

Ending the Epidemic in Texas

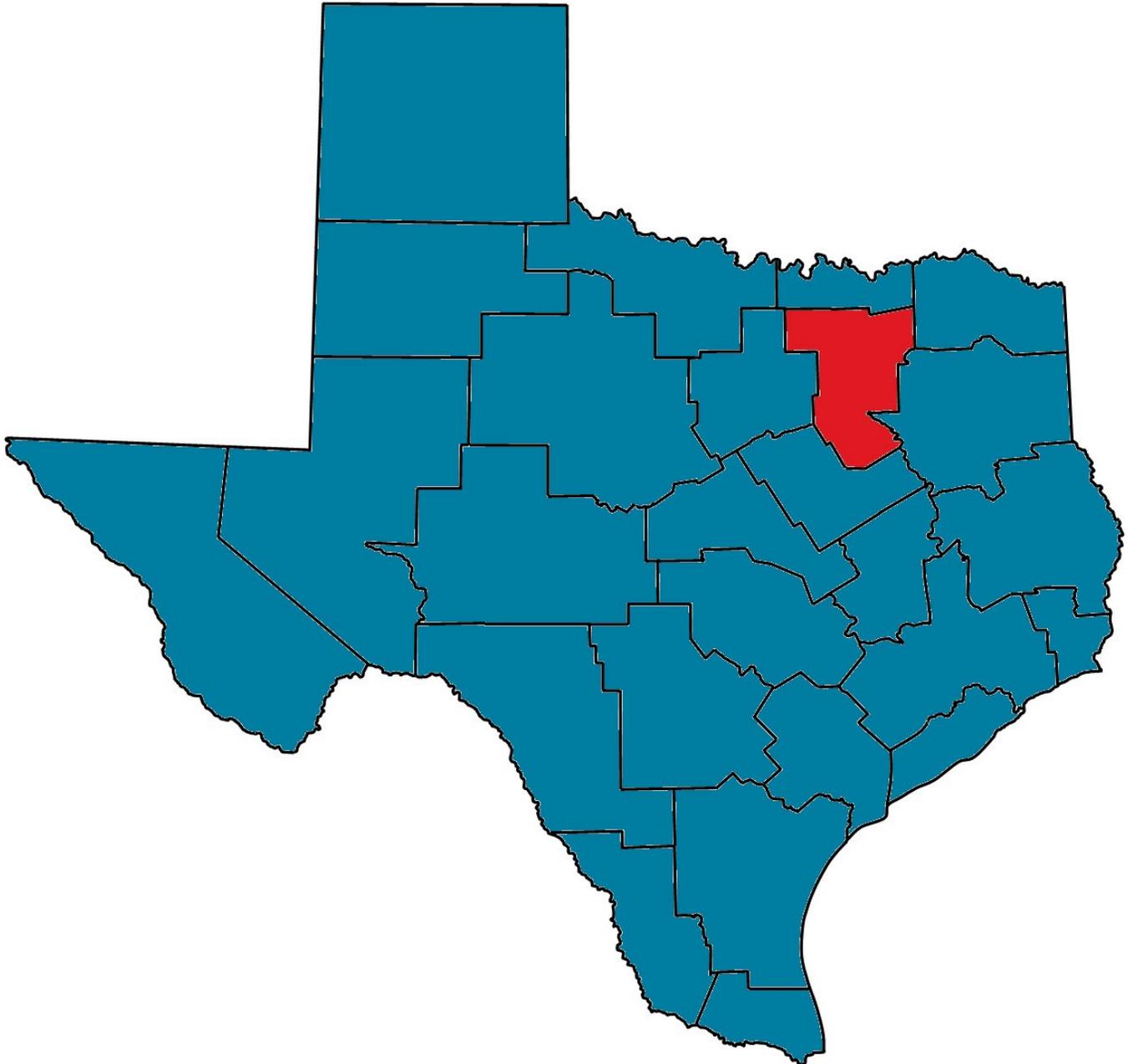
**Texas Department of State Health Services
TB/HIV/STD Section**



**Texas Department of State
Health Services**

2018 HIV CONTINUUM OF CARE

DALLAS HIV SERVICE DELIVERY AREA (HSDA)



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 2019), 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

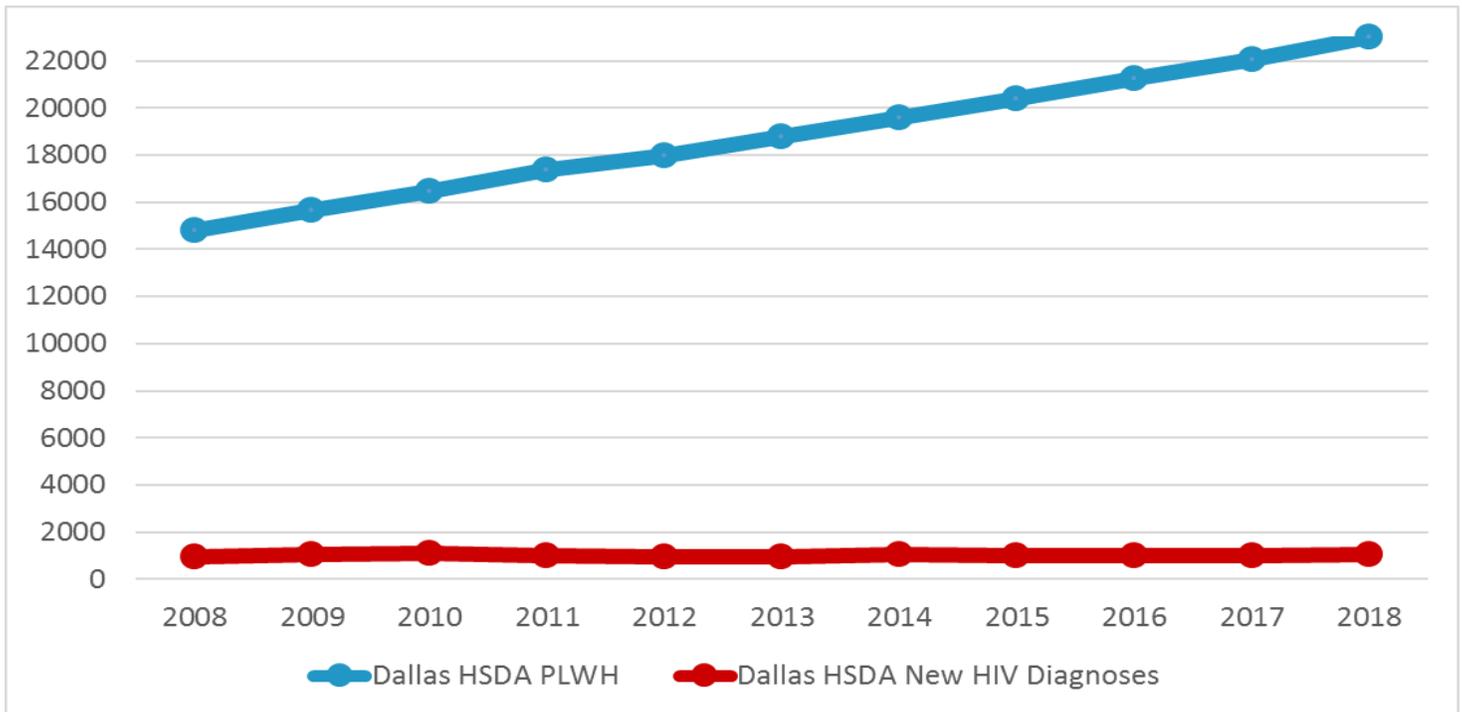


EPI PROFILE

People Living With HIV (PLWH) and New HIV Diagnoses

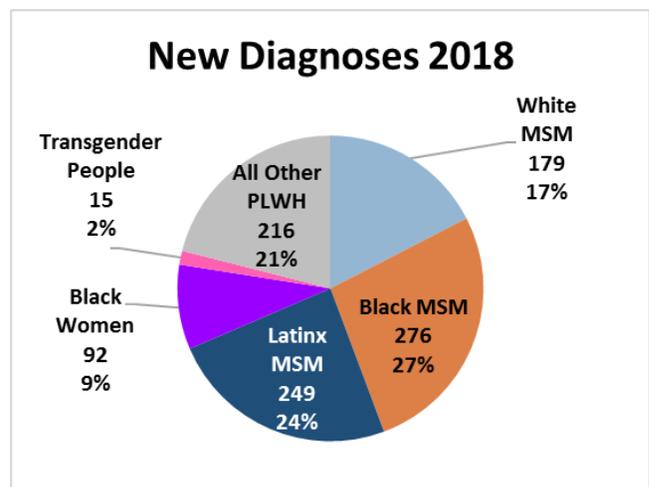
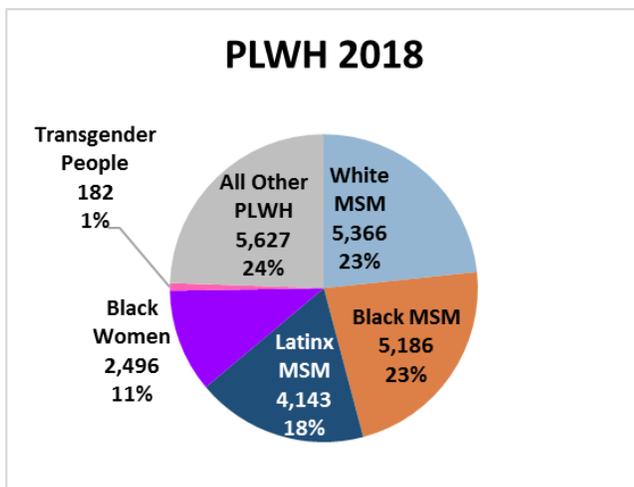
In the Dallas HSDA, the number of new HIV diagnoses has remained flat and stable for the past several years.

There were **22,999** people living with HIV (PLWH) in this area as of the end of 2018. In 2018, **1,027** 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 (76% of PLWH, 79% of New HIV Diagnoses)

Priority populations make up the majority of PLWH and the majority of new diagnoses. White MSM and Black MSM are the largest priority populations among PLWH and Black MSM are the largest priority population among new HIV diagnoses.

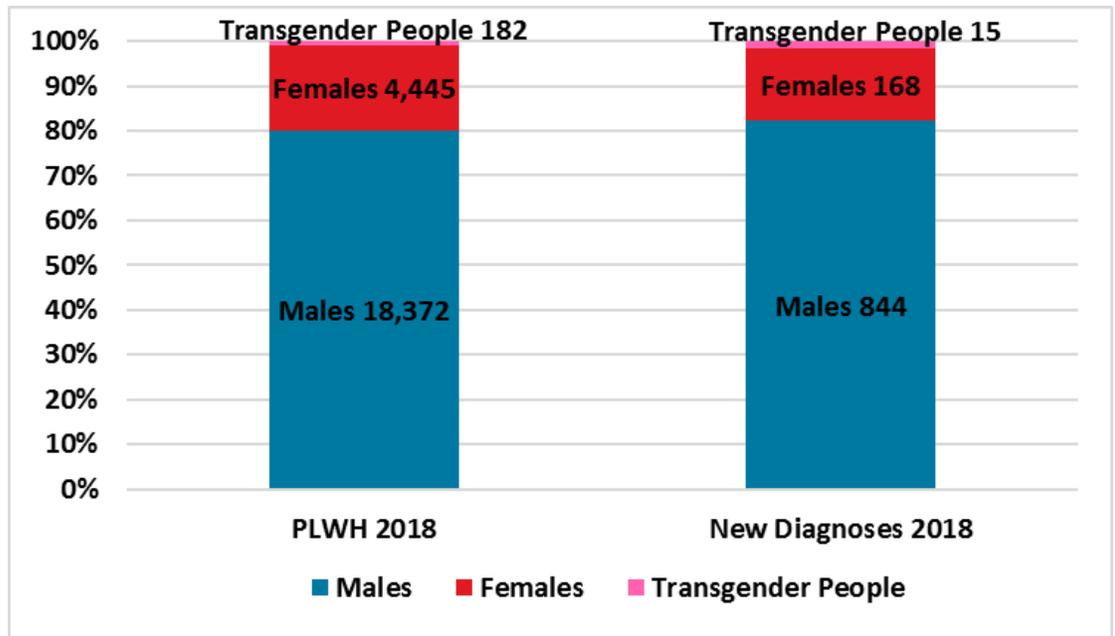


Gender

Males make up the majority of PLWH and the majority of new HIV diagnoses.

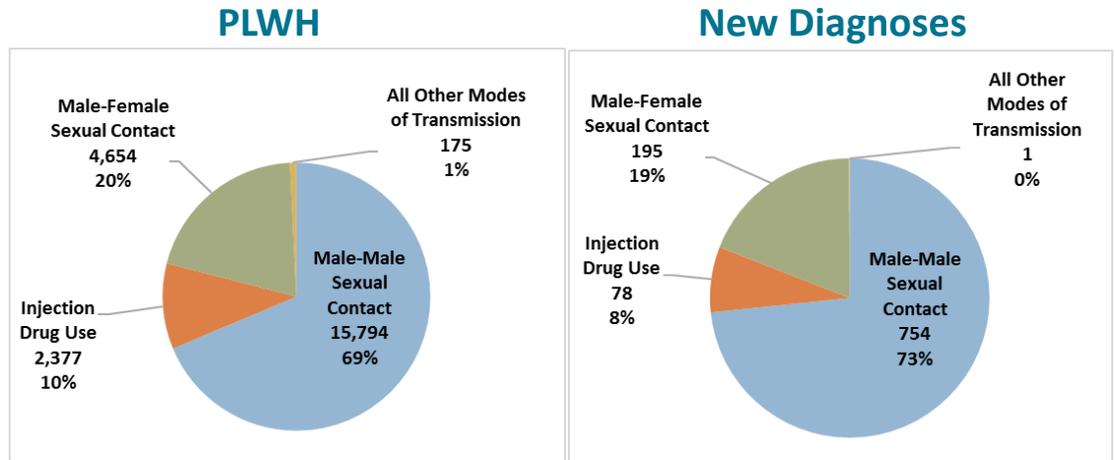
Note

Due to current reporting methods, the number of transgender PLWH are most likely underreported.



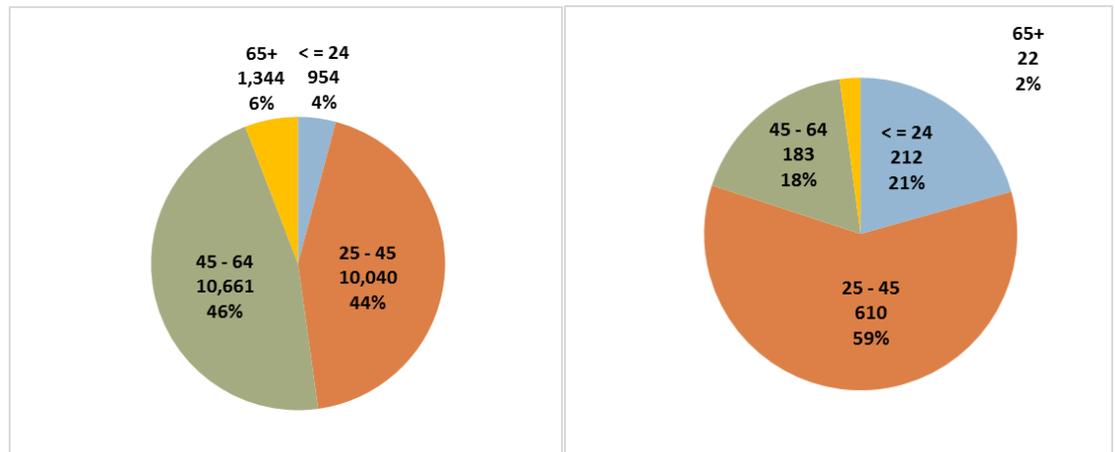
Mode of Exposure

Male-Male Sexual Contact makes up the primary mode of acquisition among PLWH and among new diagnoses.



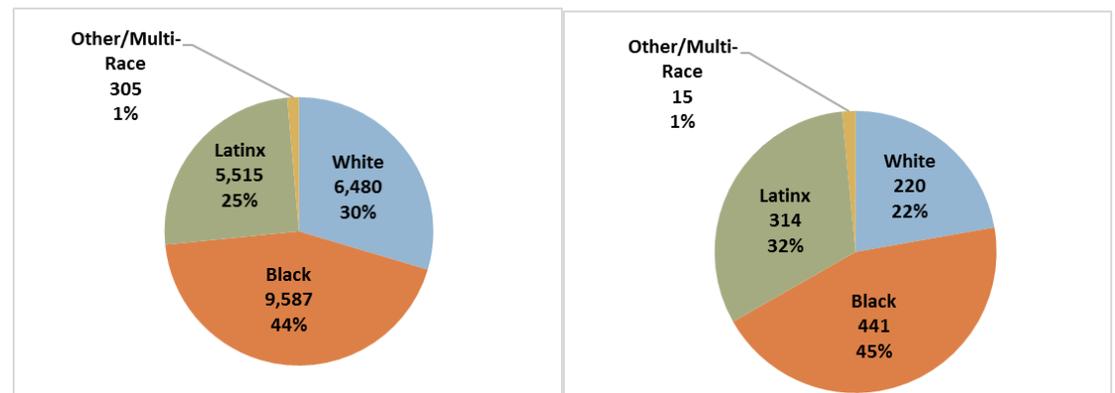
Age

The majority of PLWH is split between ages 25-45 and 45-64; the majority of new diagnoses are among people 25-45.



Race/Ethnicity

The majority of PLWH and the majority of new diagnoses are among Black individuals.



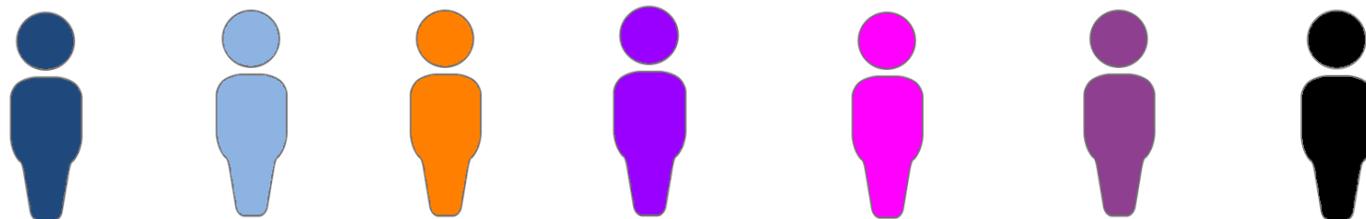
FOCUSED PREVENTION

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.

Locally Relevant Populations for Prevention

In the Dallas HSDA, HIV prevention efforts should be centered around these populations:



Latinx MSM White MSM Black MSM Black Women Transgender
People Latinx Women PWID

Local 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 - Many Men, Many Voices; Behavioral Health, Connect](#)
- [Structural Intervention—MPowerment, Community PROMISE](#)

FULL DIAGNOSIS

Texas' goal is that 90% of all PLWH know their status by 2030.

Primary Diagnosing Facilities 2013-2018

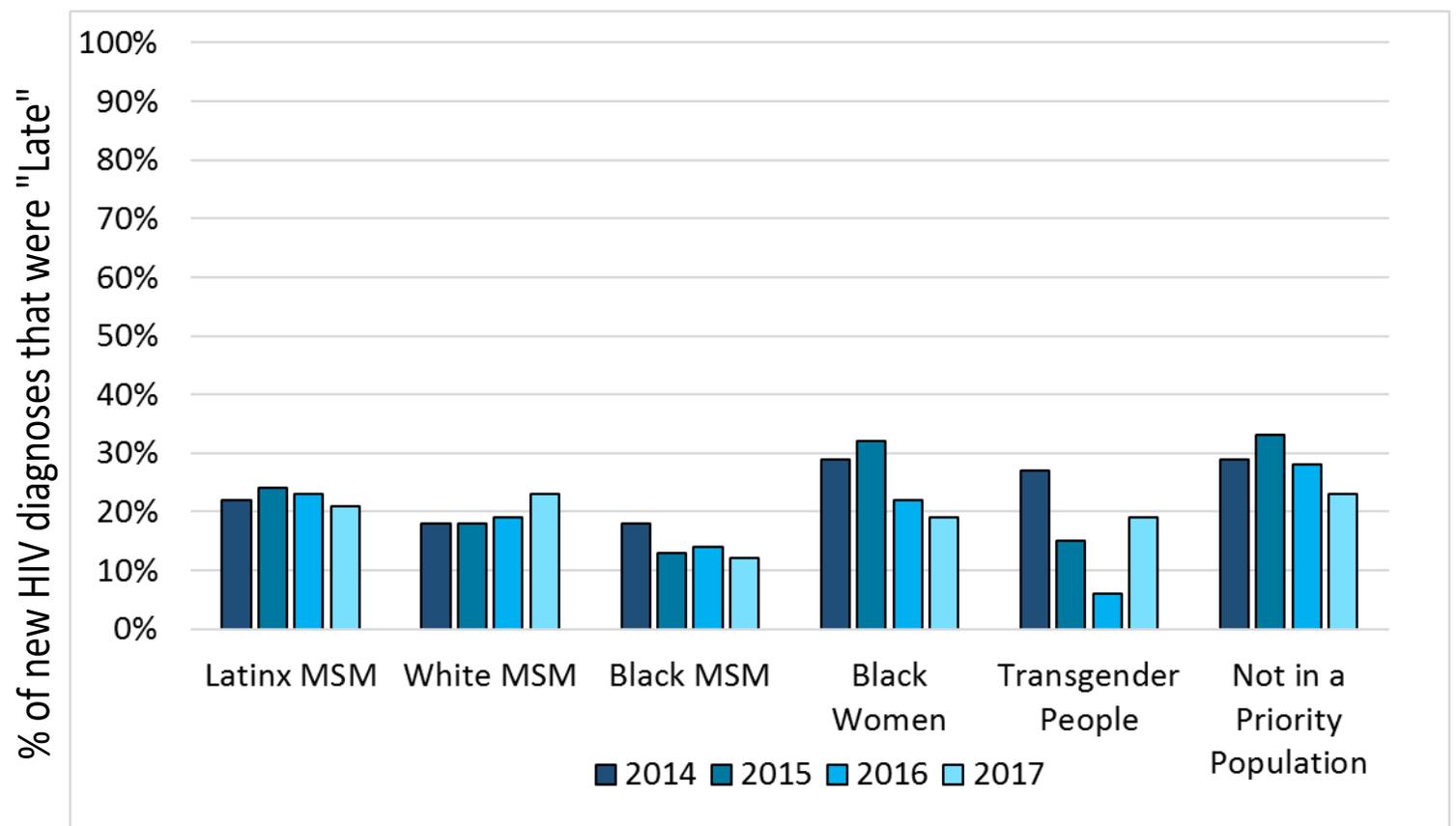
36% of HIV diagnoses in the Dallas HSDA happen in these 5 facilities. Parkland Hospital is the top diagnosing facility in the area.

Diagnosing Facility	Total # Diagnosed	% of Total Diagnoses	% Latinx MSM	% White MSM	% Black MSM	% Black Women	% Transgender People
Parkland Memorial Hospital	592	10%					
Resource Center Nelson-Tebedo	516	8%					
DCHHS—STD Clinic	514	8%					
Parkland—ER	361	6%					
AIDS Healthcare Foundation	241	4%					

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.



* 2017 is the most recently available year for late diagnosis data

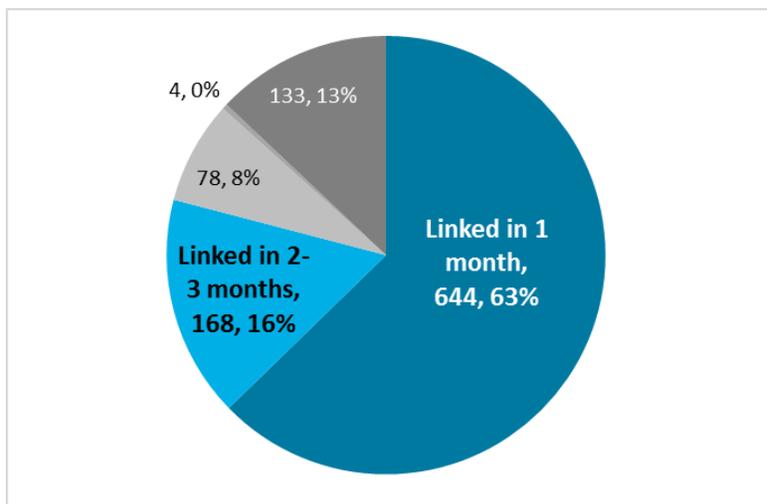
SUCCESSFUL LINKAGE

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—2018

79% of people diagnosed with HIV in the Dallas HSDA in 2018 were linked to care within 3 months.



Linked in 1 month	644	63%
Linked in 2-3 months	168	16%
Linked in 4-12 months	78	8%
Linked in 12+ months	4	0%
No Evidence of Linkage	133	13%

Timely Linkage—Priority Populations—2012-2018

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

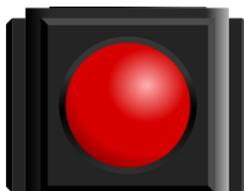
Communities and populations are prioritized using the following color coding system:

On ART /
Retention In Care

On ART/In-Care
Viral Suppression

< 69%

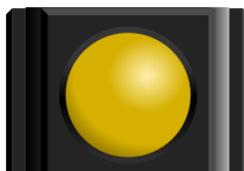
< 84%



Stop and examine further, May be a priority

70% - 89%

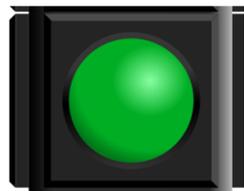
85% - 89%



May need to examine further, May not be a priority

90% <

90% <



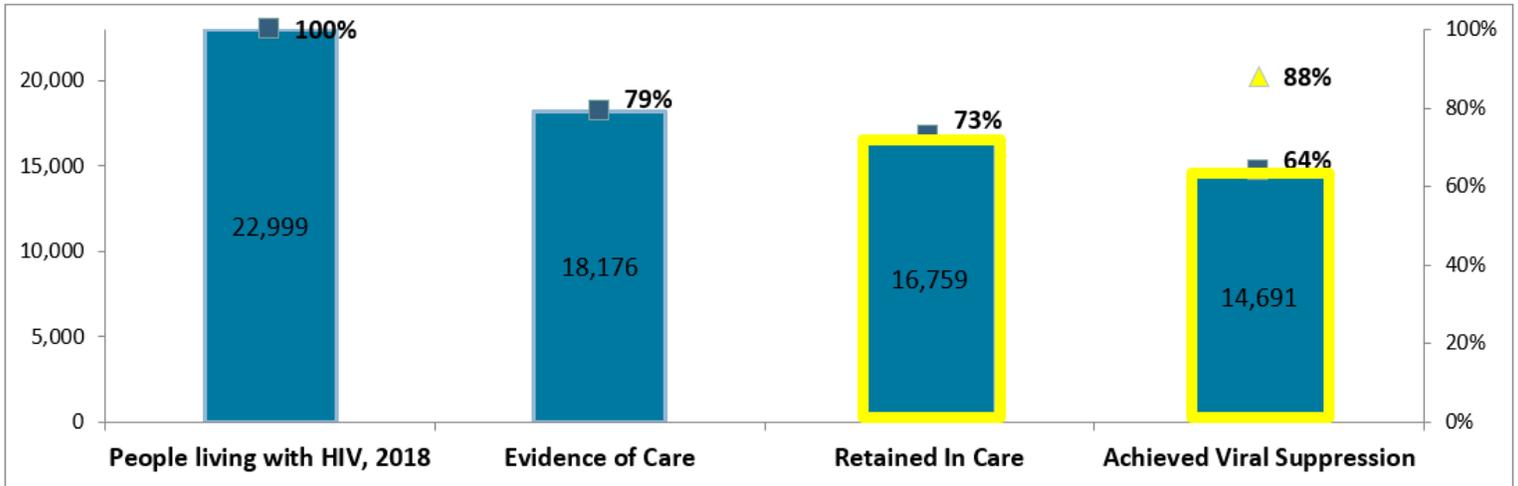
Maintain Current Activities, Look for Promising Practices

2018 Care Continuum

In the Dallas HSDA, 73% of PLWH have achieved retention in care, 64% of total PLWH have achieved viral suppression, and 88% of PLWH who are retained in care achieved viral suppression.

Retention in care is a priority for the overall Dallas HSDA.

HIV Treatment Cascade for Dallas HSDA, 2018



79% of PLWH had at least 1 episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care



64% of PLWH achieved viral suppression (last viral load of the year was <200 copies/ml). This means roughly 6 out of 10 PLWH achieved viral suppression.

This is community viral suppression



73% of PLWH were retained in care (at least 2 episodes of HIV care & treatment across the year). This means roughly 7 out of 10 PLWH were retained in care.



Of those 7 out of 10 PLWH retained in care, 88%, or roughly 6 of those 7 achieved viral suppression.

This is in-care viral suppression.

2018 Continuum of Care, Parity Table

The communities with the fewest opportunities to achieve retention in care are people under the age of 45 and Black PLWH, specifically Black MSM.

The communities with the fewest opportunities to achieve viral suppression even when retained in care are people under the age of 25, PWID, Transgender PLWH, and Black PLWH, specifically Black MSM.

People over the age of 45, Latinx MSM and White PLWH, specifically White MSM have achieved In-Care Viral Suppression goals.

90% PLWH retained in HIV care & treatment

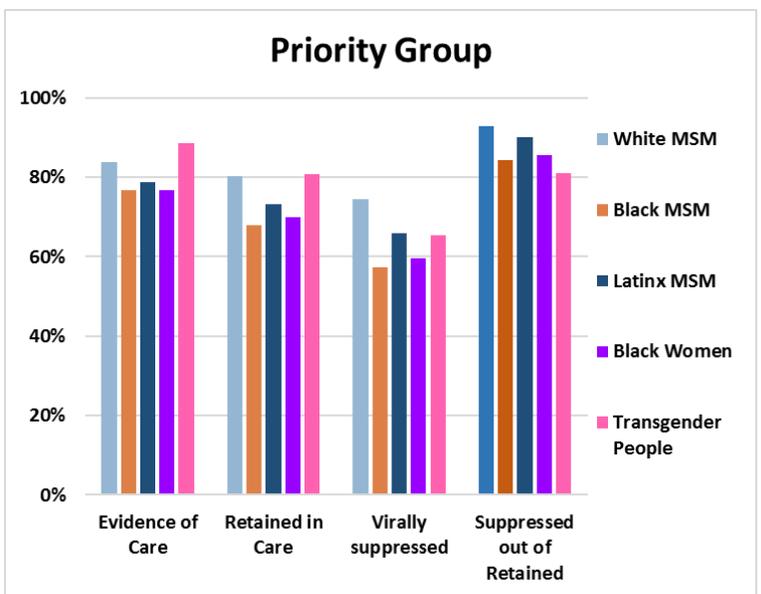
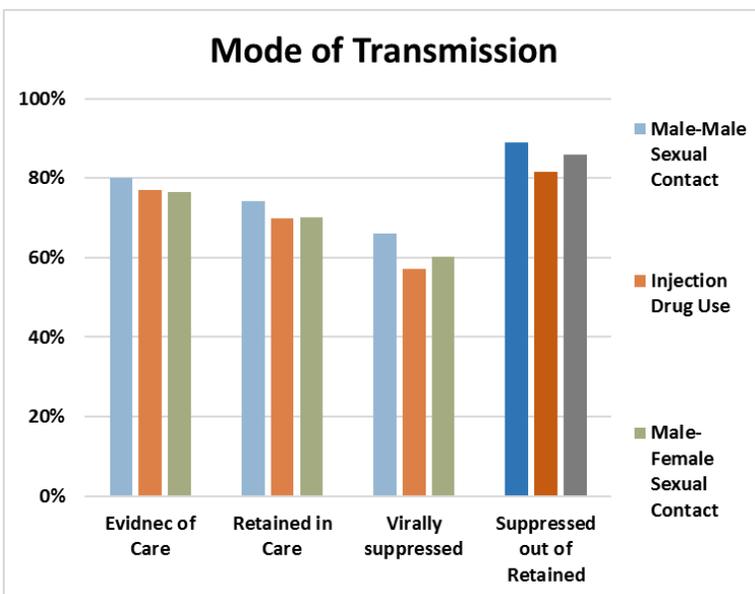
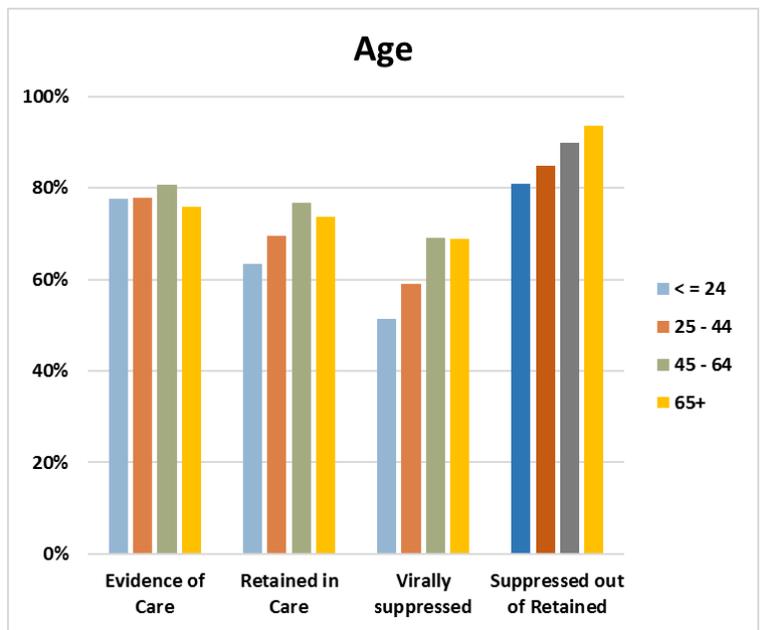
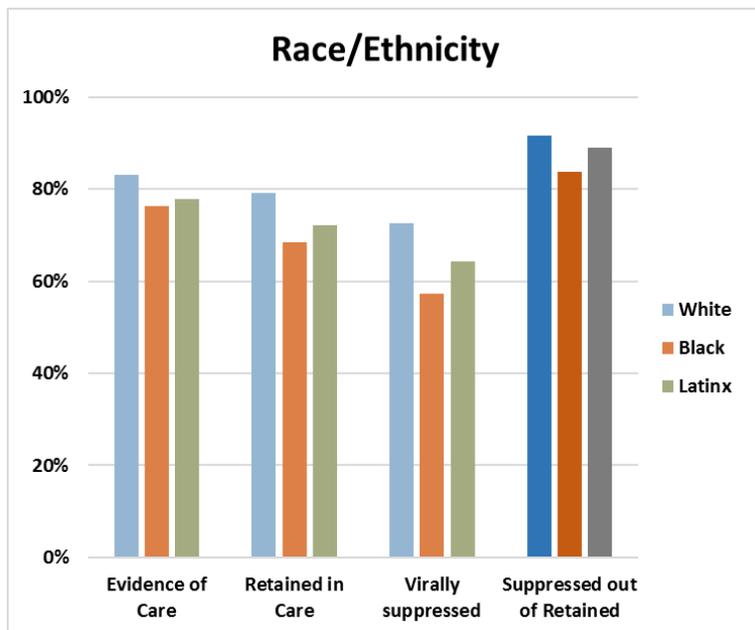
90% of those retained achieve viral suppression

	PLWH		Evidence of Care (At least one visit)		Retained in Care		Suppressed		% sup- pressed of those retained
	#	%	#	%	#	%	#	%	%
All PLWH	22,999	100%	18,176	79%	16,759	73%	14,691	64%	88%
Women	4,445	19%	3,451	78%	3,162	71%	2,695	61%	85%
Men	18,372	80%	14,564	79%	13,450	73%	11,877	65%	88%
Transgender People	182	<1%	161	88%	147	81%	119	65%	81%
White	6,480	28%	5,385	83%	5,127	79%	4,702	73%	92%
Black	9,587	42%	7,321	76%	6,565	68%	5,495	57%	84%
Latinx	5,515	24%	4,288	78%	3,978	72%	3,542	64%	89%
<=24	954	4%	740	78%	605	63%	490	51%	81%
25 – 44	10,040	44%	7,819	78%	6,972	69%	5,917	59%	85%
45-64	10,661	46%	8,598	81%	8,193	77%	7,358	69%	90%
65+	1,344	6%	1,019	76%	989	74%	926	69%	94%
Male-Male Sexual Contact	15,794	69%	12,656	80%	11,714	74%	10,434	66%	89%
Injection Drug Use	2,376	10%	3,560	77%	1,664	70%	1,357	57%	82%
Male-Female Sexual Contact	4,654	20%	3,560	77%	3,259	70%	2,801	60%	86%
White MSM	5,366	23%	4,493	84%	4,303	80%	3,994	74%	93%
Black MSM	5,186	23%	3,977	77%	3,528	68%	2,971	57%	84%
Latinx MSM	4,143	18%	3,263	79%	3,030	73%	2,727	66%	90%
Black Women	2,496	11%	1,913	77%	1,743	70%	1,489	60%	85%
Transgender Women	175	<1%	155	89%	141	81%	114	65%	81%

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

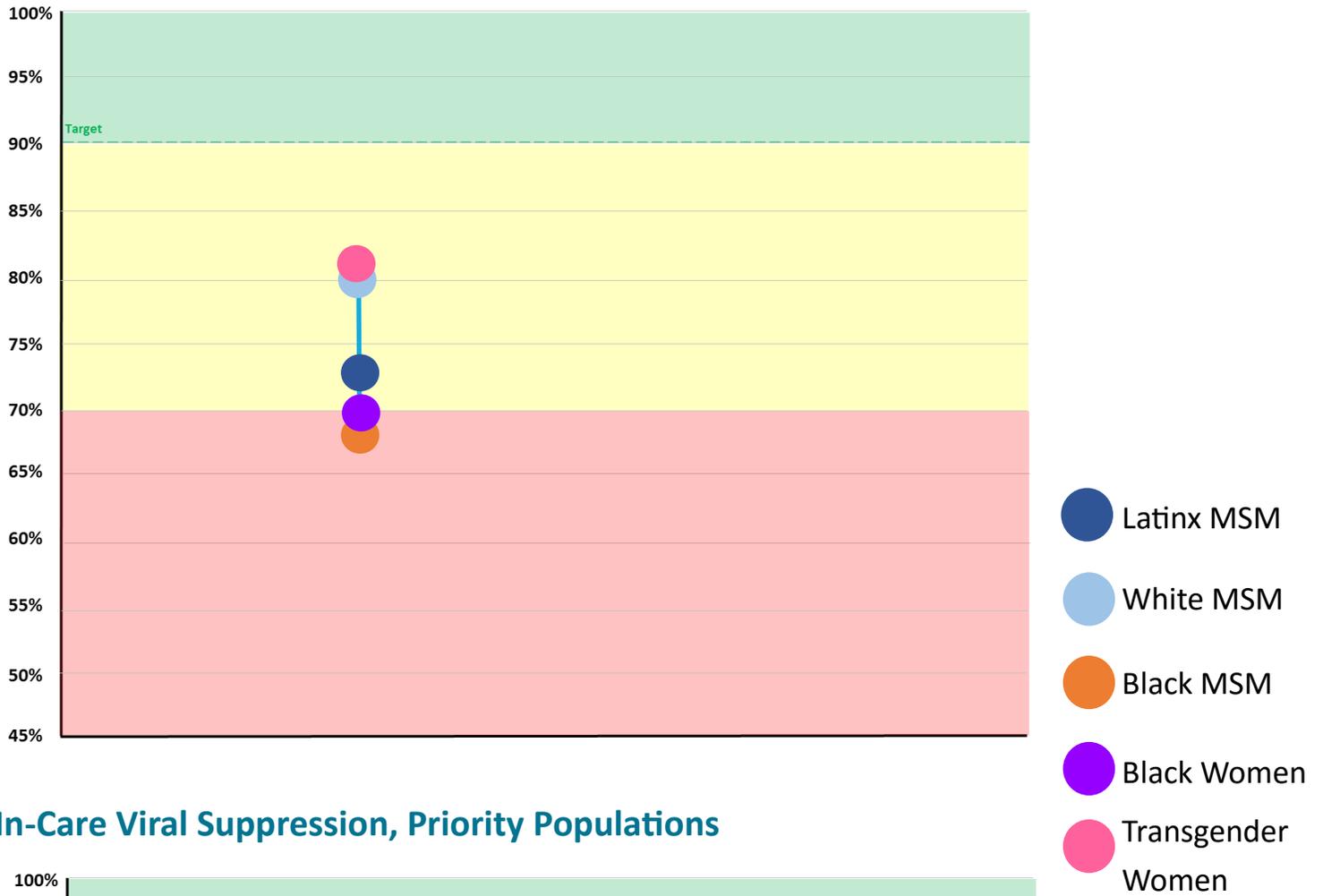


Note

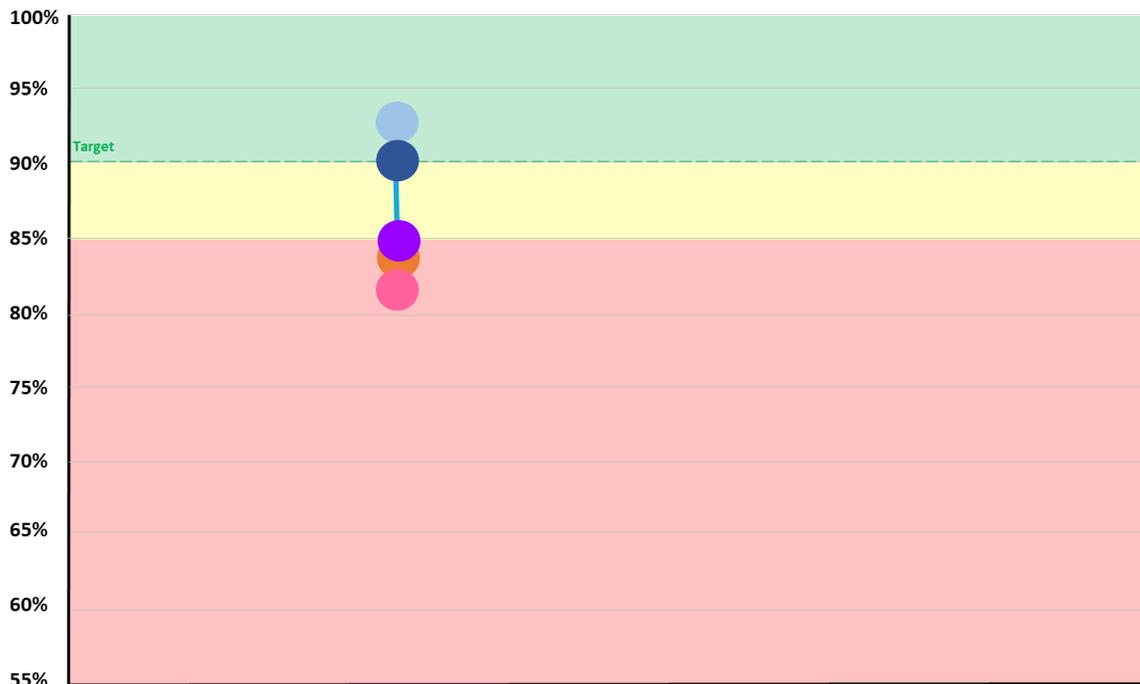
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

2018 Continuum of Care, Priority Populations, Stoplight System

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations

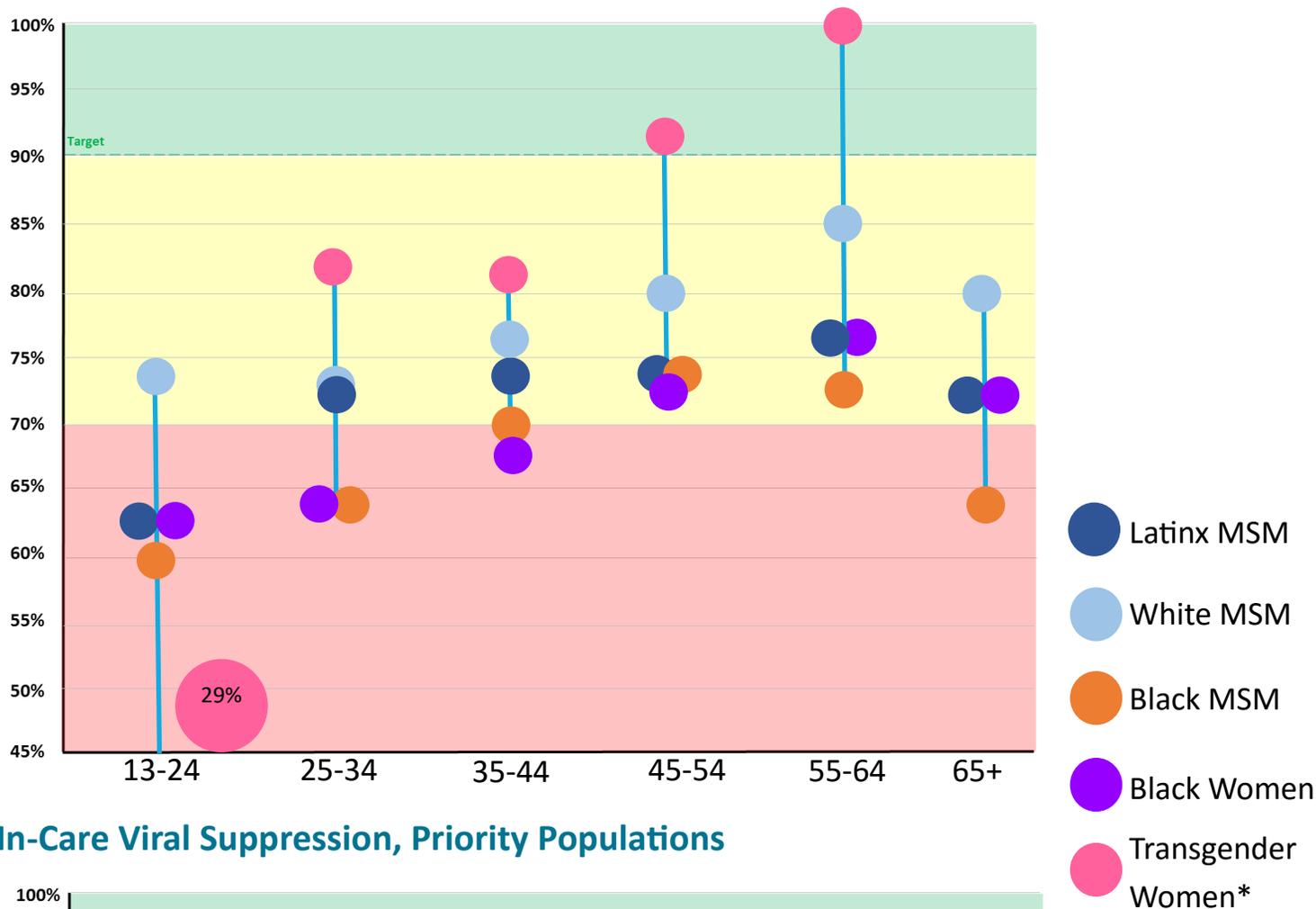


Note

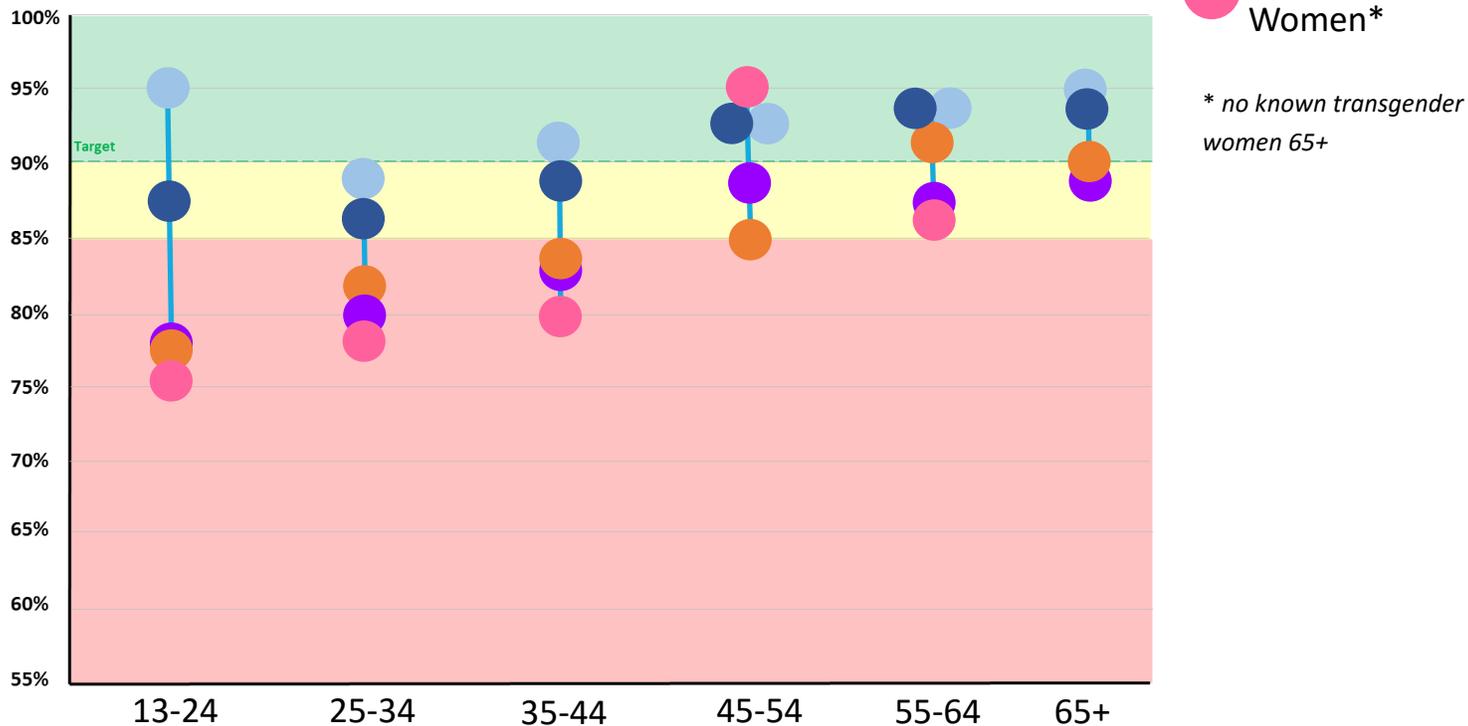
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

2018 Continuum of Care, Priority Populations by age, Stoplight System

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations



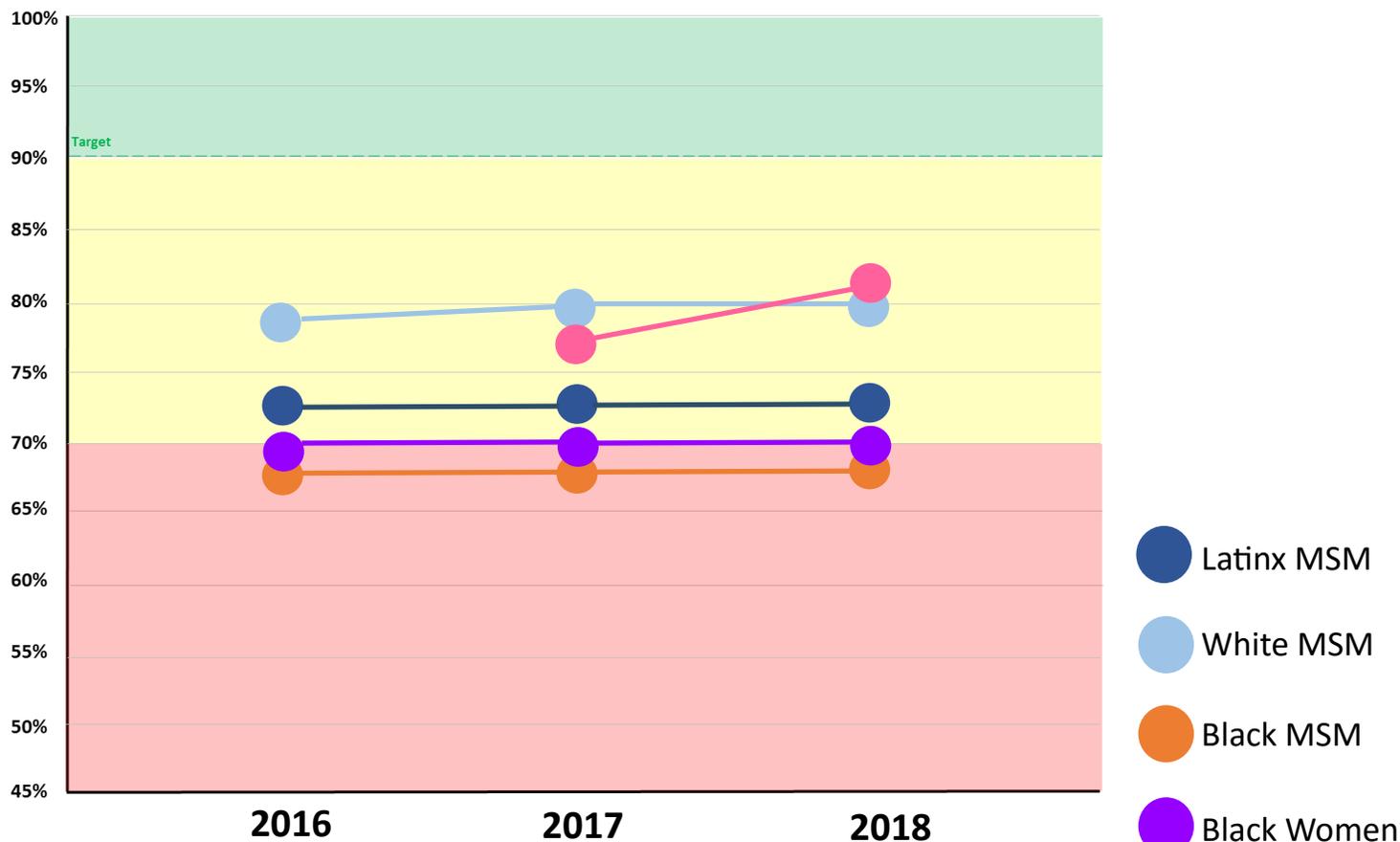
Note

** no known transgender women 65+*

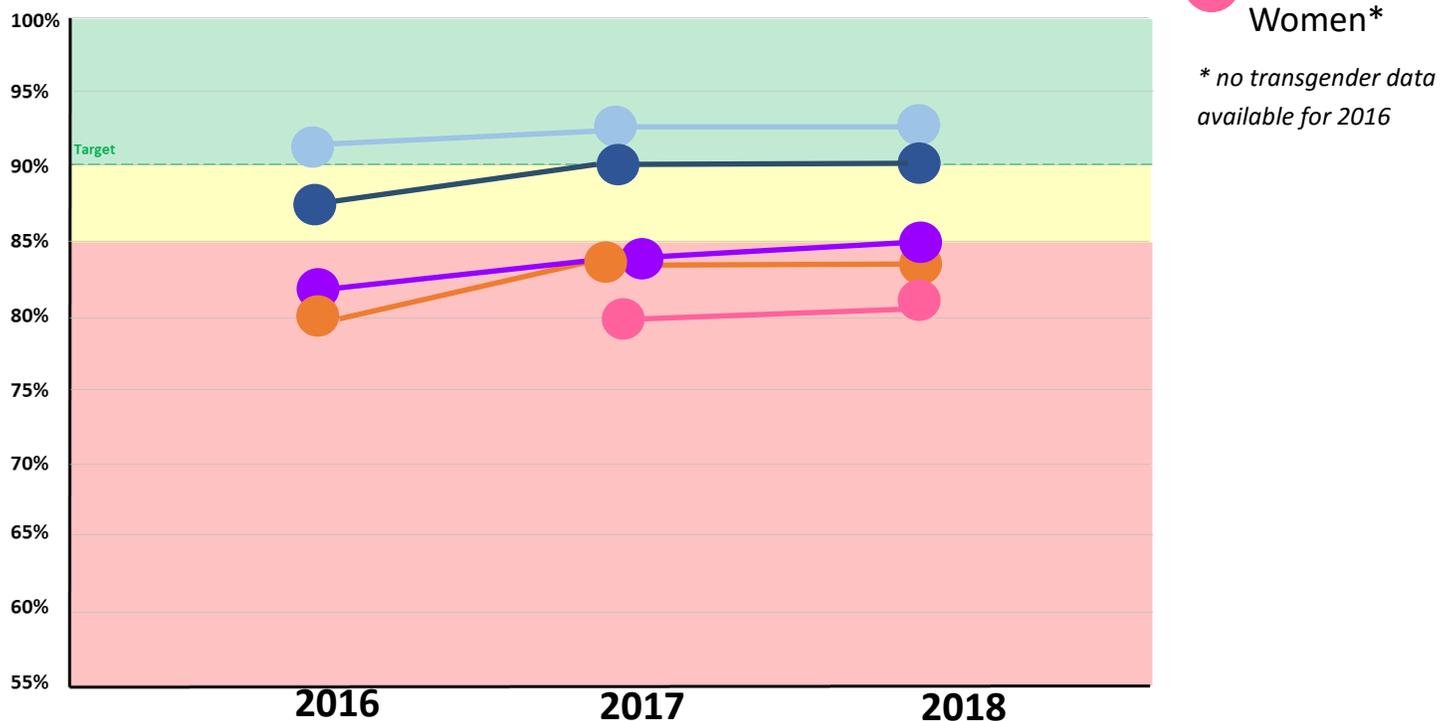
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

Continuum of Care, Priority Populations, Stoplight System 2016-2018

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations



* no transgender data available for 2016

Note

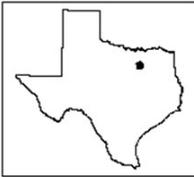
Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.

City of Dallas Retained in Care 2018

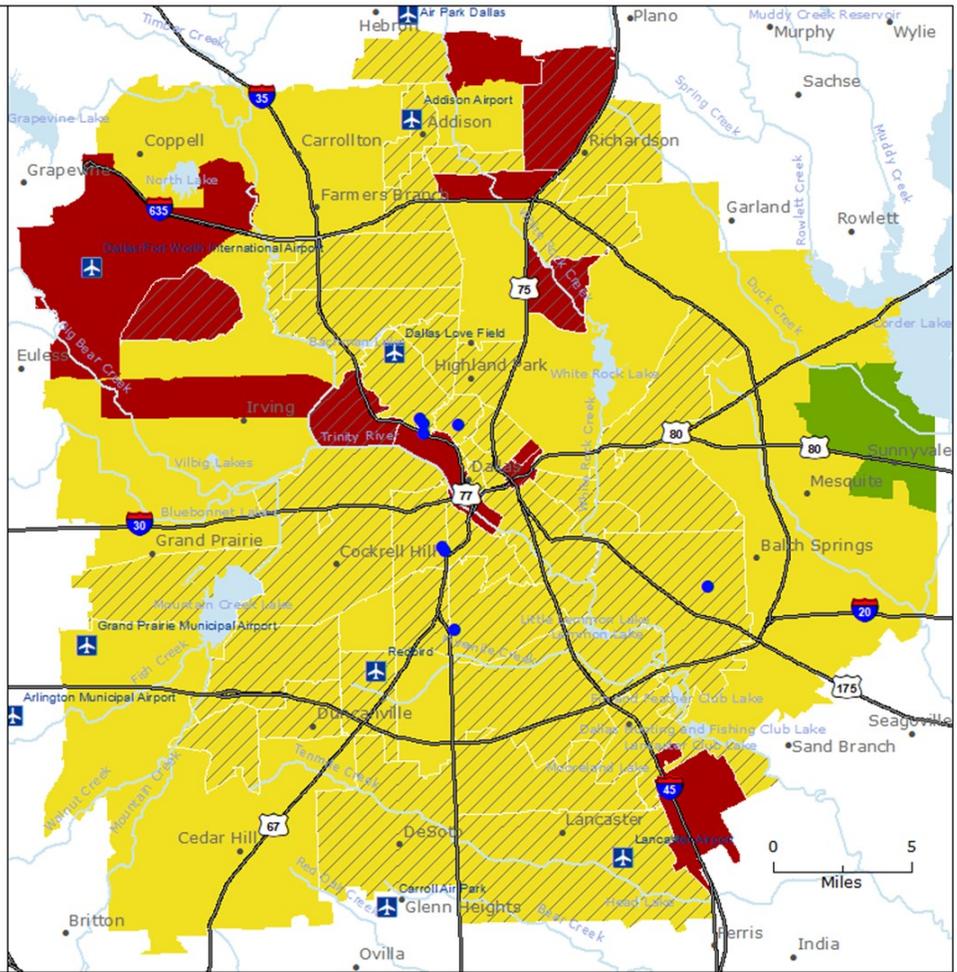
**Statewide
average = 67%**

Percent Retained in Care by ZIP Code

- ≤ 69%
- 70% - 89%
- ≥ 90%
- No data/Not shown
- ≥ 1 HIV testing site
- Care facility
- City
- Airport
- Waterbody
- Highway



Source: Texas eHARS, 2019.

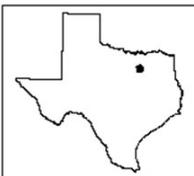


City of Dallas Suppression Among Individuals Retained in Care 2018

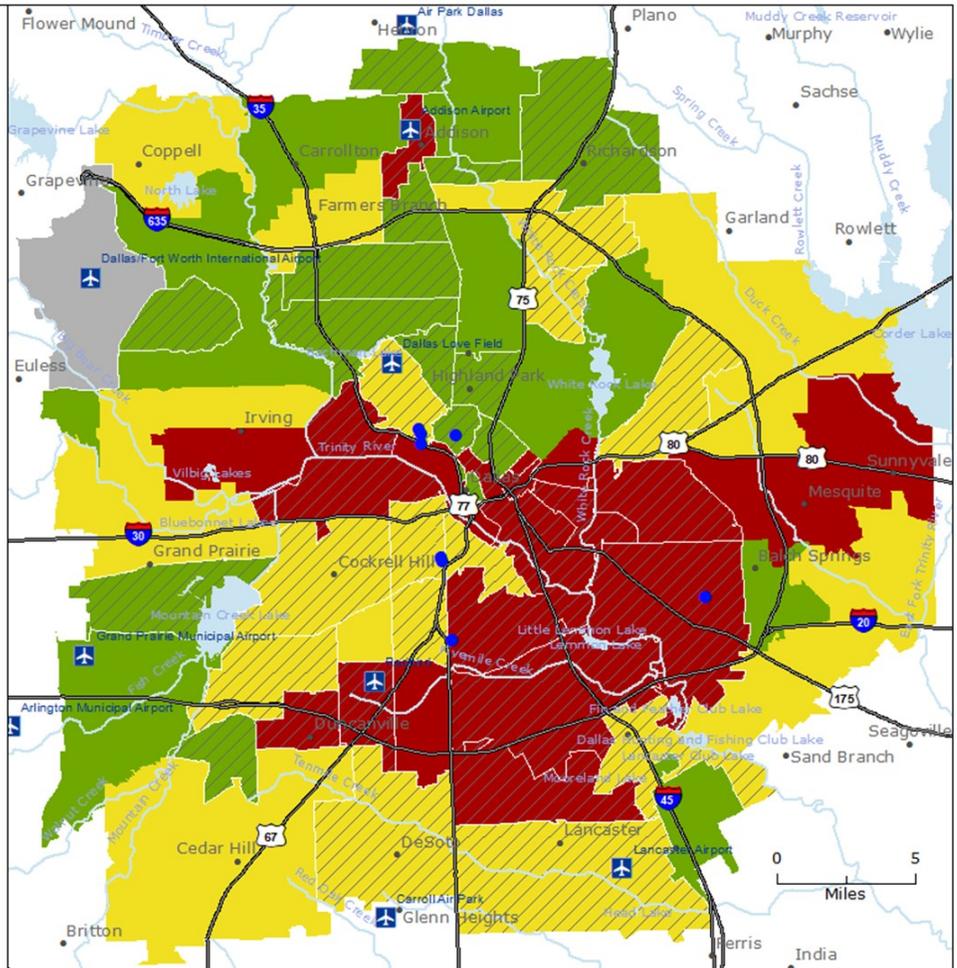
**Statewide
average = 84%**

Percent Retained in Care by ZIP Code

- ≤ 84%
- 85% - 89%
- ≥ 90%
- No data/Not shown
- ≥ 1 HIV testing site
- Care facility
- City
- Airport
- Waterbody
- Highway



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	22,999	100%	16,759	73%	20,699	3,940	14,691	18,629	3,938
Women	4,445	19%	3,162	71%	4,001	839	2,695	3,601	906
Men	18,372	80%	13,450	73%	16,535	3,085	11,877	14,882	3,005
Transgender People	182	<1%	147	81%	164	17	119	148	29
White	6,480	28%	5,127	79%	5,382	705	4,702	5,249	547
Black	9,587	42%	6,565	68%	8,628	2,063	5,495	7,765	2,270
Latinx	5,515	24%	3,978	72%	4,964	986	3,542	4,468	926
<=24	954	4%	605	63%	859	254	490	773	283
25 – 44	10,040	44%	6,972	69%	9,036	2,064	5,917	8,132	2,215
45-64	10,661	46%	8,193	77%	9,595	1,402	7,358	8,636	1,278
65+	1,344	6%	989	74%	1,210	221	926	1,089	163
Male-Male Sexual Contact	15,794	69%	11,714	74%	14,215	2,501	10,434	12,794	2,360
Injection Drug Use	2,376	10%	1,664	70%	2,139	475	1,357	1,925	568
Male-Female Sexual Contact	4,654	20%	3,259	70%	4,188	929	2,801	3,769	968
White MSM	5,366	23%	4,303	80%	4,829	526	3,994	4,346	353
Black MSM	5,186	23%	3,528	68%	4,667	1,139	2,971	4,200	1,229
Latinx MSM	4,143	18%	3,030	73%	3,728	698	2,727	3,355	629
Black Women	2,496	11%	1,743	70%	2,247	504	1,489	2,022	533
Transgender Women	175	<1%	141	81%	158	17	114	142	28

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

The Texas Department of State Health Services HIV Prevention Program awarded new five-year project period Contractors on January 1, 2020. The contracts below are for year one of the five-year project period.

DSHS 2020 HIV PREVENTION FUNDING: DALLAS HSDA									
Contractor	Routine Screening	Core Prevention	PrEP and nPEP	Client Level Interventions	CLI Intervention	Structural Interventions	Structural Interventions	Molecular Surveillance	Contract Total
Abounding Prosperity		X	X	X	3MV	X	SNS, PROMISE, Social Marketing		\$5,415,680
AIDS Healthcare Foundation - Dallas		X					N/A		
Dallas County Health and Human Services			X				N/A		
Dallas County Hospital District (Parkland)	X						N/A		
Denton County Public Health		X					N/A		
Prism Health North Texas		X	X	X	Behavioral Health	X	Mpowerment	X	
Resource Center Dallas		X				X	Mpowerment		
UT Southwestern Medical Center		X		X	Connect	X	PROMISE		

3MV: Many Men, Many Voices

SNS: Social Network Strategies

PROMISE: Community Promise