid Amplification Testing |

| | |
|---------|--|
| NHBS | National HIV Behavioral Surveillance System |
| PBC | Protocol Based Counseling |
| PCPE | Prevention Counseling & Partner Elicitation |
| PCM | Prevention Case Management |
| PCRS | Partner Counseling and Referral System |
| PEMS | Program Evaluation and Monitoring System |
| PLWHA | People living with HIV/AIDS |
| PMD | private medical doctor |
| POE | point of entry |
| POL | Popular Opinion Leader |
| PPG | Prevention Planning Group |
| PROMISE | Peers Reaching Out and Modeling Intervention Strategies |
| RAPP | Real AIDS Prevention Program |
| RRS | Risk Reduction Specialists |
| RWPC | Ryan White Planning Council |
| RW/A | Ryan White Part A |
| RW/C | Ryan White Part C |
| SEAC | Syphilis Elimination Advisory Committee |
| SIRR | Serving the Incarcerated and Recently Released |
| SISTA | Sisters Informing Sisters on Topics About AIDS |
| SITC | Safe In The City |
| SLW | Service Linkage Worker |
| SPNS | Special Project of National Significance |
| STD | Sexually transmitted disease |
| STD*MIS | Sexually Transmitted Disease Management Information System |
| SWCM | Social Worker Case Manager |
| TB | tuberculosis |
| TCADA | Texas Council on Alcohol and Drug Abuse |
| TDC | Texas Department of Corrections |
| TDSHS | Texas Department of State Health Services |
| UAM | Urban AIDS Ministry |
| VFC | Vaccines for Children |

| | |
|-------|--|
| WBI | Web-Based Interview |
| WIC | Women, Infant and Children |
| YMCSM | Young Men of Color who Have Sex with Men |
| YTF | Youth Task Force |
| | |

APPENDIX B : 2006 HIV Incidence Estimates in Houston/Harris County, TX

The estimated rate of HIV incidence in Houston in 2006 (43.6 per 100,000 persons) was almost two times greater than the national rate of new infections (22.8 per 100,000 persons) according to data released by the Center for Disease Control and Prevention (CDC) and analysis of data reported in Houston and Harris County (Table 1).

For the first time, the Houston Department of Health and Human Services (HDHHS) was able to directly estimate the number of new HIV infections in Houston and further categorize them by race, gender, age and mode of transmission. Using new technology developed by CDC, HDHHS estimated 1,700 people were newly infected with HIV in 2006.

Consistent with national findings, African Americans were most affected by HIV. This population accounted for 52% of new HIV infections, while comprising only 18% of the Houston population. In Houston, African Americans have nearly five times the rate of new HIV infections (127 per 100,000) compared to other races (35 per 100,000 among Hispanics and 19 per 100,000 among White/Other races). Overall, African Americans and Hispanics accounted for 78% of new HIV infections in 2006.

The HIV incidence rate in males (57.3 per 100,000) was almost twice the rate found in females (30.0 per 100,000).

Persons between 25-44 years old were at the greatest risk of contracting HIV. Those 13 to 24 years old made up 14% of the newly infected HIV cases. Those 25 to 34 years old accounted for 30% and those 35-44 accounted for 31% of new infections. Persons who were 45 and older comprised 25% of the new HIV infections in Houston.

Men who have sex with men accounted for 34% of new HIV infections, while persons engaged in high-risk heterosexual behavior accounted for 31%. People who used intravenous drugs or had no identified risk accounted for 35% of the new HIV infections.

The incidence methodology is new. Accuracy of estimate depends on data quality and completeness. The CDC national estimates (Table 2) were adjusted for reporting delay and cases with unknown risk were redistributed into known risk groups. The Houston incidence estimates were not adjusted for reporting delay since Houston used the most updated dataset in the analysis resulting in very few cases that were delayed in reporting. Additionally, Houston's estimates have not redistributed unknown risk into known risk groups. Modes of transmission were categorized into men who have sex with men, high risk heterosexual and other groups.

These findings show an urgent need to direct prevention programs to groups that are disproportionately affected. More aggressive efforts must be undertaken immediately to address the underlying conditions that contribute to HIV transmission. Strong commitment to implement effective prevention programs is necessary in order to control the HIV epidemic.

For further information, please contact the HDHHS HIV Incidence Surveillance Program.

Table 1

Houston/Harris County HIV Incidence Estimate for Persons 13 and Older at HIV Diagnosis, 2006
(N=1,700)

| Demographic and Risk groups | HIV Incidence Estimate ^a | Percentage | HIV Incidence Rate ^b |
|--------------------------------------|-------------------------------------|-------------|---------------------------------|
| Sex | | | |
| Male | 1,110 | 65% | 57.3 |
| Female | 590 | 35% | 30.0 |
| Race | | | |
| White/Other ^c | 370 | 22% | 19.2 |
| African American | 880 | 52% | 127.2 |
| Hispanic | 450 | 26% | 35.1 |
| Age at HIV Infection Group | | | |
| 13-24 | 240 | 14% | 26.8 |
| 25-34 | 510 | 30% | 65.4 |
| 35-44 | 520 | 31% | 70.2 |
| 45+ | 430 | 25% | 29.0 |
| Transmission Risk^d | | | |
| Men who have sex with men (MSM) | 580 | 34% | n ^{ae} |
| High-risk Heterosexual | 520 | 31% | n ^{ae} |
| Other | 600 | 35% | n ^{ae} |
| Total | 1,700 | 100% | 43.6 |

Notes. The categories displayed in this table satisfy the minimum requirement of 200 reported HIV cases, 40 incidence tests and 10 recent incidence results, except the white/other race category. These numbers have not been adjusted for reporting delay.

^a Numbers are estimates and rounded to the nearest ten.

^b Rate per 100,000 population age 13 and older based on 2006 intercensal estimates.

^c White/Other race group includes White, American Indian, Asian/Pacific Islander and unknown races.

^d Men who had sex with men (MSM) group includes both MSM and MSM who used injection drugs. (MSM/IDU). Other transmission risk group includes Injection Drug Users and persons with No Reported Risk.

^e The 2006 intercensal estimates are not available by transmission risk groups

References:

1. Dobbs T, Kennedy S, Pau CP, McDougal JS, Parekh BS. Performance characteristics of the immunoglobulin G-capture BED-enzyme immunoassay, an assay to detect recent human immunodeficiency virus type 1 seroconversion. *J Clin Microbiol.* 2004;42(6):2623-2628.
2. Centers for Disease Control and Prevention (CDC). HIV prevalence estimates--United States, 2006. *MMWR Morb Mortal Wkly Rep.* 2008;57(39):1073-1076.