Austin Area Comprehensive HIV Planning Council

Integrated HIV Prevention and Care Plan

2017- 2021

Austin Area Comprehensive
HIV PLANNING COUNCIL

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EXECUTIVE SUMMARY

The Integrated HIV Prevention and Care Plan is a five year plan to accelerate progress in the Austin Transitional Grant Area (TGA) toward preventing new HIV infections, increasing access to care, improving health outcomes, and reducing HIV-related health disparities. The first half of the plan reviews the landscape of the HIV epidemic—the demographics of those infected and at risk for HIV infection, resources and services available, and needs, gaps and barriers to prevention and care. The second half of the plan details goals and objectives the Austin TGA plans to adopt to address the needs of people living with HIV (PLWH) and people at risk of HIV infection.

In 2015, there were 5,521 PLWH in the five county TGA, with over 300 new diagnoses that year. Most (89%) of new HIV cases were in men and 80% reported an exposure category of men who have sex with men (MSM). White PLWH (2,347) made up the largest number of Austin TGA residents with HIV in 2015, but had the lowest prevalence and incidence rate. Mirroring national trends, Black MSM bear a large burden of disease in the Austin TGA, with new diagnosis rate of 794 per 100,000 in 2015. Since 2011, new diagnoses in Hispanic and young (under 35) populations have grown compared to other ethnicities and older age groups.

The HIV Treatment Cascade for the Austin TGA indicates that 60% of newly diagnosed PLWH are linked to care within one month and 83% are linked to care within three months. Of all PLWH in the Austin TGA, 79% were retained in care and 71% achieved viral suppression in 2015. Treatment Cascades for priority populations indicate that Black MSM and Youth (age 13-24) have significantly lower viral suppression rates (64% and 58% respectively) than the TGA overall.

Qualitative methods were used to engage local PLWH, persons at risk for HIV and service providers to determine primary needs and service gaps in the Austin TGA. Targeted social marketing and mass education, prevention with positives, and education and uptake of PreP were the key needs identified for persons at risk for HIV. Outpatient medical care, food bank, and non-medical case management were the most needed services for PLWH and service gaps for PLWH included access to housing, transportation and mental health.

The five year plan was developed by a collaborative workgroup of PLWH, service providers and other community stakeholders. The four goals of the plan are (1) to reduce new HIV infections (2) increase access to care and improve health outcomes for PLWH (3) reduce HIV-related disparities and health inequalities and (4) achieve a more coordinated response to the HIV epidemic. SMART objectives, aligned with the National

HIV/AIDS Strategy and reflective of the local epidemic landscape, will measure progress towards these goals. Planned strategies and activities are listed for each objective. The plan will be monitored and updated regularly by the Austin HIV Planning Council.

INTRODUCTION

Background

In July 2015, the White House issued the National HIV/AIDS Strategy for the United States (NHAS). NHAS set the foundation for improved coordination, a unified vision and common goals and objectives to prevent transmission of HIV and improve care for people living with HIV/AIDS. In line with NHAS strategy, the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA) have issued guidance on the submission of an Integrated HIV Prevention and Care Plan for Ryan White HIV/AIDS Program (RWHAP) Part A and B Grantees. This plan provides a blueprint for how the Austin TGA will achieve long term goals and objectives related to the HIV epidemic, in line with NHAS strategy.

Objectives of the Plan

The three sections of the Integrated HIV Prevention and Care Plan are (1) overview of the epidemiology of HIV as well as care and prevention needs within the Austin TGA; (2) goals and objectives framework and action plan to address these needs and (3) the process for monitoring and reporting progress.

Scope of Plan

All HIV care and prevention activities conducted directly by the Austin HIV Planning Council or otherwise supported by the Austin HIV Planning Council that occur within the Austin TGA are within the scope of this plan. Since the Planning Council does not directly provide services to the community, the actions of a broad range of service providers, government agencies, non-profit organizations and support groups supported by the HIV Planning Council are included in this plan.

It is important to note that the plan does not attempt to address all HIV related problems and issues within the community. The focus of resources on these goals and associated, measurable activities, attempts to make a difference in a few key areas which in turn will have a positive impact on the community.

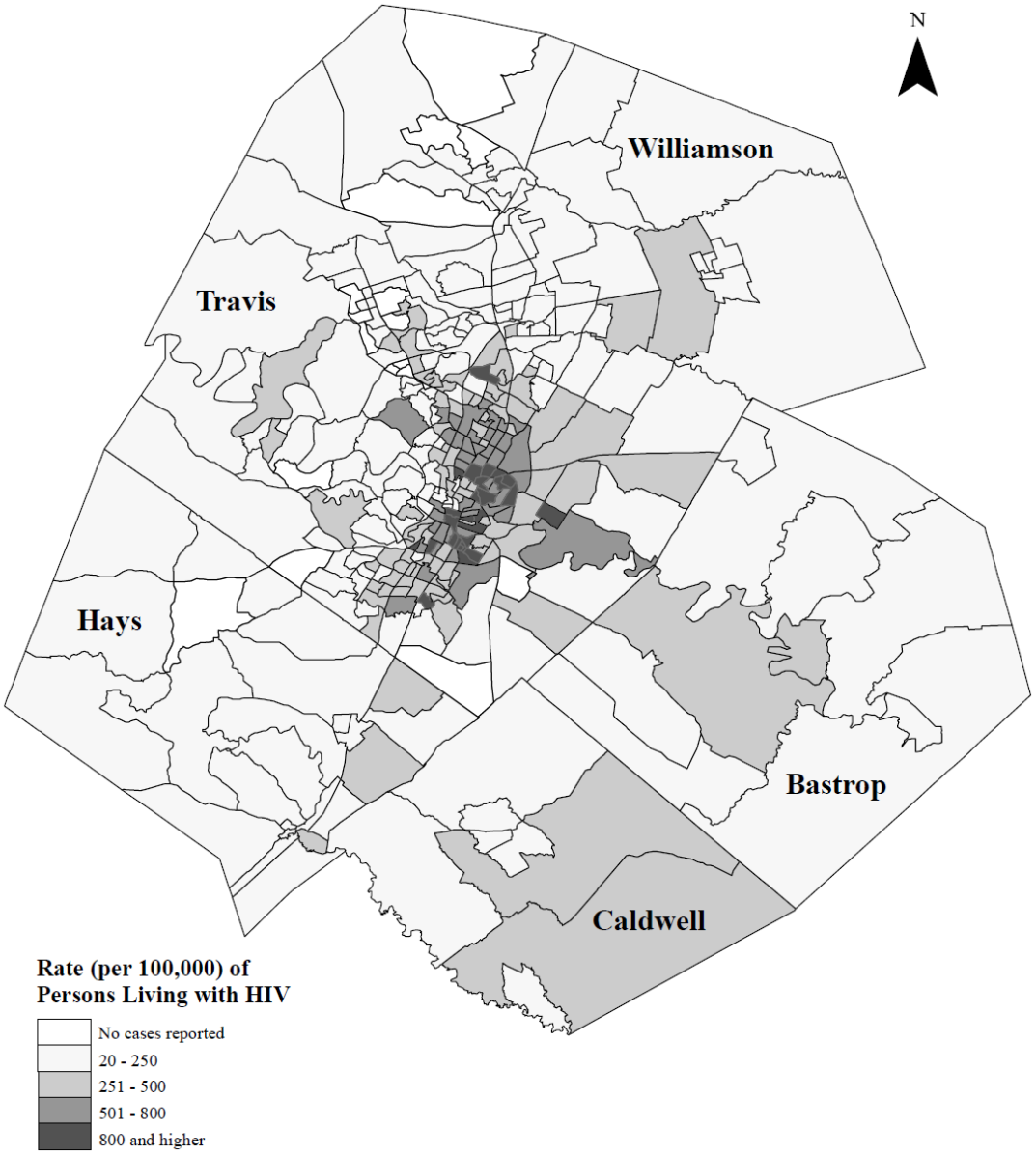
SECTION I: NEEDS ASSESSMENT

A. Epidemiologic Overview

a. Description of the geographical region of the Austin Transitional Grant Area (TGA)

Approximately two million people reside in the Austin Transitional Grant Area (TGA). Most of the TGA population is White (54%) followed by Hispanic (32%). African Americans make up 7% of the Austin TGA. Since 2011, the population of the Austin TGA has increased by 219,451 people, a 12% increase. At the end of 2015, there were more than 5,500 TGA residents living with HIV infection, with over 300 new diagnoses that year. The largest city, Austin, lies in Travis County, where the majority (80%) of people living with HIV (PLWH) reside.

Figure 1: Rates of Persons Living with HIV by Census Tract, Austin TGA, 2015



b. Socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area:

i. **Demographic data including race, age, sex, transmission category, gender identity:**

Table A shows the number, percent, and rate of newly diagnosed and total PLWH in the Austin TGA for the most recent calendar year. Overall, most new diagnoses (89%) and PLWH (86%) were among males. Most (80%) new HIV cases reported an exposure category of men who have sex with men (MSM). More than half (62%) of the new HIV cases were 13 through 34 years of age.

White PLWH (2,347) made up the largest number of Austin TGA residents with HIV in 2015, but had the lowest prevalence and incidence rate. Blacks, who make up seven percent of the Austin TGA, had a prevalence and incidence rate about four times higher compared to Whites (Table A).

Table A: New HIV Diagnoses and Persons Living with HIV by Selected Characteristics, Austin TGA, 2015

	New HIV Diagnoses			**PLWH**		
	N	%	Rate	N	%	Rate
Total	327	100	16	5,521	100	276
Sex at Birth						
Female	36	11	4	792	14	79
Male	291	89	29	4,729	86	473
Race/Ethnicity						
White	115	35	11	2,347	43	217
Black	60	18	40	1,164	21	781
Hispanic	137	42	21	1,769	32	275
Other	12	4	10	69	1	55
Unknown	3	1		172	3	
Age Group						
0-1	0	0	0	0	0	0
02-12	0	0	0	13	0	4
13-24	73	22	22	228	4	69
25-34	130	40	37	1,044	19	300
35-44	58	18	19	1,226	22	397
45-54	50	15	19	1,761	32	683
55+	16	5	4	1,249	23	306
Mode of Transmission						
MSM	262	80		3,837	69	
IDU	16	5		457	8	
MSM/IDU	11	3		357	6	

Heterosexual	38	12		819	15	
Pediatric	0	0		48	1	
Adult Other	0	0		2	0	

* Transmission categories are estimated, column values may not sum to the column total.
** Adult Other includes received clotting factor, transfusion/transplant, other and unknown.
Note: Transgender persons may be included in male, female, or unknown sex categories.

Table B: New Diagnoses and PLWH by Race/Ethnicity and Mode of Transmission, Austin TGA, 2015

Race/Ethnicity	Mode of Transmission	New Diagnoses		PLWH	
		N	%	N	%
White	MSM	96	83	1,887	80
	IDU	8	7	128	5
	MSM/IDU	7	6	173	7
	Heterosexual	4	3	146	6
	Pediatric	0	0	12	1
	Adult Other	0	0	0	0
African American	MSM	33	55	476	41
	IDU	6	10	203	17
	MSM/IDU	0	0	82	7
	Heterosexual	21	35	384	33
	Pediatric	0	0	19	2
	Adult Other			0	0
Hispanic	MSM	119	87	1,309	74
	IDU	2	1	108	6
	MSM/IDU	3	2	84	5
	Heterosexual	13	9	254	14
	Pediatric	0	0	12	1
	Adult Other	0	0	2	0

* Transmission categories are estimated, column values may not sum to the column total.
** Adult Other includes received clotting factor, transfusion/transplant, other and unknown.

Recently Incarcerated Population

Over 80% of PLWH in the Austin TGA reside in Travis County. Each year from 2011 to 2015, between 43 and 55 HIV positive inmates whose legal county of residence is Travis County were released from the Texas Department of Criminal Justice (TDCJ). TDCJ provides care of HIV positive inmates, but after their release they must be re-linked to public or private treatment and care services. Thus, this population is potentially vulnerable to being lost from care.

ii. Socioeconomic data including percentage of federal poverty level income and health insurance status:

Federal Poverty Level

Income directly affects the ability to pay for health care. A total of 5,521 PLWH reside in the Austin TGA and approximately 37% (2,043) live below 200% of the federal poverty level (FPL) according to a U.S. Census Bureau poverty status report.

Table C: Federal Poverty Level (2012 and 2013 Current Population Survey)

	% of Texans	PLWH (Texas)	PLWH Austin
100% and below	17%	14,067	939
101% - 199%	20%	16,549	1104
200%-299%	31%	25,651	1712

Note: Based on Statewide Estimates applied to known PLWH (2015)

Health Insurance Status

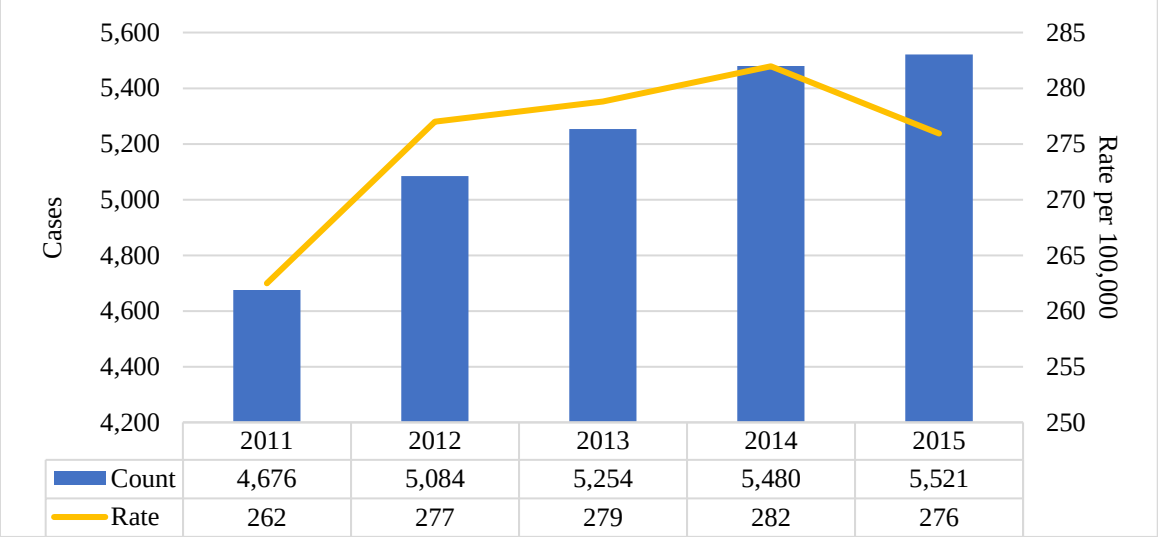
According to a report from the Episcopal Health Foundation and Rice University's Baker Institute for Public Policy the rate of adults without health coverage in Texas, previously about 25 percent in September 2013, dropped to 17 percent in March 2015. However Texas remains the state with the highest percentage of uninsured people in the nation. Studies have shown that uninsured persons are less likely to have a regular source of health care and to receive needed medical care, and more likely to die from health-related problems. Chronically-ill uninsured adults delay or forgo checkups and therapies, including medications. Uninsured PLWH are especially vulnerable to poor health outcomes, including an increased risk of death (Bhattacharya, 2013). In the Austin TGA an estimated 1,358 PLWH were uninsured in 2015.

c. Burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV:

HIV Prevalence Trends

The number of PLWH living in the Austin TGA has risen 18% over the past five years, from 4,676 to 5,521 (Figure 2). Over the past five years, PLWH rate rose from 262 per 100,000 in 2011 to peak in 2014 (282 per 100,000) and then declined slightly in 2015 to 276 per 100,000.

Figure 2: PLWH rates and count, Austin TGA, 2011-2015



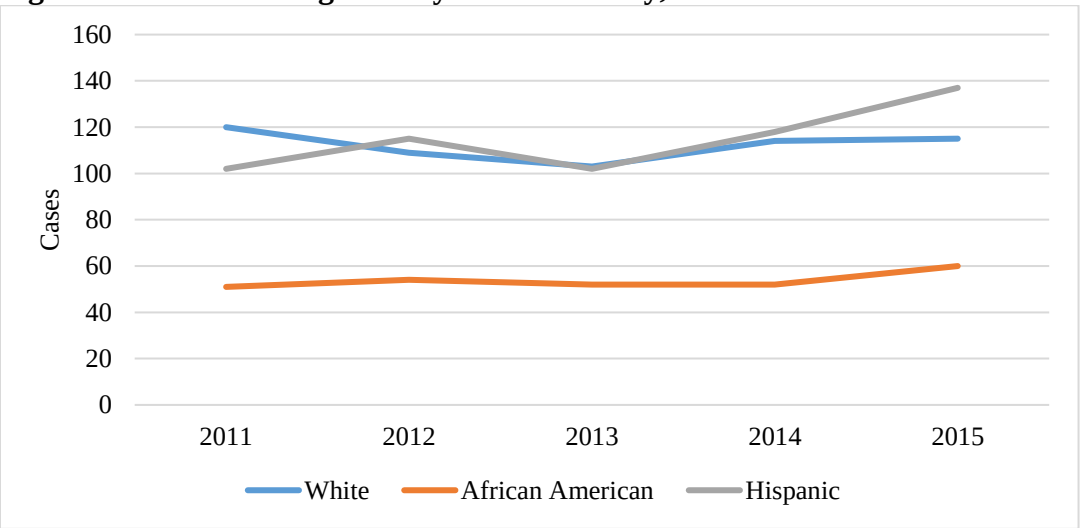
Undiagnosed HIV Infection

It is estimated that there are 1,155 people in the Austin TGA who HIV positive but unaware of their status—17% of all HIV positive individuals. Because they are unaware of their status, these individuals are not in HIV care and may not be virally suppressed, which increases their risk of negative health outcomes and spreading the disease to others.

Trends in Demographic Distribution of New Diagnosis

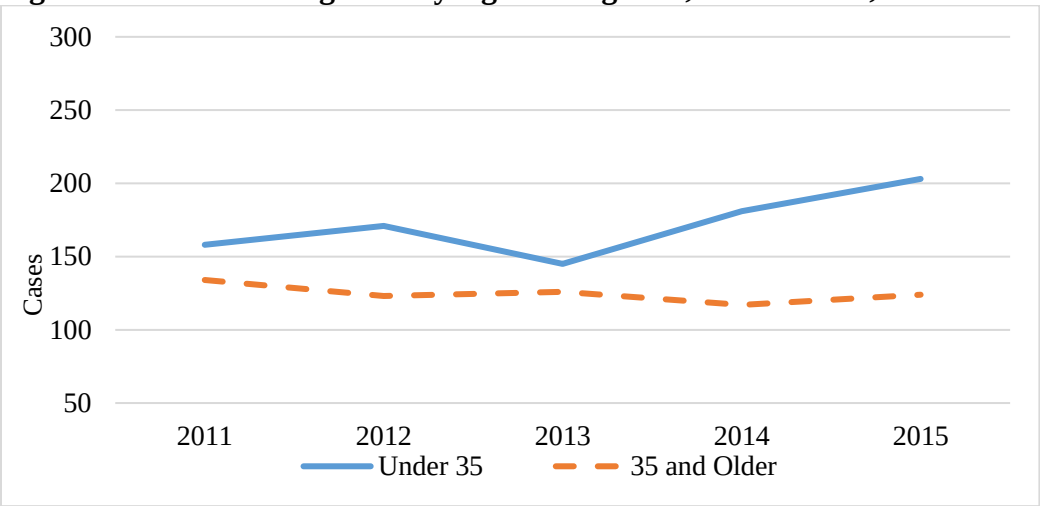
Figure 3 shows the number of new HIV diagnoses by race/ethnicity from 2011 to 2015. Hispanics showed the greatest increase in new HIV diagnoses, surpassing Whites in the number of new HIV infections in 2015.

Figure 3: New HIV Diagnoses by Race/Ethnicity, Austin TGA 2011-2015



New diagnoses in those younger than 35 years of age are on the rise, driven primarily by increases in new diagnoses in those 25-34 years of age (Figure 4). These increases in younger groups are driven by changes in the age of TGA residents at the time of diagnosis. This may indicate a trend towards infection at younger ages, or more robust testing efforts for younger TGA residents. Additional HIV prevalence trends by race, sex, age and mode of transmission is in Table D.

Figure 4: New HIV Diagnoses by Age at Diagnosis, Austin TGA, 2015



Trends in Mode of Transmission

In 2015, MSM made up more than two-thirds of PLWH and more than three-fourths of new diagnoses (Figure 5 & 6). MSM were also the only group to show significant increases in new diagnoses in 2015 (Figure 6).

Figure 7 shows the number of new HIV diagnoses by race/ethnicity among MSM. Understanding how mode of transmission intersects with race/ethnicity is important. The increase in new diagnoses among Blacks and Hispanics seen in Figure 3 can be attributed to the increases in new diagnoses in MSM.

Figure 5: PLWH by Mode of Transmission, Austin TGA, 2011-2015

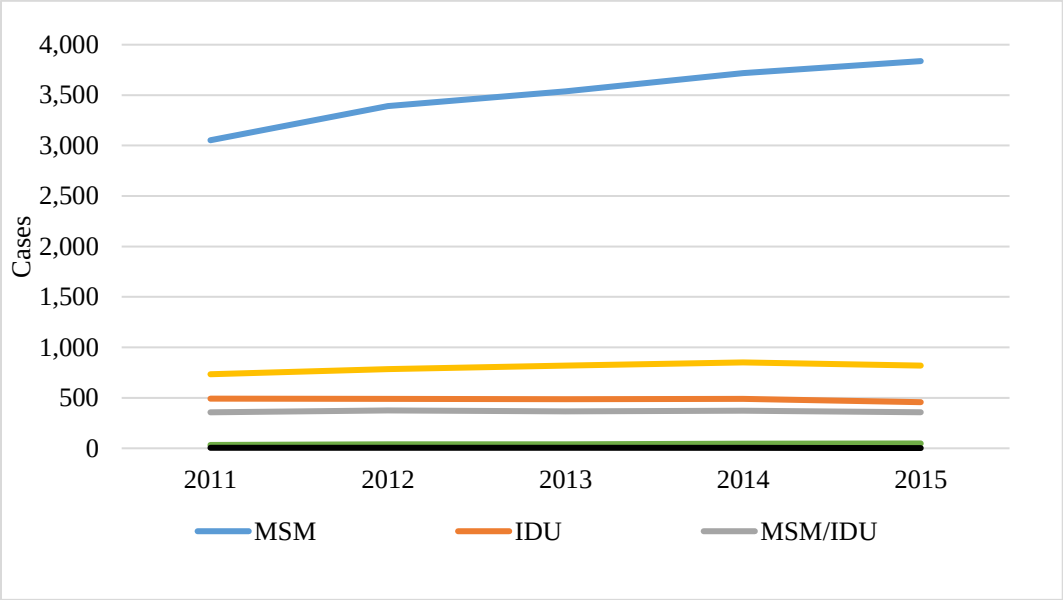


Figure 6: New HIV Diagnoses by Mode of Transmission, Austin TGA, 2011-2015

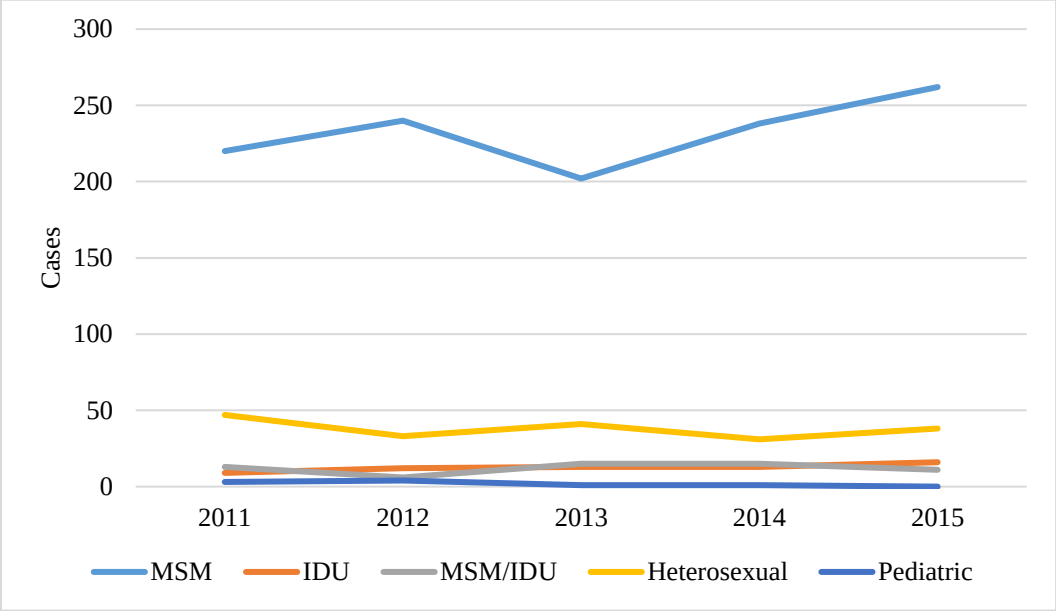
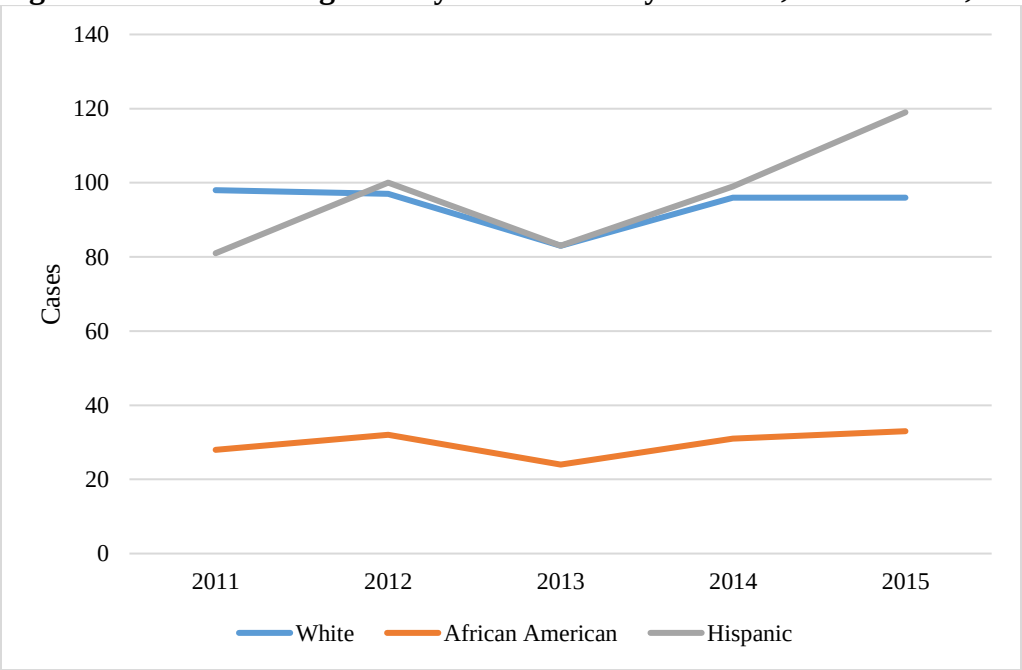


Figure 7: New HIV Diagnoses by Race/Ethnicity in MSM, Austin TGA, 2015



Disparities in Rate of New Infection

Mirroring national trends, Black MSM bear a large burden of disease in the Austin TGA. Overall the rate of new diagnosis in the Austin TGA in 2015 was 16.3 out of 100,000. The rate for Black MSM in 2015 was 794 per 100,000—almost 50 times higher than in the overall population. Although there are fewer new diagnoses for Black MSM than White and Hispanic MSM (Figure 7), the population of Black MSM population is much smaller and therefore still disproportionately affected.

Other subpopulations with high rates of new diagnosis are Black Women (27.9 per 100,000) and Youth age 14-24 (22.3 per 100,000).

Table D : Number and Percent of PLWH, Austin TGA, 2011-2015

	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
Total	4,676	100	5,084	100	5,254	100	5,480	100	5,521	100
Sex at Birth										
Female	714	15	749	15	782	15	814	15	792	14
Male	3,962	85	4,335	85	4,472	85	4,666	85	4,729	86
Race/Ethnicity										
White	2,245	48	2,302	45	2,334	44	2,387	44	2,347	43
African American	1,082	23	1,117	22	1,142	22	1,182	22	1,164	21
Hispanic	1,256	27	1,502	30	1,587	30	1,688	31	1,769	32
Other	50	1	47	1	53	1	59	1	69	1
Unknown	43	1	116	2	138	3	164	3	172	3
Age Group										
0-1	1	0	1	0	0	0	0	0	0	0
02-12	10	0	11	0	12	0	16	0	13	0
13-24	179	4	207	4	195	4	222	4	228	4
25-34	789	17	854	17	896	17	983	18	1,044	19
35-44	1,283	27	1,347	26	1,362	26	1,303	24	1,226	22
45-54	1,627	35	1,738	34	1,745	33	1,789	33	1,761	32
55+	787	17	926	18	1,044	20	1,167	21	1,249	23
Risk Category										
MSM	3,053	65	3,390	67	3,538	67	3,717	68	3,837	69
IDU	492	11	490	10	487	9	490	9	457	8
MSM/IDU	358	8	375	7	365	7	373	7	357	6
Heterosexual	734	16	786	15	820	16	851	16	819	15
Pediatric	33	1	40	1	40	1	46	1	48	1
Adult Other	5	0	5	0	5	0	3	0	2	0

* Transmission categories are estimated, column values may not sum to the column total.

** Adult Other includes received clotting factor, transfusion/transplant, other and unknown.

Note: Transgender persons may be included in male, female, or unknown sex categories.

d. Indicators of risk for HIV infection in the population covered by the service area:

i. Behavioral Surveillance Data

Limited surveillance of risk factors for HIV is done specifically in the Austin TGA, so national and statewide data are used here to (1) show risk factors in the general population and (2) focus on HIV risk behaviors in PLWH currently in care.

<u>HIV risk factors for people of negative or unknown infection status</u>

According to the Centers for Disease Control and Prevention, if current diagnosis rates continue, 1 in 2 black MSM will become infected with HIV in their lifetime (CDC,

2016). In comparison, 1 in 4 Hispanic MSM and 1 in 11 white MSM will become infected in their lifetime. Disproportionately high incidence rates of new diagnosis for black MSM in the Austin TGA confirm that this national trend is in effect at the local level.

The 2014 Texas Behavioral Risk Factor Surveillance System indicated that 58% of Texans have never been tested for HIV. Lack of testing may attribute to the significant number of people who are estimated to be infected with HIV who unaware of their status. People who are unaware of their HIV status are not taking steps to remain virally suppressed and are therefore at a greater risk of negative health outcomes and transmitting the infection to others.

As indicated previously, there has been a recent rise in number of diagnoses in younger populations. Some risk factors for HIV infection for this population are not using a condom during sex, having multiple sexual partners, and injection drug use. According to the 2013 High School Youth Risk Behavior Survey for the state of Texas, 45.9% of high school students in Texas have ever had sexual intercourse and of these, 47.1% did not use a condom during last sexual intercourse. Additionally, 14.9% of high school students had sexual intercourse with four or more persons, and 2.9% of high school students in Texas have ever injected an illegal drug.

HIV risk behaviors in PLWH currently in care

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 STD infections. Self-reported syphilis infection among sexually active MSM is low, however, latent infections canbe 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. Results in Table E.

Sexually active heterosexual persons living with HIV also reported high levels of risk behavior in the past 12 months. 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. Results in Table F.

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

		Average 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%
Race/Ethnicity										
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%
Age										
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 F: Indicators of HIV risk in the last 12 months among sexually active heterosexuals in HIV care, Texas 2013-2014

		Average 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**	**%**	**n**	**%**
Total	122	2	43	36%	28	23%	28	24%
Race/Ethnicity								
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%
Age								
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

Note: Data in this section come from the Texas and Houston Medical Monitoring Project (MMP) sites. Data are representative of PLWH receiving care in Texas.

ii. HIV Surveillance Data

Between January 1st and June 30th 2016, 1,147 targeted HIV test events were conducted in the Austin TGA. Of these, 18 (1.6%) were new positive HIV diagnoses. Targeted testing included 233 tests for young MSM, 3 of which (1.3%) were positive new diagnoses. None of the 73 testing events targeted at Black women were new positive diagnoses. Eleven (0.1%) of the 9,521 non-targeted test events resulted in new positive diagnoses.

iii. Ryan White HIV/AIDS Program Data

The Austin TGA tracks client level data for all Ryan White consumers using AIRES data. The most recent available report, from Ryan White grant year 2012-2013, indicates that the primary risk factor for 56% of Ryan White consumers was MSM, followed by heterosexual sex (21%) and injection drug use (8%). Most (80%) of Ryan White clients were male. White PLWH represented 40% of Ryan White consumers, followed by Hispanic (31%) and Black (27%). The demographics of Ryan White consumers compared to the Austin TGA for the same year is shown in Table G. Ryan White consumers include slightly more females, black people, and people with heterosexual sex as their primary risk factor compared to the overall Austin PLWH population.

Table G: Number and percent of Ryan White Consumers and Austin TGA PLWH, 2012-2013

	Ryan White Consumers		Austin TGA	
	N	%	N	%
Sex				
Male	2,367	80	4,472	85
Female	561	19	782	15
Race/Ethnicity				
White	1,183	40	2,334	44
Black	812	27	1,142	22
Hispanic	911	31	1,587	30
Primary Risk Factor				
MSM	1,642	56	3,538	67
Heterosexual	623	21	820	16
IDU	243	8	487	9
MSM IDU	167	6	365	7

iv. Other Relevant Demographic Data

Chlamydia is the most common reported sexually-transmitted infection in the Austin TGA, with over 10,000 cases reported in 2015. The number of primary and secondary syphilis cases and gonorrhea reported in the TGA was 444 and 3,100, respectively. These three diseases adversely impact PLWH. The risk of primary and secondary syphilis is

over 200 times greater in those persons living with HIV compared with the general population. The risk of gonorrhea is 19 times greater.

v. Qualitative Data

The Austin/ Travis County Health and Human Services Department contracted with Suma Social Marketing in 2014 to conduct a needs assessment, including two focus groups of MSM age 18-27. In the focus groups, alcohol abuse, a large number of sexual partners, incorrect condom use and failure to use condoms were identified as common habits and practices that increase the risk for HIV in the young gay community. Many participants, including some who usually do practice safe sex, reported having had "close calls" (unprotected sex that did not result in an STD or HIV diagnosis) in the past.

vi. Vital Statistics Data

Deaths among Texans Living with Diagnosed HIV Infections

The number of deaths in the Austin TGA, or in any one area of Texas is too limited for the type of detailed analysis below. The data here are for Texas as a whole, retrieved from the Texas Statewide Needs Assessment.

The development of effective anti-HIV medications has allowed PLWH to live longer, and deaths are less frequently attributed to HIV. Nearly half of the deaths due to HIV in 2013 occurred in Blacks and almost 30% occurred in Hispanics.

Table H shows the 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 I 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 will 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 though injection drug use (including MSM/IDU). This may be due to comorbidities associated with injection drug use, such as Hepatitis B and C, as well as the advancing age of Texans with this mode of transmission.

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

	Male Rate	Female	Total Rate
Total	19.3	25.5	20.5
Race/Ethnicity			
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
Primary Risk Factor			
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

B. HIV Care Continuum

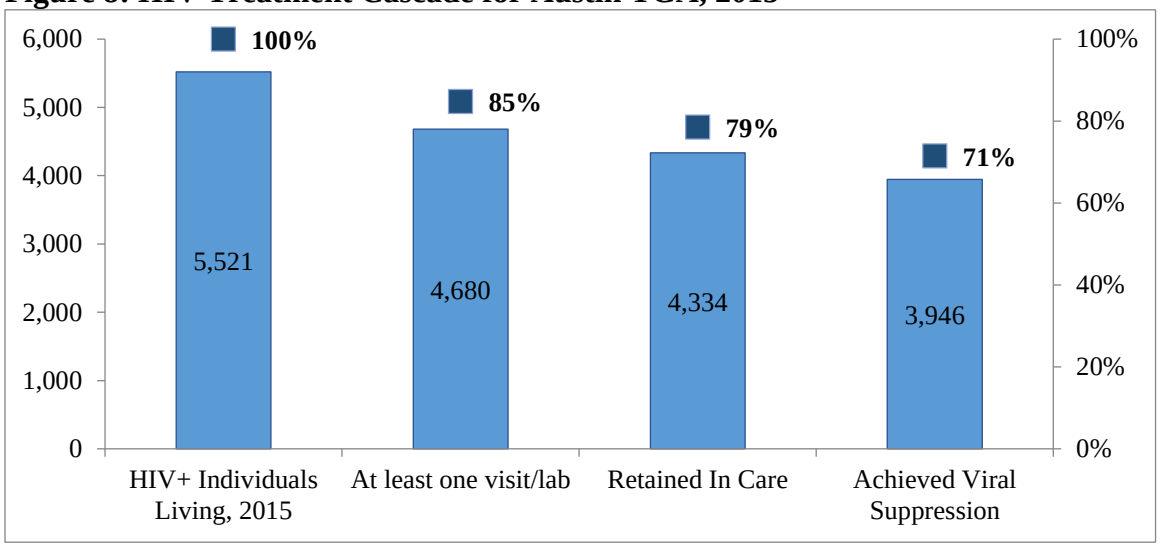
a. Graphic and narrative describing the HIV Care Continuum including definitions of numerator and denominator:

The HIV Care Continuum or HIV Treatment Cascade model consists of the collection and reporting of data on the proportion of PLWH who are engaged at five specific stages of HIV care: Diagnosed; Linked to Care; Retained in Care; Prescribed ART, and Virally Suppressed. The Care Continuum is a useful tool to measure progress of HIV care efforts and as an assessment tool to identify the steps in the process towards viral suppression that pose the largest barrier for HIV positive individuals. Information about individuals perscribed ART is not included in the Austin TGA Care Continuums for reasons addressed in the Data section of this report.

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. Timely linkage in this section, refers to getting HIV care within one month of diagnosis.CD4 and viral load tests, outpatient visits, and filled prescriptions for antiretroviral medications were used as markers of care. Overall, Austin lags behind the national average for linkage to care. Nationally in 2014, 74.5% of newly diagnosed persons were linked to HIV medical care within one month of diagnosis. The majority of people diagnosed with HIV in 2015 were linked within 1 month (60%), almost a quarter (23%) were linked in 2-3 months, eight percent linked in 4-12 months, and nine percent not linked within 2015 (Figure 9).

Figure 8 shows the proportion of PLWH who are engaged at each state of HIV care. As of December 31, 2015, a total of 5,521 persons living with HIV (PLWH) resided in the Austin TGA. A high percentage (85%) of PLWH had evidence of care defined as at least one medical visit, antiretrovial therapy prescription, viral load test, or CD4 count within a year. Most (79%) of the PLWH in the Austin TGA were retained in care by evidence of at least two medical visits, laboratory tests, or antiretrovial therapy prescriptions at least three months apart during a 12 month period. More than half (71%) of PLWH achieved viral suppession, i.e. their last viral load value in 2015 was ≤ 200 copies/ml. Data depicted in the figure was obtained from eHARS, AIDS Regional Information and EvaluationSystem (ARIES), AIDS drug assistance program, electronic laboratory reports, Medicaid, and private insurance payers.

Figure 8: HIV Treatment Cascade for Austin TGA, 2015



Source: *Texas Department of State Health Services*

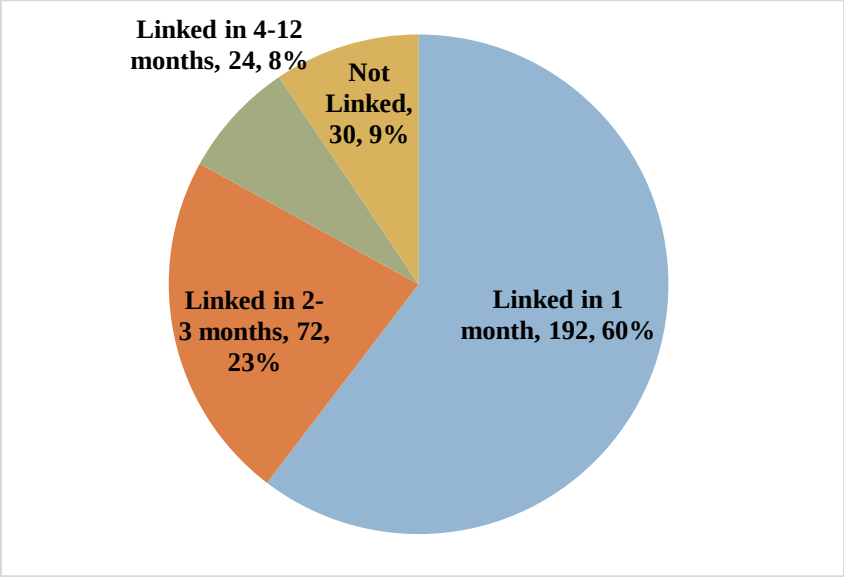
- **HIV+ Individuals at end of 2015**: Number of HIV+ individuals (alive) at the end of 2015.

- **At Least One Visit in 2015**: Number of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2015.

- **Retained in Care:** Number of PLWH with at least two visits or labs, at least three months apart or suppressed at end of 2015.

- **Achieved Viral Suppression:** Number of PLWH whose last viral load test value was
  <= 200 copies/mL at the end of 2015.

Figure 9: Newly Diagnosed Linkage to Care, Austin TGA, 2015

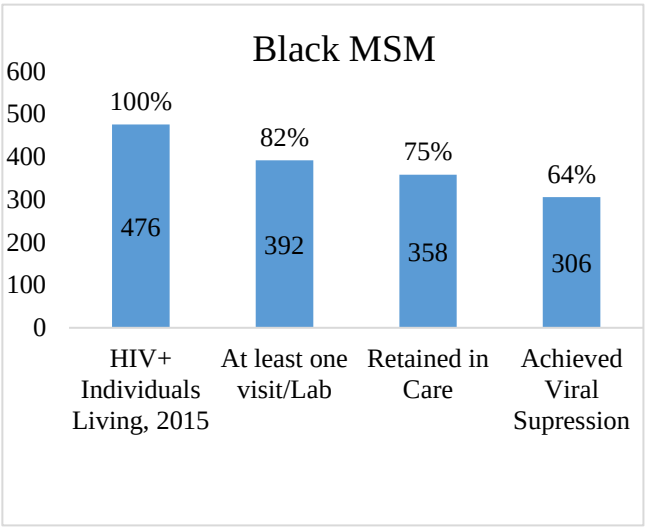


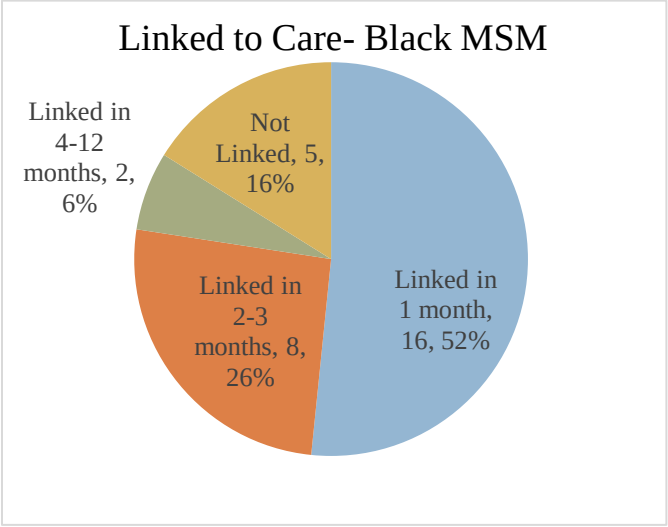
b. Disparities in engagement among key populations along the Care Continuum

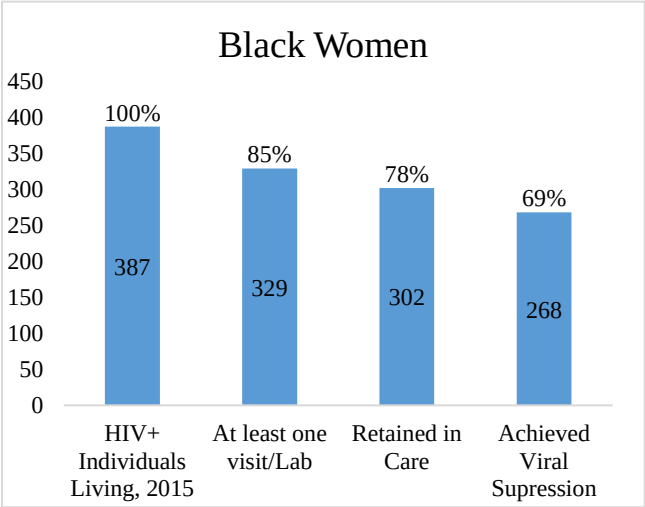
Figure 10 shows treatment cascades for five priority populations. The treatment cascades for Black Women, Hispanics and IDU is similar to that of the Austin TGA overall. Black MSM and Youth age 13-24 are less likely to be retained in care (75% and 68% retained respectively) and Youth are much less likely to be virally suppressed—only 58% of HIV positive youth were virally suppressed in 2015.

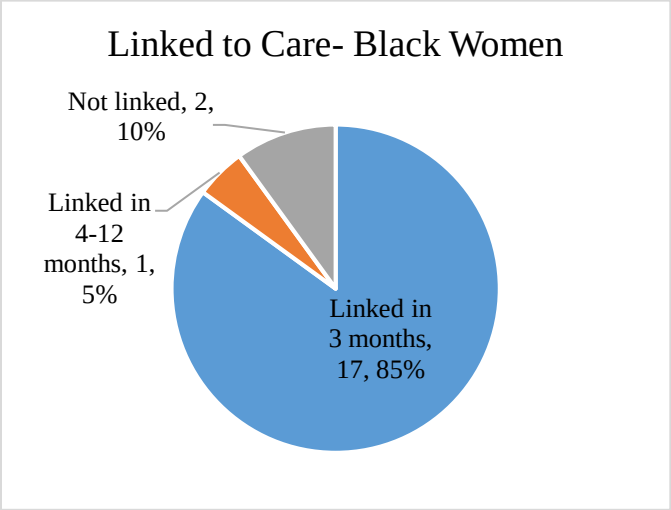
In 2015, 78% of black MSM were linked to care within 3 months in the Austin TGA, compared to 83% overall (Figure 10). Additionally, black MSM were about twice as likely (17%) to not be linked to care at all compared to the Austin TGA overall (9%). Only about half (55%) of Youth (age 13-24) were linked to care within one month. Providers have qualitatively confirmed this trend of difficulty linking youth to care. As the first step along the continuum to viral suppression, it is crucial to address these disparities to insure all groups have the same access to timely HIV medical care.

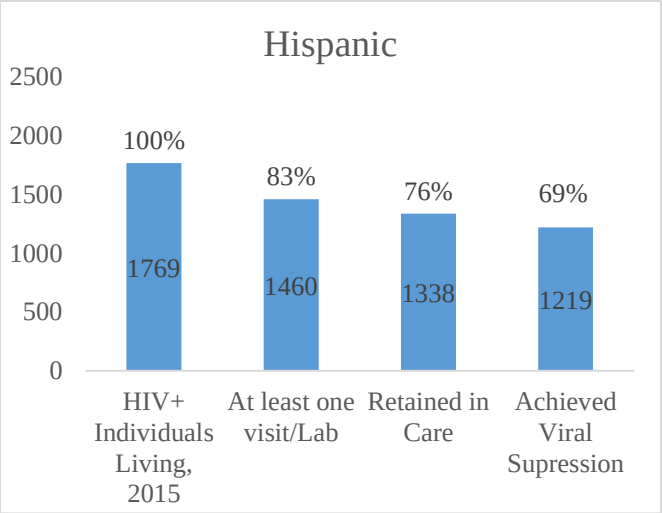
Figure 10: HIV Treatment Cascade for Priority Populations, 2015

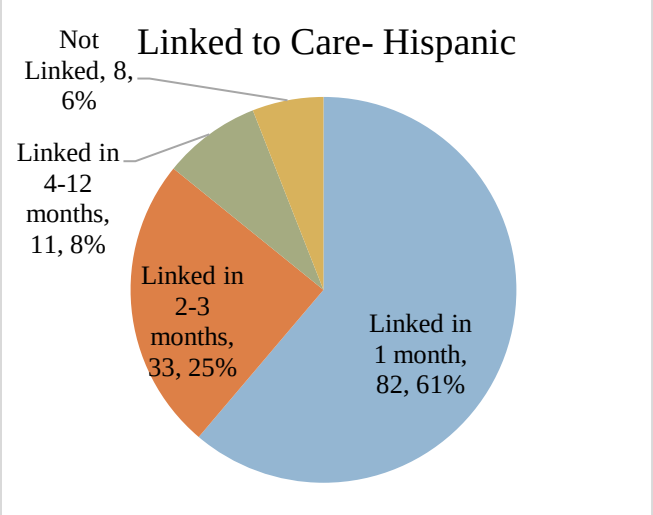


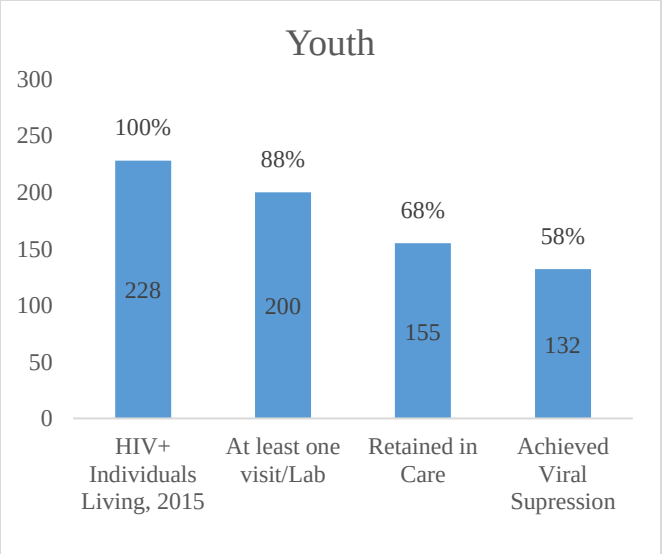


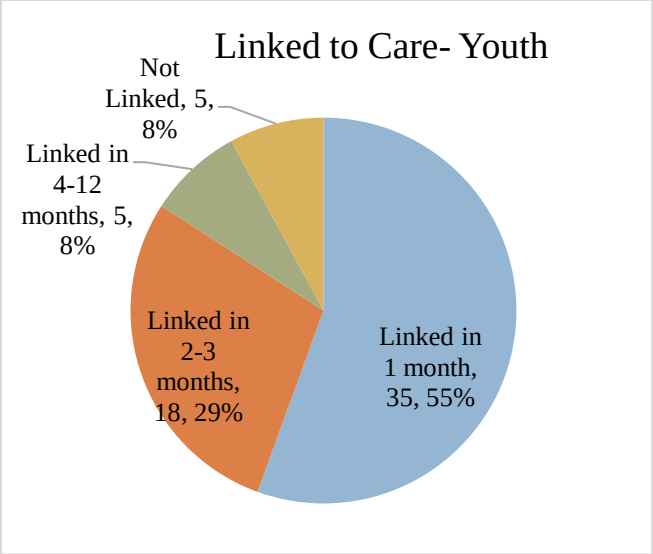


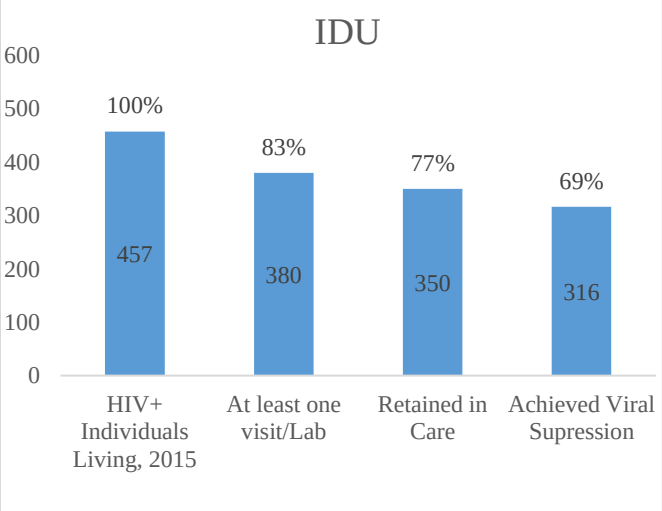


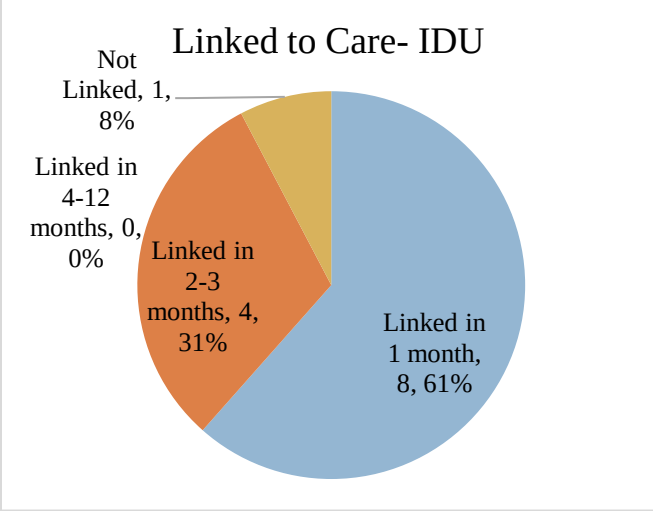












Note: Information was not available for Linked in 1 month for Black Women, so linked within 3 months was used instead.

Late Diagnosis

The best way to improve the health of people with HIV and to reduce further transmission is early diagnosis and treatment. To classify the effects of an HIV infection on immune function, 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 HIV diagnosis are considered a late diagnosis.

In 2015, one in five (19%) of the diagnoses in the Austin TGA were late diagnosis. Many of these cases already have AIDS at the time they learn they are HIV positive. Late diagnosis was most common among Hispanics, where almost one in four (23%) had a late diagnosis. Over one in three new diagnoses for people age 35-44 were late diagnoses. The heterosexual transmission category also had higher levels of late diagnosis (33%) compared to MSM (17%).

Unmet Need

The unmet need estimate derived from the HIV Care Continuum Framework is 15%. This means that 841 people who are HIV positive and aware of their status did not receive any medical services (medical visit, ART prescription, VL test, or CD4 test) over the entire year of 2015. Thus, these individuals are at higher risk of negative health outcomes related to their infection and of potentially infecting others because they are less likely to be virally suppressed. By ethnicity, Hispanics have the highest level of unmet need (17%, n=309) , followed by Blacks (16%, n=183). Injection drug users and heterosexual transmission categories also had higher than average levels of unmet need (17%). PLWH age 25-44 had higher levels of unmet need (18%) than both younger and older age groups. The five zip codes with the highest number of individuals with unmet need are 78741, 78753, 78704, 78758, and 78723. These are all in the city of Austin. Similarly, the zip codes with the highest percent of individuals with an unmet need are also located in Austin, except for 78764, which is in Round Rock, a suburban city located to the north of Austin. About a fifth (22%, n=21) of PLWH in this suburban zip code have an unmet need. This is of concern as most HIV treatment and care services are located in Austin and therefore transportation issues may limit access to care for these individuals.

c. How the HIV Care Continuum is Utilized

The concept of an HIV Care Continuum has been utilized in the Austin TGA for many years. The Care Continuum has been used as a tool to measure progress of HIV care efforts and as an assessment tool to identify which steps in the process towards viral suppression that pose the largest barrier for HIV positive individuals.

The current HIV Care Continuum in the Austin TGA shows remarkable progress made in the effort to link individuals into care, retain them in care, and achieve viral suppression. As depicted in Figure 8, the Continuum accommodates 5,521 PLWH, with 71% being virally suppressed, an increase of 3% over the previous year. This percentage, coupled with a growing number of clients who are new to the care system, demonstrates that measures to ensure access to and retention in care have been effective. Adoption of the Care Continuum concept in the Austin TGA reinforces the area's commitment to insuring the provision of support services in addition to core medical services, as both social and medical determinants effect each step along the continuum.

Monitoring progress along the Care Continuum also allows the Austin TGA to easily compare its progress to national targets and identify areas of strength and improvement. For example, the largest loss of individuals on the path towards viral suppression occurs in the first step—when people do not successfully link to care. Linkage to care has thus been identified as a key step along the Care Continuum in the Austin TGA and initiatives that address this step are prioritized. Additionally, information on the disparities along the Care Continuum helps to identify the priority populations for the Austin TGA, for which additional resources and services may be targeted. Since we know which steps along the care continuum present particular challenges for each subpopulation, such as linkage to care among Black MSM and viral suppression among youth, we are able to target specific activities towards those populations at that point on the continuum.

C. Financial and Human Resource Inventory

a. HIV Resources Inventory for the Austin TGA

See Attachment 1

b. HIV Workforce Capacity and its impact on the HIV prevention and care service delivery system:

According to the Austin Chamber of Commerce, the Greater Austin area is "a region defined by stunning growth, lower business and living costs, and a youthful, well-educated workforce"[1]. Because Austin is such an attractive place to work and live, Austin maintains a strong workforce without many deficits. Job growth in the Austin area remains high and the unemployment rate remains low—at 3.4% compared to 4.5% for

Texas and 5.3% for the United States[1]. One of the biggest industries in the Austin area is Education and Health Services, which employed 111,500 people in 2015[1]. Thus, unlike more rural areas, there is generally not a shortage of HIV medical and support service providers. One exception cited by service providers at Austin HIV Planning Council meetings is that it can be difficult to retain support service personnel, because some Community Based Organizations (CBOs) have difficulty offering competitive pay. Thus, retention in some support service positions are low.

Ryan White Funded HIV Workforce Capacity

The Austin TGA Ryan White Part A program provides care for low-income, uninsured and underinsured individuals and families affected by HIV in the 5-county TGA. Personnel funded or partially funded through Ryan White Part A provide critical support to clients as they progress through the HIV care continuum by providing both core medical and support services. Table J shows the number of medical physician, case managers, mental health counselors, oral health clinicians and substance abuse counselors funded by provider through the Ryan White Part A program in 2016. A huge diversity of professions contribute to the capacity of the local HIV workforce. Eligibility and intake specialists, dieticians, housing coordinators, outreach coordinators, nurses, caregivers, pharmacists, phlebotomists and other services staff are also funded by Ryan White Part A and contribute to the HIV workforce capacity of the city. Thus, the list of five personnel types Table J is not meant to be a holistic picture of workforce capacity, but an indication for a limited number of key services.

Table J: Workforce Capacity of Ryan White Service Provider

Agency	Personnel
Austin Travis County Integral Care	1 psychiatrist, 2 mental health counselors, 3 substance abuse counselors
Central Texas Community Health Center (David Powell Clinic)	17 physicians and nurses, 3 mental health counselors, 1 substance abuse counselors
Waterloo Counseling Center	6 mental health counselors
AIDS Services of Austin	7 medical case managers, 13 non-medical case managers, 11 oral health clinicians
Community Action, Inc. of Central Texas	3 non-medical case managers
Project Transitions, Inc.	11 hospice caregivers
Wright House Wellness Center	2 medical case managers, 2 non-medical case managers

c. Interaction between funding sources to insure continuity in HIV prevention, treatment and care

The Austin TGA has enthusiastically embraced efforts by the Texas Department of State Health Services to create and participate in the HIV Syndicate, which began in the fall of 2013. The objective of the HIV Syndicate is to bring together the various AIDS service organizations, Community Based Organizations serving HIV populations, and state and local agencies administering HIV programs in order to create a unified strategy for addressing HIV/AIDS, specifically including prioritized plans for care and prevention. The impetus for the HIV Syndicate comes from the fact that HIV planning in Texas has historically been separated into jurisdictional "siloes" lacking unified direction. The HIV Syndicate now provides a foundation for a more coordinated and effective strategy, use of resources, and the opportunity to share best practices. Through this partnership effort, the Austin TGA is laying a foundation to achieve the goals outlined in the Nation HIV/AIDS strategy for the United States.

With few exceptions, Part A is one of many funding sources for both HIV care and support services. From a global standpoint, need for services and utilization of those services is relatively steady. Variations in funding from other sources, along with changes in requirements and priorities from other funding sources, is a primary variable driving utilization. This is especially true when considering testing and prevention related services. Fluctuations in CDC funding and priorities also impact service provider focus and operations. The Austin HIV Planning Council carefully considers these fluctuations in other funding sources when considering allocations for the next grant year to insure any gaps are covered and that Ryan White funding remains the payer of last resort. For example, in 2016 Part A did not fund Home Health Care and Referral for Community Based Home Health Care because comparable services are provided by several CBOs organizations in the community.

d. Resources and/or services not provided in the Austin TGA and steps taken to secure them:

Major gaps in services identified in the Austin TGA are housing and transportation. Ultimately the fact that a service gap has been identified and deemed a high priority does not necessarily mean that the service should receive increased funding. When increasing funding to address a gap requires reduction in other service areas, the Austin HIV Planning Council must weigh the options carefully. An equally important consideration is to what extent additional funding is an effective solution.

<u>Housing</u>

Housing Opportunities for Persons With HIV/AIDS (HOPWA) is the lead funding source for housing for PLWH in the Austin TGA. The most effective way to address the service gap for housing is to improve collaboration between Part A and HOPWA. Ensuring that

HOPWA is aware of the service needs of Part A/MAI consumers and conversely, that Part A understands the services and priorities of HOPWA is the best wat to address the housing gap within the Austin TGA. One specific effort that the Austin TGA will work toward is to collaborate with HOPWA to address stigma in housing providers. A strategy that has proven effective in other EMA/TGAs is to conduct "HIV 101" presentations to members of the housing industry in order to reduce stigma related to HIV.

Transportation

Additional funding is not the solution to address transportation service needs. The most effective way to impact the transportation gap is to (1) advocate on behalf of the consumers with Capitol Metro (the City busy system) (2) review policies and procedures used to administer transportation services to determine if any policies could be modified to improve consumer access to transportations and (3) research the potential for an expansion of mobile services to reduce the amount of traveling required to receive services.

D. Assessing Needs, Gaps and Barriers

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

The identification and prioritization of HIV prevention and care service needs was done through an iterative, multistage process that combined community member and stakeholder voices with quantitative epidemiological data presented earlier. Two needs assessments, one focused on Ryan White consumers within the Austin TGA and the other focused on people living with HIV and young MSM were conducted to identify needs and gaps in prevention and care.

A Ryan White consumer needs assessment, conducted in 2014 by the Austin HIV Planning Council Needs Assessment Committee and support staff, included 346 consumer surveys, five consumer focus groups, and surveys and interviews with providers. Older individuals and heterosexuals were over-represented in the survey, but other demographics of survey respondents were representative of Ryan White consumers in the Austin TGA. Focus groups for specific populations (aged, homeless, substance abuse and mental health, Black, and Hispanic) insured that a diversity of consumer opinions were represented.

A smaller needs assessment, contracted by the Austin/Travis County Health and Human Services Department and conducted by Suma Social Marketing in 2013, assessed needs of Austin PLWH through 45 surveys of PLWHA and two focus group discussions. The assessment included a focus group of young MSM in an effort to focus on the service needs for people at higher risk for HIV.

In 2016, a workgroup was created to review findings on prevention and care needs from the needs assessments, in conjunction with up to date epidemiological and continuum of care data. This data is the basis of the Integrated HIV Prevention and Care Plan. The workgroup was developed strategically to be composed of service providers, Ryan White consumers, and other AIDS Service Organizations (ASOs) in the community. The needs identified in these assessments were presented to workgroup along with data from AIRES and eHars during the first of five workgroup sessions. The remaining four sessions were spent developing goals, objectives, strategies and activities based on these identified needs.

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

<u>HIV prevention needs of persons at risk for HIV</u>
Service needs for persons at higher risk for HIV infection are those that reduce new infections and promote early detection of infection. There were 327 new diagnoses of HIV infection in 2015 and racial/ethnic disparities in diagnosis are growing. New diagnosis rates for Hispanic MSM are growing and diagnosis rates for Black MSM (794 per 100,000) are significantly higher than for the general population (16 per 100,000). The following have been identified as key preventative service needs for persons at high risk for HIV:

- Targeted social marketing and mass education
- Prevention with Positives
- Education and uptake of PreP
- Condom distribution
- Holistic, age-appropriate universal sexual health education

Once a person becomes infected, knowledge of HIV status is the first step towards addressing the disease. It is estimated that 1,155 people in the Austin TGA have HIV/AIDS but are undiagnosed and unaware of their status. Service needs for early detection include:

- Targeted testing for high-risk populations
- Non-targeted routine, opt-out testing in facilities serving high-risk populations
- Targeted social marketing and mass education

<u>HIV prevention and care service needs of PLWH</u>
The needs of people living with HIV/AIDS develop based on where they are on the continuum of care. For newly diagnosed individuals, linkage to care as quickly as possible is the first step in the process to achieve viral suppression. Service needs for these individuals include coordination and collaboration between testing and care

providers to insure smooth transition into care services. PLWH should then be retained in care, prescribed antiretroviral therapy and achieve viral suppression. Outpatient medical care is required to achieve each of these steps along the continuum, but additional medical and support services are also needed to insure individuals maintain their overall health and wellness.

The services most needed in the Austin TGA among PLWH were identified in the 2014 Ryan White consumer needs assessment. Service needs for people already in care were determined based on the number of consumers who indicated in a survey that they need a particular service. Consumer ranking of importance of each service gave similar results, with slight changes in priority of the services. Services most frequently identified by consumers as needed include:

1. Outpatient Ambulatory Medical Care
2. Food Bank
3. Case Management Non-medical
4. AIDS Pharmaceutical Assistance
5. Oral Health Care
6. Medical Transportation Services
7. Housing
8. Health Insurance Premium Assistance
9. Nutrition Services
10. Mental Health Services

c. Service gaps identified by and for persons at higher risk for HIV and PLWH:

The following key service gaps have been identified based upon 2014 needs assessment consumer surveys and focus groups. Each of these gaps has been identified by consumers as having a significant impact on adherence to medical care as well as having an impact on populations at risk for infection:

<u>Housing</u>

Housing is without question the most significant service gap within the Austin TGA. Based upon results of the 2014 Part A Needs Assessment only 48% of consumers reported a stable housing status. While only 7% reported that they were homeless, the majority reported their housing situation was unstable. Consumers reported a broad range of temporary housing situations, including staying with a friend, various types of shelters, motels, rehabilitation facilities and other short term situations. Many survey respondents selected more than one option (e.g., jail, homeless shelter) owing to the fact that housing is unstable and a day to day challenge. Insight regarding housing challenges obtained from focus groups and community forums provide clarity to the ongoing challenge faced by many consumers – many do not know from day to day or week to

week where they will reside. Austin is one of the fastest growing communities in the nation. As a consequence of a booming economy rents are rapidly increasing. Consumers increasingly report they are simply unable to afford housing even when employed.
The implications for continuity of HIV care are profound. If a consumer is struggling to meet basic needs like housing or food, keeping a medical appointment or taking prescribed medications is only a priority if the consumer's disease has progressed to the point where they are too ill to function. There is a clear and direct relationship between unmet basic needs (including housing) and adherence to care.

Transportation
Transportation is one of the better understood service needs, and also the service need most often cited by consumers as a key issue. While the needs assessment question specifies medical transportation, respondents are influenced in their responses by the fact that large numbers of consumers have basic unmet transportation needs. Respondents do not necessarily separate out transportation for medical appointments from other travel. Approximately 93% of Austin TGA Ryan White consumers are served by the public bus system. Consumers expressed enormous frustration with both the fixed route bus system and the door to door transportation for the disabled. The bus service issue goes well beyond funding Ryan White service. The needs assessment findings reinforce two key points regarding transportation as a service gap. First, this service need cannot be resolved simply through additional funding. Second, the needs and challenges of rural consumers are quite different than those served by the metropolitan bus system.

It is also significant to recognize that transportation continues to be a frequently cited reason for missed appointments. Input from focus groups reinforced a key issue regarding medical appointments. There are times when consumers miss an appointment because they are unable to make it on the scheduled day due to not feeling well. The inability to travel on a "bad" day is influenced to a large degree by the effort required to travel via the door to door bus system available for the disabled.

Mental Health:
Much like housing, mental health has a tremendous influence on the continuum of care. Many consumers report that depression is a major reason for a delay in seeking care or the reason they stopped taking HIV medication. Needs assessments indicate that 63% of consumers report a mental health condition. However, only 38% report seeking mental health service with 35% receiving mental health service. It is important to note that there are limitations for PLWH to access MH services. Focus groups and individual interviews provide insight into the question of why consumers are not seeking mental health service:

- Depression is the number one issue reported (59%). Essentially, consumers report that mental health service is not effective in managing their depression.

One consumer stated "*I go to a support group and take my medication but the reason I am depressed is still there".* Focus group participants universally report feelings of hopelessness and isolation. Most feel the depression medication they receive is largely ineffective in reducing their depression. Some report using illegal drugs as a temporary escape from their depression.

- The other key to understanding why consumers who are experiencing mental health issues do not access services is the reluctance of consumers to acknowledge their need. Acknowledging a mental health problem is difficult for many people. Stigma is a frequently cited cause for not seeking mental health care. Focus group participants cited the double stigma of HIV and mental health.

Consequently mental health is listed as a key gap because it is a major factor in PLWHA dropping out of care and opting not to begin care. A common statement made by many consumers is that due to depression they just stop caring and just give up.

d. Barriers to HIV prevention and care services:

The table below lists identified barriers to HIV prevention and care services. This list combines input from the 2013 Suma Social Marketing PLWH focus groups and surveys, Austin HIV Planning Council members and from additional stakeholders.

Table K: HIV Prevention and Care Service Barriers

HIV Prevention and Care Service Barriers	
i. Social and structural barriers	Social: • Lack of perceived susceptibility to infection • Lack of knowledge of rise in infections in high risk groups • Poverty • Stigma around HIV Structural: • Awareness of HIV services is low
ii. Federal, state or local legislative/policy barriers	Federal: • Changing healthcare coverage landscape State: • Lack of Medicaid expansion • Absence of health carrier plan options in marketplace • Restrictions on sexual health education in schools Local: • Transportation services- Metro system difficult to access for people living in more suburban areas

	• Municipal personnel governance encumbers health department activities
iii. Health department barriers	• Need for bilingual (English/Spanish) staff • Need for personnel to assist in navigation of patient assistance and healthcare regulatory change • Need for cultural competency and cultural agility policy
iv. Program barriers	• Challenges in collecting data with AIRES • Surplus of reporting requirements and paperwork
v. Service provider barriers	• Need for cultural competency training among services providers • HIV education/updates are needed for all providers • High turnover of support service staff due to difficulty maintaining competitive salaries
vi. Client barriers	• Financial barriers • Fear or stigma within families or communities • Medical adherence • Access to affordable housing • Stigma and anxiety around testing • Access to PreP • Lack of transportation • Untreated mental health issues

E. Data: Access, Sources and Systems

a. Main sources of data and data systems used to conduct needs assessment and develop the HIV Care Continuum:

1. **Health Resources and Services Administration (HRSA) and CDC** – Best practices and guidance were pulled from reports developed by the CDC and HRSA. The CDC provides the annual projection for the number of people who are HIV positive but unaware of their status and information on transgender populations which is not available from the state.
2. **Texas Department of State Health Services (DSHS)** – DSHS produces the annual *Texas HIV Surveillance Report* which provides statistical, surveillance and demographic data at the state level with breakdowns by EMA/TGA, HSDA (Part B regions) and by county. DSHS provides the majority of the data and reports required by the Austin TGA to prepare the annual Ryan White grant applications and this plan. DSHS produces the annual Treatment Cascade and related data

profiles with information retrieved from the Enhanced HIV/AIDS Reporting System (eHARs) system.

3. **AIDS Regional Information and Evaluation System (AIRES) –** AIRES is the system used by all Texas EMA/TGAs and other Ryan White parts to facilitate Ryan White operations, including provider reporting/tracking of services delivered. The database enables each EMA/TGA to produce a wide variety of reports sorted by financial, utilization and consumer demographic profiles. This is the primary tool used by the Austin HIV Planning Council during the Priority Setting and Resource Allocation process to provide a clear understanding of the profile for consumers who utilize each service, the number of units of service delivered for each service. AIRES data is used to generate the Ryan White HIV/AIDS Program Services Reports (RSRs).
4. **Needs Assessments for the Austin TGA** –The Needs Assessment Committee of the Austin HIV Planning Council developed a needs assessment report in 2014. Additionally, SUMA Social Marketing was contracted by the Austin/Travis County Health and Human Services Department to conduct qualitative research among people with HIV/AIDS, those at risk of acquiring HIV, and are professionals working with people with HIV in a variety of settings. Qualitative data from these reports was used to identify key gaps and barriers to care for people living with HIV/AIDS.
5. Information from the AIDS Drug Assistance Program, electronic laboratory reports, Medicaid and private insurance payers was also contributed to the generation of the Austin TGA Care Continuum.
6. Additional behavioral surveillance data sources used to assess the HIV prevention and care landscape of the Austin TGA include the Texas Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System (YRBSS) and the Texas and Houston Medical Monitoring Project.

b. Data policies that facilitated and/or served as barriers to the in developing the needs assessment and the HIV Care Continuum:

1. Efforts to reduce reporting burden on health care providers who utilize AIRES also present challenges in data reliability. For example, clerks are not required to update demographic information about a consumer each time the consumer utilizes a service. Therefore, if a consumer's status changes (ie. Insurance status or homeless status), these changes may not be updated in the system. Additionally, some sub-categories in AIRES are undefined, have more than one meaning, or have many similar options. Service providers have also reported loss of data as a result of system performance and software upgrades. Both point in time view of AIRES data and trend view of AIRES data present challenges. Variance seen between years with point in time data may represent changes in

reporting timing instead of actual trends in services. Also, the definition of service components can change over time, so looking at trends in these is difficult.

2. Reports are produced for specific funding sources and the timeline for those reports is dependent upon the fiscal year for each funding source. Ryan White Part A is on a March 1 through February cycle. Part B is on a separate "unique" funding cycle and most of DSHS reports are based upon calendar year. This presents challenges for the Austin HIV Planning Council when comparing data from different sources.
3. Data and reports are generally a year or more behind the current data. This is in part due to the vetting process that ensures that public release of information has been properly verified and approved by the agency management, and in part due to the fact that many reporting sources (such as physicians and laboratories) who report HIV cases in accordance with legal requirements, are often slow in reporting.

c. Data and/or information the planning groups would like to have used but was unavailable:

The transgender population has been identified as a priority population for the Austin TGA. The Austin HIV Planning Council is interested in the epidemiology and care continuum for the transgender population in the Austin TGA and for transgender Ryan White consumers. However, reporting on gender has not been consistent across service providers and aggregate information on the transgender population is currently missing. The Austin HIV Planning Council was unable to assess unmet need and other data trends for this population. An activity in the 2017-2021 HIV Integrated Prevention and Care Plan is to research and advocate for best practices for data collection on transgender populations at the state and national level. Texas Department of State Health Services is in the process of switching to a standardized reporting format for gender.

Data for the Austin TGA Care Continuum comes from the Enhanced HIV/AIDS Reporting System (eHARs) system, which is managed by the Texas Department of State Health Services (DSHS). The HIV Care Continuum or HIV Treatment Cascade model consists of the collection and reporting of data on the proportion of PLWH who are engaged at five specific stages of HIV care: Diagnosed; Linked to Care; Retained in Care; Prescribed ART, and Virally Suppressed. DSHS was not able to isolate and provide data for the fourth stage on the HIV Care Continuum, the number and percentage of PLWH in the TGA prescribed a combination of three or more antiretroviral drugs from at least two different HIV drug classes daily to control the virus. This challenge will be resolved with continued information-sharing and other research of best practices that have been developed and used successfully by other jurisdictions. The Austin HIV Planning Council plans to collaborate with DSHS to develop a methodology that can

provide reliable data required for the Prescribed Antiretroviral Therapy (ART) stage on the HIV Care Continuum.

The data analyst position at the City of Austin which is responsible for compiling and managing AIRES data on Ryan White consumers, was vacant during the needs assessment stage of plan development. Therefore, an updated Ryan White HIV/AIDS Service Report for 2015 was unavailable and 2013 data was used instead. The hiring process is currently underway to fill this position.

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Plan

The figure and tables below include information requested on the Integrated HIV Prevention and Care Plan **a.-d.** Figure 11 is an overview of the planned goals and objectives, which is followed by a detailed list of all goals, objectives, strategies and activities planned for 2017-2021.

Figure 11: 2017-2021 Austin TGA Integrated Prevention and Care Plan- OVERVIEW

	GOAL	OBJECTIVE	SMART Objectives Dashboard BASELINE (2015)	BY 2021	% CHANGE
	Goal 1: Reduce new HIV Infections	Objective 1: Reduce new diagnoses by 25% by 2021	N=327	N=246	25%
		Objective 2: Reduce late-stage diagnoses (AIDS defining CD4 within 12 months of initial diagnosis) by 25% by 2021	22%	16.5%	25%
	Goal 2: Increase access to care and improve health outcomes for PLWHA	Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of diagnosis from 60% to at least 75% by 2021	60%	75%	15%
		Objective 2: Increase the percentage of PLWHA who are retained in HIV medical care from 79% to at least 85%	79%	85%	6%
	Goal 3: Reduce HIV-related disparities and health inequalities	Objective 1: By 2021, reduce disparities in the rate of new diagnoses by at least 15% in the following population*s:			
		Black MSM	48.7	41.4	15%
		Black Women	1.7	1.4	15%
		Hispanic	1.3	1.1	15%
		Youth	1.4	1.2	15%
		IDU	5%	4.3%	15%
		Objective 2: By 2021, reduce disparities in Viral Load Suppression by increasing Viral Load Suppression to 80% for each of the following populations:			
		Black MSM	64%	80%	16%
		Black Women	69%	80%	11%
		Hispanic	69%	80%	11%
		Youth	58%	80%	22%
		IDU	69%	80%	11%
	Goal 4: Achieve a more coordinated response to the HIV epidemic	Objective 1: By 2021, increase Ryan White non-conflicted consumer representation on the Austin HIV Planning Council to at least 33%		33%	
		Objective 2: By 2021, advocate for agenda items of collaborative entity meetings focused on improving the HIV system of care			

* Measures shown are ratios of the disparity rate in the specified group to the overall rate in the Austin TGA. Target rates were adjusted to reflect the Goal 1 target of a 25% reduction in new diagnoses overall for the Austin TGA

GOAL #1: Reduce new HIV infections

Objective 1: Reduce new diagnoses by 25 percent (from 327 to 246) by 2021.

Strategy 1: Provide easily accessible, appropriate, scientifically accurate information about HIV risks, prevention, and transmission to high-risk populations.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Support coordinated social marketing and other mass education activities focused on raising HIV awareness, including targeted messages for high risk populations (sex, age, etc.).	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Community Based Organizations	High-risk MSM, IDU, Women, Youth, Black, Hispanic	Number of social marketing messages and mass education activities; total of different types of messages
A2	2017-2021 ONGOING	Promote culturally and linguistically appropriate prevention efforts (such as community mobilization efforts and peer approaches that encourage community members who interact with target populations to be HIV prevention advocates), including reviewing current CLAS standards and the annual review and implementation methodologies.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units)	Community members who interact with target populations	Number of prevention efforts; number of community mobilization efforts; number of peer support programs
A3	2017-2021 PROJECT	Evaluate and expand Prevention with Positives interventions including treatment adherence, HIV prophylaxis, and behavior change interventions for HIV+ individuals and their partners.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); Ryan White Part A Case Management Providers	HIV+ individuals and their partners	Number of clients receiving Prevention with Positives interventions, Number of negative people who receive Prevention with Positives interventions who remain negative
A4	2017-2021 ONGOING	Sustain condom distribution for: (a) the general public and (b) for high-risk populations and communities.	HIV Planning Council; City of Austin HHS (Communicable Disease unit); HIV Task Force	General Population; High-risk MSM, IDU, Women, Youth, Black, Hispanic	Number of access points for free condoms

Strategy 2: Provide easily accessible, scientifically accurate information about area HIV trends to community providers and policymakers to inform the delivery of prevention services.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017 ANNUAL MEETING	Convene area HIV prevention providers to highlight trends and gaps in local HIV data on prevention and transmission.	HIV Planning Council; HIV Task Force; City of Austin HHS (Communicable Disease unit)	HIV prevention providers	Report produced
A2	2017-2021 ANNUAL REPORT	Educate policymakers on changing governmental policies that create barriers to HIV prevention information and tools (e.g. provide annual report including testing data and recommendations to City of Austin Health and Human Services committee).	HIV Planning Council; City of Austin HHS Department (HIV Resource Administration and Communicable Disease units); Texas Department of State Health Services Epidemiology Division	City of Austin Travis County	Number of education actions; number of government policies changed

Strategy 3: Expand local capacity and infrastructure for prevention services.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Advocate for the City of Austin to designate funding for PrEP to high risk populations.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Texas Department of State Health Services Epidemiology Division; Austin PrEP Access Project, HIV Task Force	City of Austin City Council	Number of times information and requests are sent to City Council; Amount of PrEP funding designated from City of Austin
A2	2017-2018 PROJECT	Develop guidelines to expand community-wide access to PrEP and nPEP.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Texas Department of State Health Services Epidemiology Division; Austin PrEP Access Project	People at risk for HIV	Guidelines developed; Number of people using PrEP and NPEP; Number of access points /providers prescribing

A3	2017-2018 PROJECT	Develop a toolkit for private medical doctors for how to provide PrEP/nPEP and how to link a newly diagnosed individual to the Ryan White HIV/AIDS Program.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Texas Department of State Health Services Epidemiology Division; Austin PrEP Access Project	Private medical doctors	Creation of toolkit; Number of private medical doctors who receive toolkit; Number of private medical doctors who link to HIV care
A4	2017-2021 PROJECT	Evaluate and improve the integration of appropriate harm reduction approaches into prevention programming.	HIV Planning Council; HIV Task Force; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Austin Harm Reduction Coalition	High-risk MSM, IDU, Women, Youth, Black, Hispanic	Number of harm reduction approaches implemented
A5	2017-2021 ONGOING	Advocate for early Treatment as Prevention approaches to be incorporated into existing prevention programming.	HIV Planning Council, HIV Task Force	HIV Providers	Number of persons who are virally suppressed; Number of new diagnoses; Number/percent of providers who incorporate Treatment as Prevention approaches

Objective 2: Reduce late-stage diagnosis (AIDS defining CD4 within 12 months of initial diagnosis) by 25% (from n=71 to n=54) by 2021.

Strategy 1: Tackle misperceptions, stigma, discrimination and knowledge deficits to break down barriers to HIV testing.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Support coordinated social marketing and other mass education activities focused on HIV testing as prevention, including targeted messages focusing on existing misperceptions, and social stigma in high-risk populations (sex, age, etc).	HIV Planning Council; COA HHS (HIV Resource Administration and Communicable Disease units)	High-risk MSM, IDU, Women, Youth, Black, Hispanic	Number of social marketing and mass education activities
A2	2017-2021 ONGOING	Promote culturally and linguistically appropriate prevention efforts, such as community mobilization efforts and peer approaches that encourage community members who interact with target populations to be HIV prevention advocates.	HIV Planning Council; COA HHS (HIV Resource Administration and Communicable Disease units)	Community members who interact with target populations	Number of prevention efforts; number of community mobilization efforts; number of peer support programs

Strategy 2: Support HIV testing and routine opt-out screenings in medical settings.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Sustain targeted HIV testing by community-based organizations to high-risk populations.	HIV Planning Council; City of Austin HHS (Communicable Disease unit); HIV Task Force	High-risk MSM, IDU, Women, Youth, Black, Hispanic	Number of HIV testing for high-risk populations by community based organizations
A2	2017-2021 PROJECT/ ONGOING	Expand non-targeted routine, opt-out HIV testing in facilities serving high-risk populations.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); HIV Task Force; HIV Syndicate; Department of State Health Services	TGA area medical care providers	Number of routine opt-out HIV screenings preformed in medical settings; Number of providers/organizations implementing opt-out testing

Strategy 3: Coordinate with community providers to promote awareness of and linkage to supportive services and increase testing efforts.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2019 PROJECT (Similar Activity in G1O1S1A1)	Identify and promote holistic, age-appropriate universal **sexual health education** curricula and strategies to be implemented by community partners.	HIV Planning Council; City of Austin Health & Human Services; HIV Task Force; Youth/Adult Council, The Q	General population, UT, AISD, other TGA ISDs and schools	Number of curricula identified; number of strategies identified; number of curricula/strategies employed
A2	2017-2019 PROJECT	Develop centralized web-based resource guide of supportive services available to HIV providers and HIV community.	HIV Planning Council; COA HHS (HIV Resource Administration, ATCHHSD IT)	PLWHA; HIV Providers	Number of website visits
A3	2017-2021 ONGOING	Increase awareness and use of non-traditional testing sites with expanded hours and mobile services designed to reach vulnerable populations.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); HIV Task Force	High-risk MSM, IDU, Women, Youth, Black, Hispanic; other vulnerable populations	Number of mobile and non-traditional testing sites; Number of tests performed at these sites; Number of available testing hours; Number of visits to austintexas.gov/department/where-get-tested, Number of mobile testing promotion activities

GOAL #2: Increase access to care and improve health outcomes for people living with HIV

Objective 1: Increase the percentage of newly diagnosed persons linked[1] to HIV medical care within one month of diagnosis from 60% percent to at least (75) percent by 2021.

Strategy 1: Improve coordination, communication, and alignment between (1) testing/ prevention providers and (2) HIV medical-service providers.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1a	2017-2018 PROJECT	Survey newly diagnosed people on their linkage experience and create strategies to improve linkages to care.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); Ryan White Medical Providers Health Center; Department of State Health Services	Newly diagnosed individuals	Survey created Number of newly diagnosed surveyed
A1b	2017-2018 PROJECT	Investigate and identify systematic barriers to linkage to care and evaluate opportunities to improve and execute strategies that result in successful linkage to care.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); Ryan White Medical Providers Health Center; Department of State Health Services	HIV service providers	Number of Committee meetings with this as an agenda item Report on key findings
A1c	2018-2019 PROJECT	Facilitate the development of a community definition of HIV care coordination, and assess the coordination between (1) testing/prevention providers and (2) HIV service providers.	HIV Planning Council; City of Austin (Quality Improvement Committee) HIV Taskforce; Department of State Health Services	Medical Service Providers and HIV Prevention Providers	Number of people linked to care

[1] **Linkage to Care** - No. of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test)

Strategy 2: Increase awareness and access to HIV-related support services available in the community upon HIV diagnosis.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1a	2017-2019 PROJECT	Conduct a survey of what barriers exist for newly diagnosed individuals that prevent or delay access to support services.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	Newly diagnosed individuals	Creation of Needs Assessment Survey; Number of survey respondents; Percent of newly diagnosed people that were knowledgeable about or have accessed support services
A1b	2020-2021 PROJECT	Develop training for front line staff designed to facilitate conversations about available services for HIV+ individuals and reduce barriers for attending their first medical appointment. Develop Ryan White services brochure for clients.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); HIV Taskforce	Front line workers including prevention specialists from Ryan White funded agencies	Training Created; Number of front line workers educated; Client Brochure Created; Number of brochures distributed; Survey Results from linkage survey

Strategy 3: Increase access to providers of clinical care for people living with HIV.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ANNUAL MEETING	Host forum/town hall addressing HIV clinical and service topics, including, but not limited to: care of transgender clients, CLAS standards, times of services, number of HIV service providers, and geographic availability of HIV services.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV Clinical and Service Providers HIV+ Individuals	Number of forums held; Number of Attendees

A2	2017 PROJECT	Research alternative clinic models to reach clients, including Telemedicine.	HIV Planning Council; City of Austin HHHS	HIV Clinical Providers	Completion of study and if warranted, creation of recommendations for implementation
A3	2018-2021 ONGOING	Advocate for the creation of mobile medical clinics and co-locating HIV services with other mobile services such as food distribution and needle exchange.	HIV Planning Council	HIV care and service providers; Policy makers	Number of mobile clinics and mobile services available
A4	2017-2021 ONGOING	Promote Affordable Care Act through enrollment into the marketplace for those who are living with HIV.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals	Number of people living with HIV with health insurance; Number of people living with HIV with Medicaid; Number of clients utilizing Health Assurance Premium and Cost Sharing Assistance

Objective 2: Increase the percentage of PLWHA who are retained in HIV medical care from 79 percent to at least (85) percent.

Strategy 1: Strengthen a comprehensive, patient-centered approach to HIV care that addresses HIV-related co-occurring conditions and chronic disease management.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Promote and collaborate with peer support programs, support groups, meet ups, and events.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals, Community AIDS Service Organizations	Number of events and programs
A2	2017-2021 PROJECT	Launch a re-linkage to care project that develops an expedited into care system for recently released HIV+ individuals.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	Recently released HIV+ Individuals, Medical Providers	Project implementation
A3	2017-2021 PROJECT	Educate providers regarding patient-centered care.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	Medical Providers	Number of providers educated

A4	2017-2021 ONGOING	Promote the use of case management to support those living with HIV.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals; Service Providers	Number of Ryan White clients utilizing service
A5	2017-2021 PROJECT	Explore the potential of integrating HIV medical and related services into a "one-stop" shop so all appointments can be done at the same place and time.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals	Project implementation
A6	2017-2021 ONGOING	Provide prioritized, safety net, core medical and support services for Ryan White eligible clients using Ryan White funding sources.	HIV Planning Council	HIV+ Individuals	Number/percent of clients who receive each type of core medical and support service

Strategy 2: Increase access to housing, behavioral health services, and other support services for people living with HIV.

	Timeframe	**Activity**	**Responsible Parties**	**Target Population**	**Data Indicators**
A1	2017-2021 ONGOING	Coordinate with local Ryan White and Non-HIV Ryan White service providers to increase access to services.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	Service Providers	Number of local service providers coordinated with through events or referrals
A2	2017-2021 PROJECT	Integrate behavioral health screening with HIV related services.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	Service Providers	Number of Ryan White clients who have been screened for behavioral health issues as part of a medical visit

Strategy 3: Support medical adherence education.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Encourage providers to integrate ongoing messaging on the importance of medical adherence for health outcomes into all HIV medical and support services.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit), HIV Ryan White Medical Service Providers	Service Providers; HIV+ Individuals	Number of providers who receive outreach regarding medical adherence education; Viral suppression rates

GOAL #3: Reduce HIV-related disparities and health inequities

Objective 1: By 2021, reduce disparities in the rate of new diagnoses* by at least 15% in the following populations:

Priority Population	Baseline (2015) (Ref: Table 2)	Ratio of group rate to Austin TGA rate at baseline**	2021 Target	Ratio of group rate to Austin TGA rate-2021 Target**
Austin TGA	16.3 per 100,000	1.0	12.2 per 100,000	1.0
Black MSM	794.0 per 100,000	48.7	505.1 per 100,000	41.4
Black Women	27.9 per 100,000	1.7	17.1 per 100,000	1.4
Hispanic	21.3 per 100,000	1.3	13.6 per 100,000	1.1
Youth	22.3 per 100,000	1.4	14.6 per 100,000	1.2
IDU	5% of newly diagnosed	--	4.3% of newly diagnosed	--
Transgender	No baseline available	--	Establish baseline	--

* Target rates were adjusted to reflect the Goal 1 target of a 25% reduction in new diagnoses overall for the Austin TGA.

** Measures shown are ratios of the disparity rate in the specified group to the overall rate in the Austin TGA.

Strategy 1: Adopt structural approaches and promote evidence-based programs to prevent HIV infection in high-risk communities.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Promote and sustain biomedical interventions, such as PrEP. Increase availability, accessibility, and utilization of sterile injection equipment.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Austin PrEP Access Project; Austin Harm Reduction Coalition	Gay black men, Women, Hispanic, Transgender, Youth, IDU	Number/percent of target population using PrEP and NPEP; Number/percent of target population using needle exchange program

A2	2017-2021 ANNUAL MEETING/ REPORT	Sustain CDC approved evidence-based behavioral interventions (EBIs) for HIV infected individuals and their partners such as CLEAR, Healthy Relationships, Mpowerment, and Condom distribution. Have local EBI programs provide annual updates/presentation to Planning Council.	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Evidence-Based Behavioral Invention (EBI) Providers	Gay black men, Women, Hispanic, Transgender, Youth	Number of new diagnoses among target populations

Strategy 2: Research, understand, and implement effective communication strategies customized to each of the subpopulations with health inequities.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2018 PROJECT	Address bias, stigma, and discrimination against populations with disparities in social marketing and other mass education activities using Austin specific facts/data (i.e. Present data on the risk for target populations on radio stations geared to different ethnicities; conduct anti-stigma activities with large audiences, and do a targeted campaign at different local events: Day of Remembrance, National week of prayer, etc.)	HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); Office of Support, Population representatives	Gay black men, Women, Hispanic, Transgender, Youth, IDU	Number of social marketing and mass education activities

Strategy 3: Educate providers regarding the needs of vulnerable populations.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 PROJECT	Require trauma informed care training of HIV prevention and care staff regarding the needs of those who have experienced violence and trauma	HIV Planning Council; City of Austin HHS (HIV Resource Administration); HIV Service Providers	HIV Service Providers	Number of persons trained

Strategy 4: Establish baseline data on the Transgender population

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 PROJECT	Research best practices for collecting data on Transgender populations and implement strategies locally/statewide	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); HIV Service Providers	HIV Data Collection/Management personnel	Establishment of a data plan Develop baseline

Objective 2: By 2021, reduce health related disparities in Viral Load Suppression by increasing Viral Load Suppression to 80% for each of the following populations, in line with the National HIV/AIDS strategy:

Priority Population	**Baseline (2015)**	**Percent Increase in Suppression Rate**
Black MSM	64%	+ 16%
Black Women	69%	+11%
Hispanic	69%	+11%
Youth	58%	+22%
IDU	69%	+11%
*Transgender**	No baseline available	Establish baseline
White (Comparison Group)	76%	+4%
Austin TGA	71%	80%

Strategy 1: Reduce economic disparities to improve access to care.

	Timeframe	**Activity**	**Responsible Parties**	**Target Population**	**Data Indicators**
A1	2017-2018 PROJECT	Develop a resource education campaign promoting local HIV resources and services (for example, Ryan White services including support groups, child care, transportation vouchers, workforce development opportunities, peer navigation programs, planning council membership opportunities, etc.) targeted at HIV+ consumers in waiting rooms at area medical and dental facilities, food banks, etc.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); HIV Service Providers	HIV+ Individuals	Number of programs/providers participating; Number of locations promoting campaign materials

Strategy 2: Educate providers regarding the needs of vulnerable populations.

	Timeframe	**Activity**	**Responsible Parties**	**Target Population**	**Data Indicators**
A1	2017-2021 TRAINING	Require cultural competence training for frontline HIV prevention and care staff to have: (a) standard minimum training topics (CLAS standards); and (b) methods for measuring change in knowledge, skill, and ability. Additional training topics may include transgender health, intimate partner violence, behavioral health, mental health, substance abuse, language barriers, aging, etc.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); HIV Service Providers	HIV Prevention and Care Service Providers	Number of trained persons

Strategy 3: Research, understand, and implement effective communication strategies customized to each of the subpopulations with health inequities.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING/ ANNUAL MEETING	Establish or maintain formal partnerships between the Austin Area HIV Planning Bodies and agencies or individuals representing high-risk populations; seek technical assistance and training on how the needs of these high-risk populations can be advanced; and host annual meeting to discuss best practice activities that are working to help high risk populations remain in care.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); HIV Service Providers; HIV Task Force	Gay black men, Women, Hispanic, Transgender, Youth, IDU	Number of partnerships established; Number of trainings or technical assistance received; Viral suppression rates

GOAL #4: Achieve a more coordinated local response to the HIV epidemic

Objective 1: By 2021, increase Ryan White non-conflicted consumer representation on the Austin HIV Planning Council to at least 33%, fulfilling the HRSA requirement.

Strategy 1: Address barriers and opportunities to improve PLWHA engagement and participation in the HIV Planning Council.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017 PROJECT	Identify and address barriers to HIV Planning Council participation by engaging PLWHA in the Austin TGA through instruments such as surveys, focus groups and key informant interviews.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); City of Austin Office of Innovation; City of Austin Communications and Public Information Office	HIV+ Individuals	Number of PLWHA engaged; number of survey respondents
A2	2017 PROJECT	Study other EMA/TGA's identified as having successful consumer engagement practices to develop potential new practices to recruit PLWHA as Planning Council members.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals	Number of best practices identified

A3	2017 PROJECT/ ONGOING	Develop consumer engagement plan including consideration of an advertisement to reimburse members who are living with HIV for expenses they incur in serving as planning council members, such as travel or child care.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)	HIV+ Individuals	Number of advertisement opportunities taken

Strategy 2: Launch proactive efforts to engage new and non-traditional partners in achieving the HIV Planning Council mission.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2018-2021 PROJECT	Participate in community conversations with broad-based Austin-area health, social service, and community coalitions/groups in order to engage new and non-traditional partners.	HIV Planning Council; City of Austin HHS (HIV Resource Administration unit); City of Austin Office of Innovation; City of Austin Communications and Public Information Office	Community groups whose mission and work is aligned with identified priorities affecting target populations	Number and diversity of partners engaged

Strategy 3: Coordinate with the community to provide outreach to consumers.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2018-2021 ONGOING	Coordinate with community groups who work with target populations by participating in events that promote HIV awareness.	HIV Planning Council; City of Austin HHS	Community groups who coordinate HIV awareness events: Austin faith community, AIDS Candlelight Memorial, AIDS Walk, Pride Parade etc.	Number and diversity of partners engaged

Objective 2: Improve the HIV system of care through advocacy for agenda items for collaborative meetings.

Strategy 1: Address significant barriers to care and work to improve the HIV system of care through coordination of effort between the organizations.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Sustain formal partnerships with the Housing Opportunities for People with AIDS (HOPWA) program and other **housing and homelessness prevention coalitions** and groups to address housing instability among PLWHA.	HIV Planning Council; City of Austin HHS ; City of Austin Neighborhood Housing and Community Development Office	Community entities including but not limited to the Austin Housing Coalition, Ending Community Homelessness Coalition (ECHO); One Voice Central Texas; Austin/Travis County Reentry Roundtable, Austin Travis County Integral Care, and Central Health; HOPWA	Number and diversity of partners engaged
A2	2017-2021 ONGOING	Target local and regional **behavioral health** providers and coalitions for coordination of activities.	HIV Planning Council; City of Austin HHS	Community entities including but not limited to the Austin Police Department; Austin Travis County Integral Care; Central Health and Austin State Hospital	Number and diversity of partners engaged
A3	2017-2021 ONGOING	Sustain formal partnerships with **transportation** service providers in the TGA	HIV Planning Council; City of Austin HHS	Community entities including but not limited to the Capital Metro, the Transit Empowerment Fund (TEF), and ATX Safer Streets	Number of agenda items

Strategy 2: Participate in regional and statewide advocacy efforts focused on adequate funding, efficient program administration and decreasing the administrative burden of Ryan White activities.

	Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
A1	2017-2021 ONGOING	Promote ACA marketplace enrollment for those who are living with HIV.	HIV Planning Council; City of Austin HHS	Ryan-White eligible PLWHA; Texas Department of State Health Services; Austin City Council; Central Health	Number of collaborative agenda items; Number of HIV+ people who are insured
A2	2017-2021 ONGOING	Support ongoing statewide efforts to improve Medicaid access for people living with HIV as outlined in the Texas State SHARP Report.	HIV Planning Council; City of Austin HHS; HIV Syndicate	Ryan-White eligible PLWHA; Texas Health and Human Services Commission/Texas Department of State Health Services; Austin City Council; Central Health	Number of education actions; Number of government policies changed Number of HIV+ people who have Medicaid

A3	2017-2021 ONGOING	Advocate for designated funding for PrEP to appropriate populations.	HIV Planning Council	State Legislature Budget	Amount of PrEP funding designated from State Budget.
A4	2017-2021 ONGOING	Advocate for state standards for testing to include opt-out testing statewide.	HIV Planning Council	State Testing Standards	Number of routine opt-out HIV screenings preformed in medical settings; Number of providers/organizations implementing opt-out testing

Strategy 3: Annually coordinate and communicate with community-based groups who impact the lives of those living with HIV, on the progress of the Integrated HIV Prevention and Care Plan

	Timeframe	**Activity**	**Responsible Parties**	**Target Population**	**Data Indicators**
A1	2017-2021 ANNUAL REPORT	Educate community-based organizations and other stakeholders on the progress of the Integrated HIV Prevention and Care Plan.	HIV Planning Council; City of Austin HHS	Community-based groups; PLWHA	Dashboard of progress on planned activities and core medical and support services

e. Anticipated Challenges and Barriers in Implementing the Plan:

The Austin HIV Planning Council took into consideration many potential barriers in the development of this plan. Some challenges are beyond the scope of the council, while others can be mitigated by proactive actions of the council. Beyond the scope of the council is the undetermined allocation status from the city on pre-exposure prophylaxis (PreP) for the coming years. Strategies developed by the planning council to support PreP efforts may need to be adjusted. Additionally, 2017 is an open bid year for contracts and services supported by the planning council and may need to be altered slightly as service providers may change.

Housing and transportation are the key barriers to care identified by Ryan White consumers and are addressed in integrated plan activities. However, these issues stem from infrastructure and system level changes that are happening in the city as a result of rapidly increasing population and property values in Austin. Addressing these root causes is beyond the scope of the integrated plan and improvements are likely to be slow and require increased investment and attention from local government.

Overall shortage of funds for safety net HIV prevention, care and support services will be a challenge for AIDS Service Organizations as they continue to implement new strategies and activities to address the epidemic. This plan will require collaborative development,

implementation and monitoring of activities by a number of partners who have historically been "siloes" of independent activity.

A common issue in all volunteer boards and councils is member recruitment, training, and turnover. Avoidance of council member fatigue and maintenance of a manageable shared workload among council members is a priority for the council and is addressed as key objective in the integrated plan.

Data collection through AIRES presents challenges in the ability of the HIV Planning Council to monitor progress of the plan. For example, service providers are not required to update demographic information about a consumer each time the consumer utilizes a service. Therefore, if a consumer's status changes (ie. insurance status or homeless status), these changes may not be updated in the system. Additionally, some sub-categories in AIRES are undefined, have more than one meaning, or have many similar options. Service providers have also reported loss of data as a result of system performance and software upgrades. Variance seen between years with point in time data may represent changes in reporting timing. Also, the definition of service components can change over time, so looking at trends in these is difficult.

B. Collaborations, Partnerships and Stakeholder Involvement

a. Contributions of stakeholders and key partners in the development of the plan

The Integrated HIV Prevention and Care Plan is a 5-year road map for how the community will address the HIV epidemic, including prevention and care. The plan was developed with stakeholder and partner input and is aligned with the White House HIV/AIDS National Strategy. Implementation of the plan will begin January 2017.

The City of Austin Health and Human Services Department contracted with Woollard Nichols and Associates to facilitate the Austin HIV Planning Council and community stakeholders in developing the goals, objectives, strategies and activities of the Integrated HIV Prevention and Care Plan. That process was initiated in early 2016 with the planning and preparation of a series of five work sessions to be conducted as meetings of the Comprehensive Planning Committee of the Austin Area Comprehensive HIV Planning Council. Staff conducted significant community outreach to area HIV prevention and care agencies, consumers, and other community members to maximize community participation in the planning sessions. The following community partners and stakeholders participated in the planning work sessions:

- HIV prevention service providers
- HIV care service providers
- Ryan White consumers

- HIV Planning Council members
- Faith-based community members
- LGBTQ health support workers
- Medical social workers
- Youth specialist
- Domestic violence specialist
- Support Service providers- mental health, hospice
- Interested community members

The work sessions were facilitated processes that enabled work group participants to develop a set of goals and objectives including measurable tasks and activities as the foundation for the Integrated HIV Prevention and Care Plan. The objectives of the five community meetings were as follows:

- March 9th: Planning Process Kickoff and Epidemiological Data Review
- March 29th: Identifying Long-Term Outcomes and Goals
- April 12th: Outlining Objectives and Strategies for Plan Goals #1 and #2
- April 19th: Outlining Objectives and Strategies for plan goals #3 and #4
- May 10th: Discussing Plan Activities and Implementation Steps

As the process moved forward, the draft document was continually updated and sent out to planning process participants and additional stakeholders. The goals, objectives, strategies and activities of the plan represent a summary of the results of the five work sessions and revisions by the Comprehensive Planning Committee.

b. Stakeholders and partners not involved in the planning process needed to more effectively improve outcomes along the HIV Care Continuum:

Efforts were made by the Austin HIV Planning Council to include a diverse group of participants in the planning process. Stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum include transitional and affordable housing Community Based Organizations, the Texas Department of Transportation, private providers, and Medicaid representative. Housing and transportation are the biggest barriers to care for PLWH and future efforts to include these groups may lead to new insights into these agencies are not typically involved in Ryan White programs can help address the HIV epidemic in the Austin TGA. Additionally, as the integration between prevention and care strengthens, additional prevention providers such as Planned Parenthood and CommUnity Care will be informed of the plan and progress and invited to participate in updates. Fliers and information were made available in HIV care settings, but some groups were under represented in the planning process. High risk populations including PLWH who inject drugs and transgender groups were not at the planning work groups, but efforts will be

made to keep them informed of plan progress and future recruitment efforts will focus on these groups.

c. **Letter of Concurrence**
The Letter of Concurrence from Planning Council Chair and Vice Chair is **Appendicix C**.

C. People Living with HIV (PLWH) and Community Engagement

a. **People involved in developing the plan are reflective of the epidemic:**
The people involved in the creation of the Integrated HIV Prevention and Care Plan were the Austin HIV Planning Council members as well as stakeholders and community partners. Consumers of Ryan White services were included in the planning process as well as people from high risk groups. All participants live within the jurisdiction and many either have experience working with high risk populations or are PLWH.

b. **How inclusion of PLWH contributed to the plan development:**
Current Austin HIV Planning Council membership consists of consumers who are represented on each of the sub-committees. The representation of PLWH on the Austin HIV Planning Council and key leadership positions ensures the council maintains constant focus on the needs and perspectives of PLWH. Citizens frequently attending Planning Council meetings include PLWH who contribute their insight to the decision-making process. PLWH attended all planning work groups and plan development meetings.

c. **Methods used to engage communities, PLWH, and those at risk to ensure activities are responsive to the needs in the service area:**
Multiple actions by the Austin HIV Planning Council insured that the service needs of PLWH and people at high risk for HIV infection were considered during the development of the Integrated HIV Prevention and Care Plan. Recruitment for planning workgroups occurred throughout the community and targeted areas such as HIV clinics and service provider sites. Prior to the planning process, a Comprehensive HIV/AIDS Needs Assessment (2014) was conducted, including surveys and focus group discussions to determine the needs and priorities of HIV positive individuals in the Austin area. The findings of this assessment were presented to the workshop along with epidemiological data, to insure that the needs these groups were represented in the planning process.

d. **Impacted communities are engaged in the planning process to provide insight into developing solutions to health problems to assure the availability of resources:**
PLWH and people at high risk of HIV infection provide critical insight into developing solutions to health problems. Focus group discussions from the 2014 Comprehensive

HIV/AIDS Needs Assessment highlighted the need not only for medical services, but for a holistic approach to health. Maslow's hierarchy of needs was reflected in the comments of PLWH, who said that attending medical appointments and adherence to medications were often forgone to focus on more pressing needs around housing, income, mental health, and substance abuse. These insights are considered when planning for support services such as housing, mental health, substance abuse and non-medical case management.

SECTION III: MONITORING AND IMPROVEMENT

A. Process for regularly updating planning bodies and stakeholders on the progress, soliciting feedback, and using feedback for plan improvement:

The primary tool that will be used to update planning bodies and stakeholders on the progress of the plan is the Integrated HIV Prevention and Control Dashboard. The Dashboard will show annual progress made for the specific indicators listed under each goal, objective and activity. The Dashboard will indicate if each objective and activity is on-schedule, ahead, or behind to meet the 2021 targets. The Dashboard will be updated regularly by the HIV Planning Council at Comprehensive Planning Committee. It will then be posted on the Planning Council website, emailed to all stakeholders who helped develop the plan and to all Ryan White funded and key prevention agencies in the Austin TGA. Services providers will be encouraged to share this information with Ryan White consumers and other stakeholders. Additionally, the Dashboard will be presented regularly to the Texas HIV Syndicate to insure that progress in the Austin TGA is in-line with state priorities.

The Austin HIV Planning Council will solicit feedback from the community at Comprehensive Plan Committee meetings and through email after each public update. The Austin HIV Planning Council will continue to monitor the epidemic and the provider and funding landscape, and adjust the planning priorities and activities to reflect any changes.

B. Plan to monitor and evaluate implementation of the goals and SMART objectives:

Monitoring and reporting is an essential component of this plan. Significant commitments have been made by the Austin HIV Planning Council to complete the activities detailed in Section II. Monitoring ensures that the list of activities is being managed and on schedule. But more importantly, monitoring enables the Austin HIV Planning Council to manage outcomes and evaluate how effective the plan has been to date in effecting change.

Section II of this plan includes SMART objectives which by definition specify how each activity is to be measured. The intent is that this is more than checking off a box on the work plan confirming the activity was performed on a specific date. The intent of a SMART objective is that there is a measure of quality. This means that the Austin HIV Planning Council did not simply go through the motions in completing the task, but made a concerted effort to do a quality job. While difficult to measure, the distinction is important and will have a direct bearing on outcomes.

The ultimate measure is to determine if the four goals in the plan show positive change. That is primarily measured by the Treatment Cascade and related surveillance reports published by DSHS. However, the true challenge in measurement of the plan's activities is to be able to attribute the activities to the change. Realistically that cannot be done because any cause and effect conclusion is largely inference. Thus measurement and reporting of the plan will not focus on measurement at the goal level.

What can be measured is the outcomes at the objective and activity level. For many activities there will be an element of subjectivity to crediting results to the activity. Nevertheless, there is clear merit to reporting SMART measurement at the individual strategy and activity level. That will be the basis for reporting results.

A dashboard will be developed in order to track and manage plan activity. The dashboard will be organized by goal, and will be able to track the objectives for each goal, the strategies for each objective, and the activities that will be performed. The Activities shall show (1) who is responsible for completing the activity (2) the timeline for completing the task and (3) the completion date and (4) results.

The Austin HIV Planning Council shall produce written reports as described below. These reports shall be posted on the Austin HIV Planning Council website to keep the public informed.

Monthly Status Report

The Integrated HIV Prevention and Care Plan will be a standard agenda item for each Comprehensive Plan Committee meeting. The Committee will discuss and evaluate progress and make adjustments to the dashboard as needed. The Committee shall provide input into the monthly status report and will assist staff as required.

The Integrated HIV Prevention and Care Plan will be a standard agenda item for each Business agenda. A written report will be provided by staff. The report will include the dashboard so that the planning council can see activities that have been completed, the date completed, and the activities that are to be performed in the next month. Staff will provide a summary report of outcomes for each completed activity. For upcoming activities, the Chair will ensure that responsible parties are aware of their obligation and prepared to follow through.

The monthly report is not simply informational to the planning council. It is expected that report will stimulate discussion and that the planning council will provide direction regarding any changes or guidance as appropriate.

Quarterly Assessment

On a quarterly basis the Comprehensive Plan Committee will conduct a Quarterly Assessment of the plan. The Quarterly Assessment will go beyond the monthly status

report monitoring (which is focused upon the individual work plan activities) to include an assessment of whether the plan is on track relative to outcomes at the objective and strategies level. Staff will provide a Quarterly Assessment report in draft form. The Committee will make edits to the Quarterly Assessment and provide direction to staff for completion and finalization of the report. In the event the Committee determines that the plan requires modification, the Committee will draft language which will be voted on by the Committee as a motion to present to the full Planning Council.

The Quarterly Assessment Report will be a standard Planning Council Business Meeting agenda item. The Committee Chair will present the report and any recommendations the Committee may have. Motions for change will be presented by the Committee Chair for vote.

Annual Report

The Austin Planning Council will produce and publish an annual report for the Integrated HIV Prevention and Care Plan. The annual report will provide a more comprehensive assessment of the plan's status than is achieved by the quarterly assessment. The objective of the Annual Report is to assess the overall direction and effectiveness of the plan. The Annual Report is not simply a summary of the past years Quarterly Assessments. Monthly reports and quarterly assessment are by design focused on the individual strategies and actives that are being performed. In contrast, the Annual Report enables the Planning Council to evaluate the plan as a whole and at a higher level. This means evaluating whether the plan is on course and accomplishing what was intended.

C. Strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum and impact the quality of the HIV service delivery system, including strategic long-range planning:

The issues faced by the HIV community are constantly evolving. The barriers, needs and issues that were identified when the plan was initially developed may no longer reflect the current status of the community. Priorities may need to be changed to reflect these changing community needs. Program updates will be discussed at Austin HIV Planning Council meetings on a monthly basis and adjustments to the plan will be made as necessary such that plan activities address key health outcomes along the HIV Care Continuum. Epidemiological surveillance data will be reviewed by the planning council annually, so that plan activities and priorities can be adjusted if necessary to address shifts in the demographics of the epidemic. The Annual Report will review how the activities done in the past year fit into the five year strategic plan of the Austin TGA and how that plan has evolved. Key components of the Annual Report will include:

- Plan Status – an executive summary of the plan

- Report of Accomplishments – documentation that the work is on schedule and detailing what has been done.
- Outcomes – What was the result of the strategies being employed? How effective were the activities?
- Changes in epidemiological profile of the TGA (if any).
- Issues that have been identified. This will include issues related to plan execution. This will also include discussion of changes and emerging issues that are occurring within the HIV community which may necessitate revision of the plan (in terms of priority objectives and strategies). For example, should Texas expand Medicaid the needs and priorities within the community may evolve requiring the Plan to adjust to the changes.
- Modifications to the Plan (if any).

RFERENCES

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3. Centers for Disease Control and Prevention. 2015 Youth Risk Behavior Survey Data. Available at: www.cdc.gov/yrbs. Accessed on September 16, 2016.
4. Centers for Disease Control and Prevention. “HIV Among African American Gay and Bisexual Men” June 2016. Available at: http://www.cdc.gov/hiv/group/msm/bmsm.html. Accessed September 26, 2016.
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6. Ho V, Marks E. “Health Reform Monitoring Survey – Texas, Issue Brief #11: Effects of the Affordable Care Act on health insurance coverage in Texas as of March 2015. Houston Texas: 2015”. James A. Baker III Institute for Public Policy, Rice University, The Episcopal Health Foundation.

Appendix A:

Definitions of Special Need Populations:

- **Youth:** aged 13-24
- **Homeless:** defined as individuals who lack a fixed, regular, and adequate nighttime residence, including those who live in locations not meant for human habitation such as public parks and streets, those who live in or are transitioning from temporary housing or shelters, and those who have persistent housing instability.
- **Incarcerated/Recently Released:** defined as individuals who are currently incarcerated in the jail of prison system or have been released from jail or prison within the past 12 months.
- **Injection Drug Users (IDU):** defined as individuals who inject medications or drugs, including illegal drugs, hormones, and cosmetics/tattooing.
- **Men who have Sex with Men (MSM):** defined as Men who engage in male-to-male sexual practices and identify as gay or bisexual, those who engage in male-to-male sexual practices and do not identify as gay or bisexual, and those who engage in gay or bisexual male culture regardless of gender identity (i.e., male-to-female transgender)
- **Transgender and Gender Nonconforming:** defined as individuals who cross or transcend culturally defined categories of gender.
- **Women of color:** defined as individuals who identify racially or ethnically as Black/African American, Hispanic/Latina, or Multiracial women.
- **Aging:** aged 50 and up.

Appendix B: HIV Resources Inventory

Funding Source	2016 Budget		Core Medical and Supportive Services	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Prevention and Testing	HIV Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	Surveillance	HIV Care Continuum Impact
	Dollar Amt.	%																																					
Part A	**$3,658,877**	26		1		1	1		1			1	2	2	2	1	3		1	1						1	1				1							I-V
Ryan White MAI	**$266,251**	2													1		2									1												I-V
Part B	**$1,231,527**	9		2		2	1		1				1							1					1													II–V
Part C	**$749,927**	5		1		1	1										1								1			2										I-V
City of Austin General Fund	**$557,449**	4										1					2			1																1	1		
City of Austin HHS	**$917,875**	7						1							1						1					1								1	1	1	1		
Travis County Fund	**$467,137**	3															2			1															1		1		I, III

Funding Source	2016 Budget		Core Medical and Supportive Services	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Prevention and Testing	HIV Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	Surveillance	HIV Care Continuum Impact
	Dollar Amt.	%																																					
HOPWA	**$1,084,260**	8																				2																	I-V
HUD	**$67,649**	<1																				1						1											
HIV State Services	**$1,749,601**	13		1		1		1	2				2				2			1					1	1		1						1		1			I-V
Private Funds	**$1,215,077**	9					1					1		1	2		2								1							1		1			1		I-V
CDC	**$1,103,013**	8						1							1		1				1					1		1						2	2	2	2		I, II
Department of State Health Services	**$724,999**	5																																1	1	1	1		I, II
ASA-EHF	**$102,980**	1													1																								III-V
TOTAL	**$13,896,622**	**100**																																					

Note: Numbers indicate the number of providers who fund each service using the indicated funding source.

Appendix C: Letter of Concurence

CDC/HRSA Project Officer

Dear Tempestt Woodard,

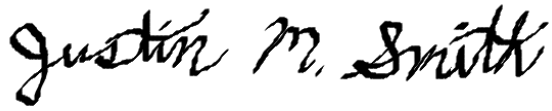
The Austin Area Comprehensive HIV Planning Council concurs with the following submission by the Austin/Travis County Health & Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan. The HIV Planning Council 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 HIV Planning Council 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 Integrated HIV Prevention and Care Plan was presented, reviewed and voted on by the full Planning Council at the Business meeting in September. The Planning Council looks forward to working with the HIV Community to set the foundation for improved coordination and unified vision to accomplish these common goals and objectives.

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

_____ 9/29/2016_____

Planning Council Chair Signature: Date:



_____ 2016-09-29T17:06-05:00

Planning Council Vice Chair Signature: Date: