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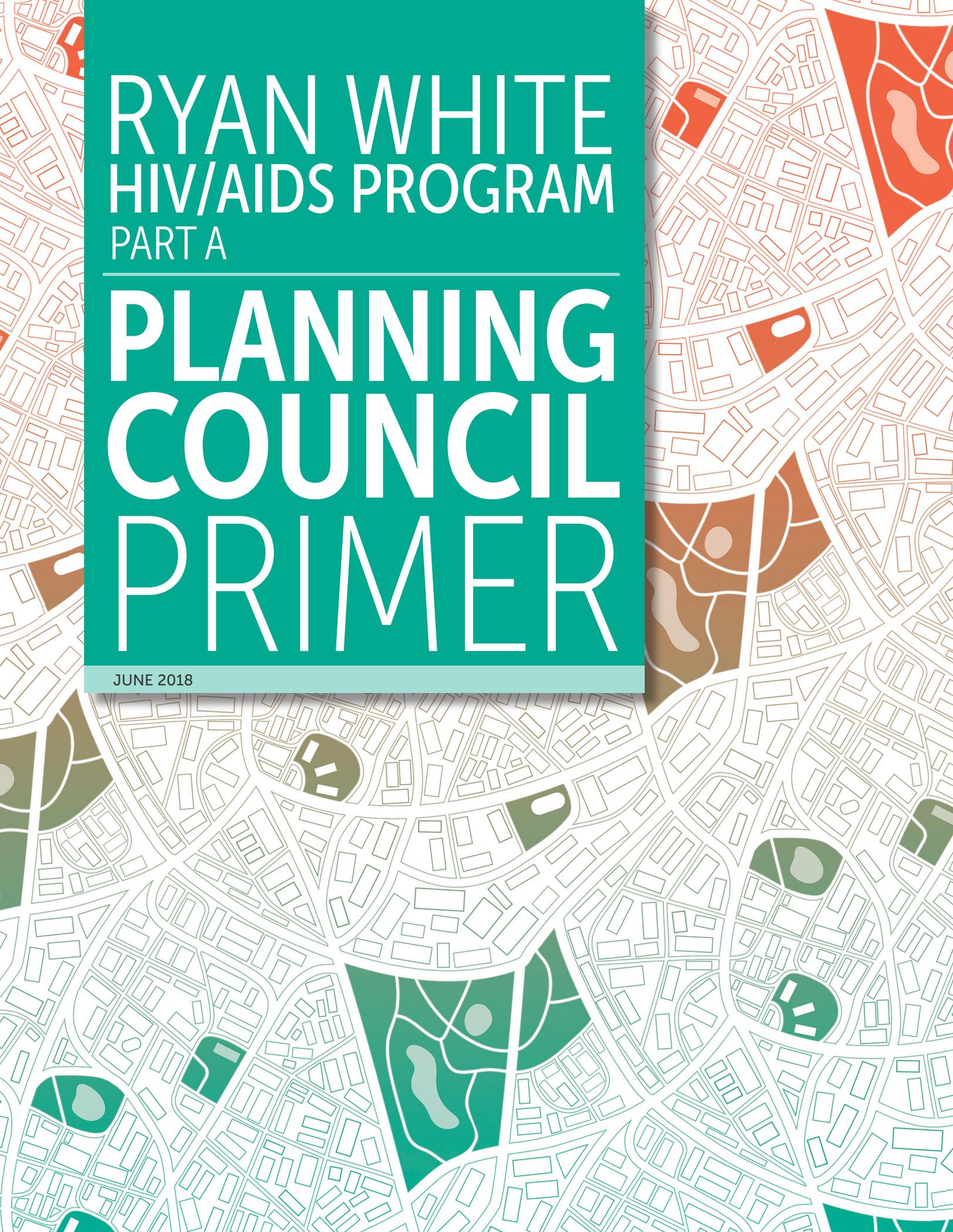
- **PLANNING COUNCIL PRIMER**
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ADDENDUM ATTACHMENTS:

- **DALLAS EMA INTEGRATED HIV PREVENTION AND CARE PLAN**
- **EHE IN TEXAS- DALLAS HSDA 2018 CONTINUUM OF CARE**



WEDNESDAY, APRIL 13, 2022



RYAN WHITE
HIV/AIDS PROGRAM
PART A

PLANNING
COUNCIL
PRIMER

JUNE 2018



PLANNING CHATT

Community HIV/AIDS
Technical Assistance & Training

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Introduction

Uniqueness and Value of Planning Councils

One of the important aspects of the Ryan White HIV/AIDS Program (RWHAP) is its focus on community health planning for HIV care and treatment. Community health planning is a deliberate effort to involve diverse community members in “an open public process designed to improve the availability, accessibility, and quality of healthcare services in their community.”¹ The process involves “identifying community needs, assessing capacity to meet those needs, allocating resources, and resolving conflicts.” For RWHAP Part A, planning councils/planning bodies play that role.

RWHAP planning councils are unique. No other federal health or human services program has a legislatively required planning body that is the decision maker about how funds will be used, has such defined membership composition, and requires such a high level of consumer participation (at least 33 percent). When more than 100 recipients, planning council leaders, and planning council support staff were asked in a recent national assessment² about the greatest value of planning councils, they most often identified the following benefits:

- Community involvement in decision making about HIV services
- A consumer voice in decisions about services
- Collaboration among diverse stakeholders, including consumers and other people living with HIV, providers, the local health department, researchers, and other community members, with everyone sitting at the same table and working together to make the best decisions for the community
- Positive impact on the service system, including improvements in access to and quality of care, and contributions to positive client outcomes including viral suppression.

Individuals who serve as RWHAP planning council members make a vital contribution to their communities by helping to strengthen and improve the service system for people living with HIV.

1 Stern J. Community Planning, American Health Planning Association, 2008. available at http://www.ahpanet.org/files/community_health_planning_09.pdf

2 McKay E., et al. Engaging RWHAP Consumers in Planning and Needs Assessment, 2016 National Ryan White Conference on HIV Care & Treatment. available at <https://careacttarget.org/sites/default/files/supporting-files/6746McKay.pdf>

Purpose of the Primer

This Primer is designed to help Ryan White HIV/AIDS Program (RWHAP) Part A planning council members better understand the roles and functioning of planning councils.

The Primer explains what RWHAP does, and describes what planning councils do in helping make decisions about what RWHAP services to fund and deliver in their geographic areas. The Primer is intended to be a basic reference to help prepare planning council members to actively engage in planning council activities, and effectively carry out their legislatively defined community health planning duties.

While most RWHAP Part A jurisdictions have planning councils, a few smaller areas have planning bodies, which serve the same purpose but are not subject to the same legislative requirements as planning councils. This Primer describes the expectations for planning councils; there are no specific requirements for other types of planning bodies. However, Health Resources and Services Administration (HRSA) encourages such planning bodies to be as similar as possible to planning councils in their membership, and to carry out the same activities as planning councils³, as outlined in the legislation. Therefore this Primer should be useful to planning bodies as well as planning councils.

³ HRSA/HAB Letter to RWHAP Part A Grantees, 2013. Available at <https://hab.hrsa.gov/sites/default/files/hab/Global/transitionalgrantareasplanningcouncilsmoving-forward.pdf>

The Ryan White HIV/AIDS Program

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. The Program reaches over half of all people diagnosed with HIV in the United States.

The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training and the development of innovative models of care. The Program serves as an important source of ongoing access to HIV medications that can enable people living with HIV to live close to normal lifespans.

The RWHAP legislation is known as the Ryan White HIV/AIDS Treatment Extension Act of 2009, and is also Title XXVI of the Public Health Service Act. The legislation was first passed in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The 2009 law is the fourth reauthorization of RWHAP by Congress. The program helps people living with HIV get into care early, stay in care, and remain healthy.

Most RWHAP funds are used for grants to local and state areas to address the needs of people living with HIV. Many decisions about how to use the money are made by local planning councils/planning bodies and state planning groups, which work as partners with their governments.

RWHAP is administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care by strengthening the healthcare workforce, building healthy communities and achieving health equity.

The RWHAP legislation supports grants under the five sections of the Act: Parts A, B, C, D, and F. Below is a short description of each. The majority of the funding that goes to RWHAP Part A and Part B is awarded under a formula based on the number of living HIV and AIDS cases in these areas.

RYAN WHITE HIV/AIDS PROGRAM FUNDING

- **RWHAP Part A:** Grants to metropolitan areas hardest hit by the epidemic for HIV medical care and support services
- **RWHAP Part B:** Grants to states and territories for HIV medical care and support services, including HIV-related medications through the AIDS Drug Assistance Program (ADAP)
- **RWHAP Part C:** Community-based early intervention services grants for HIV medical care and support services
- **RWHAP Part D:** Community-based grants for family-centered primary and specialty medical care and support services for infants, children, youth, and women living with HIV
- **RWHAP Part F:** Support for five programs—Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), HIV Dental Programs, and the Minority AIDS Initiative (MAI)

RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas

RWHAP Part A funds go to local areas that have been hit hardest by the HIV epidemic. The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV to improve their health outcomes.

Almost three quarters of people living with HIV in the U.S. live in RWHAP Part A-funded areas. These areas are called eligible metropolitan areas (EMAs) or transitional grant areas (TGAs):

- EMAs are metropolitan areas with at least 2,000 new cases of AIDS reported in the past five years and at least 3,000 cumulative living cases of AIDS as reported by the Centers for Disease Control and Prevention (CDC) in the most recent calendar year for which data are available. As of early 2018, there were 24 EMAs.
- TGAs are metropolitan areas with between 1,000 and 1,999 new cases of AIDS reported in the past five years and at least 1,500 cumulative living cases of AIDS as reported by the CDC in the most recent calendar year for which data are available. As of early 2018, there were 28 TGAs.

RWHAP Part A funds go to the **chief elected official (CEO)** of the major city or county government in the EMA or TGA. The CEO is usually the mayor; however sometimes the CEO is the county executive, chair of the board of supervisors, or county judge. The CEO is legally the recipient of the grant, but usually chooses a lead agency such as a department of health or other entity to manage the grant. That entity is also called the **recipient**. The recipient manages the grant by making sure RWHAP funds are used according to the RWHAP legislation, program policy guidance, and grants policy. The recipient works with the **RWHAP Part A planning council/planning body**, which is responsible for making decisions about service priorities and resource allocation of RWHAP Part A funds.

RWHAP Part A funds are used to develop or enhance access to a comprehensive system of high quality, community-based care for low-income people living with HIV. RWHAP Part A recipients must provide comprehensive primary health care and support services throughout the entire geographic service area. RWHAP Part A funds may be used for HIV primary medical care and other medical-related services and for support services (like medical transportation) that are needed by people living with HIV in order to stay in care, and linked to positive medical outcomes.

At least 75 percent of service funds must be used for core medical-related services, and up to 25 percent may be used for approved support services, unless the EMA or TGA successfully

applies for a waiver. A limited amount of the money (up to 10 percent of the total grant) can be used for administrative costs, which include planning, managing, monitoring, and evaluating programs. Administrative funds are also used to support a comprehensive community planning process, through the work of a planning council or other planning body. In addition, some funds (up to 5 percent of the total grant or \$3 million, whichever is less) are set aside for clinical quality management, to ensure service quality.

RWHAP Part B: Grants to States and Territories

RWHAP Part B provides funds to improve the quality, availability, and organization of HIV health care and support services in states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the U.S. Pacific Territories and Associated Jurisdictions.

Like RWHAP Part A funds, RWHAP Part B funds are used for medical and support services. A major priority of RWHAP Part B is providing medications for people living with HIV. The RWHAP legislation gives states flexibility to deliver these services under several programs:

- Grants for medical and support services for people living with HIV
- The AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications through the purchase of medications and the purchase of health insurance
- Grants to states with emerging communities that have a growing rate of HIV/AIDS.

States can receive ADAP funds through three types of grants:

- Formula funding that goes to every state and territory based on the number of living HIV/AIDS cases reported by the CDC in the most recent calendar year
- Competitive ADAP supplemental funding, supported through a five percent set aside of the ADAP base award and provided to states and territories that meet RWHAP legislative eligibility criteria and apply for additional funds to address a severe need for medications
- Competitive ADAP Emergency Relief Funding (ERF), available to states and territories that can demonstrate the need for additional resources to prevent, reduce, or eliminate waiting lists, including through cost-containment measures.

ADAP funds are used to provide HIV antiretroviral medications to low-income people living with HIV. Funds may also be used to pay for health coverage, copays, and deductibles* for eligible clients and for services that enhance access and adherence to drug treatments, or monitor drug treatments.

ADAP FORMULARY REQUIREMENTS

Each ADAP must cover at least one drug from each class of HIV antiretroviral medications on its ADAP formulary. RWHAP funds may only be used to purchase FDA-approved medications. Within these requirements, each ADAP decides which medications to include on its formulary and how those medications will be distributed. ADAP eligibility criteria must be consistently applied across the state or territory, and all formulary medications and ADAP-funded services must be equally and consistently available to all eligible enrolled people throughout the state or territory.

As with RWHAP Part A, 75 percent of RWHAP Part B service dollars must be used for core medical-related services unless the state obtains a waiver. RWHAP Part B recipients can use no more than 10 percent of their grants for administration, including indirect costs. They can also use up to 10 percent for planning and evaluation, but the total for both types of activities must be no more than 15 percent of the RWHAP Part B grant. As with RWHAP Part A, recipients may also spend up to 5 percent of their grant or up to \$3 million, whichever is less, for the establishment and implementation of a clinical quality management program.

States are required to conduct a needs assessment to determine service needs of people living with HIV. Based upon needs assessment results, states must set priorities and allocate resources to meet these needs. States must also prepare an integrated HIV prevention and care plan, including a **Statewide Coordinated Statement of Need (SCSN)**, which is a guide on how to meet these needs.

Planning is an essential part of determining how to use limited RWHAP Part B funds in providing a system of HIV/AIDS care. States are required to obtain community input as a component of planning for the use of RWHAP Part B resources, and many states do this through RWHAP Part B advisory groups. A state can choose to oversee planning itself through statewide or regional planning groups, or can assign the responsibility to consortia. Consortia are associations of public and nonprofit healthcare and support service providers and community-based organizations that the state contracts with to provide planning, resource allocation and contracting, program and fiscal monitoring, and required reporting. Some are statewide groups, while others cover specific local areas or regions. Some regional consortia also directly deliver medical and support services.

Some states also receive **Emerging Communities** grants to establish and support systems of care in metropolitan areas that are not eligible for RWHAP Part A funding but have a growing rate of HIV. To be eligible for these funds, a metropolitan area must have between 500 and 999 AIDS cases reported in the past five years. To stay eligible, it must have at least 750 cumulative living AIDS cases as of the most recent calendar year. Some Emerging Communities eventually become eligible for RWHAP Part A funding.

RWHAP Part C: Community-Based Early Intervention Services

RWHAP Part C funds local, community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people living with HIV.

RWHAP Part C funding is through **Early Intervention Services (EIS)** program grants. RWHAP Part C funds also help organizations more effectively deliver HIV care and services. Unlike RWHAP Part A and Part B, these funds are awarded competitively and go directly to community agencies like community health centers, rural health clinics, health departments, and hospitals. While RWHAP Part C funds many locations around the nation, a funding priority under the legislation is support for HIV-related primary care services in rural areas or for populations facing high barriers to access.

RWHAP Part C recipients must use at least 50 percent of the grant for EIS. They may use no more than 10 percent of their grants for administration, including indirect costs. In addition, RWHAP Part C recipients must use at least 75 percent of their grant funds for core medical services and up to 25 percent for support services. This is the same requirement that applies to Parts A and B.

RWHAP Part C also provides Capacity Development grants. **Capacity Development** grants help public and nonprofit entities strengthen their organizational infrastructure and improve their capacity to provide high-quality HIV primary care services.

RWHAP Part D: Services for Women, Infants, Children, and Youth

RWHAP Part D funds are used to provide family-centered primary medical care and support services to women, infants, children, and youth living with HIV. RWHAP Part D funds are competitive grants that go directly to local public or private healthcare organizations including hospitals, and to public agencies.

RWHAP Part D grants are used for medical services, clinical quality management, and support services, including services designed to engage youth living with HIV and retain them in care. Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth. RWHAP Part D recipients can use no more than 10 percent of their grants for administration, including indirect costs.

RWHAP PART C EARLY INTERVENTION REQUIRED SERVICES

EIS programs must include the following components:

- HIV counseling
- High-risk targeted HIV testing
- Referral and linkage of people living with HIV to comprehensive care, including outpatient/ambulatory health services, medical case management, substance abuse treatment, and other services
- Other HIV-related clinical and diagnostic services

RWHAP Part F: SPNS, AETC, Dental Programs, and MAI

RWHAP Part F provides grant funding that supports several research, technical assistance, and access-to-care programs.

- **Special Projects of National Significance (SPNS):** SPNS funds are awarded competitively to organizations that are developing new and better ways of serving people living with HIV and addressing emerging client needs. Projects include a strong evaluation component.
- **AIDS Education and Training Centers (AETCs):** AETC regional and national centers train health care providers treating people living with HIV. AETCs train clinicians and multidisciplinary HIV care team members. They help to increase the number of health care providers prepared and motivated to counsel, diagnose, treat, and medically manage people living with HIV.
- **HIV/AIDS Dental Reimbursement Program:** These funds go to dental schools and other dental programs to help pay for dental care for people living with HIV.
- **Community Based Dental Partnership Program:** These funds are used to deliver community-based dental care services for people living with HIV while providing education and clinical training for dental care providers, especially in community-based settings.
- **Minority AIDS Initiative (MAI):** MAI funds are used to improve access to health care and medical outcomes for racial and ethnic minorities— communities that are disproportionately affected by HIV. RWHAP Part A programs apply for MAI funds as part of their annual applications, and receive funds on a formula basis. They are expected to administer MAI activities as an integral part of their larger programs.

How RWHAP Part A Works

The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured people living with HIV residing in the EMA/TGA, in order to improve their health outcomes. This section of the Primer describes the people and entities that participate in RWHAP Part A and what they do.

Participants

Participants in the RWHAP Part A grant for the EMA or TGA include the following:

- The chief elected official (CEO), who receives the funds on behalf of the EMA or TGA
- The recipient, the entity chosen by the CEO to manage the grant and make sure funds are used appropriately
- The planning council (or planning body), which conducts planning, decides how to allocate resources, and works to ensure a system of care that provides equitable access to care and needed services to all eligible people living with HIV in the EMA or TGA
- The HRSA HIV/AIDS Bureau's Division of Metropolitan HIV/AIDS Programs (HAB/DMHAP), the federal government entity within HRSA that makes sure the RWHAP Part A program is implemented appropriately.

The Chief Elected Official (CEO)

The CEO is the person who officially receives the RWHAP Part A funds from HRSA. The CEO is the chief elected official of the major city or urban county in the EMA or TGA that provides HIV care to the largest number of people living with HIV. The CEO may be a mayor, chair of the county board of supervisors, county executive, or county judge. The CEO is responsible for making sure that all the rules and standards for using RWHAP Part A funds are followed. The CEO usually designates an agency to manage the RWHAP Part A grant—generally the county or city health department. The CEO establishes the planning council/planning body and appoints its members.

The Recipient

As the person who receives RWHAP Part A funds, the CEO is the recipient. However, in most EMAs and TGAs, the CEO delegates responsibility for administering the grant to a local government agency (such as a health department) that reports to the CEO. This agency is called the recipient. The word "recipient" means the person or organization that actually carries out RWHAP Part A tasks, whether that is the CEO, the public health department, or another agency that reports to the CEO.

THE RWHAP PART A AWARDS PROCESS

Each year Congress appropriates funds for the Ryan White HIV/AIDS Program, including RWHAP Part A. The money for RWHAP Part A is divided into formula and supplemental funds and Minority AIDS Initiative (MAI) funds.

- **Formula funds** are awarded to EMA or TGAs based on the number of persons living with HIV and AIDS in the EMA or TGA.
- **Supplemental funds** are awarded to the EMA or TGA based on increasing prevalence rates, documented demonstrated need and service gaps, and a demonstrated disproportionate impact on vulnerable populations.
- **RWHAP Part A MAI funds** are allocated based on each EMA's or TGA's percentage of all living HIV disease cases among racial and ethnic minorities.

EMAs or TGAs must submit a grant application to HRSA to receive RWHAP Part A formula, supplemental, and MAI funds.

The recipient should prepare the application with planning council/planning body input. The funding year begins on March 1.

The Planning Council

Before an EMA/TGA can receive RWHAP Part A funds, the CEO must appoint a planning council. The planning council must carry out many complex planning tasks to assess the service needs of people living with HIV living in the area, and specify the kinds and amounts of services required to meet those needs. The planning council is assisted in fulfilling these complex tasks by **planning council support (PCS) staff** whose salaries are paid by the grant.

The RWHAP legislation requires planning councils to have members from various types of groups and organizations, including people living with HIV who live in the EMA/TGA. A key function of the planning council is to provide the consumer and community voice in decision-making about medical and support services to be funded with the EMA/TGA's RWHAP Part A dollars.

TGAs do not have to follow the legislative requirements related to planning councils, but must provide a process for obtaining consumer and community input. TGAs that have currently operating planning councils are strongly encouraged by the HIV/AIDS Bureau to maintain that structure.

HRSA/HAB

The HRSA HIV/AIDS Bureau (HAB) is the office in the federal government that is responsible for administering RWHAP Part A throughout the country. The HRSA/HAB office is located in Rockville, Maryland. HRSA develops policies to help implement the legislation, and provides guidance to help recipients understand and implement legislative requirements. These include Policy Clarification Notices (PCNs), related Frequently Asked Questions (FAQs), and Program Letters.

Each EMA or TGA is assigned a **Project Officer** who works in HRSA/HAB. Project Officers help the recipient and planning council do their jobs and make sure that they are running the local RWHAP Part A program as the RWHAP legislation, National Monitoring Standards, and other federal regulations say they should. Project Officers make periodic site visits and hold monthly monitoring calls with the recipient. The planning council Chair is sometimes included on a part of these calls.

Planning Council and Recipient: Separate Roles and Mutual Goals

The RWHAP Part A planning council and the recipient have separate roles that are stated in the RWHAP legislation, but they also share some duties.

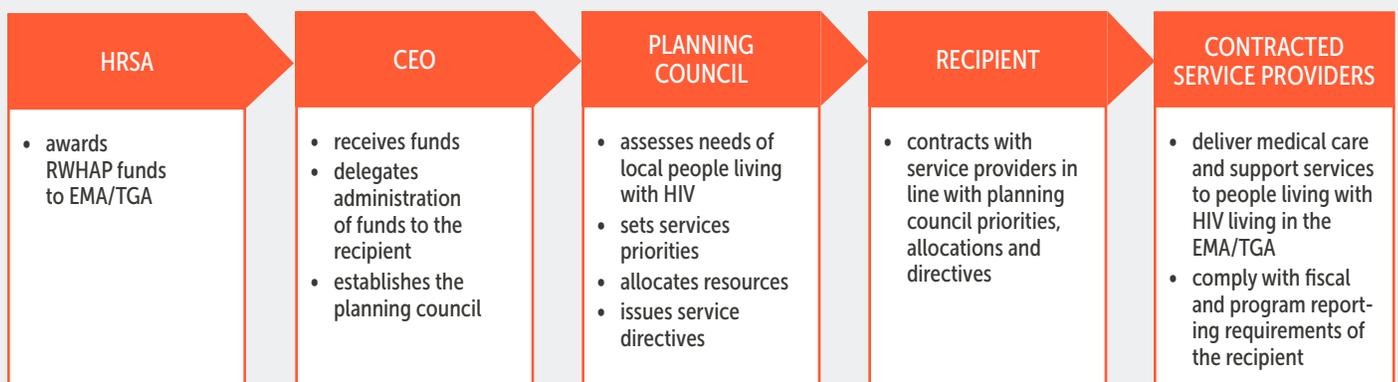
The planning council and the recipient work together on identifying the needs of people living with HIV (by conducting a needs assessment) and preparing a **CDC and HRSA Integrated HIV Prevention and Care Plan**, formerly known as a comprehensive plan (which is a long-term guide on how to meet those needs).

Both also work together to make sure that other sources of funding work well with RWHAP funds and that RWHAP is the “payor of last resort.” This means that other available funding should be used for services before RWHAP dollars are used to pay for them.

The planning council decides what services are priorities for funding and how much funding should be provided for each service category, based upon the needs of people living with HIV in the EMA/TGA. The recipient is accountable for managing RWHAP Part A funds and awarding funds to agencies to provide services that are identified by the planning council as priorities, usually through a competitive “Request for Proposals” (RFP) process.

The planning council cannot do its job without the help of the recipient, and the recipient cannot do its job without the help of the planning council. Some of the responsibilities are identified clearly in the RWHAP legislation. Others must be decided locally. It is important that the planning council and the recipient work together and come to an agreement about their duties. This agreement should be written in planning council bylaws and in a memorandum of understanding (MOU) between the recipient and the planning council.

How RWHAP Part A Improves Access and Services for People Living with HIV



The table below shows which RWHAP Part A participant has responsibility for specific roles and duties. Each of these roles/duties is described in detail in the following sections of the Primer.

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	<i>Optional</i>
Development of Service Standards		✓	✓
Clinical Quality Management		✓	<i>Contributes but not responsible</i>
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

Planning Council Duties

The planning council (and its staff) must carry out many complex tasks, summarized in the box and described below.

The first step is to set up rules and structures to help the planning council to operate smoothly and fairly (**planning council operations**). This includes bylaws, grievance procedures, conflict of interest policies and procedures, procedures that ensure open meetings, and an open nominations process to identify nominees for the planning council. It also includes a committee structure. Planning councils must be trained in planning, and new members must receive orientation to their roles and responsibilities and those of the recipient.

The planning council must find out about what services are needed and by which populations, as well as the barriers faced by people living with HIV in the EMA or TGA (**needs assessment**). Next—based on needs assessment, utilization, and epidemiologic data—it decides what services are most needed by people living with HIV in the EMA or TGA (**priority setting**) and decides how much RWHAP Part A money should be used for each of these service categories (**resource allocations**).

The planning council may also provide guidance to the recipient on service models, targeting of populations or service areas, and other ways to best meet the identified priorities (**directives**). The planning council works with the recipient to develop a long-term plan on how to provide these services (**integrated/comprehensive planning**, formerly called comprehensive planning). The planning council reviews service needs and ways that RWHAP Part A services work to fill gaps in care with other RWHAP Parts through the Statewide Coordinated Statement of Need (SCSN) as well as with other programs like Medicaid and Medicare (**coordination**).

The planning council also evaluates how providers are selected and paid, so that funds are made available efficiently where they are most needed (**assessment of the efficiency of the administrative mechanism**). All of these roles are described below.

Planning Council Operations

Planning councils must have procedures to guide their activities. Planning council operations are usually outlined in their bylaws and described in greater detail in policies and procedures covering the following areas:

MEMBERSHIP

The planning council needs a membership committee and a clear and open nominations process to choose new planning council

PLANNING COUNCIL ROLES AND RESPONSIBILITIES

- Planning council operations: structure, policies, and procedures, and membership tasks
- Needs assessment
- Integrated/comprehensive planning
- Priority setting and resource allocations
- Directives: guidance to the recipient on how best to meet priorities
- Coordination with other RWHAP Parts and other HIV-related services
- Assessment of the efficiency of the administrative mechanism
- Development of service standards
- Evaluation of program effectiveness (optional)

members and to replace members when a member's term ends or the person resigns. This includes making sure that the planning council membership overall and the consumer membership meet the requirements of **reflectiveness**—having characteristics that reflect the local epidemic in such areas as race, ethnicity, gender, and age, and **representation**—filling the required membership categories as stated in the legislation (See page 17). Particular attention should be paid to including people from disproportionately affected and “historically underserved”⁴ groups and subpopulations. At least 33 percent of voting members must be consumers of RWHAP Part A services who are “unaffiliated” or “unaligned.” This means they do not have a conflict of interest, meaning they are not staff, paid consultants, or Board members of RWHAP Part A-funded agencies.

Open nominations require member vacancies and nomination criteria to be widely advertised. The announcement of an opening on the planning council should include the qualifications and other factors that are considered when choosing members. Nomination criteria must include a conflict of interest standard so that planning council members make decisions that are best for people living with HIV in the EMA or TGA, without considering personal or professional benefits for themselves or their families. The planning council reviews nominations against vacancies and recommends members to the CEO for appointment.

LEADERSHIP

Every planning council has a leader, usually called the Chair. This responsibility may be shared by two or more persons, called Co-Chairs, or there may be a Chair and Vice Chair(s). HRSA suggests that the Chair of the planning council be elected by its members. Sometimes a Chair or one Co-Chair is appointed by the recipient from the list of members recommended by the planning council. A person who works for the recipient may not be the only Chair of the council—in this case, there must be Co-Chairs.

COMMITTEES

Planning councils do much of their work in committees. Most planning councils require each member to participate actively on one committee and to attend full planning council meetings. Bylaws usually specify several permanent “standing committees,” and may permit special ad hoc temporary or time-limited committees or caucuses as well. Committee structures vary, but most planning councils have an executive or steering committee, a membership committee (sometimes also responsible for operations such as policies and procedures), and a people living with HIV or consumer committee or caucus. In addition, they usually have one or several committees responsible for carrying out major legislative responsibilities related

⁴ Ryan White HIV/AIDS Treatment Extension Act of 2009
www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf

Required Planning Council Membership Categories



PEOPLE LIVING WITH HIV & COMMUNITY

- Members of affected communities*
- Non-elected community leaders
- Representatives of recently incarcerated people living with HIV
- Unaffiliated consumers



PUBLIC HEALTH & HEALTH PLANNING

- Public health agencies
- Healthcare planning agencies
- State agencies**



HEALTH & SOCIAL SERVICE PROVIDERS

- Healthcare providers, including FQHCs
- Community-based organizations and AIDS service organizations
- Social service providers
- Mental health and substance abuse treatment providers



FEDERAL HIV PROGRAMS

- RWHAP Part B recipients
- RWHAP Part C recipients
- RWHAP Part D recipients†
- Recipients under other federal HIV programs‡

* Including people living with HIV, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and "historically underserved⁴ groups and subpopulations

**Including state Medicaid agency and agency administering the RWHAP Part B program

† If there is no RWHAP Part D recipient in the EMA or TGA, representatives of organizations with a history of serving children, youth, and families living with HIV

‡ Including HIV prevention services

PLANNING COUNCIL BYLAWS

Each planning council must have written rules, called bylaws, which explain how the planning council operates. Bylaws must be clear and exact. They should include at least the following:

- Mission of the planning council
- Member terms and how members are selected (open nominations process)
- Duties of members
- Officers and their duties
- How meetings are announced and run, including how decisions are made
- What committees the planning council has and how they operate
- Conflict of interest policy
- Grievance procedures
- Code of Conduct for members
- How the bylaws can be amended

to needs assessment, integrated/comprehensive planning, priority setting and resource allocations, and maintaining and improving the system of care. Committees typically discuss issues, develop plans or recommendations, and bring them to the executive/steering committee for review and possible revision. Then the recommendations go to the full planning council for final discussion and action.

TRAINING

Members need to learn how to participate in the many tasks involved in RWHAP planning. Planning councils must provide orientation for new members, covering topics such as the legislation and their roles and responsibilities in planning, as well as those of the recipient. All planning council members should receive periodic training to help them carry out their roles. HRSA requires planning councils to confirm in the annual RWHAP Part A application that training for all members occurred at least once during the year.⁵

GROUP PROCESS

This includes a Code of Conduct, as well as rules for committee and full planning council operations, meeting times, and locations. These decisions are usually summarized in the bylaws and detailed in official policies and procedures.

DECISION MAKING

The planning council needs to agree on how decisions will be made—for example, by voting or consensus—and how grievances related to funding decisions and conflict of interest will be managed (see Planning Council Bylaws). For example, the planning council needs to decide whether its meetings will follow *Robert's Rules of Order*. These rules and procedures are usually included in the bylaws and further described in separate policies and procedures.

CONFLICT OF INTEREST

The planning council must define **conflict of interest** and determine how it will be handled as the planning council carries out its duties. The planning council must develop procedures to assure that decisions concerning service priorities and funding allocations are based upon community and client needs and not on the financial interests of individual service providers or the personal or professional interests of individual planning council members. Conflict of interest procedures generally include a disclosure form completed by all members that states in writing any affiliations that could create a conflict of interest.

⁵ The FY 2018 Notice of Funding Opportunity (NOFO) for RWHAP Part A requires that the letter of assurance from the planning council or the letter of concurrence from the planning body leadership provide evidence that “ongoing, annual membership training occurred, including the date(s)” [p 15].

Usually, conflict of interest policies also apply to specified family members. Thus, planning councils must decide how planning council members may or may not participate in making decisions about specific services if they or close family members are staff, consultants, or Board members of agencies that are receiving RWHAP Part A funds for these specific services, or are competing for such funds. For example, if a planning council member works for a substance abuse treatment provider receiving RWHAP Part A funds, the member may not participate in decision making about priorities, allocations, or directives related to substance abuse treatment. However, members may freely share their insights and expertise at appropriate times in a non-voting context, such as during data presentations or community input sessions, since all members can benefit from hearing a variety of perspectives and expertise.

GRIEVANCE PROCEDURES

The planning council must develop ***grievance procedures*** to handle complaints about how it makes decisions about funding. The grievance procedures must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled. The recipient must also have its own grievance procedures, which focus on handling of complaints about the process used for funding of ***subrecipients*** who provide services. The two sets of grievance procedures should be written to be in alignment with each other so that they do not conflict.

PLANNING COUNCIL SUPPORT

Planning councils need personnel to assist them in their work, and money to pay for things like a needs assessment and meeting costs. This is called ***planning council support***. Planning council support should cover reasonable and necessary costs associated with carrying out legislatively mandated functions. The planning council's budget is a part of the recipient's administrative budget, so the planning council and recipient decide together what funds are needed. The planning council then works with its support staff to develop its own budget and monitor expenses, but must meet RWHAP and recipient rules regarding use of funds. In deciding how much planning council support to pay for, planning councils and recipients should balance the need for support in order to meet planning requirements with the need for other administrative activities and for direct services for people living with HIV.

HRSA encourages planning councils to use some planning council support funds to reimburse unaffiliated consumer members for their actual expenses related to participation in the planning council, such as travel or child/dependent care. However, RWHAP funds may not be used to provide stipends to members.

Needs Assessment

The planning council works with the recipient to identify service needs by conducting a needs assessment. This involves first finding out how many persons living with HIV (both HIV/non-AIDS and AIDS) are in the area through an **epidemiologic profile**. Usually, an epidemiologist from the local or state health department provides this information. Next the council determines the needs of populations living with HIV and the capacity of the service system to meet those needs. This assessment of needs is done through surveys, interviews, key informant sessions, focus groups, or other methods.

The needs assessment seeks to determine:

- Service needs and barriers for people living with HIV who are in care
- The number, characteristics, and service needs and barriers of people living with HIV who know their HIV status and are not in care
- The estimated number, probable characteristics, and barriers to testing for individuals who are HIV-infected but unaware of their status
- The number and location of agencies providing HIV-related services in the EMA or TGA—a resource inventory of the local “system of care”
- Local agencies’ capacity and capability to serve people living with HIV, including capacity development needs
- Service gaps for all people living with HIV and how they might be filled, including how RWHAP service providers need to work with other providers, like substance abuse treatment services and HIV prevention agencies.

The needs assessment must include direct input from people living with HIV. Needs assessment is usually a multi-year task, with different components updated each year.

The needs assessment should be a joint effort of the planning council and recipient, with the planning council having lead responsibility. It is sometimes implemented by an outside contractor under the supervision of the planning council. Usually the costs for needs assessment are part of the planning council support budget. Regardless of who does this work, it is important to obtain many perspectives, especially those of diverse groups of people living with HIV, and to consider the needs of people living with HIV in and out of care, including the need to identify those who do not know their status. Results should be carefully analyzed and compared with other data, such as information from the recipient on client characteristics and utilization of funded services. (See Appendix I for a description of the multiple data sources the planning council reviews in making its decisions.)

Priority Setting and Resource Allocations

The planning council uses needs assessment data as well as data from a number of other sources to set priorities and allocate resources. This means the members decide which services are most important to people living with HIV in the EMA or TGA (priority setting) and then agree on which service categories to fund and how much funding to provide (resource allocations). In setting priorities, the planning council should consider what service categories are needed to provide a comprehensive system of care for people living with HIV in the EMA or TGA, without regard to who funds those services.

The planning council must prioritize only service categories that are included in the RWHAP legislation as core medical services or support services. These are the same service categories that can be funded by RWHAP Part B and RWHAP Part C programs. (See page 22 for a list of service categories eligible for RWHAP Part A funding.)

After it sets priorities, the planning council must allocate resources, which means it decides how much RWHAP Part A funding will be used for each of these service priorities. For example, the planning council decides how much funding should go for outpatient/ambulatory health services, mental health services, etc. In allocating resources, planning councils need to focus on the legislative requirement that at least 75 percent of funds must go to cover medical services and not more than 25 percent to support services, unless the EMA or TGA has obtained a waiver of this requirement. Support services must contribute to positive medical outcomes for clients. Typically, the planning council makes resource allocations using three scenarios that assume unchanged, increased, and decreased funding in the coming program year.

The planning council makes decisions about priorities and resource allocations based on many factors, including:

- Needs assessment findings
- Information about the most successful and economical ways of providing services
- Actual service cost and utilization data (provided by the recipient)
- Priorities of people living with HIV who will use services
- Use of RWHAP Part A funds to work well with other services like HIV prevention and substance abuse treatment services, and within the changing healthcare landscape
- The amount of funds provided by other sources like Medicaid, Medicare, state and local government, and private funders—since RWHAP is the “payor of last resort” and should not pay for services that can be provided with other funding.

ELIGIBLE RWHAP PART A & PART B SERVICES

Core medical-related services, including:

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support services, including:

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Linguistic Services
7. Medical Transportation
8. Non-Medical Case Management Services
9. Other Professional Services [for example, Legal Services and Permanency Planning]
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Healthcare and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)

The planning council also has the right to provide directives to the recipient on how best to meet the service priorities it has identified. It may direct the recipient to fund services in particular parts of the EMA or TGA (such as outlying counties), or to use specific service models. It may tell the recipient to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month). It may also require that services be appropriate for particular subpopulations—for example, it may specify funding for medical services that target young gay men of color. However, the planning council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will qualify. The planning council may review sections of the Request for Proposals (RFP) the recipient develops for RWHAP Part A services, to ensure that directives are appropriately reflected, but it cannot be involved in any aspect of contractor selection (**procurement**) or in managing or monitoring RWHAP Part A contracts. These are recipient responsibilities.

The planning council allocates RWHAP Part A service funds only. The planning council's own budget is a part of the recipient's administrative budget (as described in the Planning Council Operations section above). The planning council does not participate in decisions about the use of administrative funds other than planning council support, or in the use of clinical quality management (CQM) funds. These decisions are made by the recipient.

Once the EMA or TGA receives its grant award for the upcoming year, the planning council usually needs to adjust its allocations to fit the exact amount of the grant. During the year, the recipient usually asks the planning council to consider and approve some **reallocation** of funds across service categories, to ensure that all RWHAP Part A funds are spent and that priority service needs are met, or establishes a standard mechanism to reallocate up to some agreed-upon percentage.

Integrated/Comprehensive Planning

The planning council works with the recipient in developing a written plan that defines short- and long-term goals and objectives for delivering HIV services and strengthening the system of care in the EMA or TGA. This is called a comprehensive plan in the legislation, but is now called the CDC and HRSA Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN).

The legislation gives the planning council a lead role in the planning process, which must be carried out in close coordination with the recipient. The EMA or TGA may submit a joint plan with the state RWHAP Part B program. The plan is based, in part, on the results of the needs assessment and other information such as client utilization data. It is used to guide decisions about how to deliver HIV services for people living with HIV. The plan should be consistent with other existing local or state plans and with national goals to end the HIV epidemic.

The plan should ensure attention to each stage of the **HIV care continuum**, which measures the steps or stages of HIV medical care from diagnosis to linkage to care, retention in care and treatment, prescribing of HIV medications, and achieving the goal of viral suppression (a very low level of HIV in the body).

CDC and HRSA/HAB provide joint guidance on what the integrated HIV Prevention and Care Plan should include and when it needs to be completed. The first Integrated Prevention and Care Plan was submitted to CDC and HRSA on September 30, 2016 as a five-year plan covering the years 2017–2021. The plan should be reviewed, and where necessary updated, annually, and should be used as a roadmap for implementation of the jurisdiction’s RWHAP Part A programs.

NATIONAL GOALS TO END THE HIV EPIDEMIC

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a more coordinated national response to HIV

HIV Care Continuum



Coordination with Other RWHAP Parts and Other Services

The planning council is responsible for ensuring that RWHAP Part A resource allocation decisions account for and are coordinated with other funds and services. The planning tasks described earlier (needs assessment, priority setting and resource allocation, integrated/comprehensive planning) require getting lots of input, including finding out what other sources of funding exist. This information helps avoid duplication in spending and reduce gaps in care. For example, the needs assessment should find out what HIV prevention and substance abuse treatment services already exist. Integrated/comprehensive planning helps the planning council consider the changing healthcare landscape and the implications for HIV services.

The ***Statewide Coordinated Statement of Need***, called the SCSN, is a way for all RWHAP activities in a state to work together to identify and address significant HIV care issues related to the needs of people living with HIV, and to use that information to maximize coordination, integration, and effective linkages across programs. Representatives of the planning council—and the recipient—must participate with other RWHAP Parts (Parts B, C, D and F) in the state to develop a written SCSN. The SCSN is a part of each state's Integrated HIV Prevention and Care Plan.

Assessment of the Efficiency of the Administrative Mechanism

The planning council is responsible for evaluating how rapidly RWHAP Part A funds are allocated and made available for care. This involves ensuring that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and whether the amounts contracted for each service category are the same as the planning council's allocations. The results of this ***assessment of the efficiency of the administrative mechanism*** are shared with the recipient, who develops a response including corrective actions if needed. Both the results of the assessment and the recipient response are summarized in the RWHAP Part A funding application for the following year.

Development of Service Standards

Establishing service standards is a shared responsibility of the recipient and the planning council. While it is ultimately the responsibility of the recipient to ensure that service standards are in place, the planning council typically takes the lead in developing service standards for funded service categories.⁶ **Service standards** guide providers in implementing funded services. They typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities. The service standards set the minimum requirements of a service and serve as a base on which the recipient's clinical quality management (CQM) program is built. Developing service standards is usually a joint activity; the planning council works with the recipient, providers, consumers, and experts on particular service categories. These service standards must be consistent with HHS guidelines on HIV care and treatment as well as HRSA/HAB standards and performance measures, including the National Monitoring Standards.

Evaluation of Services

The planning council may choose to evaluate how well services funded by RWHAP Part A are meeting identified community needs, or it can pay someone else to do such an evaluation. The Part A recipient's CQM program can provide information on clinical outcomes that informs the planning council about the impact of services. The recipient may include planning council members on its CQM committee. In addition, most planning councils regularly review EMA/TGA performance along the HIV care continuum. The planning council uses evaluation findings in considering ways to improve the system of care, including changing service priorities and allocations and developing directives.

To carry out the array of planning tasks described above the planning council meets regularly throughout the year, as a whole and in committees. See Appendix II for a sample calendar describing the approximate timing of various planning council activities by months of the year.

⁶ Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/ Planning Bodies. 2014. Available at www.targethiv.org/servicestandards

CEO and Recipient Duties

CEO Duties Related to the Planning Council

The CEO has three important duties related to the planning council:

- **Establish the Planning Council:** The CEO must establish and maintain the planning council—or, in the case of a TGA, some other process to obtain community input, particularly from people living with HIV. This includes making sure that the planning council membership meets requirements related to representation, reflectiveness, and participation of unaffiliated consumers. The CEO should ensure that these requirements are specified in planning council bylaws.
- **Choose Planning Council Members:** The CEO establishes the first planning council. After that, the council itself is responsible for identifying and screening candidates and forwarding their names, the membership categories they will fill, and other requested information to the CEO so they can be considered for appointment. The CEO retains sole responsibility for appointment and removal of planning council members. If some nominees submitted by the planning council are not appointed, the CEO informs the planning council, and it provides additional nominees.
- **Review and Approve Bylaws and Other Processes:** The CEO establishes the planning council and thus has the authority to review and approve planning council bylaws and other policies. Often, the planning council is considered an official board or commission of the city or county. Its bylaws and procedures must fit the policies established for these bodies as well as meeting RWHAP legislative requirements.

Recipient Duties

The recipient has several planning duties that are shared with the planning council. These include assisting the planning council with needs assessment and integrated/comprehensive planning and providing information the planning council needs to carry out its priority setting and resource allocation responsibilities. It also shares responsibility for coordination with other RWHAP activities and services. In addition, the recipient has administrative duties, which means that it is responsible for making sure that RWHAP Part A funds are fairly and correctly managed and used. The main duties of the recipient are described below.

ADDITIONAL RECIPIENT ADMINISTRATIVE DUTIES

- Establish intergovernmental agreements (IGAs) with other cities/counties in the EMA or TGA
- Establish grievance procedures to address funding-related decision making
- Ensure delivery of services to women, infants, children, and youth with HIV
- Ensure that RWHAP funds are used to fill gaps and do not pay for care that can be supported with other existing funds
- Ensure that services are available and accessible to eligible clients
- Control recipient and provider administrative costs
- Prepare and submit the annual RWHAP Part A funding application
- Meet HRSA/HAB reporting requirements

Appendix III briefly describes these duties.

RECIPIENT ADMINISTRATIVE DUTIES

Below are the major RWHAP Part A recipient duties designed to make sure that funds are used fairly and appropriately, in a way that maximizes linkage of people living with HIV to care, retention in care, and positive medical outcomes. Additional duties are listed in the box and described in Appendix III.

Procurement of Services

The recipient is responsible for identifying and selecting qualified service providers for delivering RWHAP Part A services. The recipient must award service funds to eligible providers (**subrecipients**) based on a fair and equitable system, usually through a competitive Request for Proposals (RFP) process.

In contracting for services, the recipient must distribute RWHAP Part A funds according to the priority setting and resource allocation decisions of the planning council. The recipient can only spend the amount of money that the planning council decides should be used for each funded service category. In addition, the recipient must follow planning council directives about “how best to meet” priority needs.

The planning council has no say about how the recipient uses funds for its own administrative expenses.

Contract Monitoring

Once subrecipient contracts have been awarded, the recipient must manage them and regularly monitor subrecipients. The recipient must make sure that the providers who receive RWHAP Part A funds use the money according to the terms of the subrecipient contract they signed with the recipient and meet RWHAP Part A National Monitoring Standards and other federal requirements established by HRSA/HAB. The recipient monitors subrecipients to determine how quickly they spend RWHAP Part A funds, and if they are providing the contracted services, providing services only to eligible clients, using funds only as approved, and meeting reporting and other requirements. Contract monitoring is solely a recipient responsibility.

The planning council receives monitoring results only by service category, not by subrecipient.

The recipient must keep track of how rapidly RWHAP Part A money is, or isn't, being spent. If funds are not being spent in a timely fashion, there are two options:

1. The recipient may reallocate the funds to another provider within the same service category, or
2. The planning council may agree to reallocate funds to a different prioritized service category.

The recipient and the planning council must share information and work together to ensure that any changes are in agreement with the priorities and allocations established by the planning council.

Clinical Quality Management Activities and Evaluation of Performance and Outcomes

The recipient must establish a **clinical quality management (CQM)** program, designed to improve patient care, health outcomes, and patient satisfaction. Components include infrastructure, performance measurement, and quality improvement.

- An ideal **infrastructure** includes leadership, dedicated staffing and resources, a quality management plan that covers all funded medical and support services, a CQM committee, consumer and stakeholder involvement, and assessment of the CQM program.
- **Performance measurement** is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, and patient satisfaction with the services they receive. Recipients select a portfolio of performance measures based on funded services, local HIV epidemiology, the identified needs of PLWH, and the national goals to end the epidemic.
- Based on performance measurement results, recipients work with subrecipients in the development and implementation of **quality improvement** activities to make changes to the program to improve services.

Subrecipients must be actively involved in CQM activities. Recipients are expected to ensure that subrecipients have the capacity to contribute to the CQM program, have the resources to conduct CQM activities, and implement a CQM program in their organization.

Recipients can use up to 5 percent of the award or \$3 million (whichever is less) to conduct CQM programs. The recipient shares with the planning council the results of its CQM activities. The planning council receives information by service category, but not about individual providers/subrecipients. These CQM data help the planning council in future cycles of priority setting and resource allocation.

QUALITY MANAGEMENT, QUALITY ASSURANCE, AND QUALITY IMPROVEMENT

Clinical Quality Management is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction, as described in this section.

Quality Assurance refers to activities aimed at ensuring compliance with minimum quality standards. Quality assurance activities include the process of looking back to measure compliance with standards (e.g., HHS guidelines, professional guidelines, service standards). Site visits and chart reviews are examples of commonly used quality assurance activities.

Quality Improvement is a part of CQM. It uses CQM performance data as well as data collected as part of quality assurance processes to strengthen patient care, health outcomes, and patient satisfaction.

As part of, or along with, CQM, the recipient often evaluates clinical outcomes. These outcomes are often measured using the HIV care continuum, with its focus on linkage to care, retention in care, use of antiretroviral therapy, and viral suppression. These results may be reviewed for all people living with HIV in the service area, for all RWHAP clients, and for key client subpopulations. Subpopulations may be defined by characteristics such as race/ethnicity, gender, age, place of residence, and/or risk factor. This helps the planning council in future decision making.

RECIPIENT DUTIES SHARED WITH THE PLANNING COUNCIL

Support for Planning Council Operations

The recipient must cooperate with the planning council by negotiating and managing its budget, providing staff expertise to support committees, and providing information the planning council needs to carry out its responsibilities. This includes data on client characteristics, service utilization, and service costs, as well as information for assessing the efficiency of the administrative mechanism.

Both the planning council and the recipient have the responsibility to support participation of people living with HIV on the planning council, although primary responsibility lies with the planning council. Examples include reimbursing expenses of consumer members such as travel and child care costs. The planning council establishes reimbursement policies; the recipient helps to ensure timely payment of reimbursements. The recipient assists in training planning council members by explaining recipient roles and helping planning council members understand information provided by the recipient such as data on service costs and client utilization of funded services.

Needs Assessment

The recipient works with the planning council to assess the needs of communities affected by HIV. It usually arranges for an epidemiologic profile to be provided by its surveillance unit or by the state's surveillance unit, and it ensures that funded providers cooperate with needs assessment efforts such as surveys and focus groups of people living with HIV and providers.

Integrated/Comprehensive Planning

The recipient and planning council work together to develop, review, and periodically update the CDC and HRSA Integrated HIV Prevention and Care Plan for the organization and delivery of HIV services. The recipient helps develop goals and objectives, and works with the planning council to ensure a workable joint plan for implementing them. Usually the recipient plays a key role in arranging to collect performance and outcomes data to evaluate progress towards the goals and objectives of the plan. Both recipient and planning council participate in reviewing and updating the plan.

Coordination with Other RWHAP Parts and Other Services

The recipient and planning council work together to make sure that RWHAP Part A funds are coordinated with other services and funders. This coordination occurs partly through planning, including needs assessment and the Statewide Coordinated Statement of Need. Throughout the year, the recipient helps keep the planning council informed about changes in HIV-related prevention and care services and funding, as well as the evolving healthcare landscape.

RECIPIENT PLANNING DUTIES SHARED WITH THE PLANNING COUNCIL

- Needs assessment
- Integrated/comprehensive planning
- Development of service standards
- Coordination with other RWHAP activities and other services, including:
 - Participation in the Statewide Coordinated Statement of Need (SCSN)
 - Ensuring that use of RWHAP funds is coordinated with other funding sources and with other healthcare systems and services

Technical Assistance

The RWHAP Part A recipient and the planning council/planning body may request technical assistance from HRSA to help them develop the knowledge and skills needed to meet the responsibilities outlined in this Primer. Examples of the kinds of technical assistance that HRSA can provide include: supporting participation of people living with HIV in RWHAP planning, training the planning council on using data for decision making, helping in the design of a needs assessment, assisting the planning council to refine committee structures and operations, and providing training to help the planning council and recipient understand their roles and work well together. HRSA can provide information describing what other EMAs or TGAs have done, offer model training materials, or provide experts to work with the planning council and recipient either long distance or on-site.

RWHAP Part A recipients and planning councils may seek and request technical assistance through the following channels:

- **HRSA/HAB Project Officer:** HRSA federal Project Officers are the first point-of-contact for RWHAP recipients in accessing technical assistance. Requests for technical assistance for the recipient or the planning council must be made in writing by the recipient to the HRSA/HAB Project Officer. For more information, visit the HAB Web Site at www.hab.hrsa.gov
- **TargetHIV.org** The TargetHIV website is the central source and “one-stop shop” for finding technical assistance and training resources for the Ryan White HIV/AIDS Program. Among the website's key features are a resource library, a calendar of technical assistance and training events, contact information for RWHAP recipients, a Help Desk, and information about specific programs and services including tools and tips. Users can search for information on a particular topic or directed at a particular audience. Visit the TargetHIV website at www.targetHIV.org
- **Planning CHATT:** The *Community HIV/AIDS TA and Training for Planning* project (*Planning CHATT*) builds the capacity of RWHAP Part A planning councils and planning bodies across the U.S. to meet their legislative requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning. The Planning CHATT project provides training and technical assistance to support the work of planning council/planning body members, staff, and RWHAP Part A recipients. Find Planning CHATT on the TargetHIV website: www.targetHIV.org/planning-chatt

References and Resources for Further Information

Descriptions of Ryan White HIV/AIDS Treatment Extension Act of 2009

Materials available on the HRSA/HAB website describing the Ryan White HIV/AIDS program (RWHAP), including each of its Parts:

Overview

- About the Ryan White HIV/AIDS Program
www.hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program

RWHAP Fact Sheets

Fact sheets on all RWHAP Parts

www.hab.hrsa.gov/publications/hivaids-bureau-fact-sheets

- Part A: Eligible Metropolitan Areas and Transitional Grant Areas
- Part B: States and U.S. Territories
- Part B: AIDS Drug Assistance Program
- Part C: Early Intervention Services and Capacity Development
- Part D: Women, Infants, Children, and Youth
- Part F: Special Projects of National Significance
- Part F: AIDS Education and Training Centers Program
- Part F: Dental Programs

RWHAP Part A

- RWHAP Part A: Grants to Eligible Metropolitan and Transitional Areas, including list of current Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)
www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-a-grants-emerging-metro-transitional-areas

RWHAP Part B

- RWHAP Part B: Grants to States & Territories
www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-grants-states-territories
- RWHAP Part B: AIDS Drug Assistance Program
www.hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-aids-drug-assistance-program

RWHAP Part C

- RWHAP Part C: Early Intervention Services and Capacity Development Program Grants
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-c-early-intervention-services-and-capacity-development-program-grants

RWHAP Part D

- RWHAP Part D: Services for Women, Infants, Children, and Youth
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-d-services-women-infants-children-and-youth

RWHAP Part F

- Special Projects of National Significance
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-special-projects-national-significance-spns-program
- AIDS Education and Training Centers
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-aids-education-and-training-centers-aetc-program
- Dental Programs
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-dental-programs
- Minority AIDS Initiative
www.hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-minority-aids-initiative

RWHAP Recipients

- Recipient lists and addresses by RWHAP Part, and list of RWHAP Part A planning councils/planning bodies
www.targethiv.org/content/grantees-part

Planning Council Legislative Requirements

Current legislation, which is a part of the Public Health Service Act

- Ryan White HIV/AIDS Treatment Extension Act of 2009
www.hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf
- Title XXVI, HIV Health Care Services Program, of the Public Health Service Act
www.legcounsel.house.gov/Comps/PHSA-merged.pdf

Service Standards

- Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/Planning Bodies. December 2, 2014
www.targetHIV.org/ServiceStandards

The Planning Process

Strengthening the Healthcare Delivery System through Planning: a three-part planning institute at the 2016 National Ryan White Conference on HIV Care and Treatment

www.targetHIV.org/planning-CHATT/planning-institute-2016

- Planning Bodies 101
- Planning Infrastructures 201
- Data-Driven Decision Making 301

Planning Council Roles, Responsibilities, and Operations

RYAN WHITE HIV/AIDS PROGRAM PART A MANUAL, REVISED 2013

A primary source of information about requirements, expectations, and suggested practices for planning council operations and for implementation of legislative responsibilities. Chapters identified below address legislative duties and some key aspects of planning council operations.

www.hab.hrsa.gov/sites/default/files/hab/Global/happartamanual2013.pdf

Implementing Legislative Responsibilities

- Planning Council Responsibilities: Section X. Chapter 3
- Needs Assessment: Section XI. Chapter 3
- Priority Setting and Resource Allocations: Section XI. Chapter 4
- Integrated/Comprehensive Plan: Section XI. Chapter 5
- Effectiveness of Funded Services to Meet Identified Need: Section X. Chapter 9
- Outcomes Evaluation: Section X. Chapter 10

Planning Council Operations

Membership

- Planning Council Membership: Section X. Chapter 4
- Planning Council Nominations: Section X. Chapter 5
- Member Involvement and Retention: Section XI. Chapter 8

People living with HIV/Consumer Participation

- Section X. Chapter 6
- Section XI. Chapter 9

Policies and Procedures

- Grievance Procedures: Section X. Chapter 7
- Conflict of Interest: Section X. Chapter 8

Federal Regulations and Guidelines

National Monitoring Standards (NMS)

See Monitoring Standards Guidance under www.hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-recipient-resources

- Frequently Asked Questions
www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringfaq.pdf
- Universal Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf
- RWHAP Part A Fiscal Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringparta.pdf
- RWHAP Part A Program Monitoring Standards
www.hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf

Policy Clarification Notices (PCNs) and Program Letters

www.hab.hrsa.gov/program-grants-management/policy-notice-and-program-letters

Among the PCNs and program letters most important to Planning Councils are the following:

- *Transitional Grant Areas and Planning Councils Moving Forward*, Program Letter, December 4, 2013. Clarifies expectations and recommendations around the continued maintenance of planning councils by Transitional Grant Areas (TGAs) that were formerly Eligible Metropolitan Areas (EMAs) after Fiscal Year 2013.
- *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds* Policy Clarification Notice (PCN) #16-02, Revised December 5, 2016 and effective for awards made after October 1, 2016. Identifies eligible individuals, describes allowable service categories for RWHAP, and provides program guidance for implementation.
- *Clinical Quality Management*, Policy Clarification Notice (PCN) #15-02, undated. Clarifies HRSA RWHAP expectations for clinical quality management (CQM) programs.

Uniform Guidance

- For all federal awards, *OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Guidance)*, 2 CFR [Code of Federal Regulations] Part 200. The Guidance will supersede and streamline requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up.
www.bit.ly/2EJqWwt
- For HHS Programs: *45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards*
www.bit.ly/2GX2Cc9

RWHAP Part A Application Requirements

Ryan White HIV/AIDS Program Part A, HIV Emergency Relief Grant Program, Notice of Funding Opportunity (NOFO) No. HRSA-18-066

www.targetHIV.org/library/funding-opportunity-rwhap-fy18-part-hrsa-18-066

Program Use and Impact

- *Annual Client-Level Data Report: Ryan White HIV/AIDS Program Services Report (RSR) 2015*. Health Resources and Services Administration, December 2016.
www.hab.hrsa.gov/sites/default/files/hab/data/datareports/2015rwhapdatareport.pdf

Appendix I: Types of Data Reviewed by Planning Councils for Priority Setting and Resource Allocation

Epidemiologic profile: A description of the HIV epidemic in the EMA or TGA, usually prepared annually by local or state HIV surveillance staff, for use in both HIV prevention and HIV care planning. It usually describes characteristics of the general population, persons newly diagnosed with HIV infection, persons living with HIV disease, and persons at risk for HIV. Data help planning councils identify trends in the epidemic that will affect service needs.

Needs assessment data: Information about the number, characteristics, and service needs and barriers of people living with HIV, both in and out of care; current provider resources available to meet those needs; and service gaps. These data help the planning council improve service access and quality, overall and for specific subpopulations.

Service expenditure and cost data: Information provided by the recipient showing how much money is spent for each funded service category and what it costs to provide one “unit” of service or to serve one client for a year. Planning councils use this information in funding decisions and estimating the costs of serving additional clients.

Client characteristics and service utilization data: Data on the total number and characteristics of local RWHAP clients, including the number and characteristics of RWHAP Part A clients served in each service category. Data usually come from the annual Ryan White Services Report (RSR). Data help planning councils understand the demand for specific services and identify subpopulations facing barriers to access.

HRSA performance measures and clinical outcomes data: Data used to monitor and improve the quality of care across the EMA/TGA and in individual provider organizations, usually based on the percent of clients that meet the goal or service standard. Measures may relate to a process (such as frequency of medical visits or development of a case management care plan) or clinical outcome (such as viral suppression). Data help planning councils make funding decisions and agree on changes in service standards or models of care.

Clinical Quality Management (CQM) data: Information on patient care, health outcomes, and patient satisfaction. Performance measures are gathered through CQM processes. Then subrecipients work together on structured quality improvement projects that make changes to address identified weaknesses. CQM data help planning councils decide whether program or funding changes are needed to improve service quality and outcomes.

Testing/EIHA data: Data on the number of people who receive HIV tests, the number and percent testing positive and their characteristics, and the number referred to needed services. HRSA/HAB requires RWHAP Part A programs to implement a strategy for the Early Identification of Individuals with HIV/AIDS (EIHA). This includes identifying key target populations, locating individuals with HIV who do not know their HIV status, informing them of their status through testing, and helping link them to medical care and support services.

Unmet Need data: An estimate of the number of people living with HIV in the service area who know they are HIV-positive but are not receiving HIV-related medical care. May also include an assessment of the characteristics of individuals with unmet need and their service barriers and gaps. Planning councils use this information to make decisions about use of funds to find people with unmet need and link or relink them to care.

HIV care continuum data: Data that outline the steps or stages of HIV care that people living with HIV go through, and the number and proportion of individuals at each stage in the EMA or TGA. The continuum may begin with the estimated total number of people living with HIV (including those unaware of their status) or with the number diagnosed and living with HIV. Typical steps include diagnosis, linkage to care, retention in care (based on doctor visits and/or laboratory tests), treatment with antiretroviral therapy, and viral suppression (a very low level of HIV in the body). Planning councils use this information to improve services all along the continuum, often based on HIV care continuum data for specific RWHAP Part A subpopulations (for example, young gay men of color or African American women).

Appendix II: Sample Planning Council/ RWHAP Part A Program Calendar

Most planning councils operate on a RWHAP Part A program year, which runs from March through February. The chart below provides a “typical” annual calendar, though of course planning councils vary in their timing of key activities. Recipient activity is included in the chart, since some tasks, especially priority setting and resource allocations (PSRA), need to link to recipient deadlines, especially submission of the RWHAP Part A application. The application is usually due in September. The chart does not include regular committee meetings, but most planning councils have them monthly except in December. Most planning councils also have a retreat and/or some training during the year, but there is no set time for them.

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
January	<ul style="list-style-type: none"> • Beginning of member terms [most frequent date] • Orientation for new members • Needs assessment 	<ul style="list-style-type: none"> • Final reallocations • Review of RWHAP Part A competitive applications and selection of subrecipients for program year beginning March 1
February	<ul style="list-style-type: none"> • Election of officers [date varies] • Needs assessment (continued) • Committee development/approval of work plans for coming year 	<ul style="list-style-type: none"> • Receipt of Notice of Award (NOA) for program year starting March 1—often a partial award
March	<ul style="list-style-type: none"> • Final allocations based on actual award amount [if full award is received; happens later if a partial award is received because there is not yet a final federal HHS budget] • Needs assessment (continued) • Review of progress on Integrated Plan 	<ul style="list-style-type: none"> • Initial closeout of prior program year • Submission of Ryan White Services Report (RSR) • Review/preparation of response to conditions of award • Contracting with providers
April	<ul style="list-style-type: none"> • Town halls for input to PSRA • Obtain and review/integration of data from various sources • Directives development • Updating of Integrated Plan work plan as needed, with assignments to committees [process more complicated if joint plan was developed with state] 	<ul style="list-style-type: none"> • Review of performance and outcome measures for prior year • Input to Integrated Plan update • Completion or obtaining of epi profile/trends report
May	<ul style="list-style-type: none"> • Identification of any data problems or gaps • Assessment of the efficiency of the administrative mechanism (AAM) begins • Data presentation 	<ul style="list-style-type: none"> • Final closeout of prior year • Submission of Annual Progress Report for prior year • Submission of Program Expenditure Report for prior year
June	<ul style="list-style-type: none"> • Directives development (continued) • Priority setting and resource allocation (PSRA) begins 	<ul style="list-style-type: none"> • Review of first quarter expenditures • Subrecipient monitoring [ongoing]

MONTH	PLANNING COUNCIL ACTIVITY	RECIPIENT ACTIVITY
July	<ul style="list-style-type: none"> • PSRA work sessions and final approval • Presentation/adoption of directives • Submission of PSRA results to recipient 	<ul style="list-style-type: none"> • Submission of Annual Federal Financial Report • Planning for submission of RWHAP Part A application
August	<ul style="list-style-type: none"> • Presentation/discussion of AAM report • PC sections of RWHAP Part A application • Negotiation of PC budget amount with recipient • Development of PC budget • Reallocation of funds if needed based on expenditures 	<ul style="list-style-type: none"> • Preparation of RWHAP Part A application • Negotiation of PC budget amount • Recommendations for reallocation of funds if needed based on expenditures • Response to AAM report
September	<ul style="list-style-type: none"> • Review of draft application • Preparation of PC letter to accompany application, signed by Chair/Co-Chairs 	<ul style="list-style-type: none"> • Completion and submission of RWHAP Part A application
October	<ul style="list-style-type: none"> • Review of service standards 	<ul style="list-style-type: none"> • Issuance of RFP for RWHAP Part A services (selected services each year; often a 3-year cycle)
November	<ul style="list-style-type: none"> • Rapid reallocations • Planning for needs assessment 	<ul style="list-style-type: none"> • Rapid reallocations • Receipt of provider applications in response to RFP for RWHAP Part A services
December	<ul style="list-style-type: none"> • Planning for new program year, including committee work plans 	<ul style="list-style-type: none"> • Estimated Unobligated Balance (UOB) and estimated carryover request

Appendix III: Additional Recipient Administrative Duties

Establish Intergovernmental Agreements (IGAs): The recipient must make sure that RWHAP Part A funds reach all communities in the EMA or TGA where need exists. Thus, it must establish formal, written agreements with cities and counties within the EMA or TGA that provide HIV-related services and also account for at least 10 percent of the EMA's or TGA's reported AIDS cases. This agreement is called an Intergovernmental Agreement (IGA.) An IGA should describe how RWHAP Part A funds will be distributed and managed.

Establish Grievance Procedures: The recipient must develop grievance procedures to handle complaints about funding, such as the process by which contractors (subrecipients) are chosen. Like the planning council's grievance procedures, they must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled.

Ensure Services to Women, Infants, Children, and Youth with HIV/AIDS: The recipient must assure that the percentage of money spent on serving women, infants, children, and youth with HIV is at least in proportion to each group's percent of the total number of cases of HIV disease in the EMA or TGA. An exception is allowed when the recipient can show that their needs are met through other programs like Medicaid, Medicare, or RWHAP Part D. The planning council must consider this requirement when setting priorities and allocating resources.

Ensure that RWHAP Funds are Used to Fill Gaps: RWHAP Part A recipients must ensure that RWHAP Part A funds do not pay for services that are funded by other sources and are not used to replace local spending on HIV care. The legislation requires that RWHAP be the "payor of last resort." This means, for example, that the recipient must require subrecipients such as clinics to make sure clients are not eligible for Medicaid or some other source of funding before they use RWHAP Part A funds to pay for their care. This requirement makes sure that RWHAP funds are used to assist people living with HIV who do not have any other source of payment for the services they need.

Ensure Availability and Accessibility of Services to Eligible Clients: Recipients must ensure that RWHAP Part A services are available regardless of an individual's health condition or ability to pay and in settings that are accessible to low-income people living with HIV.

Outreach must be provided to inform people of the availability of services and to link them to care. One of the most important

priorities of the RWHAP legislation is to identify people who are unaware of their HIV status and need to be tested, help them determine their status, and refer and link people newly diagnosed with HIV to care. (This process is called Early Identification of Individuals with HIV and AIDS, or EIHA.) Another priority is to find people who know their HIV status but are not receiving regular HIV-related medical care (people with “unmet need”) and help them to enter and stay in care.

Subrecipients receiving RWHAP Part A funds must be required to work with other providers so that people living with HIV have access to services. This network of providers is called a “continuum of care” or “system of care.” As part of this, providers should prioritize getting people into care as soon after diagnosis as possible by maintaining what the legislation calls “appropriate relationships with entities that constitute key points of access to the health care system.” Key points of access include, for example, testing sites, emergency rooms, substance abuse treatment programs, and sexually transmitted disease clinics. Processes must be in place to ensure that people newly diagnosed with HIV are immediately referred and linked to care and helped to remain in care.

Control Administrative and Quality Management Costs: The recipient may use up to 10 percent of the RWHAP Part A grant for managing the RWHAP Part A program and for other administrative activities, including planning council support, and up to 5 percent of the grant for Clinical Quality Management. Examples of administrative duties include writing applications, preparing reports, and activities related to procurement and contract monitoring (including reviewing provider applications, negotiating and monitoring contracts, and paying subrecipients). The recipient must control those costs, and also ensure that local subrecipients, contractors, and other entities, collectively, spend no more than 10 percent of total RWHAP Part A service funds for administrative expenses.

Prepare and Submit the RWHAP Part A Application: The recipient is responsible for preparing and submitting a RWHAP Part A application to the federal government each year. Although this is the recipient’s responsibility, the planning council should participate in the preparation of this application because the application requires information about the planning council and how it works, as well as the planning council’s priorities and proposed resource allocations for the coming year. The Chair or Co-Chairs of the planning council must certify in writing to HRSA that the priorities in the application are the ones developed by the planning council. They must also verify that the recipient spent funds in the past year according to the planning council’s allocation decisions and indicate how the planning council established priorities for the upcoming program year.

Meet HRSA/HAB Reporting Requirements: As a federal grantee, the recipient is required to meet a variety of HRSA/HAB requirements, including submission of data, programmatic, and fiscal reports. Some reports include input from the planning council/planning body or reflect its decisions. For example, the Program Terms Report and the Program Submission are due 90 days after the final Notice of Award. The Program Terms Report includes information such as a consolidated list of contractors (subrecipients). Among the information required for the Program Submission are a signed endorsement letter from the planning council Chair or Co-Chairs endorsing the priorities and allocations submitted by the recipient, and a planning council membership roster and information on member reflectiveness. The recipient also submits an Estimated Unobligated Balance (UOB) and an estimate of anticipated carryover funding to HRSA by December 31, a RWHAP Part A and Minority AIDS Initiative Final Expenditure Report and an Annual Progress Report 90 days after the end of the program period, and a Carryover Request for any unspent funds within 30 days after the Final Expenditure Report.

All recipients under RWHAP Parts A-D, along with their contracted subrecipients, must also submit an annual client-level data report called the Ryan White Program Services Report (RSR) that covers the calendar year. The RSR provides data on the characteristics of RWHAP recipients, providers, and clients served. RSR data document program performance and accountability. RSR data on client characteristics and service utilization are used by the planning council and recipient in decision making about use of funds and the system of care. Because it provides data from all recipients, the RSR provides information used by HRSA/HAB for monitoring client health outcomes, assessing organizational capacity and service utilization, monitoring the use of RWHAP to address HIV in the U.S., and tracking progress toward the national goals to end the epidemic.



**PLANNING
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Community HIV/AIDS
Technical Assistance & Training

**Quick Reference for Planning Council Support (PCS) Staff:
Legislative Requirements for Planning Councils/Bodies,
with HRSA/HAB Definitions, Clarifications, and Expectations¹**

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
Establishment of a Planning Council or Body		
Establishment of a Planning Council	CEO “shall establish an HIV health services planning council” [Section 2602(b)(2)(A)(ii)]	All EMAs must have planning councils that meet legislative requirements.
Exception to Planning Council Requirement for TGAs	“The chief elected official of the transitional area may elect not to comply with the provisions of section 2602(b) [establishment of a planning council] if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds from the grant” [Section 2609(d)(1)(A)]	<ul style="list-style-type: none"> ▪ “All TGAs that have operating PCs are strongly encouraged by DMHAP to maintain that current structure”— “in conformity with PC legislative requirements.” [Letter to RWHAP Part A Grantees on TGA Planning Councils Moving Forward, December 4, 2013] ▪ All jurisdictions are expected to have planning bodies. [Integrated HIV Prevention and Care Plan Guidance, p 4] ▪ DMHAP encourages TGAs with planning bodies to make them similar to PCs in terms of member representation and reflectiveness as well as roles. [EGMC discussion with DMHAP Project Officers, January 23, 2017]
Planning Council/Body Membership		
Representation: Membership Categories	Section 2602(b)(2): “REPRESENTATION.—The HIV health services planning council shall include representatives of— (A) health care providers, including federally qualified health centers; (B) community-based organizations serving affected populations and AIDS service organizations; (C) social service providers, including providers of housing	<ul style="list-style-type: none"> ▪ “Representation is the extent to which the planning council includes individuals from the legislatively defined categories of membership.” [p 110] ▪ The category of grantees under Category L, other Federal HIV programs “is to include, at a minimum, a representative from each of the following:” <ul style="list-style-type: none"> - Federally-funded HIV prevention services. - A grantee funded under Part F’s SPNS, AETC, and/or Ryan

¹ Prepared in March 2017 for DMHAP based on Ryan White HIV/AIDS Treatment Extension Act of 2009. Prepared under Task Order TA003111 through MSCG/Ryan White Technical Assistance Contract.

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
	<p>and homeless services; (D) mental health and substance abuse providers; (E) local public health agencies; (F) hospital planning agencies or health care planning agencies; (G) affected communities, including people with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations; (H) nonelected community leaders; (I) State government (including the State medicaid agency and the agency administering the program under part B); (J) grantees under subpart II of part C; (K) grantees under section 2671 [Part D], or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area; (L) grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services; and (M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV/AIDS as of the date on which the individuals were so released.”</p>	<p>White Dental Programs.</p> <ul style="list-style-type: none"> - Housing Opportunities for Persons With AIDS (HOPWA). - Other Federal programs that provide HIV/AIDS treatment such as the Veterans Health Administration. [p 110] ▪ “The planning council must include at least one member to separately represent each of the designated membership categories (unless no entity from that category exists in the EMA/TGA)....<i>Separate representation means that each planning council member can fill only one legislatively required membership category at any given time, even if qualified to fill more than one.</i>” [p 110] ▪ There are 3 exceptions, in which a single person can represent multiple categories: <ul style="list-style-type: none"> - Both substance abuse and mental health provider categories “if his/her agency provides both types of services and the person is familiar with both programs.” - “Both the Ryan White Part B program and the State Medicaid agency if that person is in a position of responsibility for both programs.” - Any combination of Ryan White Part F grantees (SPNS, AETCs, and Dental Programs) and HOPWA, if the agency represented by the member receives grants from some combination of those four funding streams...and the individual is familiar with all these programs.” [p 110]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
Consumer Members	<ul style="list-style-type: none"> ▪ “Not less than 33 percent of the council shall be individuals who are receiving HIV-related services [under RWHAP Part A], are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV/AIDS” ▪ Includes parents or caregivers of children with HIV [Section 2602(b)(5)(C)(i)] 	<p>“DMHAP and its predecessor, the Division Service Systems (DSS), have consistently emphasized that planning councils can be truly effective in meeting their legislated responsibilities only if they have well-supported consumer participation and membership reflective of the local demographics of the HIV/AIDS epidemic.” [p 109]</p>
Reflectiveness	<p>PC “shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations” [Section 2602(b)(1)]</p>	<ul style="list-style-type: none"> ▪ “Reflectiveness is the extent to which the demographics of the planning council’s membership look like the epidemic of HIV/AIDS in the EMA/TGA.” ▪ Must include “at least the following: race/ethnicity, gender, and age at diagnosis.” ▪ Reflectiveness required for both the whole planning council membership and the consumer membership. ▪ PLWH should be selected “without regard to the individual’s stage of disease.” ▪ “Reflectiveness does not mean that membership must identically mirror local HIV/AIDS demographics.” [p 111] ▪ “The composition of the PC or planning body must reflect the demographics of the HIV/AIDS epidemic in the EMA/TGA.” [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 22] ▪ The required PC/B letter that accompanies the RWHAP Part A application must indicate “that representation is reflective of the epidemic in the EMA/TGA” or, if it is not, “Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA and “provide a plan and timetable for addressing each vacancy.” [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 24]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
Open Nominations	“Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria.” [Section 2602(b)(1)]	HAB/DMHAP expects that: <ul style="list-style-type: none"> ▪ The open nominations process will be “described and announced before the nominations process begins,” will “specify clear criteria on the planning council composition being sought,” will be publicized, allow people to “apply for membership or be nominated by others,” and use a “standardized, plain-language application form.” ▪ “The CEO will approve and/or appoint as planning council members only individuals who have gone through the open nominations process.” [p 118]
Roles and Responsibilities		
Duties	“(4) DUTIES — The planning council) shall— (A) determine the size and demographics of the population of individuals with HIV/AIDS; (B) determine the needs of such population...; (C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant...; (D) develop a comprehensive plan for the organization and delivery of health and support services...; (E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs; (F) participate in the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under part B;	<ul style="list-style-type: none"> ▪ <i>Extensive guidance on key duties in RWHAP Part A Manual, with separate chapters on Needs Assessment, Comprehensive Planning, Priority Setting and Resource Allocations, and the Statewide Coordinated Statement of Need RWHAP Part A Manual, Section XI. Planning and Planning Bodies, Chapters 3-6]</i> ▪ Legislatively required tasks include: <ul style="list-style-type: none"> - “Conduct an assessment of local community needs. - Develop a comprehensive service plan, compatible with existing State and local plans. - Allocate funds according to service priorities set by the planning council. - Participate along with other Ryan White partners in the development a Statewide Coordinated Statement of Need (SCSN) to enhance coordination among Ryan White HIV/AIDS programs in addressing key HIV/AIDS care issues. - Coordinate with Federal, State, and locally funded grantees providing HIV-related services. - Assess the efficient administration of funds.” [p 80]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
	<p>(G) establish methods for obtaining input on community needs and priorities which may include public meetings..., conducting focus groups, and convening ad-hoc panels; and</p> <p>(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.” [Section 2602(b)(4)]</p>	
Conflict of Interest and Grievance Procedures		
Conflict of Interest: Planning Council	<p>A planning council:</p> <ul style="list-style-type: none"> ▪ “May not be directly involved in the administration of a grant” under RWHAP Part A. ▪ “May not designate (or otherwise be involved in the selection of) particular entities as recipients” of RWHAP Part A funds. [Section 2602(b)(5)(A)] 	<ul style="list-style-type: none"> ▪ “Planning councils are strictly prohibited from involvement in the selection of particular entities to receive [RWHAP] Part A funding.” [p 191] ▪ “As part of their responsibility to determine how best to meet stated priorities, planning councils may stipulate what provider characteristics the grantee should look for in its procurement process (e.g., community-based AIDS service providers, multi-service organizations or public agencies that provide a specific service or target a specific population). They may also specify that providers should be sought in specific parts of the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA).” [p 191] ▪ “While the legislation prohibits planning councils from participating or otherwise being involved in selecting particular entities for funding, they may be involved in selecting particular entities and individuals to carry out activities directly related to planning council functions and responsibilities” such as general planning council administrative duties, needs assessments, planning activities such as writing the comprehensive plan, assessment of the administrative mechanism, technical assistance, and program evaluation. [p 145]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
Conflict of Interest: Individual Members	<p>An individual planning council member who has a financial interest, is an employee, or is a member of an entity that is seeking RWHAP Part A funds:</p> <ul style="list-style-type: none"> ▪ will not “participate (directly or in an advisory capacity) in the process of selecting entities” for RWHAP Part A funding. [Section 2602(b)(5)(B)] 	<ul style="list-style-type: none"> ▪ “Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. To illustrate, conflict of interest occurs when a planning council member has a monetary, personal, or professional interest in a planning council decision or vote. Any group making funding decisions for a Ryan White program should be free from conflicts of interest.” [p 143] ▪ “As appropriate, the definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child.” [p 147] ▪ “HAB/DMHAP expects planning councils to employ a variety of strategies to minimize conflict of interest and its potential adverse effects, such as keeping members self-aware of the potential for conflict of interest and using procedures that can minimize or address conflicts.” Of particular importance are adoption of COI policies and procedures “and their routine and consistent application in planning council deliberations and decision making.” [p 150] ▪ “Because of an individual member’s relationship to the planning council, sound practice is not to have them serve on external review panels for the selection of [RWHAP] Part A providers.” [p 144]
Grievance Procedures	<ul style="list-style-type: none"> ▪ A planning council “(1) shall develop procedures for addressing grievances with respect to funding under this subpart, including procedures for submitting grievances that cannot be resolved to binding arbitration. ▪ “Such procedures shall be described in the by-laws of the planning council and be consistent with the requirements of subsection (c)” <i>[which call for model grievance procedure to be provided by the Secretary of HHS and planning council grievance procedures to be</i> 	<ul style="list-style-type: none"> ▪ “The Ryan White HIV/AIDS Program requires [RWHAP]Part A planning councils to establish procedures to address grievances related to funding. At local discretion, grievance procedures can also address other types of disputes faced by planning councils.” [p 134] ▪ “HAB/DMHAP has developed model grievance procedures to guide local efforts in adequately addressing potential grievances....There should be periodic local review of grievance procedures and their implementation to ensure that legislative

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
	<i>reviewed by the Secretary</i> . [Section 3602(b)(6)]	requirements are being met and grievances are being resolved in a timely and appropriate manner. Any revisions in these grievances should be sent to the HAB/DMHAP project officer to be approved and kept on file.” [p 134]
Planning Council Support and Operations		
Support/Funding	Among the allowable uses of administrative funds, which are capped at 10% of the total grant, are “all activities associated with the grantee's contract award procedures, including the activities carried out by the HIV health services planning council...” [Section 2604(h)(3)(B)]	<ul style="list-style-type: none"> ▪ “The planning council needs funding to carry out its responsibilities. HAB/ DMHAP refers to these funds as ‘planning council support.’ Planning Council Support funds are part of the 10 percent administrative funds available to the grantee for managing the [RWHAP] Part A program.” [p 104] ▪ “The grantee must also ensure adequate funding for PC mandated functions within the administrative line item.” [p 31] ▪ “The planning council must negotiate the size of the planning council support budget with the grantee and is then responsible for developing and managing that budget within the grantee’s grants management structure.” [p 104] ▪ “Planning council support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need, sometimes with the help of consultants, conducting planning activities, holding meetings, and assuring PLWHA participation.” [p 104]
Officers	“The council may not be chaired solely by an employee of the grantee” [Section 2602(b)(7)(A)]	“The planning council needs a chair or co-chairs. The legislation does not permit an employee of the [RWHAP]Part A grantee to serve as the chair of a planning council. An employee of the grantee may serve as a co-chair, provided the bylaws of the planning council permit or specify that arrangement. Bylaws should specify whether there is to be a chair or co-chairs and how they are selected. They may specify that the chair is to be appointed by the CEO or elected by the Planning Council. Often, if the chair is appointed by the CEO or is an employee of the

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
		grantee, bylaws require that the planning council elect the co-chair. Sometimes bylaws require that one co-chair be a PLWHA.” [p 100]
Member Training and Materials	“The Secretary shall provide to each chief elected official receiving a grant under [RWHAP Part A] guidelines and materials for training members of the planning council...regarding the duties of the council.” [Section 2602(e)]	<ul style="list-style-type: none"> ▪ “Members must be trained to enable them to fulfill their responsibilities, in accordance with guidance from” DMHAP. [p 80] ▪ “PC or planning body members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision making.” [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 22] ▪ Letter from PC/B included in the RWHAP Part A application must address “that ongoing, and at least annual membership training took place, including the date(s).” [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 24]
Public Deliberations/ Open Meetings	<p>“(i) The meetings of the council shall be open to the public and shall be held only after adequate notice to the public.</p> <p>(ii) The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location.</p> <p>(iii) Detailed minutes of each meeting of the council shall be kept....” [Section 2602(b)(7)]</p>	<p>“To comply with legislative requirements around open meetings and public access to minutes and other planning council documents, planning councils must:</p> <ul style="list-style-type: none"> ▪ Ensure that meetings are open to all members of the general public and maintain a system that provides for public written notice of all council meetings. This includes publication of the meeting notices in local print media and through other forums accessible to the disabled (<i>i.e.</i>, the hearing- or speech-impaired). Meeting times and locations should be announced on the planning council or health department website and on other appropriate online media. ▪ Have a summary of the minutes that has been approved by the planning council and certified by the chair of the planning council available for public inspection. Both the minutes and other documents or materials made available to or prepared for the planning council should be available to the public within six weeks after the meeting date.

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
		<ul style="list-style-type: none"> ▪ Have a publicly accessible location where minutes and other legislatively required information can be inspected and copied if requested. It is important that detailed minutes are required...Minutes need to be able to show how the Council arrived at their funding decisions, especially if there is a grievance.” ▪ ...“Make available for public inspection records of the recommendations made by committees or other subgroups to the planning council, as well as the subsequent actions taken by the planning council. A sound practice to implement this requirement is to post approved planning council and committee minutes on the planning council website. ▪ Where local, county, or State regulations, ordinances, or statutes are more stringent than Ryan White requirements, follow these more stringent requirements. For example, many States and municipalities have open meeting laws that have very specific public notice or other requirements. Planning councils must adhere to these requirements, and planning council members and support staff should receive information and training about these requirements.” [pp 100-101]
Public Disclosure of Member Status	<p>“The requirement for public deliberations “does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters.” [Section 2602(b)(7)] <i>[Legislation does not address public disclosure of status by consumer members]</i></p>	<ul style="list-style-type: none"> ▪ At least two of the unaligned consumer representatives must publicly disclose their HIV status. [p 109] ▪ The planning council must “take appropriate steps to guard against disclosure of personal information that would constitute an invasion of privacy. For example, minutes should not indicate the HIV status of planning council members unless they are publicly disclosed, and should never provide medical or health status information about a member.” [p 101]

Topic	Legislation: Ryan White HIV/AIDS Treatment Extension Act	Brief Summary of HRSA/HAB Definitions/Clarifications/Expectations <i>[Page references are from Ryan White HIV/AIDS Program (RWHAP) Part A Manual unless otherwise indicated]</i>
Relationship between the Recipient and Planning Council/Body		
CEO Responsibility for Planning Council/Body	“To be eligible for assistance under <i>[RWHAP Part A]</i> , the chief elected official...shall establish or designate an HIV health services planning council.” [Section 2602(b)(1)]	“The CEO must establish a planning council and, once the planning council is established, appoint members through the planning council’s nominations process. For the TGAs funded after 2006, the CEO has the option of establishing a planning council or a process for securing community input....CEOs must enable planning councils to carry out their legislatively mandated responsibilities....” [p 80]
Recipient Compliance with Priorities and Allocations Set by the Planning Council/Body	“The Secretary...may not make any grant...to an eligible area unless the application submitted by such area... demonstrates that the grants made...to the area for the preceding fiscal year (if any) were expended in accordance with the priorities...that were established...by the planning council serving the area.” [Section 2603(d)]	<ul style="list-style-type: none"> ▪ “The planning body must provide the grantee or administrative agent with the results of the priority setting and resource allocation process, both to include in the <i>[RWHAP]</i> Part A application and as a basis for the selection of providers (the procurement process).” [p 219] ▪ The letter of assurance provided by the planning council or the letter of concurrence provided by the planning body for submission with the RWHAP Part A application must indicate whether “Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC or planning body.” [FOA HRSA-17-030, RWHAP Part A Continuing Continuation for FY 2017, p 23]

BYLAWS
of the
RYAN WHITE PLANNING COUNCIL OF THE DALLAS AREA
Revised December 2017

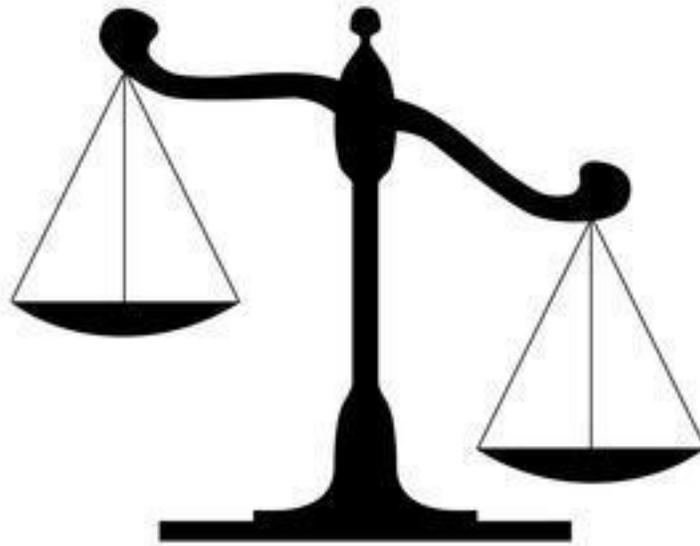


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BYLAWS

RYAN WHITE PLANNING COUNCIL OF THE DALLAS AREA

ARTICLE I: NAME

Section 1.1 – General

The name of this HIV Health Services Planning Council (HSPC) organization is The Ryan White Planning Council of the Dallas Area.

ARTICLE II: PURPOSE

Section 2.1 – General

The purpose of the Ryan White Planning Council of the Dallas Area shall be to:

- (a) Establish priorities for the allocation of the funds from the Ryan White Treatment Extension Act, and any subsequent amendments for the Dallas Eligible Metropolitan Area (EMA) and determine how best to meet such priorities in allocating funds under grants based on the following factors:
 - (i) determine the size and demographics of the population of individuals with HIV disease;
 - (ii) determine the needs of such populations, with particular attention to
 - a. individuals with HIV disease who know their HIV status and are not receiving HIV-related services; and
 - b. disparities in access and services among affected subpopulations and historically underserved communities.
 - (iii) cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available (either demonstrated or probable);
 - (iv) priorities of the HIV-infected communities for whom the services are intended;
 - (v) coordination of the provision of services with HIV prevention programs and substance abuse treatment programs;
 - (vi) availability of other governmental and non-governmental resources for funding the identified needs; and
 - (vii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities.
- (b) Develop an integrated HIV prevention and care plan for the organization and provision of HIV health and support services. The plan must:
 - (i) include a strategy to identify People Living with HIV (PLWH) out of care and to inform and enable them to utilize the services available; eliminate disparities in access and services among selected target populations, affected sub-populations, and historically underserved communities; include discrete goals, such as increased retention in care and viral suppression to reduce community viral load, a timetable, and an appropriate allocation of funds;

- (ii) include a strategy to coordinate the provision of such services with programs for HIV prevention and for substance abuse prevention and treatment; and
 - (iii) be compatible with any State or local plan for the provision of services to individuals with HIV disease.
- (c) Assess the efficiency of the administrative mechanism in allocating funds rapidly to the areas of greatest need within the Dallas EMA and evaluate the effectiveness of services offered in meeting the identified needs.
 - (d) Participate in the development of the Statewide Coordinated Statement of Need (SCSN) initiated by the Texas Department of State Health Services (DSHS).
 - (e) Establish methods and procedures for obtaining input on community needs and priorities which may include holding public meetings, conducting focus groups or community surveys, convening ad hoc panels, and other means as deemed appropriate.
 - (f) Coordinate with Federal grantees that provide HIV-related services within the eligible area.

All business conducted by the Ryan White Planning Council of the Dallas Area will adhere to all Dallas County and Grantor policy and procedure requirements.

Section 2.2 – Prohibition of Profit to Members

None of the income or net earnings of the Ryan White Planning Council of the Dallas Area shall inure to the profit of, or be distributed to, any director, trustee, officer, or any other private person, except that the Ryan White Planning Council of the Dallas Area shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its stated purpose. The Ryan White Planning Council of the Dallas Area may not contract for compensated service with a Council member, the spouse of a member nor a relative of a member or a spouse to the second degree of consanguinity.

Section 2.3 – Regarding Propaganda and Influencing Legislation

No part of the activities of the Ryan White Planning Council of the Dallas Area shall involve propaganda or other attempts to influence legislation at any level of government. The Ryan White Planning Council of the Dallas Area shall not participate in or intervene in any political campaign on behalf of a candidate for public office, including the publishing or distribution of statements on behalf of a candidate or political party.

ARTICLE III: MEMBERSHIP

Section 3.1 – Composition

The Ryan White Planning Council of the Dallas Area members shall be nominated by the Executive Committee of the Ryan White Planning Council of the Dallas Area, utilizing an open process described in Addendum A. Final appointments will be made by the Part A Grantee who is the Dallas County Judge, herein after known as the Chief Elected Official (CEO). Planning Council members are to reflect the demographics of the local epidemic with particular consideration given to consumers of Ryan White services and to disproportionately affected and historically underserved groups and sub-populations. Consumer representation must comply with federal requirements. The Ryan White Planning

Council of the Dallas Area shall include, as a minimum, all federally mandated categories and reflectiveness requirements for membership.

Section 3.2 – Nominations Process for Ryan White Planning Council of the Dallas Area Membership

The Executive Committee shall be chaired by the Ryan White Planning Council of the Dallas Area Chairperson. The Committee will consist of no more than fifteen members. Pursuant to the Ryan White Treatment Extension Act, nominations to the Ryan White Planning Council of the Dallas Area, as set out in Addendum A, shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria, including a conflict of interest standard for each nominee. Addendum A is attached hereto and fully incorporated by reference.

Section 3.3 – Qualifications of New Membership

New members must meet selected qualifications for being selected to the Ryan White Planning Council or specific standing committees as determined by the Executive Committee.

Section 3.4 – Terms of Members

Terms of membership on the Planning Council shall be limited to two (2) consecutive, three-(3-) year terms. After serving two consecutive 3-year terms, individuals must wait twelve (12) months before reapplying for membership on the Planning Council. Former members are always encouraged to participate in Planning Council meeting discussions and activities from the audience. If there is no qualified new applicant for a HRSA mandated category seat or officer position, an exception can be made and a member can serve an additional year in an emeritus position or until the position can be filled.

An individual's term begins the first day of appointment, even when filling a vacancy of an unexpired term.

Section 3.5 – Number of Members

The maximum number of Council members shall be thirty-three (33), including the Chairperson. The Ryan White Planning Council of the Dallas Area shall reflect demographic breakdown of HIV/AIDS in the Dallas EMA. In respect for each individual's right to privacy and confidentiality, it is understood that when qualifications for membership on the Ryan White Planning Council of the Dallas Area, its standing committees, sub-committees, ad hoc committees, or task forces of these groups refer to "self-identified HIV-positive" persons, such persons may limit disclosure of status to the CEO, and Ryan White Planning Council of the Dallas Area Chairperson and staff, who will be bound by confidentiality but who must attest that stipulated percentages of membership are met.

Section 3.6 – Residency of Members

The 33 members of the Ryan White Planning Council of the Dallas Area shall be residents of the Dallas Eligible Metropolitan Area, with the exception of the legislatively mandated membership categories.

Section 3.7 – Vacancies

Any vacancy occurring in federally mandated seats on the Ryan White Planning Council of the Dallas Area shall be filled by appointment of the CEO within thirty (30) days of written notice provided by the Council Chairperson. The Executive Committee will employ targeted recruitment strategies to fill vacancies and will meet with potential new planning council members quarterly to appoint vacant positions. The nomination process as described in Addendum A shall be utilized in filling vacancies on the Ryan White Planning Council of the Dallas Area.

Section 3.8 – Attendance & Forfeiture

If any member of the Planning Council/standing committee fails to attend either (i) three (3) consecutive regularly scheduled meetings during the calendar year or (ii) seventy-five (75%) percent of the meetings in any twelve- (12-) month period, (excluding excused absences), the member will forfeit their seat. A warning letter will be sent to those members that have 2 unexcused absences, notifying them of their potential forfeiture of seat. To ensure substantive involvement of the affected community, if the member of the Ryan White Planning Council of the Dallas Area or its committees has missed three (3) consecutive regularly scheduled meetings due to illness or if the member indicates an inability to attend regularly scheduled meetings, upon the member's request the CEO may appoint an alternate member to the Council to serve in place of the member. The RWPC Chair also may appoint an alternate member to the Consumer Council Committee to serve in place of the member if they are a member in good standing with the Consumer Council Committee when a member of that committee is unable to serve due to illness or disability, upon request of the committee member. Every attempt shall be made to appoint an alternate who is demographically reflective of the member. If the regular member is unable to return after three (3) additional consecutive regularly scheduled meetings, the member forfeits membership and the alternate member may be considered for regular membership with an effective RWPC appointment date beginning the day alternate status was acquired, tolled¹ for periods of inactive alternate status.

Section 3.9 – Resignation

Members that no longer desire or are unable to fulfil the requirements to sit on the Planning Council or its standing committees must give the chair of the council/committee and/or the office of support a written resignation.

Section 3.10 – Leave of Absence/ Medical Leave

Any member may request a three (3) month Medical Leave, by notifying Ryan White Planning Council staff. The Ryan White Planning Council staff will present the request to the Executive Committee for approval. At the end of the granted Medical Leave, the Ryan White Planning Council staff shall update the Executive Committee on the medical status of the committee member. It shall be understood that granting medical leave status permits excused absence at the member's monthly meetings and shall not pause the member's term of service.

ARTICLE IV: COMMITTEES

Section 4.1– General

The standing committees of the Ryan White Planning Council of the Dallas Area shall include:

- (a) Planning and Priorities Committee
- (b) Allocations Committee
- (c) Evaluation Committee
- (d) Consumer Council Committee
- (e) Needs Assessment Committee
- (f) Executive Committee

¹ Total time served equals an aggregate of days served.

Section 4.2 – Special Committees

Such special committees as may be appropriate may be created by action of the Chairperson of the Ryan White Planning Council of the Dallas Area or by the CEO. Any such committee shall have such powers and duties, and its membership shall be constituted, as the Chairperson of the Ryan White Planning Council of the Dallas Area or the CEO may determine.

Section 4.3– Meetings; Quorums for Committees

Each committee shall meet at such time as it may determine and may act by a majority of those present at any meeting at which a quorum is present. A quorum is a simple majority (51 percent) of the voting members. The Chair or Vice Chair of the Ryan White Planning Council are considered to be ex-officio members of all other standing committees' and therefore may step in and chair a standing committee for the purposes of establishing quorum, but their ability to vote must be consistent with the bylaws.

Section 4.4 – Committee Membership

- 4.4.1** Each standing or special committee shall have a Chairperson and Vice-Chairperson recommended by the Executive Committee of the Ryan White Planning Council of the Dallas Area through an open nominations process and appointed by the CEO. All Chairs and Vice-Chairs shall be appointed for a one (1) year term. At the end of such time, Chairs and Vice-Chairs will be reviewed by the Executive Committee for reappointment. The Chairperson AND Vice Chairperson of each standing committee shall be a duly appointed member of the Council.
- 4.4.2** The Executive committee shall make appointments to each standing committee of the Council. This will include a review of the application and an interview if the interviewee is not currently sitting on a Ryan White Planning Council standing committee. The appointments shall be made from the membership of the Council, and other interested citizens who have expressed an interest in serving on the committees of the Council. The standing committees shall consist of no more than fifteen (15) members, except for the Consumer Council Committee, which shall consist of no more than twenty (20) members. There are no non-voting member positions. Committee membership shall reflect in its composition the demographics of the epidemic of the Dallas EMA, in accordance with Section 3.1. All committee members shall be appointed for a one (1) year term. At the end of such time, membership will be reviewed by the Executive Committee for reappointment.
- 4.4.3** The Ryan White Planning Council of the Dallas Area staff shall ensure that accurate records are kept of the work of the committees.
- 4.4.4** All committee members shall comply with the conflict of interest standards set out in Section VII below, including the completion of a disclosure statement listing any and all affiliations with agencies which may receive or pursue funding. The Allocations Committee and the Planning and Priorities Committee may not include representation from any service provider currently receiving funds from grants involved in the community planning efforts of the Ryan White Planning Council of the Dallas Area. No member shall dually serve on the Allocations Committee and the Planning & Priorities Committee.

4.4.5 One liaison position from the Consumer Council Committee will be assigned to the Allocations, Evaluation, Planning and Priorities, Needs Assessment, and Executive Committees and any special committees. The Consumer Council Committee will nominate an eligible Consumer Council Committee member to serve as a liaison and be granted voting privileges on assigned standing committee. The Chair/Vice Chair of the Consumer Council Committee will present the liaison recommendation to the Executive Committee for approval. The sole purpose of the liaison is to establish a formal link between the two stakeholder groups and the Ryan White Planning Council of the Dallas Area committee structure. The Service Providers Council position is optional and advisory only, and not subject to voting rights.

4.4.6 No member shall serve on more than two (2) standing committees, unless you are a non-aligned consumer serving on the Consumer Council Committee or a standing committee chair sitting on the Executive Committee, in which case they would be allowed to sit on up to three (3) standing committees.

Section 4.5 – Charges to Committees

4.5.1 The charge of the Planning and Priorities Committee is to oversee development and implementation of a process to identify needs and barriers, develop strategies to meet needs and overcome barriers, prioritize the need for core medical and support services in the Ryan White community, identify priority populations, and implement a comprehensive plan that integrates prevention and care strategies. The Planning and Priorities Committee will:

- Oversee development and implementation of a process to identify needs and barriers to care and work closely with the current Needs Assessment Committee. The process must be objective; ethnically, culturally, and linguistically sensitive; and yield statistically valid results. A current integrated comprehensive plan to implement the priority goals approved by the Ryan White Planning Council of the Dallas Area will be initiated and approved for recommendation by the Planning and Priorities Committee, with support provided by the Planning Council Staff. Review, amendment, and adoption of the final document and its implementation are charged to the Ryan White Planning Council of the Dallas Area; and
- Provide recommendations for services to be purchased and prioritized based on required grantor processes, and to include recommendations on how best to meet each established priority.

4.5.2 The charge of the Allocations Committee is to develop recommendations for distribution of funds among priority goals using all available information regarding community and agency needs, current funding for HIV services, and trend data; develop recommendations for service category allocations. Recommendations for service category allocations will include how best to meet each established priority. The Allocations Committee will:

- Develop recommendations for distribution of funds among priority goals using all available information regarding community, consumer, agency needs, current funding for HIV services from all identifiable sources, priority rankings, and trend data in making recommendations; and

- Develop recommendations for service category prioritization approved by the Ryan White Planning Council of the Dallas Area. Consideration of the available community resources as well as their coordinating capacities will also be given.

4.5.3 The charge of the Evaluation Committee is to evaluate whether provider services coincide with set service priorities, and evaluate the efficacy of the Administrative Mechanism and the performance of the Planning Council according to its goals. The Evaluation Committee will:

- Ensure that the service categories set out are being met;
- Conduct an annual evaluation of the efficacy of the Administrative Mechanism and provide that evaluation to the CEO and Dallas County Commissioners Court;
- Evaluate the effectiveness of services, categorically and system-wide.

4.5.4 The charge of the Consumer Council Committee is to empower consumers through education by providing the tools and knowledge to interact with those individuals and committees that affect categorical service delivery. The Consumer Council Committee will:

- Provide the tools and knowledge to interact with those individuals and committees that affect categorical service delivery of the Ryan White Treatment Modernization Act, Texas Department of State Health Services (DSHS), and Housing Opportunities for Persons with AIDS (HOPWA) funded services;
- Conduct ongoing educational conferences and outreach for Eligible Metropolitan Area (EMA), the Eligible Metropolitan Statistical Area (EMSA), and the Health Services Delivery Area (HSDA) consumers on the Ryan White Treatment Modernization Act, Roberts Rules of Order, HOPWA policies, DSHS regulations, and other public policy that affects the Ryan White Planning Council of the Dallas Area decision-making;
- Provide HIV consumer input to the development of EMA, EMSA, and HSDA related policies and programs. This includes consumer input into the development of the Statewide Coordinated Statement of Need and the annual priority ranking process done by the Planning & Priorities Committee;
- Work with the Chair of the Ryan White Planning Council of the Dallas Area and the Executive Committee, recruit consumers for standing committees and the Ryan White Planning Council of the Dallas Area;
- Obtain feedback from consumers on issues that are authorized by the Executive Committee; and Represent all consumers including but not limited to: disproportionately affected and historically underserved groups and sub-populations and PLWH out-of care.

4.5.5 The charge of the Needs Assessment Committee is to oversee the development and implementation of the needs assessment process to identify the needs, barriers to care, and gaps in services for PLWH, and to ensure that Planning Council activities are working towards meeting the needs, overcoming the barriers and closing the gaps. The Needs Assessment Committee will:

- Design consumer surveys that will comprehensively gather demographic, epidemiologic, behavioral, and service-related data.
- Develop strategies to target special populations and organize focus groups to determine what information to gather and how to collect it. .
- Determine the best means by which to conduct the comprehensive needs assessment that meets the frequency needs of the Health Resources and Services Administration.
- Identify needs trends as identified by consumers from previous assessment cycles.
- Provide recommendations related to consumer needs to the other Ryan White Planning Council standing committees.

4.5.6 The charge of the Executive Committee, in collaboration with the CEO, will oversee an open nomination process (as described in Addendum A) for Ryan White Planning Council of the Dallas Area membership. They will also oversee how well the Ryan White Planning Council is functioning overall. They will routinely review how we operate and why we operate that way. The Executive Committee will:

- Review the annual Ryan White Planning Council budget with the office of support in order to negotiate with the Administrative Agency.
- Review the Ryan White Planning Council bylaws annually to ensure that the structure and purpose of the Planning Council and the mechanisms that make it function are still not prohibitive towards getting PLWH services they need to improve their quality of life and increase their viral suppression.
- Partner with the Administrative Agency to regularly review and agree on a Memorandum of Understanding that illustrates a beneficial, synergistic partnership.
- Make qualified appointments to each standing committee of the Council. This will include a review of the application, but will not require an interview.
- Make qualified recommendations to the CEO for members' appointment to the Ryan White Planning Council through an open nominations process.
- To review the Planning Council and standing committee membership and to develop recruitment strategies

In addition to the standing committees, there will also be an Executive Committee full of Planning Council and standing committee leadership. The charge of the Executive Committee is to ensure the orderly and integrated progression of work of the committees of the Ryan White Planning Council and plan future activities. The Executive Committee will:

- Consist of the Chairperson and Vice Chairperson(s), of the Ryan White Planning Council of the Dallas Area, the Chairpersons or Vice-Chairperson(s) of each standing committee, and at a minimum, a representative of the County Judge's office, and a representative of the Administrative Agency;

- Meet periodically to ensure the orderly and integrated progression of work of the committees of the Council, and to plan future activities. Unless expressly authorized by the full membership of the Ryan White Planning Council of the Dallas Area, the Executive Committee is not authorized to act on behalf of the Council on any matters that it is charged with executing; and
- Review the Ryan White Planning Council and all standing committees' attendance to make sure members are complying with Section 3.8.
- Serve as the governance committee to periodically review changes in the governing documents of the Ryan White Planning Council.

ARTICLE V: OFFICERS

Section 5.1 – List of Officers

The officers of the Ryan White Planning Council of the Dallas Area shall be the Chairperson and Vice Chairperson(s).

Section 5.2 – Appointment

The officers of the Ryan White Planning Council of the Dallas Area & standing committees shall be appointed from the membership of the Council. The Chairperson and Vice Chairperson(s) shall be appointed by the CEO.

Section 5.3 – Limitations of Terms

No person shall hold the same office for more than three (3) consecutive years. The officers shall be appointed or reappointed each year by the CEO, and an open application process will take place each year.

Section 5.4 – Duties

The duties and powers of the officers shall be those usually pertaining to their respective offices.

Planning Council Chair: The Chair of the Planning Council shall preside at their respective meetings. The Chair is the only official spokesperson for the Council and will be responsible for interfacing with the public and with the media. They will be responsible for correspondence to members regarding attendance and participation issues. The Chair of the Council is an ex-officio member of all committees (standing, subcommittee and work groups), and therefore may step in and chair a standing committee for the purposes of establishing quorum, but their ability to vote must be consistent with the bylaws.

Planning Council Vice Chair: The Vice Chair of the Planning Council shall preside at meetings of the Council in the absence of the Chair. The Vice Chair shall perform such other duties as the Chair may designate.

Standing Committee Chair/Vice Chair: The standing committee Chairs shall preside at all meetings of their respective committees. They may be responsible for correspondence to members regarding attendance and participation issues. The Committee Vice Chair shall preside at all committee meetings in the absence of the Chair. The Committee Chairs are responsible for the execution of the duties prescribed herein for the Committees and for such other duties as may be prescribed by the Chair of the Council.

Section 5.5 – Parliamentary

The Executive Committee may reference a current member of the Planning Council as a parliamentarian if there is a qualified and willing member to serve in such a position.

Section 5.6 – Vacancies

Vacancies occurring in an officer's position shall be filled by appointment by the CEO as specified in Section 5.2.

ARTICLE VI: MEETINGS

Section 6.1 – Frequency of Meetings

The Ryan White Planning Council of the Dallas Area shall meet not less than quarterly each year at such times and places as it may determine, or as may be specified in the notice of the meeting. Additional or emergency meetings of the Ryan White Planning Council of the Dallas Area may be called by the CEO, the Chairperson, or by at least eight (8) members of the Ryan White Planning Council of the Dallas Area.

Section 6.2 – Notice of Meetings

Notice of each meeting of the Ryan White Planning Council of the Dallas Area shall be mailed or emailed to each Council member, at their last known address as carried on the records of the organization, not less than three (3) days prior to the date of the meeting. Should an emergency meeting be called, all Council members shall be notified by telephone, and public notice of the meeting time and place shall be posted in accordance with Federal, State, and local laws.

Section 6.3 – Quorum

A quorum of the planning council/standing committee must be present at any regular or specially scheduled meeting in order for the council to engage in the meeting. A quorum of the council is defined as a simple majority (51 percent) of the planning council/standing committee membership. In computing a quorum, a vacant seat on the council shall not be considered. At all meetings of the Ryan White Planning Council of the Dallas Area, a majority of duly appointed Council members shall constitute a quorum.

Section 6.4 – Open Meetings

All meetings of the Ryan White Planning Council of the Dallas Area and committees of the Council are deemed to be covered by provisions of all applicable Federal, State, and local laws. To ensure compliance with federal, State, and local requirements, all scheduled meetings of the Council or committees must be cleared with the Ryan White Planning Council of the Dallas Area staff to ensure availability of meeting space, staff resources, and proper public posting of meetings as specified in the Texas Open Meetings Act.

Section 6.5 – Conduct of Meetings

The most up to date Robert's Rules of Order shall generally govern the conduct of meetings of the Ryan White Planning Council of the Dallas Area for Planning Council/standing committee members, the office of support, and to the public attending the meeting.

Section 6.6 – Structure of Meetings

The person chairing the committee has the authority to start the meeting on time, regardless of quorum being established, with the understanding that voting items may not be voted on until quorum has been met. Meetings will have scheduled start and finish times and also have public comment periods at the discretion of the committee chair. The person

facilitating the meeting will conduct the meeting following Robert's Rules of Order. Agenda items for regularly scheduled meetings should include discussion items, action items, and reports if pertinent. Discussion items are items typically accompanied with materials for members to review to have thorough and thoughtful discussion of consequence, action items are items that will be voted on and have an impact on the local Ryan White system, and reports are opportunities for people of other committees or bodies to summarize ongoing efforts.

Section 6.7 – Voting

Each member of the planning council/standing committee shall be entitled to one vote on any business matter coming before the council/committee. Only members of the council or standing committee are entitled to vote on matters coming before council/committee. A cast vote is defined as a positive (“aye) vote or a negative (“nay”) vote. Abstentions are not considered to be cast votes. A simple majority of the members present and voting is required to pass any matter coming before the Council/Committee. The Chair of the Council or Standing Committee shall not vote at their respective meetings, except in the event of a tie.

Section 6.8 – Minutes

Minutes must be taken of each council and committee meetings. These minutes must state the names of all in attendance and the names of members absent. Minutes must state all motions, recommendations, requests or action items fully. Minutes must also indicate any votes taken with abstentions indicated. The planning council & committee minutes must be signed by the leadership to certify that the above stated conditions are met. Any council or committee member wishing to propose corrections to the minutes shall propose corrections at the meeting at which the minutes are subject to approval.

Section 6.9 - Training

Newly appointed members are required to complete New Member Orientation within 90 days of appointment and submit their certificate of completion to the RWPC Office of Support to be included in their member file. Members are also required to sign a confidentiality statement to be kept on file yearly. Members should also participate in regular trainings given by the office of support throughout the grant year via various training materials.

ARTICLE VII: CONFLICTS OF INTEREST

Section 7.1 - General

It is the policy of the Ryan White Planning Council of the Dallas Area that any member of the Ryan White Planning Council of the Dallas Area or member of a Council standing or special committee who also serves as director, trustee, salaried employee, Board Member, or one who has a financial interest in any Agency receiving funds from grants involved in the community planning efforts of the Ryan White Planning Council or otherwise materially benefits from association with any agency that may seek funds from the Grantee is deemed to have an "interest" in said agency or agencies. The term “materially benefit” is not meant to include services received by an individual as a client that are within the normal realm of services provided by the provider agency. These members may not vote or otherwise participate in deliberations, except in response to direct questions, that come before the Ryan White Planning Council of

the Dallas Area or committees of the Ryan White Planning Council of the Dallas Area regarding awarding of funds directly to the agency/ies, or definition for the purchase of said service, in which they have an interest

This policy shall not be construed as preventing any member of the Ryan White Planning Council of the Dallas Area from full participation in discussion and debate about community needs, service priorities, allocation of funds to broad service categories, and the processes for, and results of, evaluation of service effectiveness. Rather, individual members are expected to draw upon their lay and professional experiences and knowledge of the HIV service delivery system in the Dallas area when such matters are under deliberation. In order to safeguard the Ryan White Planning Council of the Dallas Area's recommendations from potential conflict of interest, each member shall disclose any and all professional affiliations and/or service as director, advisor, or other volunteer capacity that exist currently with agencies which may receive or pursue funding. A Conflict of Interest statement form will be completed by each Council and committee member and kept on file. The Ryan White Planning Council of the Dallas Area Staff shall maintain these records and have forms updated not less than every 12 months.

All members of the Ryan White Planning Council of the Dallas Area are expected to assist in keeping the Council focused to meet the needs of individuals affected by the HIV epidemic in the most expeditious manner possible without undue regard to the benefit to specific agencies or programs. Grantor Conflict of Interest Policies must be followed.

ARTICLE VIII: NON-DISCRIMINATION

Section 8.1 - General

The officers, directors, employees, and committee members of the Ryan White Planning Council of the Dallas Area shall be selected entirely on a non-discriminatory basis with respect to age, sex, gender identity or expression, race, religious or spiritual beliefs, disability (except as a result of HIV infection), sexual orientation, or national origin.

ARTICLE IX: CODE OF CONDUCT

Section 9.1 – Purpose

This Code of Conduct has been created by the Ryan White Planning Council of the Dallas Planning Area in order to guide Planning Council and standing committee members, individually and collectively, adhere to the highest possible ethical standards.

Section 9.2 – Code of Conduct

- 9.2.1** Every Planning Council/standing committee member will treat every other member, support staff, Administrative Agency staff, and members of the public with courtesy and professionalism. Each Planning Council/standing committee member is reminded to respect and recognize the legitimate right of all other members to be a part of any discussions and decision-making processes.
- 9.2.2** Every member will conduct business related to the Planning Council/standing committees in ways that are honest, respectful of diversity, compassionate and nonjudgmental.
- 9.2.3** Every member will honor their time and meeting attendance commitments and be prepared to contribute to the best of their ability for all Council/committee work.

9.2.4 While recognizing the individual's right to dissent, once decisions are made, every member will recognize the final decision, regardless of their personal position.

9.2.5 Planning Council/standing committee members will exercise discretion when discussing confidential or sensitive information, most notably an individual's HIV or health status.

9.2.6 Every member will refrain from spreading misinformation related to the Ryan White Planning Council. The Planning Council/standing committee members will strive to address problems internally.

9.2.7 Every member should strive to support the mission, goals, strategies, programs, and/or leadership of the planning body as agreed upon by the members.

9.2.8 No member shall be under the influence of alcohol or illegal drugs at any Planning Council/standing committee meeting.

9.2.9 All items listed above are applicable to audience members as well as council/committee members.

ARTICLE X: OFFICIAL COMMUNICATIONS AND REPRESENTATION

Section 10.1 - Media Contact and Public Information

The Planning Council and standing committees shall maintain positive media relations and accurate public information messages through designated spokesperson(s), professional media contacts, coordinated and reviewed information, and consistent marketing strategies.

Planning Council/standing committee members shall refer any need for media contact or public information to the Planning Council Chair. The Chair shall select the appropriate spokesperson(s).

ARTICLE XI: REMOVAL PROCEDURES

Section 11.1 – Professionalism

The goal of disciplinary action is to ensure inappropriate and unacceptable behavior does not occur and/or repeat and that all members and participants, and the business of the Planning Council/standing committees, is protected from inappropriate/unacceptable behavior in the course of doing the Planning Council/standing committees' work.

Section 11.2 – Removal from a Meeting

If a person willfully disrupts a meeting to the extent that its orderly conduct is made impractical, the person may be removed from the meeting. The chair of the public body may, without vote of the body, declare a recess to remove a person who is disrupting the meeting. If said person refuses to leave the meeting, the office of support will request help from building security.

Section 11.3 – Removal from the Planning Council

Planning Council members may be removed only by the Chief Elected Official (CEO). The Ryan White Planning Council may recommend to the CEO that a member be removed for any of the following reasons:

- Habitual behavior which inhibits the Planning Council's ability to conduct business in a timely and efficient manner;

- Conduct that negatively impacts confidence in the Planning Council, including, but not limited to a violation of Conflict of Interest rules and/or Code of Conduct;
- Behavior that could prevent others (Planning Council/standing committee members, Office of Support staff, Administrative Agency staff, or members of the public) from attending or participating in meetings.

The CEO shall have the power to remove Planning Council members without the approval of the Planning Council.

Section 11.4 – Process for Recommending Removal from the Planning Council

Recommendation for removal for any above reasons shall be reviewed by the Ryan White Planning Council and put to a vote. Notice of, and the reasons for the Planning Council’s proposed removal will be sent to the member and the CEO. If the Planning Council votes to recommend removal of the member, the recommendation shall be forwarded to the CEO. No member should be removed by less than a two-thirds vote, a quorum voting. The Executive Committee may make a recommendation for removal of a member for any of the above stated reasons.

Section 11.5 – Removal from a Standing Committee

Standing committee members may be removed by a majority vote from the Executive Committee. Any standing committee may recommend to the Executive Committee that a member be removed for any of the following reasons:

- Habitual behavior which inhibits the standing committee’s ability to conduct business in a timely and efficient manner;
- Conduct that negatively impacts confidence in the standing committee, including, but not limited to a violation of Conflict of Interest rules and/or Code of Conduct.
- Behavior that could prevent others (Planning Council/standing committee members, Office of Support staff, Administrative Agency staff, or members of the public) from attending or participating in meetings.

Section 11.6 – Process for Recommending Removal from a Standing Committee

Recommendation for removal for any above reason shall be reviewed by the Executive Committee and if the Executive finds merit, it shall proceed with the removal of a standing committee member. No member should be removed by less than a two-thirds vote, a quorum voting. Notice of, and the reasons for the Executive Committee’s proposed removal will be sent to the member and the CEO. If the Executive Committee votes to recommend removal of the member, the recommendation shall be forwarded to the CEO.

ARTICLE XII: GRIEVANCE PROCEDURES

Section 12.1 - General

The Ryan White Planning Council of the Dallas Area shall follow procedures for addressing grievances with respect to funding, including procedures for submitting grievances that cannot be resolved to binding arbitration as described in Addendum B, the Dallas EMA Ryan White Planning Council of the Dallas Area Grievance Procedure. Addendum B is attached hereto and fully incorporated by reference.

ARTICLE XIII: AMENDMENTS

Section 13.1 - General

The Ryan White Planning Council of the Dallas Area shall have the power to alter, amend, or repeal these Bylaws at any meeting at which a quorum is present, provided that written notice of the proposed change is given at least five (5) days

prior to such meeting. Such amendments must be reviewed and approved by the Commissioners Court prior to their taking effect.

ARTICLE XIV: DISSOLUTION

Section 14.1 - General

Upon dissolution of the organization of the Ryan White Planning Council of the Dallas Area, the CEO shall, after paying or making provision for payments of all known liabilities of the Ryan White Planning Council of the Dallas Area, dispose of all of the assets of the Ryan White Planning Council of the Dallas Area in such a manner, or to such an organization or organizations organized and operated exclusively for charitable, educational, religious, or scientific purposes as shall at that time qualify as an exempt organization or organizations under Section 501(c)(3) of the Internal Revenue Code of 1954 or the corresponding provision of any future United States Revenue Law, as the Ryan White Planning Council of the Dallas Area shall determine.

APPROVED BY THE MEMBERSHIP OF THE RYAN WHITE PLANNING COUNCIL OF THE DALLAS AREA ON

DATE:

BY: _____

CHAIRPERSON

APPROVED BY THE DALLAS COUNTY COMMISSIONERS COURT ON _____

BY: _____

CHIEF ELECTED OFFICIAL

Adopted: 1-1991

Amended: (10-19-1991), (07-21-1992), (04-06-1993),
(06-09-1993), (01-25-1994), (10-05-1994),
(06-11-1997), (12-10-1997), (12-08-1999),
(01-12-2000), (02-15-2005), (04-11-2007),
(11-20-2012), (12-10-2014), (12-12-2017),

Tip Sheet: Effective Planning Council/Body (PC/B) Meetings¹

- 1. Be sure members and staff understand the importance of effective meetings to Planning Council/Body (PC/B) success.** A PC/B's ability to carry out its responsibilities for needs assessment, planning, and other decision-making roles, while ensuring broad-based community input, depends heavily on its ability to hold effective meetings.

When meetings are effective, planning body and committee members are more likely to participate, feel involved, and choose to remain active. Effective meetings therefore contribute to member recruitment and retention as well as to the successful completion of planning body tasks.

- 2. Recognize the symptoms of ineffective meetings so that changes can be made.** They include the following:

- High levels of conflict
- Divisions among members
- Limited participation
- Low attendance
- Inability to complete scheduled tasks and decision making
- A feeling that time is being wasted
- A feeling that the PC/B is not making progress or making a difference

- 3. Plan the meeting carefully:**

- Establish meeting goals and use them to guide meeting planning and implementation
- Plan the meeting location and ensure full access to all members, including individuals with limited mobility. Remember that the American with Disabilities Act (ADA) requires “reasonable accommodations” for individuals with disabilities including limited mobility² in federal programs – and a PC/B needs to ensure that accessibility is never a barrier to participation by PC/B members or the public.
- Determine necessary attendance based on the agenda, and give as much advance notice as possible to needed individuals (anyone besides members and regularly attending PCS and recipient staff); this includes identifying whether a meeting would benefit greatly from community input, then actively urging the attendance of targeted groups

- 4. Develop an agenda that:**

- Starts with a core “standing” agenda that includes items that are almost always included
- Includes items identified for action at the Executive Committee meeting before the PC/B meeting
- States what must be accomplished by the end of the meeting
- Lists in order every activity or topic of discussion planned for the meeting

¹ Refined from information from the *Training Guide: Preparing Planning Body Members*, HIV/AIDS Bureau, 2002. Developed by Mosaica; updated by EGM Consulting, LLC.

² See “Introduction to the ADA” (undated), at https://www.ada.gov/ada_intro.htm.

- Schedules the most critical items relatively early in the agenda, when attendance is highest, to assure adequate time for discussion and full participant attention
- Includes time frames (starting and ending times) for the entire meeting and for each item
- Specifies who will present information for each section (such as a committee chair)
- Clarifies which items involve action items and which are for discussion only
- References relevant materials, preferably available in order and numbered by agenda item
- Is finalized by the Chair, working with PC Support staff
- Is sent out and posted online as required by open meeting/Sunshine laws and PC/B policies and procedures

5. Be sure all needed materials are provided:

- Identify needed materials at the Executive Committee meeting
- Distribute materials in advance, including minutes of the last meeting and a timed agenda
- Be sure printed versions of materials are made available before and at meetings for those members who need them – do not assume that all members can print out materials or project them on a laptop or tablet during the meeting
- Make materials as concise as possible, write them in plain language, and present them in user-friendly formats
- Provide electronic or printed copies of PowerPoint presentations
- Be sure PCS staff or an officer has available copies of the Bylaws, policies and procedures, ground rules, and other relevant documents (such as the current integrated plan, list of service priorities, and current allocations by service category) in case they are needed during discussion

6. Be sure meetings are open and accessible to the public. In addition to following all local or state open meeting/sunshine law requirements, comply with Ryan White legislative requirements for well publicized open meetings, public access to materials disseminated at meetings, and access to minutes. Establish and carefully follow policies and procedures for public comment; this might include providing a public comment period at the beginning and/or end of each meeting, and in some cases allowing the public to comment on proposed actions – often at committee meetings.

7. Establish and consistently follow and enforce “groundrules” that are understood and agreed upon by everyone – and apply to both members and the public. Here are some commonly used groundrules; establish your own, project them or post a copy in your meeting room:

- Treat everyone with respect – as an intelligent person with a legitimate right to be a part of discussions and decision making
- Let every member or recognized speak, without interruptions
- Follow the direction of the Chair; for example, where necessary, observe limits set by the Chair on speaking time for individuals, and give each member an opportunity to speak before calling on members who have already spoken on the issue
- If you believe a proposed action or process is inconsistent with the Bylaws or policies

and procedures, immediately but politely bring that to the attention of the Chair, either directly or through the PCS staff

- Participate in decision making that follows the process established in the Bylaws or established for a specific issue prior to discussion
- Do not attack people or criticize them personally – focus on issues, not individuals
- Know when to be an advocate and when to be a planner – recognize your responsibility to present and consider the concerns of specific communities or PLWH subpopulations, and to make decisions that consider the needs of all PLWH
- Make decisions based on the best available data; do not urge actions based on your own narrow self-interest
- Help new members, and non-members understand the discussion by using plain language, avoiding use of abbreviations and complex terminology, and not assuming a knowledge of past actions
- When information is shared in confidence, maintain that confidence; do not share information on anyone’s HIV status, medical condition, or personal situation unless the individual indicates it can be shared publicly
- Accept and support decisions made by the PC/B in the agreed-upon manner, regardless of your personal position
- Speak positively about the PC/B and its members in public; address problems with the group, not outside it
- Take responsibility not only for following these groundrules, but also for speaking out to assure that other members follow them

8. Provide informed meeting management and facilitation of the meeting, by the Chair, with support as needed:

- Follow simplified *Robert’s Rules of Order* or other agreed-upon procedures
- Start and end on time
- Follow the established agenda unless the group approves an agenda revision (and meeting laws permit this)
- Keep track of policy decisions and action items during the meeting
- Use an agreed-upon decision-making process that is familiar to all participants
- Encourage active participation by all members
- Establish a balance between “doing business” and addressing other tasks, including maintaining a supportive relationship among members

9. Assess and learn from experience, by asking members and the public for advice and assistance in improving meetings.

- Try going around the table and asking everyone to comment on the positive and negative aspects of the meeting, and to offer suggestions for improving future meetings
- Periodically use a written assessment of meeting content, flow, management, use of member time, and productivity/results

10. Complete minutes promptly, and make them available for review by the Chair (and Secretary if there is one), approval at the next meeting, and posting on the PC/B website for use by the public within 6-8 weeks following the meeting.

Robert's Rules of Order – Simplified

<https://blogs.cornell.edu/deanoffaculty/files/2016/01/RobertsRulesSimplified-1ybt2mk.pdf>

Guiding Principle:

Everyone has the right to participate in discussion if they wish, before anyone may speak a second time.

Everyone has the right to know what is going on at all times.

Only urgent matters may interrupt a speaker.

Only one thing (motion) can be discussed at a time.

A **motion** is the topic under discussion (e.g., “I move that we add a coffee break to this meeting”). After being recognized by the president of the board, any member can introduce a motion when no other motion is on the table. A motion requires a second to be considered. Each motion must be disposed of (passed, defeated, tabled, referred to committee, or postponed indefinitely).

How to do things:

You want to bring up a new idea before the group.

After recognition by the president of the board, present your motion. A second is required for the motion to go to the floor for discussion, or consideration.

You want to change some of the wording in a motion under discussion.

After recognition by the president of the board, move to amend by

- adding words,
- striking words or
- striking and inserting words.

You like the idea of a motion being discussed, but you need to reword it beyond simple word changes.

Move to substitute your motion for the original motion. If it is seconded, discussion will continue on both motions and eventually the body will vote on which motion they prefer.

You want more study and/or investigation given to the idea being discussed.

Move to refer to a committee. Try to be specific as to the charge to the committee.

You want more time personally to study the proposal being discussed.

Move to postpone to a definite time or date.

You are tired of the current discussion.

Move to limit debate to a set period of time or to a set number of speakers. Requires a 2/3^{rds} vote.

You have heard enough discussion.

Move to close the debate. Requires a 2/3^{rds} vote. Or move to previous question. This cuts off discussion and brings the assembly to a vote on the pending question only. Requires a 2/3^{rds} vote.

You want to postpone a motion until some later time.

Move to table the motion. The motion may be taken from the table after 1 item of business has been conducted. If the motion is not taken from the table by the end of the next meeting, it is dead. To kill a motion at the time it is tabled requires a 2/3^{rds} vote. A majority is required to table a motion without killing it.

You believe the discussion has drifted away from the agenda and want to bring it back.
Call for orders of the day.

You want to take a short break.
Move to recess for a set period of time.

You want to end the meeting.
Move to adjourn.

You are unsure that the president of the board has announced the results of a vote correctly.
Without being recognized, call for a "division of the house." At this point a roll call vote will be taken.

You are confused about a procedure being used and want clarification.
Without recognition, call for "Point of Information" or "Point of Parliamentary Inquiry." The president of the board will ask you to state your question and will attempt to clarify the situation.

You have changed your mind about something that was voted on earlier in the meeting for which you were on the winning side.
Move to reconsider. If the majority agrees, the motion comes back on the floor as though the vote had not occurred.

You want to change an action voted on at an earlier meeting.
Move to rescind. If previous written notice is given, a simple majority is required. If no notice is given, a 2/3^{rds} vote is required.

You may INTERRUPT a speaker for these reasons only:
to get information about business – **point of information**
to get information about rules – **parliamentary inquiry**
if you can't hear, safety reasons, comfort, etc. – **question of privilege**
if you see a breach of the rules – **point of order**
if you disagree with the president of the board's ruling – **appeal**

Quick Reference					
	Must Be Seconded	Open for Discussion	Can be Amended	Vote Count Required to Pass	May Be Reconsidered or Rescinded
Main Motion	√	√	√	Majority	√
Amend Motion	√	√		Majority	√
Kill a Motion	√			Majority	√
Limit Debate	√		√	2/3 ^{rds}	√
Close Discussion	√			2/3 ^{rds}	√
Recess	√		√	Majority	
Adjourn (End meeting)	√			Majority	
Refer to Committee	√	√	√	Majority	√
Postpone to a later time	√	√	√	Majority	√
Table	√			Majority	
Postpone Indefinitely	√	√	√	Majority	√

Typical Responsibilities for Committee and Planning Council/Body (PC/B) Meetings: PC/B Leaders and PC Support (PCS) Staff¹

Area of Responsibility	Senior Leaders (Chair/Co- or Vice Chairs)	Committee Chairs/Co-Chairs	Planning Council Support (PCS) Staff
Preparation for Committee Meetings	<ul style="list-style-type: none"> • Communicate with Committee Chairs about any issues that need to be addressed and any action items committee needs to recommend at the next Executive Committee meeting (Each senior leader responsible for such communication with half the committees, based on agreed-upon assignments) 	<ul style="list-style-type: none"> • Work with PCS staff on preparations at least one week before the meeting • Work with assigned PC support staff member to develop an agenda and agree on needed materials • Work with Staff as appropriate to prepare materials • Communicate with staff if unable to attend and chair the committee (should occur as soon as Chair is aware s/he cannot attend) 	<ul style="list-style-type: none"> • If PC/B has multiple staff, have a person assigned to each committee; usually best to have the same person attend regularly for continuity and expertise • Handle logistics for committee meetings – send out notices at least one week before the meeting, post meeting schedule on website, arrange meeting locations, arrange food • Request and receive RSVPs from Committee members (should be received 48 hours before the meeting – or set local deadline for excused absence) • Work with Committee Chairs/Co-Chairs to prepare an agenda with action items (contact them at least one week before the meeting) • Work with Committee Chairs/Co-Chairs on preparation of materials for mail-out and identification of any supplemental resources PCS staff should bring to the meeting • E-mail materials to members 3-5 days before meeting (agenda, prior meeting minutes, content information needed for deliberations and decision making) – set local minimum time for review; arrange to send hard copies as necessary based on specific member needs, access to printer • Set up conference call if necessary, and send out call-in number • Check with Chair/Co-Chairs 24 hours ahead to review arrangements and RSVPs

¹ Prepared by Mosaica and updated by EGM Consulting, LLC; most recent update for DMHAP in March 2017

Area of Responsibility	Senior Leaders (Chair/Co- or Vice Chairs)	Committee Chairs/Co-Chairs	Planning Council Support (PCS) Staff
Committee Meetings	<ul style="list-style-type: none"> • Where possible, attend meetings of assigned committees, usually serving as an <i>ex officio</i>, non-voting member [unless Bylaws specify something different] • Offer advice and assistance as needed 	<ul style="list-style-type: none"> • Chair meeting • Ensure that Committee follows agenda, and discusses and votes on action items that need to be recommended to the Executive Committee and full PC/B • If this is not done by the PCS staff, prepare bullet points summarizing decisions and next steps, as well as any specific requests to the recipient 	<ul style="list-style-type: none"> • Handle logistics at meetings: set up communications, food • Staff committee meeting • Take attendance, documenting excused and unexcused absences • Take minutes, including exact wording of resolutions and results of voting or consensus reached [<i>Note:</i> In a PC/B with limited staff resources, sometimes the Chair/Co-Chair or another committee member takes responsibility for minutes; in such situations, PCS staff must ensure that minutes are taken and prepared for review] • Record and summarize any data or information requests from the committee to the recipient
Committee Meeting Follow Up	<ul style="list-style-type: none"> • Where attendance at committee meeting was not possible, communicate with the Committee Chair/Co-Chairs to receive an update and identify issues that will be coming to the Executive Committee 	<ul style="list-style-type: none"> • Review draft minutes • Identify issues and activities that will need to be addressed at the next Committee meeting and work to be done in preparation for the next meeting • Communicate with PCS staff about needed follow up such as data requests to the recipient 	<ul style="list-style-type: none"> • Prepare minutes and provide to Committee Chair/Co-Chairs for review; revise based on their input [or if policy allows for this, assume permission is given to share the draft minutes if no changes are received within a specified period]
Preparation for Executive Committee Meetings	<ul style="list-style-type: none"> • Work with PCS staff on agenda and review action items from committees • Work with staff to ensure appropriate materials are available 	<ul style="list-style-type: none"> • Work with PCS staff to ensure that Committee materials needed for the Executive Committee are prepared/revise • Prepare Committee report to PC (oral/written) • Inform staff if unable to attend Executive Committee 	<ul style="list-style-type: none"> • Handle logistics – send out notices at least one week before the meeting; arrange food • Request and receive RSVPs from Executive Committee members (should be received at least 48 hours before the meeting) • Work with whoever chaired each Committee meeting to finalize committee materials needed for Executive Committee review and action • Work with Co-Chairs on meeting agenda and action

Area of Responsibility	Senior Leaders (Chair/Co- or Vice Chairs)	Committee Chairs/Co-Chairs	Planning Council Support (PCS) Staff
		meeting (as soon as this is known)	items <ul style="list-style-type: none"> • E-mail materials to members at least 48 hours before meeting (agenda, prior meeting minutes, committee reports/action items, and other content information needed for deliberations and decision making) • Set up conference call if necessary and send out dial-in number • Check with PC/B senior leadership 24 hours ahead to review arrangements and RSVPs • Provide Chair (or Secretary, if the PC/B has one) a list of excused absences for upcoming meeting
Executive Committee Meetings	<ul style="list-style-type: none"> • Chair meeting • Provide leadership and advice as needed 	<ul style="list-style-type: none"> • Make Committee report, present action items, and request recommendation from the Executive Committee to the PC 	<ul style="list-style-type: none"> • Handle logistics at meetings: set up communications and food • Staff meeting • Make staff report • Take minutes
Preparation for Planning Council/Body (PC/B) Meetings	<ul style="list-style-type: none"> • Work with PCS staff on agenda and review action items from Executive Committee • Communicate with staff about issues and possible concerns and make needed preparations to address them 	<ul style="list-style-type: none"> • Revise/refine Committee report and action item presentation as needed, based on Executive Committee discussion/action • Work with staff on revisions as needed to written materials for PC review • If unable to attend the PC meeting, inform staff as soon as this is known and agree on who will present the report for the Committee 	<ul style="list-style-type: none"> • Handle logistics – send out notices at least one week before PC meeting, arrange food • Prepare Executive Committee minutes and provide to senior leadership (or Secretary, if there is one) for review • Request and receive RSVPs from PC members (should be received at least 48 hours before the meeting) • Work with Committee Chairs/Co-Chairs to finalize committee materials needed for PC final review and action (based on Executive Committee direction) • Work with senior leaders on meeting agenda and action items • E-mail materials to members at least 2-3 days before meeting (agenda, prior meeting minutes, Executive Committee minutes, committee reports/action items, and other content information needed for deliberations and decision making); provide

Area of Responsibility	Senior Leaders (Chair/Co- or Vice Chairs)	Committee Chairs/Co-Chairs	Planning Council Support (PCS) Staff
			printed materials to members based on need <ul style="list-style-type: none"> • Set up conference call if call-in is permitted, and send out call-in number with materials • Check with senior leaders 24 hours ahead to review arrangements and RSVPs • Provide senior leaders or Secretary list of excused absences for upcoming meeting
PC/B Meetings	<ul style="list-style-type: none"> • Chair and manage meeting • Provide leadership and advice as needed • Vote only when there is a tie 	<ul style="list-style-type: none"> • Make committee report and presentation of action items brought forward from the Executive Committee 	<ul style="list-style-type: none"> • Handle logistics at meetings: set up communications and food, provide sign-in sheets for members and public/guests • Make all needed arrangements for presenters • Staff meeting • Make staff report • Take minutes; includes recording votes and exact language of resolutions and other action items • Have copies of Bylaws, key policies and procedures for reference if needed • Obtain information from individuals making public comments if the PC/B indicates that any follow up is required • Unless the PC/B has a parliamentarian, be prepared to answer questions about procedures and about RWHAP legislation and PC/B guidance
Follow Up to PC/B Meetings	<ul style="list-style-type: none"> • Work with Staff to ensure appropriate follow up on actions taken or tasks referred to committees • Meet with people on behalf of the PC as needed 	<ul style="list-style-type: none"> • If PC/B assigns any tasks to the Committee, ensure that work on these items is on the agenda for the next meeting 	<ul style="list-style-type: none"> • Prepare minutes • Provide minutes to senior leaders (or first to Secretary if there is one) for review and make needed revisions • Follow up with Committee Chairs/Co-Chairs on any assignments made at the PC/B meeting • Follow up with the recipient on any requests made of the recipient during the PC/B meeting
New Members	<ul style="list-style-type: none"> • Where possible, attend and participate in new member orientation for those committees for which each 	<ul style="list-style-type: none"> • Ensure that new committee members receive a personal orientation to the committee purposes and responsibilities, 	<ul style="list-style-type: none"> • Work with Membership Committee to ensure prompt orientation of new members • Work with Committee Co-Chairs to ensure that new committee members receive a committee orientation

Area of Responsibility	Senior Leaders (Chair/Co- or Vice Chairs)	Committee Chairs/Co-Chairs	Planning Council Support (PCS) Staff
	senior leader is responsible	protocols for operations, annual plan and timeline, meeting schedule, relationship to other committees, any special processes and procedures, and how to read and analyze typical materials used by the committee <ul style="list-style-type: none"> • Play a lead role in this orientation 	
Other	<ul style="list-style-type: none"> • Serve as spokespersons for the PC • Follow up with members who are not meeting attendance requirements 	<ul style="list-style-type: none"> • Identify membership needs and communicate them to PC Staff and senior leaders • Recruit non-PC members for committee with help from Membership Committee • Ensure that committee prepares an annual written plan • Review progress towards plan • Arrange for any needed committee training, working with PCS staff 	<ul style="list-style-type: none"> • Ensure that all communications related to committee leadership activities go by e-mail to both the senior leaders and to the Chair/Co-Chairs overseeing that committee • Maintain committee records • Provide advice and support to committee Chairs/Co-Chairs

Dallas County

Dallas Eligible Metropolitan Area Integrated HIV Prevention and Care Plan

CY 2017 - 2021

Dallas County Health and Human Services
Grants Division
9/29/2016

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

The development of this CDC/HRSA Integrated HIV Prevention and Care Plan for the Dallas Planning Area was a collaborative process among the Ryan White Parts A and B Administrative Agency, Ryan White Planning Council support staff, Ryan White funded service providers, CDC directly funded prevention service providers, Ryan White consumers and Planning Council members, the local Housing Opportunities for Persons with AIDS (HOPWA) grantee, AIDS Education and Training Center (AETC), and the University of Texas-Southwestern. This group will comprise the ad hoc Integrated Prevention and Care Plan Committee during the implementation phase of this plan.

The group coordinated with the Texas Department of State Health Services to develop sections of the Statewide Coordinated Statement of Need, including the Epidemiologic Overview and the HIV Care Continuum for this area. All of the data for these sections are for the eight-county Dallas Eligible Metropolitan Area (EMA) unless otherwise stated. The eight counties that consist of the Dallas EMA are Dallas, Denton, Collin, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties. Some of the epidemiological data for this section is not available locally. State data is utilized in conjunction with Ryan White utilization data to expand and provide greater information for these sections.

The epidemiologic overview presents information on known cases of HIV infection in the Dallas EMA diagnosed through December 31, 2014 and reported as of June 30, 2015, as this was the most recent data available during the planning phase of this integrated prevention and care plan. While the Dallas Planning Area as a whole also includes counties in the Dallas Health Services Delivery Area (HSDA) and the Sherman-Dennison HSDA, the vast majority of the epidemic lives within the counties included in the Dallas EMA. The other four counties that make up the entirety of the Dallas Planning Area along with the Dallas EMA include Cooke, Fannin, Grayson, and Navarro counties.

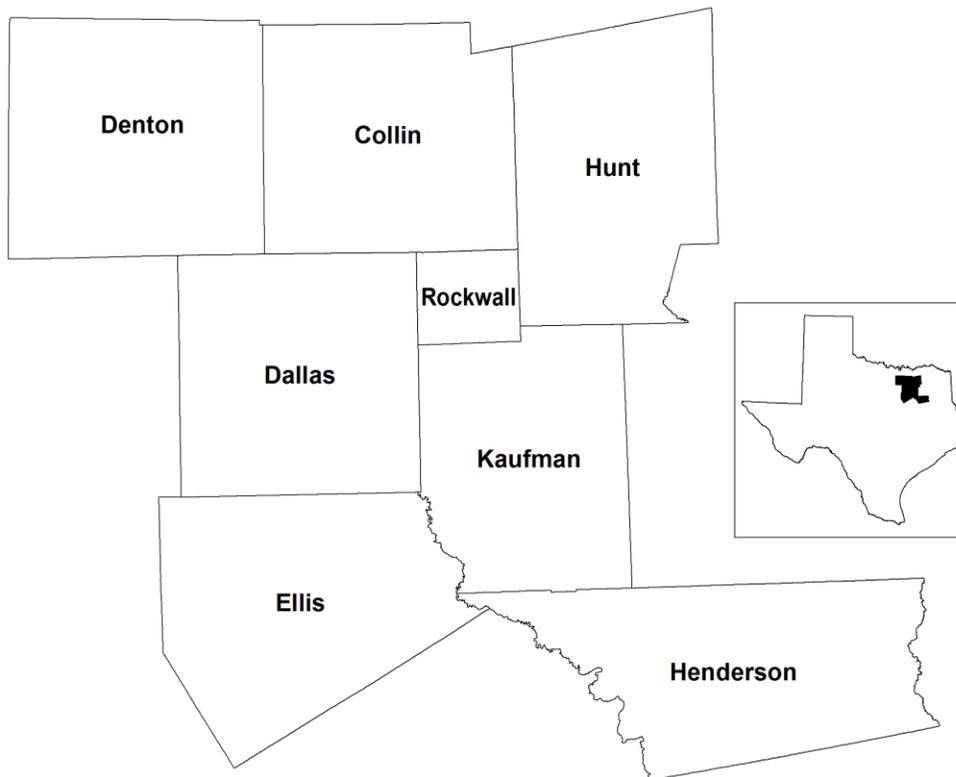
EPIDEMIOLOGIC OVERVIEW

a. Describe (map and/or narrative) the geographical region of the jurisdiction (i.e., Eligible Metropolitan Area) with regard to communities affected by HIV infection.

The information in this section is drawn from the National Center for Health Statistics and results from the Census Bureau's *American Community Survey* (information collected across 2010-2014) and *Supplement to the Current Population Survey* (2014).

The Dallas EMA covers eight counties in north east Texas, as shown in Figure 1. The city of Dallas sits in Dallas County, the largest in terms of general population and people living with a diagnosed HIV infection.

Figure 1: The Dallas EMA



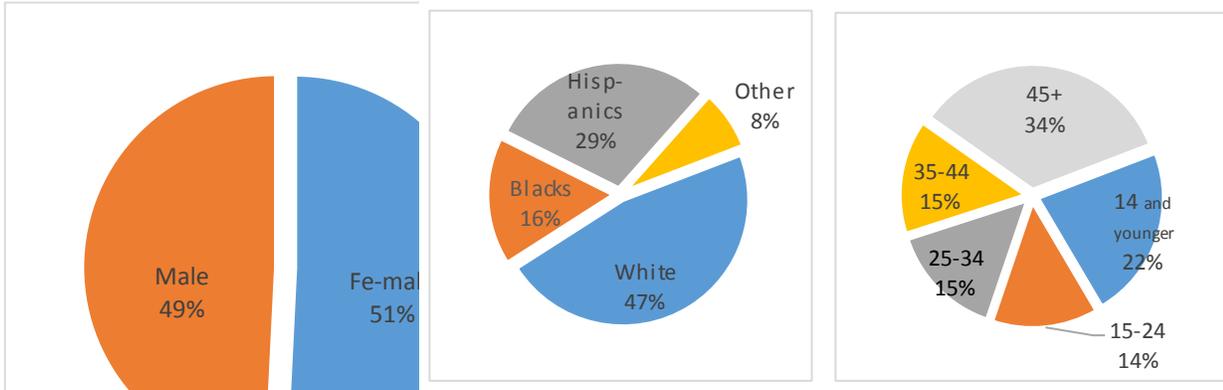
From 2010 to 2014 the Dallas EMA added about 375,000 residents, reaching 4.6 million and increasing the population by 9%. The breakdowns of the population by sex, race/ethnicity, and age group are shown below.

Overall, the Dallas Planning Area (DPA) for services, as shown in Figure 2, also includes the Dallas Health Services Delivery Area (HSDA) and the Sherman-Dennison HSDA. The Dallas HSDA has seven counties in common with the Dallas EMA, but also includes Navarro County. The Sherman-Dennison HSDA consists of Cook, Fannin, and

b. Describe (table, graph, and/or narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including the following, as available in the geographical region of the jurisdiction:

i. Demographic data (e.g., race, age, sex, transmission category, current gender identity)

Figure 3: Dallas EMA population in 2014 by sex, race/ethnicity and age



Race/Ethnicity

Blacks make up about 16% of the population of the EMA, but more than 40% of the PLWH in the area. Between 2010 and 2014, the number of Black PLWH in the EMA rose by about a quarter, and the 2014 prevalence rate indicates that more than 1% of Black residents of the EMA were living with diagnosed HIV infections (1,023.9 PLWH per 100,000 = 1.02 per 100 residents of the EMA). Prevalence rates for Blacks were consistently three times higher than the rates for Whites or Hispanics, and rose about 14% between 2010 and 2014.

Blacks also made up 45% of those newly diagnosed over the past five years, with the number of new diagnoses in Blacks being about 70% to 80% higher than diagnoses among Whites and Hispanics. The diagnosis rate for Blacks was consistently five times higher than the rate in Whites and three times higher than the diagnosis rates for Hispanics for 2010-2014.

The number of White PLWH and the prevalence rate were flat, as were the number of new diagnoses and the diagnosis rate for this group. By 2014 there were 12 Black PLWH for every 10 White PLWH.

The rate of growth for Hispanic PLWH was similar to the rate for Blacks, but there were 19 Black PLWH for every 10 Hispanic PLWH. The number and rate of new diagnoses in Hispanics shows a slow downward trend.

Figure 4: Dallas PLWH and new diagnoses by race/ethnicity

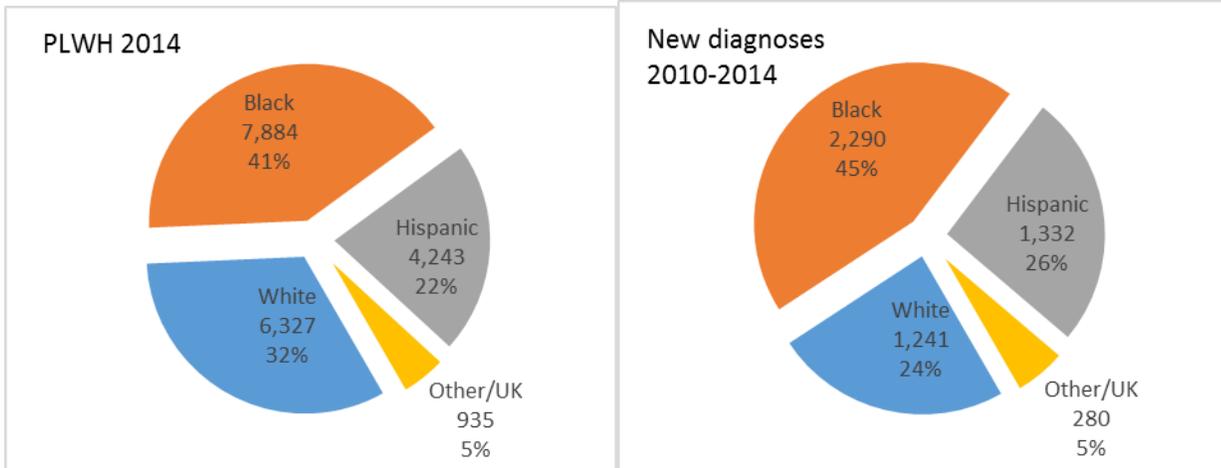


Figure 5: Changes in race/ethnicity of Dallas PLWH and new diagnoses, 2010-2014

PLWH

New Diagnoses

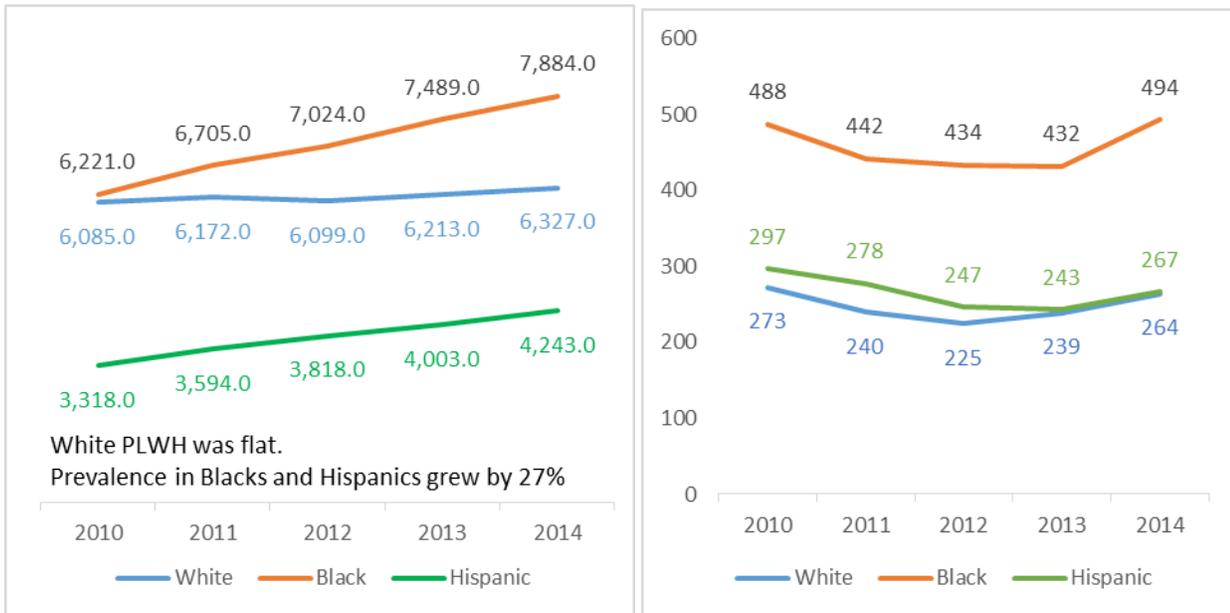
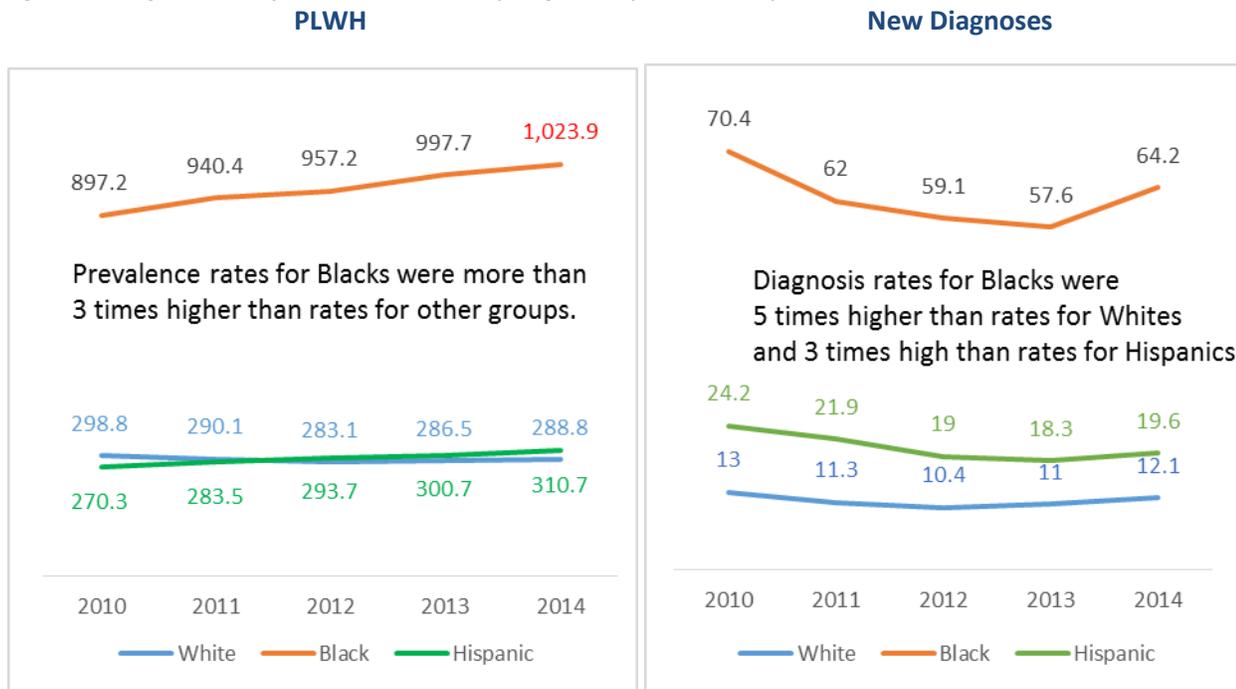


Figure 6: Changes in rates of PLWH and those newly diagnosed by race/ethnicity, Dallas 2010-2014



Age

About half the PLWH in the EMA are 45 or older, another quarter are 35-44 years old and a quarter are 34 and younger. Both the number of PLWH 25-34 and 45 or older increased, but other age groups were flat. It is difficult to discern trends in the age of EMA residents who were diagnosed between 2010-2014 due to individuals moving from one category to another in a given year.

Figure 7: Dallas PLWH and new diagnoses by age

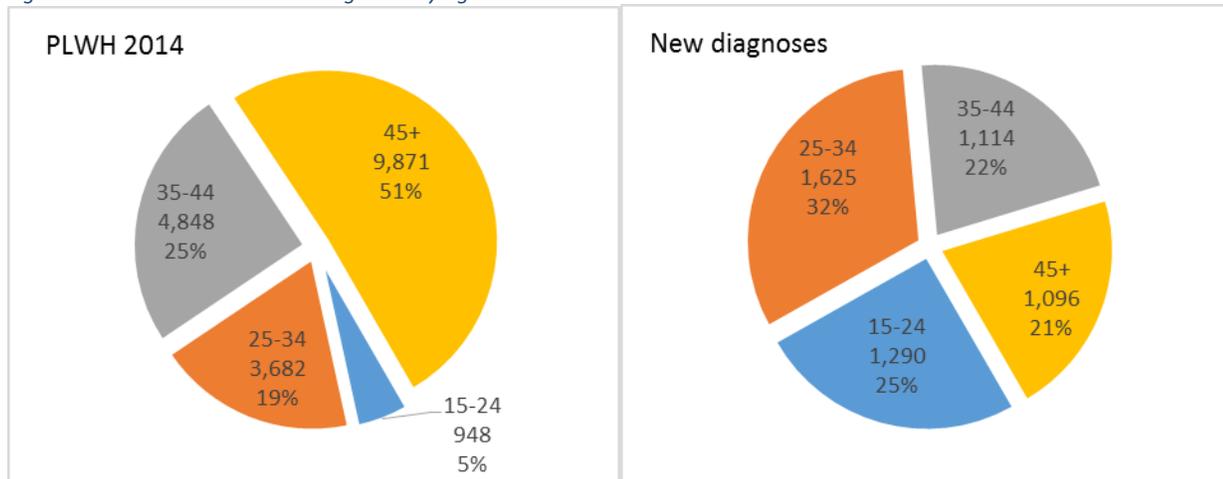
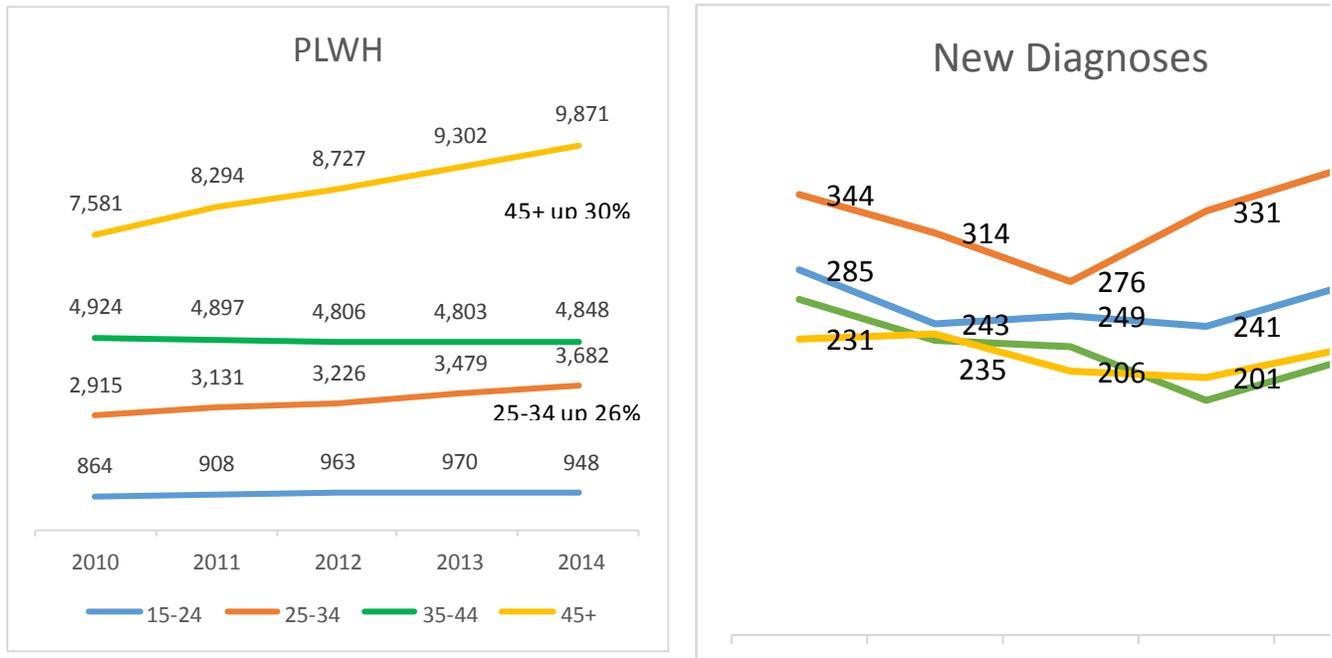


Figure 8: Changes in age of Dallas PLWH and new diagnoses, 2010-2014



Sex

About four out of five PLWH in the Dallas EMA in 2014 were men. The number of men and women grew at the same pace, so the prevalence rate of HIV for men was consistently four times higher than the rate for women.

Men also made up about four of five new diagnoses in the EMA. The decreasing numbers of infections seen in women is a continuation of a trend from 2005-2009; from 2010 – 2014 the number of new diagnoses in women fell by 14%. For men, numbers of new diagnoses fell from 2005 to 2009, but were flat from 2010-2014.

Figure 9: Dallas PLWH and new diagnoses by sex

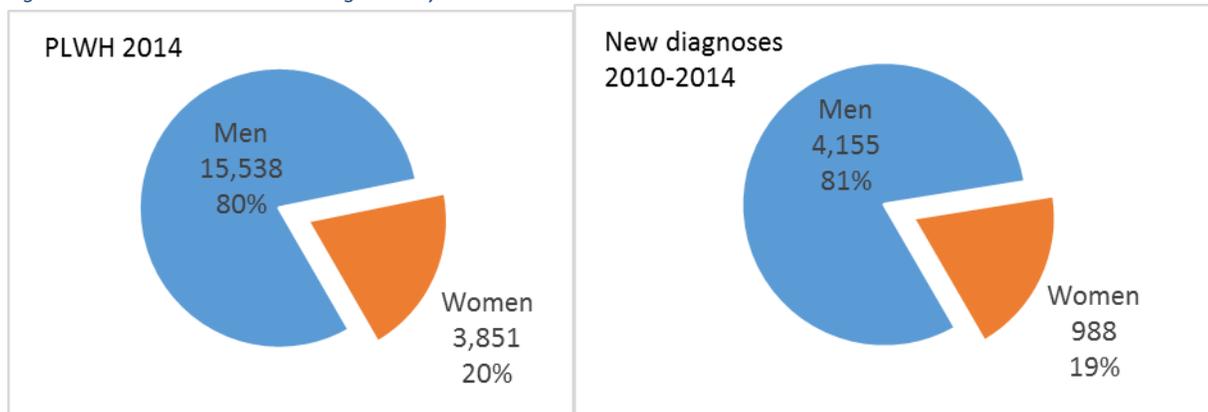


Figure 10: Changes in numbers of men and women in Dallas living with diagnosed HIV infections and with newly diagnosed infections. 2010-2014

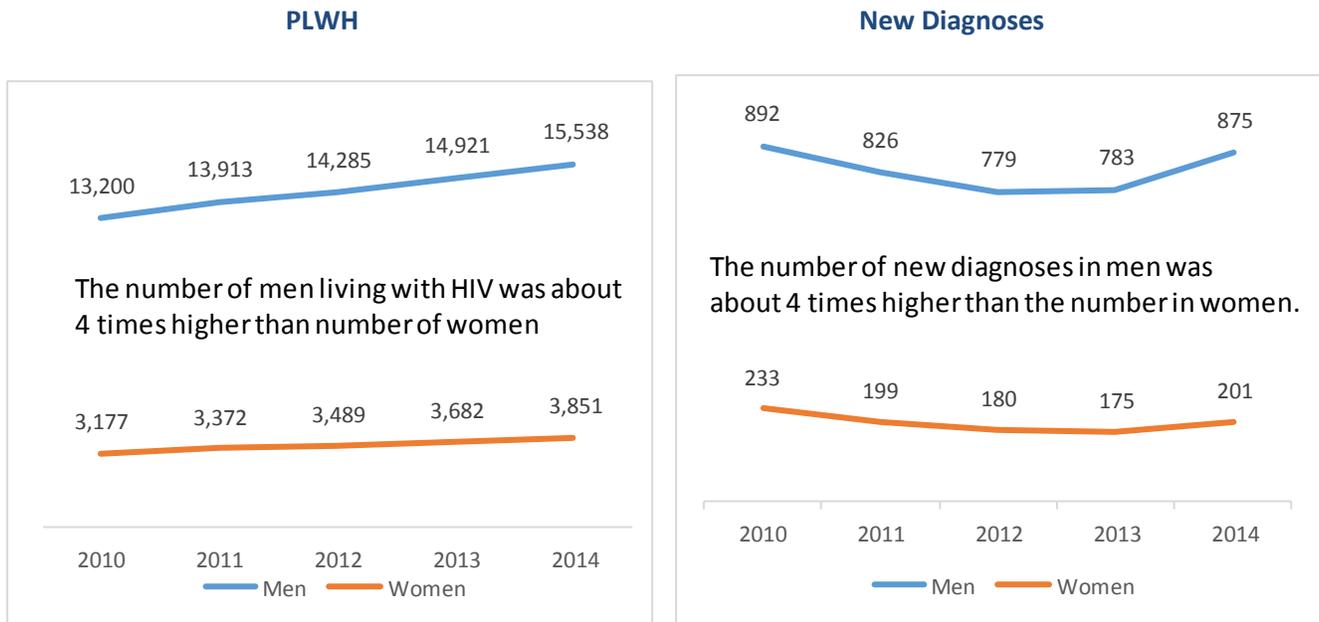
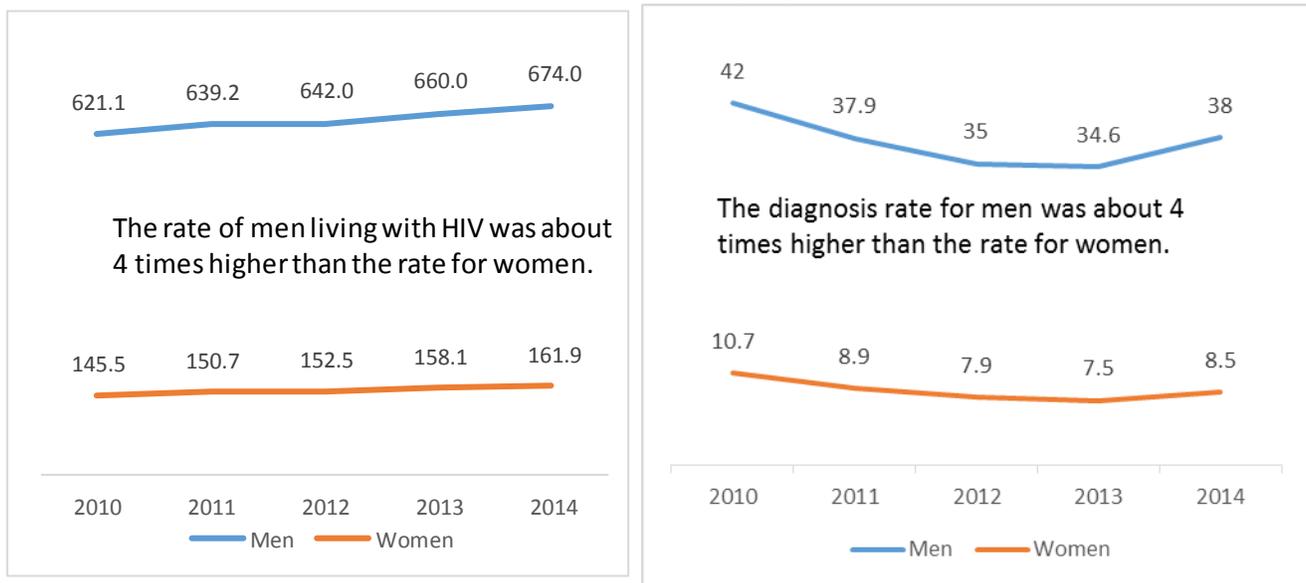


Figure 11: Changes in rates of men and women living with HIV and with newly diagnosed, Dallas 2010-2014



Mode of transmission

Public health surveillance uses the term *mode of transmission* to categorize information about people with HIV based on the most likely way they became infected. The most common modes of transmission groups are gay and bisexual men and other men who have sex with men (MSM), high risk heterosexuals (HRH), injection drug users (IDU), and MSM who also inject drugs (MSM/IDU). While locally, the planning body in Dallas believes it would be more appropriate for mode of transmission categories to better represent how each individual transmitted the disease with categories such as condomless anal sex, condomless vaginal sex, and/or sharing needles with someone who has HIV, the data received for this plan from the Texas Department of State Health Services (DSHS) used the more traditional mode of transmission categories. HIV can also be transmitted from mother to child or through blood transfusions or other medical exposures; these latter two categories account for very few PLWH.

In 2014, more than three in five PLWH and more than three in four of those newly diagnosed in Dallas were in MSM. There were three times as many PLWH and new diagnoses in MSM than in heterosexuals, the next largest group. Dallas residents with heterosexually acquired infections were about one in five PLWH or people with new diagnoses, and the number of new diagnoses in this group decreased by about 18% from 2010-2014.

Mode of transmission groups

Mode of transmission refers to the most likely way a person with HIV became infected. Major modes of transmission in Texas are

- MSM:** gay men, bisexual men, and other men who have sex with men
- HRH:** high-risk heterosexuals
- IDU:** heterosexual injection drug users
- MSM/IDU:** MSM who also inject drugs

Figure 12: Dallas PLWH and new diagnoses by mode of transmission

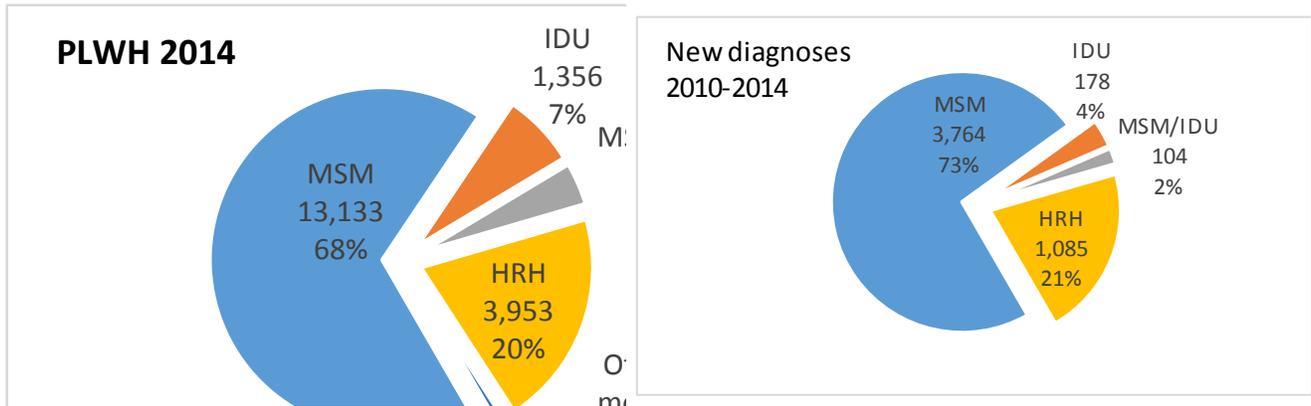
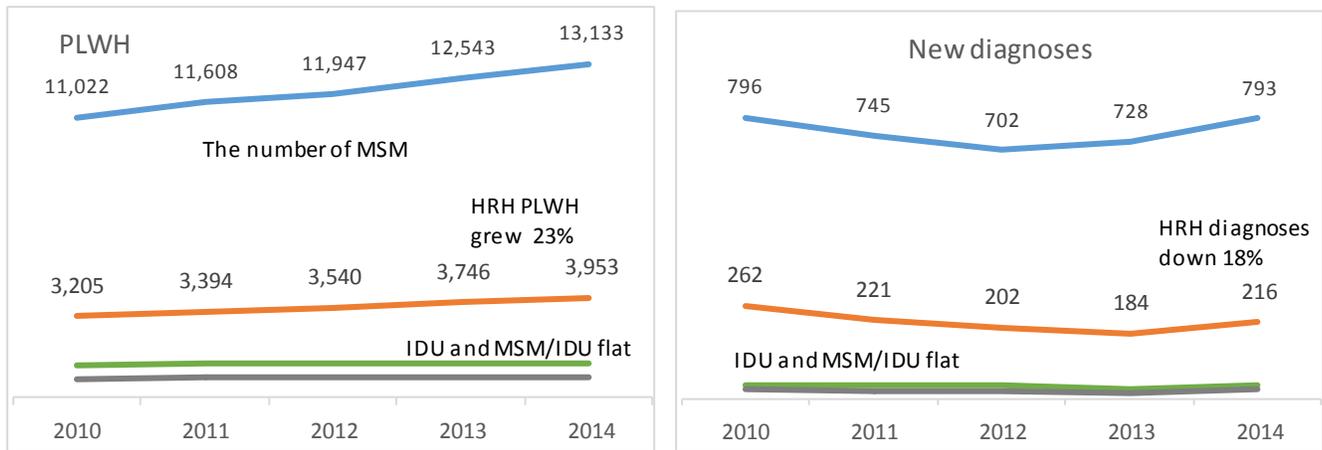


Figure 13: Changes in mode of transmission, Dallas 2010-2014



Gender identity

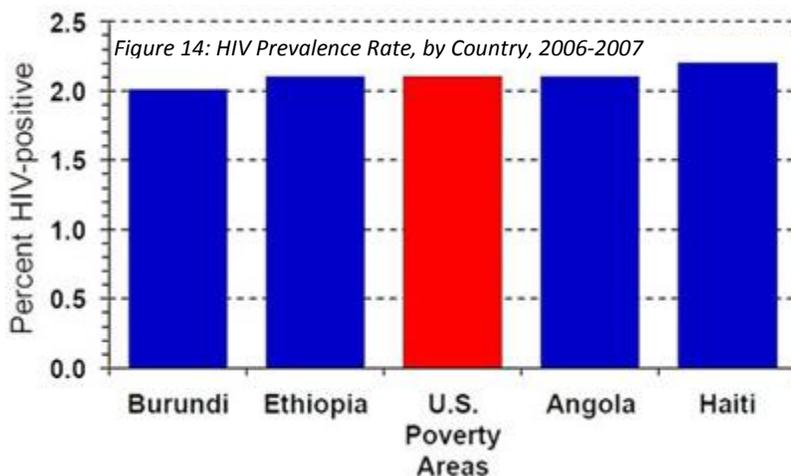
While most of the data in this section was provided by DSHS, gender identity data was not provided. Gender identity information related to HIV in the overall 12 county Dallas Planning Area for this section was obtained from the AIDS Regional Information and Evaluation System (ARIES) pertaining to clients receiving Ryan White funded services.

In 2014, 77% of Ryan White clients identified as male, whereas 22% identified as female and less than 1% identified as transgender. These numbers have been fairly consistent over the last five years (2010-2014). The percentage of Ryan White clients that identify as male has varied from 76% - 77%; the percentage of Ryan White clients that identify as female has varied from 22% - 24%; and the number of Ryan White clients that identify as transgender has varied from 0.49% - 0.65%.

ii. Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.)

Percentage of federal poverty level & Income

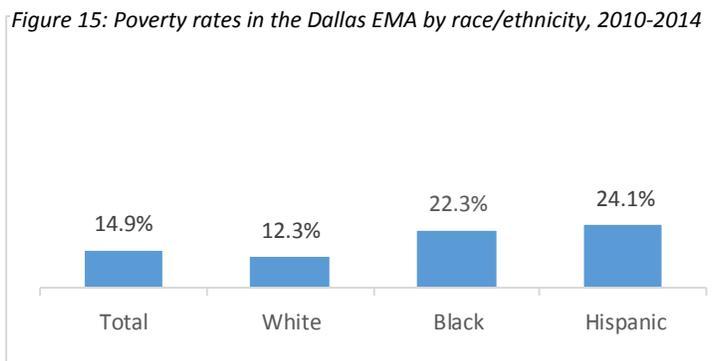
According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States has a concentrated



HIV epidemic, primarily among MSM and IDUs and has greatly affected the economically disadvantaged in many urban areas. The Centers for Disease Control and Prevention (CDC) defines a concentrated HIV epidemic as when the HIV prevalence rate is <1% in the general population, but >5% in at least one high-risk subpopulation, such as MSM. The CDC recently conducted

a study in 25 urban areas, including Dallas, which found the HIV prevalence rate to be so high in urban poverty areas, that the rate is more than 20 times greater than the rate among all heterosexuals in the U.S. HIV prevalence rates in urban poverty areas in the U.S. is similar to rates found in low-income countries such as Burundi, Ethiopia, Angola, and Haiti. HIV prevalence rates in Dallas and other U.S. urban areas are inversely related to annual household income as shown in Figure 14².

Poverty influences health directly and indirectly. Income directly affects the ability to pay for health care or health insurance. Low income is both a cause and effect for factors such as low educational attainment and housing and job instability that are associated with poor health.¹ In 2014, nearly 15% of EMA residents were living in poverty. Racial/ethnic minorities bore a higher burden of poverty – one in four Hispanic and one in five Black Dallas residents lived in poverty compared to less than one in seven Whites as shown in Figure 15.



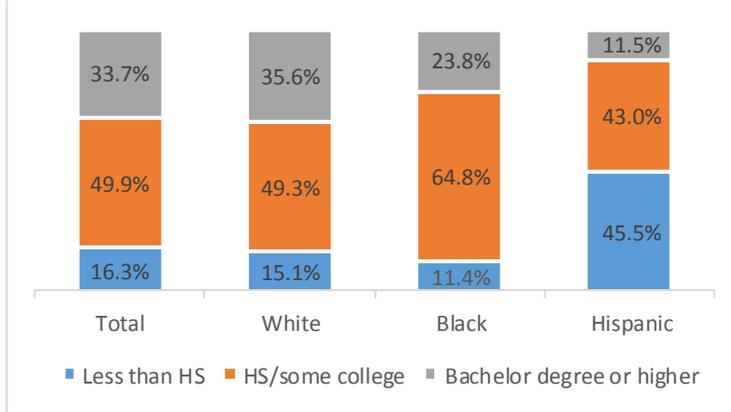
When analyzing the Federal Poverty Level (FPL) of consumers of Ryan White services in the 12 county Dallas Planning Area via the AIDS Regional Information and Evaluation System (ARIES) from 2010 – 2014, the percentage of users that were in the 0% - 100% FPL dropped dramatically in 2014 compared to the previous four calendar years. 60% of Ryan White consumers fell within this range in 2014, whereas in the previous four calendar years the percentage of Ryan White consumers that fell within this FPL was 68% in 2010 and 2011, 69% in 2012, and 70% in 2013.

²Data sources: NHBS-HET-1 2006-7 and UNAIDS HIV Estimates 2007. From: Denning P and DiNenno E. Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States? The Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/group/poverty.html>

Education

People with low levels of educational attainment (less than 12 years of formal schooling) have higher mortality rates from all causes than people with higher levels of educational attainment.² About 16% of Dallas EMA

Figure 16: Levels of educational attainment, Dallas EMA 2010-2014



residents aged 25 and older do not hold a high school diploma (or have earned a GED or equivalent). For Hispanic residents, the proportion is almost three times higher – more than two in five have not completed high school.

Trends in death rates due to HIV infection in the U.S. show that death rates for both whites and blacks individuals decreased substantially from 1993 to 2001 (Figure 17). However, both white and black men with an educational attainment of less than 12 years experienced a much lower decrease in death rates compared to those with an educational level above 16 years. Black females with an education of less than 12 years actually experienced an increase in rate of death due to HIV infection from 1993 to 2001³.

Black females with an education of less than 12 years actually experienced an increase in rate of death due to HIV infection from 1993 to 2001³.

Figure 17: Trends in age-standardized death rates (per 100,000) for HIV infection with decreasing trend in the general population among 25-64 year old U.S. adults by race, sex, and education, 1993-2001

Cause/Sex	Education in years	Whites			Blacks		
		Rate	Rate	Annual %*	Rate	Rate	Annual %*
		1993	2001	Annual %*	1993	2001	Annual %*
HIV Infection							
Men	All	31.3	6.3	-23.0 [†]	111.3	56.1	-12.1 [†]
	<12 Yrs	28.7	15.4	-12.5 [†]	123.1	120.9	-3.1
	16+ Yrs	31.4	3.5	-28.4 [†]	118.2	28.9	-20.1 [†]
	Rate difference (<12 vs. 16+)	-2.7	12.0		4.9	92.0	
	Rate Ratio, 95% CI (<12 vs. 16+)	0.9 (0.8-1.0)	4.5 (3.9-5.1)		1.0 (0.9-1.2)	4.2 (3.5-5.0)	
Women	All	1.9	0.9	-11.9 [†]	23.1	21.7	-4.6
	<12 Yrs	5.7	5.4	-3.4	41.0	52.9	0.6
	16+ Yrs	0.8	0.1	-22.9 [†]	8.9	5.9	-10.7 [†]
	Rate difference (<12 vs. 16+)	4.9	5.2		32.2	47.1	
	Rate Ratio, 95% CI (<12 vs. 16+)	7.1 (5.2-9.5)	39.2 (22.4-68.6)		4.6 (3.2-6.8)	9.0 (6.3-12.9)	

²Hummer, RA & Hernandez, EM (2013). The Effect of Educational Attainment on Adult Mortality in the United States. *Population Bulletin* 68, no. 1.

³Jemal A, Ward E, Anderson R, et al. Widening of Socioeconomic Inequalities in U.S. Death Rates, 1993-2001. *PLoS One*. 2008; 3(5): 1-8.

Housing and Homelessness

A 2016 Point-In-Time (PIT) homeless count, conducted by the Metro Dallas Homeless Alliance found an increase of 21% in the homeless population in Dallas and Collin Counties over the 2015 PIT Count. Nearly one half of those defined as being unsheltered were homeless for greater than one year⁴. In addition to poor overall physical health being more pronounced among those without a home, rates of mental illness, substance abuse, tuberculosis, hypertension, diabetes, and asthma are all higher. The rate of those living with HIV infection in the U.S. homeless population is estimated to be as high as 3.5% compared to 0.006% in the overall U.S. population⁵. This rate is consistent with historical PIT Counts from 2011 to 2015 in Dallas and Collin Counties, which show the rate of those living with HIV in the homeless population at between 3% and 6% of the homeless population.

Health insurance status

Texas is one of the states that has yet to expand its Medicaid program under the Affordable Care Act (ACA), and is home to the largest number of uninsured individuals of any state in the country (Table 1). Studies have shown that uninsured persons are less likely to have a regular source of health care and to receive needed medical care, and are more likely to die from health-related problems. Chronically-ill uninsured adults delay or forgo checkups and therapies, including medications. Low rates of insurance coverage in a community can also hurt the health of people with insurance. Data show that privately insured, working-age adults in areas with lower insurance rates are less likely to report having a place to go for care when sick, getting routine preventive care, and seeing a specialist when needed.⁶ Uninsured PLWH are especially vulnerable to poor health outcomes, including an increased risk of death.⁷

Table 1: Texans without health insurance, 2010-2014

	Total	White	Black	Hispanic
Texas	21.9%	21.0%	19.6%	33.7%
Austin TGA	17.6%	16.7%	15.6%	29.6%
Dallas EMA	21.5%	19.8%	20.4%	39.0%
Fort Worth TGA	20.3%	18.7%	20.9%	36.4%
Houston EMA	23.5%	22.2%	20.0%	38.4%
San Antonio TGA	18.7%	17.9%	15.3%	23.9%
East Texas area	20.1%	19.4%	20.0%	36.5%
US-Mexico border	31.7%	31.6%	15.2%	34.3%

⁴ <http://www.mdhadallas.org/state-of-the-homeless-address-2016/>

⁵ Zlotnick C and Zerger S. Survey findings on characteristics and health status of clients treated by the federally funded (US) Health Care for the Homeless Programs. *Health and Social Care in the Community*. 2008; 17(1): 18-26.

Between 2010 and 2014, a little more than one in five Dallas residents did not have health insurance. The proportion of Blacks and Whites with health coverage was similar, but the proportion of Hispanics with health insurance was much lower – only about 61 percent had coverage.

Supplemental data from the Census Bureau shows that the proportion of non-elderly Texans with insurance increased from 2013 to 2014, although these increases were primarily in Texans with higher incomes. The number of uninsured Texans dropped by 17 percent, but the number of uninsured persons living in poverty dropped by only ten percent.

The Medical Monitoring Project is a special surveillance study that focuses on a representative sample of PLWH receiving HIV-related care in the U.S. In 2011, 25% of the respondents reported that they had no health insurance coverage; however, due to the sampling methods, only PLWH in medical care were assessed. Those living with HIV not in medical care may be more likely to have even higher rates of being uninsured.

Social Determinants

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work, and age. Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

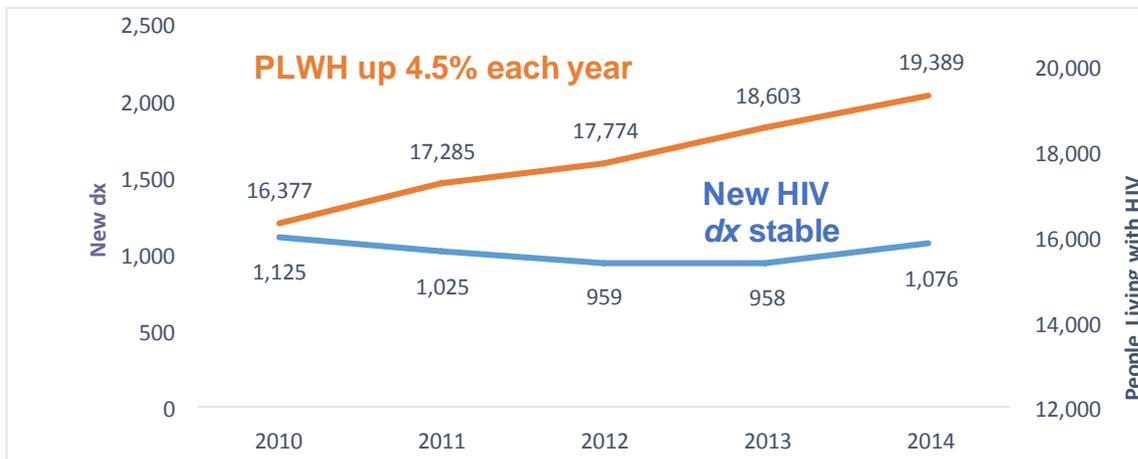
Many of these determinants increase vulnerability to illness and adversely affect health outcomes in Dallas.

- c. Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).

Number of PLWH

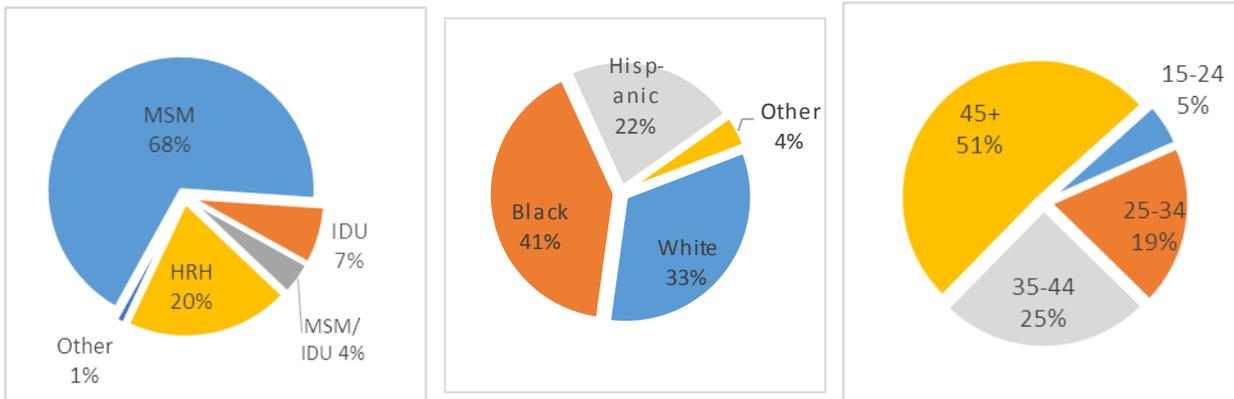
Over the past five years, the number of Dallas EMA residents living with diagnosed HIV infections has increased by about 4.5% a year, from about 16,000 in 2010 to more than 19,000 in 2014 (Figure 18). However, the number of new HIV diagnoses is not rising- the annual number of new diagnoses during this time period was stable as is shown by DSHS data which indicated that there were between 780 and 1,360 new infections in 2013. The number of people living with HIV (PLWH) has increased because highly effective treatment has lengthened their lives – people with HIV who get early treatment (and stay on treatment) have lifespans nearly comparable with people without HIV.

Figure 18: Dallas EMA residents living with diagnosed HIV infections and residents with new HIV diagnoses, 2010-2014



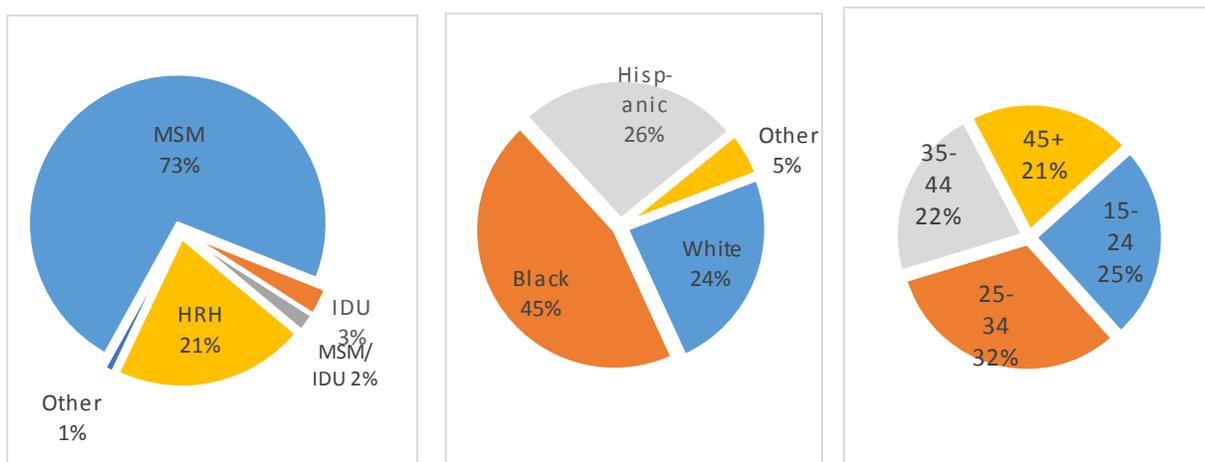
Gay and bisexual men and other men who have sex with men (MSM) made up about 68% of EMA residents living with diagnosed HIV infections in 2014. Heterosexuals made up about 20% of the EMA’s PLWH. Blacks made up the largest racial/ethnic group of PLWH – about two in five PLWH were Black. About half the PLWH were 45 or older.

Figure 19: 2014 PLWH in Dallas EMA by mode of transmission, race/ethnicity, and age



MSM have an even larger presence among those newly diagnosed, with MSM making up almost three out of four of those diagnosed between 2010-2014 (Figure 20). Heterosexuals made up about 20% of new diagnoses, which is similar to their representation in PLWH, but the count of High-Risk Heterosexuals (HRH) diagnoses fell by about 18% between 2010 and 2014. IDU diagnoses made up only about 3%, and were stable across the previous five years. Blacks made up almost half of the residents with new diagnoses, with White and Hispanic residents each accounting for about one quarter. Finally, the profile of Texans with new diagnoses is much younger than the profile of PLWH overall – more than three in five new diagnoses are in those younger than age 35, primarily young MSM.

Figure 20: Dallas EMA residents newly diagnosed with HIV from 2010-2014 by mode of transmission, race/ethnicity, age at diagnosis



Blacks make up about 16% of the population of the EMA, but more than 40% of the PLWH in the area. The 2014 prevalence rate indicates that more than 1% of Black residents of the EMA were living with diagnosed HIV infections. Prevalence rates for Blacks were consistently three times higher than rates for Whites or Hispanics, and rose about 14% between 2010 and 2014.

Reducing new HIV infections rests in: delivering targeted and effective prevention programs to local residents at very high risk; reducing the number of local residents living with undiagnosed HIV infections; and increasing access to effective and continuous treatment. The primary hallmark of good care is suppressed HIV viral load – a sustained reduction in the amount of virus in an infected person’s blood. Suppressed viral load not only benefits the person living with HIV, but also decreases the chance that HIV will be passed on to others.

In 2014, an estimated four in five EMA residents with diagnosed infections had at least one HIV-treatment visit, with one in five receiving no care. Almost three in five PLWH had viral suppression at the end of 2014. The remaining one in five EMA residents received some HIV-related care, but did not have suppressed viral load, as depicted in Figure 21 below.

PLWH stands for people living with HIV, which is also called *prevalence*. Annual prevalence is the number of people with diagnosed infections who were alive and residing in Texas as of the end of the year. It does not include people with undiagnosed infections.

New HIV diagnoses is shortened to new *dx*. An annual count of new diagnoses shows the number of people with first-time diagnoses of HIV infections in people who were residing in Texas at the time their diagnosis was made.

Rates allow direct comparison of HIV in groups of different sizes and show the intensity of HIV infection. Prevalence rates show the number of PLWH per 100,000, and diagnosis rates show the number of new HIV

Figure 21: Participation in HIV treatment and viral load suppression in the Dallas EMA, 2014

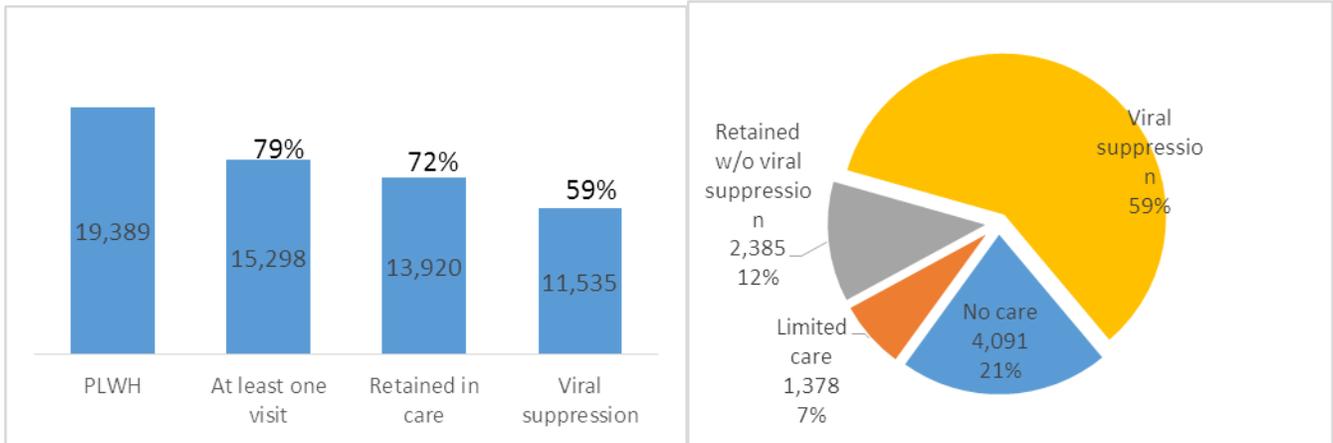


Figure 22 shows MSM as a proportion of HIV prevalence and new diagnoses within race/ethnic groups in the Dallas EMA in 2014. For instance, out of all white PLWH in the Dallas EMA in 2014, 5,282 of them were MSM and 1,045 were categorized as a different mode of transmission, meaning approximately 83% of white PLWH in the Dallas EMA in 2014 were MSM. Conversely, 4,052 black PLWH were MSM in the Dallas EMA in 2014 and 3,832 were categorized as a different mode of transmission, which means that 51% of black PLWH in the Dallas EMA in 2014 were MSM. Figure 23 shows the five year trends in PLWH and new diagnoses in the Dallas EMA from 2010-2014 for Hispanic MSM, Black MSM, and White MSM. New diagnoses has decreased slightly among Hispanic and White MSM groups, but has increased among Black MSM.

Figure 22: MSM as a proportion of all PLWH and new diagnoses in race/ethnic groups in the Dallas EMA, 2014

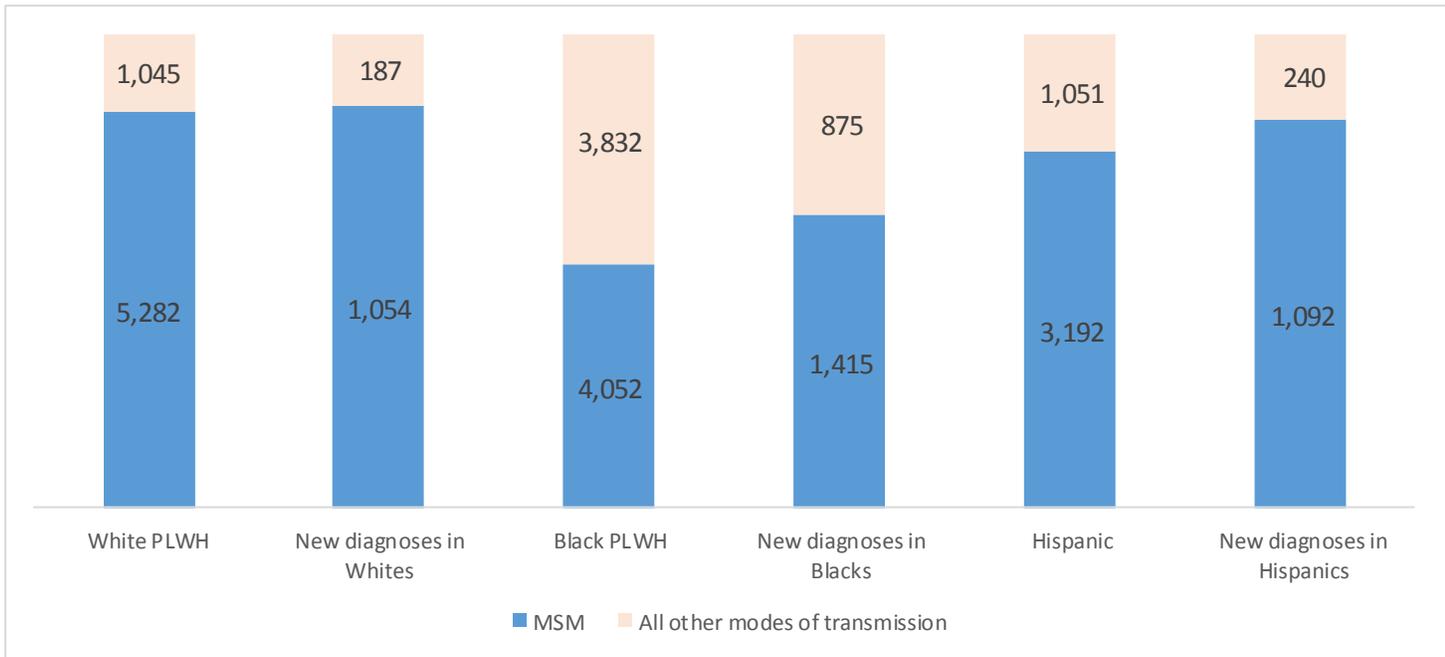
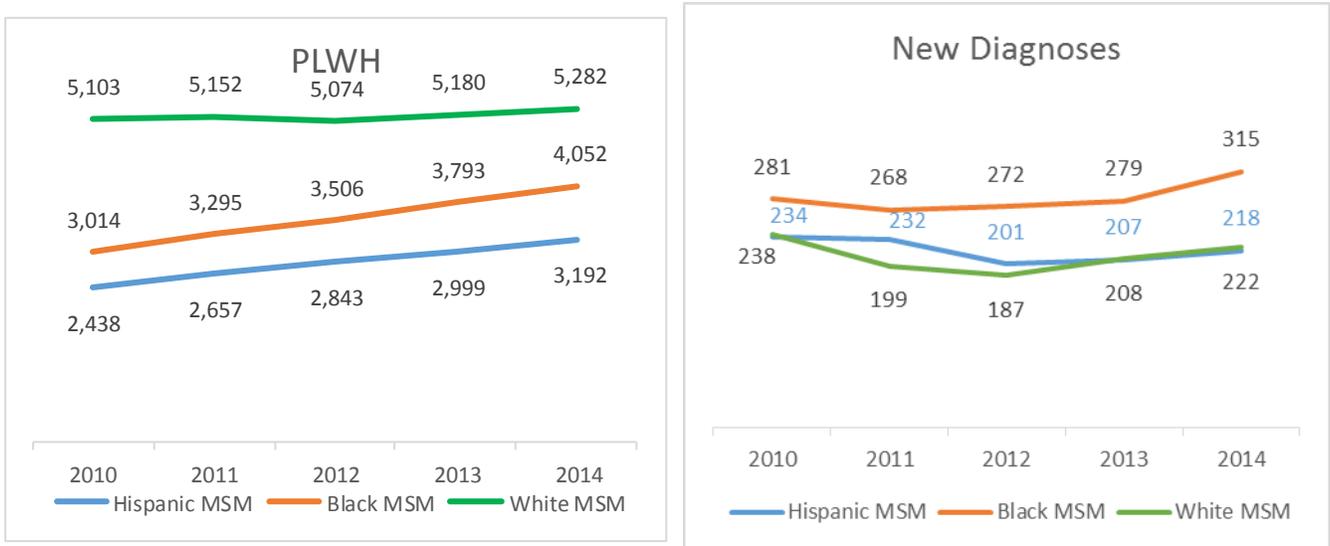


Figure 23: Changes in numbers of PLWH and new diagnoses in MSM, Dallas 2010-2014



Rates

This section provides information on the number of people living with diagnosed HIV infections as of the end of 2014 and on new HIV diagnoses from 2010 – 2014 (Figure 24). Cumulative counts of all new infections in that five-year period were used in addition to information tracking the annual number of new diagnoses. Using five

years of diagnoses provides a more reliable comparison point-to-prevalence than does a single year of new diagnoses.

The number of persons living with a diagnosed HIV infection in the Dallas EMA grew by 18% between 2010 and 2014. Over the same time period, new diagnoses fell from 2010 through 2013, and then slightly rebounded in 2014. Given the steady growth in population, the diagnosis rate in 2014 was 12% lower than in 2010 (Figure 25).

Figure 24: Dallas EMA residents living with HIV and prevalence rates, 2010-2014

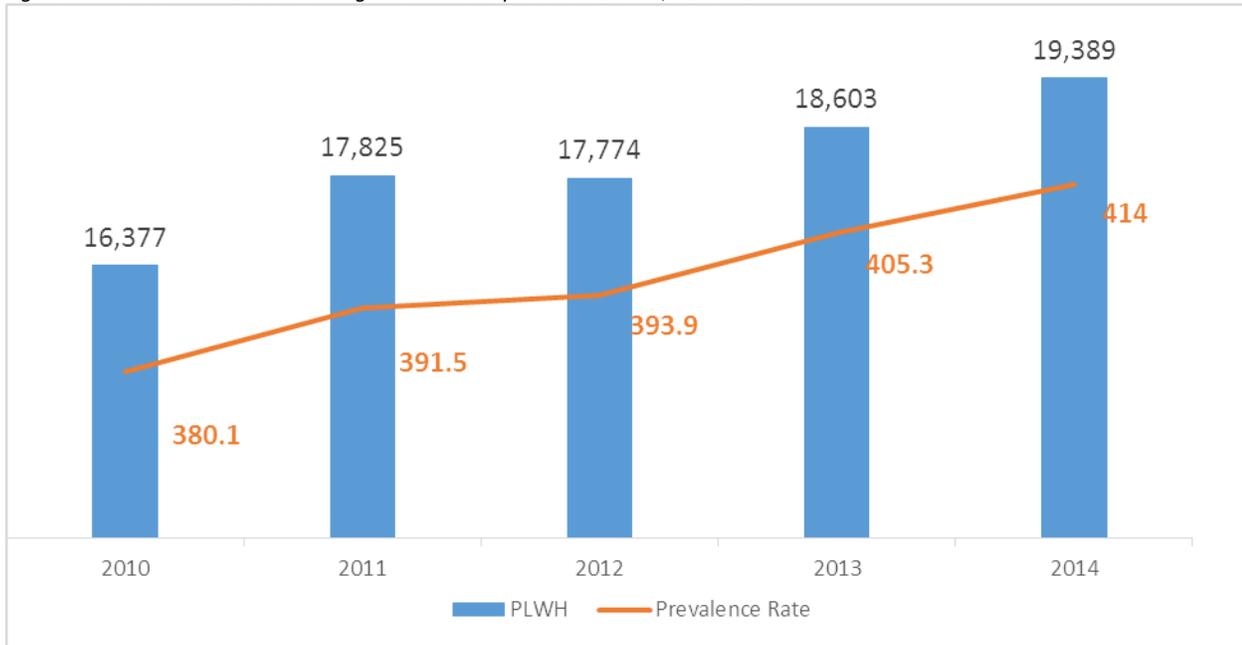
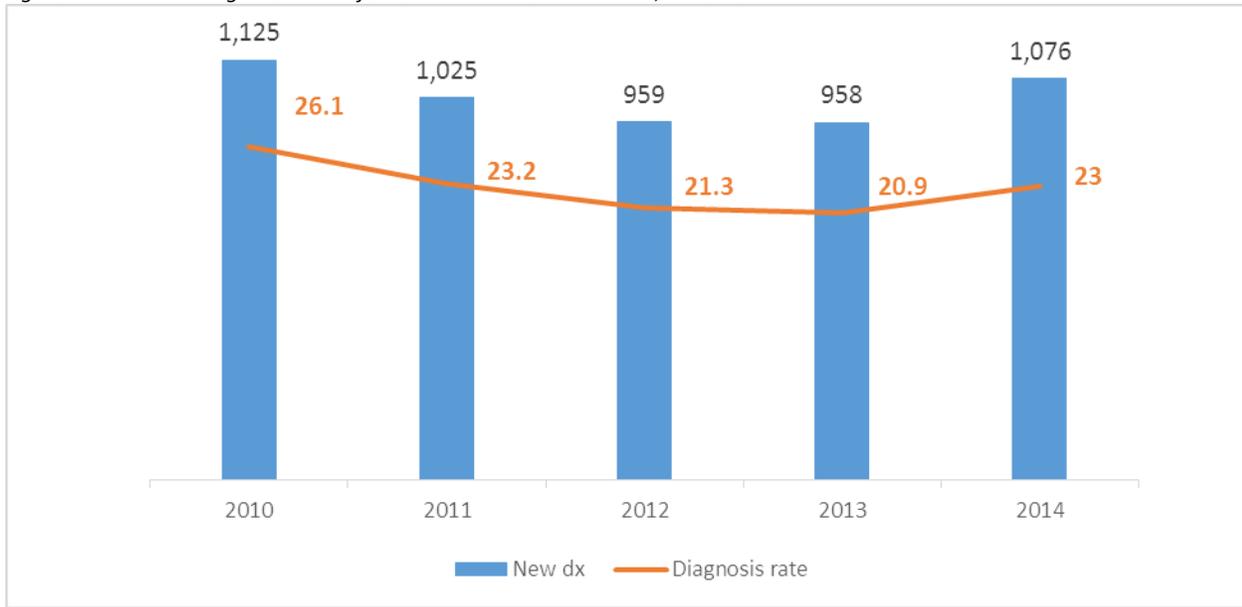


Figure 25: New HIV diagnoses and infection rates in the Dallas EMA, 2010-2014



Snapshot of PLWH and newly diagnosed Dallas EMA residents

As in years past, in 2014 about four out of five Dallas EMA residents living with HIV were men. Gay, bisexual, and other men who have sex with men (MSM) made up about 68% of the PLWH, with heterosexual men and women making up an additional 20%. Black Dallas EMA residents made up almost two in five PLWH, and more than half were 45 years old or older. Tables 2 - 4 at the end of this section provide more detail.

Table 2: PLWH in the Dallas EMA, 2010-2014

Dallas EMA																
	2010			2011			2012			2013			2014			Change
	#	%	Rate													
Total	16,377		380.1	17,285		391.5	17,774		393.9	18,603		405.3	19,389		414.0	18%
Female	3,177	19%	145.5	3,372	20%	150.7	3,489	20%	152.5	3,682	20%	158.1	3,851	20%	161.9	21%
Male	13,200	81%	621.1	13,913	80%	639.2	14,285	80%	642.2	14,921	80%	660.1	15,538	80%	674.0	18%
White	6,085	37%	289.8	6,172	36%	290.1	6,099	34%	283.1	6,213	33%	286.5	6,327	33%	288.8	4%
Black	6,221	38%	897.2	6,705	39%	940.4	7,024	40%	957.2	7,489	40%	997.7	7,884	41%	1023.9	27%
Hispanic	3,318	20%	270.3	3,594	21%	283.5	3,818	22%	293.7	4,003	22%	300.7	4,243	22%	310.7	28%
Other	171	1%	59.4	185	1%	60.3	193	1%	59.7	202	1%	59.5	229	1%	64.1	34%
Unknown	582	4%	.	629	4%	.	640	4%	.	696	4%	.	706	4%	.	21%
MSM	11,022	67%		11,608	67%		11,947	67%		12,543	67%		13,133	68%		19%
IDU	1,270	8%		1,342	8%		1,334	8%		1,355	7%		1,356	7%		7%
MSM/IDU	734	5%		789	5%		796	5%		799	4%		791	4%		8%
HRH	3,205	20%		3,394	20%		3,540	20%		3,746	20%		3,953	20%		23%
Ped*	122	<1%		127	<1%		132	<1%		137	<1%		133	<1%		9%
Adult Other	25	<1%		25	<1%		25	<1%		23	<1%		23	<1%		-8%
0-14	57	<1%	5.7	55	<1%	5.4	52	<1%	5.1	49	<1%	4.7	40	<1%	3.8	
15-24	864	5%	145.0	908	5%	149.7	963	5%	155.6	970	5%	154.3	948	5%	148.1	10%
25-34	2,951	18%	451.2	3,131	18%	471.9	3,226	18%	478.2	3,479	19%	510.8	3,682	19%	530.4	25%
35-44	4,924	30%	751.6	4,897	28%	735.4	4,806	27%	709.7	4,803	26%	703.3	4,848	25%	702.1	-2%
45+	7,581	46%	542.1	8,294	48%	567.8	8,727	49%	576.6	9,302	50%	596.2	9,871	51%	612.6	30%

*Pediatric cases are those who acquired their HIV infection through mother to child transmission

The profile of Dallas residents newly diagnosed with HIV differs from that of PLWH. MSM have an even larger presence among those newly diagnosed, with MSM making up almost three out of four of those diagnosed between 2010-2014. Heterosexuals made up about 20% of new diagnoses, which is similar to their representation among PLWH, but the count of HRH diagnoses fell about 18% between 2010 and 2014. IDU diagnoses made up only about 3%, and were stable across the previous five years. Blacks made up almost half of the residents with new diagnoses, with White and Hispanic residents each accounting for about one quarter of the total. Finally, the profile of Dallas residents with new diagnoses is much more youthful than the profile of PLWH – more than three in five younger than 35, driven by increased diagnoses in young MSM.

Table 3: New HIV diagnoses in the Dallas EMA< 2010-2014

	2010			2011			2012			2013			2014			5 year totals		Change
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	
Total	1,125	100	26.1	1,025	100	23.2	959	100	21.3	958	100	20.9	1,076	100	23	5,143		-4%
Female	233	21%	10.7	199	19%	8.9	180	19%	7.9	175	18%	7.5	201	19%	8.5	988	19%	-14%
Male	892	79%	42	826	81%	37.9	779	81%	35	783	82%	34.6	875	81%	38	4,155	81%	-2%
White	273	24%	13	240	23%	11.3	225	23%	10.4	239	25%	11	264	25%	12.1	1,241	24%	-3%
Black	488	43%	70.4	442	43%	62	434	45%	59.1	432	45%	57.6	494	46%	64.2	2,290	45%	1%
Hispanic	297	26%	24.2	278	27%	21.9	247	26%	19	243	25%	18.3	267	25%	19.6	1,332	26%	-10%
Other	23	2%	8	17	2%	5.5	12	1%	3.7	13	1%	3.8	27	3%	7.6	92	2%	17%
Unknown	44	4%	.	48	5%	.	41	4%	.	31	3%	.	24	2%	.	188	4%	-45%
MSM	796	71%		745	73%		702	73%		728	76%		793	74%		3,764	73%	0%
IDU	39	3%		38	4%		35	4%		27	3%		39	4%		178	3%	0%
MSM/IDU	26	2%		18	2%		18	2%		17	2%		25	2%		104	2%	-4%
HRH	262	23%		221	22%		202	21%		184	19%		216	20%		1,085	21%	-18%
Ped*	1	0%		3	0%		2	0%		2	0%		3	0%		11	0%	200%
0-14	3	0%	0.3	3	0%	0.3	3	0%	0.3	2	0%	0.2	3	0%	0.3	14	0%	0%
15-24	285	25%	47.8	243	24%	40.1	249	26%	40.2	241	25%	38.3	272	25%	42.5	1,290	25%	-5%
25-34	344	31%	52.6	314	31%	47.3	276	29%	40.9	331	35%	48.6	364	34%	52.4	1,629	32%	6%
35-44	262	23%	40	230	22%	34.5	225	23%	33.2	183	19%	26.8	214	20%	31	1,114	22%	-18%
45+	231	21%	16.5	235	23%	16.1	206	21%	13.6	201	21%	12.9	223	21%	13.8	1,096	21%	-3%

*Pediatric cases are those who acquired their HIV infection through mother to child transmission

Table 4: Prevalence rates for Texas MSM by area of residence and race/ethnicity, 2012

	All MSM	White MSM	Black MSM	Hispanic MSM
Texas	6,966.0	4,834.4	19,590.6	6,542.2
Austin TGA	4,692.4	4,000.3	10,022.1	5,063.5
Dallas EMA	7,575.0	5,765.3	17,997.7	6,462.5
Fort Worth TGA	3,865.2	2,596.7	11,638.9	3,579.0
Houston EMA	7,867.4	5,513.2	19,782.4	6,476.6
San Antonio TGA	6,976.4	4,220.7	12,790.3	8,195.5

Rates are per 100,000.

Trends

Estimated HIV incidence from 2009 to 2013

Incidence is the total number of new HIV infections in a given period. The estimates use the results from a laboratory test and information from newly-diagnosed persons about HIV testing and treatment history to characterize an infection as *recent* or *long-term*. *Recent* means that the HIV infection probably occurred in the last 12 months, and *long term* means that HIV infection happened more than a year ago. Information on the diagnoses categorized as recent infections is combined to estimate HIV incidence (new HIV infections).⁸

The estimates are reported as *point estimates* and *95% confidence intervals* for each year. The point estimate is the best estimate of the true number of new HIV infections in a given year. The 95% confidence interval is the range of values with a 95% probability of containing the true number of incident HIV infections. Changes in point estimates are statistically significant only if a point estimate lies outside the confidence intervals for the other estimates. For example, suppose the estimate of new infections for 2004 shows a point estimate of 4,000 new infections and a confidence interval of 3,000 to 5,000 new infections. If the point estimate for 2005 is 4,500 new infections, then this is not a true increase in new infections because 4,500 falls within the 2004 confidence interval of 3,000 to 5,000.

Between 2009 and 2013, the annual number of new infections in adults and adolescents in the EMA was stable; in 2013, there were between 780 and 1,360 new infections (Figure 26). An incidence rate is the number of new HIV infections per 100,000 adults and adolescents. The estimated incidence rate during this time period was stable, as indicated in both Figure 27 and Table 5.

⁸ More information about the methods is found at <http://www.plosone.org/article/info:doi/10.1371/journal.pone.0017502>.

Figure 26: Estimated new HIV infections in adults and adolescents in the Dallas EMA, 2009-2013

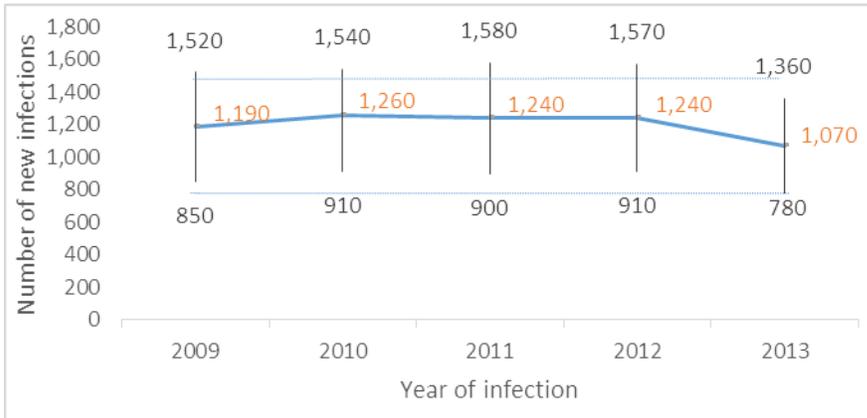


Figure 27: Estimated incidence rate for Dallas EMA adults and adolescents, 2009-2013

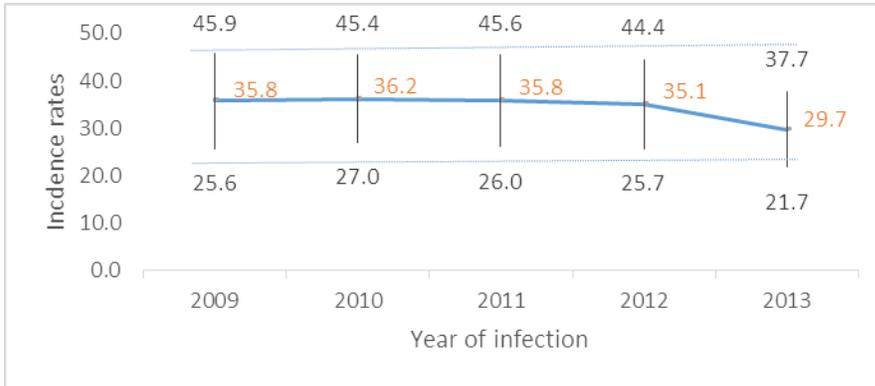


Table 5: Estimates of Texas HIV incidence by sex, race/ethnicity, and mode of transmission, 2009-2013

Men												
	MSM			IDU			MSM/IDU			HRH		
	Est #	95% CI		Est #	95% CI		Est #	95% CI		Est #	95% CI	
White	4,921	4,117	5,725	171	58	284	318	164	471	125	27	223
Black	5,379	4,530	6,229	298	141	454	128	25	231	748	497	999
Hispanic	6,532	5,575	7,489	177	54	301	210	88	331	330	170	490

Women						
	IDU			HRH		
	Est #	95% CI		Est #	95% CI	
White	274	126	421	455	263	647
Black	355	181	529	2,553	2,035	3,070
Hispanic	181	62	300	972	691	1,253

Estimates of undiagnosed HIV infections

DSHS has estimated the proportions of Texans with undiagnosed infections for 2009-2013; these estimates are not available for local areas. DSHS based these estimates on complex algorithms

developed by the CDC. As with estimates of incidence, the best way to look at the number and proportion of undiagnosed infections is by looking at the 95% CI for each group (Table 6). In 2013, an estimated 11% to 17% of Texas PLWH had undiagnosed infections.

The greatest number of estimated undiagnosed infections are in MSM- they make up two out of three Texans with undiagnosed infections; DSHS estimates that about 13% to 18% of Texas MSM living with HIV have not yet been diagnosed. Two groups are close to or have surpassed the 90% diagnosis rate goal: IDU and MSM/IDU.

Hispanics are the race/ethnic group that has the highest proportion of undiagnosed infections: about 17% to 23% of Hispanic PLWH have not yet been diagnosed. Hispanics made up two out of every five undiagnosed PLWH in 2013. Keep in mind that most new infections in Hispanics are in MSM.

Table 6: Estimates of proportion of Texans living with undiagnosed HIV infections, 2013

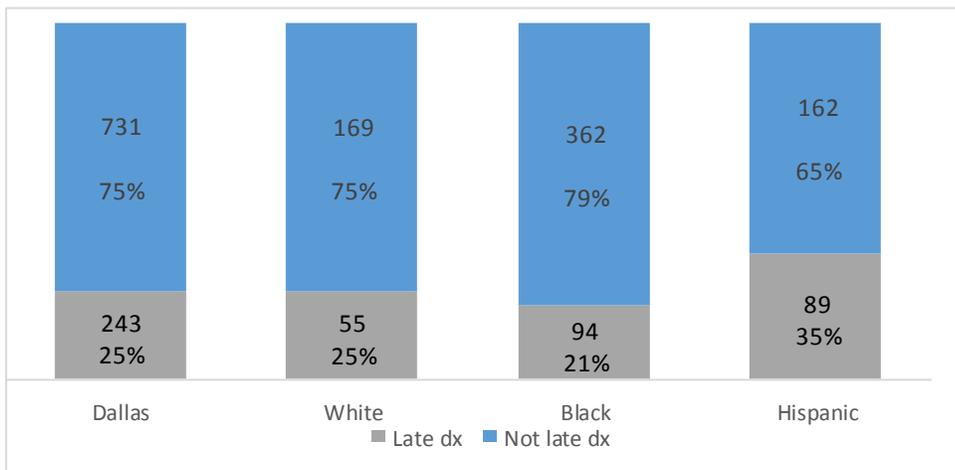
	Estimated proportion of undiagnosed infections		
	Est %	95% CI	
TOTAL	14.1%	11.2%	16.8%
Men	14.7%	12.9%	16.9%
Women	12.8%	8.3%	15.9%
White	9.7%	6.6%	13.0%
Hispanic	19.6%	16.6%	22.8%
Black	12.8%	10.4%	15.5%
MSM	15.9%	13.0%	18.0%
IDU	6.6%	2.5%	10.5%
MSM/IDU	4.2%	0.1%	9.6%
HRH	15.2%	11.6%	18.8%

Late diagnosis

To classify the effects of an HIV infection on immune functioning, people with HIV infections are grouped by stages; a Stage 3 classification indicates severe immune suppression, more commonly known as AIDS. Persons with a Stage 3 classification within three months of their diagnosis have a late diagnosis.

In 2014, about one in four of the diagnoses in the Dallas EMA were late. Late diagnosis was most common among Hispanics, where more than one in three had a late diagnosis. Rates of late diagnosis are about 1.4 times higher in Hispanics than in Whites and 1.7 times higher than in Blacks (Figure 28).

Figure 28: Late diagnoses of HIV infection in the Dallas EMA by race/ethnicity, 2014



Populations most affected

A closer look at how race and ethnicity and mode of transmission interact

Although MSM are the largest single group of PLWH and newly diagnosed persons in the EMA, the mode of transmission profiles differs by race/ethnicity. More than four out of five White PLWH are MSM as are three of every four Hispanic PLWH in the EMA. MSM are the largest group of Black PLWH – they make up about half of Black PLWH and almost two out of three newly diagnosed Blacks. Further, while White MSM are still the largest group of PLWH in the EMA, the gap between the number of White MSM and Black and Hispanic MSM PLWH is closing. Prevalence in White MSM was flat across the past five years, but the number of Black and Hispanic MSM rose by a third.

Priority Populations

Achieving the goals of the *National HIV/AIDS Strategy* and the *Texas HIV Plan* requires a common focus on the groups at highest risk of acquiring or transmitting HIV – the priority populations for the Texas Plan. These populations are also included in the outcomes of Goals 2 and 3 of the NHAS, as well as this plan, which include increasing access to care and eliminating health disparities. In the Dallas EMA, four groups made up three out of four PLWH, and four out of five of the new diagnoses over the last five years: Black MSM, Hispanic MSM, White MSM, and Black heterosexual women (*Figure 29*). All public health strategies for reducing new infections or improving outcomes must include actions for these groups.

Figure 30 shows the number of new diagnoses in Black MSM rising slightly (roughly 12%) while new diagnoses in Black women, Hispanic MSM, and White MSM dropping slightly (about 7% for Hispanic and White MSM, about 14% for Black HRH women). New diagnoses in all other groups fell about 13%.

Figure 29: Priority populations in Dallas PLWH and residents with new HIV diagnoses

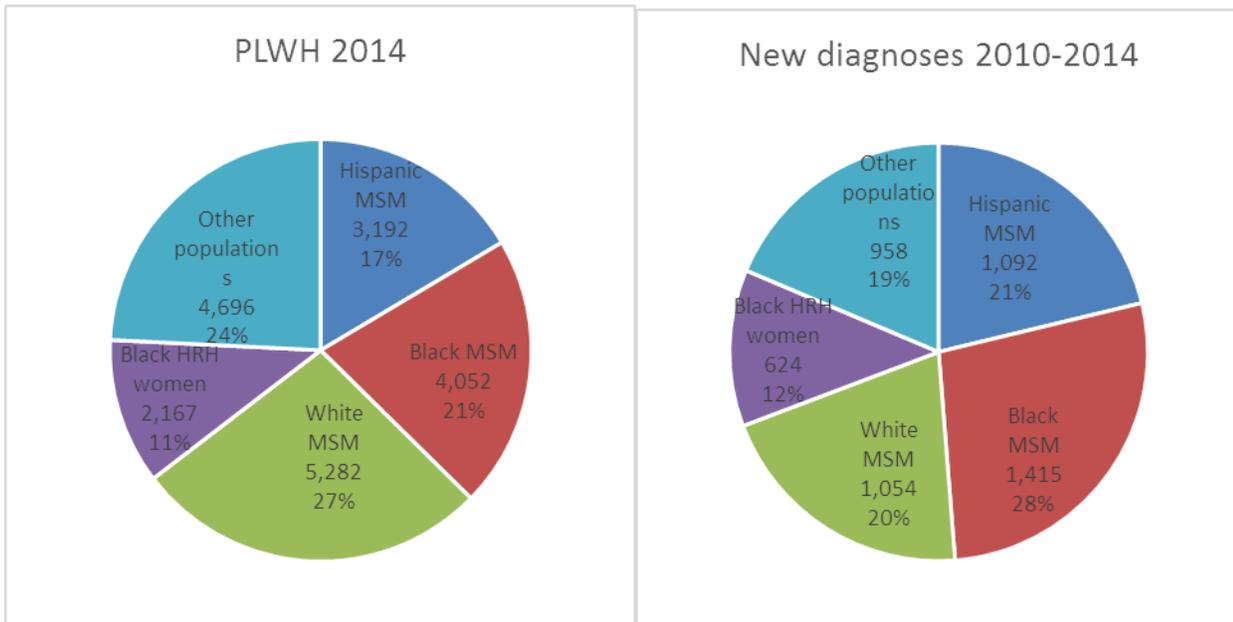
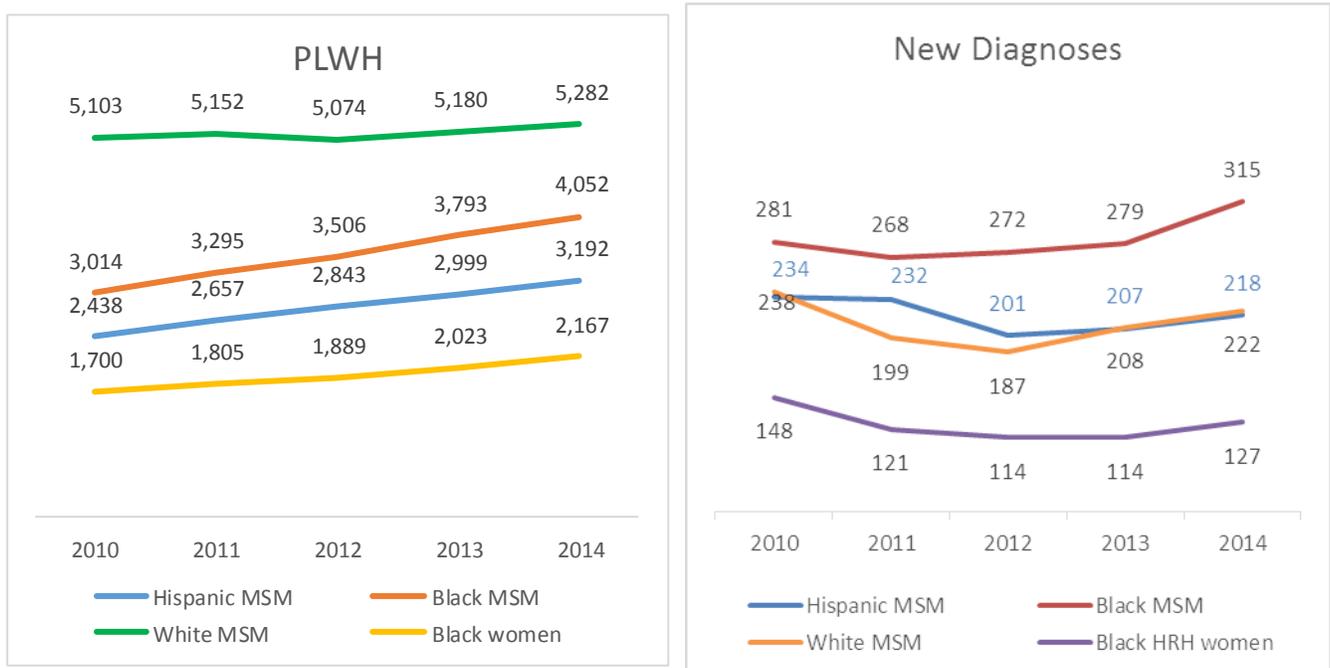


Figure 30: Changes in numbers of PLWH and new diagnoses in priority populations, Dallas 2010-2014



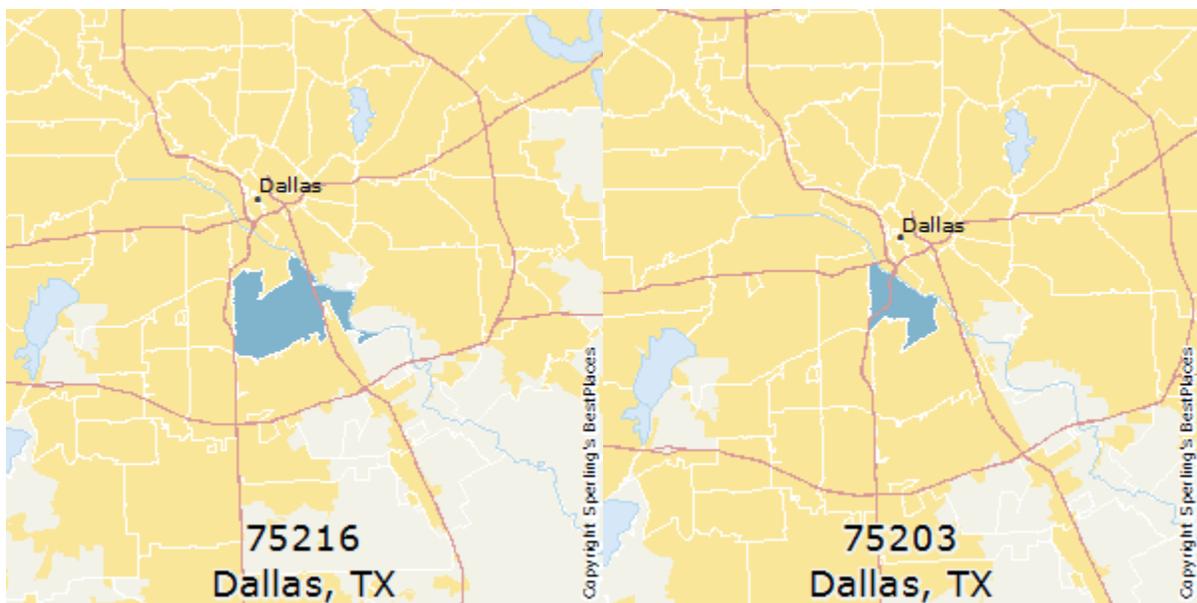
In addition to the four priority populations, this particular plan will target emerging populations of interest, such as transgender and injected (needle-sharing) drug users, in its interventions so that more robust data will be available locally in the future. Particular emphasis will also be placed on education, poverty, health insurance

status, and homelessness, as important social determinants of health, and will help to guide the developed public health strategies.

Geographic concentrations

Geographic concentration was measured by the concentration of Ryan White clients in the AIDS Regional Information and Evaluation System (ARIES) in the 12 county Dallas Planning Area. From January 1, 2015 to December 31, 2015, out of 10,025 Ryan White consumers, services were used by at least 300 individual consumers in the following five zip codes: 75219 (529 consumers), 75243 (387 consumers), 75216 (376 consumers), 75203 (312 consumers), and 75231 (300 consumers).

In the maps below, you see that 75219 is just northwest of downtown Dallas. 75243 and 75231 are adjacent and are on the northeast side of Dallas, near the cities of Richardson and Garland. 75216 and 75203 are adjacent as well and are on the south side of Dallas.



Deaths

The number of deaths in any one area of Texas is too limited for detailed analysis. Since HIV mortality rates are too low to allow for adequate analysis for a specific locality, mortality data presented below are for Texas as a whole.

Nearly half of the deaths due to HIV in 2013 occurred in Blacks and almost 30% occurred in Hispanics. Table 7 shows age-adjusted rate of death due to HIV in Texas PLWH. The rate of deaths due to HIV in Blacks is 5.8 times higher than the rate for Whites and 3.8 times the rate for Hispanics. The rate for Hispanics is 1.5 higher than the rate for Whites.

Table 8 shows the age-adjusted rate of death due to any cause in PLWH. PLWH deaths are more often due to factors other than their HIV, including diseases associated with older age, which become more common as PLWH live longer. In contrast to deaths attributed to HIV infections, the overall deaths in PLWH do not show the same race/ethnic differences. The highest rates of death in PLWH are in people who acquired their infections through injection drug use (including MSM/IDU).

Table 7: Age-adjusted rate of death due to HIV per 100,000 population, Texas 2012

Race/Ethnicity	Male Rate	Female Rate	Total Rate
Total	4.5	1.3	2.9
White	2.7	0.4	0.8
Black	13.2	5.5	4.6
Hispanic	4.0	1.0	1.2
Other Races	1.0	***	0.2

Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1)

Deaths due to HIV are those where HIV is listed as the underlying cause on a death certificate (ICD Codes B20-B24)

No deaths in females of other races were reported in 2012

Table 8: Age-adjusted rate of death due to all causes in Texans living with a diagnosed HIV infection, Texas 2012

Race/Ethnicity & Risk Group	Male Rate	Female Rate	Total Rate
Total	19.3	25.5	20.5
White	26.5	27.2	25.4
Black	20.7	24.1	19.9
Hispanic	17.0	25.4	19.3
Other Races	9.6	**	7.8
MSM	16.2	N/A	16.2
IDU	25.3	25.3	25.0
MSM/IDU	30.9	N/A	30.9
Heterosexual	22.9	24.6	22.4
Pediatric	4.5	2.3	3.5

Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1)

No deaths in females of other race or females with other risk were reported in 2012

Comorbidities: Hepatitis C, Sexually Transmitted Infections and Tuberculosis

When a person living with HIV has other health conditions or disease diagnoses, such as tuberculosis or mental health and/or substance use disorders, it is called a co-infection or a co-morbidity. Infection with HIV can increase the vulnerability of PLWH to co-infection with sexually transmitted infections (STI), tuberculosis (TB), and hepatitis C virus (HCV), among others. Co-infection can complicate treatment, reduce its effectiveness, and hamper treatment adherence. New STIs or HCV infections may be indicators of condomless sex, which can increase the chance of transmitting HIV, HCV, and other STIs.

To better understand co-infection in Texas PLWH, DSHS matched the routine disease surveillance databases for HIV, STI (chlamydia, gonorrhea, and syphilis), TB, and HCV infection which enabled reporting of the proportion of PLWH with reported comorbidities. These figures do not, however, represent the proportion of **all** PLWH with STIs, HCV infections, or latent TB. Unfortunately, HIV treatment guidelines that recommend screening for HCV, STI, and TB are not uniformly followed, and asymptomatic STIs and HCV infections may go undetected. Clinicians may not test for STI in the rectum or throat, which also allows infections to go undetected. Finally, the way public health disease reporting is carried out can also affect the statistics on co-infection. For example, in Texas only acute HCV infections are reported, not chronic infections. Without knowing how many infections are ongoing, it is not possible to get accurate data about the number of PLWH living with HCV infections.

Co-Infection with Hepatitis C Virus

Because of the limited information on HCV infections, this report includes data on only the number and proportion of co-infected persons in various geographic areas. The figures represent PLWH in 2014 who had a reported acute HCV infection in 2014 or earlier.

Table 9: Texas PLWH with reported HCV infections, 2014

	PLWH with reported HCV infections	Proportion of PLWH with reported HCV infections
Texas	7,396	9%
Austin	622	10%
Dallas	1,598	27%
Fort Worth	502	8%
Houston	1,754	29%
San Antonio	578	10%
East Texas	567	9%
US-Mexico border	398	7%

Co-Infection with Tuberculosis

Persons living with HIV who also have latent tuberculosis (TB) infection are more likely to develop TB disease because their immune systems are compromised. In Texas the rate of TB in PLWH is 16 times the rate in the general population. In 2014, almost 2% of Texas PLWH had received a TB diagnosis subsequent to their HIV diagnosis, and a little more than 2% of PLWH in the Dallas EMA had received such a diagnosis, Hispanics and Asians with HIV were more likely to have TB disease due to the endemic levels of TB in their countries of origin (data not shown).

Co-Infection with Sexually Transmitted Infections

In Texas, PLWH were considered to have an STI co-infection if their STI diagnosis occurred at least 30 days before their HIV diagnosis, was concurrent with their HIV diagnosis, or was made at any date after their HIV diagnosis. PLWH may have more than one diagnosis of any STI over the course of one year. To calculate the rate of diagnoses among PLWH, the total number of STI diagnoses in PLWH was used as the numerator and the total number of PLWH was used as the denominator.

Table 10 shows the number and rate of selected STI diagnoses in Texas PLWH in 2014. P&S syphilis refers to primary and secondary syphilis, and EL syphilis refers to early latent syphilis. The rates are per 100,000 PLWH. More than 1% of Texas PLWH had a reported STI infection in 2014. Gonorrhea and chlamydia were the most common STIs. However, syphilis infections are much more prevalent in PLWH compared to HIV-negative persons. In Texas, PLWH are 176.8 times more likely to be diagnosed with P&S Syphilis than HIV-negative persons. The disparity in chlamydia and gonorrhea case rates between PLWH and HIV-negative persons is not as large: PLWH are 3.6 times more likely to be diagnosed with chlamydia and 16.3 times more likely to be diagnosed with gonorrhea compared to HIV-negative persons. The demographic profile of PLWH diagnosed with STIs is similar to that of persons diagnosed with STIs in the general population. Young PLWH ages 15-34, Black and Hispanic PLWH, and MSM are more likely to have a diagnosed STI.

Table 11 shows the high burden of STI among MSM living with a diagnosed HIV infection. Rates are especially high for Black MSM; these men are less likely to have consistent HIV treatment and may not have the benefit of recommended routine screening for STI.

Figure 31 shows that in 2014, PLWH made up 1% - 5% of persons with chlamydia or gonorrhea infections, but they made up more than a third of P&S and EL syphilis cases. Ongoing syphilis transmission is increasingly limited to MSM in Texas.

Table 10: STI cases and incidence among Texans living with a diagnosed HIV infection, 2014

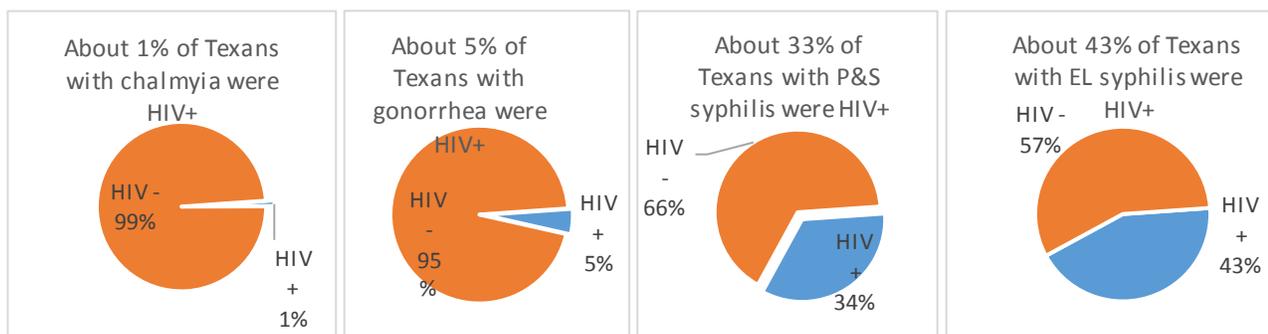
	PLWH	Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Total PLWH	80,073	1,362	1,700.9	1,596	1,993.2	538	671.9	803	1,002.8
Female	17,350	268	1,544.7	113	651.3	6	34.6	11	63.4
Male	62,723	1,094	1,744.2	1,483	2,364.4	532	848.2	792	1,262.7
15-24	3,983	282	7,081.1	323	8,109.5	100	2,510.7	122	3,063.0
25-34	14,914	568	3,807.7	683	4,578.7	215	1,441.3	292	1,957.5
35-44	19,763	302	1,528.1	330	1,669.8	110	556.6	201	1,017.1
45+	41,120	210	510.7	260	632.3	113	274.8	188	457.2
White	22,184	227	1,023.3	359	1,618.3	136	613.1	205	924.1
Black	29,895	590	1,973.6	688	2,301.4	193	645.6	258	863.0
Hispanic	24,607	474	1,926.3	459	1,865.3	181	735.6	305	1,239.5
Austin	5,304	140	2,639.5	198	3,733.0	66	1,244.3	89	1,678.0
Dallas	15,403	394	2,557.9	484	3,142.2	137	889.4	256	1,662.0
Houston	21,978	441	2,006.6	506	2,302.3	148	673.4	170	773.5
Fort Worth	4,635	70	1,510.2	86	1,855.4	56	1,208.2	75	1,618.1
San Antonio	4,248	113	2,660.1	133	3,130.9	58	1,365.3	98	2,307.0

Table 11: STI cases and incidence among Texas MSM living with a diagnosed HIV infection, 2014

	PLWH	Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
MSM	40,381	886	2,194.1	1,266	3,135.1	462	1,144.1	683	1,691.4
Black MSM	10,455	336	3,213.8	507	4,849.4	162	1,549.5	210	2,008.6
Hispanic MSM	13,751	331	2,407.1	394	2,865.2	156	1,134.5	268	1,948.9
White MSM	14,582	178	1,220.7	297	2,036.8	120	822.9	176	1,207.0

* The number of MSM PLWH differs from other reports because cases were not adjusted to assign mode of exposure to persons with no reported risk.

Figure 31: Proportions of Texans with diagnosed STI who are living with a HIV infection, 2014



d. Describe (table, graph, and/or narrative) the indicators of risk for HIV infection in the population covered by your service area using the following, as available in the jurisdiction:

Indicators of HIV Risk

HIV risk behaviors in high risk, HIV negative Texans

Data in this section come from the Dallas data collection site of the National HIV Behavioral Survey (NHBS). This information may not reflect the state as a whole. For more information, please Appendix A.

In Texas, young Black MSM have the highest rates of new HIV diagnoses. However, NHBS data indicate that White and Hispanic MSM in Dallas are more likely to engage in high-risk behaviors. Though White and Hispanic MSM seem to be engaging in riskier behavior, they may have less exposure to HIV in their sexual networks consisting of other White and Hispanic MSM, among whom HIV prevalence is lower. Results are shown in Table 12.

Injecting substances increase risk of HIV transmission through needles and equipment and certain injectable drugs lower inhibition and increase the likelihood of engaging in high-risk sexual behavior. Among people who inject drugs in Dallas, a large proportion of respondents reported sharing needles or other injection equipment,

exchanging money or drugs for sex, and having condomless sexual intercourse. All of these activities are also risk factors for Hepatitis C and B infections, which can increase the chance of complications from HIV. Results are shown in Table 13.

A high proportion of high-risk heterosexuals reported having condomless sex with a partner of the opposite sex. Older respondents were more likely to report exchanging sex for money or drugs. (*This study collected data at sites in the city limits of Dallas, but did not specify the residence of the respondents

Table 14)

Table 12: HIV risk behaviors in HIV-negative MSM over the last 12 months, Dallas* 2014

	N	Ave. number of male sex partners	Condomless anal sex						Used injection or non-injection drugs		Self-reported syphilis infection	
			With a male partner		With a male partner of unknown HIV status		With an HIV-positive male partner		N	%	N	%
		N	N	%	N	%	N	%	N	%	N	%
Total	368	7	227	62%	79	21%	19	5%	211	57%	129	35%
White	141	8	89	63%	25	18%	13	9%	83	59%	52	37%
Black	111	5	60	54%	25	23%	3	3%	59	53%	30	27%
Hispanic	86	6	54	63%	21	24%	3	3%	47	55%	33	38%
15-24	65	8	41	63%	13	20%	4	6%	41	63%	25	38%
25-34	116	8	82	71%	34	29%	10	9%	65	56%	50	43%
35-44	89	5	53	60%	18	20%	2	2%	50	56%	33	37%
45+	98	5	51	52%	14	14%	3	3%	55	56%	21	21%

*This study collected data at sites in the city limits of Dallas, but did not specify the residence of the respondents

Table 13: HIV risk behaviors in HIV-negative IDU over the past 12 months, Dallas* 2012

	N	Ave. number of sex partners		Shared needles		Shared drug paraphernalia		Exchanged money or drugs for sex		Had condomless sex	
		N	%	N	%	N	%	N	%	N	%
Total	506	6	202	40%	343	68%	198	39%	238	47%	
White	52	22	28	54%	35	67%	16	31%	13	25%	
Black	426	4	161	38%	288	68%	165	39%	212	50%	
Hispanic	13	12	5	38%	11	85%	11	85%	7	54%	
15-24	4	6	3	75%	3	75%	1	25%	2	50%	
25-34	48	10	24	63%	29	76%	22	58%	14	37%	
35-44	54	24	26	48%	39	72%	28	52%	24	44%	
45+	410	3	149	36%	272	66%	147	36%	198	48%	

*This study collected data at sites in the city limits of Dallas, but did not specify the residence of the respondents

Table 14: HIV risk behavior in HIV-negative high-risk heterosexuals over the last 12 months, Dallas 2013

	N	Ave. number of opposite-sex partners	Had condomless sex with a partner of the opposite sex		Exchanged money or drugs for sex		Had condomless sex with an HIV+ partner	
		N	N	%	N	%	N	%
Total	545	3	233	43%	110	20%	211	57%
White	22	5	12	55%	3	14%	83	59%
Black	467	4	195	42%	103	22%	59	53%
Hispanic	49	2	22	45%	3	6%	47	55%
15-24	65	8	41	63%	13	20%	0	0%
25-34	116	8	82	71%	34	29%	1	0%
35-44	89	5	53	60%	18	20%	0	0%
45+	98	5	51	52%	14	14%	0	0%

HIV risk behaviors in PLWH currently in care

Data in this section come from the Texas and Houston Medical Monitoring Project (MMP) sites. Data are representative of PLWH receiving care in Texas. For more information, please see Appendix A.

The average number of sex partners is higher among White MSM than among other race/ethnicity groups. A large proportion of sexually active MSM living with HIV report having condomless anal sex with a male partner over the past 12 months. However, the data shows that most of these reported acts were with another person living with HIV. This may be an indication of serosorting, a practice of selecting sexual partners of the same HIV status. Serosorting for condomless anal sex still leaves both PLWH and HIV- negative MSM open to STI infections. Self-reported syphilis infection among sexually active MSM is low; however, latent infections can be asymptomatic and may go unnoticed in the absence of regular screening. About a third of MSM respondents also reported drug use, including inject drug use, in the past 12 months. This is concerning, as drug use can lower inhibitions and contribute to high-risk sexual behavior. The proportion of MSM reporting high-risk behavior did not decrease with age. See the summarized results in Table 15.

Sexually active heterosexual persons living with HIV also reported high levels of risk behavior in the past 12 months (Table 16). While they reported fewer sexual partners on average, a higher proportion of heterosexual persons living with HIV reported sex with an HIV-negative or status unknown partner compared to MSM living with HIV. Unlike MSM living with HIV, the proportion of heterosexual persons living with HIV who engage in

high-risk behavior decreased with age. Drug use among heterosexuals living with HIV in the 18- 29 age group is much higher compared to other age groups in both heterosexuals and MSM living with HIV.

Table 15: Indicators of HIV risk in the last 12 months among MSM in care for their HIV infections, Texas 2013-2014

	Ave number of male sex partners		Condomless anal sex with male partner		Condomless anal sex with male partner whose HIV status was discordant or unknown		Self-reported syphilis infection		Used injection or non-injection drugs	
	N	N	N	%	N	%	N	%	N	%
Total	130	5	59	45%	17	14%	21	13%	38	30%
White	45	8	25	54%	7	17%	6	10%	13	30%
Black	42	2	20	45%	5	11%	7	13%	13	27%
Hispanic	40	3	13	34%	5	13%	7	14%	10	29%
18-29	26	7	12	51%	6	24%	3	12%	7	29%
30-39	36	3	20	52%	4	13%	8	16%	14	36%
40-49	39	4	11	29%	3	9%	5	8%	6	17%
50+	29	3	16	52%	4	11%	5	15%	11	38%

* Cell suppressed for numbers less than 3 ** Percentages are weighted

Table 16: Indicators of HIV risk in the last 12 months among sexually active heterosexuals in HIV care, Texas 2013-2014

	n	Ave number of opposite -sex partners		Condomless vaginal or anal sex with partner of the opposite sex		Condomless vaginal or anal sex with partner of discordant or unknown HIV status		Used injection or non-injection drugs	
		n	%	n	%	n	%	n	%
Total	122	2		43	36%	28	23%	28	24%
White	18	1		8	47%	4	23%	4	26%
Black	65	1		24	38%	19	30%	16	23%
Hispanic	37	3		11	29%	5	14%	6	20%
18-29	10	2		4	41%	4	41%	6	64%
30-39	26	1		12	44%	8	31%	6	25%
40-49	43	1		16	35%	11	24%	13	30%
50+	43	2		11	30%	5	13%	3	9%

* Cell suppressed for numbers less than 3 ** Percentages are weighted Cell sizes less than 10 may produce unstable estimates

B. HIV CARE CONTINUUM

The HIV Care Continuum for the Dallas EMA

The 2014 HIV Treatment Continuum for local areas has four indicators as depicted by the four bars. The first is the number of people living with diagnosed HIV infections as of the end of 2014. The second bar shows the number of PLWH who had at least one episode of HIV-related treatment. The third bar shows PLWH retained in care, meaning that there were at least two episodes of treatment at least 90 days apart or who had suppressed viral load regardless of the number or spacing of visits. The fourth bar shows the proportion of PLWH had suppressed viral load at the end of the year. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from treatment providers in the Ryan White HIV/AIDS Program, information from Texas Medicaid and from some private health plans.

The corresponding pie charts with each cascade show each individual in an exclusive grouping as opposed to cumulative groupings, as is the case with the bar graphs (Figure 32). For example, for the Dallas EMA, both the bar and pie graphs show the status of the 19,389 PLWH along the treatment cascade. However, the bar graph is cumulative. Out of the 19,389 PLWH in 2014, there were 15,298 that had at least one episode of HIV-related treatment, and of that group, 13,920 were retained in care, and 11,535 of the individuals retained in care were virally suppressed. However, the pie graph to its right shows that out of the 19,389 PLWH in 2014: there were 4,091 that were not in care; there were 1,378 that had limited care; there were 2,385 that were retained in care, but without viral suppression; and, there were 11,535 that were virally suppressed (as also depicted in the bar graph). The pie graph counts each individual once, in one exclusive group and is used to describe the intensity of engagement with the care system: PLWH with no HIV-related care, with limited care (only one visit for PLWH with non-suppressed viral load), PLWH who are retained in treatment but who are not virally suppressed, and those who have suppressed viral load.

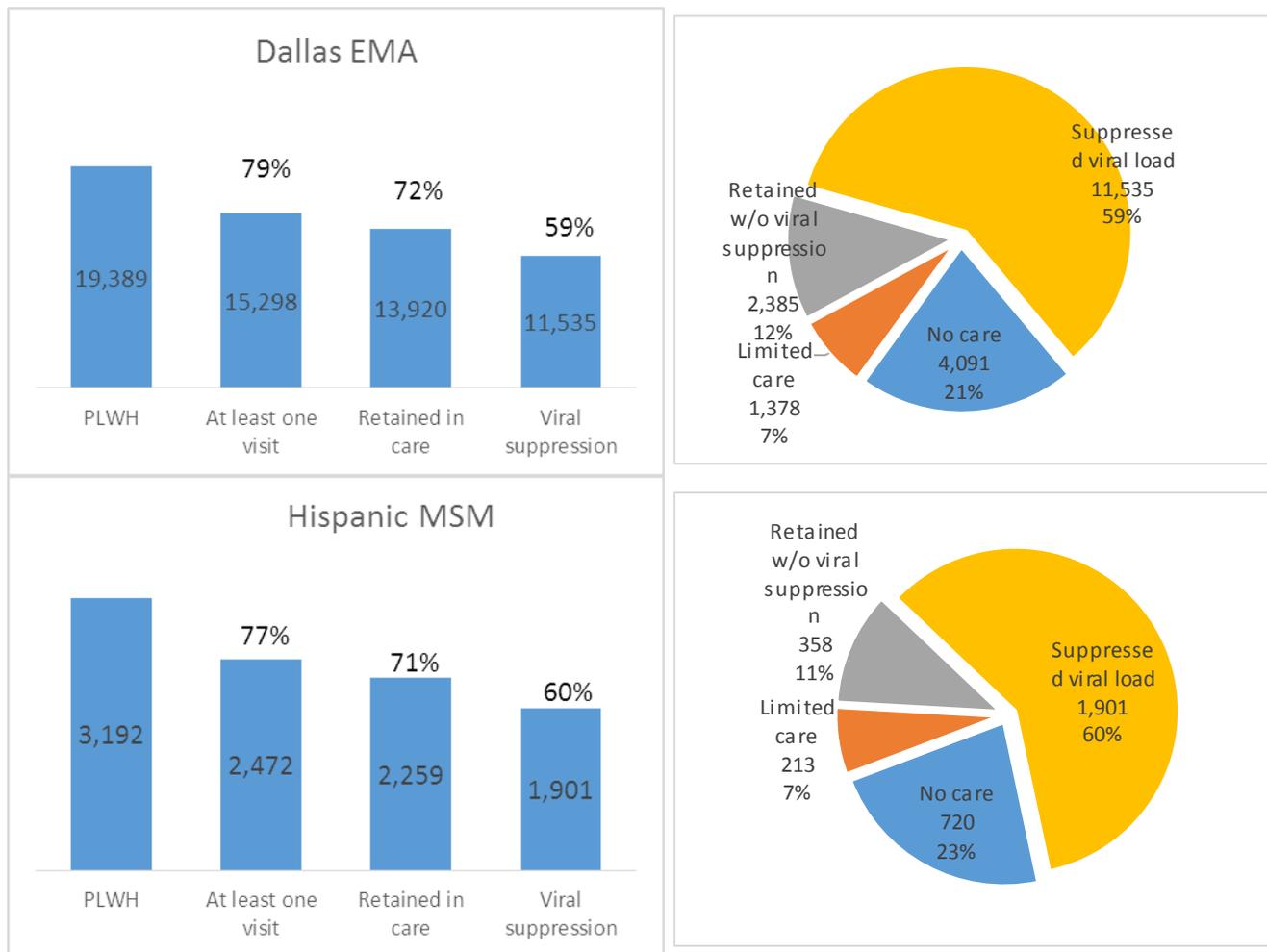
In 2014, almost four out of five of the Dallas PLWH had at least one HIV-related health visit, 72% were retained in care, and 59% were virally suppressed at the end of the year (Figure 32

Table). The best outcomes were for Whites and those 45 and older, two groups with a great deal of overlap (Table 17).

Of the priority populations, Black women and Black MSM had similar rates of retention, proportions of people with no care, and of people who were retained but not virally suppressed. At the state level, however, the suppression outcome for Black MSM can be at least partially explained by a lower estimated level of ART use.

Younger PLWH had much lower levels of participation in treatment and of viral suppression, as did IDU. Both of these were smaller populations at the opposite ends of the age spectrum. Almost all of the younger PLWH were MSM of color, particularly Black men (Table 18).

Figure 32: Treatment Cascade and participation in treatment, Dallas EMA 2014



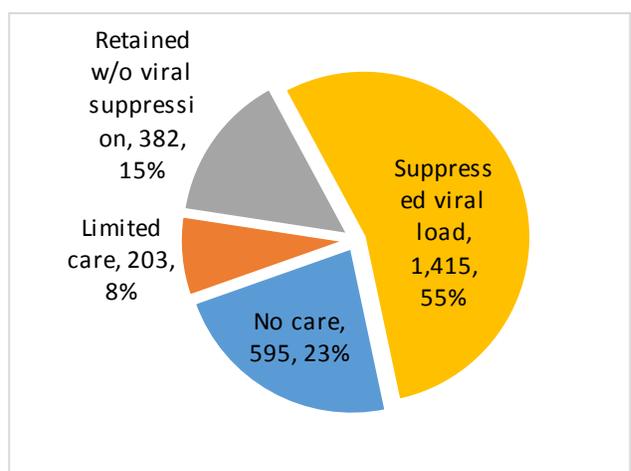
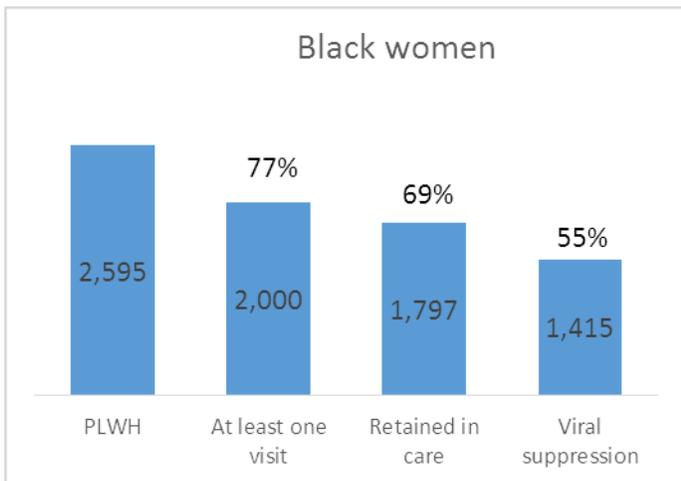
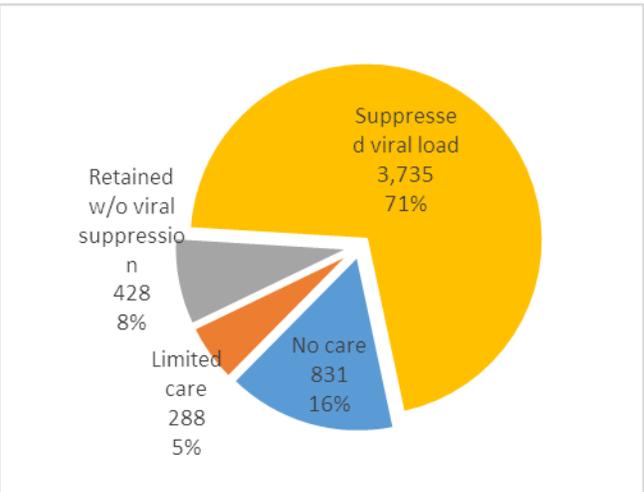
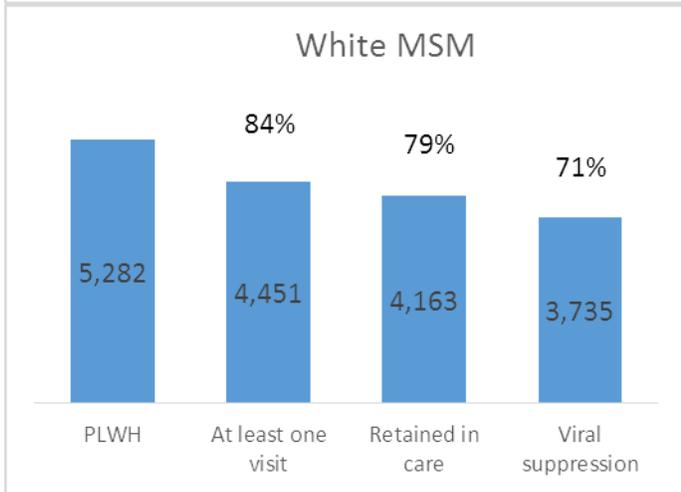
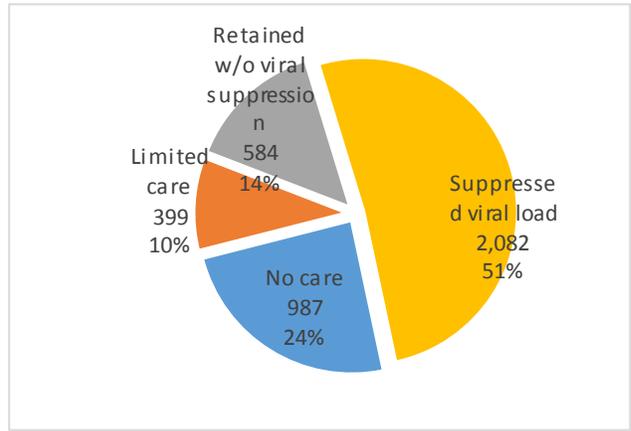
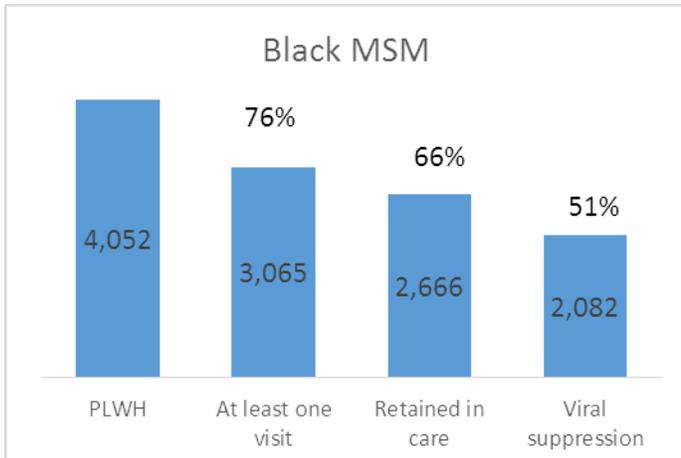


Table 17: Treatment cascades in Dallas by subpopulations, 2014

	PLWH	At least one visit		Retained in care		Suppressed viral load	
All PLWH	19,389	15,298	79%	13,920	72%	11,535	59%
Males	15,538	12,302	79%	11,210	72%	9,375	60%
Women	3,851	2,996	78%	2,710	70%	2,160	56%
Whites	6,327	5,285	84%	4,930	78%	4,363	69%
Blacks	7,884	5,961	76%	5,267	67%	4,095	52%
Hispanics	4,243	3,253	77%	2,986	70%	2,484	59%
15-24	948	738	78%	528	56%	354	37%
25-34	3,682	2,809	76%	2,386	65%	1,835	50%
35-44	4,848	3,763	78%	3,422	71%	2,778	57%
45-54	6,204	5,043	81%	4,765	77%	4,070	66%
55+	3,667	2,905	79%	2,780	76%	2,472	67%
MSM	13,133	10,508	80%	9,575	73%	8,117	62%
IDU or MSM-IDU	2,146	1,654	77%	1,508	70%	1,134	53%
Heterosexual	3,953	3,018	76%	2,726	69%	2,206	56%
White MSM	5,282	4,451	84%	4,163	79%	3,735	71%
Black MSM	4,052	3,065	76%	2,666	66%	2,082	51%
Hispanic MSM	3,192	2,472	77%	2,259	71%	1,901	60%
Black Women⁹	2,595	2,000	77%	1,797	69%	1,415	55%

⁹ This group includes all Black women and not only Black heterosexual women.

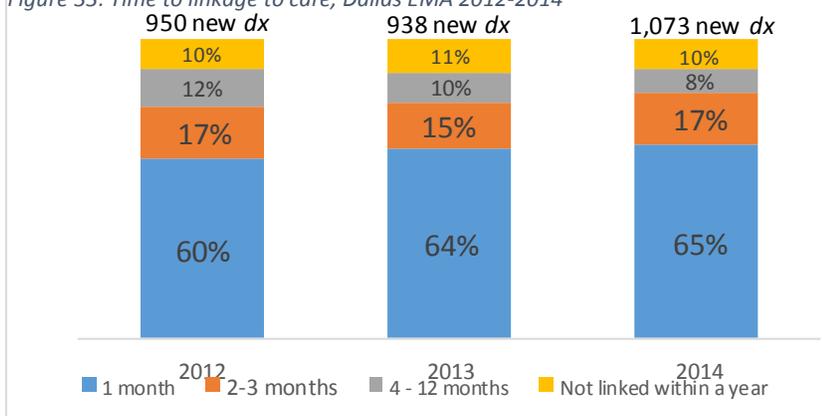
Table 18: Participation in HIV Treatment, Dallas EMA 2014

	PLWH	No Care		Limited care		Retained but not suppressed		Viral suppression	
All PLWH	19,389	4,091	21%	1,378	7%	2,385	12%	11,535	59%
Men	15,538	3,236	21%	1,092	7%	1,835	12%	9,375	60%
Women	3,851	855	22%	286	7%	550	14%	2,160	56%
Whites	6,327	1,042	16%	355	6%	567	9%	4,363	69%
Blacks	7,884	1,923	24%	694	9%	1,172	15%	4,095	52%
Hispanics	4,243	990	23%	267	6%	502	12%	2,484	59%
15-24	948	210	22%	210	22%	174	18%	354	37%
25-34	3,682	873	24%	423	11%	551	15%	1,835	50%
35-44	4,848	1,085	22%	341	7%	644	13%	2,778	57%
45-54	6,204	1,161	19%	278	4%	695	11%	4,070	66%
55+	3,667	762	21%	125	3%	308	8%	2,472	67%
MSM	13,133	2,625	20%	933	7%	1,458	11%	8,117	62%
IDU or MSM-IDU	2,146	492	23%	146	7%	374	17%	1,134	53%
Heterosexual	3,953	935	24%	292	7%	520	13%	2,206	56%
White MSM	5,282	831	16%	288	5%	428	8%	3,735	71%
Black MSM	4,052	987	24%	399	10%	584	14%	2,082	51%
Hispanic MSM	3,192	720	23%	213	7%	358	11%	1,901	60%
Black Women	2,595	595	23%	203	8%	382	15%	1,415	55%

Linkage to HIV treatment for persons newly diagnosed in 2012 -2014

Linkage to medical care after an HIV diagnosis is an important first step in getting the treatment needed to live a long, healthy, and productive life, and it is important that care not be delayed. When timely linkage is referenced in this section, it refers to getting HIV care within three months of diagnosis. CD4 and viral load tests, outpatient visits, and filled prescriptions for antiretroviral medications were used as markers of care. The counts

Figure 33: Time to linkage to care, Dallas EMA 2012-2014



of new diagnoses in this section exclude people who died before the end of the year of their diagnosis, so these figures will not match those given earlier in this report.

Figure 33 shows that 82% of Dallas EMA residents who were diagnosed in 2014 were linked to care within three months of their diagnosis, up from 77% in 2012. In Dallas, as in the rest of the state, most people were linked

within 30 days of their diagnosis.

When evaluating timely linkage in subgroups, information for 2012-2014 was combined; looking at combined data makes the comparisons more reliable. Figure 34 shows that Black MSM linkage rates are lower than the other priority groups – about 75% compared to around 81%. Linkage rates for younger EMA residents are also low; most of the new diagnoses in those under 35 years of age are in Black MSM and, to a lesser extent, Hispanic MSM.

Figure 34: Timely linkage to care in HIV Plan priority populations, Dallas EMA 2012-2014

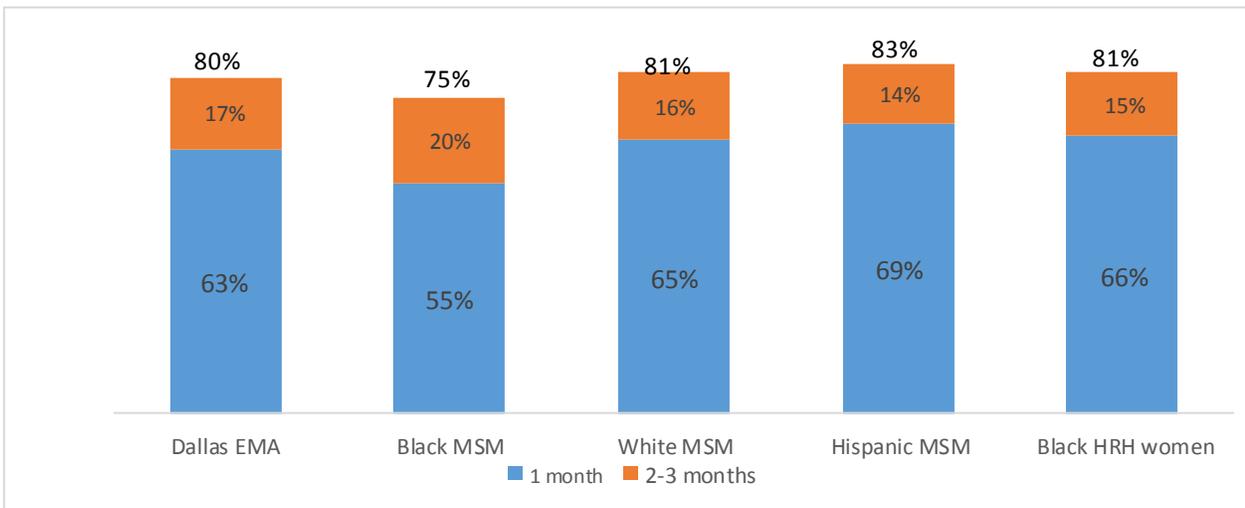
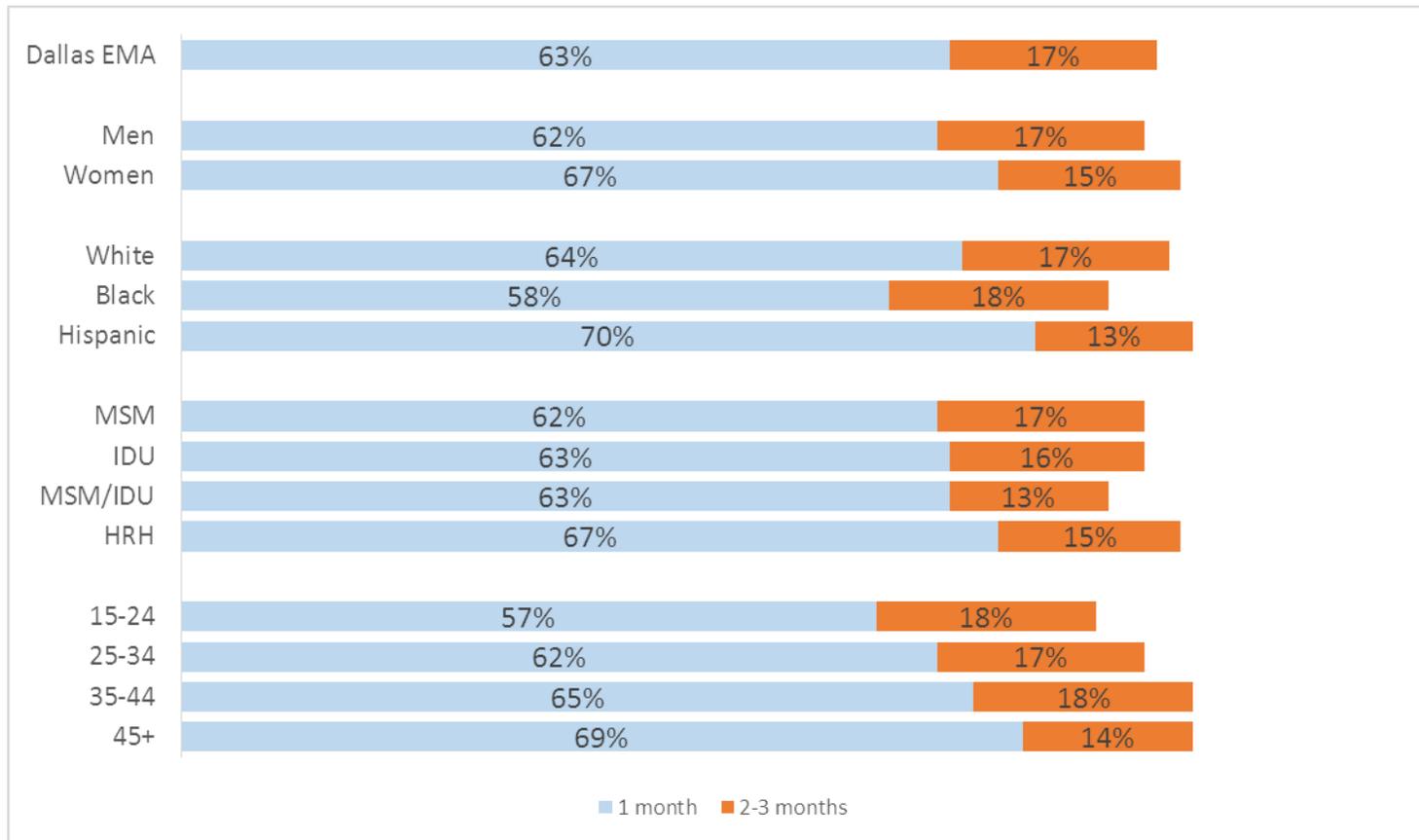


Figure 35: Timely linkage to care by selected characteristics, Dallas EMA 2012-2014



The HIV Care Continuum is utilized in planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction. 13,133 of the 19,389 PLWH in 2014 were MSM. This was the basis for breaking this down and identifying White MSM, Black MSM, and Hispanic MSM as three out of our four priority populations. The Dallas EMA also utilizes Minority AIDS Initiatives funds that specifically fund services for people of minority race and ethnicities.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Jurisdictional HIV resources Inventory

An inventory of jurisdictional HIV resources, including prevention and care, is included in the table on the next page.

b. Provide a narrative description of the HIV Workforce Capacity in the jurisdiction and how it impacts the HIV prevention and care service delivery system.

Workforce needs

In order to serve the needs of PLWHA as well as those at risk for HIV, the Dallas jurisdiction needs a diverse workforce comprising of individuals with different educational backgrounds, expertise and experience. This includes physicians and mid-level practitioners who have expertise in HIV medical care as well as those who are able to treat co-occurring conditions and have an excellent understanding of both the medical and psychosocial needs of PLWHA. The workforce must also comprise of allied health professionals who have the willingness and competence to work in the HIV arena, including navigators, counselors, outreach workers, intervention specialists and others who are willing and able to work with people at multiple levels. In addition to prevention and treatment modalities, it is imperative that providers at all levels are knowledgeable about trauma informed care, strengths-based and solution-focused counseling, motivational interviewing, harm reduction techniques and providing culturally and linguistically appropriate services (CLAS).

Capacity and Needs

The Dallas jurisdiction is home to two medical schools as well as schools which provide baccalaureate and graduate degree programs in nursing, allied health, social work, public health and other relevant disciplines. The area also has several Federally Qualified Health Centers and major health systems and is home to the South Central AIDS Education and Training Center (AETC).

In spite of the resources available, the Dallas area faces severe workforce challenges related to capacity and competence with regard to HIV care, treatment and prevention.

- HIV education and training have not been areas of focus in most professional education programs.
- Care for PLWHA and HIV prevention services have traditionally been concentrated among a few selected providers which has translated to the need for increased training and education among non-HIV providers regarding the nuances of providing care to PLWHA and effective strategies for preventing HIV acquisition among those who are at risk.
- Inadequate competence among non-HIV providers regarding the treating PLWHA with co-occurring conditions including mental health and substance use disorders in order to optimize outcomes.
- An aging workforce and a declining supply of clinicians with HIV experience are causing medical provider shortages which will have a critical impact on the effective delivery of HIV health care.
- An aging population of PLWHA and the complexity of HIV treatments leading to higher consumption of health care services resulting in increased caseloads/visits in the context of inadequate capacity.
- Increased HIV prevalence leading to increased demand for HIV related services.
- Diminished provider reimbursement as a result of static or falling public funding may impact the jurisdiction's ability to increase and improve HIV workforce capacity.

- An increase in racially and ethnically diverse, as well as younger populations living with and at risk for HIV, increases the demand for a culturally competent workforce reflective of the population served. Unfortunately, the health care professions do not in general mirror the population being served.
- Stigma, prejudice, and concerns related to the complexity of HIV care medical and other service providers in the Dallas area are persistent barriers to providing effective care.

c. Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.

Dallas area organizations that serve the HIV *positive* community have historically worked together to ensure that HIV positive people have access to necessary services on the continuum of care. However, the interactions between prevention focused services and those that provide care for the broader community have been more sporadic and may be defined by specific projects rather than systematic processes. Several strong partnerships exist between individual community based organizations (CBOs), between the local health department – Dallas County Health and Human Services and CBOs, and between other relevant organizations based on need. Collaborations may be informal or formalized through memoranda of understanding or service agreements. In addition, the Texas Department of State Health Services, the Ryan White Planning Council and other planning bodies facilitate interaction between various entities.

d. Provide a narrative description identifying any needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them.

The Dallas area has some significant deficits in terms of key resources both for prevention and treatment:

(i) Almost no resources are available for uninsured or under insured individuals at high risk for HIV to access Pre-exposure prophylaxis (PrEP) or Non- Occupational Post Exposure Prophylaxis (nPEP). Whereas counseling and education resources are available through various sources there are almost no health care providers who will provide PrEP to people without insurance.

(ii) Mental health treatment capacity is extremely limited especially for those without health insurance and/or documentation. When people needing services are finally able to access them, they may have dropped out of care or may no longer be motivated to access care.

(iii) Substance abuse treatment capacity is inadequate both in terms of inpatient and outpatient treatment services. The situation is exacerbated for those without health insurance and documents and leads to significant challenges.

(iv) Specialty care is limited for people who are uninsured or under-insured. In addition, for those who have obtained health insurance through the marketplace, access is curtailed because of extremely narrow provider networks. Access to care is negatively impacted in Texas as a whole because it did not expand Medicaid.

Steps to address gaps:

Stakeholders have taken multiple steps both independently and in collaboration to address the gaps in resources by seeking additional funding, educating policy makers, the community and others, as well as through strategic partnerships.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

a. Describe the process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed).

The Dallas Planning Area conducts a comprehensive needs assessment¹⁰ in order to identify care and service needs of people at higher risk for HIV and people living with HIV (PLWH). The latest needs assessment in this area was the 2013 Comprehensive HIV Needs Assessment. Data included in this needs assessment were population counts from the 2000 and 2010 Census, estimates for the 2012 population by county, as well as socioeconomic indicators such as income, poverty, and race/ethnicity. The needs assessment also included data from the Texas Department of State Health Services (DSHS) for the epidemiological profile, which reflected information on the epidemic in the entire Dallas Planning Area. Information collected during routine surveillance included HIV and AIDS morbidity and mortality data, focusing on data trends between 2008 and 2012, sexually transmitted diseases, and tuberculosis, and unmet need estimates which identify the number of people who are HIV-positive and out-of-care/returned to care.¹¹

Consumer survey

In addition to the data gathered and information obtained for the 2013 Comprehensive Needs Assessment, a survey of 637 people living with HIV was conducted during December 2013. This included 448 (70%) consumers receiving HIV medical care and 189 (30%) who were out-of-care/returned to care. The goal in designing the consumer survey was to obtain the desired information using the shortest, most consumer-friendly approach.

The survey was designed to obtain information about in-care, out-of-care/returned to care and each special population. It included questions in the following areas:

- Initial screening of PLWHA to determine whether they were in-care or out-of-care/returned to care and met the survey sampling criteria.
- Questions identifying reasons for being out-of-care, problems associated with HIV medical care and/or for dropping out of care.

¹⁰ Ryan White Planning Council for the Dallas Area, Comprehensive HIV Needs Assessment, 2013, published at www.dallascounty.org/departments/rwpc/hiv_needsassessment.php

¹¹ 2013 Out-of-care Criteria. PLWHA qualified to participate in the out-of-care interviews if they met one of the following criteria: (1) Not currently receiving HIV medical care, with at least 12 months since the last medical appointment. This is the HRSA definition of "out-of-care" which is "no HIV medical care, no viral load or CD4 counts and no antiretroviral medications in the last 12 months." These people may or may not be receiving other Ryan White or HIV services. (2) Diagnosed between 2010 and 2013 that failed to link to care within six months of diagnosis. They may currently be in care. (3) Diagnosed between 2010 and 2013, linked to care after diagnosis but dropped out-of-care for at least six months. They may now be back in care. (4) Dropped out-of-care for at least 12 months but are now back in care. They should have been back in care for no more than two years. (5) Began care in either 2012 or 2013 after no linkage to care after diagnosis. These people may be in care now, and may have been diagnosed at any time in the past.

- Information about diagnosis and linkage to care.
- Barriers to HIV medical care.
- Questions about current housing situations and housing service options.
- Use of and need for 26 different services most of which can be funded by Ryan White and are included in the RWPC's Continuum of Care.
- Substance abuse treatment service needs.
- Questions about the impact of the Affordable Care Act.
- Ranking of the most important/critical service needs.

A pure random sample was not feasible in this situation since it requires that every PLWHA in the Dallas region has an equal probability of selection for the survey. Therefore, a stratified convenience sample was used.

- The sampling plan that conformed to the profile of the epidemic was developed, but the final sample was more reflective of Ryan White AIDS Regional Information and Evaluation System (ARIES) consumers. This was due to:
 - Expedited survey completion timetable
 - Remote survey completion
 - Oversampling of special populations of Black/African-American men and women and Hispanic/Latino men and women.
- Out-of-care/returned to care, homebound/disabled, and other consumers were able to access the survey on-line.

Out-of-care interviews

Ryan White funded and non-funded agencies were approached to access out-of-care consumers who were willing to participate in the interview process, though referrals only came from Ryan White funded agencies. In the end, reaching out of care PLWH proved to be difficult and only 30 interviews were completed. These responses are included in the qualitative portion of this report.

Data Analysis

Using on-line survey format, immediate tabulation of all consumer responses was possible. During the course of the field work, respondent profiles were used to analyze the composition of the sample. The profiles included the number surveyed from each priority population, sample demographics, transmission mode, and county of residence. Once the surveys were completed, the data were reviewed and cleaned prior to analysis with the eCOMPAS survey system.

Respondent Overview

Survey respondents conformed to the ARIES profile of Ryan White funded service users more than to the overall epidemic with regard to gender and race.¹² The age profile of respondents showed they were older than those reflected in the regional epidemic or those using services. These issues were reviewed with the Needs Assessment Work Group and they determined that the sample should be accepted in that it was representative of the Ryan White funded population.

¹² For the respondent overview, epidemiology data are obtained from Texas DSHS HIV Surveillance, 2012 and ARIES data are obtained from DCHHS, December 1 2012 through November 30, 2013.

- Gender of the survey sample was very close to that found in the population using services (Table 19). The survey sample included 76% male respondents and 23% female. This compared to 78% males and 23% females infected in the region.
 - The epidemic included 20% female and 80% male. No transgender individuals were reflected in the data on the epidemic. Although those receiving services were 0.5% transgender and those in the survey represented 1.8%.
 - Provider key informants suggested ARIES data may under-represent transgender as some may be included using their birth gender.

Table 19			
Comparison of Consumer Survey Sample with Regional Epidemic			
Gender			
Gender	Epidemiology n=17,840	ARIES n=9,225	Consumer Survey n=615
Female	19.7%	21.9%	22.6%
Male	80.3%	77.6%	76.3%
Transgender	NA	0.5%	1.8%

- Considering race, Whites/Caucasians were under-represented in the survey sample when compared to the epidemic, but closely resembled the in-care population (Table 20). Whites/Caucasians comprised 36% of the regional epidemic but were 28% of the survey sample. Whites/Caucasians were 29% of the population receiving services. Black/African-Americans made up 41% of the epidemic but were 48% of the sample, and 46% of those receiving services. Hispanics comprised 22% of the epidemic and of those surveyed, but were 21% of those receiving services.

Table 20			
Comparison of Consumer Survey Sample with Regional Epidemic			
Race/Ethnicity			
Race/Ethnicity	Epidemiology n=17,292*	ARIES n=9,225	Consumer Survey n=615
White/Caucasian	36.5%	29.0%	27.8%
Black/African-American	40.7%	46.4%	48.3%
Hispanic/Latino	21.6%	21.5%	18.9%

*Number of PLWHA with known Race/Ethnicities.

In terms of transmission modes:

- Survey respondents' most frequently identified transmission mode were male-to-male sex (MSM) with 47% identifying this mode (Table 21). It compared to 67% of the epidemic reporting MSM transmission mode, and 56% of those in care.
- Heterosexual transmission was identified by 37% of survey respondents compared to 20% of the epidemic, and 28% in care.

- Shared needles/injecting drug use (IDU) was identified by 10% of those surveyed. This compared to 8% IDU in the regional epidemic and 4% of those in care.

Transmission Mode	Epidemiology n=17,841	ARIES n=9,225	Consumer Survey n=615
MSM	67.2%	55.8%	46.7%
IDU	7.6%	4.4%	9.6%
Heterosexual	19.9%	28.4%	37.2%

Considering age of respondents, the sample was older than the regional epidemic (Table 22).

- The sample and the epidemic include approximately 2% of PLWHA in the 13 to 24 age range.
- The 25 to 44 age group comprises 45% of the epidemic and 36% of the survey sample.
- The 45+ age group is 49% of the epidemic and 62% of the sample.

Age Group	Epidemiology n=17,840	ARIES n=9,225	Consumer Survey n=615
<2	0.0%	0.0%	0.0%
2-12	0.2%	0.4%	0.2%
13-24	5.4%	5.2%	3.4%
25-44	45.0%	46.5%	34.5%
45+	49.4%	47.9%	62.0%

As is the case with the administration of large scale surveys, some data limitations were identified. Many of these were minimized by having the survey read to consumers with low literacy and by automated skip logic so that question sequencing was done seamlessly for consumers. Nevertheless, potential survey limitations were:

- The in-care survey was primarily administered through Ryan White funded agencies. Thus, a larger percentage of PLWHA who qualify for Ryan White services may be represented.
- Misunderstanding or misinterpreting words or terms. This was minimized by previous survey validation and review of survey wording by a health literacy expert.
- Forced selection of responses without the options of “not applicable,” “don’t know” or “refused.”
- The possibility of selecting contradictory responses which was minimized using the on-line survey skip logic.

Provider Focus Group Discussions

Three focus groups directly with service providers offered additional insight into consumer needs for the broad cross section of clients they served.

- Two of the groups were comprised of Ryan White funded medical and non-medical case managers, who interacted with clients daily.
- The third focus group was conducted with Ryan White funded and non-funded outreach, counseling and testing, and linkage to care providers. Non-Ryan White funded participants of this group received a \$70 honorarium.

The Needs Assessment Work Group identified the number of case managers from each Ryan White funded agency to invite.

The prevention/linkage to care group was conducted in February 2014. Deferring this group allowed identification of areas for further research after results had begun to be compiled. This group was selected based on the limited out-of-care/return to care consumer participation.

Provider focus groups were planned to gain in depth, detailed information to enhance the understanding of client needs, including special populations, service gaps, barriers to care, impact of health care reform, reasons for consumers not receiving care, changes in the epidemic since 2010, and suggestions to improve care within the current funding environment.

Focus Group Analysis

For both consumer and provider focus groups, verbatim transcriptions were made from voice recorders. All responses were grouped by theme and commonality of response. Results are included in this report by theme, service category, and relevant priority population.

The provider focus group discussion was limited by:

- All participants of the case manager focus groups worked for Ryan White funded agencies.
- Not all agencies were represented.

GAP Analysis

The gap analysis utilizes the results of the consumer survey along with the provider focus groups, out-of-care consumer interviews, key informant interviews, provider survey and the provider inventory to inform the analysis. In doing so, the following issues were considered:

- How highly the service was ranked by survey respondents.
- The unfulfilled need ranking of respondents.
- The current availability and capacity as reported by the provider survey and inventory.
- The degree of difficulty consumers reported when attempting to access the service.
- The percent of respondents experiencing barriers, and qualitative information obtained through interviews and focus groups.

b. Describe the HIV prevention and care service needs of persons at risk for HIV and PLWH.

Table 23 shows the rankings for the total service needs of PLWH from the 2013 HIV Comprehensive Needs Assessment. This table breaks the data down by the total sample, in-care respondents, and out-of-care respondents. As shown below, dental care was ranked the highest need of the total sample, as well as among both in-care and out-of-care respondents. 64% of respondents reported a need for dental care. Dental care was also the third highest ranked unfulfilled need for all three groups. HIV outpatient medical care was the second highest overall ranked need with 56% of respondents reporting a need for the service, but this service was not ranked nearly as high insofar as being an unfulfilled need. Food bank was ranked the third highest need with 43% of respondents reporting a need. Emergency long-term rental assistance was ranked the highest unfulfilled need out of all of the services.

SERVICE	TOTAL SAMPLE			IN-CARE		OUT-OF-CARE	
	Total Need Rank	% of Need reported in the sample	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank
Dental Care	1	63.5%	3	1	3	1	3
HIV Outpatient Medical Care	2	55.7%	11	2	12	2	12
Food Bank	3	43.2%	6	3	6	3	4
Help Paying for Prescription Medications	4	41.8%	8	4	7	4	9
Primary Medical Care for general medical care not related to HIV	5	29.6%	7	5	9	6	5
Medical Care from a Specialist referred by your HIV doctor	6	27.5%	16	6	15	7	16
Emergency Long-Term Rental Assistance (Voucher)	7	27.4%	1	8	1	5	1
Help paying for co-pays and deductibles for HIV medical care visits and medications	8	26.4%	10	7	10	9	14
Mental Health Counseling	9	24.2%	21	10	21	8	17
Medical Case Management	10	23.3%	4	11	4	11	6
Transportation to Medical Care—Bus Pass/Van Service	11	23.0%	18	9	18	13	19
Emergency Financial Assistance for Rent/Mortgage or Utilities	12	22.5%	2	12	2	10	2
Nutritional Counseling	13	19.6%	13	14	13	11	11
Employment Services	14	17.4%	14	15	17	15	8

Table 23
Total Sample, In-Care and Out-of-Care
Service Need Ranking

SERVICE	TOTAL SAMPLE			IN-CARE		OUT-OF-CARE	
	Total Need Rank	% of Need reported in the sample	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank
Transportation to Other Services	15	17.1%	20	13	20	16	20
Job training Services	16	16.7%	15	16	14	14	12
Education Services	17	14.9%	12	16	11	17	18
Payment to continue health insurance	18	14.5%	19	18	16	19	21
Legal Services	19	13.2%	17	19	19	21	15
Non-Medical Case Management	20	13.2%	9	20	8	17	10
Facility Based Housing (Assisted Living Facility)	21	10.4%	5	21	5	20	7
Respite Care for Adults	22	6.4%	24	22	24	23	24
Outpatient Substance Abuse Treatment	23	6.4%	25	23	26	22	23
Early Intervention to help you get into HIV medical care (Out-of-Care Only) ¹³	24	5.5%	22			24	22
Translation or Interpretation	25	5.5%	26	26	25	25	27
Child Care while at a medical or other appointment	26	5.0%	23	24	23	26	25
Respite Care for HIV positive Children	27	4.6%	27	27	27	26	26

c. Describe the service gaps (i.e., prevention, care and treatment, and necessary support services e.g. housing assistance and support) identified by and for persons at higher risk for HIV and PLWH.

GAP ANALYSIS

The gap analysis utilized the results of the consumer survey along with the provider focus groups, out-of-care consumer interviews, key informant interviews, provider survey and the provider inventory to inform the analysis. In doing so, the following issues were considered:

- How highly the service was ranked as needed by survey respondents.
- The unfulfilled need ranking of respondents.
- The current availability and capacity as reported by the provider survey and inventory.
- The degree of difficulty consumers reported when attempting to access the service.

¹³ This question was only asked of out-of-care clients.

- The percent of respondents experiencing barriers, and qualitative information obtained through interviews and focus groups.

Gap analysis per service category according to the 2013 HIV Comprehensive Needs Assessment:

HIV OUTPATIENT/AMBULATORY MEDICAL CARE

Medical services ranked as extremely important with consumers. HIV medical care was ranked second in need and eleventh in unmet need. Primary medical care not related to HIV ranked fifth in need and seventh in unmet need. Specialty care ranked sixth in need and sixteenth in unmet need. The amount of time it takes at the clinic and transportation concerns were the top hardships in getting HIV outpatient medical care. Thirty percent of consumers had an unmet need for HIV medical care.

Thirty-six percent of consumers reported an unmet need for primary care services. The most frequently mentioned barrier to primary care was “to get all my care from my HIV doctor.” Focus groups confirmed that regular GYN screenings for mammograms and pap tests were among the hardest referrals to get.

Twenty-eight percent of respondents indicated an unmet need for specialty care. With PLWHA living longer, the likelihood of developing a chronic condition will only continue to increase. Forty-eight percent of survey respondents reported a chronic disease condition.

Focus group discussions focused primarily on the difficulty of obtaining primary and specialty care services for patients and the extremely long waits for appointments. Another issue discussed was the amount of time, and the paperwork burden for those seeking HIV outpatient medical care.

Information from the provider capacity survey suggested that limited resources would make it difficult to expand capacity.

EARLY INTERVENTION SERVICES

Early intervention services were ranked among the lowest service needs by those out-of-care (twenty-fourth). It was also ranked twenty-second in terms of unmet need. Information obtained from focus groups suggest that post-test counseling was not always provided or provided effectively. Barriers to the service included a lack of knowledge and the paperwork burden. Services must have been delivered in a culturally competent manner to ensure the individual received referral and linkage to essential services. The system in 2013 had capacity for 75 additional patients. Unless services are improved, demand is likely to remain low.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

Help in paying for continued insurance ranked eighteenth in need and nineteenth in unfulfilled need. Twenty-five percent of consumers indicated an unmet need for this service.

Based on survey responses from providers, the availability of resources was unlikely to meet the need.

Helping paying for co-pays and deductibles for HIV medical care visits and medications ranked eighth in need and tenth in unmet need. Thirty-one percent of consumers reported an unmet need for this service. Out-of-care consumers indicated that the cost of medications was both a barrier and a reason for PWLHA dropping out-of-care. According to the survey, the largest barriers to getting assistance with co-pays and deductibles were

the lack of consumer knowledge about the service and amount of paperwork involved. Although the need for this service ranked in the top third, available resources were unlikely to meet the need.

MEDICAL CASE MANAGEMENT

Medical case management ranked tenth in need but fourth in unmet need. Forty-three percent of consumers indicated their needs for this service were unmet. The primary barrier to the receipt of medical case management services were that the case manager was not available/hard to reach, identified by 30%, with an additional 18% indicating the case manager does not follow-up and too much paperwork. Since 2007, the unfulfilled need for case management services has increased. According to provider focus group participants, case loads were unmanageable and the paperwork burden was so great that most felt that establishing eligibility and performing updates had become the bulk of their work.

Two-thirds of the agencies providing case management had wait times of less than a week to four weeks for an appointment. The system reported an additional capacity for 25 clients which was far below that required to meet the unfulfilled need identified in the survey.

MEDICAL NUTRITION THERAPY-COUNSELING

Consumers gave medical nutritional counseling a mid-level service need ranking (thirteenth). Eighty-six percent of consumers reported that their need for this service was easily met. Thirty percent indicated an unmet need, including 35% of those out-of-care consumers with an unmet need. Limited additional capacity was available to those needing the service.

AIDS DRUG ASSISTANCE PROGRAM AND AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

Help paying for medications was the fourth ranked service, and the eighth ranked unfulfilled need. Seventy-five percent of consumers found the service easy to access and 36% had an unfulfilled need. Respondents identified lack of knowledge of the services as the largest barrier to receiving pharmaceutical assistance. This was followed by high co-pays and deductibles and "I didn't qualify." Medication assistance was one of the most needed services and like many of the top rated need services there was little expansion capacity within the funded agencies to fulfill needs.

MENTAL HEALTH SERVICES

Mental health counseling ranked ninth overall in need and twenty-first in unfulfilled need. Twenty-four percent of consumers identified an unfulfilled need. Individuals who used mental health services tended to be in-care. Among survey respondents, 72% of those using services were in-care.

Nearly a third of survey respondents had been diagnosed with depression within the last 12 months. Black/African-American women (36%) followed by MSM (32%) had the highest percentage of depression. The primary barrier to receiving care as reported by survey respondents was "I didn't know where to go." This was identified by 46% of consumers reporting barriers. The second most frequently identified barrier was "I didn't want to use the service" (18%).

According to the provider inventory, an additional 55 consumers could have been treated by existing providers.

The extent of unfulfilled need combined with existing capacity was consistent with the lack of awareness of available resources and the stigma attached to receiving care for a mental health issue.

ORAL HEALTH CARE

Dental services continued to be the number one need identified by survey respondents. It was ranked third in terms of unfulfilled need. Seventy-four percent of those who did not use the service needed it. The top ranked barrier to receiving care was the long wait to get an appointment, identified by 43% of those indicating a barrier, followed by limited funding (19%).

Information from the provider inventory was illuminating. There were only three Ryan White funded agencies – one had a six week wait, and one had a 30-day wait with the services being referred out with a lengthy referral process. One agency reported the ability to serve an additional 400 people. These findings were corroborated by results from the focus groups which emphasized the long waits for appointments, the high demand for services, and the fact that at least one agency was seeing patients quickly.

Based on focus group responses, it was apparent that reduced funding and the paperwork and the multi-stage referral process had become significant barriers to the receipt of services.

SUBSTANCE ABUSE SERVICES

Half of surveyed consumers reported having used some type of alcohol or street drugs in the past six months. Of that population, one-half had considered seeking substance abuse treatment and reported free treatment or immediate admission to care as the support they believed would help them get treatment. The sizable portion of the population belied the low ranked total need for services and unfulfilled need. In addition, case managers indicated that wait times to enter programs combined with the lack of ongoing support and the paucity of residential treatment programs was also problematic with regard to keeping consumers drug-free. The changing pattern of drug use from IV drugs and crack to meth, and the lack of providers providing services to patients addicted to meth further exacerbated the problem. In addition, the five Ryan White funded providers reported additional capacity for just 20 new clients.

CASE MANAGEMENT (NON-MEDICAL)

The service ranked relatively low in total need (twentieth) but was ninth highest ranked in unfulfilled need. Eighty percent of consumers felt this service was easily obtained. Thirty-five percent of consumers identified an unfulfilled need, which was highest among out-of-care Black/African-American Women and Hispanic/Latino Men and Women. Waiting periods for the service were variable among the Ryan White funded providers and there was existing additional capacity for 50 new clients. Focus groups bore out some continuing confusion about the role and responsibilities of non-medical vs. medical case managers. Among barriers, case manager availability was consumers' primary concern, and the size of existing caseloads was of concern to case managers. Outreach to those populations with the highest unfulfilled needs would ensure that existing additional capacity is utilized effectively.

CHILD CARE SERVICES

Child care services ranked low in terms of total need and unfulfilled need, and has been since 2007. Utilization was low but among those who needed the service the principal barrier to obtaining the service was a lack of knowledge about the service. There was a low availability of additional existing capacity among Ryan White funded providers. Ensuring that the population in need of the service is able to obtain it may require additional education about its availability and purpose.

FOOD BANK / HOME-DELIVERED MEALS

Food Bank services total need and unfulfilled need were highly ranked among both in-care and out-of-care consumers, and has been so since 2007. Eighty-six percent of consumers using the service found it easily obtained and 37% reported an unfulfilled need. The most common barrier to obtaining the service was location/transportation. Four Ryan White funded agencies providing Food Bank services reported a combined existing additional capacity to serve 10 additional clients. Four Ryan White funded agencies providing Congregate Meals reported a combined existing additional capacity to serve 21 additional clients and two agencies providing Home Delivered meals reported additional capacity to serve just one additional client. High utilization, high need ranking and generally high unfulfilled need combined with limited additional capacity and the importance of proper nutrition for PLWHA make this service a critical yet underfunded component of services provided for the PLWHA.

HOUSING SERVICES

The local 2013 Comprehensive HIV Needs Assessment demonstrated that consumers living with HIV considered housing to be a critical need in the Dallas area. Long-term rental assistance ranked the 7th highest overall need and the highest unfulfilled need, and emergency financial assistance for rent/mortgage and utilities as the 12th overall and 2nd highest unmet need, while facility-based assisted living ranked as the 21st highest need and 5th highest unmet need. Up to 27% of consumers who needed housing assistance (and asked for it) did not receive help.

At the time, about 3.9% of HIV+ consumers were homeless on the streets or in a shelter, and identified several housing barriers to HIV care, including having no bed to sleep in, no private place to live, no place to store medications, no money for rent, no telephone where they could be reached, and not enough food to eat. About 23.3% who were living with someone else expressed concerns about disclosure of HIV status, having no private place to live, and no place to store medications. In contrast, those renting or owning their own housing (about 61.9%) had few housing barriers to care, but were afraid of disclosure of HIV status and not having enough to eat.

Likewise, over 50% of consumers indicated that they were severely cost burdened by their housing, paying over 50% of their monthly income toward their rent/mortgage and utilities, and most indicating that they did not have enough money to pay for housing or were put on a waiting list for housing. As explained earlier, in 2014, nearly 15% of EMA residents were living in poverty. With HIV prevalence being 20 times higher in lower socio-economic areas, a significant portion of persons living with HIV are also living in poverty. The Medical Monitoring Project¹⁴ revealed the difficult economic circumstances of most persons living with HIV, with 41% of HIV participants in 2013 relying primarily on SSI or SSDI as their primary source of income, 66.3% living on less than \$20,000 in annual income, and almost 47% living below the federal poverty level (or at an extremely low income level).¹⁵ Yet, according to the National Low Income Housing Coalition (NLIHC) Out of Reach Study, a

¹⁴ Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014), published at www.cdc.gov/hiv/pdf/statistics/systems/mmp/cdc-hiv-hssr-mmp-2013.pdf.

¹⁵ “Extremely low income” (30% of the Area Median Income) for a one-person household in the Dallas area in 2016 equates to \$15,050 in annual income (published at www.huduser.gov/portal/datasets/il/il16/index.html). The 2016 poverty guideline for a one-person household is \$11,880 in annual income (published at www.aspe.hhs.gov/poverty-guidelines).

renter in the Dallas area must earn an annual income of \$31,840 to afford a one-bedroom apartment at the HUD fair market rent (\$796) for the area.¹⁶ The housing gap is significant.

Compounding the housing needs experienced by persons living with HIV in the Dallas EMA, research studies nevertheless demonstrate that housing plays a critical role both in HIV prevention (by reducing the risk of HIV transmission) and in HIV care (by improving health outcomes) and that housing may be a “stronger predictor” of improved HIV health outcomes than other factors such as gender, race, age, substance use, mental health issues, or social services.¹⁷ Nevertheless, the Dallas area (like many areas of the country) is experiencing a critical shortage of available affordable housing units, according to the NLIHC Affordable Housing Gap Analysis, which shows that the Dallas-Fort Worth area has a shortage of over 174,000 housing units that would be affordable to extremely low income persons, with only 19 units available per 100 households.¹⁸ Persons living with HIV on extremely low incomes cannot find available affordable housing and must compete for what housing units and assistance is available.

EMERGENCY FINANCIAL ASSISTANCE

Emergency Financial Assistance (EFA) for Rent/Mortgage/Utilities was the second highest ranked unfulfilled need for both in-care and out-of-care consumers. Fifty percent of consumers had needed help with housing within the last six months of the survey, but just 34% had received it; of which 80% percent said they needed the service, 70% said they did not know about the service, and 27% said they requested, but did not receive the service. Facility-Based Housing was the fifth highest ranked unfulfilled need for consumers. Just 9% of consumers received this service within the last six months of the survey, but 39% stated a need for it; of which 63% percent said they did not know about the service, and 32% said they requested but did not receive the service. Long Term Rental Assistance Voucher was the first ranked unfulfilled need for consumers. Just 13% of consumers received this service within the last six months of the survey, but 83% stated a need for it; of which 62% percent said they did not know about the service, and 27% said they requested but did not receive the service. Nearly 40% of consumers resided in a location other than an apartment/house or mobile home that they rented or owned in their own name and 52%% of consumers spent almost half or half of their income on rent/mortgage and utilities. The greatest percentages of barriers to care were predictably found among consumers living in homeless shelters or on the street/in a car. Barriers to obtaining housing assistance were highly variable by residence type. Given the highly ranked need, the available additional capacity seemed nearly non-existent.

LEGAL SERVICES

Legal services ranked nineteenth in overall need and seventeenth in unfulfilled needs. Approximately 27% of those who didn’t access these services in the last year had an unfulfilled need. Approximately 24% of those surveyed reported no barriers to care, over 50% “did not know about the service,” and 38% indicated that the

¹⁶ National Low Income Housing Coalition, Out of Reach Report, 2016, published at www.nlihc.org/orr. Affordable is defined as paying no more than 30% of annual income on housing expenses.

¹⁷ Refer to studies cited in HIV Care Continuum: The Connection between Housing and Improved Outcomes Along the HIV Care Continuum, U.S. Department of Housing and Urban Development, November 2014, published at www.hudexchange.info/resource/4143/connection-between-housing-and-improved-outcomes (see footnotes 4 through 9). See also National AIDS Housing Coalition, Fact Sheet: Housing Is HIV Prevention & Care, 2013, published at www.nationalaidshousing.org/PDF/FactSheet.pdf

¹⁸ National Low Income Housing Coalition, The Affordable Housing Gap Analysis, March 2016, published at www.nlihc.org/research/gap-report. Note that the national average is 31 units available per 100 households.

services provided were limited as they “need lawyers for other things.” There are only two Ryan White funded legal services agencies. One has a short wait and capacity for 5-10 additional consumers. The other agency has a 30-day wait time. There were 11 agencies in total providing legal services for PLWH in the DPA. The needs for services outweighed the ability of the agencies funded by Ryan White dollars, suggesting the need to reach out to other agencies providing legal services in the DPA.

LINGUISTIC SERVICES

The stated need for Linguistic/Translation services was very low; it ranked twenty-fifth out of 27 in need, and only 6% of consumers identified an unfulfilled need, and just 3% of out-of-care consumers had an unfulfilled need. Seventy percent of consumers using the service found it easily obtained. Of the unfulfilled need, in-care Hispanic/Latino Men and Women had the highest percentage (16.4%). Of those reporting barriers, 65% stated it was because they did not know the service was available. Focus groups revealed that monolingual speakers were at greater risk for not accessing care and that while for some the language barrier was an issue, the greater concern may be that many were also new to the country and may not have been able to navigate the system well – regardless of language barriers. There were two Ryan White funded providers and existing additional capacity for 20 new clients. This was a low ranked need, low utilization service but may be crucial to the population it is targeted towards.

RESPIRE CARE

Respite Care for Adults was ranked very low in overall need and just 9% of consumers had an unfulfilled need. Eighty-four percent of consumers found their service need easily met. Eighty percent of consumers felt this service was easily obtained. Respite Care for Children was the lowest ranked service in overall need and 92% of those who used the service found it easily obtained. There was existing additional capacity for 10 adult clients and 10 children. Given the low priority of stated need, the relatively low utilization of the service and existing additional capacity there appeared to be few, if any, gaps in service need and availability.

TRANSPORTATION SERVICES

Twenty-nine percent of consumers who had dropped out of care for six months or more in the last five years identified transportation issues as a contributing factor. Transportation to medical care ranked eleventh in overall need and eighteenth in unfulfilled need. Fifty-eight percent of consumers found the service easily obtained and 27% had an unfulfilled need. The unfulfilled need was highest among out-of-care Black/African-American Men and Hispanic/Latino Men and Women. The primary barrier identified by consumers was the need to take multiple buses to their clinic. Transportation to other services was ranked lower than transportation to medical care and 74% of consumers found their need for the service easily met. Fifty-six percent of consumers did not know about service availability. Among Ryan White Transportation to Medical Care funded providers, there existed additional capacity for 40 clients for bus passes and 60 new clients for van service. Focus groups revealed a sense that the use of transportation services for just medical appointments created some limitations for clients. Out-of-care consumer interviews revealed a general sense that transportation (funded or not) creates many difficulties when consumers have to make choices about remaining in care.

HIV PREVENTION SERVICES

Although prevention services were not ranked by consumers, consumer behaviors as evidenced by survey response, suggested that additional work needed to be done in this area to educate consumers about risk. This was also borne out in the focus group discussion.

Less than 50% of consumers used protection when engaging in sexual activity. Given reports from the out-of-care interviews and by provider focus groups this number may be under-estimated given beliefs that HIV cannot be transmitted through oral sex and that being in a long term relationship does not require that people use protection.

There are four agencies funded to provide prevention services in the DPA and most of the providers expressed the belief that prevention efforts have to be re-emphasized, targeted and reinvented.

d. Describe barriers to HIV prevention and care services, including, but not limited to:

SERVICE NEED AND BARRIERS

The consumer survey services section asked the following questions about the 26 core and support services outlined:

- **Do You Use This Service Now or Over the Past Year?**
 - If a service is being used, it is assumed the service is needed.
 - If the service is being used, the next question asks about ease of use.
 - If the service is not being used, the next question asks about need for the service.
- **How Easy Was It For You To Get the Service?**
 - The number and percentage of people who use the service and found it easy to get is presented as **Need Met Easily**
 - The number and percentage of people who use the service and found it hard or somewhat hard to get is presented as **Need Met Hard**.
 - Anyone with a service that was hard or somewhat hard to get was asked the reason under the barriers section.
- **Unfulfilled need for a service.**
 - If someone is not using the service but states a need for it, he/she is considered to have an unfulfilled need for the service.
 - The number and percentage of people who have an unfulfilled need is presented as **Need Not Met**.
 - Anyone with an unfulfilled need was asked the reason under the barriers section.
- **Barriers to Care.**
 - If a service fulfilled the criteria for either Need Met Hard or Somewhat Hard or Need Not Met, the respondent was asked either, **“What is the *main* reason you were not able to get this service?”** or **“What is the *main* reason this service was hard to get?”**
 - Specific barriers were identified for each service.
 - A list of “problems” with HIV medical care asked early in the survey replaced the barrier questions for Ambulatory/Outpatient Medical Care.

The service need and barriers are provided for the total sample, in-care and out-of-care consumer respondents.¹⁹ For most services, the priority populations' service need and barriers are also presented. The total number of respondents for any question is displayed with "n."

BARRIERS TO CARE

Services That Are Needed But Are Not Available

Providers were asked to identify services that are not available to people living with HIV/AIDS. While the majority of providers felt that the full continuum is available, some service gaps were mentioned:

- Vision and hearing
- Transportation
- Food
- Routine testing at medical sites
- Low-cost housing options
- Specialist physicians, including psychiatry
- Inpatient hospital coverage
- Affordable child care and employment opportunities

Other comments:

- While providers offer a full array of services, none are available without full and complete documentation.
- Undocumented PLWHA that remain "hidden" or do not present to service providers will be left out of care.

Services That Should Be Increased

Providers commented on the need for treatment retention and services related to keep PLWHA in care. Specific services mentioned multiple times include:

- Treatment adherence counseling;
- Medical case management;
- Transportation and public bus passes;

¹⁹ Throughout this section in-care consumers are those that responded *positively* to any of the following questions: Have you had any of the following within the last 12 months? (1) CD4 tests, (2) Anti-retroviral medication; (3) Viral load tests. Consumers meeting one of the following five criteria were considered out-of-care. (1) Consumers not currently receiving HIV medical care, with at least 12 months since the last medical appointment. These consumers meet the HRSA definition of "out-of-care" which is "no HIV medical care, no viral load or CD4 counts and no antiretroviral medications in the last 12 months." These people may or may not be receiving other Ryan White or HIV services. (2) Consumers diagnosed between 2010 and 2013 that failed to link to care within six months of diagnosis. These consumers may currently be in care. (3) Consumers diagnosed between 2010 and 2013, linked to care after diagnosis but dropped out-of-care for at least six months. These consumers may now be back in care. (4) Consumers who dropped out-of-care for at least 12 months but are now back in care. They should have been back in care for no more than two years. (5) Consumers who began care in either 2012 or 2013 after no linkage to care after diagnosis. These people may be in care now, and may have been diagnosed at any time in the past.

- Food and meals.

Other suggestions:

- Expand approved dental codes to mirror Medicaid; change funding to a fee-for-service model;
- Provide in-home assistance with activities of daily living;
- More available housing for PLWHA.

Services That Should Be Delivered Differently

The majority of comments focused on the system of medical and non-medical case management.

- Some providers favored funding only medical case management in primary care settings, arguing that only medically experienced professionals have the experience to navigate healthcare systems.
- Case management intake and centralized eligibility documentation would increase access.

Other services that should be delivered differently:

- Translation services in languages other than Spanish;
- Dental services in Denton;
- Housing.

E. DATA: ACCESS, SOURCES, AND SYSTEMS

Data Sources Used in the Overview

This overview presents information on known cases of Human Immunodeficiency Virus (HIV) in the Dallas Eligible Metropolitan Area (Dallas EMA) diagnosed through December 31, 2014 and reported as of June 30, 2015. Information on people living with HIV (PLWH), or prevalence, represents the cumulative total of people diagnosed with HIV who are not known to have died and have a current residence in the Dallas EMA. Information on new HIV diagnoses in 2014 includes people residing in the Dallas EMA with a new diagnosed case of HIV infection. Cases are considered new diagnoses regardless of the stage of disease at the time of diagnosis. Statistics on new diagnoses of HIV are based on the earliest available diagnosis date.

The primary source of information for this report comes from disease surveillance. Texas laws and regulations require health care professionals and laboratories report test results or results of diagnostic evaluation that indicate infection with HIV. These results are maintained in the Texas Electronic HIV/AIDS Reporting System (eHARS). eHARS does not include those unaware of their HIV infection or those who tested positive for HIV infection solely through anonymous testing.

Rates and counts

When making decisions about resource allocation and setting priorities, it is important to include both the total number and rate of cases. If the population of different groups is of significantly different sizes, rates of new diagnoses and number of PLWH offer better comparison between such groups. HIV rates are usually expressed in terms of 100,000 members of the defined population. *Prevalence rates* show

the number of PLWH per 100,000 members of the population, and *diagnosis rates* show the number of new diagnoses per 100,000 members of the population. For example, the current prevalence rate of PLWH in Texas is 302.1 per 100,000, meaning that there are about 302 PLWH for every 100,000 Texans. The current newly reported HIV case rate is 16.3 per 100,000, meaning that there are about 16 new diagnoses for every 100,000 Texans. Comparing case rates shows the relative difference of the burden of disease across groups with different population sizes, allowing for the identification of which demographic or geographic areas are being disproportionately impacted.

Sex and gender identity

The information in disease surveillance on sex reflects biological sex. This report does not include information on transgender persons. DSHS began collecting information on gender identity in 2014; additional information on gender identity and HIV risk will not be available for at least another two years.

Mode of transmission

The mode of exposure assigned to each HIV case represents the most likely way that the individual became infected with HIV based on the risk behaviors found during disease reporting or investigation. Nearly 15% of new HIV cases are reported without an identified risk factor. DSHS uses a multiple imputation method to assign a risk factor for these which replaces missing risk factors with a range of possible values. Estimates of population sizes for risk behavior groups, with the exception of Men who have Sex with Men (MSM), are unknown; therefore, case rates were not calculated for Injection Drug Use (IDU), persons engaging in condomless heterosexual sex, and MSM/IDU. The 2014 Census Data used for calculating MSM population estimates was not available at the time of this report; therefore, the latest year available data on HIV rates in MSM is 2013.

Information on the general population

The profile contains information on the overall population of Dallas; the sources for those data are numerous, and cited within the text.

Information on linkage to treatment, retention in care, ART prescription, and HIV viral suppression

The profile also contains information on several aspects of treatment and care for PLWH, such as linkage to care, prescription of antiviral medication (ART) and maintenance in treatment. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from publicly funded treatment providers in the Ryan White HIV/AIDS (Parts A-D, including the Texas AIDS Drug Assistance Program), information from Texas Medicaid and from some private health plans. Information from special surveillance studies, especially the Medical Monitoring Project, a project involving chart reviews and interviews with a representative sample of patients in care with Texas HIV medical providers were also used for estimates of ART prescription.

STI/HIV and TB/HIV Comorbidity

A cross-registry match was performed between eHARS and the Texas Sexually Transmitted Disease (STI), Hepatitis C, and tuberculosis (TB) registries to identify PLWH co-infected with TB or any of three reportable STIs (chlamydia, gonorrhea, and syphilis) during 2014. PLWH were considered to be co-infected if their co-infection was diagnosed ≥ 30 days prior to their HIV diagnosis or at any date in 2014 after their HIV diagnosis.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

1. **NHAS Goal:** Reduce new HIV infections
 - a. **Objective 1:** By the end of 2021, increase the percentage of people living with HIV who know their serostatus by at least 10 percent.
 - i. **Strategy:** Increase testing programs that effectively reach high-risk populations

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, DCHHS, UTSW, and other prevention-funded entities	Reinvigorate the HIV Testing Coalition	High risk HIV negative individuals	Active HIV Testing Coalition
By the end of 2021:	CBO's, DCHHS, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Conduct targeted HIV testing in areas/ locations where and times when people at high risk for HIV can be accessed	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of tests performed; percent positive
By the end of 2021:	CBO's, DCHHS, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Partner with other community organizations to facilitate collaborative testing activities serving populations at risk for HIV	Hispanic MSM, black MSM, white MSM, black heterosexual women, transgender individuals, and veterans	Number of tests performed; percent positive
By the end of 2021:	CBO's, Ryan White Part C and Part D Service Providers, UTSW, and other prevention-funded entities	Access and test social contacts of HIV positive individuals and those at high risk for infection	Social networks of HIV infected individuals and those at high risk for infection	Number of tests performed; percent positive
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based	Offer testing when utilizing evidence-based interventions and	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals

	organizations and educational institutions	effective strategies		enrolled; and number of individuals graduated
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ii. **Strategy:** Promote routine testing programs

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Prevention-funded entities	Educate individuals about routine testing and promote routine testing	Individuals who have not had an HIV test within the previous 12 months	Number of individuals engaged in information sessions
By the end of 2021	AETC, Test Texas Coalition, CBOs, educational institutions	Educate providers about routine testing and promote routine testing	Primary care providers, emergency rooms, urgent care centers, correctional institutions, and community health centers	Number of information sessions engaging primary care providers, emergency rooms, urgent care centers, correctional institutions, and community health centers
By the end of 2021:	DSHS, area hospitals	Implement routine HIV testing in at least one new area hospital emergency room	Individuals who have not had an HIV test within the previous 12 months	Number of tests performed; percent positive
By the end of 2021:	DSHS, FQHCs and other community health clinics	Implement routine HIV testing in at least one new area community health clinic or service	Individuals who have not had an HIV test within the previous 12 months	Number of tests performed; percent positive
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based	Utilize effective strategies, including social media to promote	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of individuals reached through social media and

	organizations and educational institutions	routine testing		effective strategies (self reported)
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- iii. **Strategy:** Utilize partner notification services to test sexual and social partners of newly diagnosed individuals

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	DCHHS	Locate, interview, and test sexual contacts of newly diagnosed individuals	Sexual partners of newly HIV infected individuals	Number of tests performed; percent positive
By the end of 2021:	DCHHS	Locate, interview, and test social contacts of newly diagnosed individuals	Social networks of newly HIV infected individuals	Number of tests performed; percent positive

- b. **Objective 2:** By the end of 2021, increase the percentage of young gay and bisexual men who are engaged in activities that reduce the risk of HIV by at least 10 percent.

- i. **Strategy:** Expand access to effective prevention services, including PrEP and PEP.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, local hospitals, and community health centers, and other prevention-funded entities	Create and sustain at least one community PrEP clinic which allows access regardless of insurance or financial resources	Uninsured MSM that are at high risk for HIV infection	Number of uninsured, high-risk individuals receiving PrEP
By the end of 2021:	CBOs, local hospitals, and community health centers, and other prevention-funded entities	Offer PrEP services for high-risk populations	Recently released from prison, Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender	Number of high-risk individuals accessing PrEP

			individuals.	
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Continue and improve strategic condom distribution activities	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of condoms distributed; number of distribution sites
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	High risk populations for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers, number of referrals into PrEP and PEP services

- ii. **Strategy:** Expand prevention services for people living with HIV by ensuring effective psychosocial support

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	HUD, HOPWA, DCHHS, City of Dallas Housing Programs, CBOs	Reduce barriers to accessing housing services	Homeless and at risk of homelessness individuals living with HIV	Number of homeless and at risk individuals in permanent housing
By the end of 2021:	CBOs	Enhance integrated care models that enable psychosocial,	Newly diagnosed individuals, individuals with co-occurring medical conditions	Number of people accessing co-located services and support

		mental health, and substance abuse treatment and risk reduction counseling to be co-located with HIV primary medical care ²⁰		
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies to expand support for people living with HIV	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

- iii. **Strategy:** Tackle misperceptions, stigma, and discrimination to break down barriers to HIV prevention, testing, and care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council	Identify key areas and barriers which affect the care continuum	Individuals living with HIV	Barriers identified
By the end of	Ryan White Planning	Conduct at least a	Lost-to-care	Needs

²⁰ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014.

2021:	Council/Administrative Agency	biannual comprehensive needs assessment that helps identify gaps in the care continuum	individuals; clients utilizing Ryan White-funded services	assessment completed
By the end of 2021:	CBOs	Utilize evidence-based social marketing and education campaigns, and leverage digital tools and new media technologies	Populations and communities at greatest risk for HIV	Number of programs utilizing social media; number of hits, followers, interactions by community and clients on social media
By the end of 2021:	Ryan White Planning Council, community organizations such as the Positive Justice Project	Decrease stigma and discrimination resulting from criminal practices that target people living with HIV through education.	Local law enforcement and district attorneys, general population	Number of dissemination activities; number of persons attending symposiums, meetings, etc.
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Young gay and bisexual men who have engaged in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Increase outreach, including utilizing community health workers, to at least four communities or populations	Traditionally non-targeted populations	Number of outreach activities; Number of individuals reached

		traditionally not targeted		
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c. **Objective 3:** By the end of 2021, increase the percentage of all individuals who are engaged in activities that reduce the risk of HIV by at least 10 percent.

i. **Strategy:** Expand access to effective prevention services, including PrEP and PEP.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2019:	CBOs, local hospitals, and community health centers	Create and sustain at least one community PrEP clinic which allows access regardless of insurance or financial resources	Black women, transgender women, and people who engage in condomless heterosexual sex	Number of community PrEP clinics
By the end of 2021:	CBOs, local hospitals, and community health centers	Offer PrEP services	Recently released from prison, black women, transgender women, and people who engage in condomless heterosexual sex, MSM, serodiscordant couples	Number of individuals receiving PrEP in the priority population
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Continue and improve strategic condom distribution activities	Individuals who engage in HIV-risk behaviors	Number of condoms distributed; number of distribution sites
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational	Utilize evidence-based interventions and effective strategies	Individuals who engage in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of

	institutions			individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

- ii. **Strategy:** Expand prevention services for people living with HIV by ensuring effective psychosocial support

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	HUD, HOPWA, DCHHS, City of Dallas Housing Programs, CBOs	Reduce barriers to provide access to housing services	Homeless and at risk for homeless individuals living with HIV	Number of people living with HIV in permanent supportive housing
By the end of 2021:	CBOs	Enhance integrated care models that enable psychosocial, mental health, and substance abuse treatment and risk reduction counseling to be co-located with HIV primary medical care ²¹	Newly diagnosed individuals, individuals with co-occurring medical and mental health conditions	Number of people accessing co-located services and support
By the end of	CBOs, local	Utilize evidence-	Individuals who	Number of

²¹ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014.

2021:	hospitals, community clinics, faith-based organizations and educational institutions	based interventions and effective strategies	engage in HIV-risk behaviors	activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize trained community health workers and other peer-based programs in communities most impacted by HIV/AIDS	People who engage in high risk behaviors for HIV infections, including MSM, women, trans individuals, youth, and other data-driven priority populations	Number of community health workers and other peer-based programs staff trained; number of peer-based programs

- iii. **Strategy:** Tackle misperceptions, stigma, and discrimination to break down barriers to HIV prevention, testing, and care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council	Identify key areas and barriers which affect the care continuum	Individuals living with HIV who are at or below 200% of the FPL	Barriers identified
By the end of 2021:	Ryan White Planning Council/Administrative Agency	Conduct at least a biannual comprehensive needs assessment that helps identify gaps in the care continuum	Lost-to-care individuals; clients utilizing Ryan White-funded services	Needs assessment completed
By the end of 2021:	CBOs	Utilize evidence-based social marketing and education campaigns, and leverage digital tools and new	Populations and communities at greatest risk for HIV	Number of programs utilizing social media; number of hits, followers, interactions by

		media technologies		community and clients on social media
By the end of 2021:	DCHHS	Work with local law enforcement and district attorneys to ensure better implementation of DSHS recalcitrant policy as opposed to criminal prosecution	Recently released from prison, including black women, transgender women, and people who engage in condomless heterosexual sex, MSM, serodiscordant couples	The number of meetings between local law enforcement and the work group.
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Utilize evidence-based interventions and effective strategies	Individuals who engage in HIV-risk behaviors	Number of activities delivered; number of individuals enrolled; and number of individuals graduated
By the end of 2021:	CBOs, local hospitals, community clinics, faith-based organizations and educational institutions	Increase outreach to at least four communities traditionally not targeted, but which have high risk behaviors that can increase acquisition and transmission of HIV and AIDS.	Traditionally non-targeted, high-risk populations	Number of outreach activities; Number of individuals reached

2. NHAS Goal: Increase access to care and improving health outcomes for PLWH

a. **Objective 1:** By the end of 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their diagnosis by at least 10 percent.

i. **Strategy:** Intensify at the community level the ability for patients to access HIV medical care within one month of diagnosis

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Administrative Agency	Capture and report annually on the number and percentage of Ryan White-funded clients that are linked to HIV medical care within one month of entering services	Newly diagnosed individuals without health insurance or eligible for Ryan White-funded services	Time to Early Intervention or first Intake Visit; Time to First Completed Medical Appointment
By the end of 2021:	CBOs	Conduct intensive linkage to care activities for clients that are likely to not be engaged in medical care	Newly diagnosed, high-risk individuals, homeless individuals, those recently released from prison	Number of clients utilizing services per year; number linked to medical care

ii. **Strategy:** Intensify linkage to care efforts across health systems and community partners

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, UTSW, RWPC, AETC, State partners (TX HIV Syndicate)	Inform community partners about results of the latest needs assessments related to barriers to care and facilitators to linkage to promote collaboration	Front line and other key staff within and outside of the Ryan White system of medical care	Number of individuals engaged in information sessions Number of occurrences where Needs Assessment Results were shared
By the end of	AETC	Educate medical	Medical providers	Individuals who

2021:		providers about current HIV treatment modalities and protocols utilizing multiple educational platforms	at Community Health Centers, ACOs, etc.	have not had an HIV test within the previous 12 months
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iii. **Strategy:** Ensure HIV testing organizations maintain a robust capacity to ensure linkage to care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, DCHHS STI Testing, EIC, UTSW	Implement effective service agreements with HIV medical providers	HIV medical providers	Number of agreements developed that promote timely linkage
By the end of 2021:	CBOs, DCHHS STI Testing, EIC, UTSW	Ensure that testing organizations have aligned testing and linkage efforts	Newly diagnosed PLWH from testing sites	Number of individuals who test positive linked to care
By the end of 2021:	RWPC, CBOs, DCHHS STI Testing, EIC, UTSW	Identify and disseminate specific solutions to address barriers that prevent PLWH from linking to and being retained in care	Medical, social service support organizations (influencers and frontline staff)	Number of effective strategies developed and implemented; number of newly diagnosed individuals completing first HIV medical visit; number of PLWH retained in care

b. **Objective 2:** By the end of 2021, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65 percent.

i. **Strategy:** Address barriers to accessing behavioral health and substance abuse treatment services which inhibit the ability to stay adherent to HIV medications.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, County Mental Health Authorities	Support capacity to screen, treat, and/or link to substance abuse and mental health services	PLWH	Number of PLWH screened for SA/MH disorders; number of people screening positive for SA/MH disorders
By the end of 2021:	Ryan White-funded HIV primary care providers & CBOs, Ryan White Grant Administrative Agency	Support comprehensive, coordinated, integrated patient-centered mental health and/or substance abuse care and treatment	PLWH at high risk for co-occurring mental health and substance abuse conditions	Number of clients that utilize both outpatient medical care and mental health or substance abuse services

- ii. **Strategy:** Address gaps in support services which impact a client’s ability to effectively access medical care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs	Improve access to transportation	PLWH with transportation needs	Number of Ryan White clients receiving assistance
By the end of 2021:	CBOs	Improve access to childcare services	PLWH with children	Number of Ryan White clients with children accessing childcare services
By the end of 2021:	CBOs and HOPWA grantee	Improve access to Housing Services	PLWH with housing needs	Number of clients receiving housing assistance

- iii. **Strategy:** Ensure adequate workforce capacity to enable the latest evidence-based HIV treatment.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	AETC	Coordinate and complete at least 1 to 2 preceptorships per month allowing opportunities to clinically shadow clinicians in multiple settings for the care of HIV+ patients	All Types of Providers: 1. Physicians 2. Nurses, 3. Nurse Practitioners 4. Physician Assistants 5. Allied Health Professionals 6. Oral Health Professionals 7. Dentists 8. Social Workers 9. Case Managers 10. Community Health Workers 11. Pharmacists	Records for All Participants Including: 1. AETC Event Records 2. Participant Evaluations
By the end of 2021:	AETC	Provide ongoing longitudinal training to at least three primary care providers AND/OR primary care clinics about the long-term care of HIV+ patients.	Primary Care Providers/Clinics	Records for All Participants Including: 1. AETC Event Records 2. Participant Log showing Ongoing Training 3. Participant Evaluations

3. NHAS Goal: Reducing HIV-related disparities and health inequities

- a. **Objective 1:** By 2021, create, distribute, and monitor progress of a local HIV Care Continuum that is targeted to reduce HIV infections and improve health outcomes among priority populations.

- i. **Strategy:** Develop a baseline of HIV-related disparities in the community for monitoring to ensure progress.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 6/30/2017:	Ryan White Planning Council/ Administrative Agency	Collect and analyze state and local data on local disparities in access to care, retention in care, and clinical outcomes	Black/African American and Hispanic/Latino MSM	Data presented to stakeholders at July 2017 Planning and Priorities Meeting
By 9/30/2017	Ryan White Planning Council, Administrative Agency, Ryan White Providers, Community Prevention Providers	Develop strategies and protocols from analyzed data to address HIV-related health disparities on the local level Implement at participating CBOs	Populations identified in step 1.	Strategies and protocols developed with stakeholder input, and disseminated to providers
By 12/31/2017 And quarterly thereafter	EMA/HSDA Quality Management Coordinator	Develop a monitoring system to review progress toward the reduction of health disparities	Funded providers	Quarterly monitoring will show improvement within three quarters, or the implemented strategies and protocols will be reviewed for efficacy.
06/30/2018 And semi-annually thereafter	EMA/HSDA Quality Management Coordinator	Monitored results for the prior 12 months (as available) will be disseminated to the Planning & Priorities Committee semiannually.	RWPC and the Planning & Priorities Committee	Reporting scheduled on committee agendas.

- ii. **Strategy:** Support engagement in care for groups with low-levels of viral suppression.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
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By 6/30/2017	Ryan White Planning Council Administrative Agency Ryan White Providers	Expanding on collected data, conduct surveys of convenience (patient population) at provider sites of persons in the target populations to get their feedback on the types of activities that would support retention in care and reduce non-adherence.	Individuals from target populations who are not virally suppressed	Completed surveys and data presented to Priorities & Planning Committee July 2017 meeting
By 12/31/2017	Ryan White Planning Council Administrative Agency Ryan White Providers Community Prevention Providers	With TA from HRSA, DSHS, and local experts, develop interventions that improve engagement of target populations in ongoing HIV care to improve health outcomes and reduce HIV related health disparities	N/A	Interventions developed and disseminated to provider sites for implementation
By 6/30/2018 And semiannually thereafter	EMA/HSDA Quality Management Coordinator	Perform Continuous Quality Improvement on enacted interventions to identify the top interventions for each target population. Monitor the retention of targeted populations to measure efficacy of those interventions. Report results to the Priorities & Planning Committee semiannually.	N/A	Reporting scheduled on committee agendas.

- iii. **Strategy:** Improve viral suppression among persons experiencing/formerly experiencing HIV-related disparities by 15%.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 06/30/2017	Ryan White Planning Council Administrative Agency	Establish baseline viral suppression averages for each demographic identified as experiencing HIV-related disparities	Black/ African American and Hispanic/ Latino MSM Black Women Transgender Women	Baselines measured & reported to Priorities & Planning Committee by July 2017 meeting
By 09/30/2017 And quarterly thereafter	EMA/HSDA Quality Management Coordinator	Monitor progress toward the improvement of viral suppression rates among persons experiencing/ formerly experiencing HIV-related health disparities	N/A	Viral suppression rates among persons experiencing HIV-related health disparities
06/30/2018 And semi-annually thereafter	EMA/HSDA Quality Management Coordinator	Monitoring results for the prior 12 months (as available) will be disseminated to the Priorities & Planning Committee semiannually.	N/A	Reporting scheduled on committee agendas.

- iv. **Strategy:** Ensure available funding for undocumented immigrants or individuals not otherwise eligible for health insurance or Medicare/Medicaid.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Planning Council/Administrative Agency	Apply for available funding for	Undocumented immigrants or individuals not otherwise eligible for health insurance or Medicare/Medicaid	Submitted grant proposals
By the end of 2021:	CBOs, RWPC Planning & Priorities and	Ensure inclusion and adequate	Undocumented immigrants or	Inclusion of represented

	Allocations Committees, Administrative Agency	representation of priority populations during the prioritization and allocation process	individuals not otherwise eligible for health insurance or Medicare/Medicaid	priority populations in needs assessments
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b. **Objective 2:** By the end of 2021, reduce disparities in rate of new diagnosis by at least 10 percent in identified priority populations.

i. **Strategy:** Adopt structural approaches to reduce HIV infections and improve health outcomes

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, RWPC	Conduct regular culturally appropriate awareness campaigns on HIV risk, importance of getting tested, and engaging in care	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of campaigns conducted; number of Latino/a individuals getting tested for HIV; number of HIV positive Latino/a individuals engaging in medical care
By the end of 2021:	CBOs,	Culturally appropriate outreach and education conducted within the Latino/a community by Promotors	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of outreach activities conducted; number of Latino/a individuals interacting with Promotors; number of individuals engaged in activities

- ii. **Strategy:** Create new and alternative settings for effective HIV prevention and treatment activities

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	CBOs, community organizers, community leaders	Intensify community engagement through culturally appropriate outreach teams that reflect priority populations	Younger communities of color and lower SES, Black and Hispanic MSM	Number of educational outreach events, Number of partnerships with community organizations, Number of social media interactions
By the end of 2021:	CBOs, community organizers, community leaders	Engage priority population youth via social media	Hispanic MSM youth, black MSM youth, white MSM youth, young black heterosexual women, and transgender youth.	Social media likes, follows, and shares
By the end of 2021:	CBOs, specifically organizations serving priority population communities	Utilize prevention strategies from Goal 1 with local service organizations to increase HIV testing in nontraditional settings among priority populations.	Hispanic MSM, black MSM, white MSM, black heterosexual women, and transgender individuals.	Number of testing events in priority population communities

- iii. **Strategy:** Establish system-wide workforce development requirements for adopting the Culturally and Linguistically Appropriate Service (CLAS) standards developed by the Office of Minority Health into practices and protocols that address systemic issues contributing to health disparities.

Timeframe	Responsible	Activity	Target Population	Data Indicators
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	Parties			
By the end of 2021	DCHHS, DSHS, Office of Mental Health (OMH), CBOs	Convene a work group of funders and stakeholders to work with OMH staff to develop minimum staff training requirements for RW Sub-Recipients regarding the 15 OMH CLAS Standards.	Ryan White sub-recipients	Work group convened
By the end of 2021	DCHHS, DSHS, Office of Mental Health (OMH)	Policies and procedures, contract verbiage, and other requirements codified.	Ryan White sub-recipients	Policies, procedures, and other verbiage established and prepared for implementation in contracts established.

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Describe the specific contributions of stakeholders and key partners to the plan.

When the workgroup was formed to steer the planning process of the CDC/HRSA Integrated HIV Prevention and Care Plan for 2017-2021, the goal was to form a planning group that had representatives from HIV prevention programs, the local Housing Opportunities for Persons with AIDS (HOPWA) grantee, AIDS Education and Training Center representatives, Federally Qualified Health Centers, Ryan White funded care providers, consumers of Ryan White services, Ryan White Planning Council members, support staff, and Dallas County Health and Human Services (Ryan White Parts A and B Administrative Agency) representatives. All of these different stakeholders and key partners had equal opportunities to come to the planning sessions and respond to the ongoing plan electronically. For the Epidemiologic Overview and HIV Care Continuum portions of Section I in this plan, the work group sent a formal letter of request to the Texas Department of State Health Services (DSHS) for their

assistance. The state responded positively and sent in a completed section with 2014 state surveillance data. The group then worked together (mostly consisting of Community Based Organizations, the local research university and medical school, Ryan White consumers and Ryan White Planning Council members) on rearranging the Epidemiologic Profile so that it would fit in with the CDC/HRSA Integrated HIV Prevention and Care Plan Guidance that was released in June 2015. Volunteers from two separate CBOs took the lead on creating the Financial and Human Resources Inventory from relevant previously submitted applications and verifying the data from the Grants Division of Dallas County Health and Human Services.

The group also had a local CBO take the lead on creating the foundation for the actual Integrated HIV Prevention and Care Plan in Section II. The group then divided into three groups that corresponded to the first three National HIV/AIDS Strategy Goals: reduce new HIV infections; increase access to care and improving health outcomes for PLWH; and reducing HIV-related disparities and health inequities. Each of these groups still consisted of local CBOs, Ryan White consumers, DCHHS health educators, RWPC members, and representatives for the University of Texas – Southwestern. Once the objectives, strategies, and activities under all three goals were finalized, and the first section was complete, the Ryan White Planning Council support staff collaborated with the Planning Council’s leadership to work on the sections regarding the collaborative process and concurrence from the planning bodies.

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum.

This process could have used a larger contingent of PLWH that was more reflective of the epidemic in Dallas. While consumers were part of the planning process, more consumers could have been utilized to enrich this perspective, specifically from Hispanics and Trans people, as well as youth from all walks of earth.

c. Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives (Appendix B)

C. PEOPLE LIVING WITH HIV (PLWH) AND COMMUNITY ENGAGEMENT

a. Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.

The people involved in developing the Integrated HIV Prevention and Care Plan was more reflective of the prevention and care services provided in the jurisdiction than the epidemic itself. Black MSM, White MSM, and Black Heterosexual women were represented in the CDC/HRSA Integrated HIV Prevention and Care Planning Work Group insofar as HIV-positive members were concerned, though all were underrepresented.

b. Describe how the inclusion of PLWH contributed to the plan development.

Throughout this planning process, the CDC/HRSA Integrated HIV Prevention and Care Planning Work Group had 13 official meetings. 11 of 13 meetings included someone living with HIV at the table and all 13 meetings invited PLWH. The two meetings that were without someone living with HIV were due to scheduling conflicts.

During the planning process, PLWH contributed heavily in determining the identified priority populations, specifically identifying heterosexual black women as a priority population, as well as contributions throughout the plan insofar as activities and what would be feasible and effective when working with HIV-positive populations.

c. Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

The Ryan White Planning Council of the Dallas EMA provided the work group with engaged people living with HIV. The only method used to engage the people involved in the planning process was a call to action at the Planning Council level. The Ryan White Planning Council has a Consumer Council Committee that engages and educates the community on topics most pertinent to People Living with HIV in the Dallas community. This committee has been and will continue to be updated on the plan and allow for feedback opportunities so that the voice of PLWH is not lost during the development and implementation of this plan.

d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

Community outreach and educational forums are opportunities to engage impacted communities and seek input and critical insight to take back to the planning work group to aid in developing solutions to health problems and assure the availability of necessary resources. Additionally, much of the data pulled for this report was taken from the 2013 Comprehensive HIV Needs Assessment, which engaged many people that are part of impacted communities. When discussing needs of PLWH, and barriers for PLWH to get into and remain in care, this was pulled directly from impacted communities.

Section III: Monitoring and Improvement

a. Describe Process for regularly updating planning bodies and stakeholders on progress of plan implementation, soliciting feedback, and using feedback for improvements.

The Dallas EMA will utilize the current planning body that developed the CDC/HRSA Integrated HIV Prevention and Care Plan to have regular meetings to assess and evaluate progress made on the submitted plan. Like this plan, the ad hoc committee that will implement and evaluate the plan will be dynamic as well, as there will be efforts to improve representation of the at-risk populations. Representatives from this group will invite both CDC HIV Prevention and Ryan White Care providers to Ryan White Planning Council meetings to give quarterly feedback to the Ryan White Planning Council of the Dallas EMA and the public regarding this progress. Ryan White funded agencies, including CBOs and stakeholders, regularly attend these meetings, so all interested parties will be given the opportunity to be present at these meetings and solicit feedback for improvements to the work group that created the Integrated HIV Prevention and Care Plan. All Ryan White Planning Council meetings must comply with the Texas Open Meetings Act, which means that the public is notified of each meeting's agenda with no less than 72 hours of notice, which will help with the soliciting of feedback.

b. Describe plan to monitor and evaluate implementation of goals from Section II.

The CBOs, DCHHS, UTSW, Ryan White Part C and D Providers and other prevention funded entities will address each SMART objective throughout the duration of this plan. The ad hoc Integrated Plan committee will track the progress of each SMART objective and present them at the Ryan White Planning Council meetings when the quarterly reports are given as described above. There will also be a regular collection of data from agencies to provide a basis for evaluation and learning. Data and information from new HIV infections, routine testing, partner notifications, expanded preventative services, stigma and barrier breakdowns, community engagement, linkage to care, gaps in services, and HIV treatment disparities, that reflect the demographic from the partner agencies will guide the Dallas EMA to monitor and evaluate their goals, objectives and strategies in the Integrated HIV Prevention and Care Plan by the timeframe indicated in the plan. Each SMART objective has data indicators that will be measured by individual agencies, collected by the ad hoc Integrated Plan committee, and reported to the community at the Ryan White Planning Council meetings. After data is collected and analyzed, the ad hoc Integrated Plan committee will make adjustments to the plan as needed.

c. Describe strategy to utilize surveillance and program data to assess and improve health outcomes along HIV Care Continuum – strategic long range planning.

Epidemiologic data and information that is gathered by both local agencies carrying out activities outlined in this plan, as well as by the Texas Department of State Health Services, are needed to assess the projected need beyond the Integrated HIV Prevention and Care Plan by 2021 to support long-range improvement in health outcomes along the HIV Care Continuum. The data will be utilized to monitor which activities are effective, and where activities are effective amongst which populations. While the plan will be in place for 2017-2021, it will also be treated as a living document that will be adjusted throughout the implementation process. All adjustments during the implementation process will be data-driven adjustments. Surveillance and program data will assess populations in need and service gaps, as well as incidence and diagnosis among the current priority populations throughout the duration of this plan.

Glossary

AETC – AIDS Education and Training Center – Program supports the National HIV/AIDS Strategy by building clinician capacity and expertise along the HIV Care Continuum.

ARIES – AIDS Regional Information and Evaluation System – System used to collect and analyze the utilization of Ryan White services

CBO – Community Based Organization – public or private nonprofit that is representative of a community or a significant segment of a community and is engaged in meeting community needs, in this case, as related to HIV

Dallas EMA – Dallas Eligible Metropolitan Area - covers eight counties in north east Texas, including Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties.

DCHHS – Dallas County Health and Human Services. This agency serves as the administrative agency for Ryan White Part A, MAI, Part B, and Texas Department of State Health Services funds.

DSHS – Texas Department of State Health Services.

FQHCs – Federally Qualified Health Centers – include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid.

HOPWA – Housing Opportunities for Persons With AIDS – the only Federal program dedicated to the housing needs of people living with HIV/AIDS.

IDU – Intravenous Drug User – a person who introduces a drug into their bloodstream via a hollow hypodermic needle and syringe, which is pierced through the skin into the body.

MSM – Men who have sex with men

PLWH – People Living with HIV

UTSW – the University of Texas Southwestern Medical Center

Appendix A: NHBS and MMP

Medical Monitoring Project (MMP)

MMP collects behavioral and clinical information from a nationally representative sample of adults receiving medical care for HIV infection in outpatient facilities in the United States and Puerto Rico. The Texas and Houston MMP sites are two of 23 project areas that were funded to conduct data collection activities for the 2013 MMP data collection cycle. Patients who received medical care during January–April 2013 at an MMP participating facility were interviewed once during June 2013–April 2014 regarding HIV care experiences, health behaviors, risk behaviors, and unmet need during the 12 months preceding the interview. In addition, patients' medical records were abstracted for documentation of medical care including prescription of ART and HIV viral load and clinical outcomes for the 24 months preceding the interview. All percentages were weighted for the probability of selection and adjusted for nonresponse bias.

National HIV Behavioral Surveillance (NHBS)

NHBS is an ongoing behavioral surveillance system that collects cross-sectional data among populations at high risk for acquiring HIV, including men who have sex with men (MSM), injection drug users (IDU), and heterosexuals at high risk for HIV infection (HET). NHBS activities are implemented in one-year cycles so that data are collected from each risk group every three years; these study cycles are referred to as NHBS- MSM, NHBS-IDU, and NHBS-HET. Individuals who consent to participate undergo an anonymous interview, receive an HIV test and are given a monetary incentive for their participation.

Appendix B: Letter of Concurrence

Mrs. Frances Hodge

Dear Mrs. Hodge:

The Ryan White Planning Council of the Dallas Area concurs with the following submission by Dallas County Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body leadership has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The signature(s) below confirms the concurrence of the planning body leadership with the Integrated HIV Prevention and Care Plan.

Signature:



Date:

Sept. 26, 2016

Planning Body Chairs



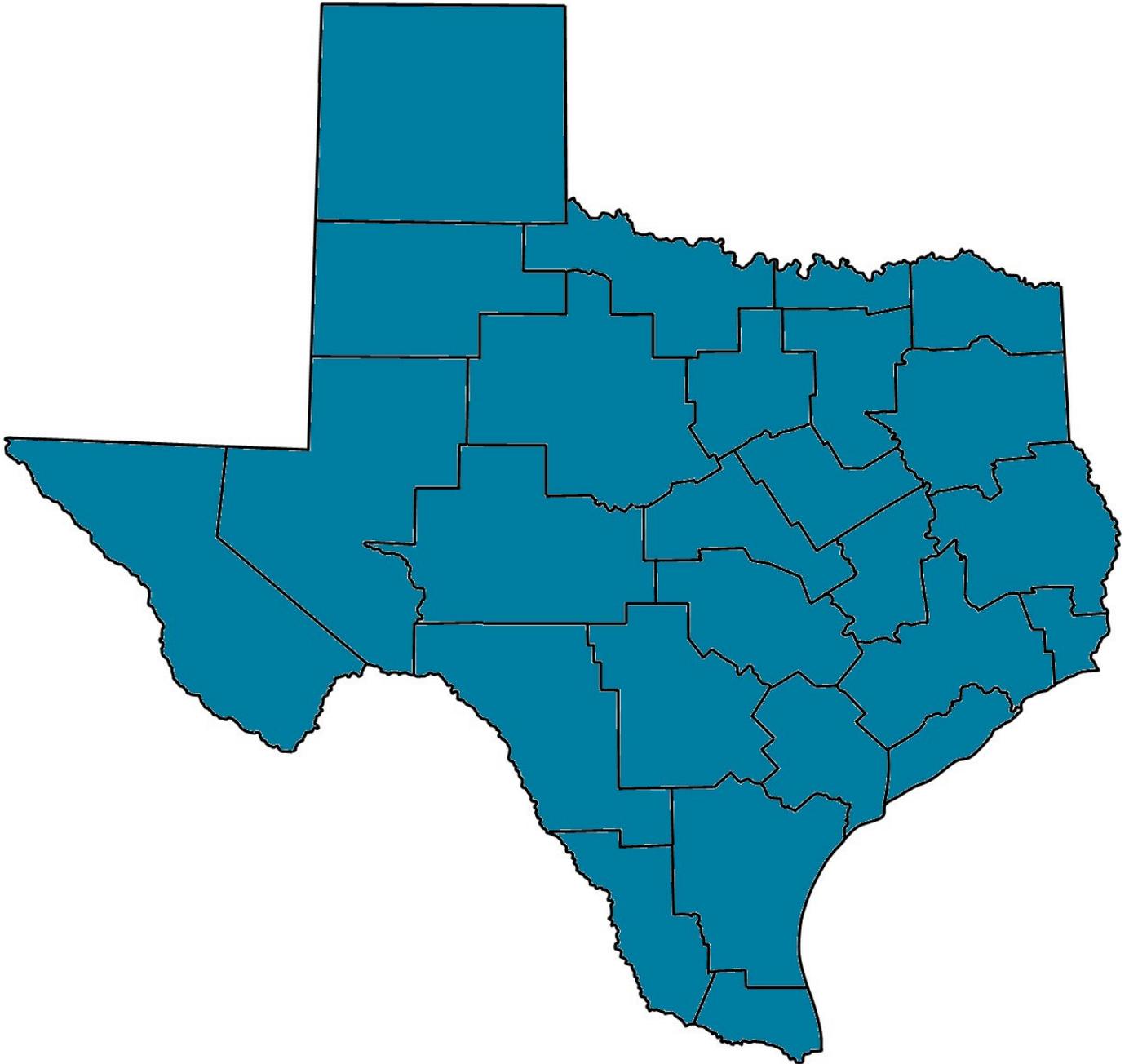
Sept 26, 2016



9-30-16

2018 HIV CONTINUUM OF CARE

TEXAS



www.achievingtogethertx.org

DATA SOURCES

The data contained in this report is compiled by the Texas Department of State Health Services; HIV/STD Branch.

*Data sources include: Enhanced HIV AIDS Reporting System (as of July 2, 2017), Medicaid, ARIES (Ryan White Program database), ADAP (AIDS Drug Assistance Program), STD*MIS (Prevention and Public Health Follow Up database), the Texas Medical Monitoring Project and private insurance data.*

TERMINOLOGY & ABBREVIATIONS

PLWH—People Living With HIV

HSDA—HIV Service Delivery Area (based on HIV Care & Treatment funding)

Mode of Exposure—How a person acquired HIV—a person’s biological sex (i.e. sex assigned at birth) is used to determine mode of exposure

- **Male-Male Sexual Contact**—HIV acquisition most likely occurred due to sexual contact between two men
- **Injection Drug Use**—HIV acquisition most likely occurred due to injection drug use
- **Male-Female Sexual Contact**—HIV acquisition most likely occurred due to sexual contact between a man and a woman.

Priority Populations—Populations who are disparately and disproportionately impacted by HIV

Latinx—a gender neutral term used in place of Latino or Latina

Latinx MSM—Latinx gay, bisexual and other cisgender Men who have Sex with Men

White MSM—White gay, bisexual and other cisgender Men who have Sex with Men

Black MSM—Black gay, bisexual and other cisgender Men who have Sex with Men

Black Women—Black cisgender Women who have sex with men

Transgender People—includes both transgender men and transgender women. A significant majority of Transgender PLWH are transgender women.

Latinx Women—Latinx cisgender Women who have sex with men

PWID—People Who Inject Drugs

PrEP—Pre-Exposure Prophylaxis—HIV Prevention Medication

nPEP—non-occupational Post-Exposure Prophylaxis

Behavioral Interventions—interventions designed to change behaviors that make people more vulnerable to acquiring HIV. These can include individual, group and community level interventions.

Retention in Care—2 contacts with the care system, at least 3 months apart in the calendar year (contacts include a visit with a medical provider, HIV lab work, or and ART prescription)

Viral Suppression—a viral load \leq 200 copies/ml

In-Care Viral Suppression—Viral Suppression among PLWH who have achieved Retention in Care

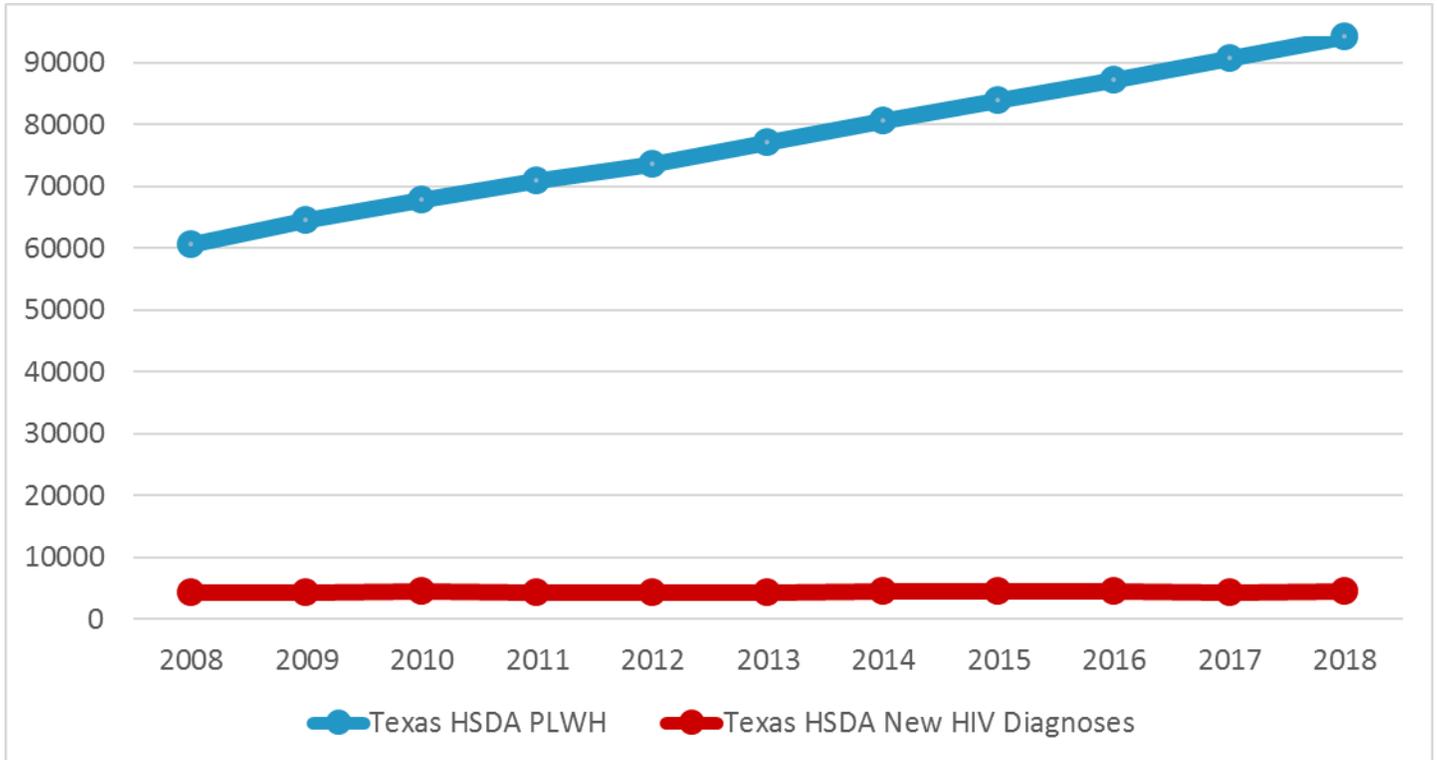


EPI PROFILE

People Living With HIV (PLWH) and New HIV Diagnoses

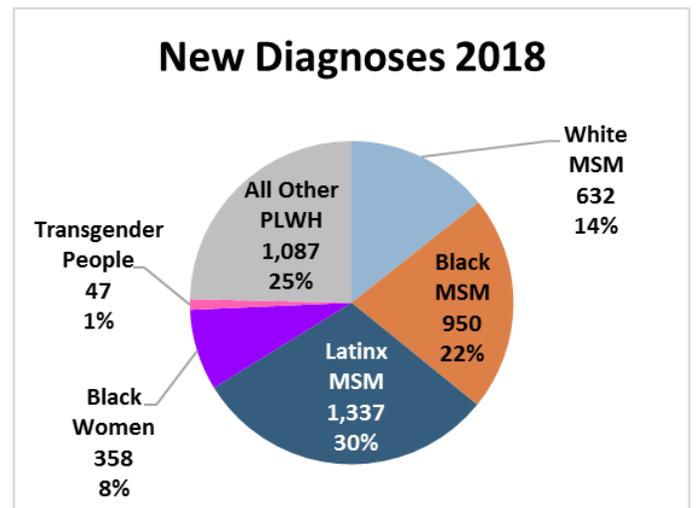
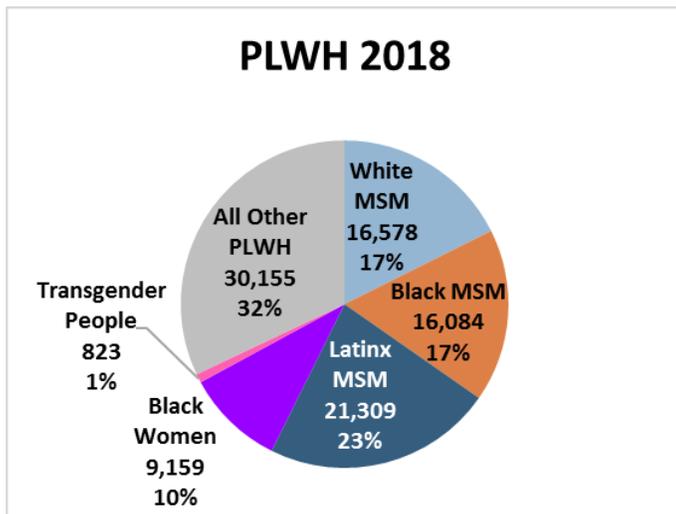
In Texas, the number of new HIV diagnoses has remained flat and stable for the past several years.

There were **94,106 people living with HIV (PLWH)** in this area as of the end of 2018. In 2018, **4,410 people were newly diagnosed with HIV**. This includes only people with diagnosed HIV with a current address in this area. People with undiagnosed HIV are not included.



Priority Populations (68% of PLWH, 75% of New HIV Diagnoses)

Priority populations make up the majority of PLWH and the majority of new diagnoses. Latinx MSM are the largest priority population among PLWH and among new HIV diagnoses.

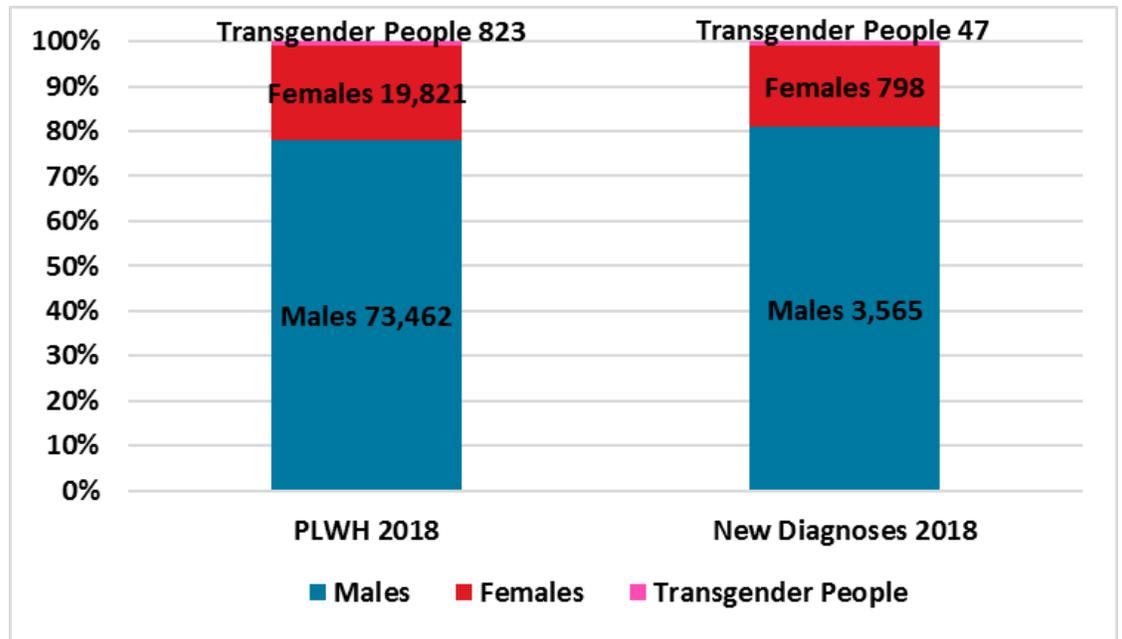


Gender

Males make up the majority of PLWH and the majority of new HIV diagnoses.

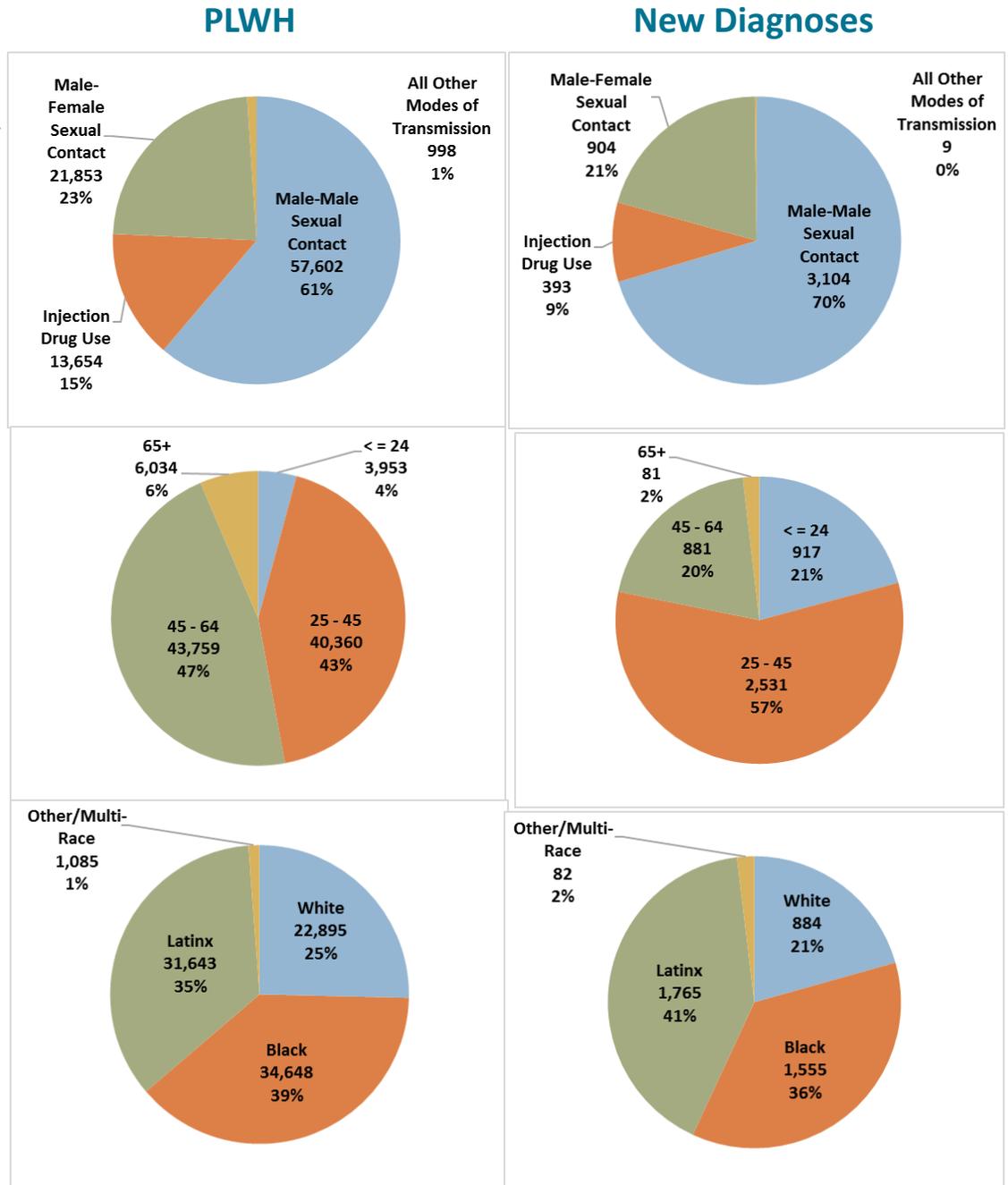
Note

Due to current reporting methods, the number of transgender PLWH are most likely underreported.



Mode of Exposure

Male-Male Sexual Contact makes up the primary mode of acquisition among PLWH and among new diagnoses.



Age

The majority of PLWH are people 45-64; the majority of new diagnoses are among people 25-45.

Race/Ethnicity

The majority of PLWH are Black and the majority of new diagnoses are among Latinx individuals.

FOCUSED PREVENTION

Focused Prevention involves ensuring that HIV prevention efforts are centered around those populations and communities where HIV is most heavily concentrated. These populations are often disparately impacted by HIV and any efforts to significantly reduce new HIV incidence must focus on meeting the needs of these groups. Focused Prevention interventions are based on the concept of Combination Prevention. Combination Prevention values client autonomy and includes Behavioral Interventions, Condoms/Lubricant, HIV/STI Testing, and Biomedical Interventions like PrEP, nPEP and Treatment as Prevention (TasP).

Texas' goal is that all people with increased vulnerabilities to acquiring HIV have equitable access to Combination Prevention.

Statewide Relevant Populations for Prevention

In Texas, HIV prevention efforts should be centered around these populations:



Latinx MSM



White MSM



Black MSM



Black Women



Transgender
People

Prevention Interventions—DSHS Funded (see [Appendix A](#) for intervention descriptions)

- [Routine HIV Screening in Health Care Settings](#)
- [Core HIV Prevention](#)
- [PrEP and nPEP](#)
- [Client Level Interventions](#)
- [Structural Intervention](#)

FULL DIAGNOSIS

Texas' goal is that 90% of all PLWH know their status by 2030.

Primary Diagnosing Facilities 2013-2018

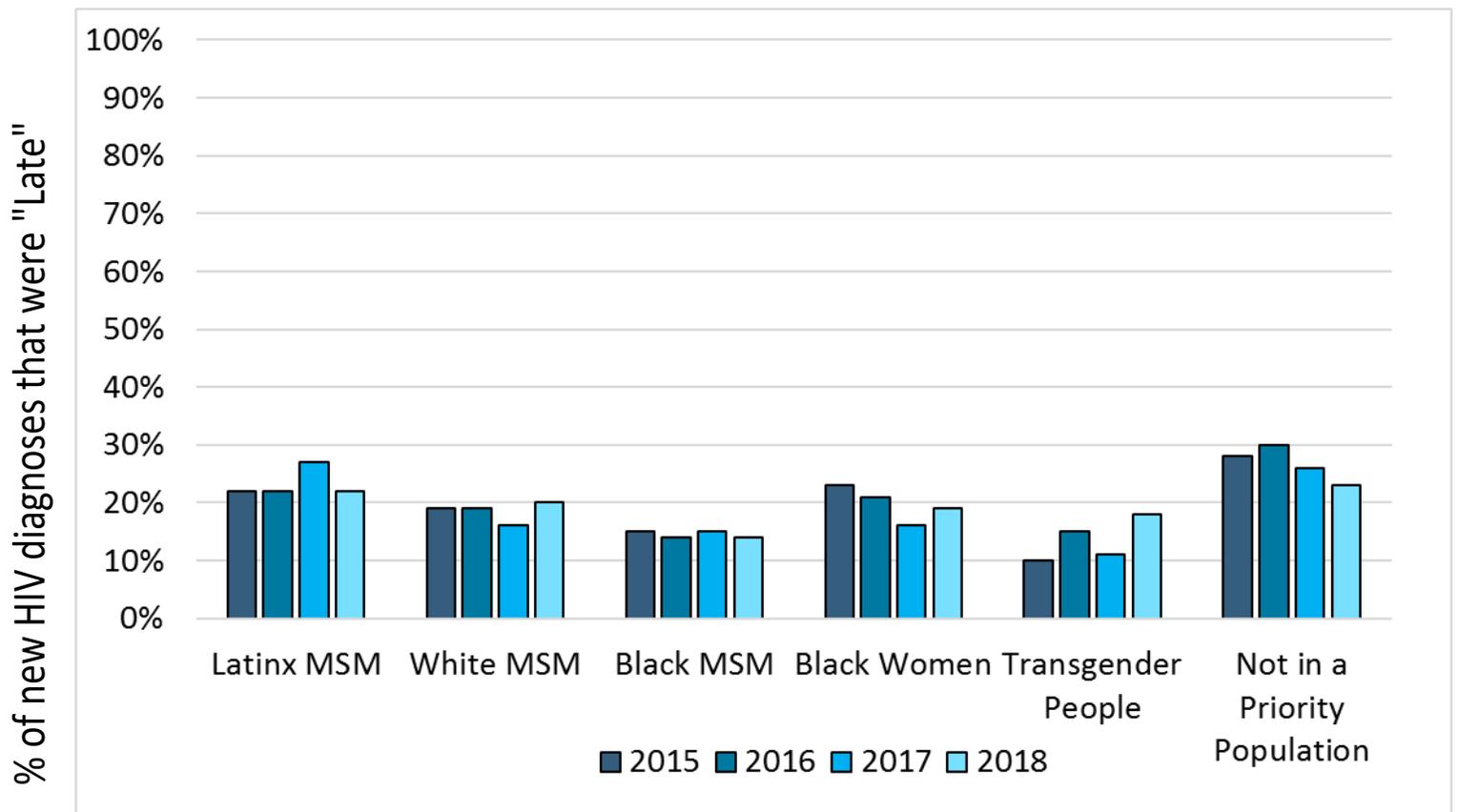
These are the top 10 diagnosing facilities in the state

Diagnosing Facility	Total # Diagnosed	Diagnosing Facility	Total # Diagnosed
Legacy CHS—Houston	666	San Antonio Metro HD—STD Clinic	431
Houston Health Clinic	598	Ben Taub GH—Houston	427
Parkland Memorial Hospital—Dallas	592	Parkland—ER—Dallas	361
Resource Center—Nelson-Tebedo—Dallas	516	LBJ Hospital—Houston	276
Dallas Co HHS—STD Clinic	514	Hospital District Clinic—Houston	270

Late Diagnosis 2014—2017

A “late diagnosis” is when a person receives a Stage 3/AIDS diagnosis within 3 months of their initial HIV diagnosis. Studies have linked late HIV diagnoses to slower CD4 gains, faster disease progression and higher mortality.

Late diagnoses among Black Women have been decreasing over the past few years.



SUCCESSFUL LINKAGE

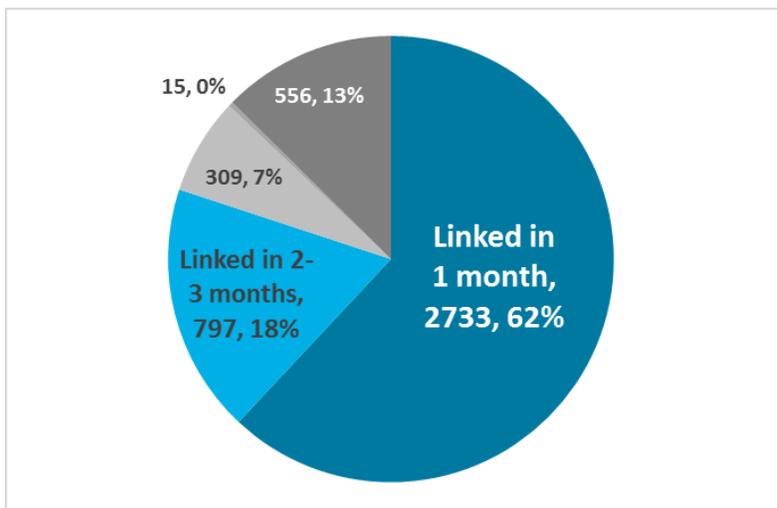
We know that treatment for HIV keeps PLWH healthier longer and reduces deaths, but it is most effective if treatment starts soon after the diagnosis is made. Linkage refers to the time it takes from the person's diagnosis to when they have their first episode of HIV medical care.

Texas' goal is for 90% of all people newly diagnosed with HIV to be linked to care within 3 months.

Timely Linkage—2017

80% of people diagnosed with HIV in Texas in 2017 were linked to care within 3 months.

Linkage to care is a priority



Linked in 1 month	2,733	62%
Linked in 2-3 months	797	18%
Linked in 4-12 months	309	7%
Linked in 12+ months	15	<1%
No Evidence of Linkage	556	13%

Timely Linkage—Priority Populations—2012-2017

Coming Soon

RETENTION IN CARE. VIRAL SUPPRESSION

Retention in Care and Viral Suppression are two key measures that help us understand individual level health, efficacy of HIV care systems, and Community Viral Load. **Retention in Care** is defined as at least 2 contacts with the care system during the year (either an HIV medical appointment, HIV lab work, or an ART prescription). **Viral Suppression** is defined as a viral load that's less than/equal to 200 copies/ml. For these purposes we're looking at the last viral load of the year.

Studies have shown that PLWH who are able to maintain viral suppression (for at least 6 months) can not transmit HIV.

Health Outcomes—Stoplight System

Texas' goals by 2030 are:

90% PLWH retained in HIV care & treatment

90% of those retained achieve viral suppression

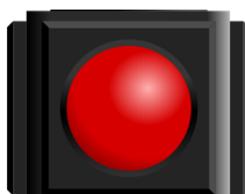
Communities and populations are prioritized using the following color coding system:

On ART /
Retention In Care

On ART/In-Care
Viral Suppression

< 69%

< 84%



Stop and examine further, May be a priority

70% - 89%

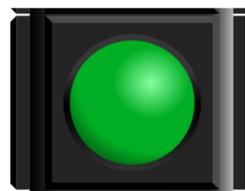
85% - 89%



May need to examine further, May not be a priority

90% <

90% <

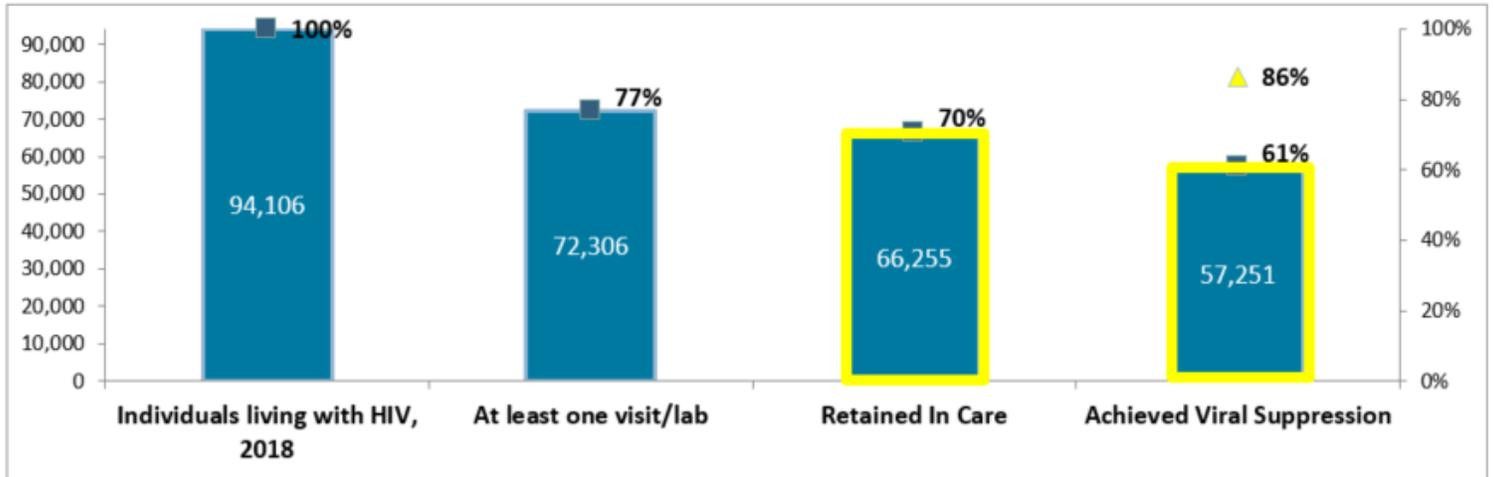


Maintain Current Activities, Look for Promising Practices

2018 Care Continuum

In Texas, 70% of PLWH have achieved retention in care, 61% of total PLWH have achieved viral suppression, and 86% of PLWH who are retained in care achieved viral suppression. Retention in care is a priority area for the overall state.

HIV Treatment Cascade for Texas, 2018



77% of PLWH had at least 1 episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care



61% of PLWH achieved viral suppression (last viral load of the year was <200 copies/ml). This means 6 out of 10 PLWH achieved viral suppression.

This is community viral suppression



70% of PLWH were retained in care (at least 2 episodes of HIV care & treatment across the year). This means 7 out of 10 PLWH were retained in care.



Of those 7 out of 10 PLWH retained in care, 86% , or roughly 6 of those 7 achieved viral suppression.

This is in-care viral suppression.

2018 Continuum of Care, Parity Table

Communities with the fewest opportunities to achieve retention are people under the age of 45, PWID, Latinx PLWH, people who acquired HIV through male-female sexual contact and Black PLWH, specifically Black MSM And Black Women

The communities with the fewest opportunities to achieve viral suppression even when retained in care are people under the age of 45, Transgender PLWH, Women, people who acquired HIV through male-female sexual contact, and Black PLWH, specifically Black MSM, Black Women.

People over the age of 65 White MSM and Latinx MSM have achieved In-Care Viral Suppression goals.

90% PLWH retained in HIV care & treatment

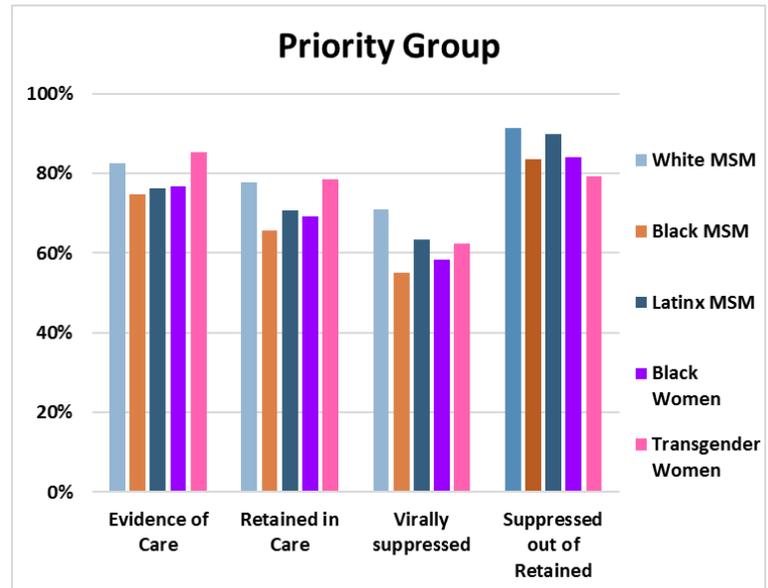
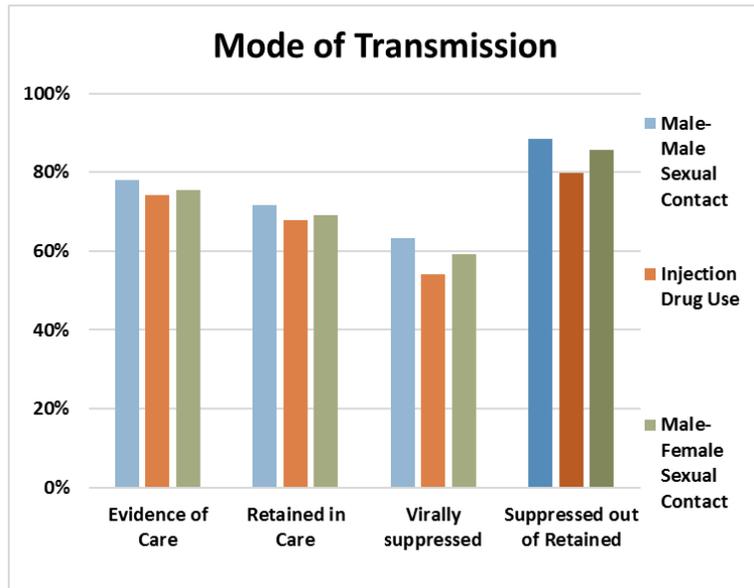
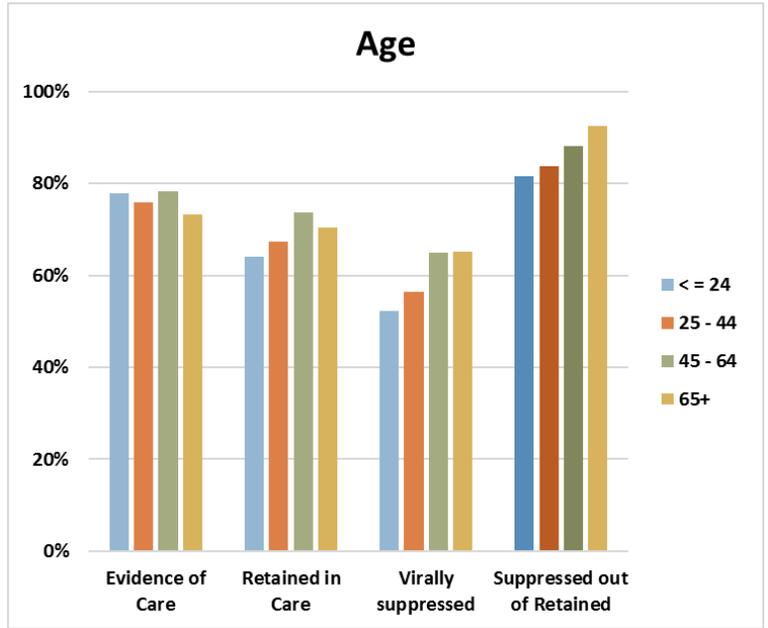
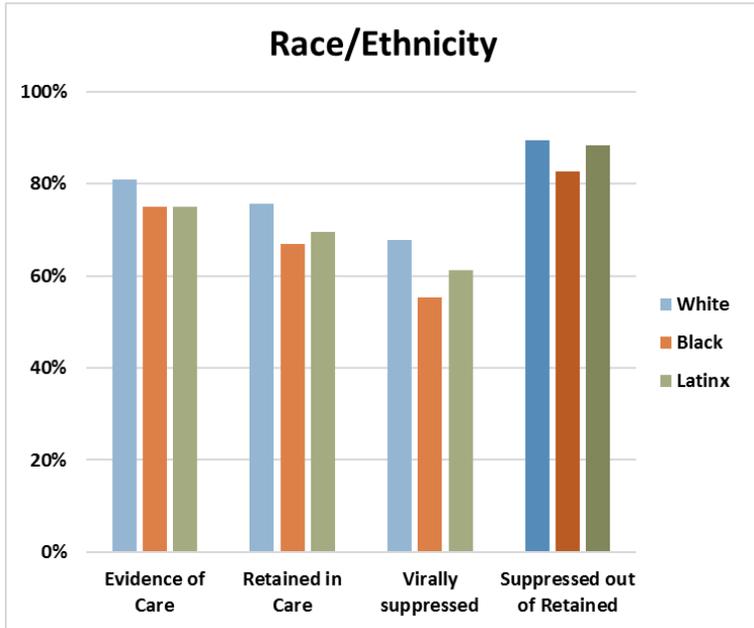
90% of those retained achieve viral suppression

	PLWH		Evidence of Care (At least one visit)		Retained in Care		Suppressed		% sup-pressed of those retained
	#	%	#	%	#	%	#	%	%
All PLWH	94,106	100%	72,306	77%	66,255	70%	57,251	61%	86%
Women	19,821	21%	15,299	77%	13,990	71%	11,799	60%	84%
Men	73,462	78%	56,304	77%	51,618	70%	44,939	61%	87%
Transgender People	823	1%	703	85%	647	79%	513	62%	79%
White	22,895	24%	18,538	81%	17,328	76%	15,493	68%	89%
Black	34,648	37%	25,981	75%	23,217	67%	19,182	55%	83%
Latinx	31,643	34%	23,715	75%	21,972	69%	19,392	61%	88%
<=24	3,953	4%	3,074	78%	2,531	64%	2,066	52%	82%
25 – 44	40,360	43%	30,577	76%	27,216	67%	22,804	57%	84%
45-64	43,759	46%	34,231	78%	32,258	74%	28,452	65%	88%
65+	6,034	6%	4,424	73%	4,250	70%	3,929	65%	92%
Male-Male Sexual Contact	57,602	61%	44,957	78%	41,246	72%	36,549	63%	88%
Injection Drug Use	13,654	15%	10,146	74%	9,275	68%	7,396	54%	80%
Male-Female Sexual Contact	21,853	23%	16,514	76%	15,102	69%	12,918	59%	86%
White MSM	16,577	18%	13,667	82%	12,869	78%	11,742	71%	91%
Black MSM	16,084	17%	12,015	75%	10,571	66%	8,839	55%	84%
Latinx MSM	21,309	23%	16,256	76%	15,038	71%	13,495	63%	90%
Black Women	9,158	10%	7,023	77%	6,342	69%	5,334	58%	84%
Transgender Women	800	1%	687	86%	632	79%	498	62%	79%

Note

Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

2018 Continuum of Care, Parity Bar Charts

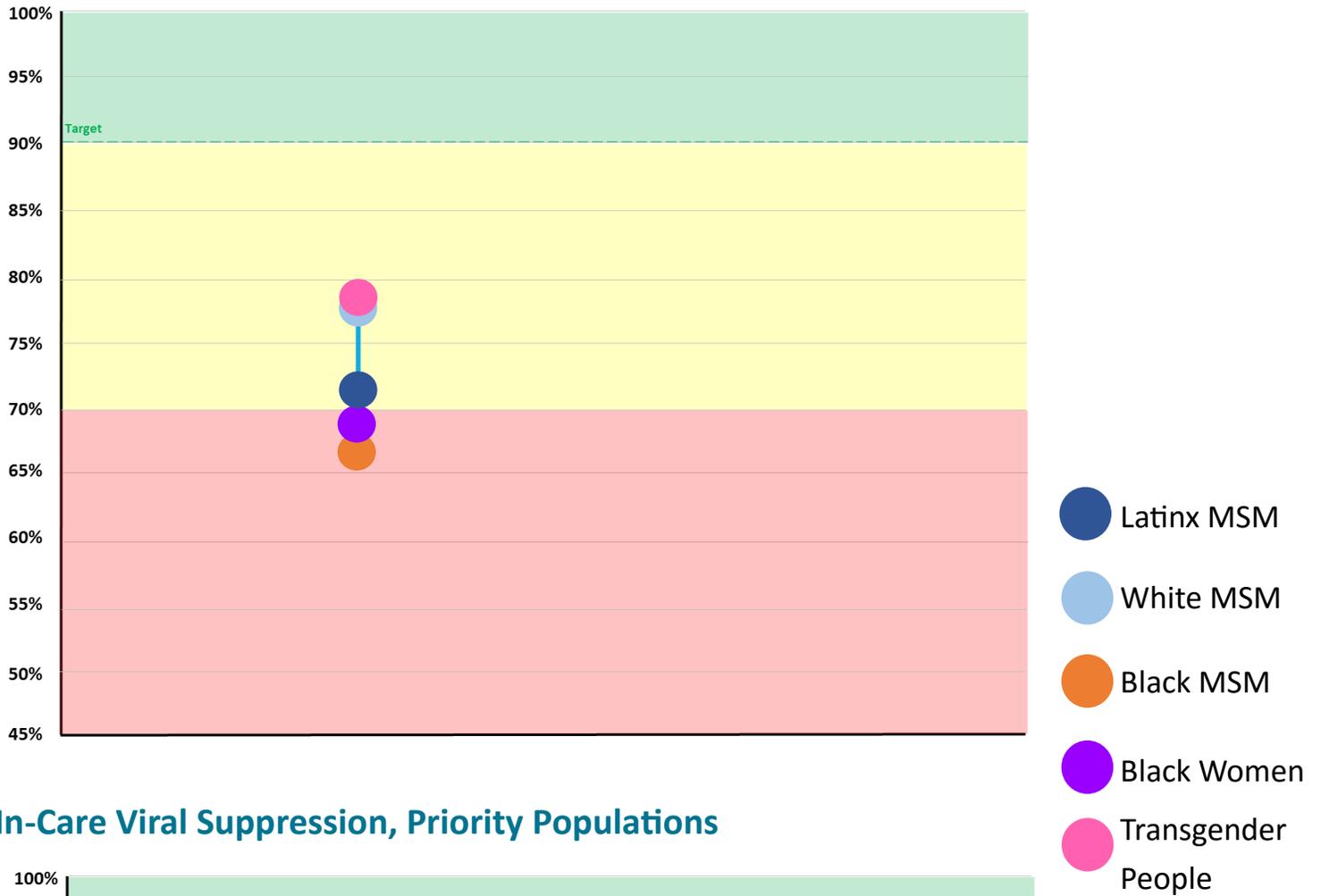


Note

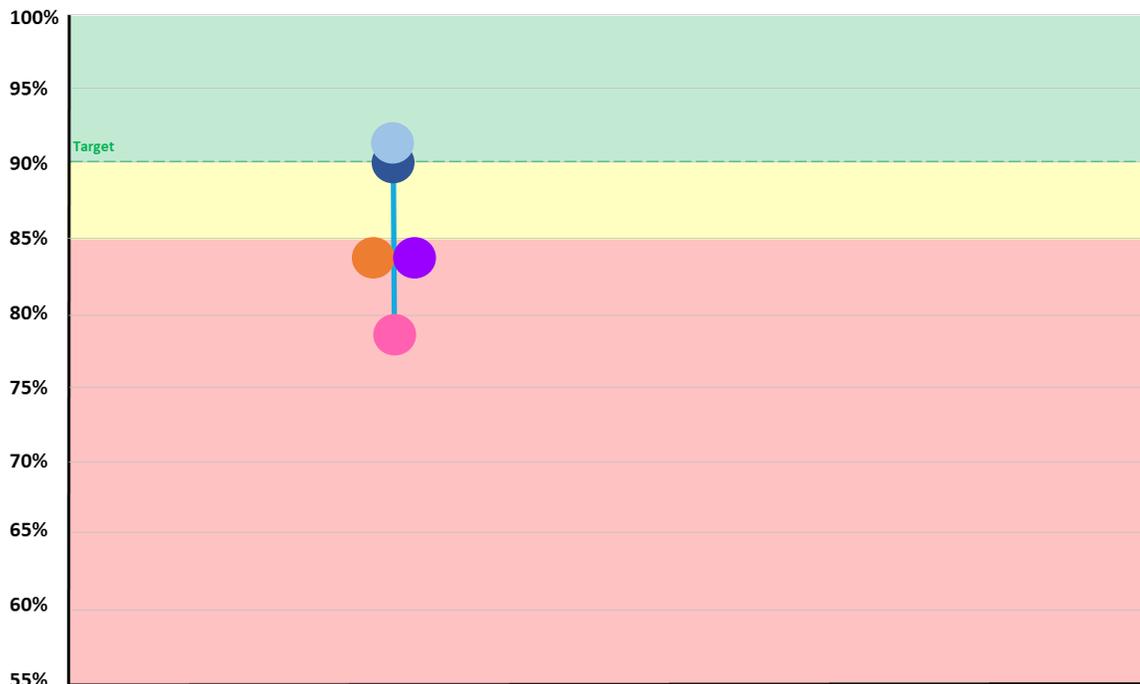
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

2017 Continuum of Care, Priority Populations, Stoplight System

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations

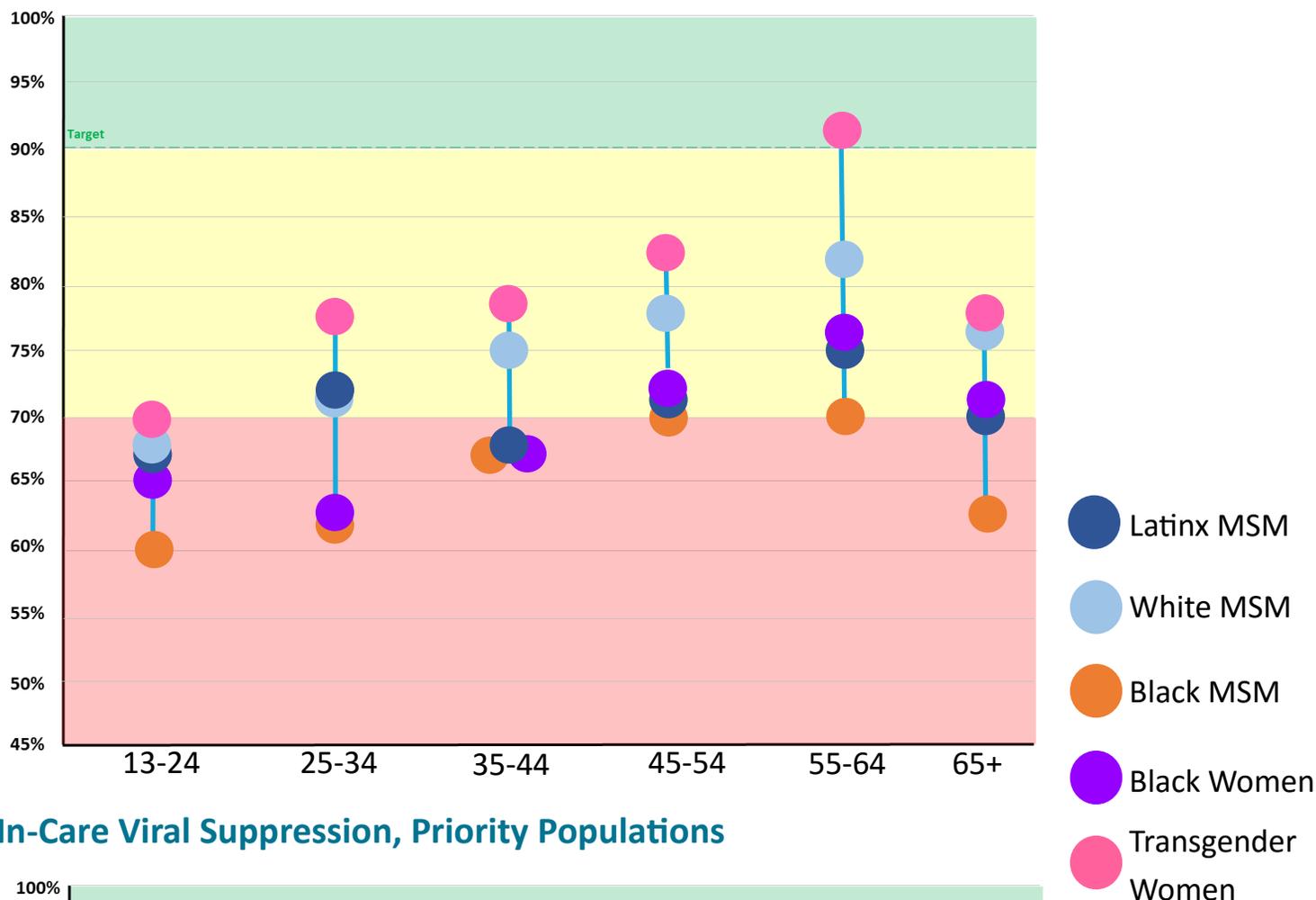


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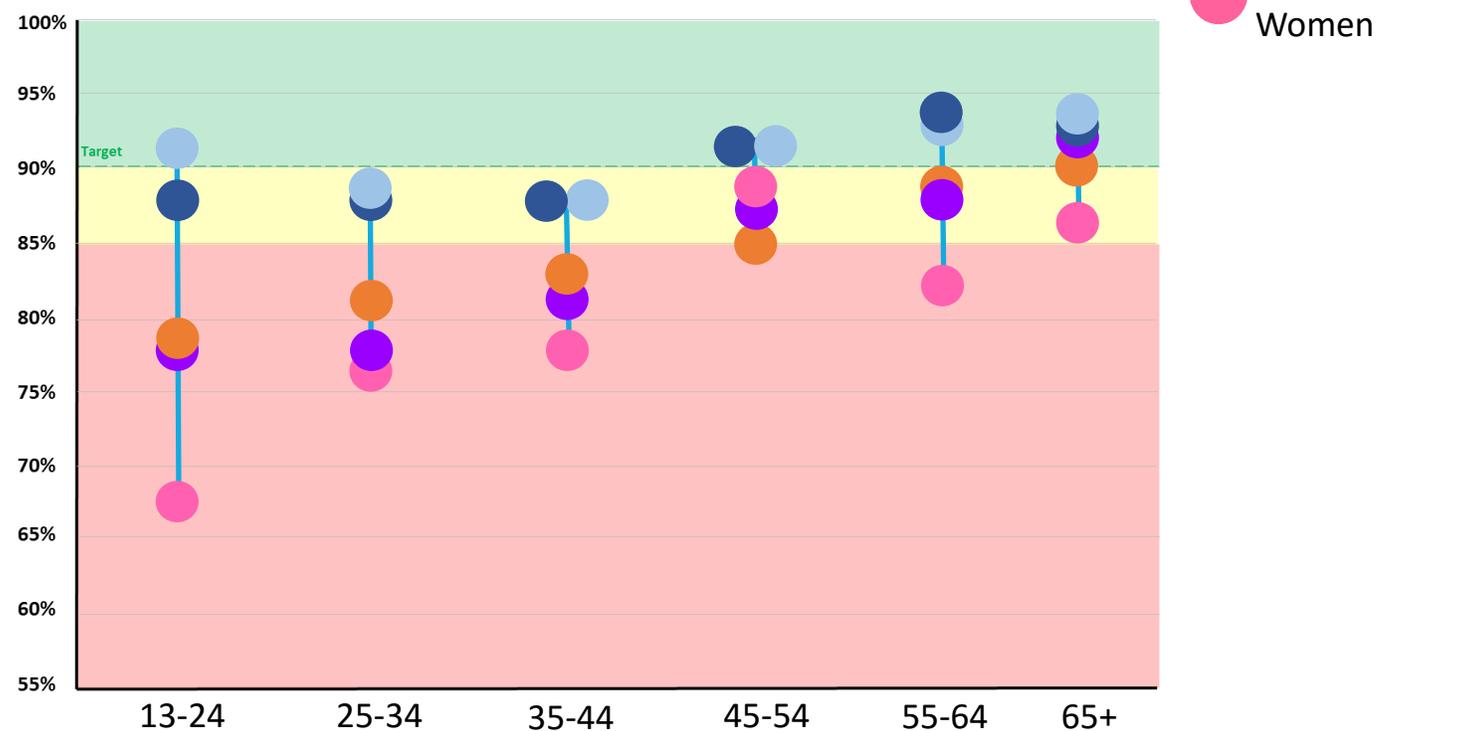
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

2018 Continuum of Care, Priority Populations by age, Stoplight System

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations

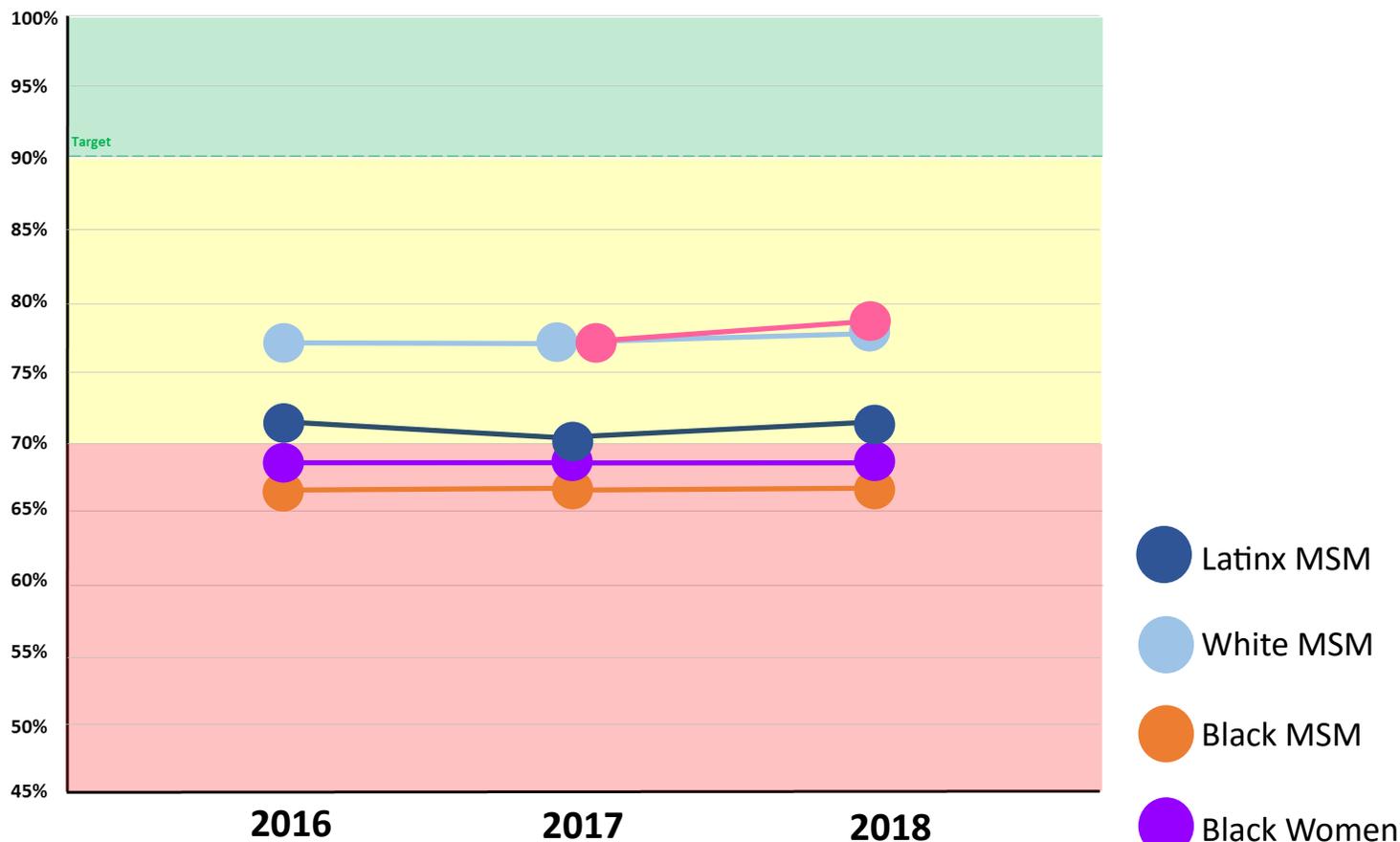


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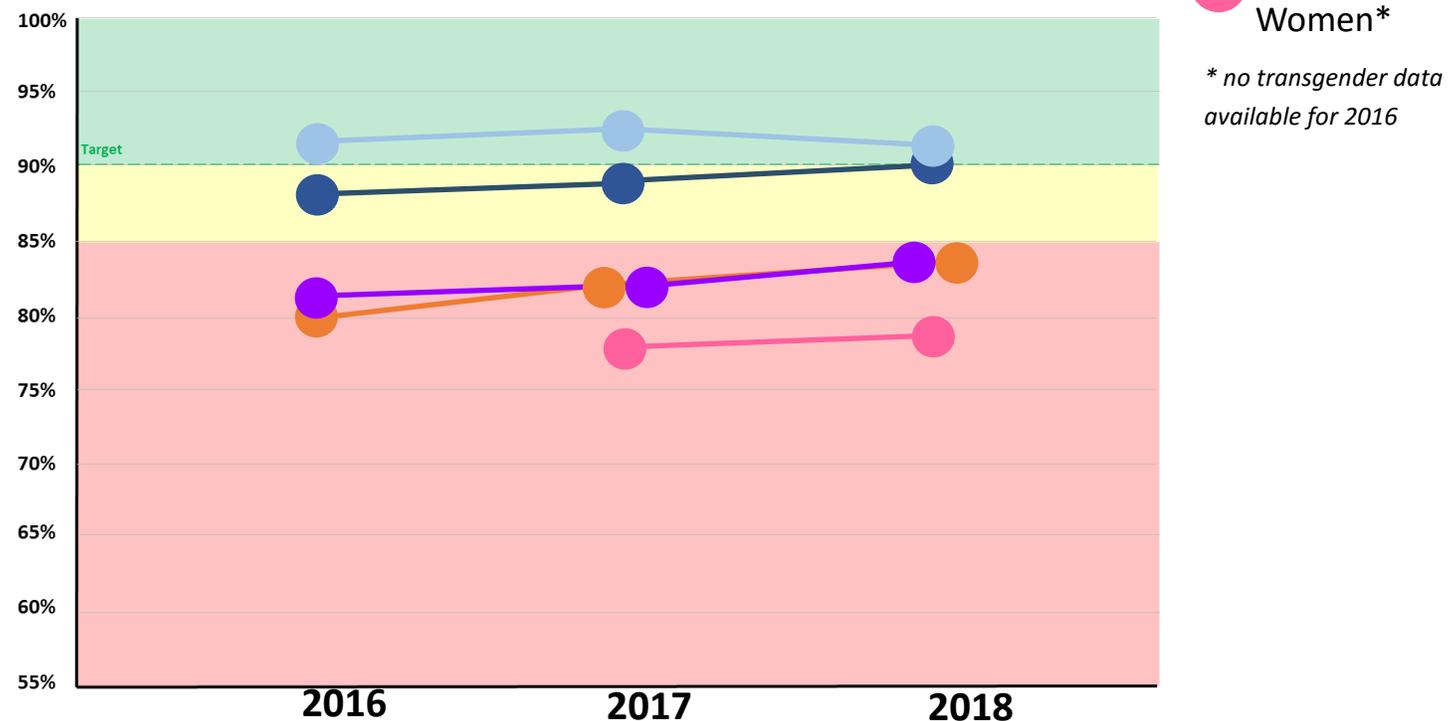
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

Continuum of Care, Priority Populations, Stoplight System 2016-2018

Retention in Care, Priority Populations



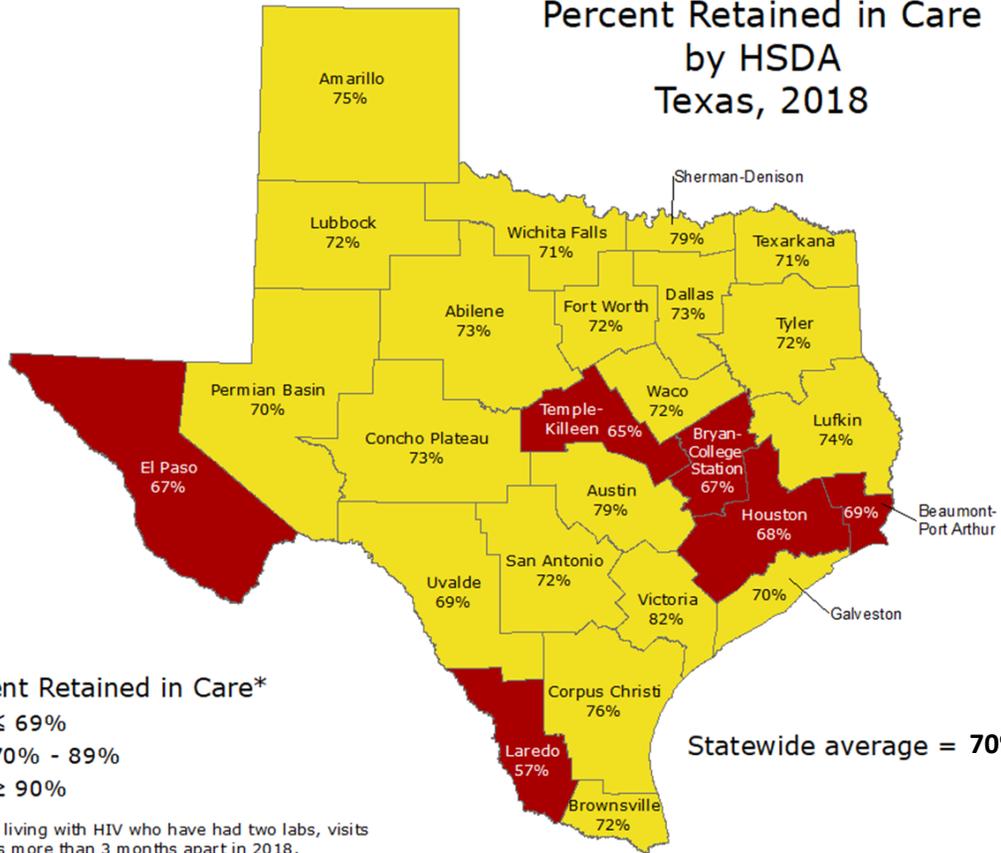
In-Care Viral Suppression, Priority Populations



Note

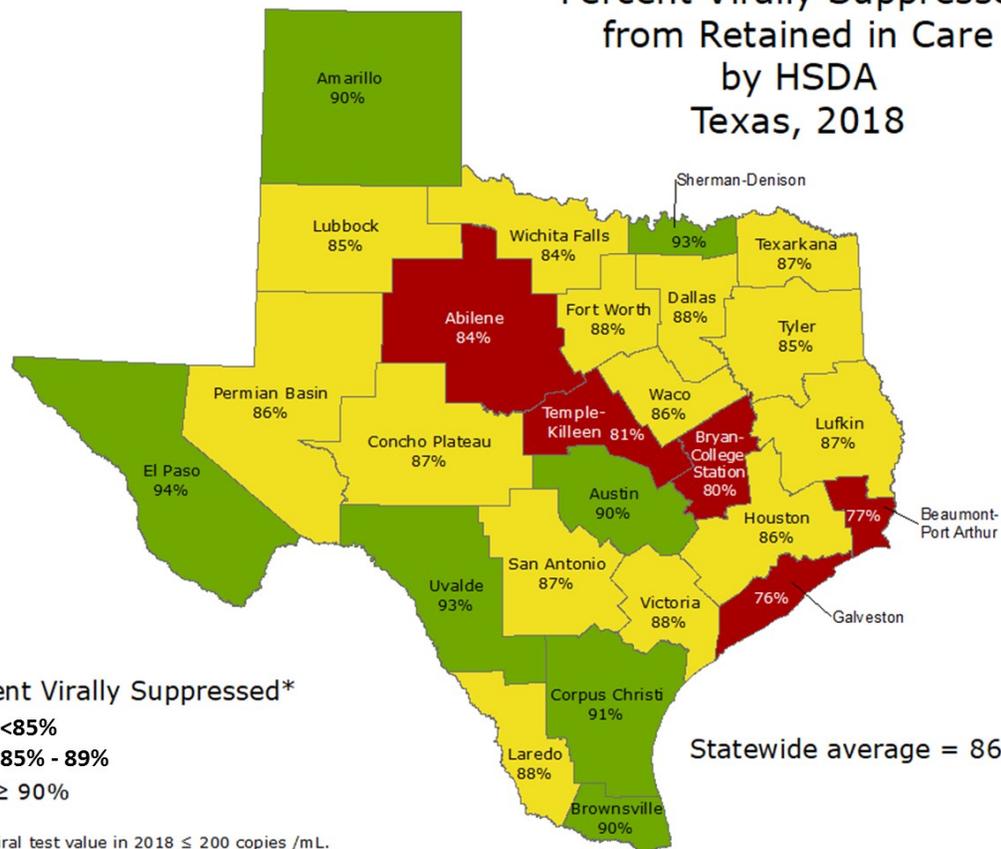
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

Percent Retained in Care by HSDA Texas, 2018



Source: Texas eHARS, 2019

Percent Virally Suppressed from Retained in Care by HSDA Texas, 2018



Source: Texas eHARS, 2019

Targets

The number of people who need to be able to access and engage with our systems in order to equitably meet our 90-90 goals (based on current number of PLWH who know their status).

90% PLWH retained in HIV care & treatment

90% of those retained achieve viral suppression

	PLWH		Retained in Care		90% Retained goal	Gap	Suppressed	90% In-Care Viral Suppression goal	Gap
	#	%	#	%	#	#	#	#	#
All PLWH	94,106	100%	66,255	70%	84,695	18,440	57,251	76,226	18,975
Women	19,821	21%	13,990	71%	17,839	3,849	11,799	16,055	4,256
Men	73,462	78%	51,618	70%	66,116	14,498	44,939	59,504	14,565
Transgender People	823	1%	647	79%	741	94	513	667	154
White	22,895	24%	17,328	76%	20,606	3,278	15,493	18,545	3,052
Black	34,648	37%	23,217	67%	31,183	7,966	19,182	28,065	8,883
Latinx	31,643	34%	21,972	69%	28,479	6,507	19,392	25,631	6,239
<=24	3,953	4%	2,531	64%	3,558	1,027	2,066	3,202	1,136
25 – 44	40,360	43%	27,216	67%	36,234	9,108	22,804	32,692	9,888
45-64	43,759	46%	32,258	74%	39,383	7,125	28,452	34,445	6,993
65+	6,034	6%	4,250	70%	5,431	1,181	3,929	4,888	959
Male-Male Sexual Contact	57,602	61%	41,246	72%	51,842	10,596	36,549	46,658	10,199
Injection Drug Use	13,654	15%	9,275	68%	12,288	3,013	7,396	11,059	3,663
Male-Female Sexual Contact	21,853	23%	15,102	69%	19,668	4,556	12,918	17,701	4,783
White MSM	16,577	18%	12,869	78%	14,920	2,051	11,742	13,428	1,686
Black MSM	16,084	17%	10,571	66%	14,476	3,905	8,839	13,028	4,189
Latinx MSM	21,309	23%	15,038	71%	19,178	4,140	13,495	17,260	3,765
Black Women	9,158	10%	6,342	69%	8,243	1,901	5,334	7,419	2,085
Transgender Women	800	1%	632	79%	720	88	498	648	150

Note

Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

Appendix A: Prevention Interventions

The following are brief overviews of DSHS funded HIV prevention activities. With the exception of Routine HIV Screening in Health Care Settings, all prevention activities are focused on populations who have increased vulnerabilities to acquiring HIV. See the Focused Prevention section for locally relevant populations who are appropriate for Focused Prevention activities.



Routine Screening in Health Care Settings

The CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care and those with increased vulnerabilities to HIV (including gay, bisexual and other men who have sex with men) get tested more frequently. DSHS funded Routine Screening programs are opt-out testing programs and can be found in a variety of facilities, including hospital emergency departments, community health centers, and jail medical services.

Activities conducted in Routine Screening programs must include:

- [Routine HIV screening and notification of HIV-positive results](#); and
- Linkage to and engagement in HIV medical care for people with HIV-positive test results

More information on evidence-based linkage programs can be found at the CDC in the [Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention](#)



Core HIV Prevention

Core HIV Prevention programs must include the following activities:

- Engaging populations with increased vulnerability to HIV
- Condom distribution
- [Focused HIV and syphilis testing in non-clinical settings](#) (emphasis on locations with high probability of encountering the locally relevant population for focused prevention)
- Linkage to and engagement in HIV medical care for people with HIV-positive test results; and
- Referral to PrEP, nPEP and other needed services for people with HIV-negative test results and increase vulnerabilities to acquiring HIV

More information on evidence-based linkage programs can be found at the CDC in the [Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention](#)

Appendix A: Prevention Interventions, continued



PrEP and nPEP

The CDC states that when taken daily, PrEP is highly effective for preventing HIV. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74% when taken daily.

PEP is also highly effective at preventing HIV. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure.

Activities conducted in PrEP and nPEP programs must include:

- Promotion and marketing of PrEP/nPEP through community education and awareness activities
- Promotion of adoption of PrEP/nPEP by local clinical providers; and
- Delivery of PrEP/nPEP clinical and client support services (this funding may not be used to pay for PrEP/nPEP medications, but it may be used for: navigation staff, clinical staff, initial and ongoing medical testing, adherence counseling and benefits counseling).



Client Level Interventions

Client Level Interventions are evidence-based or practice-based behavioral interventions delivered to individuals or groups that have shown effectiveness in preventing HIV transmission and acquisition. These interventions may be focused on both PLWH or HIV-negative people with increased vulnerabilities to acquiring HIV. Programs funded through DSHS may use approved “homegrown” interventions, or one of the CDC interventions listed in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention.

Currently funded interventions in Texas include:

- Healthy Relationships
- Personalized Cognitive Counseling
- CLEAR
- Many Men, Many Voices
- Behavioral Health
- Connect
- ¿ Y Ahora Que?
- VOICES/VOCES

Appendix A: Prevention Interventions, continued



Structural Interventions

Structural interventions are projects implemented at the community or system level in order to reduce the risk of HIV transmission and acquisition. These programs must work to reduce health inequities, and new HIV infections by directly addressing the social determinants of health such as stigma, lack of support, or policies or organizational practices that create barriers to prevention and treatment. Activities must be centered on one or more of the outcomes below:

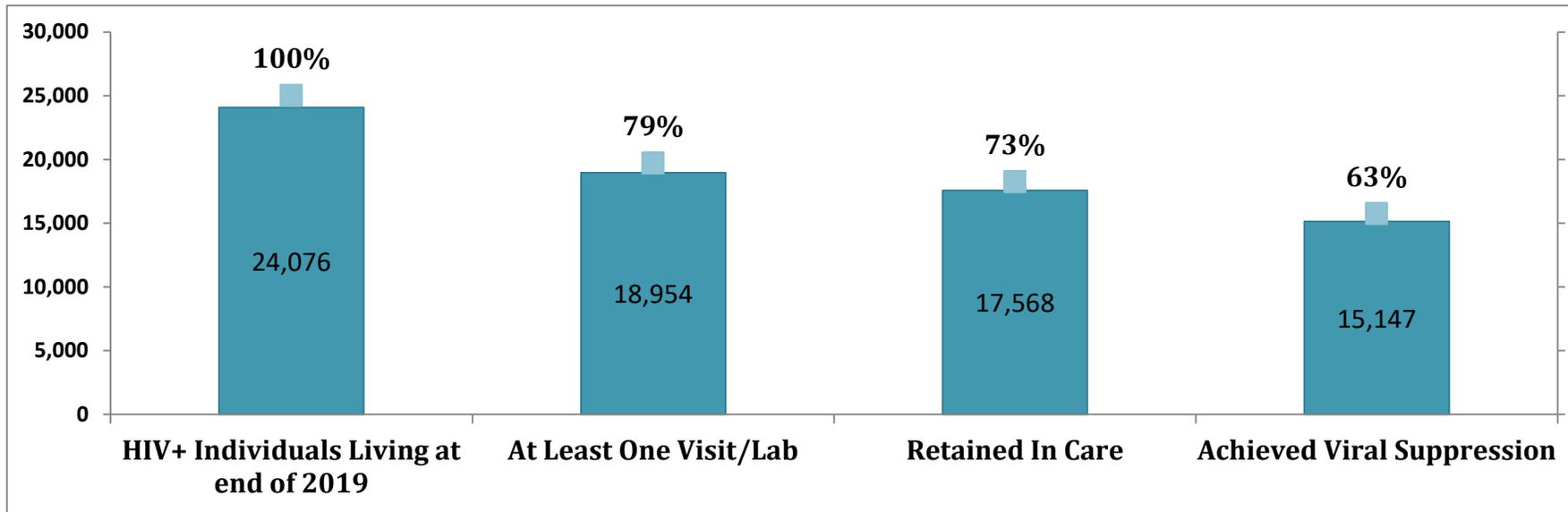
- Strengthening community involvement in HIV prevention efforts by increasing a sense of community ownership, participation, and collaboration in HIV prevention activities;
- Increasing local coordination and collaboration among community members, groups, organizations, and sectors (e.g., private business, public institutions);
- Increasing community support, education, and dialogue;
- Creating an environment in which people of color, LGBTQ individuals, youth, and other marginalized populations are empowered to reduce the risk of HIV acquisition and barriers to accessing HIV prevention are reduced/eliminated;
- Elimination of structural, social, and economic barriers related to healthcare;
- Improved health outcomes for LGBTQ communities and people of color; and
- Increased participation in HIV-related care and PrEP\

Programs may use ‘traditional’ community-level interventions as part of their structural intervention. Programs funded through DSHS may use approved “homegrown” interventions, or one of the CDC interventions listed in the [Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention](#), or one of the Community and Structural-level interventions found on the CDC’s [Effective Interventions](#).

Currently funded interventions in Texas:

- [MPowerment](#)
- Stigma Reduction
- [Community PROMISE](#)
- Addressing Stigma

Texas HIV Treatment Cascade for Dallas EMA, 2019



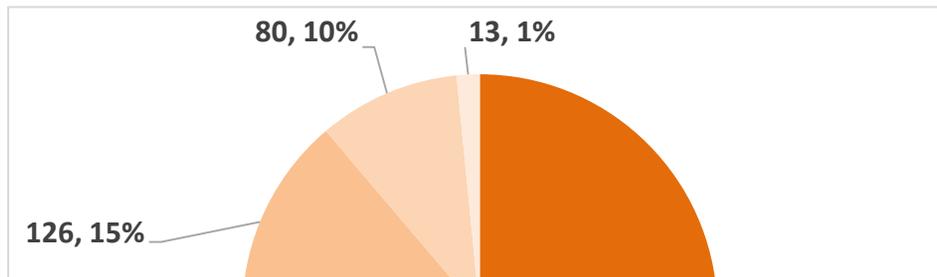
HIV+ Individuals at end of 2019 - No. of HIV+ individuals (alive) at the end of 2019.

At Least One Visit in 2019 - No. of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2019.

Retained in Care is number of PLWH with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2019.

Achieved Viral Suppression at end of 2019 - No. of PLWH whose last viral load test value of 2019 was ≤ 200 copies/mL.

Linkage to Care



Linked in 1 month	610	66%
Linked in 2-3 months	126	14%
Linked in 4-12 months	80	9%
Linked in 12+ months	13	1%



