NORTH TEXAS HIV PREVENTION AND CARE PLAN 2027–2031

Building a Healthier North Texas. Together.

A FIVE-YEAR ROADMAP TO REDUCE NEW HIV INFECTIONS, IMPROVE HEALTH OUTCOMES, AND ELIMINATE DISPARITIES ACROSS NORTH TEXAS.

PREVENT NEW HIV INFECTIONS

IMPROVE HEALTH OUTCOMES

ADDRESS DISPARITIES & SOCIAL DRIVERS OF HEALTH

BUILD STRONGER SYSTEMS & PARTNERSHIPS

UNITED FOR IMPACT.
COMMITTED TO EQUITY.
FOCUSED ON OUR FUTURE.

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DCHHS, CAI, Inc., Community Stakeholders, and Champions with Lived Experience

NORTH TEXAS INTEGRATED PLAN

Acknowledgments

Integrated HIV Prevention and Care Plan | 2027-2031

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Southern Black Policy and Advocacy Network

United for impact. Committed to equity. Focused on our future.

Dallas EMA | Dallas HSDA | Sherman/Denison HSDA

Acronyms and Terms

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	**FHIR**	Fast Healthcare Interoperability Resources	**PMEP**	Performance Measurement and Evaluation Plan
ART	Antiretroviral Therapy	**FTC**	Fast Track Counties	**PrEP**	Pre-Exposure Prophylaxis
CAI	Cicatelli Associates Inc.	**HIV**	Human Immunodeficiency Virus	**QI**	Quality Improvement
CDC	Centers for Disease Control and Prevention	**HMIS**	Homeless Management Information System	**RAI**	Ready, Aim, Innovate
CQM	Clinical Quality Management	**HRSA**	Health Resources and Services Administration	**RAPID ART**	Rapid Antiretroviral Therapy
DALISS	Data Analytics Local Investigation System	**HSDA**	HIV Service Delivery Area	**RWHAP**	Ryan White HIV/AIDS Program
DCHHS	Dallas County Health and Human Services	**KPI**	Key Performance Indicator	**U=U**	Undetectable = Untransmittable
DIS	Disease Intervention Specialist	**LC**	Learning Collaborative	**SPNS**	Special Projects of National Significance
eCR	Electronic Case Reporting	**MOC**	Model of Care	**STI/STD**	Sexually Transmitted Infection / Sexually Transmitted Disease
ED	Emergency Department	**MPRA**	Multi-Party Readiness Assessment	**TEP**	Technical Expert Panel
EHE	Ending the HIV Epidemic	**PEP**	Post-Exposure Prophylaxis		
EMA	Eligible Metropolitan Area	**PLWH**	People Living with HIV		

KEY TERMS

Care Continuum - Framework describing stages of HIV care, including diagnosis, linkage to care, treatment, retention in care, and viral suppression.

Community Engagement - Involving community members, people with lived experience, providers, planning bodies, and partners in identifying needs and priorities.

Dallas EMA - Ryan White Part A planning and service coordination area for the Dallas Eligible Metropolitan Area.

Dallas HSDA - HIV Service Delivery Area used for Ryan White Part B and state service planning.

Epidemiologic Profile - Summary of HIV-related data used to describe who is affected, where needs are concentrated, and where strategies should focus.

Health Equity - Ensuring all people have a fair and just opportunity to achieve optimal health outcomes.

Incidence - Number of new HIV diagnoses or infections occurring in a defined population during a specific period.

Linkage to Care - Connecting a person newly diagnosed with HIV, or returning to care, to HIV medical care and support services.

Medical Neighborhood - Coordinated network of clinical, public health, community, and support-service partners.

Needs Assessment - Structured process for gathering data, surveys, interviews, focus groups, provider input, and community feedback to identify gaps and priorities.

Planning Council - Community planning body that helps set service priorities, guide resource allocation, and support HIV planning efforts.

Prevalence - Total number of people living with HIV in a defined population at a specific point in time.

Rapid ART / Rapid Start - Model focused on starting HIV treatment as quickly as possible after diagnosis or re-engagement in care.

Retention in Care - Ongoing engagement in HIV medical care over time.

Sherman/Denison HSDA - HIV Service Delivery Area including Cooke, Fannin, and Grayson counties.

Status-Neutral Approach - Whole-person approach connecting people to HIV prevention, testing, treatment, and support services regardless of HIV status.

Structural Barriers - System-level conditions that make it harder to access or remain engaged in care, such as transportation, housing, insurance, stigma, or fragmented systems.

Viral Suppression - Health outcome when HIV treatment reduces the amount of virus in the body to a very low level, commonly defined as less than 200 copies/mL.

Workplan - Structured plan outlining goals, objectives, strategies, activities, responsible parties, and timelines for implementation.

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SECTION 1: Introduction

The Dallas Regional Integrated HIV Prevention and Care Plan, CY 2027–2031, establishes a shared roadmap for HIV prevention, care, treatment, response, implementation, monitoring, and improvement across the Dallas Regional Area. The Plan is intended to guide coordinated action among Dallas County Health and Human Services, the Ryan White Planning Council, the Fast Track Counties group, the HIV Task Force, funded prevention and care providers, community-based organizations, clinical partners, people with HIV, people who may benefit from HIV prevention services, and other community stakeholders. It is designed to align local HIV prevention and care activities with national HIV goals and the Ending the HIV Epidemic framework of Diagnose, Treat, Prevent, and Respond.

The 2027–2031 Plan builds on the foundation established in the 2022–2026 Dallas Regional Integrated HIV Prevention and Care Plan. The prior plan brought together several planning efforts into one regional framework, including the National HIV/AIDS Strategy, the Fast Track Counties plan, the previous integrated HIV prevention and care plan, the Texas state HIV planning framework, and activities identified through the Dallas HIV Task Force. In 2022, these plans and activities were cross-walked to create a central master plan for North Texas. For 2027–2031, Dallas County did not begin from scratch; instead, the jurisdiction reviewed the previous plan, assessed progress toward the goals and objectives that had been established, identified where objectives had been met or were still in progress, and used those findings to inform a more focused, measurable, and implementation-ready plan.

The previous plan also helped clarify what needed to change in the next planning cycle. Goals and objectives that were met demonstrated areas of progress and local capacity that can be sustained or expanded. Goals and objectives that were not fully met provided an opportunity to re-examine whether the strategy, metric, data source, timeline, or implementation structure needed to be revised. Through this process, partners identified the need for more specific performance measures, clearer data sources, stronger alignment between goals and monitoring activities, and a more formal annual review process. This updated plan responds to those lessons by including more specific baselines, measurable objectives, defined data indicators, and a structure for ongoing monitoring, evaluation, reporting, and plan improvement.

This Plan is also grounded in the most recent needs assessment activities, epidemiologic data, service system information, community feedback, and planning discussions available to the jurisdiction. Needs assessment findings and community input served as a foundation for understanding ongoing barriers related to HIV testing, linkage to care, retention, viral suppression, PrEP access, behavioral health, substance use, housing, transportation, stigma, service navigation, and social determinants of health. These findings were reviewed alongside epidemiologic data to identify populations and communities experiencing disproportionate HIV burden or poorer HIV-related outcomes. The resulting goals and objectives prioritize both biomedical HIV prevention and treatment strategies and the broader service supports needed to help people access, remain engaged in, and benefit from care.

The populations of focus for the 2027–2031 Plan include gay, bisexual, and other men who have sex with men, particularly Black and Latinx men; Black women; people who inject drugs; and residents ages 25–34. These populations were identified based on review of local epidemiologic data, needs assessment findings,

community input, and ongoing planning discussions. The Plan recognizes that reducing new HIV transmissions and improving HIV health outcomes requires both population-specific strategies and system-level improvements that reduce barriers across the continuum of prevention and care.

Approach to Developing the Plan

The approach to developing the 2027–2031 Plan was intentionally collaborative, data-informed, and focused on implementation. Dallas County Health and Human Services and planning partners began by reviewing the prior 2022–2026 Integrated Plan, including the goals, objectives, strategies, data indicators, and implementation structure. Strategies and activities from the prior plan that remain relevant and continue to support local and national HIV goals were retained or refined. Areas where progress was limited were revisited to determine whether objectives needed to be revised, strengthened, or supported by clearer performance measures.

The planning process also included review of current community-level data, epidemiologic trends, program data, needs assessment information, and feedback from community and partner meetings. Particular attention was given to aligning the goals and objectives in Section V with the implementation, monitoring, and evaluation structure in Section VI. This alignment was a major priority because the jurisdiction intends for the Plan to function not only as a required planning document, but also as a practical tool for tracking progress, guiding partner activity, informing funding decisions, and communicating progress back to the community.

A significant amount of planning time was dedicated to the development of updated goals and objectives. The Ryan White Planning Council's Evaluation Committee's monthly meeting served as a key venue for integrated planning discussions, including review of data, draft goals and objectives, and proposed strategies. Fast Track Counties participants, HIV Task Force members, providers, community partners, and other stakeholders were also engaged in the broader planning process. This approach allowed the jurisdiction to focus on the "meat and potatoes" of the plan: the specific goals, objectives, strategies, data indicators, and implementation processes that will guide work over the next five years.

The 2027–2031 Plan is new, but it is built from the structure, lessons, and momentum of the earlier regional master plan. The previous plan created a unified framework for North Texas by bringing multiple planning efforts into one shared document. The updated plan uses that framework as a base, while adding stronger metrics, clearer baselines, updated data sources, and a more deliberate monitoring and annual review process. In this way, the new Plan reflects both continuity and improvement: it sustains the core regional commitment to ending the HIV epidemic while strengthening the jurisdiction's ability to measure progress and make data-informed adjustments over time.

Overview of the Plan

The Plan is organized into six core sections. Section II describes the community engagement and jurisdictional planning process, including the roles of the Ryan White Planning Council, Fast Track Counties group, HIV Task Force, people with HIV, providers, funded partners, and other stakeholders. Section III presents contributing data sets and assessments, including data sharing and use, the epidemiologic snapshot, the prevention, care, and treatment resource inventory, and needs assessment findings. Section IV provides the situational analysis, summarizing the major strengths, gaps, barriers, and opportunities identified through data review and community input. Section V outlines the 2027–2031 goals, objectives, strategies, partners, data indicators, and

data sources. Section VI describes implementation, monitoring, evaluation, improvement, reporting, and dissemination.

The goals in the Plan are organized around the national Ending the HIV Epidemic strategies:

Goal 1: Diagnose all people with HIV in the Dallas Region as quickly as possible.
The Plan includes objectives to increase the percentage of people with HIV who are aware of their status, increase the number of HIV tests conducted annually, and maintain an annual HIV positivity rate that reflects targeted and effective testing. Strategies include social marketing campaigns, routine opt-out testing in healthcare settings, capacity building for testing partners, expanded community-based testing, identification of new testing locations, maintenance of a community calendar, use of partner services and network-based testing, and targeting of high-prevalence ZIP codes.

Goal 2: Treat all people with HIV in the Dallas Region quickly and effectively to reach sustained viral suppression.
The Plan includes objectives to increase linkage to care within 30 days of diagnosis, increase engagement in care, increase retention in care, and increase viral suppression. Strategies include a rapid ART learning collaborative, development of rapid ART protocols and workflows, implementation of a Medical Neighborhood Model, rapid linkage into Ryan White services, use of technology to support linkage, culturally responsive and trauma-informed capacity building, expanded clinic hours, Data to Care and re-engagement activities, mobile and home-based lab services, strengthened case management coordination, telehealth, behavioral health and substance use support, and messaging related to U=U and advances in HIV care.

Goal 3: Prevent new HIV transmissions in the Dallas Region by using proven interventions, including PrEP.
The Plan includes objectives to reduce new HIV diagnoses, increase the number of people prescribed PrEP, and increase the PrEP-to-Need Ratio. Strategies include condom distribution, recruitment of credible messengers, collaboration with non-traditional partners and organizations serving priority populations, social marketing campaigns focused on PrEP and newer PrEP options, provider education, telehealth and mobile PrEP options, communication strategies to increase provider awareness, and surveys to assess awareness of PrEP, PEP, and U=U.

Goal 4: Respond quickly to potential outbreaks by getting prevention and treatment services to Dallas Regional residents who need them.
The Plan includes objectives to develop a regional Cluster Detection and Response Plan, implement annual community and partner engagement strategies focused on social determinants of health, and maintain a comprehensive directory of prevention, care, and supportive services. Strategies include gathering examples from other jurisdictions, updating data sharing and use practices through contracts, MOUs, and data sharing agreements, participating in surveillance and outbreak response capacity building, conducting community listening sessions and consumer surveys, holding annual provider meetings, maintaining the FindHelp directory, reviewing external service directories, and establishing formal partnerships between funded and non-funded organizations.

Across all goals, the Plan emphasizes measurable progress, community accountability, and continuous improvement. The updated goals and objectives include more specific baselines and performance measures than the prior plan, which will support stronger implementation monitoring over the five-year period. DCHHS and

partners intend to develop a community-facing dashboard to track and visualize progress toward key goals and objectives, making the Plan more transparent and useful to both community members and implementation partners.

Implementation, Monitoring, and Continuous Improvement

The 2027–2031 Plan will serve as the primary planning and implementation resource for HIV prevention and care activities in the Dallas Regional Area. It will help guide funding decisions, resource allocation, partner coordination, and new initiatives to ensure that local activities align with the goals, objectives, and strategies identified through the planning process.

Implementation will be supported by multiple planning and partner bodies. The Fast Track Counties group will serve as a key implementation and monitoring venue, with support from the Ryan White Planning Council. The HIV Task Force will continue to support community engagement, dissemination, and connection to people with lived experience and community partners. DCHHS will support implementation through multiple funding streams and program areas, including Ryan White Part A, Part B, Part C, Part D, Part F, State Services, MAI, HOPWA, HRSA EHE, CDC EHE, and CDC Prevention funding, as well as partnerships with housing, behavioral health, women's health, correctional systems, and other community-based organizations.

Monitoring and evaluation will occur through quarterly updates, partner meetings, ongoing review of epidemiologic and program data, and routine reporting on performance measures. DCHHS and partners will use these data to assess progress toward the goals and objectives, identify barriers to implementation, and determine where strategies should be sustained, modified, or expanded. The Plan will be reviewed at least annually, and updates will be made as needed based on data, community feedback, partner input, and progress toward objectives. This annual review process is intended to ensure that the Plan remains a living document and continues to reflect the needs of the Dallas Regional Area throughout the 2027–2031 planning period.

SECTION 2: Community Engagement and Planning Process

Jurisdiction Planning Process

Dallas County Health and Human Services (DCHHS) implemented a multi-faceted collaborative planning process to inform the development of the Dallas Regional HIV Prevention and Care Plan, also referred to as the Integrated Plan. This process created structured opportunities for community stakeholders to assess current priorities, review data, provide input on goals and strategies, and strengthen coordination across HIV prevention, care, treatment, and support systems. The planning process intentionally incorporated diverse perspectives from across the region, including people living with HIV (PLWH), individuals accessing or in need of pre-exposure prophylaxis (PrEP), consumers of Ryan White services, community advocates, funded service providers, public health partners, and individuals with related lived experience.

The overall aim of the planning process was to identify and prioritize strategies that strengthen coordinated HIV prevention and care efforts, improve health outcomes for individuals impacted by HIV, and advance progress toward a significant reduction in new HIV transmissions. The planning process was organized around a data-to-strategy approach. Stakeholders first reviewed available data to develop a shared understanding of current needs, service gaps, priority populations, and trends across the HIV prevention and care continuum. These data included epidemiologic data, Ryan White needs assessment findings, stakeholder experience evaluation data

from consumers of Ryan White services, focus group feedback from PLWH, service utilization trends, PrEP and testing data, and pillar-specific data related to Diagnose, Treat, Prevent, and Respond. While DCHHS and CAI supported the physical drafting of the plan, the content of the plan was driven by data, needs assessment findings, stakeholder expertise, and community input.

The planning process included several key steps: reviewing prior Integrated Plan feedback; identifying gaps from the previous planning cycle; reviewing epidemiologic, needs assessment, stakeholder experience, and implementation data; identifying priority populations and service gaps; engaging stakeholders through existing planning meetings; facilitating discussion on goals, objectives, and strategies; sharing draft sections for review and comment; and aligning the updated goals and objectives with the workplan and monitoring process. This approach allowed DCHHS to use local data, community experience, and partner expertise to inform the plan while also responding to prior feedback that the previous plan needed more specific strategies, and more measurable goals and objectives.

Entities Involved in the Planning Process

The planning process was guided by leaders and partners across HIV prevention and care settings in North Texas, as well as representatives from funded partner agencies. Stakeholders reviewed goals and objectives on a recurring basis to provide oversight, support alignment with community priorities, and inform plan development. Between meetings, draft sections were shared for stakeholder review, comment, and discussion prior to upcoming meetings. Members provided feedback on the scope and framework of the Integrated Plan and offered recommendations to strengthen the content of each section.

Individuals and organizations were not selected based on a narrow participation criterion. Instead, DCHHS intentionally cast a wide net by sharing information about the planning process and opportunities to participate through multiple community and planning structures. Integrated planning discussions were shared during Planning Council meetings, and email invitations were shared broadly with the Fast Track Counties listserv, which includes more than 400 individuals. Information about planning and review meetings was also shared with Ryan White and EHE subrecipients, HIV Task Force participants, community partners, and other stakeholders. Meetings were open, membership was not required, and attendees were encouraged to share invitations and planning materials with their own networks.

Role of the RWHAP Part A Planning Council/Planning Body

The Ryan White Planning Council is a community-based body appointed by the County Judge to guide the organization and delivery of HIV services funded through Ryan White Part A, Ryan White Part B, Minority AIDS Initiative funds, and State Services funds. The Council is composed of volunteer members selected to reflect the diversity of the Dallas service area, including PLWH, members of the general public, funded service providers, and representatives from 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 PLWH through coordinated planning, evaluation, and continuous system improvement across medical, support, and prevention-related services in the North Texas region. The Planning Council plays a central role in reviewing community needs, setting service priorities, informing resource allocation, supporting coordination across Ryan White services, and evaluating whether the local HIV service system is responsive to the needs of PLWH.

The Ryan White Planning Council operates through six standing committees, including the Planning and Priorities Committee and the Evaluation Committee. These committees supported the Integrated Plan by

reviewing data, discussing goals and strategies, elevating consumer perspectives, and advising on service needs and priorities. Integrated Plan discussions were incorporated into Evaluation Committee meetings to align with existing stakeholder availability. Through these structures and written feedback opportunities, PLWH and community stakeholders helped review, prioritize, and revise the goals, objectives, and strategies included in the plan.

Ryan White Planning Council Evaluation Committee

The Ryan White Planning Council Evaluation Committee served as the primary meeting space for Integrated Plan development and review. Meetings were held on the fourth Tuesday of each month from 3:00–4:30 p.m. and were open to PLWH, prevention partners, care providers, community advocates, Fast Track Counties members, HIV Task Force members, and other stakeholders. Using this existing meeting structure helped reduce duplication and created a consistent space for reviewing data, discussing service gaps, and providing input on goals, objectives, strategies, monitoring, and evaluation.

During the planning process, most of the stakeholder review and discussion occurred through Evaluation Committee meetings. These meetings supported status-neutral collaboration across prevention and care by bringing partners together to discuss testing, PrEP, linkage to care, treatment, retention, viral suppression, behavioral health, housing, and other supportive services. The Evaluation Committee will continue to serve as a primary mechanism, along with the Fast Track Counties Workgroup, for ongoing plan implementation, progress review, and community accountability.

Engagement of People with HIV

PLWH were engaged throughout the Integrated Plan process through Ryan White Planning Council structures, Evaluation Committee meetings, Consumer Council activities, Fast Track Counties meetings, HIV Task Force engagement, needs assessment activities, and written feedback opportunities. Planning Council and standing committee representation for community engagement regarding the Integrated Planning process met or exceeded 25%–38% at all meetings, ensuring that consumer and community perspectives were included in discussions related to data review, priority setting, goals, objectives, and strategies.

Input from PLWH and people with lived experience was incorporated both through direct meeting participation and through data sources reflecting consumer experiences, including needs assessment findings, Ryan White stakeholder experience evaluation data, and focus group feedback. PLWH will continue to be engaged in implementation, monitoring, evaluation, and improvement of the plan through ongoing committee participation, progress review, future needs assessment activities, and feedback opportunities built into Ryan White and Integrated Plan monitoring processes.

Collaboration with RWHAP Parts

Representatives from all Ryan White Parts participated in Integrated Plan discussions through existing planning and stakeholder forums, including Planning Council meetings, Evaluation Committee meetings, Fast Track Counties meetings, and Dallas HIV Task Force meetings. This included Ryan White Part A, Part B, Part D, and Part F representation, as well as partners supported through State Services, Minority AIDS Initiative, Ending the HIV Epidemic, and CDC Prevention funding.

Collaboration across the HIV prevention and care system was a priority throughout the planning process. Participation from partners across these programs helped align local and state-funded services, reduce

duplication, identify gaps, and support development of the Integrated Plan as a coordinated framework connected to existing Ryan White, EHE, prevention, and community planning efforts.

Role of Planning Bodies and Other Entities

In addition to the Ryan White Planning Council structure, the Integrated Plan was informed by several broader community planning and coordination bodies, including the Fast Track Counties to End HIV Workgroup and the Dallas HIV Task Force. These groups provided important spaces for prevention partners, care providers, public health staff, community-based organizations, advocates, consumers, and nontraditional partners to review data, discuss service gaps, and identify opportunities for coordination across the HIV prevention and care continuum.

These bodies helped broaden participation beyond formal Ryan White planning structures and supported a status-neutral planning approach by bringing together partners focused on testing, PrEP, linkage to care, treatment, retention, viral suppression, behavioral health, housing, reentry, and other supportive services. The following sections describe the role of each planning body in greater detail.

Role of the Fast Track Counties Committee

Dallas County became a Fast Track County in 2019 when County Judge Clay Jenkins signed Dallas County onto the global Fast-Track Cities initiative. While the Ryan White Planning Council serves as the formal Ryan White planning body, the Fast Track Counties workgroup serves as a broader status-neutral planning and implementation body.

Fast Track Counties meetings are held quarterly and are led by Dr. Philip Huang, Medical Director of DCHHS. Dr. Huang's broad public health role supports participation from a wide range of partners, including large hospital systems, emergency departments, jails, federally qualified health centers, HIV service providers, social service organizations, consumers, advocates, and partners outside the traditional HIV care system. This broad participation makes Fast Track Counties a key venue for status-neutral coordination across the full HIV continuum.

The meeting structure includes an epidemiologic overview of new quantitative or qualitative data received during the previous quarter, followed by a shared review of the Integrated Plan workplan, including goals, objectives, and strategies. During meetings, community partners provide updates on activities connected to the plan, identify progress, and discuss barriers or emerging needs. Through this structured process, Fast Track Counties serves as a primary mechanism for monitoring progress on Integrated Plan goals, objectives, and strategies throughout the plan period.

Role of the Dallas HIV Task Force

The role of the Dallas HIV Task Force shifted in 2026 to better complement Dallas' existing planning structures, including the Ryan White Planning Council and Fast Track Counties meetings. Rather than serving as another formal data review or planning meeting, the Task Force now functions as an accessible entry point for community members, younger advocates, and emerging leaders who want to learn more about HIV advocacy, planning, and opportunities for involvement. Meetings are held on nights and weekends, include dinner, and are structured as less formal mixers with introductions, announcements, networking, and opportunities to connect participants to next steps.

The Task Force's primary program is the Ambassador Program, which provides structured training, mentorship, and support for individuals interested in becoming future leaders in the HIV movement. This body remains important because it creates a lower-barrier space for younger community members, grassroots leaders, and people not yet connected to formal planning bodies to engage, build relationships, and determine the level of advocacy or planning involvement that is right for them.

Priorities Identified Through Planning and Community Engagement

Several key priorities emerged through the planning and community engagement process, informed by epidemiologic data, continuum of care data, PrEP and testing data, needs assessment findings, and stakeholder feedback.

The first priority is improving timely linkage to care, rapid access to treatment, and re-engagement for people newly diagnosed with HIV or returning to care. Section III data show that while many people are diagnosed and connected to services, gaps remain in timely linkage, retention, and viral suppression. Stakeholders emphasized the importance of reducing delays between diagnosis, eligibility, linkage, and antiretroviral therapy initiation, particularly for individuals diagnosed outside traditional HIV service settings or experiencing barriers to re-engagement.

The second priority is improving retention in care and viral suppression by addressing barriers that affect long-term engagement. Continuum data show that retention remains one of the largest gaps in the local HIV care system, and stakeholder feedback identified transportation, housing instability, behavioral health needs, substance use, food insecurity, stigma, insurance barriers, and system navigation challenges as ongoing barriers. These findings support strategies focused on care navigation, case management coordination, supportive services, and culturally responsive retention efforts.

The third priority is strengthening HIV prevention access, including PrEP, PEP, testing, and status-neutral referrals. Section III data highlight continued disparities in HIV diagnoses and differences in PrEP awareness and uptake across populations. Stakeholders identified the need for clearer referral pathways, stronger coordination between testing sites and PrEP providers, and expanded access points in emergency departments, community clinics, reentry settings, and other nontraditional service locations.

The fourth priority is strengthening the systems needed to support implementation, accountability, and community leadership. This includes improving data infrastructure, workplan tracking, public reporting, and ongoing review of goals, objectives, and strategies. It also includes maintaining meaningful involvement of PLWH, people accessing prevention services, and communities disproportionately impacted by HIV through Evaluation Committee meetings, Fast Track Counties meetings, the HIV Task Force, annual reviews, and other feedback opportunities.

Ongoing Engagement and Accountability

Community involvement will continue beyond plan development through quarterly Fast Track Counties meetings, annual reviews of plan progress, Ryan White Planning Council activities, and Dallas HIV Task Force engagement. Quarterly Fast Track Counties meetings will provide a dedicated space to review implementation progress, identify barriers, elevate emerging needs, and discuss whether strategies are reaching priority populations. Annual reviews will be used to assess progress on goals, objectives, strategies, and outcomes, including areas of success and areas where disparities or service gaps persist. Following submission of the

Integrated Plan, DCHHS will also work to develop a public-facing online dashboard to show clear progress on goals, objectives, and strategies; highlight accomplishments; and identify areas of opportunity that may need additional coordination, scale-up, or support. These ongoing structures are intended to support transparency, accountability, and continued community and stakeholder involvement throughout the life of the plan.

SECTION 3: Contributing Data Sets & Assessments

Data Sharing and Use

The data discussed throughout this section come from several public health, clinical, programmatic, and population-based sources used to support assessment and planning across North Texas. Core sources include DCHHS, DSHS, CDC surveillance and reporting systems, Ryan White program data, Medicaid and ADAP utilization data, and U.S. Census population estimates. Needs assessment and stakeholder experience data provide another source of community and provider feedback. Together, these data help the jurisdiction understand HIV trends, service needs, health outcomes, disparities, and community priorities.

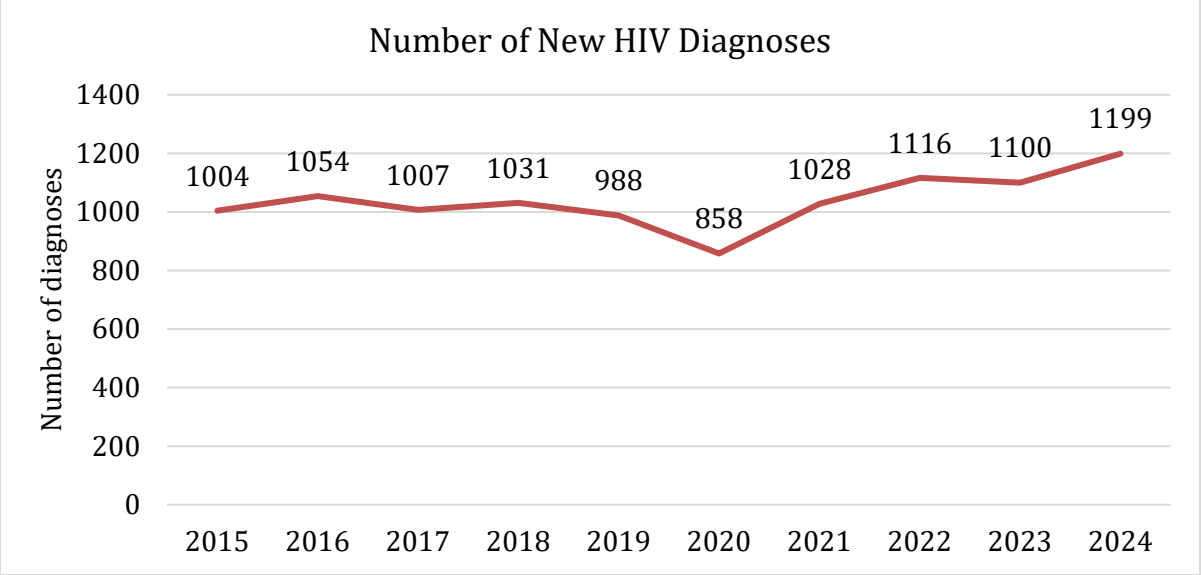
As the Ryan White Part A administrative agency and a public health funder, DCHHS does not rely on broad jurisdiction-wide data-use agreements for all planning data. Much of the programmatic data used for planning is collected through contracts with funded providers. DCHHS currently contracts with 13 community-based, clinical, and service organizations that submit routine service, utilization, and performance data for grant reporting, monitoring, quality management, service gap analysis, and planning. Other data are made available through public health reporting systems, state and federal reporting mechanisms, surveillance activities, and public datasets. These sources are used to assess service delivery, identify gaps, monitor progress, inform goals, objectives, and strategies, and support Integrated Plan implementation tracking. Data are reviewed in aggregate or de-identified form whenever applicable to protect client confidentiality.

Epidemiologic Snapshot

Populations with Newly Acquired HIV

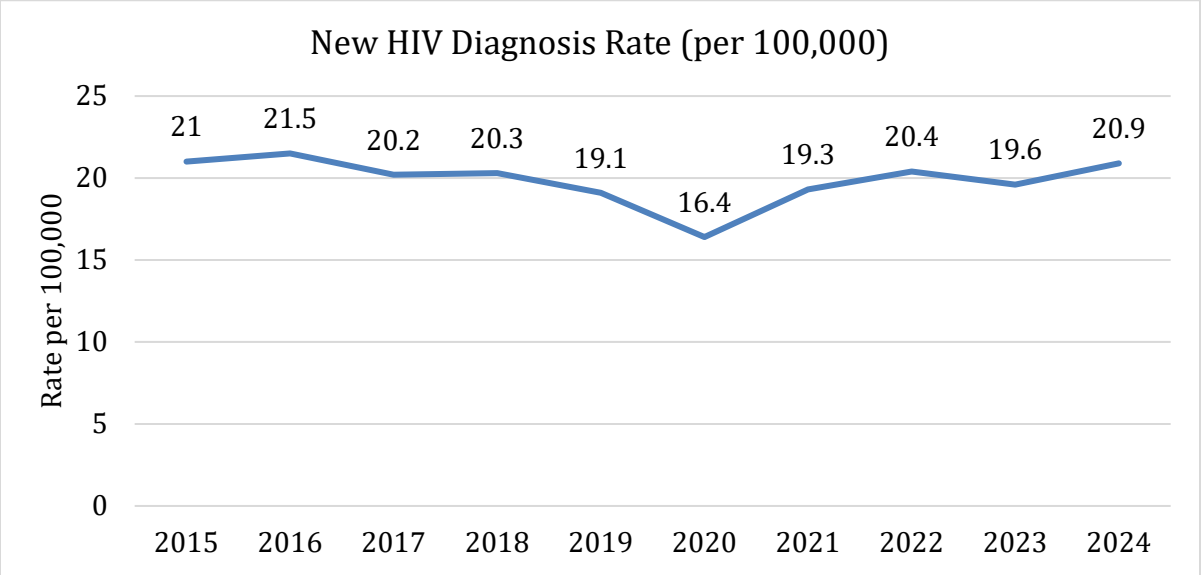
Current data trends in the Dallas EMA demonstrate a gradual increase in new HIV diagnoses, following the decline observed during the COVID-19 pandemic, with the lowest number of new diagnoses reported in 2020 (Figure 1). This decline likely reflects the disruptions in routine healthcare utilization during the pandemic period, including reduced access to HIV screening, testing, and other preventive healthcare services. Figure 2 further contextualizes these trends by presenting diagnosis rates standardized per 100,000 population between 2015–2024, allowing for more accurate year-to-year comparisons despite changes in population across the region. From 2015 to 2024, new HIV diagnoses in the Dallas EMA increased from 1,004 to 1,199. While annual counts fluctuated during the period, this reflects an average increase of approximately 22 diagnoses per year, or an average annual percent increase of 2.4%. These increases are likely influenced by more targeted testing efforts, expanded opt-out testing locations, and improved identification of people with HIV in emergency room settings, rather than reflecting a confirmed increase in new HIV transmission.

Figure 1: Dallas EMA new HIV diagnoses, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Figure 2: Dallas EMA new HIV diagnoses rate per 100,000, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

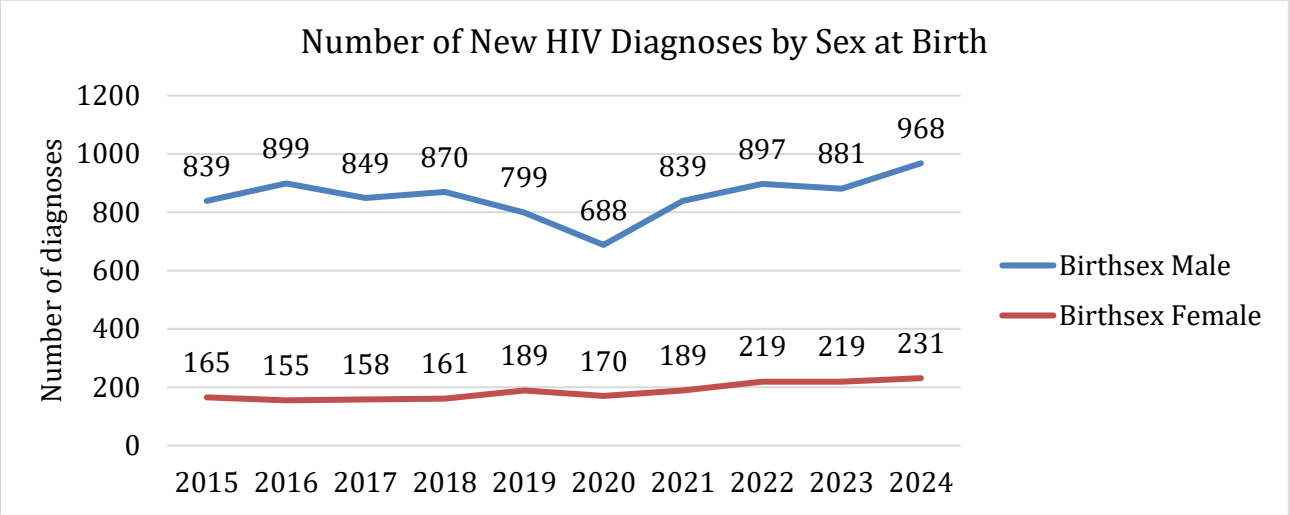
Sex

The demographic distribution of new diagnoses by sex reflects broader trends in HIV diagnoses across the Dallas EMA. Figure 3 shows that males continue to account for substantially higher numbers of new HIV diagnoses compared to females, consistent with long-standing regional, state, and national HIV trends. Across the 2015–2024 period, males represented approximately 82% of new HIV diagnoses in the Dallas EMA, while females represented approximately 18%. However, the rate-based data in Figure 4 provide important additional context. Although the number of new diagnoses among males increased, the rate among males decreased slightly from 35.6 to 34.0 per 100,000, representing a 4.5% decline. This suggests that the increase in the number of male diagnoses did not outpace growth in the male population and may reflect progress in reducing new diagnoses relative to population size.

In contrast, both the number and rate of new diagnoses among females increased over the same period. Female diagnoses increased from 2015 to 2024, while the rate increased from 6.8 to 8.0 per 100,000, representing a

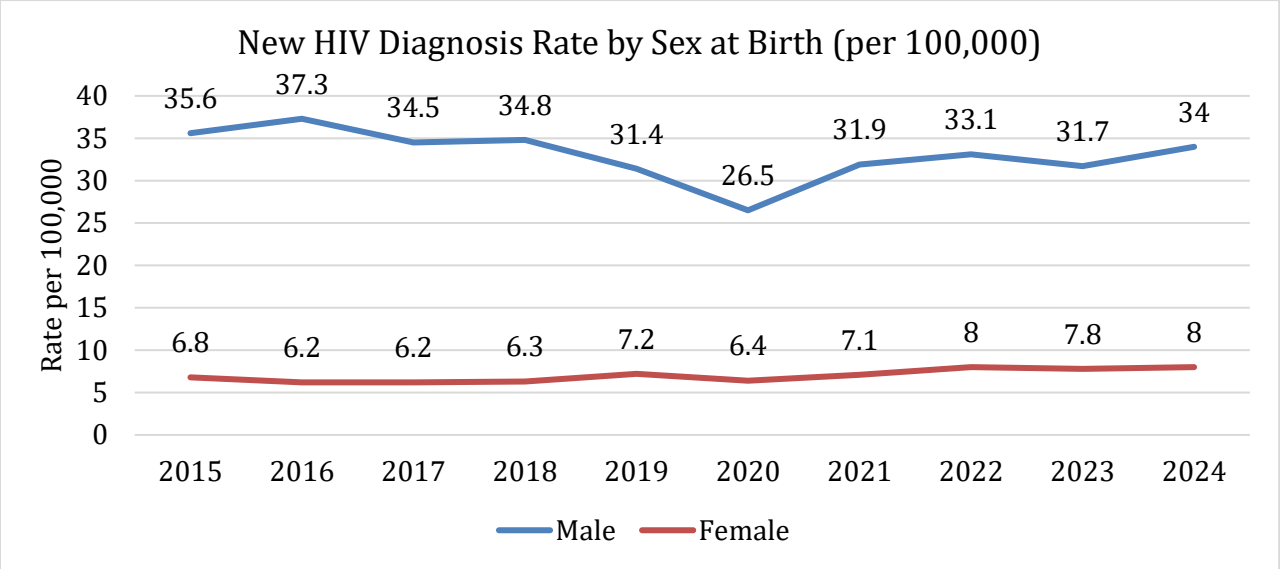
17.6% rate increase. This finding suggests that the increase among females is not explained by population growth alone and should be monitored as an emerging trend. The increase may be partially influenced by increased prioritization in local HIV prevention efforts, including funding and initiatives that specifically seek to increase HIV screening among Black women. Taken together, Figures 3 and 4 show that males continue to account for the majority of new diagnoses, while the rate of new diagnoses among females has increased more notably over time.

Figure 3: Dallas EMA new HIV diagnoses by sex assigned at birth, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Figure 4: Dallas EMA new HIV diagnosis rate per 100,000 by sex assigned at birth, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Age Group

New HIV diagnoses in the Dallas EMA remain concentrated among adults ages 25–44, with the 25–34 age group consistently accounting for the highest number of new diagnoses across the ten-year period. From 2015 to 2024, diagnoses among individuals ages 25–34 increased by 37.5%. Diagnoses among individuals ages 35–44 also increased over the period, rising by approximately 40% based on the trend shown in Figure 5. In contrast,

diagnoses among individuals ages 15–24 declined overall, suggesting a shift in the age distribution of newly identified diagnoses toward adults in their late twenties through early forties.

Other age groups experienced lower overall numbers but show important differences in direction. Diagnoses among individuals ages 45–54 remained relatively stable with a slight overall decline, while diagnoses among individuals ages 55–64 increased from a smaller baseline. Diagnoses among individuals ages 0–14 and 65 and older remained comparatively low throughout the period. Figure 6 further contextualizes these patterns by presenting diagnosis rates standardized per 100,000 population, allowing for more accurate comparison across age groups over time. Overall, the data indicate that new diagnoses continue to be concentrated among adults ages 25–44, with the most notable growth occurring among individuals ages 25–34.

Figure 5: Dallas EMA new HIV diagnoses by age group, 2015-2024

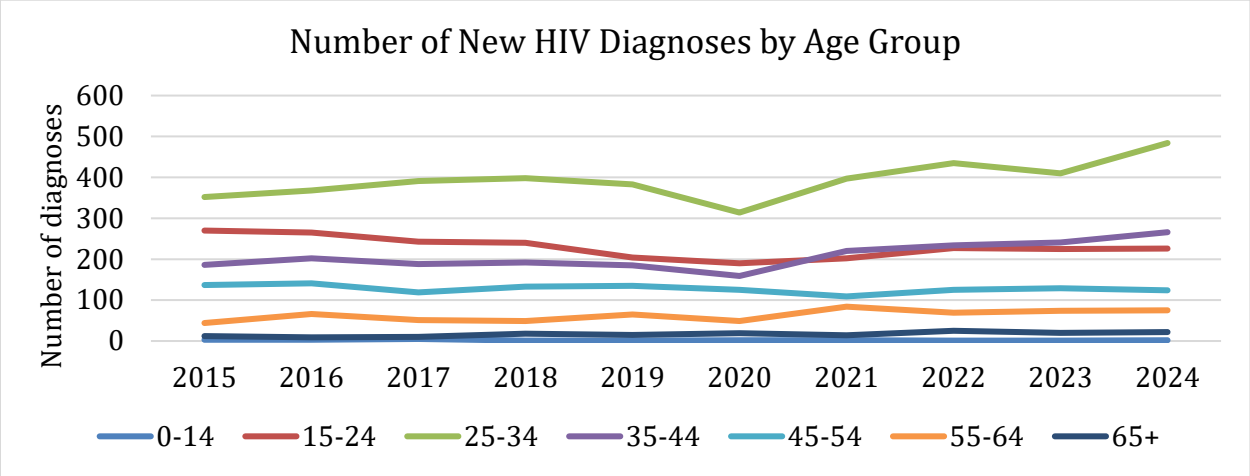
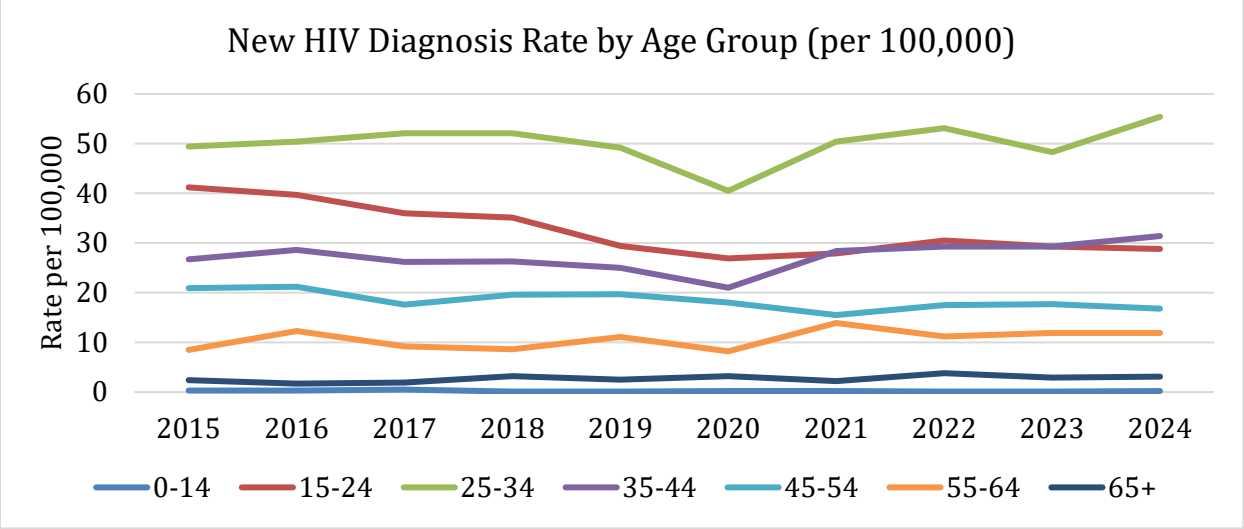


Figure 6: Dallas EMA new HIV diagnosis rate per 100,000 by age group, 2015-2024



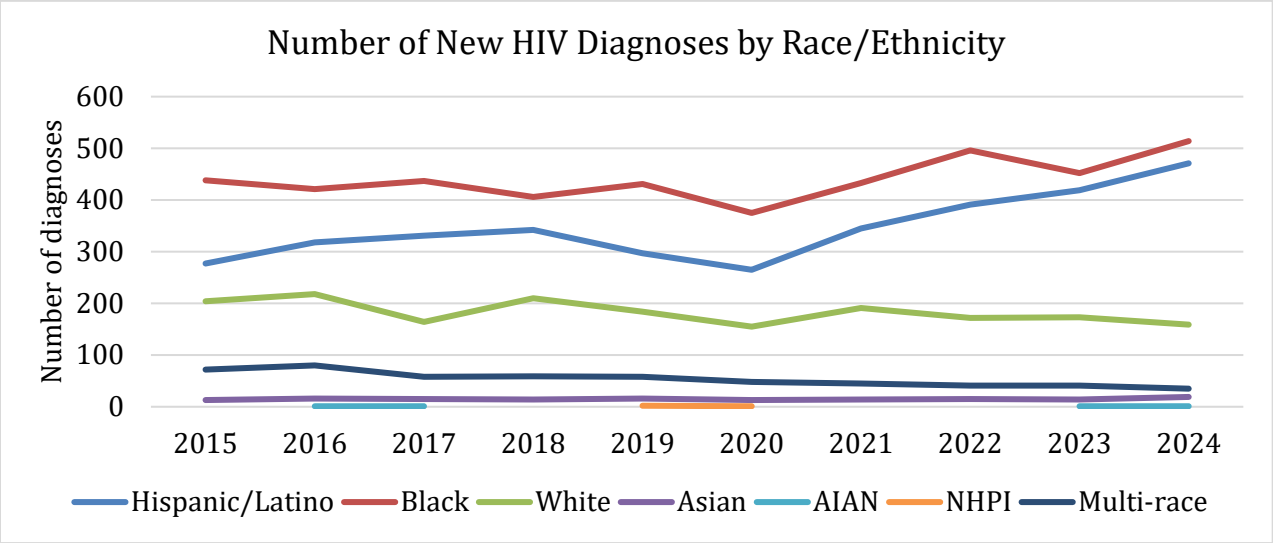
Source: DSHS HIV/STI Surveillance Unit. September 2025.

Race and Ethnicity

New HIV diagnoses in the Dallas EMA continue to show substantial racial and ethnic disparities. As shown in Figure 7, Black/African American individuals accounted for the highest number of new diagnoses throughout most

of the 2015–2024 period and remained the largest proportion of new diagnoses in 2024. Hispanic/Latino individuals experienced the most notable increase over the decade, with diagnoses rising substantially from 2015 to 2024 and reaching a level that now closely approaches the number of diagnoses among Black/African American individuals. In contrast, diagnoses among White individuals declined overall during the same period. Diagnoses among Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and multiracial populations remained comparatively lower in number, though smaller counts should be interpreted with caution because year-to-year changes can appear more pronounced in smaller populations.

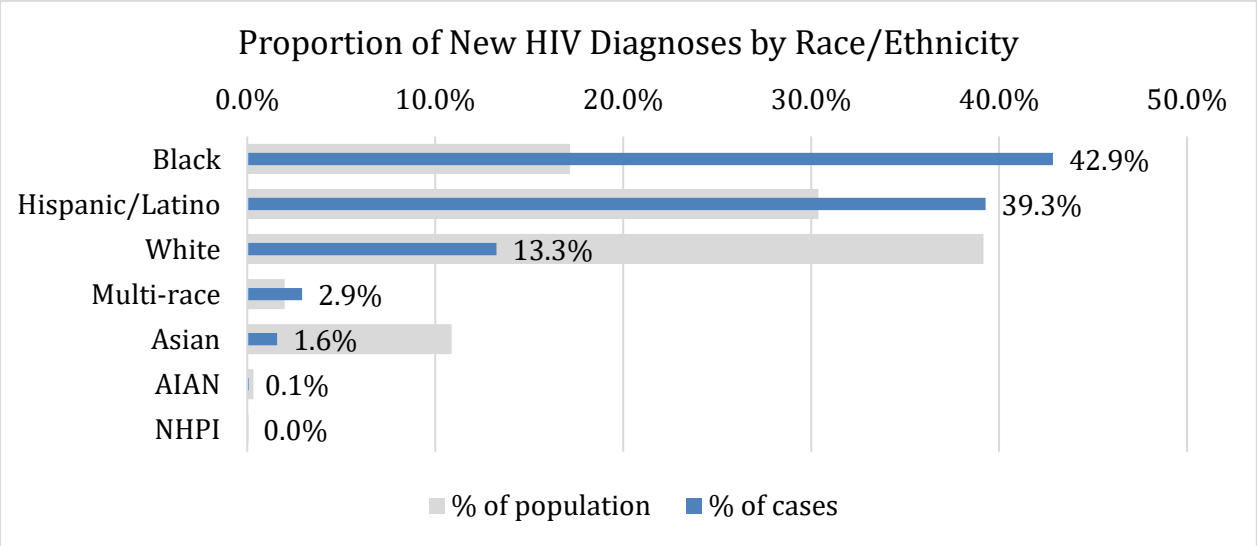
Figure 7: Dallas EMA new HIV diagnoses by race/ethnicity, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Figure 8 provides additional context by comparing each racial and ethnic group's share of 2024 new diagnoses with its share of the overall Dallas EMA population. Black/African American individuals represented 17.2% of the Dallas EMA population but accounted for 42.9% of new HIV diagnoses, indicating a disproportionate burden relative to population size. Hispanic/Latino individuals accounted for 39.3% of new diagnoses compared with approximately 30.4% of the EMA population, indicating overrepresentation among new diagnoses, though the disparity was less pronounced than among Black/African American residents. White individuals represented a much larger share of the population than of new diagnoses, accounting for 13.3% of new diagnoses in 2024. Together, these figures show that the burden of new HIV diagnoses is most concentrated among Black/African American and Hispanic/Latino communities, with Black/African American residents experiencing the greatest disparity relative to population size.

Figure 8: Dallas EMA proportion of new HIV diagnoses by race/ethnicity, 2024



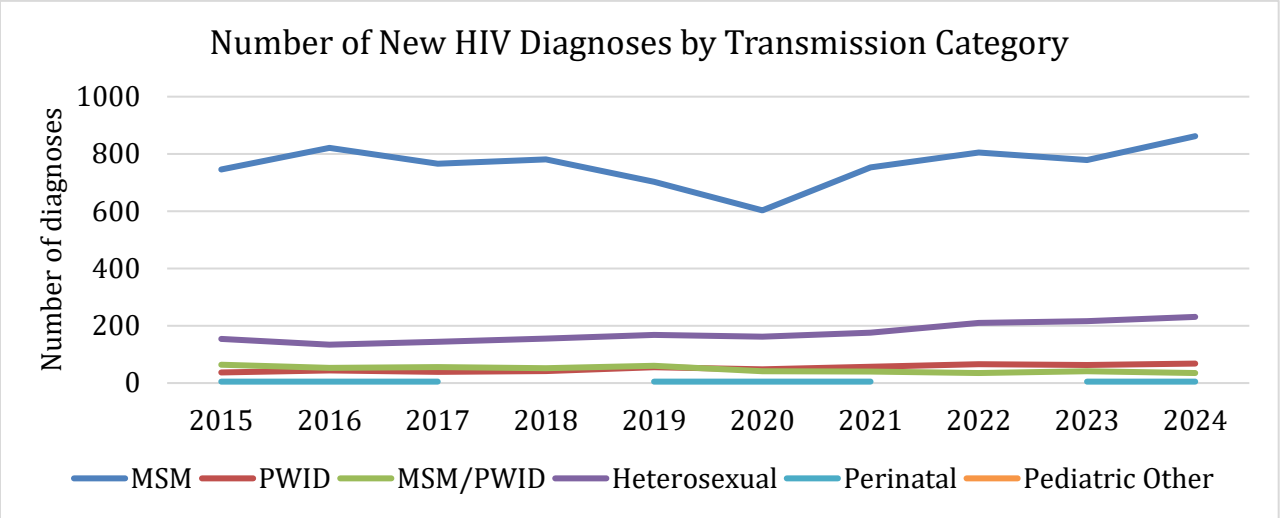
Source: DSHS HIV/STI Surveillance Unit. September 2025.

Mode of Transmission

Analysis of transmission categories shows that male-to-male sexual contact remains the primary reported mode of HIV transmission in the Dallas EMA. As shown in Figure 9, diagnoses among MSM remained substantially higher than all other transmission categories across the period. After some fluctuation over time, MSM diagnoses increased by about 15%. Heterosexual transmission was the second most common reported category and also increased over the decade, increasing by nearly 48%. Diagnoses associated with injection drug use, MSM/injection drug use, perinatal exposure, and pediatric other transmission remained comparatively low throughout the period.

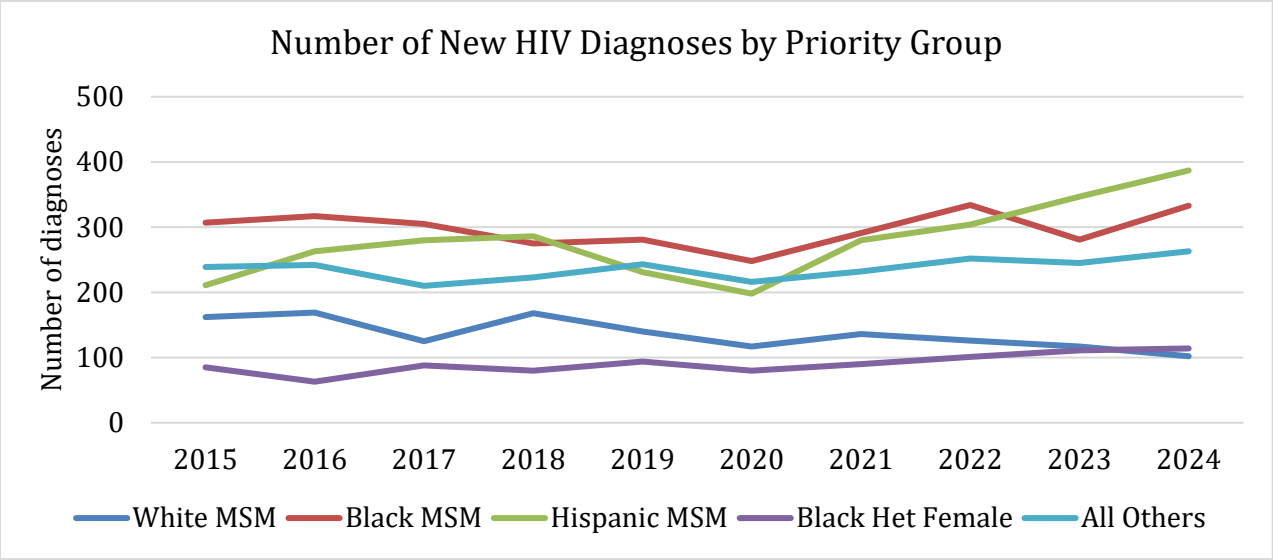
Figure 10 provides additional detail on priority groups within transmission categories. Hispanic MSM experienced the most pronounced increase at around 83%. Black MSM also remained consistently high throughout the period and increased overall by approximately 8%. Historically, Black MSM accounted for the highest number of diagnoses among priority groups; however, Hispanic MSM surpassed Black MSM in 2023 and 2024. White MSM diagnoses declined overall, while diagnoses among Black heterosexual females remained relatively stable with a slight increase by 2024. Overall, these figures show that male-to-male sexual contact continues to account for the largest share of new diagnoses, with the most notable recent growth occurring among Hispanic MSM.

Figure 9: Dallas EMA new HIV diagnoses by transmission category, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Figure 10: Dallas EMA new HIV diagnoses by priority group, 2015-2024



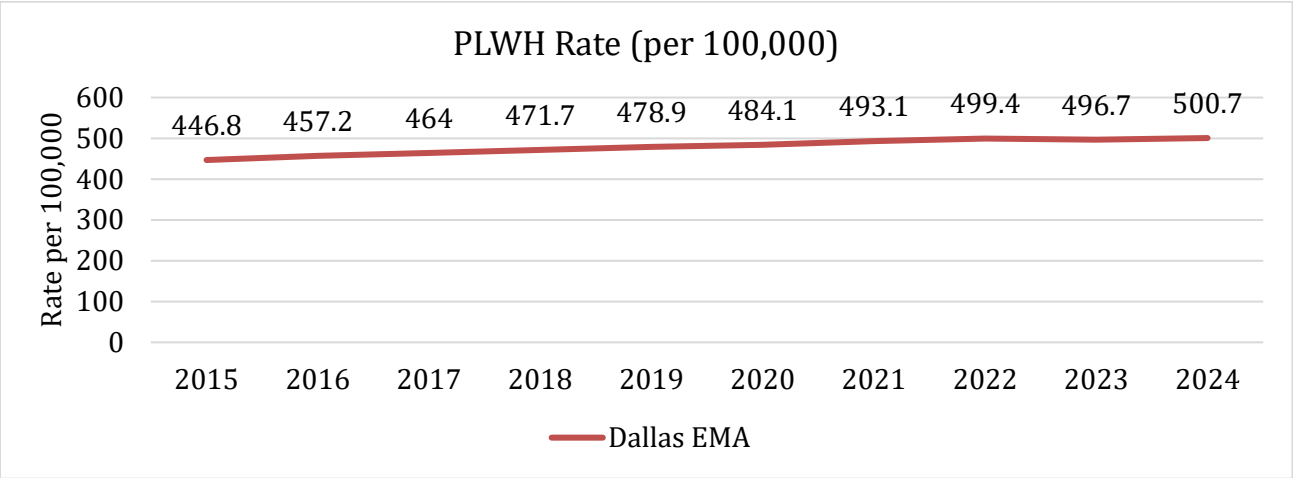
Source: DSHS HIV/STI Surveillance Unit. September 2025.

People Living with HIV and Undiagnosed HIV

While new diagnosis data are essential for understanding where HIV is currently being identified, data on people living with HIV (PLWH) provide important context for the broader and ongoing impact of HIV across the Dallas EMA. Together, these measures help distinguish between trends in newly identified cases and the long-term service, treatment, and care needs of people already diagnosed and living with HIV.

From 2015 to 2024, the number of PLWH in the Dallas EMA increased from 21,399 to 28,687, representing a 34.1% increase. When adjusted for population size, the rate increased around 12% (Figure 11). This steady increase likely reflects several factors, including longer life expectancy for people with HIV, ongoing linkage to care, increased awareness of HIV status, and continued identification of individuals who were previously undiagnosed.

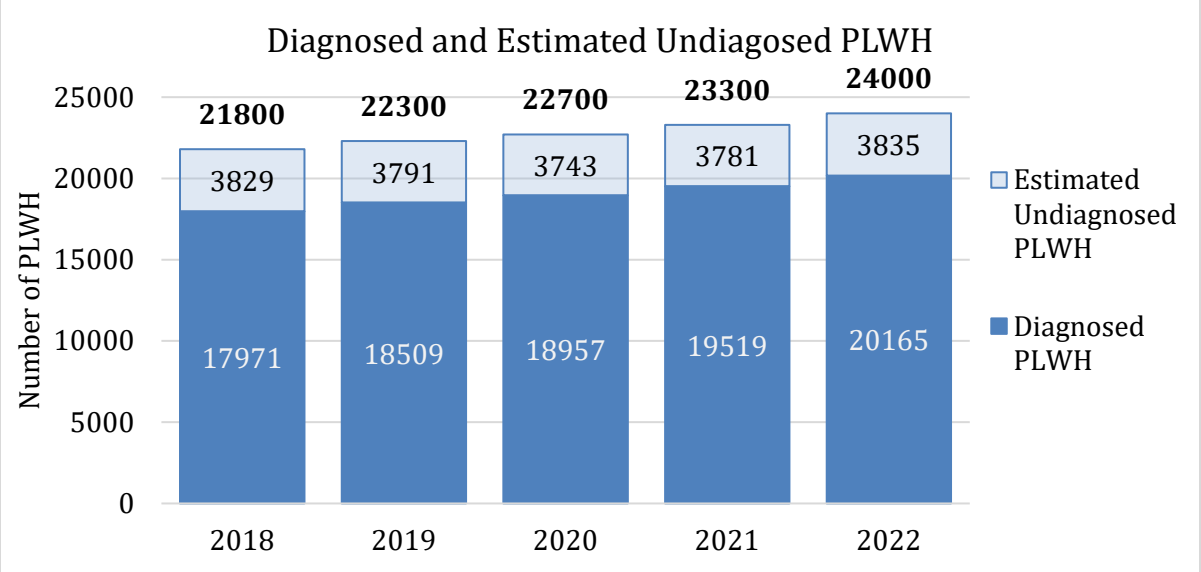
Figure 11: Dallas EMA PLWH rate per 100,000, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

The distinction between diagnosed and undiagnosed HIV is particularly important for interpreting trends in new diagnoses. Increased new diagnoses do not necessarily indicate increased HIV transmission. In some cases, they may reflect successful testing strategies that are identifying people who were previously living with HIV but unaware of their status. According to CDC estimates, approximately 24,000 people were living with HIV in Dallas County in 2022, including both diagnosed and undiagnosed individuals. Based on available estimates, the proportion of PLWH who had received a diagnosis increased from 82% in 2018 to 84% in 2022 (Figure 12). This indicates progress in status awareness, while also showing that a portion of PLWH remain undiagnosed.

Figure 12: Dallas County diagnosed and estimated undiagnosed PLWH, 2018-2022



Source: Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2018-2022.

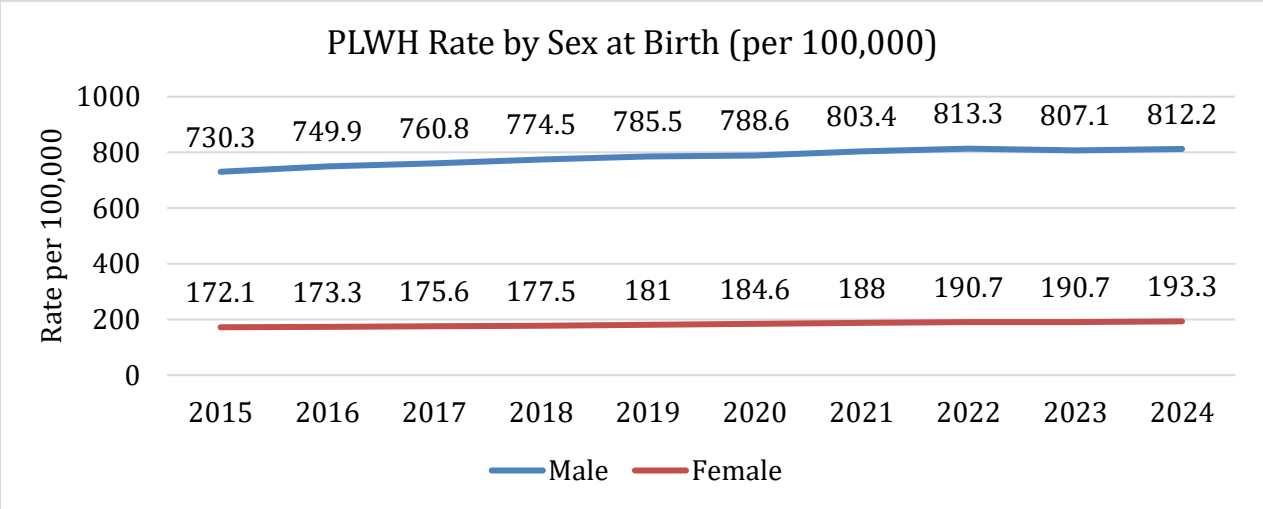
People Living with HIV by Sex

Among PLWH in the Dallas EMA, males continue to represent the majority of cases. From 2015 to 2024, the rate among males increased 11.2%. Among females, the rate increased at 12.3%. Although the relative increase was

similar across both groups, the 2024 rate among males was more than four times the rate among females (Figure 13).

This trend is consistent with the new diagnosis data in showing that males continue to account for most HIV cases in the Dallas EMA. However, the data also show that rates among females have increased over time. This means that while males remain the larger share of both new diagnoses and PLWH, the gradual increase among females is still an important trend to monitor, particularly as local testing and screening initiatives continue to expand.

Figure 13: Dallas EMA PLWH rate per 100,000 by sex assigned at birth, 2015-2024



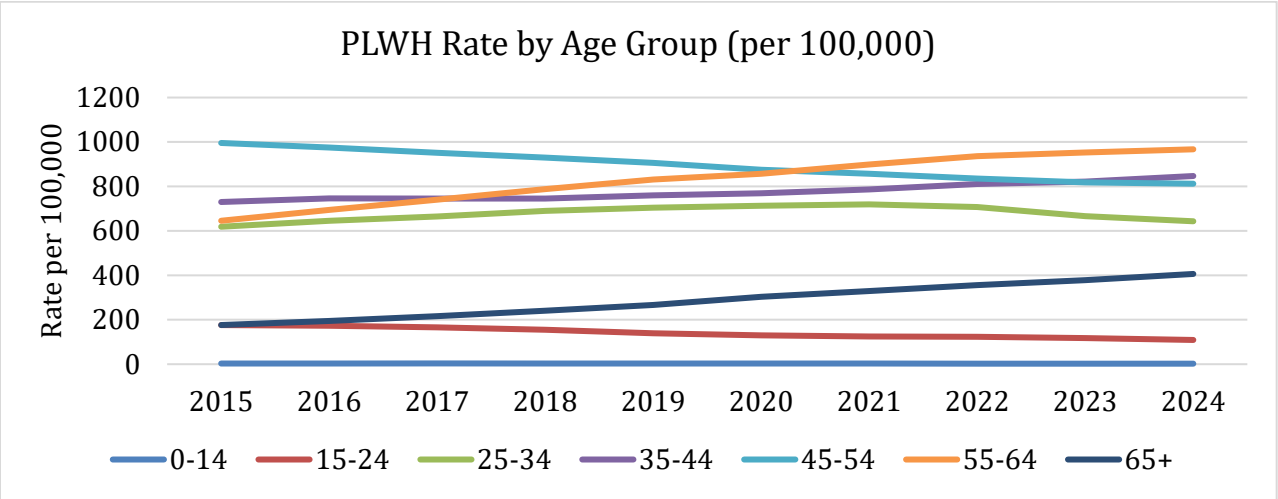
Source: DSHS HIV/STI Surveillance Unit. September 2025.

People Living with HIV by Age

The age distribution of PLWH differs from the age distribution of new diagnoses. New diagnosis data show that adults ages 25–34 account for the highest number of newly identified cases (Figure 6). However, among PLWH, the trend shifts older, with adults ages 35–44 and 45–54 representing a larger share of the diagnosed population (Figure 14). This reflects the cumulative nature of HIV prevalence, where people diagnosed in earlier years continue to age while living with HIV.

The rate-based figure provides important context because it allows comparison across age groups with different population sizes. From 2015 to 2024, the rate among individuals ages 35–44 increased by 16.0%. The increase among individuals ages 55–64 was more substantial, rising by 49.8% over the same period. This trend suggests that the Dallas EMA is experiencing the broader national pattern of an aging population of PLWH, likely reflecting long life expectancy and sustained engagement in HIV care.

Figure 14: Dallas EMA PLWH rate per 100,000 by Age Group, 2015-2024



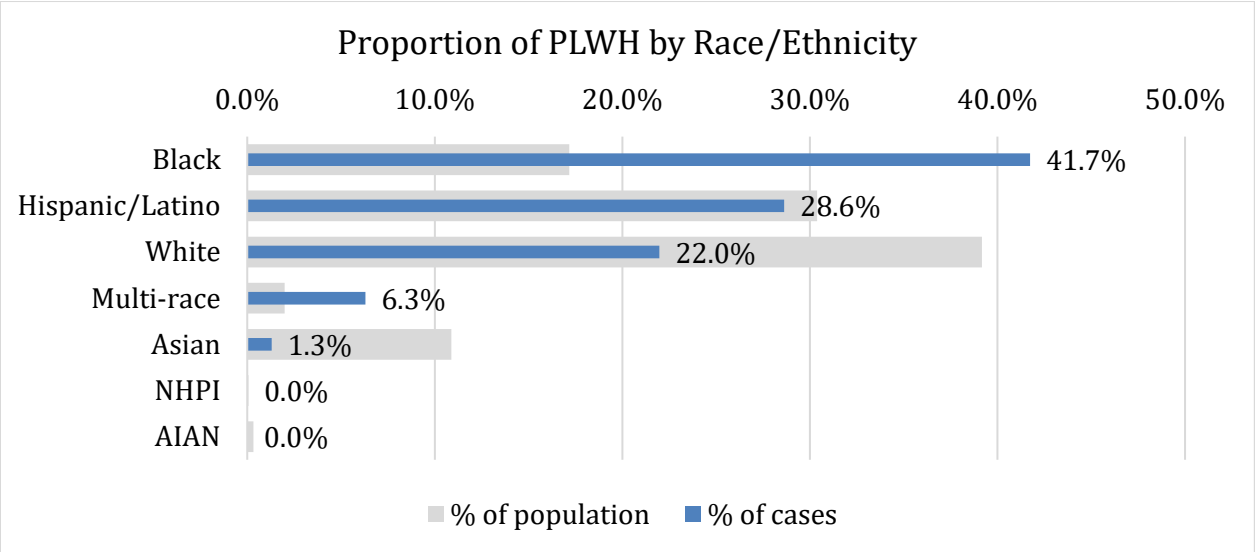
Source: DSHS HIV/STI Surveillance Unit. September 2025.

People Living with HIV by Race and Ethnicity

Race and ethnicity trends among PLWH show persistent disparities across the Dallas EMA. Black/African American individuals represent the largest share of PLWH, followed by Hispanic/Latino individuals. In 2024, Black/African American individuals accounted for 41.7% of PLWH, while Hispanic/Latino individuals accounted for 28.6%. Together, these two groups represented 70.3% of PLWH in the Dallas EMA.

This pattern is similar to new diagnosis data, where Black/African American and Hispanic/Latino communities also account for the largest share of new diagnoses. However, the comparison between new diagnoses and total people living with HIV is important. New diagnoses among Hispanic/Latino individuals have increased more sharply in recent years, while Black/African American individuals continue to experience the highest burden among PLWH overall. This suggests both a persistent long-term disparity among Black/African American communities and an emerging or increasing concentration of new diagnoses among Hispanic/Latino communities.

Figure 15: Dallas EMA proportion of PLWH by race/ethnicity, 2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

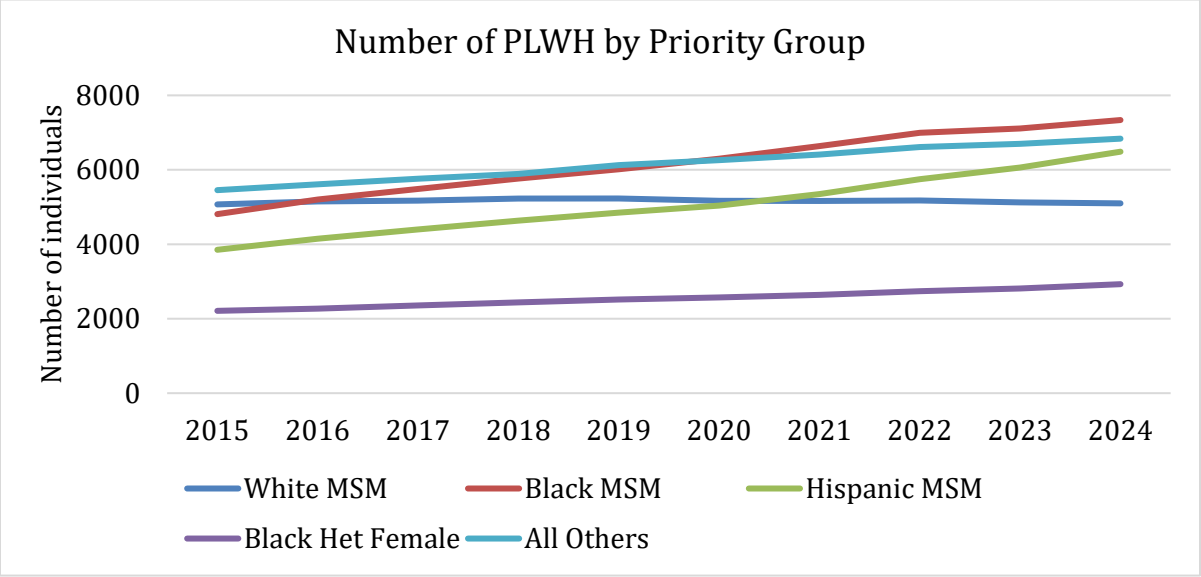
People Living with HIV by Transmission Category and Priority Group

Among PLWH in the Dallas EMA, male-to-male sexual contact remains the most common reported transmission category. This mirrors the new diagnosis data, where MSM also represent the largest transmission category. Other transmission categories remained substantially lower over time, though heterosexual transmission continues to represent an important share of both new diagnoses and PLWH.

Priority group data provide a more detailed view of how transmission category intersects with race and ethnicity. Among MSM, Black MSM and Hispanic MSM represent the largest groups of PLWH. This aligns with new diagnosis data showing that Hispanic MSM have increased substantially in recent years. At the same time, the number of Black MSM living with HIV remains high, reflecting the long-standing cumulative burden of HIV in this population.

The "All Other" priority group also increased in recent years and now approaches the levels seen among Black MSM and Hispanic MSM. This trend should be interpreted carefully because the category combines multiple populations and may reflect changes in classification, reporting, or shifts across smaller groups. Still, it is useful to note because it suggests that the population of PLWH is not static and that trends outside the largest named priority groups should continue to be monitored.

Figure 16: Dallas EMA PLWH by priority group, 2015-2024



Source: DSHS HIV/STI Surveillance Unit. September 2025.

Socioeconomic and Geographic Characteristics

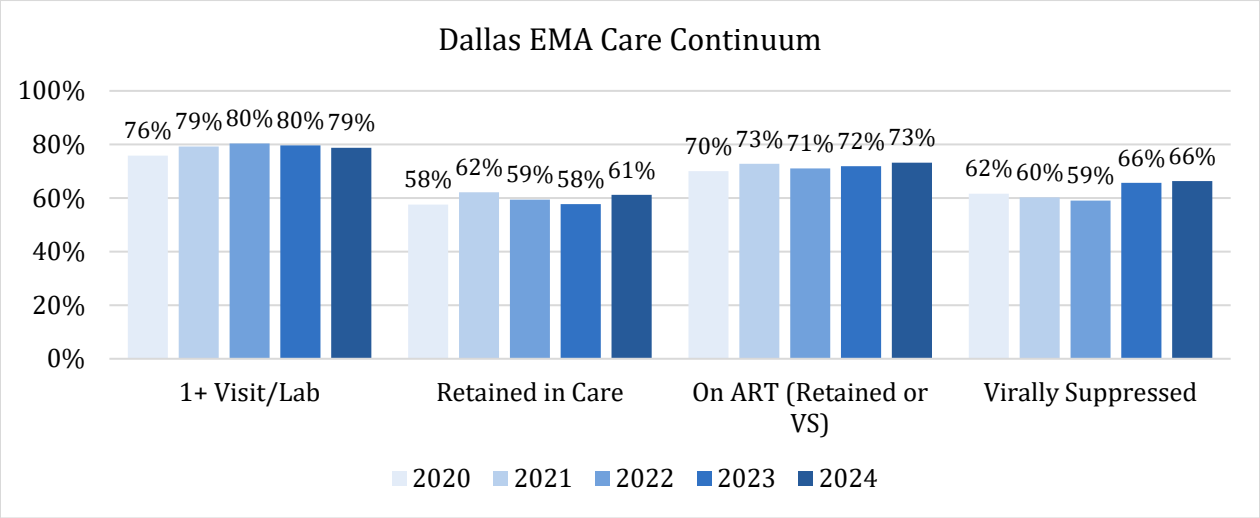
Socioeconomic and geographic factors continue to shape HIV prevention and care access across the Dallas EMA. Needs assessment and consumer experience data identified transportation, housing instability, insurance gaps, food insecurity, medication access, dental care delays, mental health needs, substance use needs, and administrative burden as recurring barriers to care. These barriers are particularly important in suburban and rural parts of the service area where HIV-specific services may be less geographically accessible. The concentration of Ryan White and HIV specialty services in and around Dallas creates access challenges for residents who live farther from core service locations, particularly those with limited transportation, unstable housing, limited income, or competing basic needs. These findings support continued investment in mobile

services, care navigation, transportation support, housing coordination, telehealth or decentralized service options, and stronger referral systems across the region.

The HIV Care Continuum

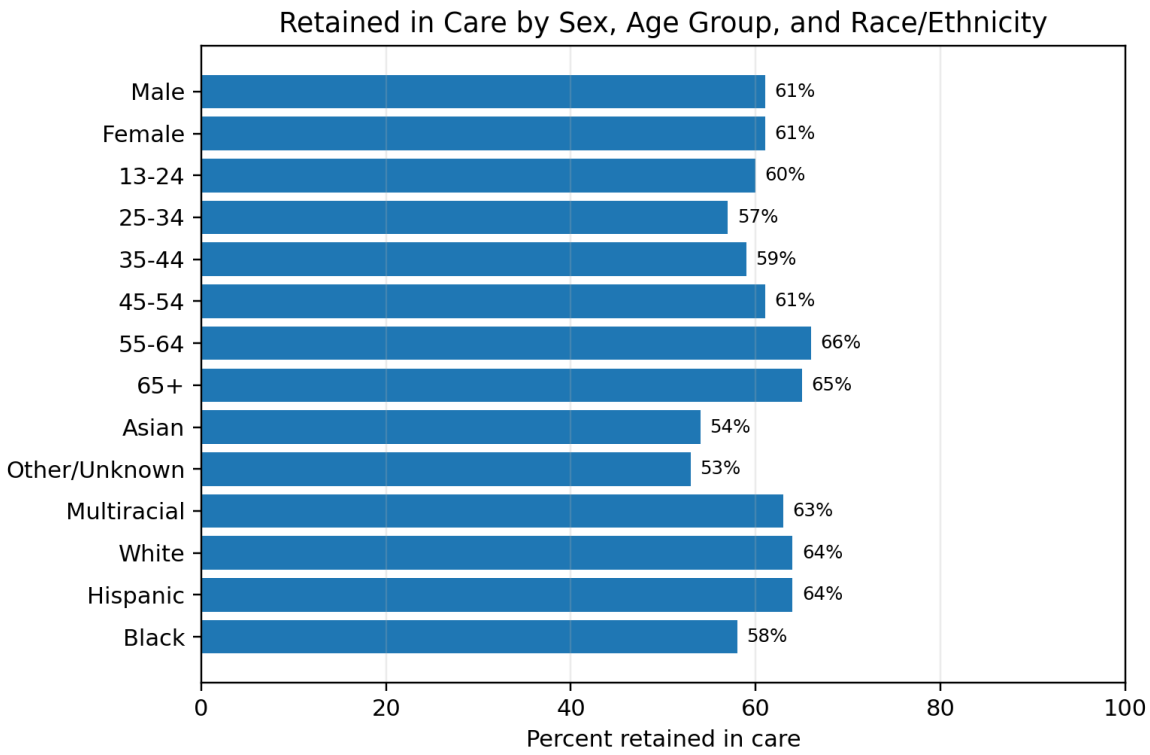
Figure 17 shows that the Dallas EMA care continuum remained relatively stable from 2020 to 2024. In 2024, 79% of PLWH had at least one visit or laboratory test, 61% were retained in care, 73% were on ART, and 66% were virally suppressed. Because retention in care is the lowest-performing continuum measure, Figure 18 provides additional detail on retention by sex, age, and race/ethnicity. Retention varied by age and race/ethnicity, but small population groups should be interpreted with caution because small denominators can produce unstable percentages. Among larger population groups, retention was lowest among Black PLWH, followed by Hispanic and White PLWH. By age, retention was lowest among adults ages 25–34, followed by adults ages 35–44 and youth/young adults ages 13–24. These patterns suggest that retention strategies should prioritize younger adults and Black PLWH while continuing to monitor smaller racial and ethnic groups as data allow.

Figure 17: Dallas EMA Care Continuum by Percentage



Source: Enhanced HIV AIDS Reporting System as of Aug 1, 2025, Medicaid, ELR, Ryan White Services data (TCT), and ADAP

Figure 18: PLWH Retained in Care by Sex, Age, and Race/Ethnicity



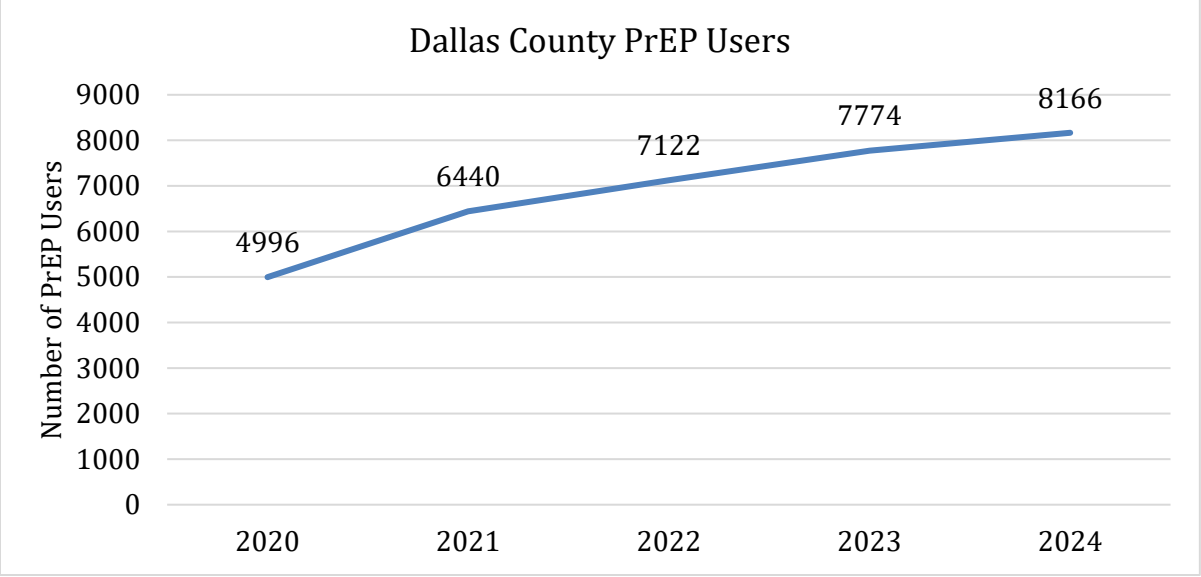
Source: Enhanced HIV AIDS Reporting System as of Aug 1, 2025, Medicaid, ELR, Ryan White Services data (TCT), and ADAP

Taken together, the HIV epidemiologic profile suggests that interventions for people living with HIV in the Dallas EMA should focus most heavily on sustained engagement in care, retention, and viral suppression. While the number of people living with HIV has increased over time, the care continuum shows that the largest drop-off occurs after initial evidence of care, with retention in care remaining the lowest-performing continuum measure. Demographic breakdowns further indicate that retention challenges are not evenly distributed, with lower retention among adolescents and younger adults, particularly those ages 13–44, and among Black PLWH and some smaller racial and ethnic groups. These patterns suggest that the greatest opportunity for impact is not only identifying and linking people to care, but helping them remain consistently engaged through re-engagement efforts, care navigation, transportation and benefits support, behavioral health and housing linkages, and other services that address barriers to ongoing care.

PrEP Usage

This section examines PrEP use as a key HIV prevention strategy in Dallas County. PrEP data provide insight into the extent to which biomedical prevention is reaching communities that may benefit from additional HIV prevention options. The figures below describe overall PrEP use over time, as well as differences by sex, age, and race/ethnicity. Together, these data help show where PrEP uptake has expanded and where additional attention may be needed to better understand gaps in awareness, access, prescribing, and ongoing use.

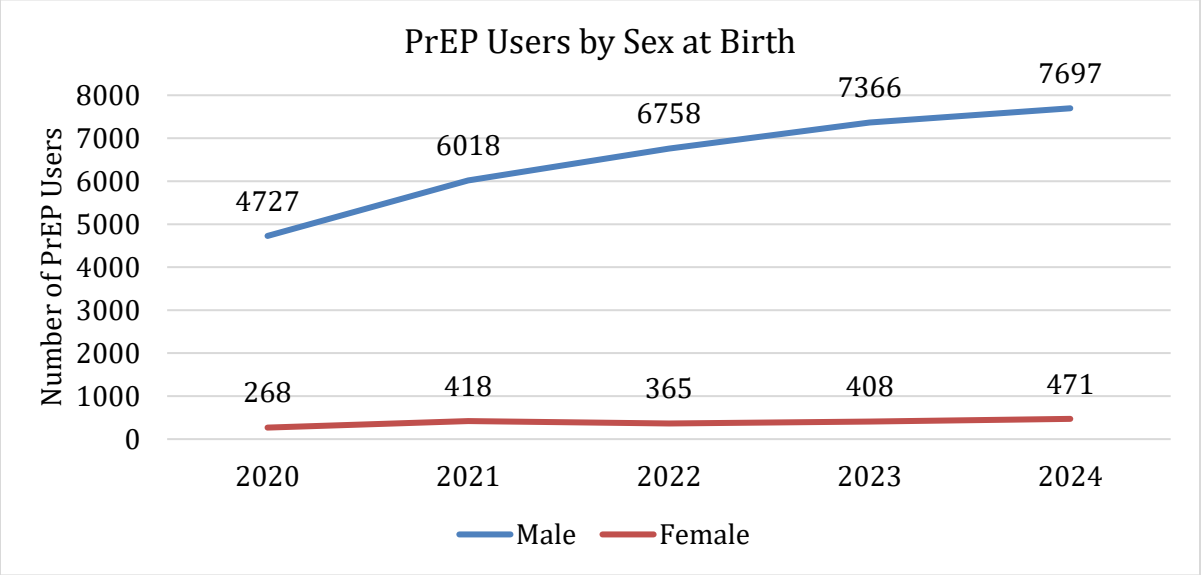
Figure 19. Dallas County PrEP Users



Source: AIDSVu Dallas County, TX. Prevention and Testing. April 2026.

Figure 19 shows steady growth in the number of Dallas County PrEP users from 2020 to 2024. The number of PrEP users increased approximately 63% over the five-year period. The largest year-to-year increase occurred between 2020 and 2021, followed by continued but more gradual growth from 2021 through 2024. This trend suggests that PrEP access and uptake have expanded in Dallas County, though the pace of growth has slowed in recent years.

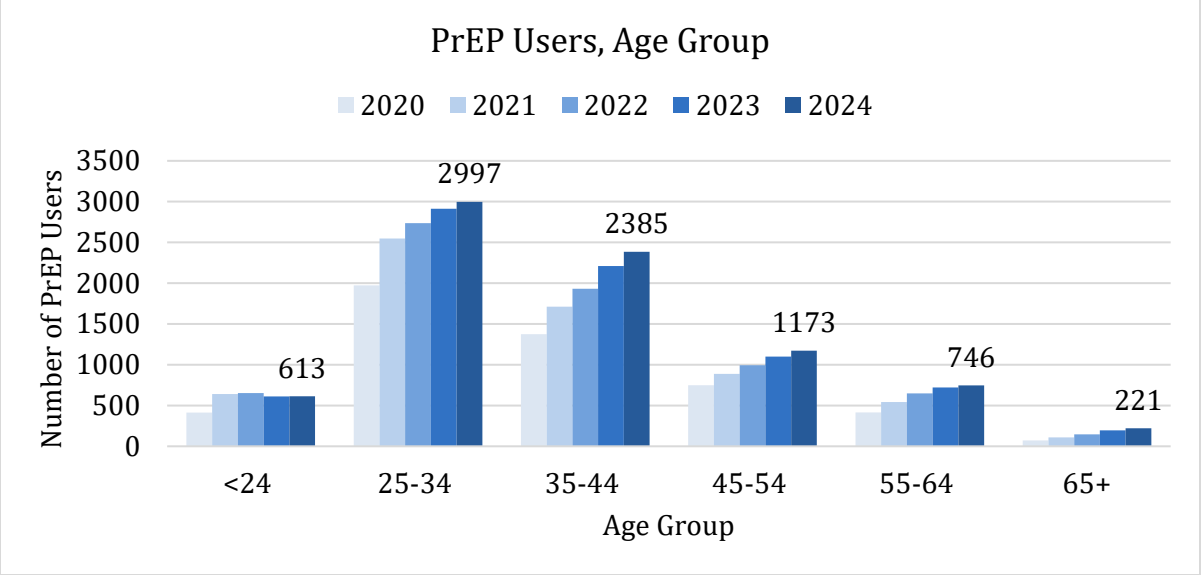
Figure 20. Dallas County PrEP Users by Sex at Birth



Source: AIDSVu Dallas County, TX. Prevention and Testing. April 2026.

Figure 20 shows that PrEP use in Dallas County remains heavily concentrated among males. In 2024, males accounted for approximately 94% of PrEP users, while females accounted for approximately 6%. This distribution was relatively consistent across the five-year period, indicating that although PrEP use increased for both males and females, the overall gender gap in PrEP uptake remained substantial. Female PrEP use increased from approximately 5% of users in 2020 to approximately 6% in 2024, showing modest proportional growth but continued underrepresentation among total PrEP users.

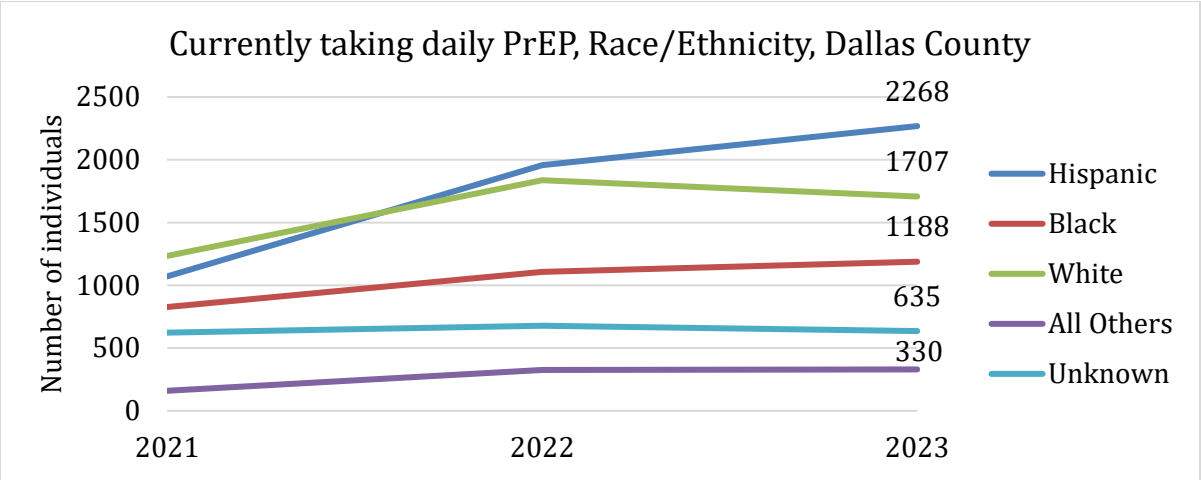
Figure 21. Dallas County PrEP Users by Age Group



Source: AIDSVu Dallas County, TX. Prevention and Testing. April 2026.

Figure 21 shows that PrEP use in Dallas County is concentrated among adults ages 25–44. In 2024, this age range accounted for approximately 66% of all PrEP users, making it the primary age group reached by current PrEP uptake. By comparison, people under age 24 represented approximately 8% of PrEP users, while adults ages 45 and older represented approximately 26%. PrEP use increased over time across most adult age groups, but the lower share among people under 24 may be important to examine alongside HIV diagnosis data, particularly if adolescents and young adults continue to represent a meaningful share of new diagnoses.

Figure 22. Dallas County PrEP Users by Race/Ethnicity

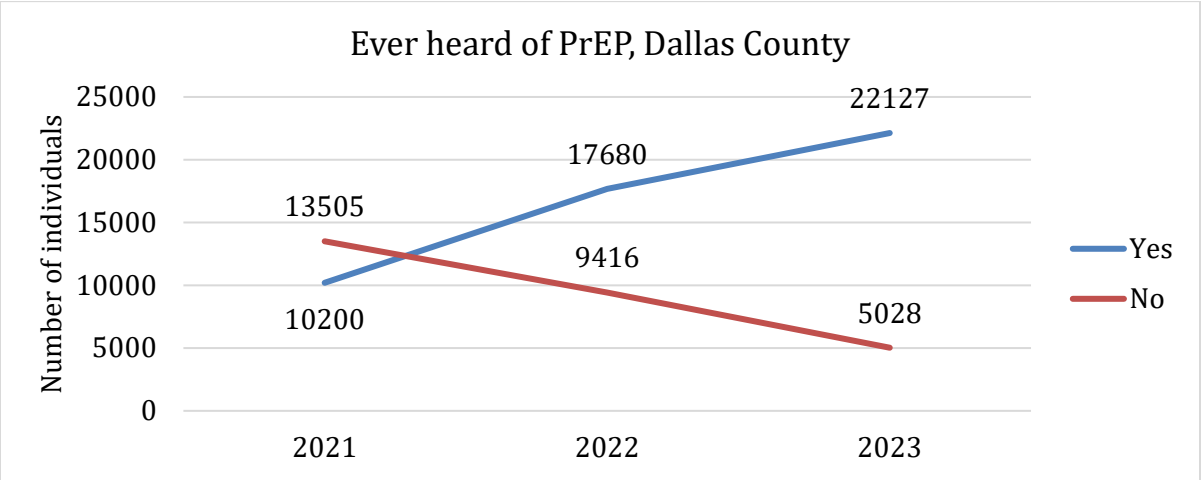


Source: EvaluationWeb, Dallas County, 2024.

Figure 22 shows differences in PrEP use by race and ethnicity from 2021 to 2023 among individuals represented in EvaluationWeb. By 2023, Hispanic residents represented the largest share of PrEP users at approximately 34%, followed by White residents at approximately 31% and Black residents at approximately 28%. Hispanic residents also showed the largest proportional increase over the period shown, growing from about 23% of PrEP users in 2021 to about 34% in 2023. During the same period, the share of PrEP users who were White decreased, while the share who were Black increased modestly but remained lower than both Hispanic and White residents. These data should be interpreted as a partial view of PrEP use and should not be treated as a

complete estimate of all PrEP use in Dallas County. The data are based on self-reported PrEP use among individuals receiving pre- and post-test counseling through CDC-funded HIV testing activities and do not include PrEP use reported through testing funded by other mechanisms or occurring outside of this data system.

Figure 23. Ever Heard of PrEP



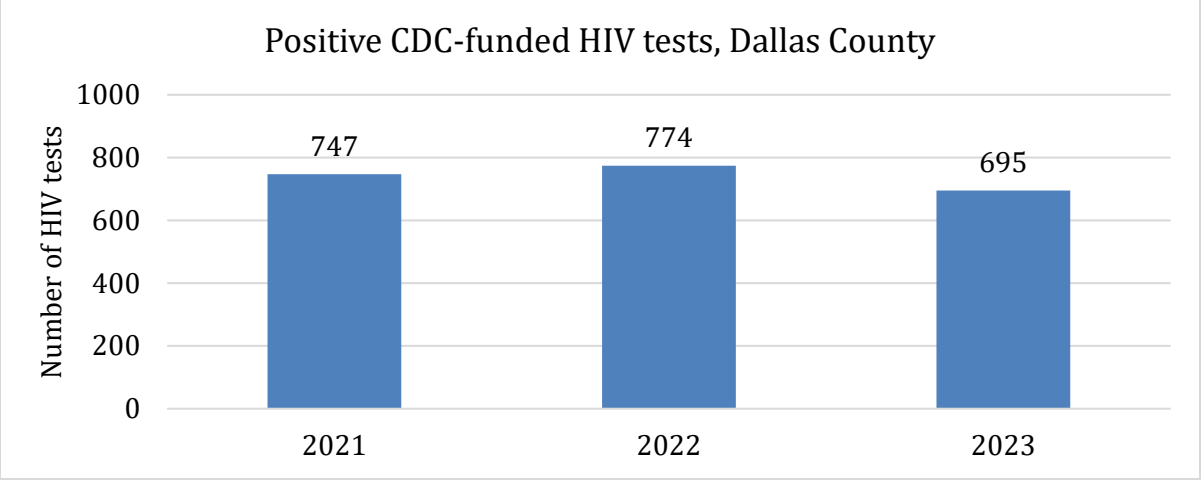
Source: EvaluationWeb, Dallas County, 2024.

Figure 23 shows a substantial increase in reported PrEP awareness from 2021 to 2023 among individuals represented in EvaluationWeb. The number of individuals reporting that they had heard of PrEP increased by approximately 117% during this period, while the number reporting that they had not heard of PrEP decreased by approximately 63%. This suggests that PrEP awareness efforts have improved over time among the population represented in the data. However, when viewed alongside the PrEP utilization data, awareness alone does not necessarily translate into PrEP use across all populations. Continued differences by sex, age, and race/ethnicity suggest that the next level of analysis should focus on where awareness, access, prescribing, and persistence may be breaking down for specific groups.

HIV Testing

HIV testing is an important component of ending the HIV epidemic. Comprehensive testing services support earlier detection of HIV, timely linkage to care, and earlier initiation of HIV treatment. Testing also serves as an important pathway to prevention services, including PrEP education, risk assessment, and referral or linkage to PrEP for individuals who test negative but may benefit from biomedical prevention. Testing data has historically been challenging to access across the full HIV service system because tests may be funded through multiple sources, including CDC prevention funding, private or public insurance, 340B resources, and other clinical or organizational funding streams. DCHHS is working to expand regional testing data analysis through EvaluationWeb and other relevant data systems. EvaluationWeb data are limited to CDC-funded tests and do not capture all HIV testing occurring in Dallas County. Despite these limitations, EvaluationWeb remains one of the most readily accessible sources for understanding CDC-funded HIV testing activity, positivity trends, and related prevention service patterns.

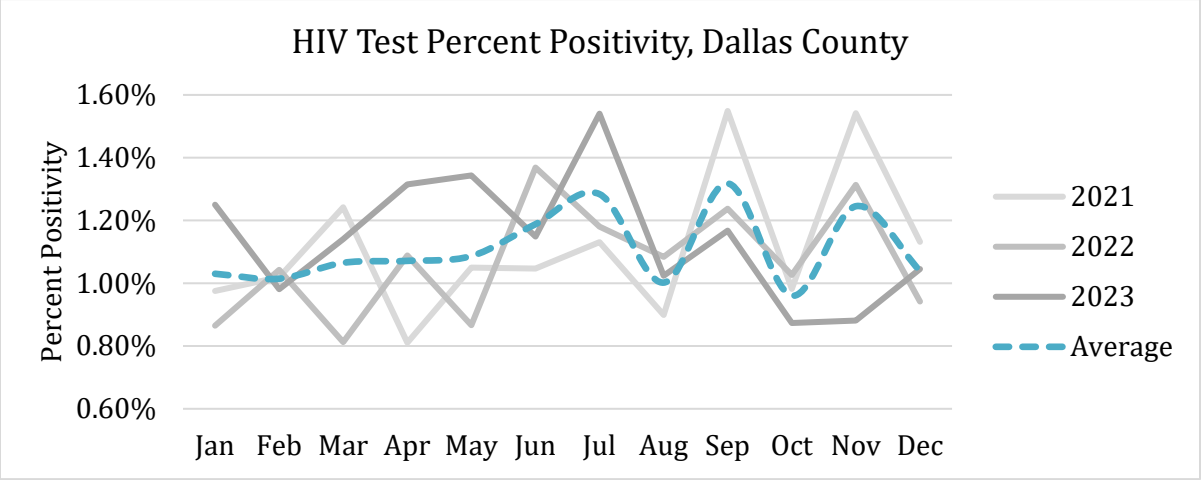
Figure 24. Positive CDC-funded HIV Tests, Dallas County, 2021–2023



Source: EvaluationWeb, Dallas County, 2024.

Figure 24 shows that the number of positive CDC-funded HIV tests in Dallas County remained relatively consistent from 2021 to 2023. Positive tests increased slightly from 747 in 2021 to 774 in 2022, then declined to 695 in 2023. This represents an overall decrease of approximately 7% from 2021 to 2023. While the number of positive tests fluctuated modestly, the data suggest that CDC-funded testing programs continued to identify a consistent number of people with HIV across the three-year period.

Figure 25. HIV Test Percent Positivity, Dallas County, 2021–2023



Source: EvaluationWeb, Dallas County, 2024.

Figure 25 shows that percent positivity among CDC-funded HIV tests averaged 1.11% from 2021 to 2023. Monthly positivity varied across the year, with several visible increases occurring around mid-year and early fall. However, the overall average remained relatively stable, suggesting that CDC-funded testing efforts continued to reach populations with ongoing HIV risk. In 2023, there were 60,865 HIV tests reported to EvaluationWeb in Dallas County. Of these tests, 60,135 were negative, 695 were positive, and 35 were inconclusive. These data should be interpreted within the limitations of EvaluationWeb, as they do not represent all HIV testing conducted in Dallas County, but they provide an important view of CDC-funded testing activity and positivity trends over time.

People Vulnerable to HIV Acquisition

Taken together, the new diagnosis, PrEP, and HIV testing data indicate that people vulnerable to HIV acquisition include communities experiencing disproportionate rates of new diagnoses and communities that may not be reached equitably by existing prevention tools. New diagnoses remain concentrated among MSM, particularly Black MSM and Hispanic MSM, and among adults ages 25–44. Diagnosis data also show persistent racial and ethnic disparities and an increasing number and rate of diagnoses among females. PrEP use has increased overall, but uptake remains concentrated among males and adults ages 25–44, while people under 24 and females represent smaller shares of PrEP users. These patterns support continued status-neutral planning that links people who test negative to PrEP, PEP, sexual health education, harm reduction information, STI services, and supportive services based on individual need and local epidemiologic patterns.

HIV Clusters:

DCHHS supports cluster detection and response efforts in coordination with the state. When individuals are identified through cluster detection activities and may need support accessing HIV care, the DCHHS DIS and EHE teams help facilitate linkage to care. The number of individuals referred through this process has been low, with 33 individuals identified in 2023, 18 in 2024, and 4 identified in 2025 as of the date of this draft. While these numbers represent a small portion of overall linkage activity, the process remains an important response mechanism to ensure those identified through cluster detection are connected to appropriate care and services.

HIV Prevention, Care, and Treatment Resources Inventory

The resource inventory was completed using Ryan White and EHE grant contracts, provider service descriptions, one-on-one meetings, email exchanges, and follow-up with funded partners to confirm accuracy. The inventory was developed over several weeks and provides a current baseline of funded HIV prevention, care, treatment, and supportive services across the Dallas EMA. While the current inventory focuses primarily on Ryan White, EHE, prevention, and related funded services, it will serve as a foundation for adding additional non-funded community resources over time.

The inventory shows a broad network of funded providers, including community-based organizations, federally qualified health centers, county health department services, hospital-based programs, and other clinical and social service partners. Services captured include core medical services, support services, and status-neutral activities such as HIV testing, PrEP, navigation, outreach, transportation, housing-related supports, behavioral health, and case management. The full resource inventory is included in Appendix A. Future updates will include a more detailed funding analysis, including pie charts and data tables, to support at-a-glance review of service coverage, gaps, duplication, and opportunities for alignment or expansion.

Needs Assessment

Dallas County Health and Human Services used multiple needs assessment activities, stakeholder engagement processes, and data sources to inform the goals, objectives, and strategies included in this Integrated HIV Prevention and Care Plan. These included the 2022 Status Neutral Needs Assessment, the 2023 and 2024 Ryan White Stakeholder Experience Evaluation for Consumers, epidemiologic and programmatic data reviewed during planning meetings, feedback from standing community planning bodies, and the 2026 Needs Assessment currently underway. The 2022 Status Neutral Needs Assessment remains the most comprehensive recent

assessment of HIV prevention and care needs across the Dallas Eligible Metropolitan Area and Sherman-Denison Health Service Delivery Area. Because final 2026 Needs Assessment findings will not be available before this plan is submitted, DCHHS used the 2022 assessment as the primary comprehensive needs assessment source and supplemented it with more recent consumer experience data, program data, and stakeholder feedback. Once the 2026 Needs Assessment is complete, DCHHS will review the findings and update strategies as needed.

The 2022 Status Neutral Needs Assessment used a mixed-methods approach that included a respondent-driven survey, key informant interviews, and focus groups. It assessed HIV testing, prevention, linkage to care, unmet need, service availability, barriers to care, and opportunities to strengthen a status-neutral system. The assessment identified priority populations for focused prevention and care efforts, including Black and Hispanic/Latinx communities, men who have sex with men, youth and young adults, and people who inject drugs. These findings were supplemented by the 2023 and 2024 Ryan White Stakeholder Experience Evaluation for Consumers, which gathered feedback from Ryan White consumers on service access, satisfaction, stigma, eligibility, care coordination, and barriers to care.

Themes:

Across these sources, several consistent themes emerged. First, there is a continued need to expand HIV testing in community-based, geographically accessible, and nontraditional settings. Stakeholders identified the importance of mobile testing, outreach events, satellite services, routine testing in healthcare settings, and services located closer to communities most impacted by HIV. Findings also reinforced the need for culturally responsive testing environments that feel safe for people who may experience stigma, discrimination, immigration-related fear, confidentiality concerns, or barriers related to sexual orientation, language, transportation, or geography.

Second, the findings support continued expansion of HIV prevention services, including PrEP, PEP, prevention navigation, sexual health education, and provider education. The 2022 assessment found gaps in awareness of PrEP and PEP among people who may benefit from these services. Stakeholders also emphasized the need for stronger referral pathways between testing programs and PrEP providers, expanded access in emergency departments, community clinics, reentry settings, and other nontraditional access points, and continued outreach to populations and geographies most impacted by HIV. Harm reduction was also identified as an important prevention need, particularly for people who inject drugs; however, current state law limits implementation of syringe services programs in Texas. As a result, the jurisdiction must continue to identify allowable strategies, including harm reduction education, overdose prevention, substance use service linkage, and HIV/HCV/STI testing and prevention.

Third, the needs assessment identified rapid linkage to HIV care after diagnosis as a key system priority. While many people living with HIV are linked to care within one month, some experience delays related to stigma, paperwork, transportation, housing instability, lack of insurance, unresolved trauma, or difficulty finding a trusted provider. These findings support the need for coordinated linkage infrastructure, warm handoffs, care navigation, rapid start pathways, culturally responsive providers, and improved information sharing between agencies, particularly for individuals diagnosed in emergency departments, community testing programs, jails, plasma centers, public health settings, and other nontraditional settings.

Fourth, maintaining HIV care and reaching and sustaining viral suppression require both high-quality medical care and strong support services. The 2023 and 2024 consumer experience evaluations found generally positive consumer experiences, including high levels of satisfaction, perceived support, and provider communication. At the same time, consumers continued to identify barriers related to medication access, dental care delays, housing, transportation, food and nutrition, mental health, substance use, appointment scheduling, service delays, stigma, eligibility, information access, and awareness of grievance processes. The 2023 evaluation also showed that care coordination is often stronger when consumers receive services from one organization, while coordination across multiple organizations remains more challenging. This supports continued efforts to improve referral tracking, cross-agency communication, shared data systems, and navigation for clients receiving services from multiple providers.

The needs assessment findings also highlighted broader policy and system barriers that affect HIV prevention and care. Texas has not expanded Medicaid, which continues to affect insurance access for low-income people living with or vulnerable to HIV and increases reliance on Ryan White, ADAP, safety-net systems, and other public health resources. Restrictions on syringe services programs limit the jurisdiction's ability to implement a key evidence-based HIV prevention strategy for people who inject drugs. Eligibility and recertification requirements can also create administrative burden for clients and providers, although recent consumer experience data indicate that most Ryan White consumers find eligibility manageable.

Together, these findings support the plan's focus on expanded testing access, PrEP and PEP navigation, rapid linkage, re-engagement, retention in care, viral suppression, supportive services, culturally responsive care, cross-agency coordination, data system alignment, and status-neutral service delivery. The findings reinforce that people should be connected to the right service at the right time, whether they need HIV testing, PrEP, PEP, rapid ART, re-engagement in care, support services, or long-term retention and viral suppression support.

Action Taken

DCHHS and community partners have taken several actions to respond to needs and barriers identified through the needs assessment process. To better target HIV testing and outreach, DCHHS is working with the Parkland Center for Clinical Innovation to identify vulnerable areas in Dallas at the block-group level, allowing for more precise coordination than zip-code level planning alone. This is important because community need can vary significantly from street to street. Through the Community Vulnerability Compass, partners can review micro-level neighborhood data using the Community Vulnerability Index, which includes indicators related to household essentials, demographics and education, environmental and safety factors, and health outcomes. These data help DCHHS and partners identify areas with overlapping social, economic, and health-related needs and prioritize outreach, mobile services, HIV/STI testing, and prevention activities in locations closer to communities most impacted by HIV. CBO's are also developing new partnerships with community-based organizations and trusted community businesses, such as barbershops and corner stores, where people already gather in vulnerable areas.

To strengthen HIV prevention access, DCHHS and partners have expanded PrEP, PEP, and sexual health services across multiple access points. More community-based organizations are offering same-day PrEP, mobile PrEP, telePrEP, PEP, and doxy-PEP options, helping reduce barriers for people who may not access

traditional clinic-based services. CBO's also support a comprehensive trauma-informed sexual health education program that includes HIV prevention, STI prevention, PrEP and PEP awareness, consent, communication, and linkage to services. In addition, Dallas County received opioid settlement dollars, which has supported greater collaboration with overdose prevention activities aligning harm reduction and sexual health efforts. Community-wide naloxone distribution now includes condoms, sexual wellness guides, and hygiene kits, with supplies distributed through vending machines in high-incidence areas and smaller dispensers in bars and restaurants. Large-scale condom distribution efforts are also supported by numerous community-based organizations across the jurisdiction.

To improve linkage, rapid start, re-engagement, retention, and viral suppression, Dallas EHE, Ryan White-funded providers, and non-funded community partners are participating in year one of a five-year Rapid ART Learning Collaborative. The collaborative includes a readiness assessment, currently underway, followed by customized training, curriculum development, and technical assistance to support same-day rapid start activities across clinics. The effort will also include technology supports and streamlined workflows for people diagnosed in nontraditional settings, such as emergency departments, correctional settings, plasma centers, community testing programs, and public health settings, to ensure rapid linkage to care regardless of the diagnosing facility's familiarity with the HIV prevention and care system. In addition, an increasing number of community-based organizations are incorporating peer navigation and patient navigation positions to provide more flexible, real-time support for individuals experiencing barriers within the system.

To improve system coordination and reduce barriers to care, DCHHS has supported the development and implementation of E2Dallas, a universal eligibility and client documentation system designed to streamline intake, reduce duplicative paperwork, and improve the client experience across Ryan White-funded agencies. DCHHS has also continued to build Salesforce-based systems to support care navigation, client encounter support, linkage support, reengagement-to-care activities, and future status-neutral service support. These systems are intended to improve real-time coordination, identify clients in need of outreach, support quality improvement, and reduce fragmentation across prevention and care efforts.

To strengthen monitoring, evaluation, and accountability, DCHHS brought in a community partner with subject matter expertise in monitoring and evaluation to support development of the plan's monitoring and evaluation framework. This approach is intended to move beyond general feedback collection by building clearer structures for annual review, strengthened data sources, SMART goals, and a public-facing dashboard that will show progress on goals, objectives, and strategies over time. Stronger metrics will also support more intentional quarterly review of plan activities, helping partners identify areas of progress, gaps, and opportunities for additional coordination or scale-up.

Direct consumer and community feedback will continue to inform implementation through ongoing needs assessment activities, including surveys, focus groups, and key informant interviews conducted over the next four years. These activities will help assess whether strategies are working for people accessing services, as well as people who need services but may not yet be connected. Together, these efforts will support a more responsive planning process that uses data, community feedback, and regular review to guide improvements throughout the life of the plan.

c. Approach

DCHHS used a layered approach to inform the Integrated Plan, combining the most recent comprehensive needs assessment with updated consumer experience data, epidemiologic trends, program data, service utilization patterns, and stakeholder input. The 2022 Status Neutral Needs Assessment served as the baseline assessment as it provided the most comprehensive review of needs across HIV testing, prevention, linkage, care, treatment, support services, and barriers to access. The 2023 and 2024 SEE-C reports added more recent consumer feedback from people receiving Ryan White services, including information on service access, care coordination, stigma, eligibility, communication, service delays, and ongoing barriers.

This approach allowed DCHHS to assess needs across the status-neutral continuum without relying on a single data source. Input from people with HIV, consumers, providers, community-based organizations, planning bodies, and partners from prevention, care, behavioral health, housing, reentry, and social service settings was incorporated through existing engagement structures and review processes. The 2026 Needs Assessment is currently underway and will provide the next comprehensive update. Once complete, DCHHS will review the findings with planning partners and community stakeholders and update strategies as needed to ensure the plan remains responsive to current needs and community priorities.

SECTION 4: Situational Analysis

Overview

The data, needs assessments, stakeholder feedback, and community engagement activities presented in Sections II and III demonstrate that the HIV epidemic in the Dallas EMA/HSDA continues to evolve in ways that reflect both meaningful advancements in HIV prevention and treatment and persistent inequities across the HIV care continuum. Over the current planning cycle, the region expanded mobile outreach and testing services, strengthened coordination across Ryan White, EHE, Fast Track Counties, and community-based systems, increased emphasis on status-neutral service delivery, and invested in improved data infrastructure and cross-system planning efforts. These activities strengthened coordination across prevention, linkage, treatment, behavioral health, and supportive service systems and created a stronger foundation for integrated HIV prevention and care planning.

New HIV diagnoses increased from 1,004 diagnoses in 2015 to 1,199 diagnoses in 2024, representing an approximately 19% increase over the ten-year period. Although new diagnoses declined in 2020, this decrease likely reflects reduced healthcare utilization, HIV testing, and surveillance activity during the COVID-19 pandemic. For this reason, 2020 should be treated as an outlier, with greater attention placed on the overall trend across the full ten-year period. During the same period, the number of PLWH in the Dallas EMA increased, reflecting both ongoing transmission and longer life expectancy among PLWH due to advances in HIV treatment and care engagement. Collectively, these trends demonstrate that the Dallas EMA/HSDA must simultaneously support a growing and aging population of PLWH while continuing efforts to reduce new HIV transmissions.

The HIV care continuum further demonstrates that while many individuals successfully engage with HIV care systems initially, substantial gaps remain in long-term retention and viral suppression. In 2024, approximately 79% of PLWH had at least one documented healthcare visit or laboratory result, while approximately 73% were

identified as receiving antiretroviral therapy. However, engagement declined across later stages of the continuum, with approximately 61% of PLWH retained in care and 66% achieving viral suppression. These trends suggest that the primary challenge within the regional HIV system is not solely initial linkage to care, but sustained engagement across long-term treatment and support systems. Needs assessment findings, stakeholder feedback, and consumer experience data consistently identified disconnected systems of care, repeated eligibility and documentation requirements, transportation barriers, unmet behavioral health and substance use needs, housing instability, stigma, medical mistrust, and limited access to culturally responsive services as barriers that interfere with continuity of care, prevention engagement, and long-term health outcomes.

Persistent disparities across race, ethnicity, transmission category, age, geography, and social conditions continue to shape HIV outcomes across the Dallas EMA/HSDA. Black/African American residents continue to experience the highest rates of new HIV diagnoses relative to population size, while Hispanic/Latino communities, particularly Hispanic MSM, experienced substantial increases in new diagnoses during the current planning period. Adults ages 25 to 34 continue to account for the largest number of new HIV diagnoses, while older adults represent a growing proportion of PLWH, reflecting the increasing number of individuals aging with HIV. Community engagement findings further demonstrate that residents living in suburban, rural, and geographically underserved areas often experience additional barriers related to transportation, limited provider availability, and reduced access to specialized HIV prevention and treatment services.

This situational analysis examines the strengths, challenges, service gaps, and unmet needs shaping HIV prevention and care outcomes across the Dallas EMA/HSDA. It also examines the structural and systemic factors that influence service access, prevention engagement, continuity of care, and overall health outcomes.

Strengths Across the HIV Prevention and Care Continuum

One major strength is the region's established stakeholder and planning infrastructure. The Dallas EMA/HSDA maintains recurring coordination across Ryan White-funded programs, CDC Prevention activities, EHE initiatives, Fast Track Counties efforts, healthcare systems, behavioral health providers, housing and supportive service organizations, and community-based partners. Existing structures, including the RWPC Evaluation Committee, Fast Track Counties to End HIV Workgroup, and Dallas HIV Task Force, created opportunities for stakeholders to review epidemiologic and programmatic data, monitor implementation progress, identify service gaps, and provide input on HIV prevention and care priorities. The planning process also expanded engagement with nontraditional partners, including hospital systems, federally qualified health centers, reentry programs, behavioral health organizations, and substance use service providers, strengthening coordination across systems that influence HIV-related health outcomes.

The Dallas EMA/HSDA also maintains a well-established Ryan White HIV/AIDS Program infrastructure that remains a critical safety net for uninsured and underinsured individuals living with HIV. Ryan White-funded organizations provide HIV medical care, medications, behavioral health services, transportation assistance, housing-related support, psychosocial services, substance use services, and risk reduction counseling. Several providers in the region use integrated care models that co-locate medical and supportive services, improving care coordination and reducing barriers to sustained engagement in care and viral suppression.

The region also expanded community-based prevention and outreach capacity during the current planning cycle. Mobile service delivery units operated by DCHHS and partner organizations increased access to HIV testing, STI screening, and prevention services outside traditional healthcare settings, particularly in underserved communities and areas with limited access to care. PrEP utilization also increased substantially during this period, with the number of PrEP users in Dallas County increasing from 4,996 individuals in 2020 to 8,166 individuals in 2024. Together, these activities demonstrate increased prevention capacity and expanded use of biomedical HIV prevention strategies across the region.

Another important strength is the region's continued investment in data infrastructure and cross-system coordination. DCHHS strengthened data and planning infrastructure through initiatives including Salesforce system consolidation, expanded program monitoring efforts, geographic targeting activities conducted in partnership with Parkland's Center for Clinical Innovation (PCCI), and development of the E2Dallas universal eligibility platform. These efforts were designed to improve coordination across outreach, linkage, navigation, prevention, and care systems while reducing administrative burden associated with fragmented intake and eligibility processes.

These strengths provide an important foundation for the Dallas EMA/HSDA HIV response which are set up against various challenges where there is opportunity to address the HIV prevention and care continuum with innovation and sustainable investment. The following sections examine ongoing gaps, barriers, and identified needs across the four EHE strategic pillars: Diagnose, Treat, Prevent, and Respond.

Diagnose All People with HIV as Early as Possible

Current trends suggest that testing and diagnosis efforts have improved following disruptions during the COVID-19 pandemic. DCHHS and regional partners have expanded testing efforts through community outreach, mobile service delivery, emergency department testing initiatives, and opt-out testing approaches. Section III findings indicate that increased diagnoses may partially reflect improved identification of individuals previously unaware of their HIV status rather than a confirmed increase in transmission alone.

Consequently, the remaining challenge is not simply whether testing exists. The challenge is whether testing reaches the right people early enough and consistently enough across the full-service area. New HIV diagnoses increased in 2024. Some of this increase likely reflects restored testing and healthcare engagement after COVID-19 disruptions, but the continued concentration of new diagnoses among Black/African American residents, Hispanic/Latino residents, MSM, and adults ages 25 to 34 indicates ongoing transmission and uneven access to early diagnosis.

Needs assessment findings and stakeholder feedback indicate that some individuals continue to receive diagnoses through emergency departments or primary care settings rather than through routine, community-based, or prevention-focused screening. Therefore, in some instances diagnosis often occurs late in the course of disease. This pattern suggests that testing opportunities remain too dependent on when and where people enter healthcare systems. Residents in suburban, rural, and geographically underserved areas face additional barriers when HIV testing, prevention counseling, and linkage resources are concentrated in central Dallas or specialized HIV service settings.

Data infrastructure also remains incomplete. Evaluation Web data currently captures only CDC-funded HIV testing activity and does not include testing conducted through private insurance, Medicaid, 340B programs, or

patient assistance programs. This limits the region's ability to fully assess testing coverage and identify gaps across the broader HIV prevention system while DCHHS continues strengthening Salesforce infrastructure and cross-system reporting capacity.

The planning implication is clear: the next phase of work should strengthen routine and community-based testing, improve geographic targeting, expand status-neutral entry points, and ensure that people who test positive are connected quickly to care while individuals who test negative but remain at increased risk for HIV acquisition should be connected to PrEP, PEP, STI screening, and navigation support.

Treat People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

The more notable gap across the HIV care continuum in the Dallas EMA is not initial entry into care, but long-term retention and sustained viral suppression. Although a majority of PLWH had at least one documented care visit or laboratory result in 2024, substantial declines remain between initial engagement, retention in care, and viral suppression. This pattern indicates that many individuals successfully enter the care system but encounter barriers that interfere with long-term treatment continuity. It's noteworthy to mention that newer injectables may reduce the frequency of medical visits which can present, by definition, a reduced number of reported individuals retained in care through HRSA definitions (2 viral load tests at least 3 months apart within a 12 month period).

The data and stakeholder feedback suggest that these barriers are not driven by a single issue. Instead, they reflect interconnected structural and administrative challenges that affect an individual's ability to consistently remain engaged in care over time. Participants described difficulties navigating multiple service systems, repeated eligibility and recertification requirements, fragmented referral processes, transportation barriers, unstable housing, behavioral health needs, substance use challenges, and inconsistent access to supportive services. These barriers collectively increase the likelihood of interruptions in treatment and ongoing disengagement from care.

Disparities across retention and viral suppression also mirror the broader epidemiologic trends observed throughout the region. Black/African American residents continue to represent a disproportionate share of people living with HIV, while Hispanic/Latino communities represent a growing proportion of both new diagnoses and individuals requiring long-term HIV care. Younger adults also continue to experience lower engagement across portions of the care continuum. Community feedback additionally highlighted concerns related to healthcare experiences themselves. Participants described stigma, perceived judgment, lack of cultural humility, and limited trust in healthcare systems as factors affecting sustained engagement in care. Some respondents also identified difficulty finding providers who understood the needs of communities including immigrant populations, or individuals experiencing co-occurring behavioral health and social service needs.

The Dallas EMA has implemented several initiatives intended to strengthen continuity across the care continuum. These efforts include expanded care navigation services, community health worker models, efforts to improve data coordination, and the development of systems such as E2Dallas to support streamlined eligibility and referral coordination. Existing Ryan White and EHE infrastructure also provides a strong foundation for multidisciplinary HIV care and supportive services throughout the region.

Despite these strengths, the current system remains highly dependent on individuals navigating multiple disconnected systems to maintain consistent care engagement. The situational analysis demonstrates that future treatment-focused strategies must prioritize long-term retention, reduction of administrative burden, integrated behavioral health and supportive services, and stronger coordination across care systems. Improving viral suppression rates will require addressing both clinical care access and the broader social and structural barriers that interfere with sustained treatment engagement.

Prevent New HIV Transmissions

Prevention efforts across the Dallas EMA have expanded in recent years, particularly through increased PrEP utilization, mobile outreach services, and broader HIV prevention education activities. Between 2020 and 2024, the number of reported PrEP users in Dallas County increased from 4,996 to 8,166, representing a substantial increase in uptake.

Nonetheless, PrEP utilization remained concentrated primarily among men, who represented approximately 94% of PrEP users in 2024. During the same period, new HIV diagnoses among females increased, highlighting persistent gaps in prevention access, outreach, and awareness among women. Community feedback also identified stigma as an ongoing barrier to HIV prevention services, with individuals ultimately deciding to not seek services for fear of social backlash or receiving prejudiced care. Feedback further revealed limited awareness of PrEP and PEP among many individuals at increased risk for HIV. From these conversations it was indicated that many people remained unfamiliar with available biomedical prevention tools despite reporting behaviors associated with HIV exposure risk. Collectively, these findings suggest that prevention messaging has not consistently reached all populations with increased vulnerability to HIV acquisition.

The current prevention system also remains heavily dependent on individual awareness and the ability to independently navigate services. Many participants described difficulty identifying where to access PrEP services, uncertainty regarding cost and insurance coverage, and confusion about how prevention services connect to broader healthcare systems. These findings indicate that prevention services are not yet consistently integrated into routine healthcare delivery and community-based systems.

Several prevention-focused improvements have already been implemented. DCHHS and partner organizations expanded mobile outreach services capable of providing on-site testing, PrEP services, and rapid syphilis testing in underserved communities. Trauma-informed sexual health education programs targeting youth populations were also implemented through partnerships with local outreach teams and educational settings.

The situational analysis demonstrates that future prevention strategies must focus not only on expanding prevention services, but also on improving prevention equity. Future efforts will need to strengthen culturally responsive outreach and messaging, improve prevention access outside traditional healthcare settings, increase integration between prevention and care systems, and prioritize populations experiencing disproportionate HIV burden and lower engagement with existing prevention infrastructure.

Respond Quickly to Potential HIV Outbreak

The Dallas EMA/HSDA has established response infrastructure to identify and respond to emerging transmission patterns. Individuals are supported by DCHHS EHE teams for care navigation and linkage to care. From 2023 to 2025, the number of individuals identified was 33 in 2023, 18 in 2024, and 4 in 2025. These data

show that monitoring exists and, given the abovementioned activities, there are referral processes in order to respond to emerging needs.

The region's response capacity is supported by broader investments in surveillance, data coordination, geographic prioritization, and cross-system planning. DCHHS has strengthened infrastructure through Salesforce consolidation, expanded program monitoring and geographic activities with PCCI. The remaining challenge, therefore, is not whether the Dallas EMA/HSDA has a response system, it is whether that system is consistently fast, coordinated, and connected enough across surveillance, prevention, care navigation, behavioral health, housing, and community-based services.

Stakeholders emphasized the importance of improving real-time communication and referral coordination across agencies while continuing to strengthen status-neutral linkage systems capable of rapidly connecting individuals to HIV treatment, PrEP, PEP, behavioral health services, and supportive services based on identified need. Community feedback also highlighted the importance of ensuring that response activities remain culturally responsive, geographically accessible, and grounded in community engagement in order to maintain trust among disproportionately impacted populations.

Populations and Communities Disproportionately Impacted by HIV

The community engagement process described in Section II and the epidemiologic and needs assessment findings presented in Section III consistently demonstrated that HIV does not affect all populations equally across the Dallas EMA/HSDA. The planning process identified Black/African American residents, Hispanic/Latino residents, MSM, youth and young adults, PWID, and individuals experiencing housing instability, incarceration or reentry, behavioral health needs, or limited healthcare access as populations disproportionately impacted by HIV and related barriers to prevention and care services.

Black/African American Communities

Black residents continue to experience the highest rates of new HIV diagnoses and represent a disproportionately large share of PLWH across the region. Black individuals represented 42.9 percent of new diagnoses in 2024 despite accounting for only 17.2 percent of the overall population.

These disparities remain particularly visible in historically underserved areas of Dallas County where communities continue to experience higher rates of economic instability, uninsured/underinsured status, housing instability, and reduced access to healthcare services. Community engagement findings also highlighted ongoing concerns related to stigma, medical mistrust, and inconsistent access to culturally responsive providers and services. Stakeholders emphasized that many Black residents continue to experience barriers navigating disconnected prevention and care systems, particularly when seeking services outside of traditional clinic settings.

Hispanic/Latino Communities

Hispanic/Latino communities continue to experience increasing HIV burden across the Dallas EMA/HSDA, particularly among Hispanic MSM, who represent one of the fastest growing populations impacted by HIV in the region. Epidemiologic trends suggest that the increasing number of diagnoses among Hispanic residents reflects both population growth within the region and persistent gaps in prevention access and engagement.

Community engagement findings identified several barriers affecting prevention and care engagement among Hispanic/Latino residents, including language access barriers, inconsistent insurance coverage, stigma, immigration-related concerns, and limited availability of linguistically and culturally responsive services. Stakeholders also noted that fear surrounding immigration enforcement activity and concerns regarding confidentiality may discourage some residents from accessing HIV testing, prevention services, and ongoing healthcare, particularly among undocumented individuals and mixed-status families. These concerns may contribute to delayed engagement with healthcare systems and reduced continuity of care across portions of the population.

Black MSM and Hispanic MSM

Black MSM and Hispanic MSM remain among the populations most disproportionately impacted by HIV across the Dallas EMA/HSDA. Epidemiologic trends demonstrate continued disparities in both new diagnoses and prevalence among these populations. Community discussions also emphasized the continued need for status-neutral approaches to care, expanded peer engagement, and outreach strategies that reflect the lived experiences of MSM communities across Dallas and surrounding service areas.

Youth and Young Adults

Adults ages 25 to 34 continue to experience the highest rates of new HIV diagnoses, while individuals ages 35 to 44 represent the largest proportion of people currently living with HIV. These findings reinforce the importance of strengthening prevention and engagement efforts among youth and young adults, particularly those ages 13 to 24.

Community engagement findings highlighted concerns related to stigma, confidentiality, inconsistent sexual health education, unstable insurance coverage, and limited engagement with healthcare systems among younger populations. Stakeholders also noted that many younger residents continue to receive inconsistent information regarding HIV prevention, testing access, and available supportive services, particularly outside of Dallas County's more centralized healthcare systems.

People Experiencing Substance Use, Housing Instability, and Geographic Access Barriers

People who inject drugs, individuals experiencing housing instability, and residents living in rural or geographically underserved communities continue to face significant barriers to HIV prevention and care services.

Community engagement activities identified transportation barriers, limited availability of specialized HIV providers and behavioral health services, siloed systems of care, housing instability, and limited harm reduction infrastructure as ongoing challenges affecting engagement in care. These barriers are especially significant for residents living outside central Dallas, including suburban and rural portions of the EMA/HSDA where HIV services may be limited or require extensive travel to access care.

This analysis provides the foundation for the goals and objectives that follow. Those goals and objectives identify the target populations, proposed activities, responsible organizations, required resources, and intended outcomes needed to address the gaps identified throughout the Dallas EMA. The strategies are designed to

respond directly to these needs while advancing measurable progress toward reducing new HIV transmissions and improving equitable health outcomes.

SECTION 5: Goals, Objectives and Strategies

Goals and Objectives Description

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

- Strategies/Activities, Partners, Data Indicators, and Data Sources present in the previous 2022-2026 Integrated Plan that are ongoing and continue to be relevant to furthering EHE goals have remained incorporated in the updated 2027-2031 Integrated Plan.
- A crosswalk of existing plans, needs assessments, and key data sources was conducted to identify opportunities to strengthen the Integrated Plan's goals and objectives.
- The Ryan White Planning Council's Evaluation Committee convened monthly and helped develop the goals and objectives noted in this section.

Populations of Focus

According to the data, the populations below bear the heaviest burden of new HIV infections and disproportionally poor HIV health outcomes in the Dallas EMA. By intentionally integrating strategies in the integrated plan to address the challenges and barriers faced by these populations, we ensure the plan is both impactful and successful in helping to end the HIV epidemic in the Dallas EMA.

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

Goal 1: Diagnose all people with HIV in the Dallas region as quickly as possible.

Objective 1- By 2031, increase the percentage of people with HIV in Dallas County who are aware of their HIV status to 90% from an estimated baseline of 83.6%.

Key Activities/Strategies:

1. Implement social marketing campaigns to encourage routine HIV testing and status awareness.
2. Implement routine, opt-out HIV testing practices in healthcare facilities such as hospitals, emergency departments, primary care centers, urgent care centers, federally qualified health centers (FQHCs) and FQHC lookalikes, and urgent care centers, particularly in disproportionately impacted communities.
3. Offer capacity building to organizations willing to implement routine opt-out testing, such as hospitals, emergency departments, primary care centers, FQHCs and FQHC lookalikes, and urgent care centers.

4. Work with the Texas Department of State Health Services to obtain HIV status awareness data in the Dallas Regional Area on an annual basis.

Key Partners: County health departments, organizations focused on youth, women, the LGBT community, and substance use/behavioral health services, Community based organizations (CBOs) with a strong social media presence, Dallas County Medical Society, emergency rooms, urgent care centers, OB/GYN providers, primary care providers, FQHCs and FQHC lookalikes, AETCs and other capacity building providers, Texas Department of State Health Services

Data Indicators:

- Percentage of people with HIV (PWH) in Dallas County who are aware of their HIV status
- Number of agencies funded to implement social marketing campaigns to increase testing and status awareness
    - Campaign metrics – number of unique clicks, impressions, and views of campaign assets
- Number of non-funded or external agencies/healthcare centers with a documented HIV testing policy that specifies routine, opt-out testing
- Number of funded prevention and care partners with a documented HIV testing policy or protocol that specifies routine, opt-out testing
- Percentage of funded partners with a documented HIV testing policy or protocol that specified routine, opt-out testing
- Number of testing-focused capacity building events or sessions conducted
- Number of staff receiving capacity building support for HIV testing
- Formalized process for obtaining status awareness data from the State in place

Data Sources: CDC HIV Surveillance Supplemental Report, DCHHS, contracts with funded partners, agency-level social marketing campaign reports, organization HIV testing policies or protocols, calendars of training and capacity building sessions and events, Training and capacity building attendance logs and reports, Texas Department of State Health Services

Objective 2 - By 2031, increase the number of HIV tests conducted annually in Dallas County to 75,000 from a baseline of 60,135.

Key Activities/Strategies:

1. Work with clinical and community-based organizations to implement community-based strategies to increase testing among priority populations, including Black women, MSM, particularly Black and Latinx MSM, people who inject drugs, & Dallas EMA residents aged 25-34 years old.
2. Identify new community testing locations and venues where priority populations live, work, and frequent.
3. Maintain a Community Calendar to provide information to the community about mobile and community testing events.
4. Work with the Texas Department of State Health Services to obtain HIV testing data in the Dallas Regional Area on an annual basis.

Key Partners: Organizations focused on youth, women, the LGBT community, and substance use/behavioral health services, organizations with mobile health/testing programs, DCHHS HIV/STI Division, Texas Department of State Health Services

Data Indicators:

- Number of HIV tests conducted using CDC-funded HIV tests in the Dallas Region
- Number of HIV tests conducted using CDC-funded HIV tests in the Dallas Region among:
    - Black Women
    - Men who have sex with men
        - Black MSM
        - Latinx MSM
    - People who inject drugs
    - People ages 25-34
- Number of CBOs engaged to support and implement community-based and mobile testing events and initiatives
- Number of new mobile and community testing locations identified
- Number of testing events listed in the Community Calendar
- Formalized process for obtaining HIV testing data from the state in place

Data Sources: DCHHS HIV/STI Division, Evaluation Web, Community Calendar, community feedback, consumer surveys, listening sessions, Texas Department of State Health Services

Objective 3 - Through 2031, achieve an HIV positivity rate of 1% annually for all HIV testing conducted in the Dallas Regional Area.

Key Activities/Strategies:

1. Increase the use of partner services and network-based case finding to quickly diagnose and link people into care.
2. Identify a list of high prevalence ZIP codes to target for community and mobile testing events.
3. Increase the number of testing events in high-prevalence zip codes.
4. Partner with and distribute HIV testing and other educational materials to organizations serving priority populations to increase testing.

Key Partners: Partner Services, DCHHS HIV/STI Division, organizations focused on youth, women, the LGBT community, and substance use/behavioral health services, organizations in high-prevalence zip codes

Data Indicators:

- HIV positivity rate in the Dallas Region
- Number of PWH diagnosed and linked through partner services
- List of high prevalence ZIP codes identified
- Number of HIV testing events held in high prevalence zip codes
- Educational resources on HIV testing and linkage developed

Data Sources: Evaluation Web, DCHHS HIV/STI Division, state and local surveillance data, Community Calendar, Funded prevention and care partners

Goal 2: Treat all people with HIV in the Dallas Region quickly and effectively to reach sustained viral suppression.

Objective 1 – By 2031, increase the percentage of people newly diagnosed with HIV who are linked to care within 30 days of diagnosis to 90% from a baseline of 76%.

Key Activities/Strategies:

1. Implement a multi-year rapid ART learning collaborative to enhance implementation of rapid antiretroviral therapy (ART) throughout the Dallas Regional Area.
2. Develop protocols, policies, and workflows for rapid ART for rapid linkage and treatment at the agency level.
3. Implement Medical Neighborhood Model to connect newly diagnosed PWH to needed wraparound services.
4. Rapidly link eligible clients into the Ryan White system for care and supportive services.
5. Utilize technology to facilitate nontraditional linkage opportunities such as texting and messenger systems, etc.

Key Partners: RAI, rapid ART learning community participants, AETC and other capacity building centers, large medical systems, organizations offering HIV testing, HIV care providers, FQHCs and FQHC lookalikes, Urgent Care centers, Emergency Rooms, housing and homeless services providers, outreach workers, case managers, linkage navigators, Ryan White-funded providers

Data Indicators:

- Percentage of people newly diagnosed with HIV linked to care within 30 days
- Percentage of people newly diagnosed with HIV linked to care within 1 day
- Percentage of PWH not linked to care within 1 year
- Number of agencies participating in rapid ART learning collaborative
- Number of agencies with rapid ART protocols and workflows developed
- Medical Neighborhood Model developed
- Number of new clients enrolled in Ryan White Part A system
- Number of new technological strategies implemented to support linkage

Data Sources: RAI, DCHHS, AETC and other training centers, Texas Department of State Health Services - HIV/STI Surveillance Unit, partner organizations offering HIV testing, agency-level reports

Objective 2 – By 2031, increase the percentage of people with HIV who are engaged in care to 90% from a baseline of 79%.

Key Activities/Strategies:

1. Offer capacity building to staff at healthcare and community-based organizations on key topics to promote engagement in care such as cultural humility, stigma reduction, motivational interviewing, and trauma-informed care.
2. Increase access to care through expanded clinic hours and appointment availability.
3. Implement Data to Care and other targeted outreach initiatives to re-engage PWH who are out of care back into care.
4. Implement mobile & home-based lab services for people with HIV who have significant barriers to accessing in-person lab services.

Key Partners: AETC and other capacity building centers, case management and supportive service providers, EIS, hospitals, ERs, Outreach workers, linkage navigators, Disease Intervention Specialists (DIS), providers with mobile medical and phlebotomy services

Data Indicators:

- Percentage of PWH in the Dallas Regional Area with at least one lab visit in a calendar year
- Number of staff receiving capacity building support to promote engagement in care
- Number of engagement-focused capacity building sessions or events held
- Number of funded providers with evenings or weekend hours available
- Number of PWH determined to be out of care who are re-engaged in care.
- Number of funded providers offering mobile or home-based lab services

Data Sources: DCHHS, AETC and other training centers, contracts with funded providers, provider websites, Texas Department of State Health Services - HIV/STI Surveillance Unit

Objective 3 – By 2031, increase the percentage of people with HIV who are retained in care to 75% from a baseline of 61%.

Key Activities/Strategies:

1. Implement system-wide program to enhance coordination of case management services across the Dallas Regional Area.
2. Recruit and hire people with lived experience (HIV positive, experience utilizing the system) to provide key services including case management, linkage and navigation services, and support group facilitation.
3. Expand access to telehealth for PWH who have significant barriers to attending in-person medical appointments.
4. Analyze data to identify PWH who are not retained in care for increased outreach.

Key Partners: System-wide Case Manager position, case managers at funded organizations, funded care providers, housing and homeless services organizations, substance use and behavioral health providers, linkage navigators, peer navigators, outreach workers, telehealth providers

Data Indicators:

- Percentage of PWH in the Dallas Regional Area with two or more lab visits more than 3 months apart in a calendar year

- System wide case management model/program developed
- Number of people with lived experience hired by funded providers
- Percentage of PWH in the Dallas Regional Area with two or more lab visits more than 3 months apart in a calendar year
- Number of providers offering telehealth programs
- Number of PWH identified to be engaged in care but not retained in care

Data Sources: Ryan White Program data, FindHelp, DCHHS, System-wide Case Manager position, funded care providers, providers funded for reengagement activities, agency-level reports, Texas Department of State Health Services - HIV/STI Surveillance Unit

Objective 4 – By 2031, increase the percentage of people with HIV who are virally suppressed to 90% from a baseline of 66%.

Key Activities/Strategies:

1. Address barriers to accessing behavioral health and substance abuse treatment services.
2. Implement social marketing campaigns to communicate key messages to promote viral suppression including U=U and advancements in HIV care.
3. Implement consumer survey(s) to better understand barriers to medication access and adherence.
4. Analyze data to identify PWH who are engaged in care but not virally suppressed for additional outreach and support.

Key Partners: Pharmacies, pharmaceutical companies, substance use, mental and behavioral health services providers, funded HIV care providers, agencies funded for social marketing campaigns, transportation providers, case managers

Data Indicators:

- Percentage of PWH in the Dallas Regional Area with viral load of <200 copies/mL
- Number of Ryan White clients accessing mental health and substance use treatment services
- Number of agencies funded to implementation social marketing campaigns focused on U=U and advancements in HIV care
    - Campaign metrics – number of campaign assets, clicks, views, impressions
- Number of individuals responding to consumer and other surveys
- Number of PWH identified as being engaged in care but not virally suppressed

Data Sources: Ryan White program data, FindHelp, DCHHS, Agency-level campaign reports, Texas Department of State Health Services - HIV/STI Surveillance Unit, organizations offering HIV care, agency-level reports, CDC HIV Surveillance Supplemental Report

Goal 3: Prevent new HIV transmissions in the Dallas Region by using proven interventions, including Pre-Exposure Prophylaxis (PrEP).

Objective 1 – By 2031, reduce the number of new HIV diagnoses in the Dallas Regional area to 551 from a baseline of 1,101.

Key Activities/Strategies:

1. Promote condom distribution and access programs.
2. Recruit credible messengers to serve as community liaisons and engage community members in prevention education and awareness activities.
3. Strengthen collaboration with non-traditional partners and community-based organizations that serve priority populations, including Black women, MSM, particularly Black and Latinx MSM, people who inject drugs, & Dallas EMA residents aged 25-34 years old.
4. Offer capacity building to staff at healthcare and community-based organizations to promote awareness and use of HIV prevention strategies like condoms, PrEP, and U=U.

Key Partners: DCHHS, HIV Task Force, organizations focused on youth, women, the LGBT community, and substance use/behavioral health services, community champions/credible messengers, housing/homeless services organizations, outreach workers

Data Indicators:

- Number of new HIV Diagnoses in the Dallas Region
- Total number of condoms distributed to organizations and at large-scale events
- Number of community events held to distribute condoms and increase awareness of HIV prevention options
- Number of credible messenger/community liaisons recruited
- Number of capacity building sessions or activities held on HIV prevention
- Number of staff receiving capacity building support for HIV prevention

Data Sources: AIDSVu PrEP Data, CDC HIV Surveillance Data Tables, DCHHS, Clinic-level reports, HIV testing and PrEP providers, HIV care providers, agency-level reports, AETC and other training centers

Objective 2 - By 2031, increase the number of people prescribed PrEP in the Dallas Regional Area to 17,600 from a baseline of 11,042.

Key Activities/Strategies:

1. Implement social marketing campaigns to raise community awareness of PrEP and newer options for PrEP like long-acting injectables.
2. Strengthen collaboration with clinical and community-based organizations that serve populations who underutilize PrEP.
3. Provide education and resources to medical providers and community-based organizations on available PrEP options to increase awareness and prescription of PrEP.

Key Partners: HIV Task Force, pharmaceutical companies, sexual health clinics, reproductive health centers, primary care centers, FQHCs and FQHC lookalikes, CBOs, specifically those serving priority populations, organizations that serve the LGBTQ community, AETC and other training centers

Data Indicators:

- Number of people in the Dallas Regional Area with a PrEP prescription

- Number of agencies funded to implement social marketing campaigns implemented to promote PrEP
    - Campaign metrics – number of campaign assets, clicks, views, impressions
- Number of educational resources developed on available PrEP options

Data Sources: AIDSVu PrEP Data, CDC HIV Surveillance Data Tables, Clinic-level reports, DCHHS, social marketing campaign reports

Objective 3 – By 2031, increase the PrEP-to-Need Ratio in the Dallas Regional Area to 32 from a baseline of 10.

Key Activities/Strategies:

1. Implement telehealth and mobile health options to expand access to PrEP across the Dallas Regional Area.
2. Implement communication strategies to increase awareness of PrEP among healthcare providers (dear colleague letters, direct outreach, etc).
3. Implement surveys to assess community awareness of PrEP, PEP, and U=U.

Key Partners: RAI, HIV Task Force, EHE Coordinator, Funded prevention and PrEP providers

Data Indicators:

- PrEP to Need Ratio in the Dallas Regional Area (number of people with a PrEP prescription divided by the number of new HIV diagnoses in a given year)
- Number of providers offering tele-PrEP and mobile PrEP programs.
- Number of communication strategies implemented to increase provider awareness of PrEP
- Percentage of survey participants who report being aware of:
    - PrEP
    - PEP
    - U=U

Data Sources: AIDSVu PrEP Data, CDC HIV Surveillance Data Tables, Clinic-level reports, Status Neutral Needs Assessment data

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

Objective 1- By 2031, Develop a regional Cluster Detection and Response Plan for the Dallas Regional Area.

Key Activities/Strategies:

1. Connect with other jurisdictions to gather examples of regional cluster detection and response plans.
2. Ensure that data sharing and use practices are updated in contracts, MOUs, and formal data sharing agreements between the state, counties, testing agencies, community organizations, hospitals.
3. Surveillance and epidemiology staff to participate in capacity building opportunities (such as workshops, tabletop exercises, etc.) to prepare for potential HIV clusters or outbreaks.

Key Partners: Tarrant County HIV Administrative Agency, HIV Task Force, Texas Department of State Health Services - HIV/STI Surveillance Unit, funded prevention and care partners

Data Indicator(s):

- Dallas Regional Cluster Detection and Response plan developed
- Number of example regional Cluster Detection and Response plans gathered
- Number of data use and sharing agreements, contracts, and MOUs in place
- Number of capacity building sessions or events attended by surveillance and epidemiology staff

Data Source(s): DCHHS, Tarrant County HIV Administrative Agency, funded prevention and care partners, Texas Department of State Health Services - HIV/STI Surveillance Unit event registration and attendance records

Objective 2 – Through 2031, implement 3 community and partner engagement strategies annually to increase access and coordination of supportive services that address social determinants of health.

Key Activities/Strategies:

1. Conduct community listening sessions to better understand barriers and needs of priority populations, including Black women, gay & bisexual men of color, people who inject drugs, and individuals aged 25-34.
2. Implement consumer surveys to better understand barriers and social determinants of health impacting PWH and people at greater risk of acquiring HIV in the Dallas Regional Area.
3. Conduct annual provider meetings that bring together prevention, care, and other community partners and stakeholders.

Key Partners: Ryan White Planning Council, HIV Task Force, Fast Track Counties, organizations focused on youth, women, the LGBT community, and substance use/behavioral health services, funded prevention and care partners

Data Indicator(s):

- Number of community and partner engagement strategies implemented annually
    - Number of community listening sessions conducted
    - Number of people completing consumer surveys
    - Number of annual meetings conducted that bring together prevention and care providers
        - Number of meeting attendees per event
- Status neutral needs assessment implemented biannually
    - Number of focus groups conducted
    - Number of individuals completing status neutral needs assessment survey

Data Source(s): RAI, DCHHS, community listening session data/notes, consumer survey data, status neutral needs assessment data, meeting registration and attendance records

Objective 3 - Through 2031, maintain a comprehensive directory of prevention, care, and supportive services to facilitate rapid, status neutral linkage to services.

Key Activities/Strategies:

1. Continuously review external databases and directories to stay up to date on service providers offering mental and behavioral health, substance use services, housing, transportation, food and nutrition services, etc.
2. Work with organizations to ensure accurate contact and referral information is reflected in the FindHelp directory system.
3. Establish formal partnerships between identified non-funded organizations and funded prevention and care organizations.

Key Partners: FindHelp, Organizations serving priority populations, Ryan White Planning Council, HIV Task Force, Fast Track Counties, funded prevention and care partners

Data Indicator(s):

- FindHelp directory system reviewed and updated annually
- Number of external federal, state, and local service directories documented and reviewed annually
- Number of funded partners updating and submitting FindHelp contact and referral information annually
- Number of formal partnership agreements (MOUs, business agreements, etc.,) implemented between funded prevention and care and non-funded partners

Data Source(s): FindHelp, federal, state, and local service directories, funded prevention and care partners

SECTION 6: Implementation, Monitoring and Jurisdictional Follow Up

1. 2027-2031 Integrated Planning Implementation Approach

The Dallas Regional Area Integrated HIV Prevention and Care Plan 2027-2031 will anchor the planning, implementation, monitoring, and evaluation of all HIV prevention and care activities in the Dallas Regional Area over the next five years. The Plan will serve as a primary resource and reference as decisions are made regarding funding, resource allocation, and new initiatives to ensure that all funded prevention and care activities align with the Goals, Objectives, and Strategies outlined in the plan.

a. Implementation

Once the plan is finalized and approved, it will be disseminated widely to all funded prevention and care organizations and through additional public channels to let key stakeholders in the Dallas Regional Area know that the Plan will guide work to end the HIV epidemic in the Dallas EMA over the next five years. There are multiple groups in the Dallas Regional Area that will support implementation of the Integrated Plan. The Fast Track Counties group will serve as the key implementation and monitoring group for the Integrated Plan, with support from the Ryan White Planning Council. The HIV Task Force, comprised of individuals with lived

experience and/or individuals who support prevention efforts, will support community engagement and dissemination of information as it relates to the Integrated Plan.

Dallas County Health and Human Services (DCHHS) will support implementation of Integrated Plan objectives through multiple funding streams, including Ryan White Part A, Part B, State Services, MAI, HOPWA, HUD, HRSA EHE, CDC EHE, and CDC Prevention funding. While DCHHS does not directly receive SAMHSA funding, some subrecipients may receive SAMHSA funds and may be able to support related activities through their own funding streams. In addition, DCHHS will continue to leverage partnerships with local support services and systems, including housing, behavioral health, women's health, correctional systems, and other community-based partners, where alignment supports Integrated Plan objectives. To support community engagement, stakeholders will be invited to attend and engage with important planning bodies like Fast Track Counties and Ryan White Planning Council, and will also have an opportunity to attend conferences, provider meetings, and summits that take place in the jurisdiction. Prevention and testing activities are supported through coordination across DCHHS, DSHS, CDC-funded programs, and community partners. Within DCHHS, the STI/HIV Division oversees prevention activities completed through the medical mobile unit, while the county sexual health clinic supports STI screening and treatment throughout the Dallas regional area. In addition, the EHE team oversees CDC EHE-funded testing and prevention activities, and DSHS and CDC funding support broader prevention, testing, surveillance, and implementation efforts across the jurisdiction.

b. Monitoring

There are several groups that will play a role in overseeing the implementation and monitoring of the 2022-2026 Integrated Plan, including the Fast Track Counties committee and Ryan White Planning Council. The Fast Track Counties group will convene quarterly, while the Ryan White Planning Council will continue to support the process through its established committee structure. These meetings will focus on reviewing current roles and tasks related to implementation and monitoring, and discussing progress made towards the goals and objectives.

Currently, agencies, including RWHAP-funded and EHE-funded agencies, submit quarterly updates using an established workplan template during Fast Track Counties meetings. DCHHS has also hired a system-wide case manager whose primary responsibility will be to lead a regional case management operating committee to support regular data collection from all funded agencies.

Prevention and testing activity implementation will be monitored through contractually required reports, the workplan, quarterly updates, peer-to-peer collaboration, and ongoing partner engagement. DCHHS will also communicate updates and coordinate with other EHE jurisdictions, such as Tarrant County, on a monthly basis to discuss key initiatives and progress toward ending the HIV epidemic in Texas. Program staff and data staff will work together to conduct ongoing data collection, evaluation of epidemiological data, and oversee completion of other monitoring to support reporting requirements.

In addition to continuous communication and collaboration among key implementation and monitoring groups, there will be a liaison between all standing committees responsible for receiving and sharing information among these groups outside of regularly scheduled meetings.

c. Evaluation

On a biannual basis, data and program staff will conduct analyses, run reports, and collect data using performance measures spreadsheet to document progress made toward Plan Goals and Objectives. They will also coordinate with funded care and prevention partners, state surveillance contacts, and other collaborators to collect data on performance measures to demonstrate progress toward Plan Objectives. The Clincal Quality Management (CQM) Programs for RW and EHE will support reporting of Integrated Plan performance measures through routine monitoring for funded providers, including EHE and Prevention funded providers.

DCHHS and partners will also develop a data dashboard to track and visualize real-time performance measure data and to support routine reporting and monitoring of progress toward Plan Objectives.

d. Improvement

The Planning and Priorities and Evaluation Committee of Ryan White Planning Council will review the Plan on an annual basis and determine if any modifications need to be made to the Plan. If any suggested modifications are identified, Dallas County Health and Human Services and the Ryan White Planning Council will convene funded HIV prevention and care partners as needed to review and share proposed changes. After partner feedback is obtained and incorporated, the updated Plan will be shared with both the Ryan White Planning Council and Fast Track Counties group for review, updates, and concurrence. Once approved, the Plan will be disseminated through stakeholder and community channels to ensure funded and non-funded partners have access to the most recent version of the Plan.

Ongoing monitoring and evaluation activities will support decisions if plan updates need to be made. If specific activities described in Section 5 are not leading to progress toward Goals and Objectives, current activities may be deprioritized, or new activities may be considered and added to the plan.

To engage community stakeholders and encourage wide community awareness and participation, DCHHS hosts an annual World AIDS Day Summit. DCHHS also has a Community Advisory Board that will be provided with opportunities to provide input on implementation activities. Additional community input will be gathered through Planning Council meetings, annual consumer experience surveys, and other community engagement activities.

e. Reporting and Dissemination

In addition to the quarterly updates shared during the Fast Track Counties meeting, and the public facing dashboard, DCHHS will prepare a summary on progress made toward Objectives and Strategies included in the plan on an annual basis. This report will be disseminated to the Ryan White Planning Council, Fast Track Counties, HIV Task Force, and key prevention and care partners. In addition, this report will be published on relevant websites (e.g., EMA and Ryan White Planning Council websites).