Dallas Regional Integrated HIV Prevention and Care Plan

CY 2022-2026

Prepared by Community Solutions, Inc.
December 2022

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Section I. Executive Summary

The Development of the CDC/HRSA Integrated HIV Prevention and Care Plan, CY 2022-2026 for the Dallas Regional areas was a collaborative process of the Ryan White Parts A and B Administrative Agency, Ryan White Planning Council, funded service providers, HIV Task Force, Fast Track Counties committee, consumers, and community stakeholders. A steering committee was convened comprised of members of each of these groups to guide the integrated planning process, and meetings were held monthly from August-December 2022. Goal-specific workgroups were convened in October 2022 to craft the goals, objectives, and strategies for the integrated plan, as well as provide feedback on how progress toward meeting them should be tracked, reviewed, and communicated to stakeholders. Finally, listening sessions with consumers were held to hear directly from them about what should be done to improve access to care and resources in the Dallas regional area.

Following the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021 (Appendix A), several important changes have been enacted, despite the COVID-19 pandemic taking place during much of the last 2 years of the Plan's implementation. Many of the Ryan White-funded organizations now offer more flexible hours which makes it easier for consumers to access them. Several clinics have been relocated that have increased the capacity of clients served as well as the types of services offered. Providers have been able to make several changes in how they provide services, including updating their forms to be more inclusive, providing increased education on transgender issues, increasing cultural humility and awareness, and implementing of a Rapid Start Clinic. Finally, there has been an increase in funding resources available due to funds from the American Rescue Act. As a result, there are now more housing opportunities available for people living with HIV (PLWH).

Even still, consumers that participated in the Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment (Appendix B) and 2022 listening sessions identified several areas where improvement is still needed. While the American Rescue Act has made more housing opportunities for PLWH available, there is still a need for additional safe and affordable housing opportunities, particularly for middle to low-income individuals and families, including families with a history of incarceration and aging/elderly PLWH. Some providers have started offering the injectable, long-acting PrEP option, but it has not been made widely available, particularly to identified priority populations as noted later in this plan. PLWH continue to face barriers such as access, transportation, and financial challenges when trying to access treatment and care services and supports. Mental health and substance use needs have increased, especially during the COVID-19 pandemic, and there are gaps in services available services and support to help PLWH manage stress and anxiety. Finally, transportation continues to be a challenge for PLWH to access services and resources, particularly those in rural areas.

The goals to be addressed throughout this Plan include:

- Diagnose all Dallas Regional Residents as quickly as possible.
- Treat all HIV diagnoses quickly and effectively.
- Prevent new transmissions among Dallas Regional Residents using proven methods and strategies.
- Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas Regional Residents who need them.

Within the goals, the objectives and strategies are meant to help address the needs highlighted from previous plans and consumer feedback.

The following documents were reviewed and/or referenced throughout this Plan to meet the requirements as outlined:

- Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021.
- 2018 Achieving Together: A Community Plan to End the HIV Epidemic in Texas.
- Ryan White Council of the Dallas Area 2019 Comprehensive HIV/AID Needs Assessment.
- Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021.
- 2021-2022 Community Services Handbook: A Guide for North Texans Living with HIV.

Section II. Community Engagement and Planning Process

Jurisdiction Planning Process

Dallas County Health and Human Services (DCHHS) used multiple strategies to develop this collaborative, data-driven, results-oriented planning process creating the Dallas Regional HIV Prevention and Care Plan (Integrated Plan). The planning process provided community stakeholders with an opportunity to take stock of current priorities, goals, and plans, engage diverse perspectives from across the community – especially people living with HIV or AIDS (PLWHA) and others with meaningful and relevant lived experience – to develop strategies that will drive community-wide efforts to support the health and well-being of PLWH and reach the goal of a 90% reduction in new transmissions.

DCHHS engaged a community planning and development firm called Community Solutions, Inc. (Community Solutions) to facilitate the planning process. Based in Indianapolis, Indiana, Community Solutions has provided organizational strategic planning and community-wide planning support to dozens of groups who have a strong desire to make a meaningful impact in the community.

Entities Involved in the Planning Process

The planning process was guided by a Steering Committee (Appendix C) composed of key leaders in prevention and care settings throughout the service area and across agencies that convened monthly from August through December 2022 (Appendix D). Steering Committee members advised on the scope and framework of the Integrated Plan, helped to identify key partners and data sources, and co-designed the approach to gathering community input. Well over one hundred people who are members of the previously existing Ryan White Planning Council, HIV Task Force, Fast Track Counties committee, as well as representatives from Ryan White funded agencies, were invited to participate on the Steering Committee. Ultimately, forty-eight (48) people joined the Steering Committee, including five who identified as PLWH (Appendix C). Throughout the process, Steering Committee members were encouraged to reach out to additional community stakeholders, especially PLWH, to participate in Steering Committee and workgroup meetings to ensure the voice of consumers provided guidance throughout the process.

Collaborating with the Steering Committee, Community Solutions developed a framework for the Integrated Plan that is organized around the four pillars of the National Ending the HIV Epidemic (EHE) Plan - Diagnose, Treat, Prevent and Respond. Workgroups of experts and community members were organized around each of the four pillars, and they were able to provide additional detail to the goals and objectives, as well as outline specific strategies and timelines for accomplishing them. During the month of October, there were four (4) goal-specific workgroups convened where stakeholders, including PLWH, provided targeted guidance and feedback on the Plan's goals, objectives, and strategies. Each workgroup

meeting saw about 13 people in attendance, including at least one PLWH. Feedback on the plan's goals, objectives and strategies are captured in Section VI.

Role of the RWHAP Part A Planning Council/Planning Body

The Ryan White Planning Council (RWPC) is a community group appointed by the County Judge to plan the organization and delivery of HIV services funded by Part A, Part B, Minority AIDS Initiative (MAI) and State Services of the Ryan White HIV/AIDS Treatment Act. Council members are volunteers who have been carefully selected to reflect the diversity of the community; they represent the general public, people living with HIV, funded service providers, and other health and social service organizations. The mission of the Ryan White Planning Council of the Dallas Planning Area is to optimize the health and well-being of people living with HIV/AIDS through coordination, evaluation, and continuous planning to improve the North Texas regional system of medical, supportive, and preventative services. Currently there are 26 members of the RWPC, and 7 seats are vacant. The racial breakdown of the members is as follows: 14 Black, 8 white, 3 Latinx, 1 AAPI.

The RWPC has six (6) standing sub-committees, two (2) of which were integrally involved in the development of the integrated plan. The Planning & Priorities Committee oversees the projects of the RWPC (including implementation of the integrated plan) and is responsible for advising the Administrative Agency on how best to meet the need for prioritized services. The Consumer Council Committee is comprised of PLWH, and advocates on critical issues for the Dallas Regional HIV community, such as the service prioritization and setting process.

The Community Solutions team attended monthly full RWPC and Planning & Priorities meetings, from July through December. Although there were members of both groups who also served on the integrated planning steering committee, attending these meetings was an opportunity to connect with consumers and groups that were serving consumers in the Dallas Regional area and hear directly from them on what was going on in the communities.

Role of the Dallas HIV Task Force

The Dallas HIV Task Force is a local collaboration committed to a compassionate, inclusive, and comprehensive approach seeking to enhance the prevention, care, and treatment of HIV/AIDS in the Dallas Health Services Delivery Area and the communities served in the Ryan White Eligible Metropolitan Area. The HIV Task Force meets monthly and is comprised of consumers, community stakeholders, representatives from ASOs, members of the Ryan White Planning Council and Administrative Agency. Fifteen members of the Task Force participated on the integrated planning steering committee. In addition, a listening session was held in September with 11 consumers who are part of the HIV Task Force.

Role of the Fast Track Counties Committee

The Fast-Track Cities initiative is a global partnership between cities and municipalities around the world and four core partners – the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations

Human Settlements Programme (UN-Habitat), and the City of Paris. Mayors and other city/municipal officials designate their cities as Fast-Track Cities by signing the Paris Declaration on Fast-Track Cities, which outlines a set of commitments to achieve the initiative's objectives. Initially heavily focused on the 90-90-90 targets, the Paris Declaration was recently updated to establish attainment of the three 90 targets as the starting point on a trajectory towards getting to zero new HIV infections and zero AIDS-related deaths.

In 2019, Dallas became a Fast Track County and as such meets quarterly with stakeholders, medical providers, and consumers with the goal of coordinating activities and reporting outcomes on 90-90-90 goals. These meetings are hosted by the Medical Director of Dallas County Health and Human Services. Members of the Fast Track Counties committee were invited to participate on the integrated plan steering committee, and the committee received regular updates on the work of the steering committee during the throughout the planning process.

Collaboration with RWHAP Parts – SCSN Requirement

RWPC members were invited to serve on the steering committee and workgroups that were convened to oversee the integrated planning process. Members participated in three (3) steering committee meetings from August-November 2022 to develop the structure of the Integrated Plan and identify additional partners who should be involved in the process. There were approximately 26 participants per meeting, and minutes for each of the steering committee meetings are included in Appendix D.

Engagement of People with HIV – SCSN Requirement

In addition to the steering committee and goal-specific workgroup meetings, three (3) listening sessions were held in September. The listening sessions were conducted during the already scheduled Planning & Priorities and Consumer Council Committee meetings, as well as the HIV Task Force meeting. PLWH and other consumers were asked to respond to the following questions:

- What are some words you would use to describe what your experience has been in terms of getting the care you want and/or need?
- What the gaps in services or supports that you need? What is missing?
- Have there been any resources/services that have worked particularly well for you?
- If you had a magic wand, what would you do to make it possible for everyone to get the care they want?

The Integrated Plan also engaged PLWH in identification of service gaps and needs through the 2019 Ryan White Council of the Dallas Area Needs Assessment (Appendix B). This needs assessment utilized Consumer Focus Groups and Consumer Surveys to identify areas where PLWH saw the biggest need for improvement. As a follow-up, an Interim Needs Assessment was conducted in 2021 that collected feedback from PLWH on the gaps identified in the 2019

needs assessment and the changes implemented (Appendix E). The 2022 Dallas Area Needs Assessment is currently underway. Any findings or recommendations generated through that assessment will be incorporated into the annual review and updated process of the Integrated Plan.

Section III. Contributing Data Sets and Assessments

Data Sharing and Use

The data discussed and highlighted in this section were provided by Dallas County Health and Human Services and Texas State Health Department, through a series of data files, reports, and plans. Dallas regional population data was gathered from the Census. Dallas County Health and Human Services has data-sharing agreements that can be provided on request.

Epidemiologic Snapshot

This snapshot reviews trends in data and characteristics for populations with newly acquired HIV, populations currently living with HIV, populations that do not know their status, and persons at risk for exposure to HIV.

Populations with Newly Acquired HIV

Within Dallas County in 2020, cisgender men accounted for 78.1% (N=665) of newly acquired HIV, transgender women accounted for 2.2% (N=19), and transgender men account for 0.1% (N=1) of all new diagnoses (Figure 1). In previous years (2015 – 2019) transgender populations that acquired HIV remained consistent in counts. Data regarding accurate numbers for transgender men and women is limited due to inconsistent practices for capturing gender-related demographic information.

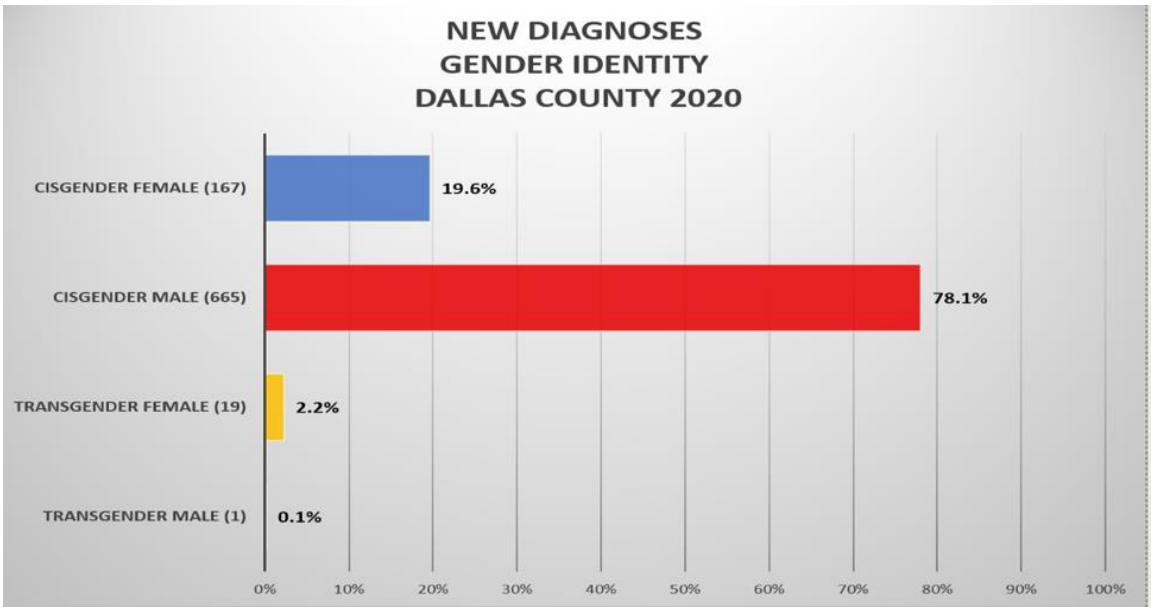

Figure 1. New Diagnoses of HIV by Gender Identity in Dallas County 2020
Source: Texas HSDA

Within the Sherman-Denison region, gay and bisexual men, and other men who have sex with men (MSM) have consistently represented the majority percentage of newly acquired HIV transmissions in the past 5 years (2015 – 2020). For transgender populations living within the Sherman-Denison region, there is limited data regarding newly acquired HIV transmissions. Transgender women living in Sherman-Denison accounted for 1% (N=1) of newly acquired HIV transmissions in 2020. There is no available data for previous years regarding transgender men.

Consistent with national trends, Black and Latinx populations were disproportionally affected by HIV in 2020. Black residents of Dallas County represented 47.3% (N=403) of all newly acquired HIV cases in 2020. Hispanic residents represented 29% (N= 247) of all newly acquired cases, white and Asian residents represented 18.9% (N=161) and 1.9% (N=16) of all newly acquired HIV transmissions in Dallas County, respectively (Figure 2).

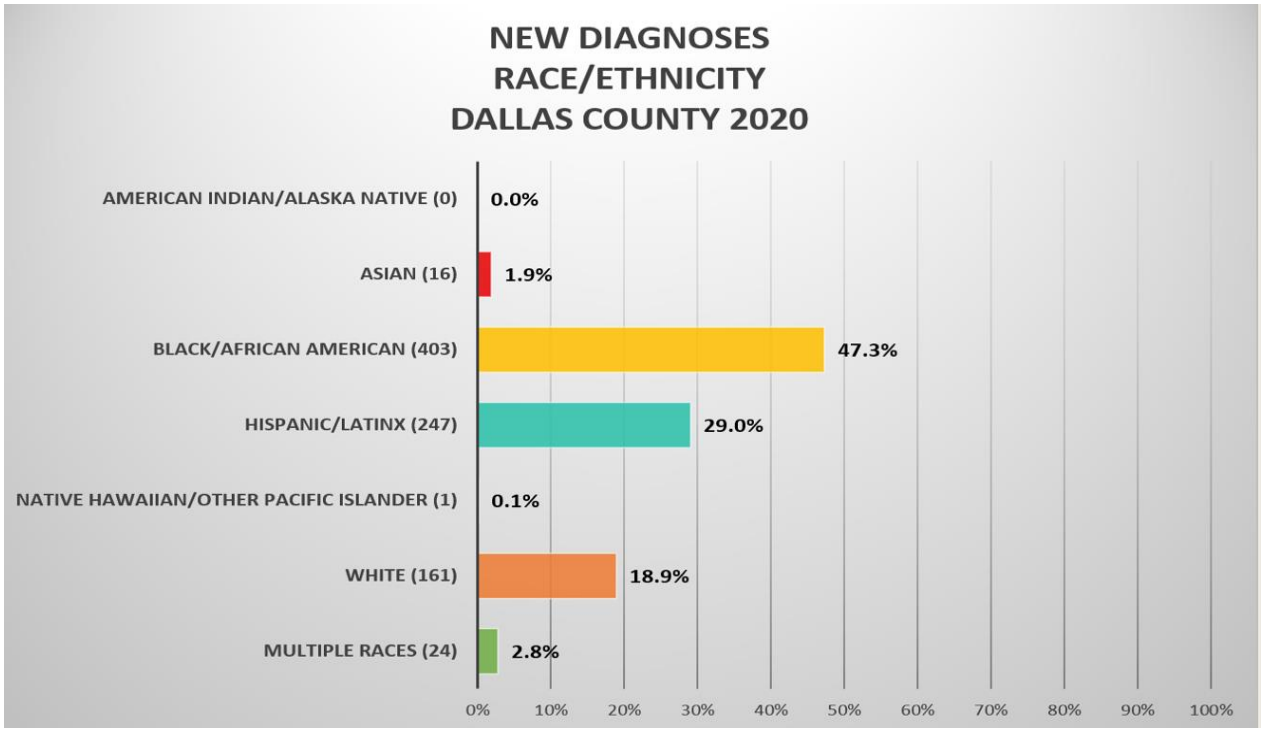

Figure 2. New Diagnoses of HIV in Dallas County by Race/Ethnicity 2020
Source: Texas HSDA

Within the Sherman-Denison region, there were 3 newly acquired cases of HIV for both Latinx and white residents and 2 newly acquired HIV cases for Black residents. In previous years (2015 – 2020) white residents of the Sherman-Denison region represented the majority of newly acquired cases, but this rate declined between 2016 thru 2018 (Figure 3).

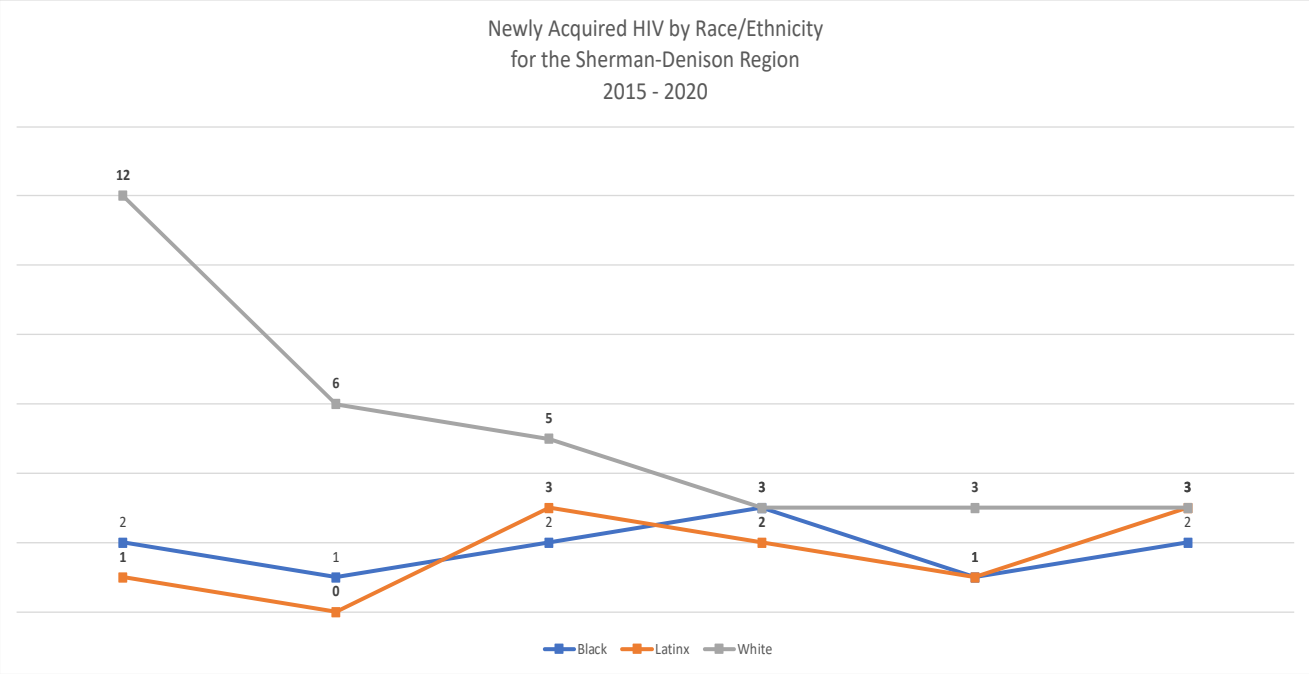

Figure 3. Newly Acquired HIV Trend by Race/Ethnicity for Sherman-Denison Region 2015 - 2020
Source: Texas HSDA

Consistent with national trends, Dallas County residents between ages 25–34 represented the majority of newly acquired HIV cases for 2020, followed by residents aged 15–34. The age group with the highest number of cases over the past 5 years (2015 – 2020), has consistently been age group 25-34 (Figure 4).

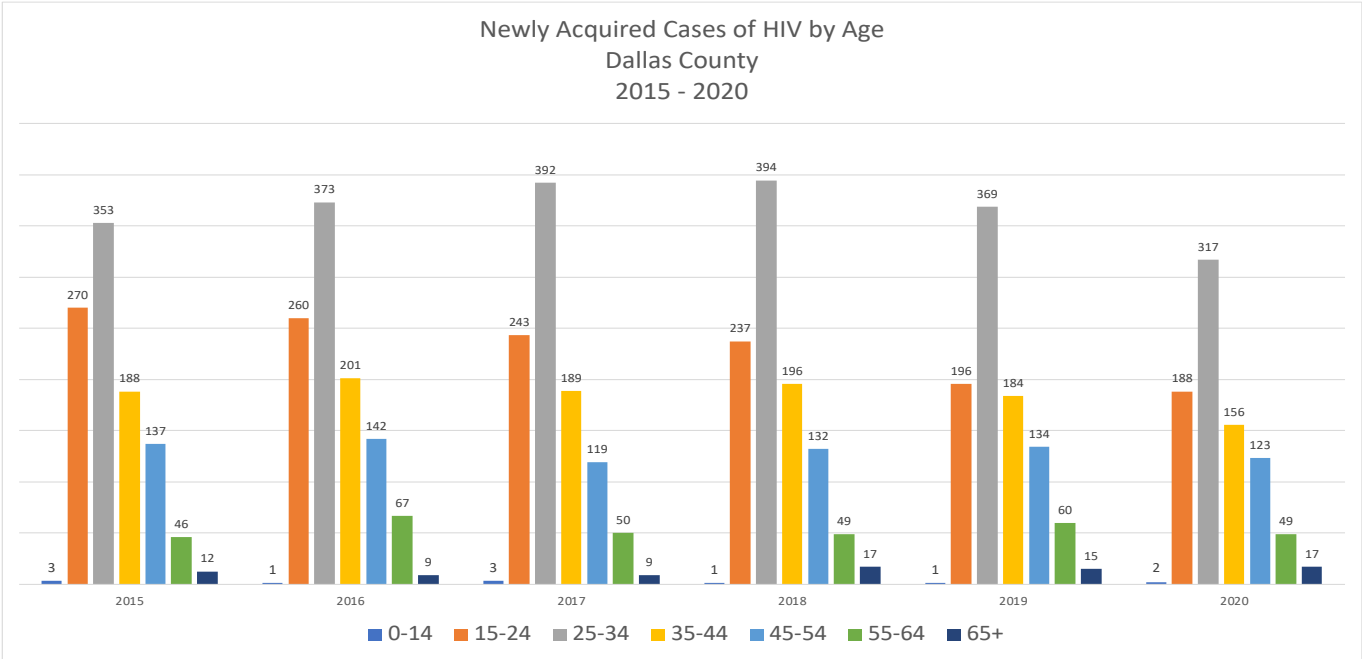

Figure 4. Newly Acquired Cases of HIV by Age Dallas County 2015 – 2020
Source: Texas HSDA

The Sherman-Denison region in recent years (2019-2020) has seen an increase in newly acquired HIV cases among residents of ages 25-34 years old, though other age groups could be underrepresented due to the COVID-19 pandemic (Figure 5).

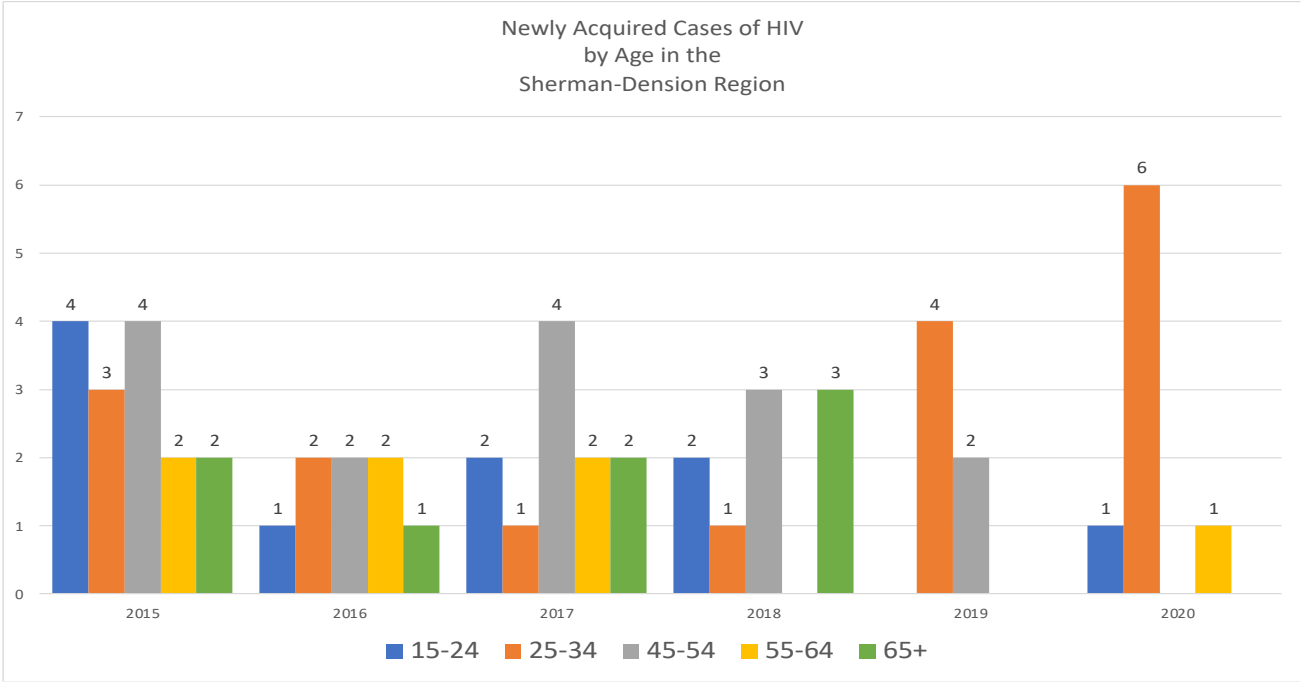

Figure 5. Newly Acquired Cases of HIV by Age Sherman-Denison 2015 – 2020
Source: Texas HSDA

Consistent with trends over the past five years (2015 – 2020) gay and bisexual men and other MSM have consistently represented the majority of all new HIV diagnoses within Dallas County. For modes of transmission outside of MSM, women who have sex with men (WSM) have had consistently higher counts of newly acquired cases in previous years (2015 – 2020), when compared to people who inject drugs (PWID), men who have sex with men who also have sex with people who inject drugs (PWID/MSM), and men who have sex with women (MSW) (Figure 6). Within the Sherman-Denison region, trend data for 2015 – 2020 for these groups is limited.

Populations at Risk of Exposure to HIV

Within the Dallas region, cisgender men were 4 times more likely to acquire HIV in 2020 when compared to cisgender women. In previous years (2015 – 2020) cisgender men have consistently been 4 times more likely to acquire HIV within the Dallas region. In previous years (2015 – 2015) transgender women have been at greater risk for acquiring HIV in the Dallas region (data regarding transgender men has been either non-existent or limited).

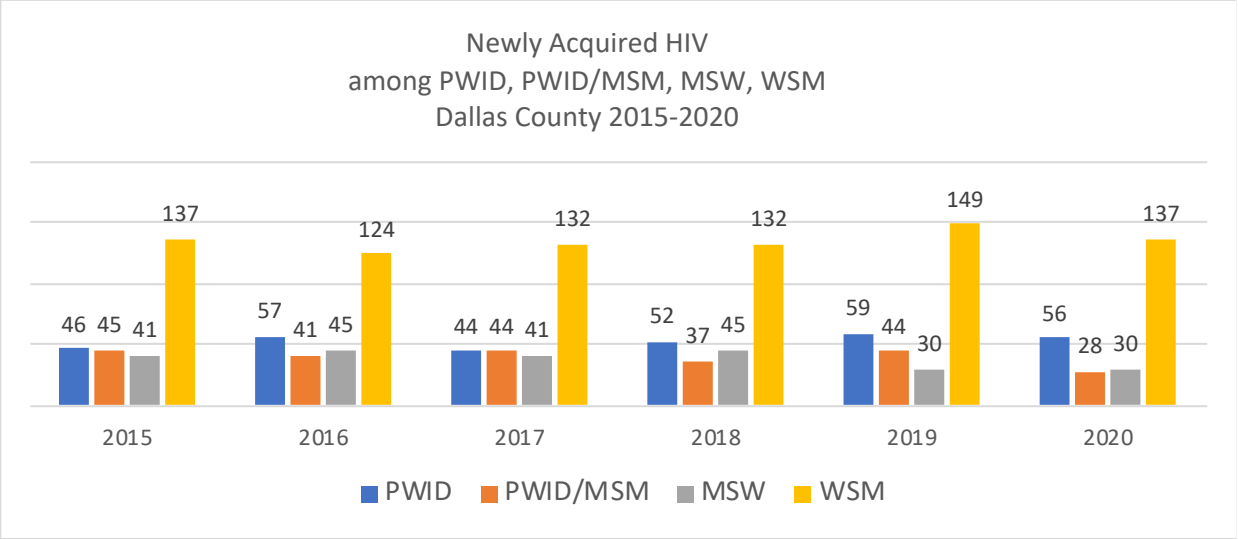

Figure 6. Newly acquired HIV cases among PWID, PWID/MSM, MSW, and WSM within Dallas County 2015 – 2020

Consistent with national trends, Black and Latinx MSM, continue to be the populations with the greatest risk of acquiring HIV in 2020 within the Dallas region. Residents in the Dallas region, who identified as Black were 1.6 times more likely to acquire HIV in 2020.

Populations Living with HIV within the Dallas Region

At the end of 2021, the total number of Dallas region residents living with HIV was 25,492 (Figure 7). The Dallas region represented 24.7% of the total number of residents within the Texas cascade system living with HIV.

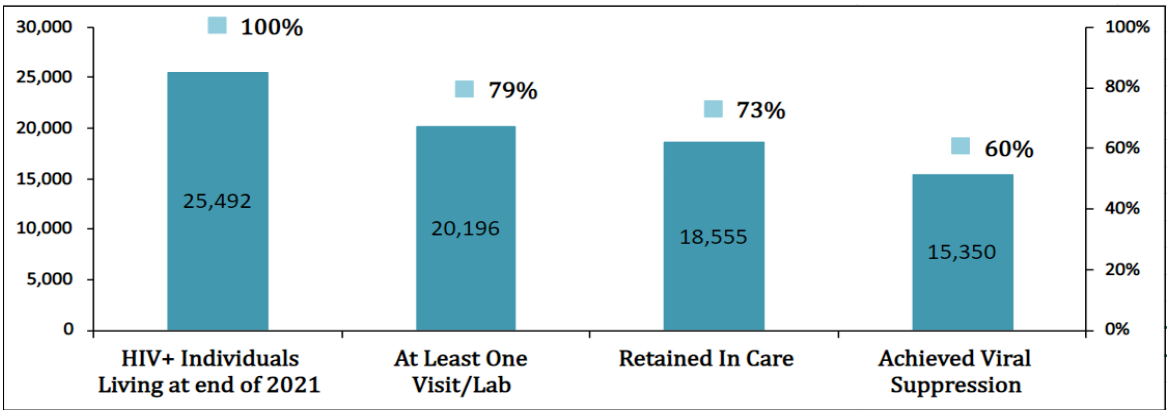

Figure 7. Texas HIV Treatment Cascade for Dallas Region 2021
Source: Enhanced HIV Reporting System as of July 1, 2022, Medicaid, ELR, Ryan White Services Data (ARIES), ADAP, and Private Payers

Priority populations identified by the HIV National Strategic Plan for the Dallas region, include Black and Latinx men who have sex with men, Black women who have sex with men, white men who have sex with men, and transgender people.

Black residents represent 22% of the total population (N=2,613,539) within the Dallas region, yet Black residents account for 42% (N=10,509) of the total prevalence of people PLWH within the Dallas region in 2020. Similarly, Latinx residents represent 40% of the total population, and account for 25% (N=6,109) of the total prevalence of PLWH within the Dallas region in 2020. Trends in previous years (2015 – 2020) have shown an increase in PLWH among priority populations. Between 2015 – 2020, the number of Latinx MSM living with HIV increased by 29%, Black MSM experienced an increase of 31%, White MSM experienced an increase of 3%, Black WSM experienced an increase of 16%, and transgender residents experienced an increase of 59% within the Dallas region (Figure 8).

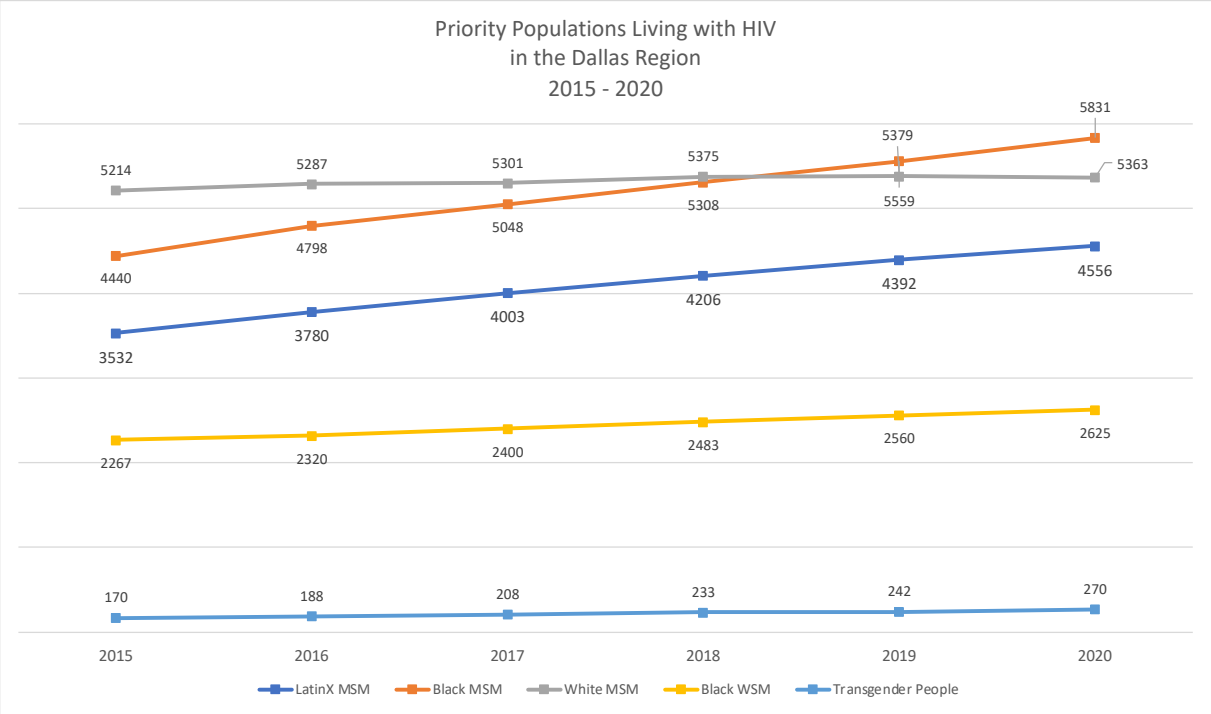

Figure 8. Priority Populations Living with HIV in the Dallas Region 2015 – 2020

In 2020, 6% (N=1,488) of PLWH in Dallas County identified as people who inject drugs. 4.6% (N=1,126) of PLWH identified as MSM and PWID. Over the past 5 years (2015-2020) the number of PLWH who identify as people who inject drugs has increased 8.2%. Trends for PLWH who identified as MSM and PWID have also increased by 9.2% over the 5-year period.

Populations Living with Undiagnosed HIV

Due to the COVID-19 pandemic, estimates regarding the number of people in the Dallas region living with HIV is likely to have been depressed because of decreased HIV testing. General trends over previous versus exact figures should be considered.

In 2020, most people suspected to be living with undiagnosed HIV are men who have sex with men (MSM), followed by women who have sex with men (WSM), and men who have sex with women (MSW). The largest estimated population by race living with undiagnosed HIV is Black MSM (Figure 9).

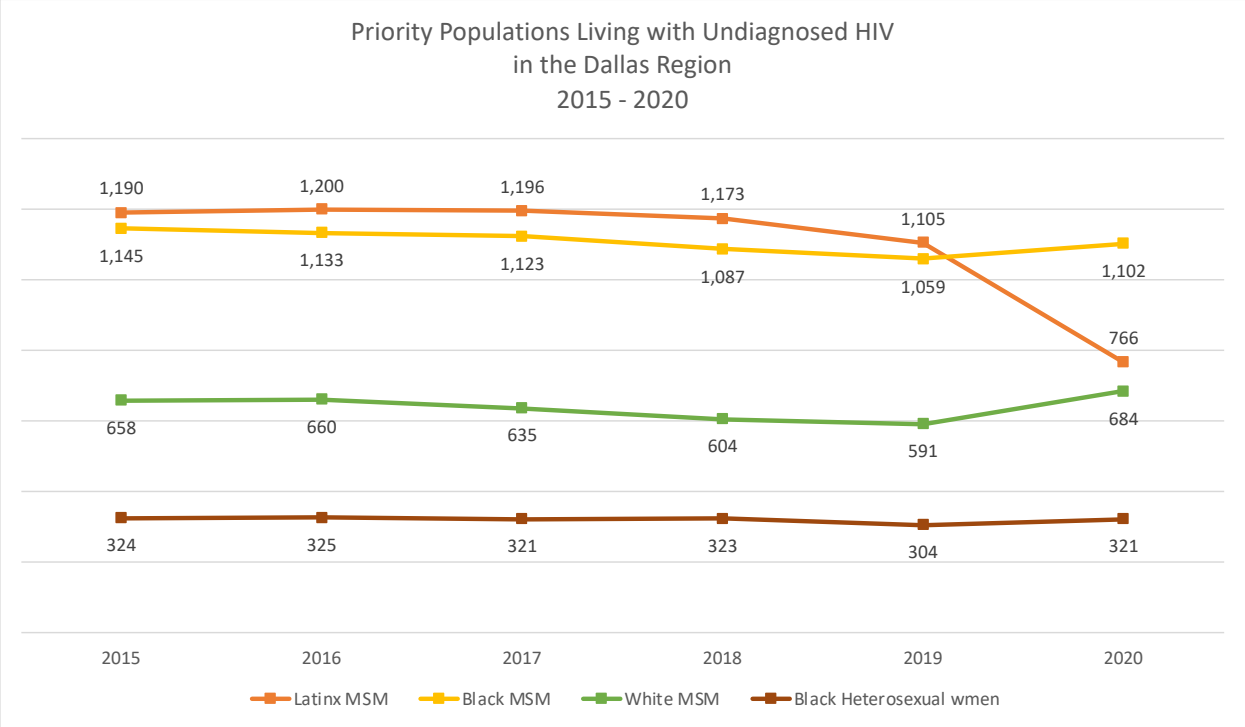

Figure 9. Priority populations living with Undiagnosed HIV in Dallas Region 2015 – 2020
Source: Routine disease surveillance for the number of people with diagnosed HIV, with the total prevalence, proportion diagnosed, and number of people with undiagnosed HIV estimates were produced using a CDC algorithm customized for use with Texas jurisdictions.

Estimates regarding the number of people who are transgender or gender-diverse living with undiagnosed HIV in the Dallas region is limited or not available.

HIV Prevention, Care and Treatment Resource Inventory

Through various Ryan White, state, federal, and local funding, the Dallas region can offer a variety of medical and/or supportive services for PLWH (Appendix E). Currently, there are a total of 21 organizations offering services for PLWH in the Dallas EMA through RW funding. [1]

[1] 2019 RW Needs Assessment

Ryan White Funded Organizations and Services Provided	AIDS pharmaceutical assistance	Case management	Emergency financial assistance	Food bank/home delivered meal	Health insurance assistance	Housing	Legal services	Linguistics	Medical case management	Medical transportation	Mental health services	Non-medical case management	Oral Health	Outpatient medical care	Outreach lost to care	Referral for healthcare	Respite care (Adult)	Substance abuse
AHF Healthcare Center (Dallas)	■		■	■				■	■	■		■		■		■	■	
AIDS Services of Dallas (ASD)				■		■			■	■		■				■		
Bryan's House		■														■		
Callie Clinic	■			■	■				■	■		■		■		■		
Community Dental Care													■			■		
Health Services of North Texas	■		■		■				■		■			■		■		
Legacy Cares				■		■					■	■				■		■
Legal Hospice of Texas							■									■		
Parkland Hospital	■								■	■	■	■		■	■	■		■
Prism Health North Texas	■	■			■				■		■	■	■	■		■		
Resource Center Health Campus				■	■							■	■	■		■		

Strengths and Gaps

The 2019 Ryan White Council of the Dallas Area Needs Assessment and Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021 findings, along with feedback from the 2022 Listening Sessions were used to identify the changes and updates made since the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan- CY 2017-2021. Many Ryan White-funded organizations offer flexible hours, allowing for easier access to services. Extensive language services are available at most Ryan White-funded organizations, as well as diverse options for payment. In the Dallas region, there are also a range of services and resources available to youth under the age of 18. The most prevalent needs not being met were affordable housing, mental health care, and prevention messaging. Rural areas have specific unmet needs that include funding needed for outreach, peer support and navigation, support groups, and PrEP/nPEP. These are long-existing challenges that do not appear to have any infrastructure or funding available to support them. As such, this is an opportunity to engage groups serving PLWH or other at-risk populations and enlist their help in developing solutions to serve these populations.

Housing

There is a need for increased safe, affordable housing opportunities, specifically for middle to low-income individuals and families, including individuals with a history of incarceration and

homes for aging/elderly PLWH. For those who earn above federal housing support income guidelines, there is a need for more assistance in obtaining and maintaining housing. Although these individuals exceed income guidelines, those guidelines do not account for medical and other expenses, causing a further financial strain on this group of individuals.

There has been an increase in funding for housing resources available, specifically because of the American Rescue Act funds. Additionally, Dallas County has purchased a hotel in partnership with Catholic Charities and the City of Dallas for COVID-19 that will be used to offer 180 units of permanent supportive housing (PSH) to PLWH. St. Jude offers PSH, and the county will be expanding access to Emergency Housing Vouchers (EHVs). Individuals can be placed on the housing priority list by calling the MDHA Homeless Crisis Line.

Medical Care

Since the implementation of the Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan- CY 2017-2021, the Dallas region has worked to increase access to medical care and treatment throughout the city. The Dallas region now has clinics with more flexible hours, including Saturday and evening hours available at one clinic, as well as a new Rapid Start Clinic. The relocation of the Amelia Court Clinic, now known as the Adult Comprehensive Care and Engagement Support Services (ACCESS) Clinic, has been relocated to increase capacity of clients served and services offered, including HIV care and treatment, referral services, geriatric care and healthy aging, and behavioral health.[2] In addition, the Community Health Center for Health Empowerment PrEP Clinic has begun providing HIV care to decrease the share of clients who were not getting connected to treatment. The Dallas region has also implemented mobile testing units located outside of nightclubs in two districts to increase testing access, which are being utilized by many.

Further, changes reported by providers include updates to forms to be more inclusive, increased education on transgender issues, increased cultural humility and awareness, full wraparound services (including pharmacy and medical clinic), increased Spanish-speaking services and additional bilingual therapist(s), and implementation of a Rapid Start Clinic.

Listening Session participants shared that the use of injectable, long-acting PrEP offered by some service providers has been useful to help protect patients' HIV/AIDS status, ultimately reducing patient stress and anxiety. These injectable medications, however, have not yet been rolled out on a large-scale.

In terms of prevention, treatment, and care services and supports, barriers need to be addressed to ensure PLWH are not facing additional challenges and burdens in receiving necessary care. Medical staff and patient communication improvements, specifically to include a focus on the quality of life, should be implemented to reduce stigma surrounding

[2] https://www.parklandhealth.org/locations/adult-comprehensive-care-and-engagement-support-se-148

HIV/AIDS. The ability to pay for medical and oral care remains a challenge for PLWH in the Dallas region. Inadequate services and supports available in immigration detention centers, as well as challenges in accessing care post-release from criminal justice systems, is an additional gap in services. Reduced paperwork requirements, increased PrEP/nPEP, and improvements in access and affordability for necessary medications and healthcare services and supports should be implemented to decrease patient burden and stress. For PLWH who are age 16 or younger, testing is not easily available, thus identifying a need for universal testing to be implemented in healthcare and sports physicals for individuals aged 13 to 64.

Prevention

The HIV Taskforce is working to increase distribution of free condoms through partnerships with community-based organizations, social service organizations, and other non-profit organizations. Prism Health North Texas has implemented a new program called Nice Package. This program was implemented to provide contactless delivery options for condoms to decrease transmission rates.

There has been an increase in the Dallas region of providers offering PrEP and nPEP.

Mental Health and Substance Use

There has been an increase in the need for mental health and substance use disorder (SUD) services and supports, specifically strategies for coping with anxiety and depression caused by isolation and fear during the pandemic. There are also current gaps in the available services and supports for managing stress. Increases in available mental health and SUD services and support are especially needed for PLWH who are underinsured, uninsured, and/or living in poverty, as well as those living in rural areas.

Peer Support

Participants in the Listening Session conversations noted that the ability to connect with other individuals living with HIV/AIDS has been beneficial. Peer support, including support groups, provides a platform to expand trust, have a conversation around areas they are struggling in, and gain new insights and perspectives. Holding non-traditional support groups has allowed for greater comfortability in attending and voicing concerns. Although progress has been made to increase the availability of services and supports, gaps were still identified that need to be addressed.

Transportation

Transportation presents additional challenges in accessing all necessary services and resources. Utilization of ride-share services, such as Uber and Lyft, and gas cards in lieu of bus tickets would be beneficial in assisting PLWH who have disabilities in accessing services. PLWH who have disabilities also have an additional barrier to accessing healthy groceries. Assistance with grocery shopping and carrying groceries into the homes would be helpful.

Needs Assessment

Dallas County Health and Human Services employs multiple methods of assessing HIV prevention and care service needs and barriers to services for residents of the Dallas Region. Importantly, PLWH are actively recruited and engaged in community planning and oversight activities to ensure that the voice and perspective of people with lived experience influences the system. While a Comprehensive Needs Assessment is currently underway in the jurisdiction – and therefore results are not yet available to inform this Plan – data on service needs and barriers drawn from three other recent planning and/or assessment processes were consulted in the development of this Plan:

- Ryan White Planning Council of the Dallas Area Interim Needs Assessment- August 2021
- Ryan White Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment
- Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan, CY 2017-2021.

In 2019, the Dallas region facilitated the Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment (Appendix B). The plan was meant to assist in developing funding allocation priorities and a comprehensive plan aimed at meeting the needs of people living with HIV/AIDS. The objectives of the Comprehensive Needs Assessment were to:

- Identify trends in the HIV epidemic within the Dallas region, focusing on recent changes and emerging affected populations.
- Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.
- Obtain detailed information and analyze the treatment initiation gap for PLWH after being diagnosed.
- Obtain detailed information on PLWH with unmet need for medical care; including demographics, barriers, and strategies to connect to care.
- Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of service that PLWH use.
- Evaluate the systems for and rate of linking PLWH into medical care.
- Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWH enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.
- Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

Epidemiologic data were collected and compiled by Brad Walsh at Parkland Health and Hospital System. The Texas State Department of Health Services provided quantitative data

for incidence, prevalence, trends, co-morbidities, and services. He also obtained ARIES data from the local provider data system to supplement the state data. These data were provided to the contractor, Susan Wolfe, and Associates, who conducted additional analyses, compilation, and used the data to prepare graphs for this report. Additional data were obtained online from the United States Census American Community Survey and the Center for Disease and Control Prevention risk surveys.

Priorities

The following are the key priorities that arose from the needs assessment process:

Identify trends in the HIV epidemic within the Dallas region, focusing on recent changes and emerging affected populations.

The incidence of new cases has remained fairly steady since 2013. The highest numbers of new HIV and AIDS diagnoses are in Dallas County, followed by Collin and Denton Counties. The prevalence of HIV/AIDS in the Dallas region continues to rise. Both the number of PLWH and the rate per 100,000 population is highest in Dallas County. Collin and Denton Counties have higher numbers of PLWH compared with other counties in the Dallas region. The rate of prevalence per 100,000 persons is higher in Collin and Kaufman Counties. The remaining counties have lower prevalence and rates.

HIV/AIDS mortality rates for Black PLWH in the Dallas region are over five times the rate for non-Hispanic white PLWH, suggesting a need to identify the reasons for the higher death rate and address them.

There is a lack of data for transgender individuals. Reliable estimates for the number are difficult to find, and HIV rates are unknown. Recent HRSA HIV/AIDS program client-level data suggest there are 157 identified transgender individuals receiving Ryan White services in the Dallas region. There is no such data available for counties in the Sherman-Denison HSDA.

Results of the breakdown of new cases by race and ethnicity suggest that efforts to prevent racial and ethnic disparities in new cases and reduce new cases overall would have the greatest impact by targeting African American and Hispanic/Latinx communities. Also, new diagnoses are fastest growing among the 25 to 34 years age group.

New diagnoses of HIV among MSM continue to rise in recent years (2015-2020) indicating a need to increase prevention efforts and messaging that specifically targets MSM.

Poverty rates are high among PLWH in the Dallas EMA. While the poverty rate for individuals residing in the Dallas region is 11%, an estimated 23% of PLWH in the Dallas region have incomes at or below the poverty level. Data were not available for the Sherman-Dennison HSDA.

Emerging health issues and comorbidities that complicate HIV care include sexually transmitted infections, obesity, diabetes, heart disease, and hypertension. Providers also

reported increased mental health problems and substance abuse. Because of improvements in treatment, more PLWH are living longer which is increasing the need for specialized geriatric care for this population.

Identify consumer service needs, needs that are not currently being fulfilled, service utilization patterns, and barriers to care.

Providers in the Dallas region identified challenges to HIV/AIDS prevention. Younger people who did not see the epidemic in the beginning view HIV/AIDS as another chronic but treatable disease. There is still stigma associated with HIV and it creates barriers to treatment. HIV prevention should be included with general health prevention messaging such as prevention regarding illicit drug use, improving diet, and increased exercise. Even with PrEP, people need to understand the need to use condoms to prevent other sexually transmitted infections. Messaging needs to be tailored toward audiences that experience the highest rates of transmission.

Barriers to HIV care cited by survey participants were the amount of time it takes to get care, the paperwork burden, the time it takes to get an appointment, lack of weekend and evening hours, the clinic treats HIV and not their other medical conditions, and the staff does not understand their culture. It is important to keep in mind that survey participants were predominantly from the Dallas region. Evidence from data and providers suggests that for individuals living in suburban and rural areas, the paucity of services locally and resources and time necessary to reach services located in Dallas may also serve as a barrier.

Obtain detailed information and analyze the treatment initiative gap for PLWH after being diagnosed.

Barriers to successful linkage to care were identified using consumer surveys and focus groups. Patients perceived stigma when they go to HIV clinics. There are institutional barriers such as considerable time elapsing and the paperwork burden between diagnoses and seeing a provider. PLWHA sometimes have higher order needs, such as housing instability or unresolved trauma that need to be resolved before they will seek treatment. Transportation may not be available, especially in rural areas. Psychosocial barriers include denial or having to come out to their families as they share their diagnosis.

Obtain detailed information on PLWH with unmet need for medical care; including demographics, barriers, and strategies to connect to care.

In 2021 the State of Texas estimated that as many as 3,997 individuals in the Dallas region may be undiagnosed. Estimated numbers were higher among males, Black people, people ages 25-34, and MSM.

Among PLWH, in 2021, in the Dallas region, 79% were linked to care; 73% were retained in care, and 60% were virally suppressed. A total of 87.7% of PLWH who were retained in care were virally suppressed. [3]

There are barriers to retaining PLWH in care. There is a high administrative burden with paperwork required every six months. Information is not centralized so PLWH who are seeking care must complete such updates with all of their providers. Youth lose their Medicaid coverage when they turn 19 and may drop out of care at that time. Resources are primarily centralized around downtown Dallas and not easily accessible to individuals living in Dallas County outside of the city or in other rural counties. Sometimes other needs arise and take priority, such as loss of housing, substance abuse issues, or life disruptions where people fall out of their routines. Not all PLWH are comfortable with all providers, and they may leave treatment after a couple of appointments.

Programs that are successful at linking people to and keeping people in care are generally collaborative, comprehensive, and offer a single system of care where all partners are fully informed. They offer high quality care with sincere and knowledgeable providers. They are often innovative and will try a variety of strategies and are designed specifically to meet the needs of the population they serve.

In summary, efforts to improve retention in care are needed, specifically targeting Black PLWH, younger PLWH (ages 13-44), and PWID. Efforts should focus on linking Black PLWH to care and retaining them in care to increase their viral suppression percent. Additional efforts should be focused on Hispanic/Latinx PLWH whose numbers are increasing and whose percentage of virally suppressed is less than that of White PLWH, as well as PWID and ages 44 or younger individuals among the PLWH population. Innovative and culturally relevant strategies are needed to overcome logistical barriers such as transportation, geographic distance, and hours/days of service as well as psychological barriers such as stigma, feelings of invulnerability, and denial.

Identify and evaluate the system of HIV care, evaluating current capacity gaps, and barriers (including but not limited to eligibility barriers) in the continuum and treatment cascade. This will include HIV/AIDS services providers and providers of services that PLWH use.

The Dallas region has excellent health care, although it is not necessarily available for or accessible by all PLWH in the Dallas region. There is an insufficient supply of mental health care available to meet the needs of the population. There is also a need for mental health providers who are knowledgeable about LGBTQ individuals, HIV, and navigating life with HIV, as well as more culturally appropriate and community competent providers. Dental and vision services also need increased capacity in more locations.

[3] Enhanced HIV AIDS Reporting System, "Texas HIV Treatment Cascade for Dallas EMA," 2022.

There are 21 identified organizations providing a spectrum of HIV related services to PLWH in the Dallas region who may not have sufficient resources for disease management. Potential areas of improvement identified include relatively longer wait times for dental care (average 0 to 50 days) and mental health counseling (average 0 to 10 days). These wait times were substantially longer than other services such as outpatient HIV medical care (0-7 days) or outpatient OB/GYN services (0-2 days).

The most prevalent needs not being met were needs for affordable housing, mental health care, and prevention messaging. Rural areas had specific unmet needs that included funding needed for outreach, peer support and navigation, support groups, and PrEP/PEP. Needs varied across priority populations.

Prevention services are not universally available throughout the Dallas region. They need to target specific geographies and populations and be more culturally responsive to them. Planning and assessment efforts for prevention need to be more inclusive and examine within group variation. PrEP and PEP are not accessible to everyone. There is a need for more widely available education about safe sex. Prevention initiatives need to target stigma among the larger population and within sub-populations, including rural, African American, and Latinx communities.

Evaluate the system for and rate of linking PLWH into medical care.

In 2021, 12% of PLWH in the Dallas region were not linked to care. The percent of PLWH with unmet needs and 20 or more PLWH was highest in the 75454 (Melissa; 43%); 75247 (Dallas west; 38%); 76205 (Denton; 37%); 75402 (Greenville, 36%); and 75401 (Greenville, 35%) zip codes. Many areas with unmet needs did not have Ryan White-funded services in proximity or were in rural areas or suburbs that do not have specialized HIV care.

Linkage to care varied by sex and race/ethnicity for previous years (2020), showing that 75.6% of cisgendered women were linked to care compared to 75.8% of cisgender men linked to care. Of transgender women, 84% were linked to care and 100% of transgender men were linked to care. Data is limited regarding transgender populations due to being unable to ascertain what percentage of clients were asked about their gender identity vs being assumed by the provider. Percentages linked to care are lower for Black and Hispanic PLWH (74.1%) compared to White PLWH (77.8%).

In summary, targeted efforts to link PLWH with care in the Dallas region are needed for women, Black and Hispanic persons, PWID, heterosexual individuals, transgender individuals, and age groups 0-12, 13-24, and 65 and older. Peer support and peer navigation were suggested as potentially effective strategies.

Identify and evaluate the impact of health care reform on Ryan White enrollment and types of services most needed after PLWH enroll in expanded Medicaid programs or health insurance exchanges/marketplaces.

Respondents to the provider survey reported that the impact of the Affordable Care Act on their organizations and clients was mixed that there was mostly little to no impact. This was primarily attributable to Texas not accepting the expanded Medicaid provision. Other problems cited were restrictive eligibility requirements and insurance premiums that are not affordable, adding to the barriers to clients accessing care.

Evaluate and interpret the use of alcohol and other non-prescribed drugs and the impact on adherence and make recommendations to identify the best approach to address the subject.

Providers reported they are seeing an increase in substance abuse among PLWH. Consumer respondents reported the most frequently used substances were alcohol, marijuana, stimulants, depressants, and non-prescribed painkillers. Among consumers who dropped out of care, 26% reported using drugs as a reason. They also reported there are few services available for low-income PLWH who need substance abuse treatment. Substance abuse and other behavioral health services should be integrated into primary care. Resources are needed to expand inpatient substance abuse treatment as well. Explore the feasibility of programs that provide both housing and substance abuse aftercare support.

Recommendations for Services

Target prevention initiatives toward youth (ages 13-35), Black, and Hispanic/Latinx communities, and MSM. Make testing more widely available, and work to have it incorporated into more routine health care. Provide testing at health fairs and large community events. Inform youth that they can be tested without parental consent. Provide youth with more consistent sexual health information and education.

Expand to more geographic locations and target populations identified as needing prevention and intervention services. Include individuals from underserved populations when developing strategies at the table as decision-makers (e.g., transgender individuals; more people of color; youth).

Address racial disparities at multiple levels. At the individual level, target unmet needs. At the community level, address stigma toward LGBTQ individuals and HIV/AIDS. At the systems level, systemic racism must be acknowledged and addressed.

Identify ways that the paperwork burden on both consumers and providers can be reduced. Consider a universal intake system and longer periods between required re-certification.

Join with other groups to advocate for Medicaid expansion and affordable housing options. As Dallas neighborhoods continue to gentrify, an increasing number of low-income individuals and families are being pushed out and unable to find affordable housing, including PLWH. Such work can also help improve access and stability for people living in rural communities.

Provide comprehensive services with one-stop shops to the extent possible. Include services to meet psychosocial needs and peer navigators who can provide guidance and support.

Take a deep dive into examining the system of care. Incorporate more evaluation into services to determine both their efficiency and effectiveness and use findings for continuous improvement. Include voices of Black gay men, Black and Hispanic heterosexual women, members of the transgender communities, and others who have been traditionally excluded at the table for planning and decisions (2019 Needs Assessment- Appendix B pp. 12-16).

Actions Taken

The 2019 needs assessment report was delivered in March 2020, just before Dallas County begin to experience the impact of COVID-19. This left little opportunity for providers and the RWPC to give it adequate attention as they have been busy since that time managing the impact of the pandemic on their organizations and consumers. Nonetheless, the interviews and focus groups asked questions to determine whether providers and consumers had seen or heard of the results from the 2019 needs assessment. They also asked about changes made by providers and consumers' observations of changes.

Did providers and consumers hear or see the results?

Consumers who participated in the focus groups reported they were not aware of the results. Among providers, more than half had seen the report or at least browsed parts that were relevant to them.

What changes did providers make?

Providers described some changes they had made after they read the results of the needs assessments. Others had made changes that were unrelated to the results, but consistent with the recommendations, nonetheless. Some changes that were planned had to be put on a back burner due to COVID-19.

Rural providers outside of the Dallas region did not find the needs assessment to be helpful because it focuses primarily on the needs of populations they do not serve.
Reported changes based on the needs assessment are listed below.

- Including clients more often in decisions about how services are provided.
- Using the data to support grant writing and shifting grants to specifically support medical case management.
- Integrating primary care with the management of HIV in a clinic to improve access and reduce stigma of visiting an HIV service only clinic.
- Working across the Dallas region to reduce the eligibility burden with each agency having its own eligibility burden and clients having to do the same things multiple times, creating undue burden. This is still a work in progress.
- Increasing access and the number of new patients seen.

- Doing research about transgender issues; engaging in work on cultural humility and awareness; and changing forms to be more inclusive and include preferred name, as they are required to enroll people based on their legal names.
- Providing full wraparound services with pharmacy and a full medical clinic. This includes Spanish-speaking services, including transcription services for others.
- Implementing a Rapid Start Clinic. They were already considering it, but the needs assessment influenced them to move forward.
- Being intentional about hiring more bilingual staff.

What changes did consumers observe?

Consumers reported they have seen some changes since the 2019 needs assessment was completed, although they are not sure that they were related, or expressed that they were unrelated.

- One clinic is open on some Saturdays and has evening hours.
- Another clinic opened and there is more access in different parts of the city, including the southern sector and Fair Park area.
- The Amelia Court clinic moved to the new professional building at Parkland. Staff have more resources and room to provide care.
- The Community Health Center for Health Empowerment PrEP clinic started HIV care because they were seeing so many come in for testing who were not getting into care.
- Mobile testing units were out by nightclub locations in the Design District and Cedar Springs areas. They noticed a lot of people out and about participating in the mobile units (2019 Needs Assessment- Appendix B pp. 8-10).

In 2020, Susan Wolfe and Associates, LLC (SWA), in collaboration with Dr. Kyrah Brown from the University of Texas at Arlington presented the report with the results of the 2019 Dallas EMA Ryan White Needs Assessment. When the report was presented, the Ryan White Planning Council (RWPC) prepared a plan to respond to the findings and began implementing the plan. Shortly after the Needs Assessment findings were shared, however, the COVID-19 epidemic disrupted the operations of systems providing health and supportive care for PLWH and providers were forced to develop alternative ways to conduct outreach and deliver care.

In 2021, as COVID-19 rates declined and vaccination rates increased, there were expectations that providers and PLWH would be able to return to providing and receiving services with the same methods used pre-COVID-19. However, COVID-19 era adaptations led to innovations and new ways of doing things that may be retained. The Interim Needs Assessment offered an opportunity to capture not only the impact of COVID-19 on providers and consumers, but also the lessons learned.

The purpose of the Interim Needs Assessment was to:

- Identify how COVID-19 impacted the care delivery system and outreach, especially for underserved populations and populations with special needs.

- Determine the extent to which COVID-19 impacted individuals from identified underserved populations and their ability to access prevention and care services (Interim Needs Assessment- Appendix E).

Approach

The Key Informant Surveys were conducted by the contractor, Dr. Susan Wolfe. Dallas County Health and Human Services provided Dr. Wolfe with a list of organizations, contact names, and contact information for individuals who play a key role in the development and provision of services to PLWH in the Dallas region. E-mail invitations were sent to individuals from 27 different organizations requesting their participation. Recipients were asked to click on a link to Sign-Up Genius to select a date and time slot to schedule their interview. Follow-up invitations were sent to non-respondents after the sign-up deadline passed. Twenty-three individuals responded and signed up to be interviewed. One individual was unable to participate at her designated time due to an unforeseen event; one had to cancel because of a conflict and did not reschedule; and another did not show at the scheduled time. The final number of interviews was 20 key informants.

The interview was conducted using a semi-structured interview protocol via Zoom conferencing technology on the computer or telephone. All Key Informants agreed to having their interviews recorded. Interviews lasted from 45 minutes to 1.5 hours and averaged one hour. Three interviewees were unable to complete the entire interview because of scheduling conflicts or other time limitations. All interviews were completed between October 17, 2019, and November 25, 2019.

Organizations represented housing services, health care services, mental health services, children's health services, consumers, policy and advocacy services, transgender services, and other service providers serving PLWH in the Dallas region. Nineteen respondents served Dallas County and one respondent served the Sherman-Dennison HDSA.

Twelve focus groups were conducted. Three of the focus groups were conducted in June and July of 2018 by the Care Coordination Ad Hoc Committee. Two focus groups were conducted in April and June 2019 by Brad Walsh from Parkland Health and Hospital System. The remaining seven focus groups were conducted by the contractor, Susan Wolfe and Associates. All focus groups used a standard, semi-structured protocol. Eleven of the 12 focus groups were recorded. Participants were asked if they consented to recording and one participant in one group asked that the focus group not be recorded. Participants were asked to sign an informed consent form and each participant received a gift card as compensation for their time and input. All focus groups were arranged by Dallas County Health and Human Services in collaboration with service providers. The purpose of the focus groups was to gain added input from priority populations (2019 Needs Assessment- Appendix B pp. 2-6).

Section IV: Situational Analysis

Dallas region stakeholders have been building local momentum to address the HIV epidemic. There are many groups engaged in activities aimed at ending the HIV epidemic in the Dallas Region, including the Ryan White Planning Council, HIV Task Force and Fast Track Cities Committee. While each group has identified priorities and developed plans, they have not yet been able to land on an approach that would allow them to collaborate and leverage each other's resources and strengths effectively. The Integrated Plan provided an opportunity to engage key stakeholders from across the community to work together to develop shared priorities and collaborative strategies for HIV prevention and care in the Dallas Region. A cross-sector group of stakeholders was convened comprised of members of these active community groups to guide the planning process. This steering committee ensured that the community input described in Section II and the Data and Assessments discussed in Section III were used to identify current strengths, challenges, and identified needs for HIV prevention and care in the Dallas Region.

Diagnose

It is important to note that the COVID-19 pandemic has created challenges for not only the affected populations but for reviewing crucial data regarding new cases of HIV. Due to the COVID-19 pandemic, the counts of newly diagnosed persons with HIV are likely to be artificially low; thus, interpretation of the year-to-year trend in diagnoses should be approached with caution until more yearly data is available.

Testing for individuals under the age of 16 has been identified as an area of improvement as testing is not easily available for this age group. In 2019, men who have sex with women, men who inject drugs, women who inject drugs, and men who have sex with men and people who inject drugs were all more likely to be designated as AIDS-presenting at diagnosis. Data suggests that among women who have sex with men, numbers may be artificially low in 2020 due to, among other factors, the limited number and types of settings offering high-quality HIV testing as well as a lack of pervasive peer norms in support of HIV testing.

An identified strength is that all Parkland facilities have implemented opt-out testing. Further coordination with government institutions and other public/private partnerships are needed to increase access to testing. Collaboration with hospital emergency departments, schools, and correctional facilities has also been identified as an area of improvement.

Structural inequalities in Dallas area systems of care show that cultural proficiency training for providers and staff could lead to the removal of a barrier to care for these high-risk populations. Black and Latinx residents of the Dallas region are disproportionally affected by the HIV epidemic. These communities accounted for 76.3% (N=650) of all new HIV diagnoses in 2020 compared to their white counterparts who accounted for 18.9% (N=161). There are structural and systemic issues that lead to barriers to access to care for Black and Latinx

residents. In the Ryan White Planning Council of the Dallas Area Interim Needs Assessment-August 2021 (Interim Needs Assessment), Black communities reported barriers to care including poor experiences with providers, a lack of providers of color, and distance from providers. Latinx communities continue to face language barriers due to the availability of Spanish-speaking case managers and providers.

Identified needs for the Dallas area include priority prevention methods for the following communities: gay, bisexual, and other men who have sex with men and residents between the ages of 24 – 34. Men who have sex with men accounted for 70% (N=596) of all new HIV diagnoses followed by women who have sex with men at 16.2% (N=138), and then people who inject drugs at 6.5% (N=55) of all new diagnoses for HIV in 2020.

Treatment

At the end of 2021, of the 25,492 Dallas area residents living with HIV, 20,196 residents were in care within the Texas HIV treatment cascade system. Of the residents that were in care, 18,555 were designated retained in care; 15,350 achieved viral suppression. Identified strengths in the program are that 74% of all new diagnoses were linked to care within 1 month.

Stage	Number of Clients	Percentage of Clients
Total New Diagnoses	964	
Linked in 1 month	717	74%
Linked in 2-3 months	85	9%
Linked in 4-12 months	47	5%
Linked in 12+ months	3	0%
Not Linked	112	12%

One area of strength includes enhanced integrated care models. AHF Healthcare Center, Prism Health North Texas, and ASD all offer integrated care models which enable psychosocial, mental health, and substance abuse treatment, as well as risk reduction counseling that is co-located with HIV primary care providers. Increased public and private partnerships to address the gaps in coverage has been identified as an area of improvement.

Other strengths identified in the 2021 Interim Needs Assessment include reports of flexible hours in Ryan White funded organizations, as well as extensive language services, and diverse options for payment. Some providers within Dallas area reported offering more specialized services for target populations, such as services specifically for transgender consumers, including a transgender clinic. Participants also reported a range in youth services for populations under the age of 18.

Barriers to HIV treatment cited by survey participants were the amount of time it takes to get care, the paperwork burden, the time it takes to get an appointment, lack of weekend and evening hours, the clinic treats HIV and not their other medical conditions, and the staff does

not understand their culture. Evidence from data and providers suggests that for individuals living in suburban and rural areas, the paucity of services locally and resources and time necessary to reach services located in Dallas may also serve as a barrier.

While there is a lack of data pertaining to PLWH who identify as transgender, participants in the Interim Needs Assessment identified a lack of services pertaining to transgender individuals as a challenge. Transgender women report barriers related to fear given the number of transgender women who have been murdered. Transgender men report receiving limited attention regarding their specific needs. Both transgender men and women reported experiencing discrimination by providers.

Increased supports for populations in immigration detention centers, and post-release support from criminal justice systems is another identified need. Improvements are also needed in affordability of services and medications.

Prevent

In 2021, 15,350 Dallas area residents achieved viral suppression within the Texas HIV treatment cascade system. The use of long-acting PrEP has been useful in protecting patient status. Within the Dallas metro area there are 10 PrEP providers for uninsured populations and 17 locations that assist patients in accessing PrEP through verifying insurance and other options of assistance. The Sherman-Denison region has limited services with only one service provider for PrEP for the region.[4] Increasing data monitoring of PrEP usage has been identified as an area of improvement, and planning is ongoing to address this need. Another area of improvement is employing harm reduction techniques such as syringe service programs.

Other challenges identified by providers in the Interim Needs Assessment include stigma, lack of prevention messaging, and condom usage. Providers stated that younger populations tend to not understand the severity of living with HIV, and view HIV as another chronic but treatable disease. Providers expressed challenges due to stigma as a barrier to prevention methods in the Ryan White needs assessment. Stigma is highest among Black and Latinx communities. This caused providers to struggle with getting people tested and into care, especially if there is a risk of being identified as HIV positive from being seen at a care facility.

The Interim Needs Assessment identified areas of service gaps within the Ryan White network. These gaps in services included many social determinants of health which include housing instability, transportation services, and services in rural areas. Specific service gaps for rural communities include a lack of funding for outreach, peer support, and PrEP/PEP (Appendix E).

[4] "PrEP Locator: A National Database for US PrEP Providers," US PrEP Provider Directory, accessed November 28, 2022, https://preplocator.org/.

Respond

In order to detect and respond to outbreaks, the ability to distinguish between new and pre-existing diagnoses is critical. Data sharing across organizations and sectors is important in increasing the capacity to detect and respond to outbreaks. However, the challenges of data security and maintaining of confidentiality are presented with any expansion of data access. Organizations are often cautious in respect to this; therefore, consensus among relevant organizations regarding data sharing is needed.

In the event of an outbreak, connecting people quickly to the prevention and treatment services they need is critical. The challenges of fragmentation of services between various organizations and the need for clients to provide data multiple times, as expressed in listening sessions, present challenges in responding to outbreaks efficiently. Greater collaboration among service providers and coordination across counties is needed.

The DCHHS has a broad plan that utilizes the health department which could serve as a starting point in data sharing to increase the capacity to detect and respond to outbreaks. CQM data may also prove to be an opportunity that will also provide important insights. Increased funding for data surveillance and the expansion of public/private partnerships will be needed. Uniform data reporting requirements are also needed.

Priority Populations

Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, each of the goals, objectives and key activities/strategies has a focus on the priority populations that have been identified. There are specific activities noted to engage with priority populations, or organizations that work with them, to ensure they get access to the services and resources needed.

Section V: 2022-2026 Goals and Objectives

The goals and objectives in this section were developed through a number of activities during the Integrated Planning process:

- A crosswalk of existing plans was completed to identify similarities among the goals, objectives, and strategies of each plan.
- Listening sessions were conducted with PLWH and other consumers to hear directly from them about what should be done to improve access to care and resources.
- The Integrated Planning Steering Committee convened monthly and helped develop the goals and objectives noted in this section.
- Goal-specific workgroups were convened to revise the goals and objectives as necessary, as well as to identify specific strategies the jurisdiction should engage in to meet the goals as outlined.

Goal 1: Diagnose all Dallas Regional residents as quickly as possible.

Objective 1- 90% of Dallas Regional Residents will know their HIV status.

Key Activities/Strategies:

1. Develop and implement strategies for testing residents in rural communities.
    - Establish baseline testing data.
    - Engage mobile medical partners.
    - Increase the efficacy of at-home testing.
2. Develop a "community calendar" for Dallas Regional Residents to access that will provide updated testing information.
    - Compile a list of partners who should be engaged to provide information to populate the community calendar.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Specialty groups in rural counties; primary care providers; large employers; Black Greek organizations (Divine 9); community centers; transportation providers.

Data Indicator(s): Total number of tests performed; community calendar developed.

Data Source(s): DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Objective 2- Promote and increase community-based HIV testing opportunities in healthcare and non-healthcare settings.

Key Activities/Strategies:

1. Convene/attend conferences and meetings to share information and resources for healthcare providers and other healthcare professionals around HIV testing strategies and support.
2. Expand or increase opt-out, routine screening in healthcare and other institutional settings, particularly in highly impacted communities.
    - Develop educational materials for providers to have readily available and visible in their offices.
3. Encourage and support CBOs use of targeted social media posts encouraging routine testing.
4. Develop community-based strategies for targeted testing for priority populations.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Dallas County Medical Society; ER staff; OB/GYN providers; primary care providers; large medical systems, particularly those who serve members of priority populations; insurance groups; corrections personnel.

Data Indicator(s): Total number of tests performed; number of community testing events listed on community calendar; number of social media posts from CBOs encouraging routine testing.

Data Source(s): DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Goal 2: Treat all HIV diagnoses quickly and effectively.

Objective 1- Increase the percentage of Dallas Regional residents who are linked to care within 14 days of diagnosis

Key Activities/Strategies:

1. Develop and implement a survey to understand the most pressing social determinants of health that PLWH need support with.
2. Standardize the definition of “linkage to care.”
3. Provide culturally responsive training to case managers.

4. Establish a 'warm handoff' system where providers connect people receiving a positive diagnosis directly to a case manager/navigator.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AIDS Education Technical Assistance Consortium (AETC); academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations.

Data Indicator(s): Social determinants of health survey developed and implemented; standardized definition of "linkage to care" created; number of case managers who complete culturally responsive training; linkage to care data.

Data Source(s): DCHHS, AETC, TBD

Objective 2- Increase the percentage of Dallas Regional residents who are living with HIV that are retained in care.

Key Activities/Strategies:

1. Maintain a network of case managers so they can keep caseloads low and address other social determinants of health for their clients.
2. Recruit and hire people with lived experience (HIV positive, experience utilizing the system) to serve as case managers and navigators.
3. Provide training and professional development for PLWH to earn a living wage and develop the tools necessary for the role for which they are hired.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations

Data Indicator(s): TBD

Data Source(s): TBD

Objective 3- Increase the percentage of Dallas Regional Residents who are living with HIV that are reconnected to care within 90 days of contact.

Key Activities/Strategies:

1. Establish a 'warm handoff' system where providers reconnect people getting reestablished in care directly to a case manager/navigator.
2. Recruit and hire people with lived experience (HIV positive, experience utilizing the system) to serve as case managers and navigators.
3. Provide training and professional development for PLWH to earn a living wage and develop the tools necessary for the role for which they are hired.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; organizations that work with the unhoused population; organizations that serve priority populations

Data Indicator(s): TBD

Data Source(s): TBD

Objective 4- Enhance the HIV care continuum that coordinates resources and services.

Key Activities/Strategies:

1. Create opportunities for case managers to build relationships with case managers outside of their service delivery areas.
2. Remove siloes that exist between organizations.
3. Develop local "medical neighborhoods" where clients can access multiple services in a single location. The services should be available in the evenings and on weekends.

Target Population(s): All Dallas Regional Residents who are PLWH, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people

- People who inject drugs
- Residents aged 25-34

Key Partners: AETC; academic institutions; technical training programs; primary care providers; large medical systems, particularly those who serve members of priority populations; Insurance groups.

Data Indicator(s): TBD

Data Source(s): TBD

Goal 3: Prevent new transmissions among Dallas Regional Residents using proven methods and strategies.

Objective 1- Increase the use of PrEP and nPEP by 50%, especially for priority populations.

Key Activities/Strategies:

1. Collaborate with providers to provide strategies to help them identify and prescribe PrEP to priority populations they serve.
2. Create awareness and opportunities and availability of nPEP to community members.
3. Community organizations should identify and hire credible messengers to engage community members in prevention activities.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, HIV Task Force, EHE Coordinator, pharmaceutical companies.

Data Indicator(s): Number of providers offering PrEP and nPEP prescriptions; number of credible messengers hired by community organizations.

Data Source(s): TBD

Objective 2- Employ harm reduction strategies that are proven to prevent the transmission of HIV.

Key Activities/Strategies:

1. Engage and educate State Representatives who are from and/or represent priority populations.
2. Advocate for policies that ease restrictions on proven harm reduction strategies.

3. Engage and train non-traditional partners to reach community members who engage in high-risk behaviors.
4. Gather a report on the landscape of sexual health education in schools.
5. Promote comprehensive sexual health education through schools.

Target Population(s): All Dallas Regional Residents, especially PLWH who are members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: Local social media influencers; State Representatives; organizations that provide food support; houselessness outreach workers; sex workers; organizations that serve the LGBTQ community; high schools and universities.

Data Indicator(s): Report on the landscape of sexual health education in schools; laws enacted that ease restrictions on harm reduction strategies.

Data Source(s): TBD

Objective 3- Develop and conduct workforce development/training for healthcare professionals on HIV testing guidelines, risk factors, prevention tools and culturally responsive efforts.

Key Activities/Strategies:

1. Educate providers on talking to their patients about sexual health and risk.
2. Educate providers on cultural competency/humility and anti-stigma.
3. Integrate HIV and sexual health education into curricula at medical schools, nursing schools, and other schools that train healthcare professionals.

Target Population(s): High school and university students; students in medical schools, nursing schools and other healthcare fields.

Key Partners: Primary care providers; food providers; houselessness outreach workers; sex workers; organizations that serve the LGBTQ community.

Data Indicator(s): TBD

Data Source(s): TBD

Goal 4: Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas Regional Residents who need them.

Objective 1- Ensure accurate and reliable data is available to the appropriate entities for prompt surveillance efforts.

Key Activities/Strategies:

1. Develop a "standard of care" around data collection.
2. Ensure that data use agreements (between the county, testing agencies, community organizations, hospitals, etc.) are current and MOUs are in place.
3. Develop strategies to collect data about the transgender population.
4. Increase funding to support trends identified by surveillance data.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Data Indicator(s): TBD

Data Source(s): TBD

Objective 2- Engage in local and regional outbreak response planning to be implemented when outbreaks are detected.

Key Activities/Strategies:

1. Determine whether there is a local/regional outbreak response plan.
    - If so, review and update the plan, as necessary.
    - If not, identify an entity that will be responsible for developing and implementing a response plan.
2. Identify an objective entity that can host an annual data sharing event.
3. Review zip code data to understand prevalence among priority populations.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: CDC, State/Local Health Departments, Community Organizations

Data Indicator(s): Identification or development of an outbreak response plan; identification of an objective entity to hold an annual data sharing event; TBD.

Data Source(s): TBD

Objective 3- Increase access to support services that address social determinants of health for Dallas Regional residents.

Key Activities/Strategies:

1. Develop and implement a survey to understand the most pressing social determinants of health that PLWH need support with.
2. Conduct a crosswalk of existing plans to identify strategies to support the needs of PLWH.
3. Increase the public/private partnership to address gaps in the Ryan White part A network.

Target Population(s): All Dallas Regional Residents, especially members of priority populations including:

- Gay, bisexual, and other men who have sex with men (MSM), particularly Black and Latinx men
- Black women
- Transgender people
- People who inject drugs
- Residents aged 25-34

Key Partners: DCHHS, EHE Coordinator, HIV Task Force, RWPC, ASOs, CBOs, Stakeholders.

Data Indicator(s): Social determinants of health survey; TBD

Data Source(s): TBD

Updates to Other Strategic Plans Used to Meet Requirements

There were no updates to other strategic plans to meet the requirements.

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

As previously discussed, there are multiple groups in the Dallas region engaged in activities aimed at ending the HIV epidemic. Specific strategies around implementing, monitoring, and evaluating the integrated plan will be developed in more detail in the coming year, when several of the groups will be going through a restructuring process. Part of the restructuring will involve clarifying the roles they will have in monitoring the progress of the goals, objectives, and strategies of the integrated plan.

Implementation

DCHHS will create a report template that all Ryan White- funded agencies and entities that were part of the integrated planning process will complete on a quarterly basis. The report template will contain consistent reporting detail including metrics such as HIV testing data, viral suppression, number of community-based testing events, etc. Currently, Ryan White-funded agencies submit invoices that also capture some potentially relevant data, so they will be reviewed to determine what should be reported across all agencies. The jurisdiction will determine which entity will be responsible for compiling and sharing the data collected. The data collected from the template is the first step for the jurisdiction to begin gathering relevant data that will assist with understanding whether the goals and objectives have been met.

DCHHS is considering establishing a system-wide Case Manager whose primary responsibility will be to lead a Regional Case Management Operating Committee. As this role is being developed, there is consideration that this role will also assist in exploring and establishing regular data collection from the funded agencies.

Monitoring

There are several groups that will play a role in overseeing the implementation and monitoring of the 2022-2026 Integrated Plan, including the HIV Task Force, Fast Track Counties committee and Ryan White Planning Council. It should be noted that in 2023, both the HIV Task Force and Fast Track Counties committees will convene to revamp how they do their work. Discussions will involve clarifying the mission of each group, the role of leadership, how each group will be staffed, and the role of the committees for each. Currently, the HIV Task Force meets monthly, and the Fast Track Counties committee meets quarterly, and this is likely to continue. They will also consider the respective roles they play with implementation and monitoring of the Integrated Plan, including the identification of a liaison responsible for receiving and sharing information with the Ryan White Planning Council.

The Planning and Priorities committee of the Ryan White Planning Council is tasked with overseeing projects and will receive updates about the status of goals and objectives. For

each monthly meeting, there will be a standing agenda item dedicated to updating the committee on the progress of the goals and objectives of the plan. Any critical updates and/or recommendations will be made to the Ryan White Planning Council.

Evaluation

The jurisdiction, through the Continuous Quality Management (CQM) Committee of the RWPC, will continue to refine the metrics used to evaluate the Integrated Plan. While the data template is the first step to having regular and consistent data available to track progress, the development of a data dashboard that metrics will be reported directly into is a longer-term goal for the jurisdiction. This will allow real-time and trend data to be available to allow the jurisdiction to make informed decisions about how funding should be allocated to best meet the needs of Dallas Regional residents. Until then, funded agencies will complete and submit the data templates on a quarterly basis, and then present the findings to the RWPC.

Improvement

The Planning and Priorities Committee will review the Plan on an annual basis to assess its implementation. They will also review the data that has been collected over the previous year to determine whether there has been progress made toward meeting the goals, objectives, and strategies as outlined. If there are changes recommended to any areas of the plan, they will be submitted to the full RWPC for discussion and adoption.

Reporting and Dissemination

The Ryan White Planning Council will ensure that each of its committees receives quarterly updates on the progress of implementing the Plan, as well as any changes made based on evaluation and improvement efforts. In addition, the liaisons to the HIV Task Force and Fast Track Counties committee will ensure those entities receive *at least* quarterly updates that are provided to the RWPC.

Section VII: Letters of Concurrence

RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

Dear (Name):

The Ryan White Planning Council Dallas ***concurs with reservations*** for the inclusion of specified updates to be incorporated with the following submission by the Dallas County Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Ryan White Planning Council Dallas has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV.

The Ryan White Planning Council Dallas ***concurs with reservations for the inclusion/updates of the following provisions: The Executive Summary must incorporate progression details from the 2017-2021 Integrated Plan; the Data Sets must incorporation a caveat for the Rural HSDA's; the Situation Analysis section must incorporate changes/improvements comparable information as applicable to the 2nd 5-Year Plan to further demonstrate*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Ryan White Planning Council Dallas and Standing Committee Members participated in the Steering Committee, in addition to listening sessions that were aimed at getting input on needs, priorities, gaps, and opportunities. In addition, three listening sessions were conducted in September 2022 to hear directly from consumers about what should be done to improve access to care and resources. Individuals were convened in September 2022 to discuss current strengths and gaps in services for Dallas County residents living with HIV/AIDS.

The Ryan White Part A Planning Council received multiple updates about the status of the Integrated Planning process, in which several Planning Council members participated. In addition, members of the Planning and Priorities and Consumer Council Committee (sub-committees of the RWPC) who are also PLWHA assisted in recruiting and convening other consumers to participate in listening sessions and share feedback on what should be done to improve access to care and services, particularly for identified priority populations.

The Ryan White Planning Council Dallas and Standing Committees have an established monthly schedule to conduct meeting whereby the EHE/Grants Department will have standing agenda items dedicated for presentation from program representatives.

The signature(s) below confirms the ***concurrence with reservations*** of the Ryan White Planning Council Dallas with the Integrated HIV Prevention and Care Plan.

Signature: _____Date: _____
Helen Zimba Ryan White Planning Council Co Chair(s)

Integrated Planning Body (Dallas County Integrated Planning Steering Committee)

Program Officer Name

Dear Program Officer,

The Dallas County Integrated Planning Steering Committee [***concurs or concurs with reservations***] with the following submission by the Dallas County Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Dallas County Integrated Planning Steering Committee was convened to advise on the scope of the Integrated Plan, identify key partners and data sources, and provide feedback on the approach to gathering community input. The Steering Committee also assisted in identification, recruitment, coordination, and facilitation of goal-specific, planning workgroups. The group met monthly from August through November 2022.

The signatures below confirm the [***concurrence or concurrence with reservations***] of the planning bodies with the Integrated HIV Prevention and Care Plan.

Signatures:

Planning Body Chair(s), Date

Dallas HIV Task Force (EHE Planning Body)

Program Officer Name

Dear Program Officer,

The HIV Task Force [***concurs or concurs with reservations***] with the following submission by the Dallas County Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body [***concurs or concurs with reservations***] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIV Task Force serves as the EHE Planning Body and received multiple updates about the status of the Integrated Planning process, in which several HIV Task Force members participated. In addition, members of the Task Force who are also PLWHA assisted in recruiting and convening other consumers to participate in listening sessions and share feedback on what should be done to improve access to care and services, particularly for identified priority populations.

The signatures below confirm the [***concurrence or concurrence with reservations***] of the planning bodies with the Integrated HIV Prevention and Care Plan.

Signatures:

Planning Body Chair(s), Date

Appendix A: Dallas County Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan CY 2017 - 2021

Appendix B: Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment February 2020

Appendix C: Integrated Plan Steering Committee Roster

Appendix D: Dallas County IP Steering Committee Notes

Appendix E: Ryan White Planning Council of the Dallas Area Interim Needs Assessment August 2021