Austin Area HIV Planning Council

Integrated HIV Prevention and Care Plan

2022-2026

Table of Contents **Page #**

SECTION I. EXECUTIVE SUMMARY OF INTEGRATED PLAN AND SCSN

The Integrated HIV Prevention and Care Plan is a five year plan to accelerate progress in the Austin Transitional Grant Area (TGA) towards diagnosing all people with HIV early as a possible, **treating people with HIV rapidly and effectively to reach sustained viral suppression, preventing new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), and responding quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them** in order to increase access to care, improve health outcomes, and reduce HIV-related health disparities. This plan reviews the landscape of the HIV epidemic in the Austin TGA—the demographics of those living with and more likely to be impacted by HIV/AIDS, 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 in accordance with the plans of our partners initiatives Ending the HIV Epidemic and Fast Track Cities.

In 2019, there were 6,721 people living with HIV/AIDS (PWH) within the five county TGA, with over 100 new diagnoses that year. A majority (85%) of people with HIV are male. Among males, Whites have a higher prevalence at 42%, followed by Latinx at 36%. Black females comprise 48% of all females with HIV, while Black males comprise 16% of all males with HIV.

Men who have sex with men (MSM) continue to bear a heavy burden of HIV in the Austin TGA. Table D demonstrates the distribution of mode of transmission by race/ethnicity among persons living with HIV in the Austin TGA. The most common mode of transmission was MSM (70%) for all races/ethnicities. MSM was the most common mode of transmission for HIV cases among all groups: Black (47%), Latinx (75%) and White (78%). The next highest category for HIV transmission was heterosexual exposure, with Black at 31% followed by Latinx at 13%.

Qualitative methods were used to engage local PWH, 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 PWH, service providers and other community stakeholders. 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.

SECTION II. COMMUNITY ENGAGEMENT AND PLANNING PROCESS

Jurisdictional Planning Process

Role of the RWHPA Planning Council and Entities Involved in the Process

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 2023 partially due to some delays in the new Needs Assessment process related to the COVID-19 pandemic response.

The City of Austin, HIV Planning Council, and community stakeholders collaborated in developing the goals, objectives, strategies and activities of the Integrated HIV Prevention and Care Plan. That process was initiated in early **2018** with the planning and preparation of a series of meetings and work session between the HIV Planning Council and the County's new participation in the Fast Track Cities' Initiative. Staff has 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 have been involved with the planning process:

- HIV prevention service providers
- HIV care service providers
- Ryan White Part A clients
- HIV Planning Council members
- Faith-based community members
- LGBTQ health support workers
- Medical social workers
- Youth specialist
- Support Service providers- mental health, hospice
- Interested community members
- Townhalls and focus groups for MAI and EIIHA populations

Role of Planning Bodies and Other Entities

The Austin HIV Planning Council collaborates with numerous partners to ensure the coverage on all parts along the HIV Care continuum, including prevention. A key partner in prevention is the Ending the Epidemic initiative in Austin. This initiative aims at reducing the number of new HIV

infections by 50% in 2030, compared to 2018 rates. A key feature is that the Ending the Epidemic initiative can fund prevention efforts, including access to Pre-exposure Prophylaxis (PrEP) and Post-exposure prophylaxis (PEP), which makes them an essential partner to be able to provide prevention services to the Austin area. The Ending the Epidemic liaison at Austin Public Health is tasked with providing routine updates to the HIV Planning Council on the initiatives progress.

Fast Track Cities (FTC) is an additional initiative that is partnered with the Austin HIV Planning Council. The Fast Track Cities program performs critical role in ending inequalities related to HIV/AIDS and reducing the number of new infections. The Fast Track Cities initiative for Austin, Texas is a pledge to accelerate their AIDS response, to reach ambitious targets, create strategic partnerships, and address significant disparities in access to services, social justice, and economic opportunity. The Fast Track Cities liaison at Austin Public Health is tasked with providing routine updates to the HIV Planning Council on the initiatives progress. *The FTC Social Determinants of Health Workgroup has partnered with the Austin Area HIV Planning council to provide technical support for the Stigma Index 2.0 project, which aims to gather evidence on how stigma and discrimination affect the lives of individuals living with HIV.*

The Texas HIV Syndicate is another group that works with and is represented on council as many council members are a part of the state of Texas integrated HIV prevention and care planning group. The Office of Support planner is also required to take part in the HIV Syndicate and Planner's Network of Texas to assist Planning Council in the alignment of efforts with the state and their Achieving Together Texas plan. The Achieving Together Texas plan reflects the ideas, recommendations, and guidance of the Texas HIV Syndicate and Achieving Together Partners, as well as statewide community engagement efforts with people impacted by HIV, people living with HIV, clinicians, and researchers.

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The council also regularly works with Ryan White HIV/AIDS Part B program, which is responsible for providing supplemental grants to Texas grant recipients in need. The Part B program relays updates to council through monthly Part B updates given by the assigned Part B Planner on council, to ensure that timely and routine updates are given on the funding for supplemental grants. Ryan White HIV/AIDS Program Part C, Part D, and Part F *subrecipients are connected to council via a monthly digest, routine emailing*, or are representing their program on council. Subrecipients of Ryan White HIV/AIDS Programs A through F engage with Planning Council by coordinating community events, such as World AIDS Day and community feedback efforts.

Details regarding this process can be found in Appendix A

PRIORITIES

Key priorities that arose from this planning process and review of data for the Ryan White Part A jurisdictions which included the EHE and FTC areas, was the need to focus on those populations that are disproportionately impacted by HIV/AIDS. The identified priority populations for the Austin transitional grant area include *Black men who have sex with (MSM), Black women who have sex with men* (WSM), Latino MSM, and transgender and gender diverse persons of color. More on these populations and supporting data can be found in SECTION III in more details on this document. We aim to engage our priority populations through townhalls to solicit feedback on HIV prevention and care efforts to inform the priorities of the upcoming fiscal year. Recruitment efforts for feedback were conducted for the identified populations at community events. Additionally, these voices needed to be elevated and sought after more to engage in the process of making decisions that impacted their specific communities.

Commented [DN1]: Update MSM language

Commented [DN2R1]: Aim to Align priority populations in Stigma Index

Stakeholders and partners not involved in the planning process needed to improve outcomes more effectively 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, entities working with recently incarcerated individuals, harm reduction organizations, 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 CommUnity Care will be informed of the plan and progress and invited to participate in updates. 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. Efforts will continuously be made with ongoing Needs Assessment activities to involve these groups and others as this plan progresses.

The Austin Area HIV Planning Council has partnered with Fast Track Cities' Social Determinants of Health workgroup to initiate the development of the Stigma Index 2.0 for PLWH in the Austin TGA. As Planning Council has committed to aiding in the recruitment and marketing campaign for the Steering Committee of this project, members aim to engage the mentioned priority populations throughout the recruitment process.

UPDATES TO OTHER STRATEGIC PLANS TO MEET REQUIREMENTS

Maintaining and building upon long-term internal and external partnerships is critical for effective implementation of the EIIHA plan. Internally, all HIV-related programs of Austin Public Health (APH) [HIV Prevention, HIV Surveillance, Health Equity Unit, HIV Resources Administration Unit, and Planning and Evaluation Unit], meet regularly to coordinate efforts. Meetings currently are focused on funding opportunities, collaborations, and special study development with the Ending the HIV Epidemic: A Plan for America grants, Fast Track Cities, and HIV Planning Council's Office of

Support. Externally, the Planning Council maintains partnerships with many community-based organizations. The objective is to develop a unified approach for HIV prevention and care planning, data sharing, and provision of cultural competency training. These are long-established collaborations that have deep roots within the community. Relationships have been strengthened through the FTC initiative and the development of the local plan for FTC.

Fast-Track Cities: In an unprecedented effort for the Austin area, the FTC Initiative has brought together an extensive network of community members to discuss strategies for ending the HIV epidemic by 2030. Community involvement and guidance is extensive, as demonstrated by the 10 Steering Committee organizations that lead the efforts. More than 200 individual volunteers participate in FTC. Partners and volunteers who lead FTC represent local HIV service and other community-based organizations, the City of Austin, Travis County, pharmacies and pharmaceutical

companies, the Travis County Healthcare District, and the Austin/Travis County Mental Health Authority. The FTC action plan includes four priority areas which also align with EHE's key strategies-Diagnose, Prevent, Treat, and Respond:

1. Prevention (EHE: Prevent)
2. Testing and Rapid Linkage to Care (EHE: Diagnose & Treat)
3. Retention, Reengagement and Viral Suppression (EHE: Treat)
4. Ending Stigma (EHE: All)

Each priority area is represented in a community plan with objectives and goals organized by community members participating in workgroup meetings and a quarterly consortium. Feedback was widely solicited via Survey Monkey to allow anyone in the TGA to provide feedback, comment about unmet service needs, or identify potential new FTC partners. All FTC activities are reviewed by broad constituencies to ensure transparency and inclusivity. Additional methods for community input have been leveraged via FTC's meetings and their participation in coordinated planning sessions for Peer Support and other HIV Planning Council activities.

Austin Public Health and Ending the HIV Epidemic Grant Opportunities: Austin Public Health (APH) serves as the administrator of the RWHAP, coordinates and facilitates the local FTC efforts, conducts disease surveillance throughout Travis County, and works with DSHS to carry out HIV prevention efforts. Planning has recently focused on grant opportunities with a common theme of Ending the HIV Epidemic. The EHE grants are awarded by the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). The local HRSA Ending the Epidemic (EHE) partnership with FTC emerged as a means of gathering community input to inform EHE activities as they align with the EHE Pillars. Throughout Summer and Fall 2020, staff within the HIV Resource Administration Unit (HRAU) worked with community groups and stakeholders through the local FTC initiative to develop outlines for future contracts that directly support EHE. Trainings, workshops, and focus groups helped to shape discussions to better align with the contracting process used to distribute funds to Community-Based Organizations. Staff provided feedback on the deliverables created from this process and critically reviewed documents to identify which objectives, strategies, and key activities best fit the HRSA EHE Pillar. This collaboration went on to guide the development of the EHE work plan and will continue to facilitate alignment and leverage of other HIV/AIDS resources and efforts.

The EHE funding opportunities align with the current EIIHA goals in the following ways:

- Pillar I Diagnose: FTC's Testing & Rapid Linkage aligns with EHE Pillar I Diagnose. The jurisdiction will release funding opportunities from the CDC EHE funds that will support increased and targeted testing.
- Pillar II Treat: The HRSA funds will support Rapid ART, Peer Support programming, and Transportation which supports FTC Retention, re-engagement, and ultimately viral load suppression.
- Pillar III Prevent: The CDC's funds will support PrEP/nPEP accessibility in alignment with FTC's Prevention group and plans.
- Pillar IV Respond: HRSA funds will purchase a new mobile Unit for the CDU program to link positive clients to Rapid ART within 72 hours of diagnosis. This will support treatment and linkage efforts and planning.

This collaborative process will continue as the HIV Planning Council will work with both groups to complete its 2021 Needs Assessment activities and integrated plan development in 2022.

While FTC and planning meetings for the Ending the HIV Epidemic represent extensive internal and external partnerships, they do not provide a comprehensive list of all collaborations that will support the EIIHA plan. Additional partnerships include the Planning Council's work with the Health Equity Policy Board, which ensures that opt-out testing is adopted by all safety-net clinics that are likely to treat uninsured individuals who are unaware of their status. The EIIHA plan is supported by ongoing relationships with HIV service organizations to increase PrEP and PEP medications.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

Data Sharing and Use

The main sources of data and data systems used to develop this plan are as follows:

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.

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, Health Service Delivery Areas HSDA(Part A and B regions) and by county. DSHS provides the majority of the data and reports required by the Austin TGA to prepare theannual 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.

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 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).

Commented [DN3]: This is being replaced with TCT, how to ensure data is shared?

Needs Assessments for the Austin TGA –The Strategic Planning/Needs Assessment Committee of the Austin Area HIV Planning Council led the administering of the 2022 Needs Assessment Survey on service needs and barriers for those in and out of care following a two year delay due to the onset of the COVID-19. Meanwhile other Needs Assessment activities were completed including a Provider Capacity and Capabilities survey, focus groups, community town halls, and a System of Care Analysis, the survey itself wasn't administered until August 2022 through November 2022. The survey was developed through the guidance and direction of the Strategic Planning/Needs Assessment Committee of the Austin Area Planning Council. The public was invited to comment through the public

communication portion of committee meetings. Participating locations for survey distribution were sent copies of the survey beforehand for comment and review. This served as a mechanism to build rapport with location liaisons to better reach the clients served. This relationship was supported through routine check-ins via Zoom with location staff to assist with survey dispersal.

A preliminary analysis was drafted in 2023, this analysis was delayed due to staff-turnover in conjunction with the COVID-19 pandemic. An overview report has been provided to the Strategic Planning/Needs Assessment committee via email in February 2024 and in person in April 2024 to assist in selecting a service need or barrier that should be explored. The selected barrier for year two is lack of affordable/accessible housing and how this issue impacts the HIV care continuum.

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.

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, and the Youth Risk Behavior Surveillance System (YRBSS).

Epidemiologic Snapshot

Over two million people reside in the Austin Transitional Grant Area (TGA), which encompasses Bastrop, Caldwell, Hays, Travis, and Williamson Counties. Table A shows the TGA population by race/ethnicity and county. A majority of the TGA population is White (51%) followed by Latinx (33%). Black people make up 7% of the Austin TGA. The largest city, Austin, lies in Travis County, where the majority (80%) of people with HIV reside.

Table A: Distribution of Austin TGA population by race/ethnicity and county, 2019

Race/Ethnicity	County					Total
	Bastrop	Caldwell	Hays	Travis	Williamson	
White (not Hispanic)	46,301	16,812	122,810	608,874	346,411	1,141,208
Black (not Hispanic)	6,233	2,416	5,928	104,003	37,300	155,880
Hispanic	34,494	22,991	90,525	442,687	146,554	737,251
Other	2,536	980	9,101	117,990	58,951	189,558
Total	**89,564**	**43,199**	**228,364**	**1,273,554**	**589,216**	**2,223,897**

Source: *Texas Demographic Center. Texas Population Estimates Program. https://demographics.texas.gov/data/tpepp/estimates/*

At the end of 2020, there were 6,930 persons diagnosed with HIV living in the Austin TGA, including 222 new HIV diagnoses. An additional 1,332 HIV cases are estimated to be undiagnosed in the TGA, making the estimated HIV/AIDS prevalence to be 8, 262. Most people living with HIV (86%) were males. Whites comprised 38% of people with HIV, followed by Hispanic/Latinx at 35%. Over half (54%) of people with HIV were 45 years of age or older. Incidence rates and annual numbers of new diagnoses have gone down in the past five years. However, there has been a steady increase in the total number of people with HIV in the Austin TGA over the last five plus years. Detailed demographic information on new diagnoses and people with HIV is reported below.

The Austin TGA's HIV and AIDS prevalence and incidence data through December 31, 2019. During 2019, 104 new AIDS cases were reported in the Austin TGA. A majority of the new AIDS cases were males (83%). By race/ethnicity, more were Latinx (44%) followed by Whites (26%), and 93% were 25 years of age or older. Men who have Sex with Men (MSM) was the primary risk category for 68% of the new AIDS cases, followed by heterosexual transmission with 19% of the new AIDS cases.

As of December 31, 2019, the number of people with HIV (not AIDS) in the Austin TGA was 3,486. The number of people with AIDS was 3,235. Most (85%) were males, with Whites comprising 37% of persons with AIDS, followed by Latinx at 35%. The majority (72%) of these persons were 45 years of age or older.

The table below shows the number of people with HIV in the Austin TGA by gender identity and race/ethnicity. A majority (85%) of people with HIV are male. Among males, Whites have a higher prevalence at 42%, followed by Latinx at 36%. Black females comprise 48% of all females with HIV, while Black males comprise 16% of all males with HIV.

Table B : Number of people with HIV/AIDS by race/ethnicity and gender identity, Austin TGA, 2019

Race/Ethnicity	Gender Identity								Total	
	Female		Male		Transgender Female		Transgender Male			
	N	%	N	%	N	%	N	%	N	%
White (not Hispanic)	202	21	2354	42	12	16	1	0	2,568	38
Black (not Hispanic)	462	48	973	17	18	23	0	0	1,451	22
Hispanic	246	26	2,067	36	46	60	0	0	2,357	35
Other	14	1	88	1	0	0	0	0	102	2
Multi-Race	38	4	207	4	1	1	0	0	243	4
Total	**959**	**100**	**5,684**	**100**	**77**	**100**	**1**	**0**	**6,721**	**100**

Source: *Texas Department of State Health Services, eHARS*

Men who have sex with men (MSM) continue to bear a heavy burden of HIV in the Austin TGA. Table D demonstrates the distribution of mode of transmission by race/ethnicity among persons living with HIV in the Austin TGA. The most common mode of transmission was MSM (70%) for all races/ethnicities. MSM was the most common mode of transmission for HIV cases among all groups: Black (47%), Latinx (75%) and White (78%). The next highest category for HIV transmission was heterosexual exposure, with Black at 31% followed by Latinx at 13%.

Table C: People with HIV by race/ethnicity and mode of transmission*, Austin TGA, 2019

Exposure Category	White (not Hispanic) N	%	Black (not Hispanic) N	%	Hispanic N	%
MSM	2,004	78	679	46.8	1,765	74.9
IDU**	129	5	217	15	113	4.8
MSM/IDU**	247	9.6	87	6	154	6.5
Heterosexual	174	6.8	444	30.6	311	13.2
Perinatal Transmission	13	0.5	24	1.7	13	0.6
Adult Other***	1	0.0	0	0.0	2	0.1
Total	**2,568**	**100**	**1,451**	**100**	**2,358**	**100**

Source: *Texas Department of State Health Services, eHARS*

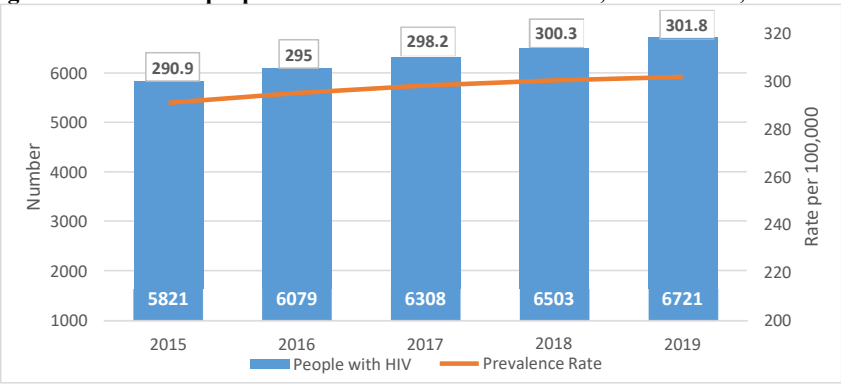
* Transmission categories are estimated; column values may not sum to the column total.

** Injection Drug User

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

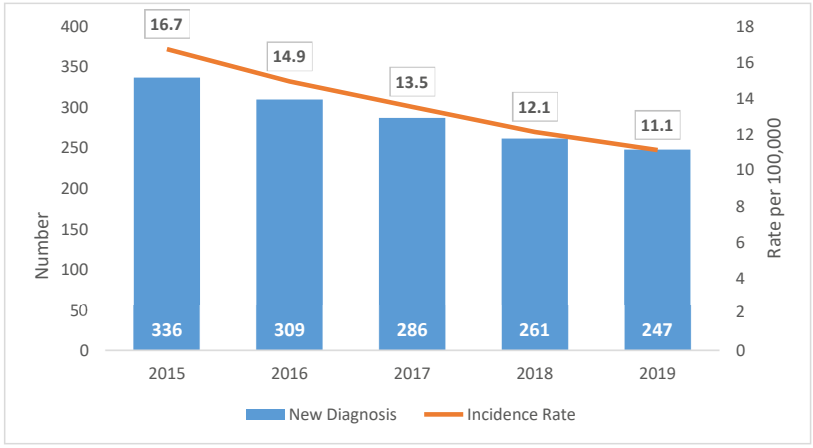
The Austin TGA's HIV/AIDS prevalence and incidence data through December 2019 are shown in Figures 1 and 2, respectively. The number of people with HIV in the TGA grew by 15% between 2015 and 2019. Over the same period, new diagnoses peaked at 336 diagnoses in 2015, but have since declined 27% with 247 diagnoses in 2019.

Figure 1: Number of people with HIV and Prevalence rates, Austin TGA, 2015-2019



Source: *Texas Department of State Health Services, eHARS*

Figure 2: New HIV Diagnoses and Incidence Rates, Austin TGA, 2015-2019



Source: *Texas Department of State Health Services, eHARS*

Education Level

Socioeconomic data for all clients in the AIDS Regional Information and Evaluation System (ARIES) database show significant disparities, when comparing the 2017-2019 education level for different racial/ethnic groups in the Austin TGA. In 2019, 25% of all Hispanics reported "no high school" or "some high school," compared to 18% of Blacks and 5% of Whites. Twenty-two percent (22%) of Whites reported "college degree," while 12% of Hispanics and 9% of Blacks reported "college degree." See Attachment 3 for more information.

Income Sources

In 2019, Hispanics comprised 63% of all clients reporting salary, compared to 37% for Blacks and 47% for Whites. Data indicate that public assistance programs are used more frequently by Blacks than by Hispanics and Whites. For example, in 2019, 45% of all clients receiving SSI and SSDI were Black, compared to 21% for Hispanics and 37% for Whites.

Federal Poverty Level

Income directly affects consumers' ability to pay for health care. A total of 6,721 people with diagnosed HIV reside in the Austin TGA, and approximately 2,688 (40%) are living below 200% of the federal poverty level (FPL), according to a U.S. Census Bureau poverty status report. Based on client-level data in ARIES, an average of 78% of all clients were living below 200% of the FPL over the three-year period of 2017-2019.

Health Insurance Status

As of 2019, Texas had the highest number of uninsured individuals of any state in the nation, and the numbers are on the rise. Studies have shown that uninsured persons are less likely to have a regular source of health care or to receive needed medical care, and more likely to die from health-related problems. [1] Chronically ill and uninsured adults often delay or opt out of checkups and treatments, including medications. Uninsured people with HIV are particularly vulnerable to adverse health outcomes, including an increased risk of death.[1] In Texas, 23,150 people with HIV are estimated to be uninsured. In the Austin TGA, 56% of clients with HIV reported being uninsured in 2019 (See Attachment 3), and 58% report being uninsured in 2020.

Primary Language

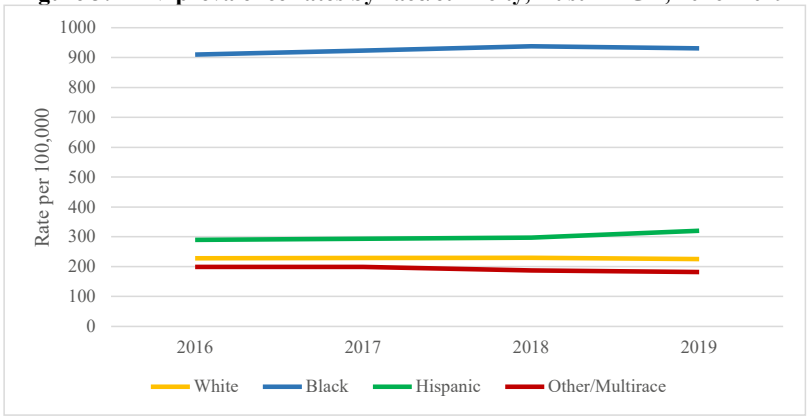
In 2019, 14% of all clients in the ARIES database report Spanish as their primary language. The Austin TGA's need for interpersonal and document translation services was discussed in the 2020-2021 *Austin Area HIV System of Care Analysis and Recommendations* report.

Within the Austin TGA, HIV/AIDS disproportionately affects several subpopulations including Transgender people, Latinx MSM, Black MSM, and Black Women. These populations were identified through a review of the most recently available trends in incidence and prevalence.

The majority of the Austin TGA population is White (51%), followed by Latinx (33%). White people with HIV (38%) make up the largest percentage of Austin TGA residents with HIV in 2019, followed closely by Latinx (35%). The incidence rate of HIV among the Latinx population is the highest while the prevalence in this group is the second highest. Overall, 7% of the Austin TGA is Black; however, 20% of the new HIV cases reported in 2019 were Black. While approximately 3% of the Austin TGA population is Black males, 10% of people with HIV are Black males. Black females represent 4% of the Austin TGA population, while 7% of people with HIV are Black females.

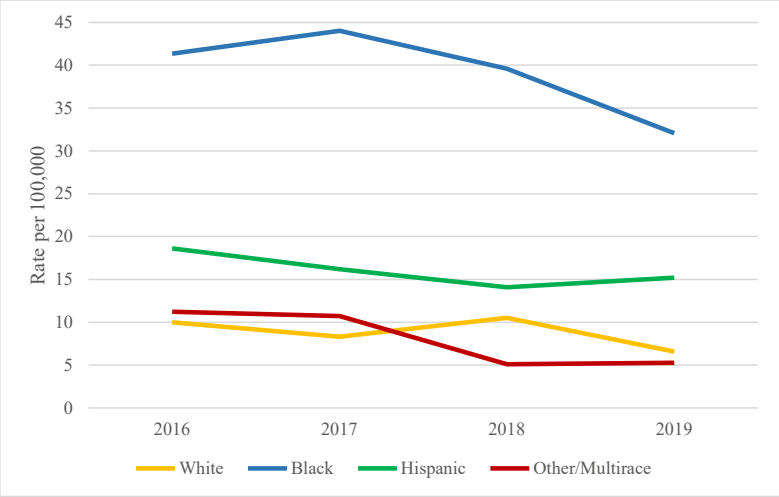
Figures 3 and 4 show HIV prevalence and incidence rates by race/ethnicity for the Austin TGA. Rates for Blacks were consistently higher for each year compared with Whites, Latinx, and others. Blacks, who comprise a smaller portion (7%) of the Austin TGA population, have a prevalence rate that is three times higher when compared to Whites, and almost two times the incidence rate as Latinx.

Figure 3: HIV prevalence rates by race/ethnicity, Austin TGA, 2016- 2019



Source: *Texas Department of State Health Services, eHARS*

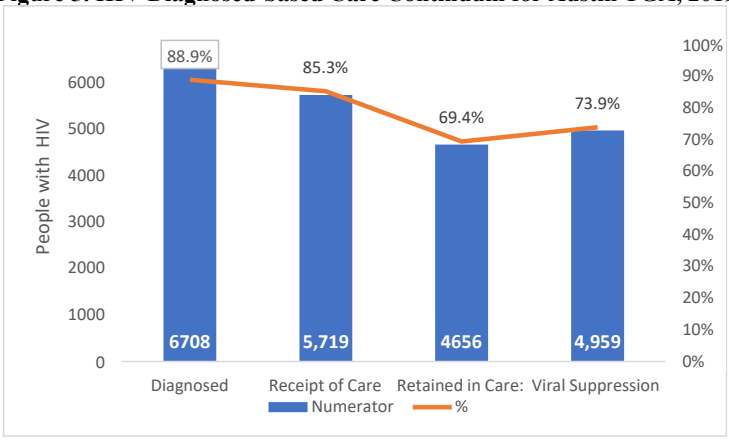
Figure 4: HIV incidence rates by race/ethnicity, Austin TGA, 2016-2019



Source: *Texas Department of State Health Services, eHARS*

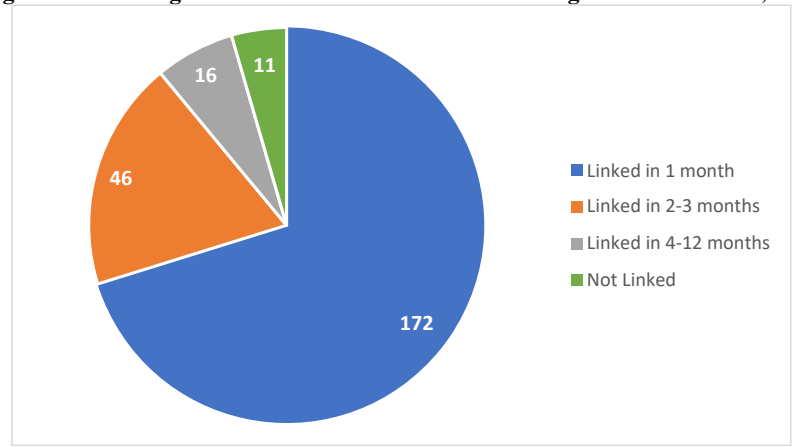
Black MSM, Black Women, Latinx MSM, and Transgender people are populations with emerging disparities related to HIV.

Figure 5: HIV Diagnosed-based Care Continuum for Austin TGA, 2019



Diagnosed: Number of persons aged ≥13 years with HIV infection in the jurisdiction at the end of the calendar year who know their serostatus.
Receipt of Care: No. of persons aged ≥13 years with HIV infection with at least one: medical visit, ART prescription, VL test, or CD4 test in 2019.
Retained in Care: No. of persons aged ≥13 years with HIV infection least 2 visits or labs, at least 3 months apart in 2019.
Suppression: No. of persons aged ≥13 years with HIV infection whose last viral load test value of 2019 was <= 200 copies/mL.

Figure 6: HIV Diagnosed-based Care Continuum- Linkage for Austin TGA, 2019



Linkage: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.
Source: *Texas Department of State Health Services, eHARS*, 2019

As shown above, Black MSM, Black Women, and Latinx MSM are the Subpopulations of Focus for the Austin TGA due to disproportionately being impacted along the care continuum.

Viral Suppression by Race for those in Care, Austin TGA 2019

Race / Ethnicity	Virally Suppressed		Not Virally Suppressed	
	#	%	#	%
White, not Hispanic	1977	89%	252	11%
Black, not Hispanic	973	80%	240	20%
Hispanic	1752	88%	233	12%
Other	73	90%	8	10%
Multi-race	174	82%	37	18%

Total Population	4949	87%	770	13%

Source: *Texas Department of State Health Services, eHARS*, 2019

HIV Prevention Care and Treatment Resource Inventory

Prevention Care and Treatment Resource Inventory

HIV Resources Inventory for the Austin TGA
See Appendices B and C

Strengths and Gaps

Appendices B-D

Approaches and Partnerships
Appendices B-D

NEEDS ASSESSMENT

The Austin Area HIV Planning Council like most jurisdictions across the country has experienced some delays in their Needs Assessment activities. This is in large part due to the aftermath of living through and post the COVID-19 pandemic and its subsequent restrictions or fallout. The HIV Planning Council has not been able to carry about many of its needs assessment activities or experience some delays. Additionally, the Texas Department of State Health Services (DSHS) has shifted and refocused efforts on the pandemic response mostly due to a mass exodus of employees. This has contributed to a delay in many data needs. The following activities are in progress or have been completed after much delay:

- System of Care Analysis: The HRAU (Administrative Agent) for the jurisdiction funded an analysis of the system of care which resulted in some client, AA staff, Office of Support staff, and provider interviews in the area to identify gaps, needs, and barriers to service delivery. The result were some recommendations for improvements that the PC, AA, and many stakeholders have implemented. Details on this can be found in Appendix D.
    - There are recommended actions to take for improvement and priorities identified in this report.
    - The PC has adopted the following recommendations:
        - The introduction of peer navigators or peer support to improve the HIV Care Continuum outcomes for MAI and EIIHA populations
        - A directive that requires the OAHS subrecipient to provide services beyond the Austin/Travis county area of the jurisdiction
- Epidemiological Profile: This profile has been completed up until 2019 with 2020 data being ~~forthcoming~~forthcoming. Updates will be provided to thisdocument once that information is available. In the meantime, data is discussed in detail in Epidemiologic Snapshot on this document.
- Provider Capacity and Capabilities Survey: This PC has decided to implement its first survey of this kind during the winter of 2022 with more details coming once the analysis is complete.
- The Needs Assessment survey, for the assessment of service needs and barriers for those in-care and out of care, was conducted virtually and in person during the months of August-November 2022 with 388 participants across the jurisdictions. Currently the Planner and HIV Epidemiologist are finalizing results which were preliminary reported in April 2024 to the PC and community.

Commented [DN4]: Description on purpose of survey was added

SECTION IV. SITUATIONAL ANALYSIS

Detailed in System of Care Analysis Appendices A and D

SECTION V. 2022-2026 GOALS AND OBJECTIVES

The HIV Planning Council has been a part of the planning processes for the EHE and FTC Action Plans and has decided to implement these plans for the entire jurisdiction. Please reference Appendices A and E with a desire to add more as information becomes available in the areas surrounding substance abuse and use disorders, and quality of life.

SECTION VI: 2022-2026 INTEGRATED PLANNING IMPLEMENTATION APPROACH

Monitoring and Evaluation

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

Section V. 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 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 and quantifiable changes. 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 Planning Council's website to keep the public informed.

Feedback and Improvement

The primary tool that will be used to update the Planning Council 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 2026 targets. The Dashboard will be updated regularly by the HIV Planning Council's Office of Support Staff and presented during the Strategic Planning/Needs Assessment subcommittee and included on the monthly Staff report for the full body PC meetings, Business Committee. This document will be available as a part of meeting materials or meeting packets that will 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. Service providers will be encouraged to share this information with their respective contact lists and other stakeholders. Additionally, the Dashboard will be presented regularly to the Texas HIV Syndicate, EHE's relevant committees, and FTC committees to ensure that progress in the Austin TGA is in-line with state and local initiative priorities.

To create the Dashboard, the planner will collaborate with Texas Department of State Health Services and the administrative agent to gather the data needed to display integrated plan progress regarding the 2026 targets. The planner is currently waiting on available data related to the goals of the Austin TGA. The dashboard will be powered through PowerBi. *The planner will collaborate with the Project Officer and the Planning Council to conjure an alternative solution with existing resources as dashboard planning is time-consuming.*

The Austin Area HIV Planning Council will solicit feedback from the community at special town halls that target specific priority populations such as EIIHA and MAI identified groups and via email after each public update. The townhalls are expected to be held in a hybrid format, *where online submissions are accepted continuously throughout the spring and summer months leading to the grant application deadline, while townhalls are planned for specific dates*. Topics for the townhall include discussions on the challenges faced, services needed, barriers to services, and review of Planning Council deliverables such as the integrated plan and needs assessment items. The information gathered at these townhalls will be compiled to inform the HIV Planning Council's PRSA efforts for the upcoming fiscal year. 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 in their monthly Strategic Planning/Needs Assessment committee meetings.

Reporting and Dissemination

Monthly Status Report

The Integrated HIV Prevention and Care Plan will be a standard agenda item for each Strategic Planning/Needs Assessment sub 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. A report to the full PC will be provided during the monthly Business meetings via the Staff Report.

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. This report will also be presented in a monthly or quarterly basis to the FTC and EHE initiative committees as well during their respective meetings.

Quarterly Assessment

On a quarterly basis the Strategic Planning/Needs Assessment 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. This is important to take place as part of the data packets and updates that the PC uses for the yearly Priority Setting and Resource Allocations process (PSRA).

Updates to Other Strategic Plans Used to Meet Requirements

The issues faced by the HIV community are constantly evolving. Fortunately many of the FTC and EHE initiatives are being implemented or will be implemented in concurrence with the HIVPC's Integrated plan for 2022. The barriers, needs and issues that were identified when the planwas initially developed may no longer reflect the current status of the community. Priorities may need to be changed to reflect these changingcommunity 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).

Appendix A.

Austin/Travis County Fast-Track Cities Action Plan

May 2020

Table of Contents

Section 1: Introduction & Overview

Introduction

The information in this section was obtained from the *Texas Response to Federal Ending the HIV Epidemic: Phase One Jurisdiction Planning for San Antonio, Austin, Dallas, Fort Worth* (Texas Department of State Health Services, 2018). In the fall of 2017, the Texas HIV Syndicate (the integrated statewide HIV care and prevention community group) launched efforts to develop a statewide plan to end the HIV epidemic in Texas. What would become the Achieving Together Plan was developed over a year long process and launched in the fall of 2018. Over 140 community members from across Texas participated in the development of the goals, measures, guiding principles and focus areas of the Achieving Together Plan. Throughout 2019, Texas HIV Syndicate members and other community partners have engaged in campaigns to spread awareness of the plan and connect with local stakeholders to increase participation in planning activities.

Simultaneously, community members and HIV stakeholders in cities across Texas became increasingly interested in developing local momentum and planning to address HIV in their own cities. Previously, Houston had developed a local plan to end the HIV epidemic in their city. As the energy to focus attention on ending strategies built at a statewide and local level, San Antonio was the first to become a Fast Track City in Texas in 2017. By organizing local leaders and signing onto the Fast Track Cities (FTC) Initiative, San Antonio joined Houston in expressly focusing on their local need to address and end HIV. Austin/Travis County would follow a year later in 2018 by also signing onto the Fast Track Cities Initiative, followed by Dallas and Houston in 2019.

Currently, there are a plethora of plans existing at various jurisdictional levels that address HIV across Texas. At a statewide level, there are the 2017-2021 Texas HIV Plan and the Achieving Together Plan. The 2017-2021 Texas HIV Plan is the legislatively required integrated care and prevention plan for Texas and was a foundational structure for the development of the Achieving Together Plan. In addition to these statewide plans, the five cities identified in phase one of the National Ending the HIV Epidemic each also include legislatively required HIV plans as part of their Ryan White Part A grant requirements in addition to their local ending HIV or Fast Track Cities plans. Lastly, Texas is divided into multiple HIV administrative service areas, each of which develops and implements plans to address the needs of people living with HIV and other HIV related community needs.

This plan serves as a baseline of activity for Austin/Travis County. The Center for Disease Control's funding announcement 19-1906[1] creates the ability to begin a local and state planning process to bring into alignment all of the multiple plans which direct action in these cities with the added benefit of creating structures to align and coordinate plans across all jurisdictions within the state. This plan is intended to be provided as a baseline of the activities outlined for Austin/Travis County. The activities were all identified through Fast-Track Cities Consortiums and Workgroup meetings. From this plan activities can be added, removed, combined and prioritized in alignment with the priorities and direction

[1] CDC funding announcement 19-1906, https://www.cdc.gov/hiv/pdf/funding/announcements/ps19-1906/cdc-hiv-PS19-NOFO.pdf

from Austin/Travis County Fast-Track Cities' participants. The activities identified in this plan are intended to guide the funding and program development throughout the Austin/Travis County Community.

Community Engagement

Austin/Travis County began working toward ending HIV in their communities by adopting the Fast Track Cities model of planning.

Under this structure, a steering committee is developed to organize and lead efforts within the area. The steering committee may consist of governmental leaders, medical professionals, leaders of HIV/AIDS service organizations, people living with HIV, and other relevant community leaders. The steering committee is responsible for planning and carrying out city-wide consultations, including developing the agenda and all other logistics.

During city wide consultations, the process is structured to develop consensus across participants on the ending HIV targets. The consultations also introduce the participants to local epidemiological data, current provider networks and structures, current funding availability, and any policies or other information necessary to understand the existing state of HIV in that community. Participants in these consultations also arrive at consensus about how progress will be monitored, how communications with communities and stakeholders will be handled, and most importantly, what interventions or strategies will be implemented to address key areas identified to impact HIV/AIDS.

The table below displays a historical timeline of the Austin/Travis County Fast Track City Initiative.

Historical Overview of Austin/Travis County FTC

Timeframe	Activity	Detail
May 2018	Executive Meeting	• 90-90-90-50 Goals Established • Buy-in on 4 priority areas
June 2018	Launch of Local Initiative	• Signing of the Paris Declaration by Austin Mayor Steve Adler and Travis County Judge Sarah Eckhardt
August 2018	Workgroup Meeting #1	• Each workgroup met and reviewed a list of best/promising practices that relate to their priority area • Facilitated process used to prioritize the top best /promising practices for each priority area. Workgroups picked top 3-7 strategies, then a dot voting method was used to narrow down to two • Also hosted evening and weekend sessions

October 2018	Workgroup Meeting #2 to developed draft Implementation Plan	• Facilitated action planning process for strategies selected in August: action steps included responsible parties and timelines • Also identified critical factors for success • Deliverable: Implementation Plan
November 2018-	Workgroups Meetings #3 Update and Monitor Implementation Plan	• Workgroups review each item in the Implementation Plan at the meeting and discuss updates and next steps • Plan was updated to include additional activities as items were identified •
January 2019	Workgroups Meetings #4 Update and Monitor Implementation Plan;	• Workgroups review each item in the Implementation Plan at the meeting and discuss updates and next steps • Plan was updated to include additional activities as items were identified • Seamless System of Care and Social Media Committees were launched

March 2019	Workgroup Meeting	• Implementation Plan Monitoring Update
		• Review of Draft Action Plan
		  ○ Planning Taskforce received the Draft Action Plan via email with instructions for comment. Only 1 comment was received.
		  ○ Planning Taskforce was presented the Draft Action Plan at a meeting and asked for feedback. There was general agreement of the need for the development of an Action Plan, but no feedback on the language or content of the plan.
		  ○ Workgroups were oriented to the Draft Action Plan during the March meeting. Workgroups completed an alignment exercise to identify how the two plans aligned. This alignment was captured by the note-takers and included in the minutes.

May 14 2019	Executive Meeting	• Update on status of Fast Track Cities • Identified Core Coordinating Committee Members
May- June 2019	Core Coordinating Committee Meetings	• Workgroup Chairs lead process to finalize Action Plan • Design engagement strategy to solicit feedback and buy-in to the Action Plan • Signing Anniversary Celebrated by Austin City Council and Travis County Commissioners' Court • Community Comment Survey on Action Plan

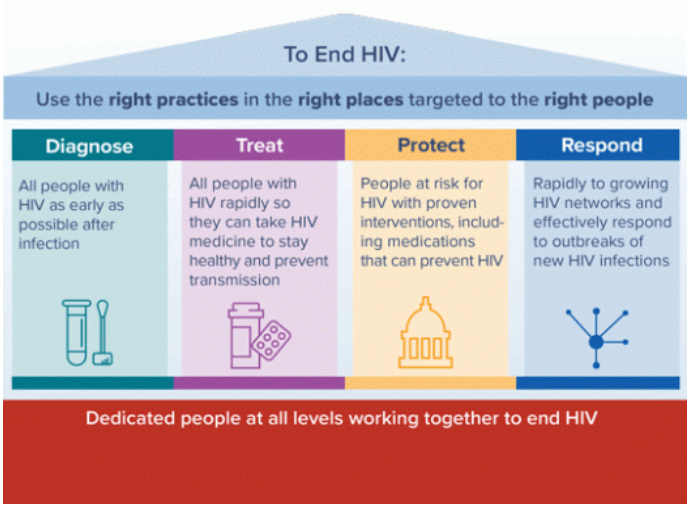
August 2019	Consortium Meeting	• Combined workgroup session • Networking • Workgroup breakout sessions
October 16, 2019	Core Coordinating Committee Meeting	• Review key takeaways from International FTC Conference: London • Review key takeaways from FTC Action Plan Survey Responses • Prepare for November Consortium Meeting and Executive Meetings • Announcements: City Council Proclamation, World AIDS Day
October-November 2019	Priority Workgroup Meetings	• Review FTC Action Plan Survey Responses • Review and refine Action Plans • Identify current status, barriers, and next steps • First Ending Stigma Workgroup Meeting on November 13 • Prepare for November Consortium and Executive Meetings
November 14, 2019	Consortium Meeting and City of Austin World AIDS Day Proclamation	• Priority Workgroup Highlights/Re-caps/Next Steps • Interactive Activity: Dot voting on Action Plan items based on survey responses • Launching FTC SharePoint
November 19, 2019	Executive Committee Meeting	• Update on status of FTC: Global to local • Identifying agency representatives to serve on Core Committee • Presentation of workgroup priorities/highlights • Next Executive Meeting Announced: May 12, 2020
December 2019	Launch of FTC SharePoint	• Core Coordinating Committee members invited as Visitors to the FTC SharePoint
January – February 2020	Priority Workgroup Meetings	• Workgroups work toward finalizing the Action Plan
February 25, 2020	Austin/Travis County FTC hosted Ready, Set, PrEP	• The Office of Infectious Disease & HIV/AIDS Policy (OIDP) division of the U.S. Department of Health and Human Services presented the Ready, Set, PrEP campaign to FTC members and others working in HIV/AIDS prevention • Directors from the Prevention through Active Community Engagement (PACE) program, which sits in the Office of the Assistant Secretary for Health: presented HIV/AIDS data; introduced the Ready, Set, PrEP initiative; and opened the discussion up to attendees.

February 25, 2020	Consortium Meeting	• Draft of the Action Plan presented • Priority Workgroups presented objectives and strategies moving forward
March 2020	Priority Area Workgroup Meetings Core Coordinating Committee Meeting FTC SharePoint	• Priority Workgroups began to utilize virtual meetings • Priority Workgroups continued to develop Action Plan and add detailed activities and identify community partners • Core Coordinating Committee reviewed the Austin/Travis FTC Initiative within the context of COVID-19 • The SharePoint site hosts a virtual Discussion Board for members to share challenges and success in delivering health and social services in the midst of COVID-19
April 2020	Austin/Travis County Fast-Track Cities members were invited to participate in a virtual 2-day Liberating Structures Workshop	• Attendees learned and practiced facilitation and prioritization tools and methods to strengthen the initiative moving forward
May 2020	Virtual Consortium Meeting	• Attendees reviewed grant funding streams, participated in a prioritization exercise, and received updates from Workgroup Co-Chairs
June 2020	Austin/Travis County Fast-Track Cities members were invited to participate in a virtual 2-day Liberating Structures Workshop	• Attendees learned and practiced tools and methods to prioritize and implement Action Plan items

Moving forward in 2020

Planning processes in 2020 will include structured and detailed analysis of existing needs, resources, and challenges across the HIV Care Continuum with a focus on the areas indicated by the National Ending the HIV Epidemic plan pillars (*Picture 1*). Through these planning processes the local Fast-Track Cities Initiative will continue to be a roadmap for how the local community plans to address needs and provide care.

Picture 1: National Ending the HIV Epidemic Plan Pillars[2]



[2] National Ending the HIV Epidemic Plan Pillars. Image retrieved from https://files.hiv.gov/s3fs-public/styles/card_hero/public/field/image/ToEndHIV-540.gif?XMGQ2nxefSSy.33xU1Bgegq9fcebPALc&itok=GYgYGUk7

Section 2: Epidemiological Data

2017-2018 HIV Epidemic Profiles

The Austin/Travis County Fast-Track Cities Initiative has established the following goals:

- 2020:
  - 90% of all PLWH will know their HIV status
  - 90% of all those diagnosed with HIV infection will receive sustained antiretroviral therapy (ART)
  - 90% of all diagnosed people receiving sustained ART will achieve viral suppression
  - Zero discrimination
- By 2025
  - Reduce new HIV infections by 75% (compared to 2018 data)*
    - * Ending the Epidemic goal

The information in this section was obtained from the *Texas Response to Federal Ending the HIV Epidemic: Phase One Jurisdiction Planning for San Antonio, Austin, Dallas, Fort Worth* (Texas Department of State Health Services, 2018). These profiles are snapshots of HIV in Texas and the Austin Transitional Grant Areas (TGA). They focus on descriptions of people living with HIV in 2018 and on the current standings on the key measures *in Achieving Together*, which guides work to end the HIV epidemic in Texas.

*Measure/Indicator	Source and method
People with diagnosed and undiagnosed HIV in 2017	Estimated using CDC algorithms on 2018 routine disease surveillance information
People with new diagnoses in 2018	Reported through routine disease surveillance
PLWH with diagnosed HIV in 2018	Reported through routine disease surveillance
PLWH with undiagnosed HIV in 2017	Calculated using the figures above
PLWH on ART in 2018	Retention in care is a proxy for ART use. Retention information comes from disease surveillance supplemented with information from public and private payors for HIV treatment.
PLWH with suppressed viral load in 2018	Viral load information comes from disease surveillance supplemented with information from public and private payors for HIV treatment.
Number of people with new infections in 2017	Estimated using CDC algorithms on 2018 routine disease surveillance

*These measures and indicators use varied sources and methods, so we can't always able to provide the same level of detail or group breakdowns across the indicators.

This document highlights groups with lower rates of diagnosis, care, or viral suppression and groups with larger numbers of PLWH who are undiagnosed, out of care, or do not have a suppressed viral load. We focus on groups that give the most information on how to improve services and systems. For example, knowing that there are high numbers of Black MSM (men who have sex with men) who have undiagnosed HIV gives more information than just saying there are higher numbers of men with undiagnosed HIV.

Summary

While their epidemic profiles differ, most of the Texas areas had similar levels of diagnosis, retention in care, and viral suppression among people retained in care. The Austin TGA stands out as having greater proportions of retention in care and viral suppression among those retained in care. In general, women have higher levels of diagnosis, participation in care, and viral suppression, Black women are the exception, and they are cited in several areas as needing action on diagnoses, retention and suppression.

Across areas, gay and bisexual men and other MSM have greater numbers of PLWH who are undiagnosed or out of care than other groups, and actions taken to improve outcomes for MSM will improve overall outcomes. Young PLWH (15-24 years old) are more likely to be undiagnosed and out of care; outcomes for transgender people are more mixed. The number of youth and transgender persons living with HIV is relatively small, but actions focused on youth and transgender persons are necessary to reduce disparities and inequities.

Table 1: Standing on Achieving Together measures

	Texas	Austin TGA
All people with diagnosed and undiagnosed HIV in 2017	107,700	7,300
% of all PLWH with a diagnosis in 2017	84%	85%
% of diagnosed PLWH who are retained in care in 2018	70%	79%
% of PLWH retained in care who have a suppressed viral load in 2018	86%	90%
Number of people with new HIV infections in 2017	4,600	320

HIV in Texas

In 2018 there were 94,106 Texas residents living with diagnosed HIV. More than two-thirds were in one of five key groups:

1) Latinx gay and bisexual men and other MSM
2) Black MSM
3) White MSM
4) Black women who have sex with men (WSM) and,
5) Transgender people

More than half were aged forty-five years or older. In this same year, 4,520 Texans were diagnosed with HIV. The profile of people with new diagnoses is younger and has a greater proportion of MSM of color. The statewide standings on the key measures and indicators are shown in the summary.

*Figure 1: Texas residents who were **living** with diagnosed HIV in 2018*[3]

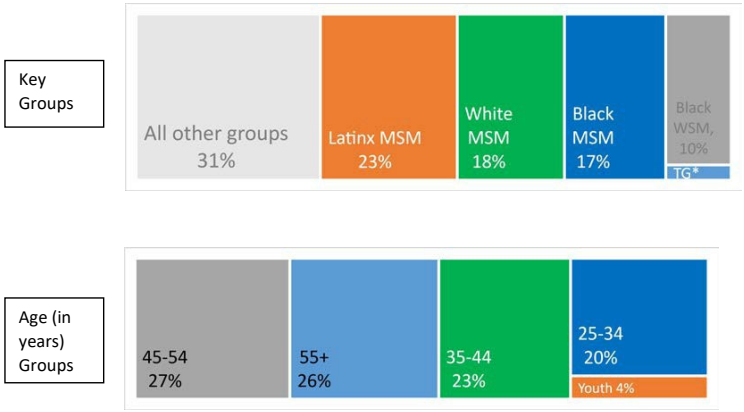
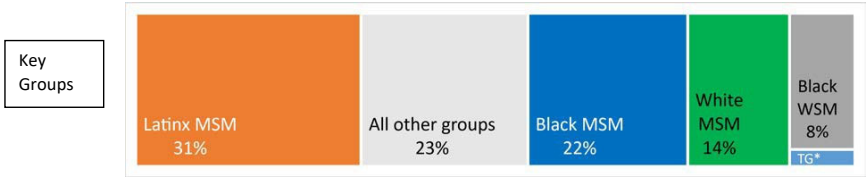
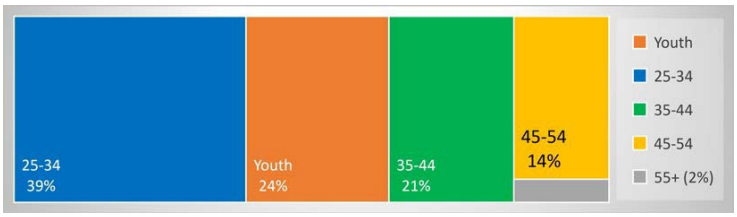


*Figure 2: Texas residents who were **diagnosed** with HIV in 2018*



[3] *TG: Transgender residents made up about 1% of all people living with diagnosed HIV and about 4% of youth.

Age (in years) Groups

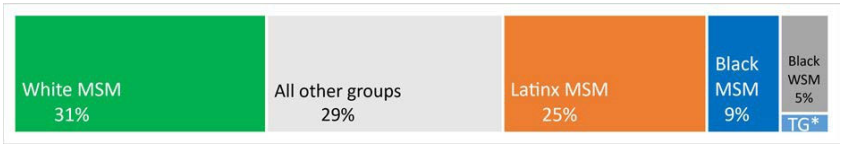


Austin TGA

In Austin in 2018 there were 6,445 people living with diagnosed HIV and 284 people were newly diagnosed with HIV. MSM made up the greatest number of both diagnosed PLWH and people with new diagnoses. **The profile of people with new diagnoses is younger and has a greater proportion of MSM of color.**

*Figure 3: Austin TGA residents who were **living** with diagnosed HIV in 2018*[4]

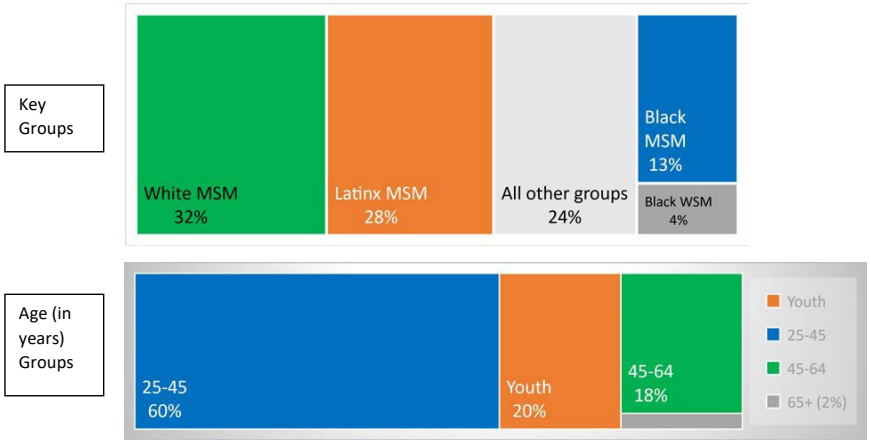
Key Groups



Age (in years) Groups

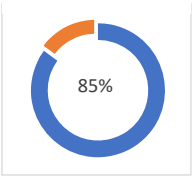
[4] *TG: Transgender residents made up about 1% of all people living with diagnosed HIV.

*Figure 4: Austin TGA residents who were **diagnosed** with HIV in 2018*[5]



Percent of Austin PLWH with a Diagnosis

Figure 5: Austin PLWH who have been diagnosed, 2017



More than four out of five PLWH in Austin are aware of their status. The 'diagnosis level' has been steady since 2010. Health equity goals call for every group of PLWH to have a 90% diagnosis level, but **actions should also focus on the groups of people with the greatest number of people with undiagnosed HIV**. Groups with lower rates of diagnosis and greater number of people with undiagnosed HIV are shown in Table 2. **Looking across these groups, a focus on MSM, especially Latinx MSM and those under 45 years old, is essential for reaching diagnosis goals.**

Table 2: Groups with the (a) lower diagnosis rates and the (b) greater numbers of people who are undiagnosed, Austin 2017

a) Lower diagnosis ***rates***

	Percent diagnosed	Number **not** diagnosed
Overall	85%	1,075
Youth	52%	235
25-34 year olds	66%	623

[5] Transgender residents made up less than 1% of all people who were diagnosed in 2018, and residents aged 65 years or older was 2%.

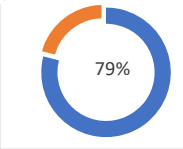
Latinx residents	81%	486

b) Greater ***numbers*** not diagnosed

	Percent diagnosed	Number **not** diagnosed
Total	79%	1,075
All MSM	86%	712
25-34 year olds	66%	623
Latinx residents	81%	486

Retention in care for diagnosed PLWH in Austin

Figure 6: Retention in care for diagnosed PLWH in Austin, 2018



In 2018, almost four out of five PLWH in Austin who had a diagnosis were retained in HIV care, with 1,382 diagnosed PLWH not retained in care. Most of the PLWH not retained in care showed no evidence of any care at all in 2018. Retention rates have been level since 2013.

Table 3 shows groups with lower rates and greater numbers of PLWH who were not retained in care. **Improving retention in gay and bisexual men and other MSM will have the greatest overall effect on retention.**

Table 3: Groups with the (a) lowest retention rates and the (b) greatest number of people not retained in care, Austin 2018

a) Lower retention ***rates***

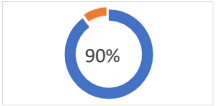
	Percent retained	Number **not** retained
Overall	79%	1,382
Black MSM	72%	166
Black WSM	73%	87
Youth	73%	66

b) Greater ***numbers*** not retained

	Percent retained	Number **not** retained
Total	79%	1,382
25-64 year olds	78%	1,241
White MSM	81%	370
Latinx MSM	78%	350

HIV viral suppression in Austin PLWH who are retained in care

Figure 7: Viral suppression in Austin PLWH retained in care, 2018



In Austin, nine out of ten people who are retained in care have had suppressed viral load every year since 2015. Most groups have similarly high rates of viral suppression. The groups with lower suppression

rates and greater numbers of people with unsuppressed viral loads are shown below.

Table 4: Groups with (a) lower viral suppression rates and (b) greater number of people not suppressed among those in care, Austin 2018

a) Lower suppression ***rates***

	Percent suppressed	Number **not** suppressed
Overall	90%	503
PWID	86%	105
Black WSM	88%	28
25-64 years old	89%	476

b) Greater ***numbers*** not suppressed

	Percent suppressed	Number **not** suppressed
Total	90%	503
25-64 year olds	89%	476
White MSM	91%	140
Latinx MSM	92%	105

Austin residents with new HIV infections

In 2017, an estimated 320 Austin TGA residents acquired a new HIV infection. This number has been steady since 2010. **Six people in the Austin area acquire a new HIV infection every week. Almost three out of four Austin residents with new HIV infections in 2017 were gay and bisexual men and other MSM.**

Section 3: Action Plan

How to use the Action Plan

This Action Plan is intended to be a living document. Detailed activity updates/next steps will be ongoing. However, update to the Objectives, Strategies and Activities sections will be addressed on a bi-annual basis at the April and October Core Coordinating Committee meetings. The process is as follows:

- Workgroup Chairs will report Objective, Strategy, and/or Activity updates (additions, edits, removals, workgroup or taskforce transfer) to the Austin Public Health FTC Support Staff
- Austin Public Health FTC Support Staff will list the updates as an agenda item for the next Core Coordinating Committee meeting designated to review Objective, Strategy, and Activity updates (identified above as April and October)
- The respective Workgroup Chair(s) will present updates to the Core Coordinating Committee; the presentation is simply intended to inform the Core Committee of the updates

*In the event that there is no Core Coordinating meeting in April or October, any updates will be presented at the next regularly scheduled Core meeting (or Consortium if deemed appropriate)

Please note that the Cross-Cutting Strategies involve two or more Priority Workgroups.

This plan will have a companion document which includes a table that allows workgroups or ad-hoc taskforces to capture detailed updates, including partnering organizations and FTC members leading activities.

Strategies

The following outlines the strategies identified through the Austin/Travis County Fast-Track Cities Initiative. This Action Plan is in conjunction with previously existing activities such as the Ryan White Part A jurisdictional plan. The Austin/Travis County Action Plan was used to develop the Texas statewide plan.

Planning processes in 2020 will focus on aligning activities across all levels of existing plans and ensuring that coordination between plans exists to ensure that no duplication of efforts exists. The action plan is divided into five separate sections:

- Prevention
- Testing and Rapid Linkage to Care
- Retention, Re-engagement and Viral Load Suppression
- Ending Stigma
- Cross-Cutting Strategies

Priority Area 1: Prevention

Objective 1.1: Prevent New HIV Infections

Strategy 1.1.1: Educate Providers on PrEP

Activities

a) Educate primary care clinicians on how to provide PrEP access at primary care.
b) Understand and address barriers to testing and PrEP provision for providers.
c) Maintain and encourage use of updated PrEP provider list.
d) Collect data from local providers on services offered and aggregate patient demographic information.

Strategy 1.1.2: Educate Health-Services Students on PrEP

Activities

a) Health-Services Schools and programs, including Medical, Nursing, and Pharmacy: Research what is currently happening around PrEP education. Can engage Medical and professional societies: Make a sustained systemic policy.
b) Investigate development of a program or materials that can be used by various universities, public and private, to add to standard curriculum.

Strategy 1.1.3: Partner with CBOs

Activities

a) Partner with community-based organizations for PrEP outreach-provide more educational programs to the community about PrEP.
    i) Research what is happening around PrEP at local universities, especially private ones; What are the policies? (St.Edwards, Concordia, UT, etc.)
    ii) Convene event (by geography, zip code) for groups looking to align with HIV prevention/reduction goals (TasP).
b) Using data collected to partner with CBOs and other organizations to understand challenges to providing access to care and develop strategies that will address those challenges.

Strategy 1.1.4: Suburban and Rural PrEP

Activities

a) Expand PrEP education and services to reach outlying areas of Austin and Travis County.

b) Partner with CBOs in rural areas to share information, resource guides, and prevention access methods.
c) Using data collected to partner with CBOs and other organizations to understand challenges to providing access to care and develop strategies that will address those challenges.

Strategy 1.1.5: Resource Guide

Activities

a) Create and maintain a resource guide that is sustainable, app-based or online, crowd-sourced, and easily updateable.
b) Train 211, 311 on rapid linkage services identified in resource guide

Strategy 1.1.6: Treatment as Prevention

Activities

a) Collect data on TasP services and activities currently underway.
b) Perform research on TasP activities in other jurisdictions that are not taking place here and can be exploited in Austin/Travis County.

Strategy 1.1.7: Telemedicine

Activities

a) Identify Telemedicine Best-Practices
    i) Review current literature on telemedicine, with special consideration to pre- and post COVID-19 practices in order to identify opportunities and challenges
    ii) Gather input from Austin/Travis County organizations to gain insight into telemedicine practices, strengths, and opportunities for improvement
        a. This may be achieved through a variety of methods such as a survey, email communications, or the FTC SharePoint site
b) Develop, or build upon, a guiding document based on the compiled and analyzed literature and community input; consider hosting on an online platform to enable updates
c) Utilize social media outlets to promote and share an updated list of agencies conducting telemedicine services
    i) For activities b and c, consider similar efforts employed under Strategy 1.1.5 Resource Guide

Potential Partners/Resources for Priority Area 1: Prevention

- Austin Public Health (APH)
- Center for Health Empowerment (CHE)
- Gender Health Equity Lab at the University of Texas at Austin
- Gilead Science
- Texas Health Action
- Walgreens Specialty Pharmacy
- University of Texas at Austin
- Vivent Health

Priority Area 2: Testing & Rapid Linkage to Care

Objective 2.1: Establish Rapid Linkage Program

Strategy 2.1.1: Define "Rapid Linkage to Care"

Activities

a) Develop an Austin definition of "rapid linkage to care" across all testing and treatment providers.

Strategy 2.1.2: Expand and Coordinate Intake

Activities

a) Create and maintain list of providers with intake slots available for newly diagnosed individuals.
b) Work with multiple agencies to insure there are as many options as possible for clients to link quickly into care.
c) Dedicated "walk-in sessions" (e.g. weekends, evenings)

Strategy 2.1.3: Alignment of HIV protocols

Activities

a) Alignment of HIV protocols (Rapid Response Team). Standardize the workflow process of linking from testing sites to treatment sites and then within treatment sites to support initiation of care and provision of ART with agreed upon timeline.

Strategy 2.1.4: Share Best Practices

Activities

a) Establish quarterly meetings of case managers and navigators.

Strategy 2.1.5: Expand Community Engagement

Activities

a) Engage area hospitals and medical providers to actively participate with Priority Groups.

Objective 2.2: Testing

Strategy 2.2.1: Increase Testing Access

Activities

a) Encourage primary clinics to do routine opt-out testing for all.
b) Increase mobile testing capabilities
c) Increase knowledge of testing locations and treatment

Strategy 2.2.2: CME/CMU for STI/HIV Training

Activities

a) CME/CMU for STI/HIV training

Strategy 2.2.3: Testing for Homeless Population

Activities

a) Develop community-wide standard for testing area homeless population.

Strategy 2.2.4: Routine Testing in Area Emergency Rooms

Activities

a) Meet with leaders of hospitals in Austin and Travis County to encourage adoption of routine screening for HIV

Strategy 2.2.5: Opt-out HIV Testing in Austin and Travis County Jails

Activities

a) Priority Group to research current practices and areas for improvement in opt-out HIV testing in area jails

Objective 2.3: Rapid Linkage

Strategy 2.3.1: Advocate for State Drug Assistance Program Improvements

Activities

a) Meeting with State re: AIDS Drug Assistance Program (ADAP).

Strategy 2.3.2: Rapid Linkage from Emergency Departments

Activities

a) Emergency Departments to get navigators and embedded DIS workers to assist in rapid linkage to care (not just social workers).

Strategy 2.3.3: Rapid Linkage in Area Jails

Activities

a) Priority Group to research current practices and areas for improvement in rapid linkage, treatment, and re-entry in Austin area jails

Partners/Resources for Priority Area 2: Testing & Rapid Linkage to Care

- Austin Public Health (APH)
- AVITA Pharmacy
- Center for Health Empowerment (CHE)
- CommunityCare
- Friends of the David Powell Clinic
- Gilead Sciences
- HIV Planning Council
- Integral Care
- Johnson & Johnson
- Texas Health Action
- ViiV Healthcare
- Vivent Health

Priority Area 3: Retention, Re-engagement and Viral Suppression

Objective 3.1: Defining Terms

Strategy 3.1.1: Establish Austin/Travis County FTC definitions as a base for this Priority Area

Activities

a) Research different agency definitions for Retention, Re-engagement and Viral Suppression with special consideration to data collection and resources

Objective 3.2: Minimize Burden on Clients

Strategy 3.2.1: Strategic Decentralization Plan

Activities

a) Determine what larger service providers are doing to decentralize services

Strategy 3.2.2: Promote Education Around Benefits and Enrollment Assistance

Activities

a) Set up meeting with payers/ Benefits Counselors (Medicaid); What do my benefits cover? Partner and have Medicare/Medicaid/QI in the discussion.

Strategy 3.2.3: Transportation

Activities

a) Improve transportation options for clients to access care

Strategy 3.2.4: Childcare

Activities

a) Improve childcare options for clients to access care

Strategy 3.2.5: Engage Pharmacists

Activities

a) Include pharmacists with other workgroups
    i) Ask a Pharmacist Program;
    ii) Association to connect with other specialty pharmacies

Strategy 3.2.6: Streamline Ryan White Eligibility

Activities

a) Reduce paperwork burden on people who use Ryan White services by exploring centralized eligibility for Ryan White services.

Objective 3.3: Bundling and Co-locating Services

Strategy 3.3.1: Co-locating City/County Services

Activities

a) Compile and review models of bundling/co-locating services
b) Compile and review other social determinants of health factors, such as transportation and housing, to inform bundling/co-locating services decisions
    i) Consider partnerships with academic and research institutions

Strategy 3.3.2: Utilizing State Strategies Related to Achieving Together Plan to Widen the Circle of Involvement in FTC

Activities

a) Engage funders with Priority Groups (Ryan White/DSHS, non-traditional partners).
b) Review Achieving Together strategies and create partner categories (such as housing, AIDS services, pharmacy, academic/research, health department) in order to identify focused partners for collaboration

Potential Partners/Resources for Priority Area 3: Retention, Re-engagement & Viral Suppression

- Austin Public Health (APH)
- Center for Health Empowerment (CHE)
- CommunityCare
- Friends of the David Powell Clinic
- Gilead Sciences
- Integral Care
- HIV Planning Council
- Texas Health Action
- Walgreens Specialty Pharmacy
- Vivent Health

Priority Area 4: Social Determinants of Health and Equity

Objective 4.1: Inclusion

Strategy 4.1.1: Respectful and Inclusive Language

Activities

a) Find appropriate language document (Glossary of Terms) and share out
   Step 1: Gather existing resources
   Step 2: Workgroup uses existing resources to develop FTC language guide and sends to consortium, Social Media workgroup, CHE group who is training providers etc. Continue conversation around removing AIDS from vocabulary
b) Promoting respectful and inclusive language throughout Provider or Agency verbal and written communications

Strategy 4.1.2: Incentivize Participation

Activities

a) Identifying key populations to ensure they are included in events and decision making
b) Engage or leverage current youth groups or conveners for participation (meeting on their own terms)
   i. include nontraditional youths as well
c) Identifying resources and funding to incentive participation of key populations
d) First identify their needs and wants
e) Engage peer education
   i. involve current peer education programs

Strategy 4.1.3: Ensure Future Medical Providers are Adequately Trained on Gender Affirming Care

Activities

a) Develop or identify a training or curriculum focused on Transgender, sexual minorities and gender affirming care
b) Implement sexual health curriculum and trainings
c) Training focused on providers or future providers and incentivizes providers to participate
d) On-going quarterly training with evaluation component
e) Develop resource inventory that identified groups already doing this for public knowledge and publishing on IAPAC site

Objective 4.2: Advocacy and Education

Strategy 4.2.1: Implement the People Living With HIV Stigma Index

Activities

a) Coordinate with HIV Planning Council's efforts to support bringing the index to UT Austin and Huston-Tillotson and other academic institutions
b) Work with existing programs that survey community needs:
    i. CHA/CHIP, HIV planning council, LGBTQ QOL surveyors
c) Table at different community events
d) Provide more community engagement and education at monthly community health paramedics programs
e) City-wide wellness fair

Strategy 4.2.2: Empowering and Uniting Through Story Sharing and Promoting Community

Events

Activities

a) Create or add to calendar of local events within our community
b) Support these events by promotion and involvement
    i) Support the Hill Country Ride for AIDS
    ii) Support the Austin AIDS Walk
    iii) Support the Hill Country Ride for AIDS in publicizing stories of participants affected by HIV
    iv) Support the Austin AIDS Walk in publicizing stories of participants affected by HIV
    v) *Whats in the mirror* provides opportunity to discuss Black mens mental health and other hot topics
    vi) *Opening the door to more LGBT organizations within the city*
        i. Austin Pride
        ii. Queer Bomb
        iii. Austin Latinx Pride
        iv. Pflugerville Pride
        v. Black Trans leadership Austin
        vi. Sex Workers Educating & Empowering Texans (SWEET)
        vii. Magdalene Austin
        viii. Texas Harm Reduction

Strategy 4.2.3: Establish Leadership of Community Advocacy Council

Activities

a) Access the current leadership or Community Advocacy Council to determine what resources already exist
b) Leverage current leadership or community advisory council to be leaders in advocacy for ending stigma in the healthcare setting
c) Provide training around Transgender, sexual minorities and gender affirming care.

Potential Partners/Resources for Priority Area 4: Ending Stigma

- Austin Public Health (APH)
- Allgo
- Cardea
- Center for Health Empowerment (CHE)
- CommunityCare
- Friends of the David Powell Clinic
- HIV Planning Council
- Huston-Tillotson University
- Texas Health Action
- Travis County Health and Human Services
- University of Texas at Austin Dell Medical School
- Vivent Health

COVID-19 & Ending Stigma

This section is being developed: More details will be shared as they become available. The International Association for Providers of HIV Care (IAPAC) requested for Fast-Track Cities to incorporate COVID-19 into planning. Please visit https://www.iapac.org/hiv-covid-19/ for more information.

Area 5: Cross-Cutting Strategies

Objective 5: Cross-Cutting

Strategy 5.1: Peer Advocate Program

Activities

b) Gather models of peer advocate programs from other disease states (cancer)

c) Develop system of peer navigators and support for newly diagnosed individuals to help them get into and stay in care.

Strategy 5.2: Being Grant Ready

Activities

a) Compile a list of Request for Proposals (RFPs) to share with organizations

Strategy 5.3: Universal Messaging

Activities

a) Establishing city-wide participation, consistent information, and a universal message (not organization-centric)

Strategy 5.4: Provide Diversity Training for the Workforce

Activities

a) Identify areas of diversity to address; with special consideration to equitable and inclusive language

Strategy 5.5: Normalize HIV Testing

Activities

b) Activities will give special consideration to efforts around Ending Stigma and Prevention

References

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Acknowledgements

Thank you to the Austin/Travis County community that informed this Fast-Track Cities Initiative. We value your collective insights and professional knowledge that guide this important work.

The dedication and expertise of the following agencies and people have made Austin/Travis County Fast-Track Cities a collaborative and engaging initiative that will lead our planning efforts moving forward. Thank you!

Executive Committee

Name	Organization
Akeshia Johnson-Smothers	APH
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Anjelica Barrientos	APH
Barry Waller* (Testing and Rapid Linkage Co-Chair)	HIV Planning Council
Chip House	AVITA Pharmacy
Christopher Hamilton	Texas Health Action
Dr. Colette Burnette* (Ending Stigma Co-Chair)	Huston-Tillotson
Colt Woods* (Prevention Co-Chair)	Walgreens Specialty Pharmacy
Danielle Houston	Gilead Sciences
David Evans	Integral Care
Donald Wilkerson	St. David's
Earl Maxwell	St. David's Foundation
E Marks	St. David's Foundation
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Greg Hartman	Seton
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Nicolas Yagoda	CommunityCare
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Workgroup Members

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Joanna	CHE
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S.D. Butler	CHE
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Sandra Ford	AIDS Healthcare Foundation
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Priority Area 2: Testing & Rapid Linkage

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Vanessa Sarria	Cardea
Laura Still	APH

Priority Area 3: Retention, Re-engagement & Viral Suppression

Workgroup Members

Name	Organization
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Colt Woods	Walgreens Specialty Pharmacy
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Roy Wenmohs	Integral Care
Sandra Chavez	Ashwell
Sandra Ford	AIDS Healthcare Foundation
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Priority Area 4: Ending Stigma

Workgroup Members

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Stephanie Hayden	APH
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Celebrating 2 Years
June 20, 2020
FAST TRACK CITIES AUSTIN
The Austin/Travis County Fast-Track Cities Initiative thanks its members and community for their efforts to end the HIV/AIDS epidemic

Appendix B. **HIV Services in the Austin Area**

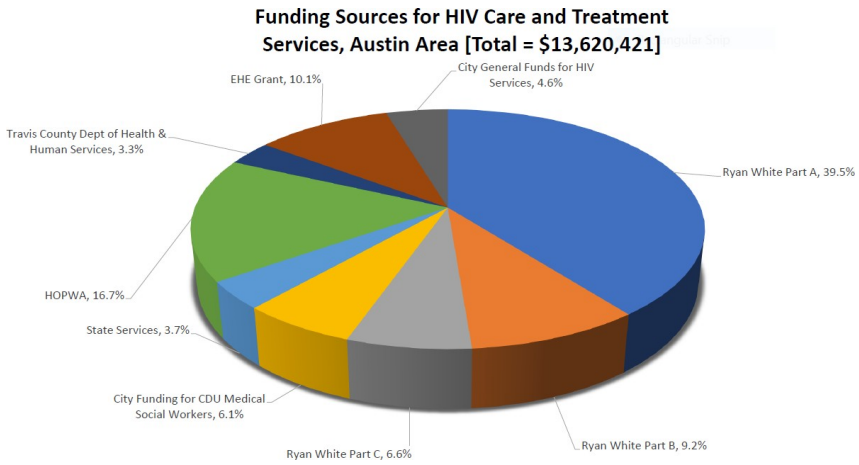
Service	Funding Source					Number of Different Subrecipients	
	Part A	Part B	Part C	Other	Other	Part A	Total, RW and City
HIV Medical Care: Outpatient/ Ambulatory Health Services (OAHS)	✓	✓	✓	✓	340B drug rebate funds	3	4
Medications:							
AIDS Drug Assistance Program (ADAP) Treatments		✓		✓	340B	0	0
AIDS Pharmaceutical Assistance [Local Pharmaceutical Assistance Program or LPAP]	✓	✓				2	2
Case Management:							
Medical Case Management, including Treatment Adherence Services	✓					4	4
Medical Case Management, Community Health Worker	✓					1	1
Non-Medical Case Management Services	✓	✓	✓	✓	City of Austin, Travis County	5	9
Health Insurance Assistance: Health Insurance Premium & Cost Sharing Assistance for Low-Income Individuals	✓	✓				2	2
Dental Care: Oral Health Care	✓	✓	✓	✓	EHE	1	3
Mental Health Services	✓	✓				3	3
Substance Use Treatment:							
Substance Use Outpatient Care	✓					1	1
Substance Use Residential Services	✓					1	1
Housing Assistance: Housing	✓			✓	HOPWA, City of Austin	1	2
Linking or Relinking PWH to Care: Early Intervention Services (EIS)	✓	✓		✓	City of Austin[4]	2	3
Medical Nutrition Therapy	✓					1	1
Emergency Assistance: Emergency Financial Assistance (EFA)	✓	✓				3	3
Food: Food Bank/Home-Delivered Meals	✓	✓		✓	Travis County	1	1

Transportation: Medical Transportation	✓	✓	✓	✓	EHE	6	9
Referrals: Referral for Healthcare and Support Services (Referral HC/SS)		✓	✓			0	2
Linguistic Services	✓					6	6
Outreach				✓	EHE grants to FQHCs	0	0
Legal Services				✓	Volunteer Legal Services of Central TX[5]	0	0

[4] City of Austin General Fund for HIV Services supports services within Austin and Travis County only.

[5] ASA and Volunteer Legal Services of Central Texas (VLS) work together to provide free legal assistance to low- income individuals and families living with HIV/AIDS in Central Texas. Since 1990, Capital Area AIDS Legal Project

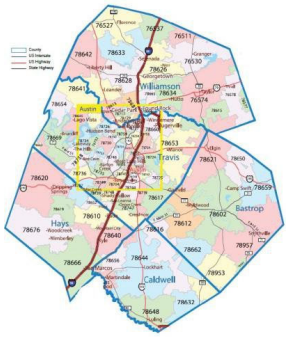
Appendix C.


Funding Sources for HIV Care and Treatment Services, Austin Area [Total = $13,620,421]
City General Funds for HIV Services, 4.6%
EHE Grant, 10.1%
Travis County Dept of Health & Human Services, 3.3%
Ryan White Part A, 39.5%
HOPWA, 16.7%
State Services, 3.7%
City Funding for CDU Medical Social Workers, 6.1%
Ryan White Part C, 6.6%
Ryan White Part B, 9.2%

Appendix D.

Summary Report

Analysis of the Austin System of HIV Care



Prepared for:
HIV Resources Administration Unit
Austin Public Health
Austin, TX

Prepared by:
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EGM Consulting, LLC

March 2021

Executive Summary

Background

This summary report presents the results of a five-month comprehensive analysis of the current system of HIV care in the Austin, Texas area, prepared for the Austin HIV Resources Administration Unit (HRAU) of Austin Public Health (APH). The purpose of the analysis was to identify system of care strengths, weaknesses, challenges, service gaps, access issues, and opportunities for improvement, and provide recommendations for refining and enhancing the system of HIV care along all stages of the HIV care continuum and meeting Fast Track Cities (FTC) goals. In addition, the analysis was to include identification of service models and strategies in use elsewhere that Austin might consider adapting and implementing. The analysis was carried out remotely from October 2020 through February 2021 by EGM Consulting, LLC (EGMC) of Washington, DC. It began with extensive document review and a quick online survey completed by 70 providers, people with HIV (PWH), HIV Planning Council members, APH staff, Fast Track Cities participants, and other stakeholders. In addition, individual or small-group interviews were conducted with 97 stakeholders, among them 33 consumers, 43 providers (subrecipients and non-Ryan White HIV service providers) 10 APH staff, and 7 Planning Council members. Focus topics are shown in the box.

System of Care Analysis:
Topics for Information Gathering

1. Current System of Care
2. Current Service Availability, Accessibility, and Appropriateness
3. Service Quality and Outcomes
4. Use of Technology
5. Provider Participation Factors
6. Community Health Centers/Federally Qualified Health Centers (FQHCs) as Providers
7. Multiple Planning and Funding Components
8. Long-term Impact of COVID-19 Epidemic
9. Community and Consumer Engagement
10. Promising Service Strategies and Models

This summary report provides an overview of findings, as well as conclusions and recommendations. Additional information is provided in a separate detailed report providing topic-based analyses of the main components of the system review, from service utilization to the appropriateness of services for key subpopulations of people with HIV. It presents models and strategies for centralized eligibility and intake, peer navigation, telehealth, and use of rideshare for Medical Transportation.

Conclusions

- **This is not a system in crisis**. Services are considered to be generally good, seldom less than adequate, and in many cases excellent.
- **There is not currently a coordinated, comprehensive network of services,** due to a lack of consistent and collaborative procedures that can help clients enter care and move within and across providers to obtain needed services. Case managers are often the "glue" for a system of care, but only about a quarter of Austin consumers receive case management, and the models are extremely varied.

- **Services do not yet fully reflect and address the needs of the diverse population of people with HIV in the Austin area,** particularly Transgender, Black, Latinx, and female PWH.
- **Austin does not meet the Ryan White goal of equal access for all regardless of who they are and where they live.** Clients who live outside the city must often travel a long way for care, and can receive services such as HIV-related medical care and Oral Health services only by going to Austin.
- **Some services have long waiting periods.** This is often true for Mental Health and Oral Health because of low allocations or other factors.
- **The small number of providers means a lack of client choice.** Most Part A services are available from only one subrecipient.
- **Some innovations are occurring, but there few structured, system-wide efforts to continuously improve services**. The greatest innovation in recent years has come from the new clinics, most of them established to provide Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), and funded largely through a system of drug rebates. Some efforts are being made by the Planning Council and Fast Track Cities. Many stakeholders believe that limited change reflects the lack of a competitive procurement for Part A services during the past ten years.

Recommendations for Strengthening the System of Care

1. **Strengthen services and processes that play a critical role in client access and coordination.** This includes the following:
   - Carry out a comprehensive review of case management services.
   - Require action to streamline eligibility determination.
   - Consider whether it is still necessary to have different income limits for different services in order to ensure access for those with the greatest need.
   - Review the variety of current approaches to intake and initial client assessment, and provide additional guidance or requirements to increase efficiency and ensure that all clients receive certain basic intake components.
   - Ensure that every person with HIV who enters care is aware of service choices.
   - Review service category-specific intake requirements to eliminate unnecessary forms and other paperwork.
2. **Increase information sharing, coordination, and collaboration among subrecipients and with non-Ryan White funded providers.** Among the possible approaches:
   - Provide clear guidance to subrecipients regarding cross-agency collaboration and referrals.
   - Provide for regular meetings, joint training, and information sharing opportunities that involve all subrecipients and, in some cases, non-Ryan White providers as well.
3. **Continue to focus on increasing service appropriateness for disproportionately affected PWH subpopulations.** This should include efforts such as the following:
   - Increase the diversity of clinicians, case managers, and other frontline staff.

- Use the planned procurement to encourage applicants to propose Minority AIDS Initiative (MAI) strategies designed to increase linkage, retention, treatment adherence, and viral suppression among minority populations.
- Obtain community input on service appropriateness and needed changes, through in-depth Planning Council needs assessment efforts.

4. **Increase access to care for residents of the outer counties by increasing the number of services and locations outside Austin and outside Travis County.** This might be accomplished by such efforts as:
   - Requiring at least one Outpatient/Ambulatory Health Services (OAHS) provider to offer services in one or several of the outer counties.
   - Funding certain services with the requirement that one provider must be located outside Travis County.
   - Encouraging or requiring co-location of staff daily or on a scheduled basis in a subrecipient facility outside Travis County; this might include mental health or substance use counselors.
   - Make it financially feasible for personnel to travel to meet with clients outside central Austin and in the rural counties, given transportation issues.
5. **Increase client choice** by funding more than one provider of a service category wherever possible, and ensuring that providers make clients aware of their service options**.**
6. **Rethink Housing Opportunities for People with AIDS (HOPWA) services and design.**
7. **Determine whether action may be needed to increase availability of services like Mental Health and Medical Case Management, given long wait times.**
8. **Consider funding a three-year pilot peer navigation program.**
9. **Ensure that long-term use of telehealth benefits all clients,** by addressing connectivity and considering whether the client has a safe and private place to participate in telehealth.
10. **Rethink Medical Transportation in preparation for the Request for Applications (RFA).**
11. **Use the upcoming competitive procurement to refine and reshape the system of care.**
12. **Continue to strengthen the Planning Council's role in improving the system of care.** This includes efforts by the Council to:
    - Continue providing training for new members and updates for veteran members.
    - Continue to engage consumers both as members and in other less demanding ways
    - Explore and reach a decision about use of peer navigators.
    - Consider how to engage and learn from subrecipients and other providers.
    - Have a committee review service utilization data, including trends over time.
    - Plan for an in-depth consumer-focused needs assessment.
    - Consider how best to address the need for language services for PWH with limited English.
    - Consider how to help ensure equitable access to care for PWH regardless of where they live in the Austin Transitional Grant Area (TGA).

Acknowledgments

The Austin system of care analysis was implemented over a five-month period, entirely remotely (from Washington, DC) because of the pandemic. It could not have been completed without an enormous amount of assistance from many people. Most important was the help provided by Brenda Bounous, the City's Contract Manager for the project and the Quality Management Coordinator for the HIV Resources Administration Unit (HRAU) at Austin Public Health (APH). EGM Consulting (EGMC) requested an enormous number of documents, and Brenda gathered, organized, and emailed them all, answered our questions and provided advice via Zoom and email, connected us with a wide range of key stakeholders, and assisted with every aspect of the work. We are also grateful to many other people:

- All the other HRAU staff, who made themselves available for initial and in-depth interviews and provided essential information and documents
- Austin/Travis County Fast Track Cities staff, especially Hailey de Anda, Interim Program Manager of the APH Planning and Evaluation Unit, who provided contacts, information, and advice
- Austin Area HIV Planning Council members and the Office of Support, especially Jaseudia Killion, Planning Council Planner, who provided much-valued information and advice at multiple times
- Subrecipient staff who made it possible for us to individually interview 33 consumers, especially Moe Lujan and Esteban Olave of ASHwell and ASHwell management who approved these efforts and the matching of EGMC incentives, and Ashley Vidal, who worked to recruit clients; and Emily Johnston and all the CARE Program staff at Integral Care, who also helped to recruit consumers
- The 33 consumers who allowed us to interview them
- All 70 people who completed the online Austin Providers and Stakeholders Survey
- Staff of all seven of Austin's Ryan White Part A subrecipients, key informants from Texas Health Action, Travis County, The APH Sexual Health Clinic, the Ryan White Part B Administrative Agent Brazos Valley Council of Governments (BVCOG), Lone Star Circle of Care, People's Community Clinic, and the Dell Medical School, who participated in interviews lasting from half an hour to an hour and a half
- Nineteen case managers, counselors, and program directors from Integral Care, ASHwell, Vivent, and CommUnityCare's David Powell Clinic, who participated in small-group sessions

We particularly appreciate the willingness of people to be interviewed and to share their thoughtful, frank, incisive explanations and perspectives on HIV services in the Austin area.

We also value the assistance from Isabel van Isschot in providing rapid Spanish translations of the survey and the consumer interview guide, and to Canela Torres, who conducted interviews in Spanish from Los Angeles and provided other consultation to the project.

Table of Contents

Summary Report

Background and Purpose of the Analysis: This report summarizes the results of a five-month comprehensive analysis of the current system of HIV care in the Austin, Texas area, prepared for the Austin HIV Resources Administration Unit (HRAU) of Austin Public Health (APH). HRAU manages funds provided under Part A and Part C of the Ryan White HIV/AIDS Program (RWHAP), as well as Austin's Housing Opportunities for Persons with AIDS (HOPWA) Program. The analysis encompassed the system of care in the Austin area, as served by RWHAP Parts A, B, and C and the HOPWA Program. The Austin Part A Transitional Grant Area (TGA) includes five counties: Bastrop, Caldwell, Hays, Travis, and Williamson. HOPWA serves the same five counties. The Part C program serves these counties plus five others that are part of the Ryan White Part B HIV Service Delivery Area (HSDA): Blanco, Burnet, Fayette, Lee, and Llano. The new Ending the HIV Epidemic (EHE) effort serves Travis County, which is also the focus for Austin's Fast Track Cities (FTC) initiative. The analysis was carried out by EGM Consulting, LLC (EGMC), located in Washington, DC. Because of the COVID-19 pandemic, the entire analysis had to be carried out remotely, with extensive use of Zoom interviews.

This summary report provides an overview of findings, as well as conclusions and recommendations. The major topics listed in Figure 1 are addressed in much more detail in a set of Topic-Based Analyses that are the other major products of the analysis.

Figure 1: System of Care Analysis: Topics for Information Gathering

1. Current System of Care
2. Current Service Availability, Accessibility, and Appropriateness
3. Service Quality and Outcomes
4. Use of Technology
5. Provider Participation Factors
6. Community Health Centers/Federally Qualified Health Centers (FQHCs) as Providers
7. Multiple Planning and Funding Components
8. Long-term Impact of the COVID-19 Epidemic
9. Community and Consumer Engagement
10. Promising Service Strategies and Models

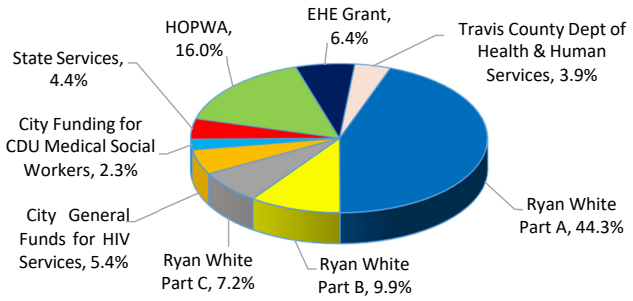
Methods: The analysis focused on ten topics (shown in Figure 1) and involved a variety of information gathering and analysis methods, including document review, individual and group interviews, an online survey, and online research. Data gathering began within initial interview with APH staff, introduction of the project at scheduled meetings of key groups, and use of SurveyMonkey to obtain perceptions of the system of care – strengths, weaknesses, availability of services, barriers to care, and subpopulations facing the greatest access challenges – from a diverse group of 70 people with HIV (PWH), managers and frontline staff of subrecipients and other service providers, APH staff, Planning Council members, Fast Track Cities core coordinating committee members, and other stakeholders. Many had multiple affiliations. EGMC interviewed a total of 97 individuals, including 33 consumers, primarily through individual Zoom meetings and calls, plus several small-group sessions with frontline staff. Group sessions were challenging to arrange remotely. Several individual consumer interviews were in Spanish. EGMC was able to interview individuals from all subrecipients and identified non-Ryan White providers, but would have liked additional input from one non-Ryan White provider.

Findings and Summary Analysis

Description of Current Services

- **The Austin area has more than $11.5 million in grant and contract funding and City General Funds for HIV care and treatment,** as Figure 1 shows, and that does not count Part B funds for the Texas HIV Medications Program (THMP), which is managed by the State, or 340B drug rebate funds, which are the primary source of support for several PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis) clinics in Austin. Of the 28 core medical and support service categories that can be funded under Ryan White, a total of 17 receive funding from at least one Ryan White Part. Part A supports 9 medical and 6 support services; and Part B provides THMP funding. Non-Ryan White funds support several additional services, including legal services. HOPWA supports 8 service categories provided through two project sponsors: facility-based housing (FBH); master leasing (ML); tenant-based rental assistance (TBRA); short-term rent, mortgage, and utility assistance (STRMU); hotel/motel assistance (H/M); permanent housing placement services (PHP); housing case management (HCM); and Supportive Services for housing clients (SS).

Figure 1: Funding Sources for HIV Care and Treatment Services, Austin Area [Total = $11,663,000]



- **Austin has a relatively small number of Ryan White-funded service providers – seven**. They include ASHwell (formerly the Wright House Wellness Center); Community Action, Inc., of Central Texas (which serves counties other than Travis); the federally qualified health center (FQHC) CommUnityCare (and its David Powell Clinic); Integral Care (Austin Travis County Mental Health and Mental Retardation Center); the housing organization Project Transitions; Vivent Health (formerly AIDS Services of Austin); and Waterloo Counseling Center (as of January 1 a part of Texas Health Action, which operates the Kind Clinic). Three Part A subrecipients also receive both Part B and Part C funds, and two are HOPWA project sponsors. Texas Health Action (THA) has no Part A funding except Waterloo's Mental Health funds, but has some Part B funding.
- **Consumers have limited choice in providers.** Most service categories have only 1-2 providers. For example, Part A funds only one provider for each of the following: the Local AIDS Pharmaceutical Assistance Program (LPAP), Outpatient/Ambulatory Health Care (OAHS), Health Insurance premium and Cost-Sharing Assistance (HIPCSA), Oral Health, both Outpatient and Residential Substance Use Treatment, Medical Nutrition Therapy, Early Intervention Services (EIS), Housing, and Food Bank/Home Delivered Meals. Part B funds an additional provider for some of these services.

- **People with HIV in the ten-county Austin area generally receive most of their services in Austin.** Only one subrecipient, Community Action, Inc., of Central Texas is located and has offices outside Travis County.
- **Few changes have occurred in Part A services over the past decade,** since there has been no competitive procurement since 2011, but the number of HIV service providers has increased and some new applicants are likely when Part A services are competed.
  - There are new organizations and new clinics. THA's Kind Clinics, the Center for Health Empowerment (CHE), and the ASHwell Clinic were established as Sexually Transmitted Infection (STI) clinics providing PrEP and PEP; they continue to receive substantial 340B funding[1], but have expanded their services. Vivent's Moody Clinic was established to expand access to HIV primary care, specialty care, and PrEP services; it now has Part B funding for OAHS.
  - FQHC engagement in HIV services has increased. Both CommUnityCare and two other area FQHCs, Long Star Circle of Care (LSCC) and People's Community Clinic (PCC) received Ending the HIV Epidemic (EHE) Primary Care HIV Prevention funding from the Bureau of Primary Health Care (BPHC), and both LSCC and PCC are now providing HIV outreach and testing, PrEP and PEP; PCC is training providers and expects to be able to provide HIV primary medical care in the future.
  - Some existing subrecipients indicated an interest in applying for funding in additional service categories, and some organizations with no Part A funding expressed possible interest in applying under a new Request for Applications (RFA).

Service Availability, Accessibility, and Appropriateness

The following are important factors in assessing services:

- **Availability** is the extent to which needed HIV-related medical and support services exist in the service area, usually based on the number of "slots" and whether there are waiting lists.
- **Accessibility** involves the extent to which services in the Austin Area can be obtained conveniently by people who need them, based on such factors as location, access to public transportation, service hours, wait time, and Americans with Disabilities Act (ADA) compliance. **Barriers** to care are factors that limit access.
- **Appropriateness** involves the extent to which they meet the needs of various PWH subpopulations, in terms of languages spoken and cultural competence/cultural humility of personnel in serving people with HIV with particular characteristics, usually with a focus on race/ethnicity, sexual orientation, gender/gender identity, and age.

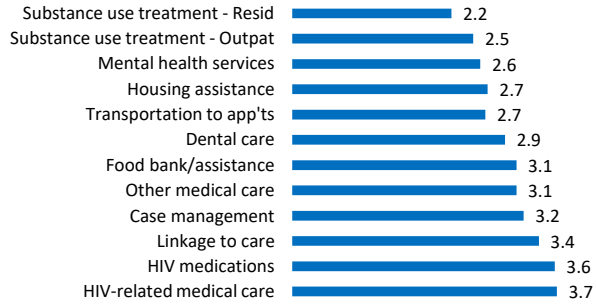
Availability: Availability of care varies by service category. HIV-related medical care (OAHS) and HIV medications were identified in the survey as the most available services, and substance use residential and outpatient treatment and mental health services as least available. Figure 2

[1] Section 340B of the Public Health Service Act requires pharmaceutical companies providing Medicaid and Medicare covered drugs to provide discounts on drugs for patients served by "covered entities," which include not only hospitals but also FQHCs, state AIDS Drug Assistance Programs (ADAPs), Ryan White providers, and Sexually Transmitted Infection (STI) clinics.

shows the mean availability of various services based on a 4-point scale, where 1 = Not at all, 2 = A little, 3 = Moderately, and 4 = Very Available.

- Six services are considered less than "moderately" available.
- People with HIV who completed the survey indicated that Residential Substance Use Treatment, Outpatient Substance Use Treatment, Mental Health Services, and Housing Assistance are only "a little" available.
- Several providers said there is sometimes a waiting list for Mental Health Services and also for case management.
- During interviews, people frequently said that affordable housing overall and housing specifically for people with HIV are very limited.

Figure 2: Service Availability: (Weighted Means) [N = 70]



Based on a 4-point scale from 1 = Not at all to 4 = Very available

- Emergency assistance is hard to obtain; Emergency Financial Assistance (EFA) under Part A is used only for bridge medications, not for food, housing, or utility assistance.
- While HIV-related medical care is considered widely available, primary medical care and specialty care are much less available. Texas is not a Medicaid expansion state, and the locally supported Medical Assistance Program (MAP) is available only to Travis County residents. CommUnityCare and Moody Clinics generally provide primary care for their HIV clients, but several consumers who receive OAHS from other providers said they have no regular source of non-HIV medical care.

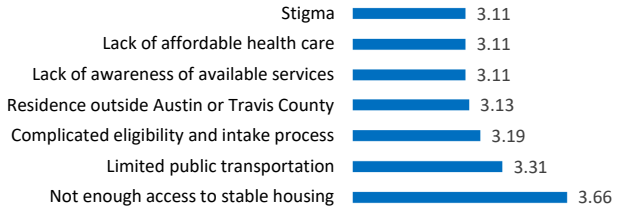
Accessibility and Barriers to Care: Access to care varies by county of residence and by subpopulation.

- **Location of services.** Overall, there is broad agreement that HIV services are far more accessible for residents of Austin than for people living farther out in Travis County and for residents of the other TGA counties. Only one subrecipient provides services outside Travis County, and it does not provide OAHS, although one in six clients lives in the other four counties. Providing OAHS outside of Austin was identified by consumers as one of the most-needed changes to increase access to care.
- **Limited weekend or evening hours.** During non-COVID times, limited weekend or evening hours make it difficult for employed consumers to obtain care, especially if they do not live or work near the provider locations, most of which are near central Austin.
- **Transportation issues.** Transportation is a major challenge for consumers living outside Travis County, but was also identified as a challenge for some residents of Travis County.

Several people reported that bus trips can involve multiple transfers and two hours of time one-way. Several providers use Uber or Lyft to transport clients to and from appointments, usually with 340B funds. Case managers at some subrecipients report that they typically travel to clients in the outer counties rather than meeting them at the office, especially when the clients do not have easy access to a car. A few subrecipients sometimes take consumers to appointments at other providers. Some subrecipients allow staff to transport clients in their own cars; others do not because of insurance issues.

- **Wait time for appointments.** Consumers report that wait times for appointments can be long for Substance Use Treatment, OAHS, Mental Health, and Oral Health Services, even when there are no waiting lists.
- **Lack of awareness of available services and lack of outreach.** Many consumers indicated being unaware of the range of available services other than those provided by their current providers. There is no up-to-date HIV service directory for consumers. One social worker reported providing a double-sided page listing local AIDS service organizations (ASOs), their contact information, and the services they provide, and highlighting some of them in discussion. Asked if their doctor, case manager, or other provider staff have ever helped them get services from another provider, only 41% said yes. Several providers and administrators noted the responsibility of service providers to publicize their services, but said that such outreach has not always been a priority in recent years.
- **Other factors limiting access.** Administrators, frontline staff, and consumers all described complex intake forms and procedures as factors limiting access to care. Consumers identify stigma as an issue, especially when a provider is an ASO and they feel "outed" by going there. Lack of connectivity is also limiting access to care during the pandemic, when many appointments are via telehealth.

Figure 3: Greatest Barriers to Care
(Weighted Means) [N = 70]



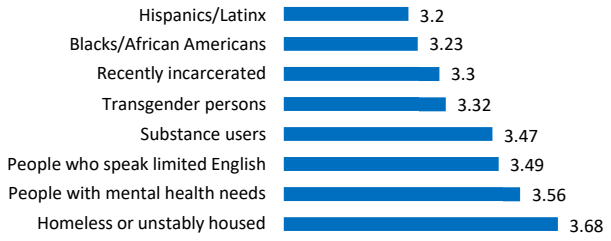
Based on a 4-point scale from 1 = Not at all to 4 = Very serious barrier

Barriers to Care: Figure 3 shows the factors considered by survey respondents to be the greatest barriers to care. A weighted mean greater than 3.0 means the factor is considered a moderately or very serious barrier to care. Housing, transportation, and the complicated eligibility and intake process were identified as the most serious barriers.

Populations Facing Special Challenges: Survey respondents were asked to what extent various subpopulations face in obtaining needed care and achieving viral suppression – with the subpopulations defined in terms of race/ethnicity, English fluency, gender identity, and co-occurring conditions. As Figure 4 shows, there was a high level of agreement across all respondent groups that homeless or unstably housed people with HIV face the greatest challenges in both obtaining services and becoming virally suppressed, and that people with

mental health needs and substance users also face special challenges. Consumers, providers, and Planning Council members were particularly likely to emphasize the access to care challenges for clients with limited English. It is hard for them to identify providers, get through intake, obtain appointments, and communicate with providers while obtaining services.

Figure 4 : Subpopulations Facing the Greatest Difficulty in Obtaining Needed Care and Achieving Viral Suppression: Weighted Average [N = 70]



Based on a 4-point scale from 1 = None to 4 = Great difficulty

Level of Services: In 2019, 2,463 unduplicated clients were served in the TGA and over 70,000 service units were provided with RWHAP Part A, Part A MAI, Part B, Part C, and General Funds (The RWHAP Services Report includes a larger number of clients because it includes people served with other funding such as Medicaid and Medicare). As Figures 5 and 6 show, both the number of total clients and the number of service units supported through Part A funds were lower in 2019 than in 2013, but the numbers have increased annually since 2017.

Figure 5: Unduplicated Clients Served by Year, 2013-2019 (Ryan White & City General Funds)

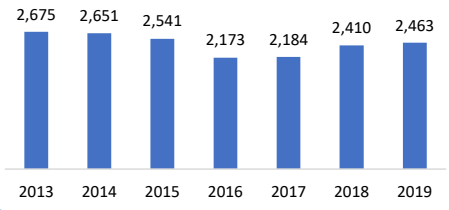
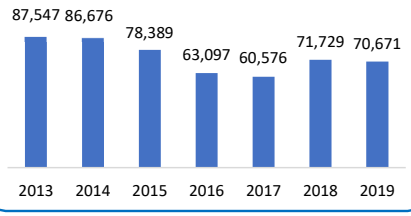


Figure 6: Total Service Units by Year, 2013-2019 (Ryan White & City General Funds)



There is great variation in the number of service units provided per service category, as shown in Figures 7 and 8. For example, the average number of OAHS service units (which include labs as well as medical visits) was 6, Mental Health – 4, Medical Case Management – 59, and Non-Medical Case Management – 53. Service units are defined for each service category. For example, a service unit for OAHS is one visit or one laboratory test; for case management it is a 15-minute contact. For most services, the TGA does not currently state an expected or desired average number of service units per client. A few services do have a limit, such as the number of times a consumer may receive groceries from the Food Bank or the number of days a client can spend in temporary housing.

Figure 7: Average Number of Service Units per Client, by Core Service Category, 2019 [Total = 33,646 Core Service Units]

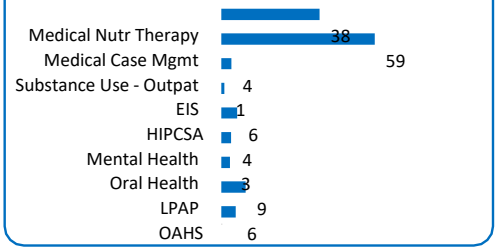
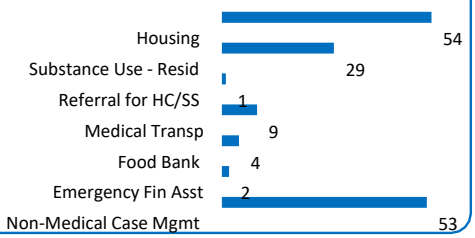


Figure 8: Average Number of Service Units per Client, by Support Service Category, 2019 [Total = 36,615 Support Service Units]

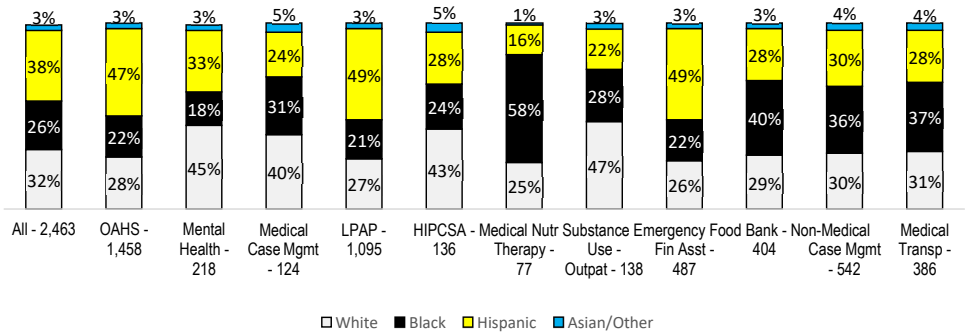


Service Appropriateness: Ryan White programs are expected to provide appropriate services for all people with HIV in the jurisdiction. Appropriateness can be assessed for the system of care as a whole and for specific service categories. Special attention is usually given to how well services are meeting the needs of disproportionately affected and traditionally underserved PWH subpopulations, such as racial/ethnic minorities, LGBTQ PWH, young adult and older PWH, and women. The current Ryan White client population has the following characteristics:

- **Race/ethnicity:** In 2019, more than half of consumers were from communities of color: 32% were White non-Hispanic, 38% Hispanic/Latinx, 26% Black/African American non-Hispanic, about 1% Asian and other, and 4% of unknown race/ethnicity.
- **Gender identity:** About 80% of clients were reported as male, 18% female, and 2% transgender (the transgender population is often undercounted).
- **Age:** Almost half (47%) of clients were age 25-44 and 45% were 45-64, while 4% were 13-24 and 5% were over 65.
- **Other characteristics:** About 62% of clients had MSM (men who have sex with men) reported as a risk factor. Two-thirds (66%) of consumers had incomes below 138% of the Federal Poverty Level (FPL), which means they would be eligible for Medicaid if Texas were an expansion state.

Service utilization: Among the factors to consider are utilization of various services by key populations and perceived quality of these services. EGMC looked at use of each core medical and support service category in 2019 by race/ethnicity, gender identity, and age for the 2,463 unduplicated clients receiving services through Ryan White Part A, Part B, Part C, and City General Funds. Figures 9, 10, and 11 show selected findings (Data for all service categories are provided in the Topic-based Analysis of Service Utilization). Over- and under-representation often reflect differences in service needs, but, when considered along with other information, can also reflect level of service appropriateness.

Figure 9: Utilization of Selected Service Categories by Race/Ethnicity, 2019 (Percent)

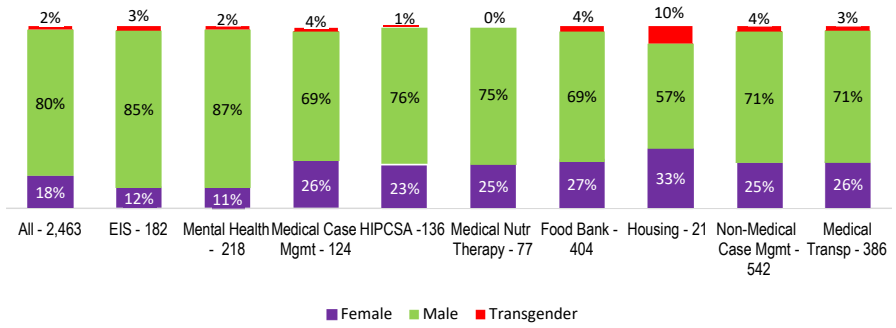


The 2019 data provided in Figure 9 show considerable differences in utilization of different service categories by different groups. For example, with regard to racial and ethnic groups:

- **White non-Latinx** PWH make up 32% of Austin consumers, but 47% of Outpatient Substance Use Treatment clients and 45% of Mental Health Services clients, and only 25% of Medical Nutrition Therapy clients and 26% of Emergency Financial Assistance clients.
- **Black PWH** are 26% of consumers. They are overrepresented as clients of Medical Nutrition Therapy (58%), Food Bank (40%), and Medical Transportation (37%), but underrepresented as recipients of Mental Health (18%), LPAP (21%), OAHS (22%), and Emergency Financial Assistance (22%).
- **Latinx PWH** are 38% of consumers but are overrepresented as clients of LPAP (49%), Emergency Financial Assistance (49%), and OAHS (47%), and underrepresented as users of Outpatient Substance Use Treatment (22%), and Medical Case Management (24%).
- **PWH from Asian and other racial groups** make up 3% of all clients. They are especially likely to receive Medical Case Management and Health Insurance Premium and Cost-Sharing Assistance (HIPCSA) (5% each), and less likely to receive Medical Nutrition Therapy (1%).

More analysis would be helpful to understand some of these differences. For example, the high rate of use of LPAP, EIS, and OAHS by Latinx clients may reflect the fact that they are especially likely to be uninsured and to depend on Ryan White for medical care and medication assistance. The high rate of Medical Nutrition Therapy and Food Bank use by African American clients could reflect low income levels and therefore a greater need for supplements and other food assistance. More information is needed to understand why both African American and Latinx clients are underrepresented as Mental Health Services clients.

Figure 10: Use of Selected Services by Client Gender Identity, 2019 (Percent)



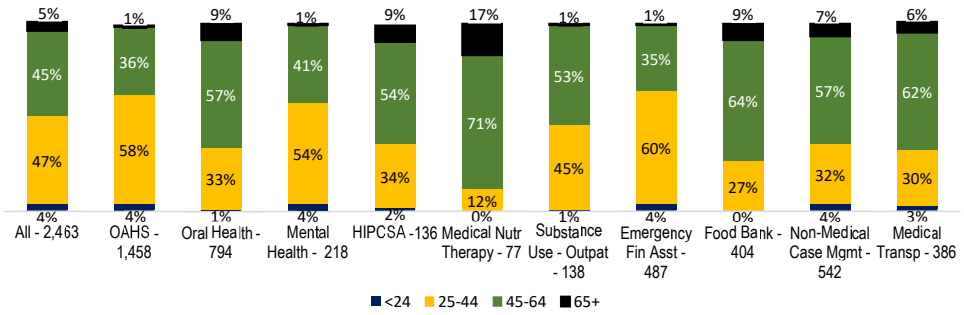
There are also some large differences in utilization of some service categories based on client gender identity, as shown in Figure 11. For example:

- **Women** are 18% of all clients but are especially likely to be clients of Housing (33%), though the total number of clients is very small, Food Bank (27%), Medical Transportation (26%), and Medical Case Management (26%), and much less likely to receive Mental Health Services (11%) and Early Intervention Services (12%).
- **Men** are 80% of all clients and an especially high proportion of clients of Mental Health (87%) and Early Intervention Services (85%), and a relatively low proportion of Housing (57%), Food Bank (69%), and Medical Case Management (69%) clients.
- **Transgender** PWH are 2% of all clients and are particularly likely to be receiving Housing Services (10%), though as previously noted, the total number of clients very low (21), and also Medical Case Management, Non-Medical Case Management, and Food Bank services (4% each).

With regard to age, the data in Figure 11 show considerable differences in use of some services by the youngest and oldest clients. For example:

- **PWH aged 13-24** are 4% of all clients, but 0% (which statistically means less than half of 1%) of Medical Nutrition Therapy and Food Bank clients. Not overrepresented in any service category, they are most likely to be receiving OAHS, Mental Health, Emergency Financial Assistance, and Non-Medical Case Management services (4% each).
- **PWH 65 and older** are 5% of clients, but 17% of those receiving Medical Nutrition Therapy, and 9% of Oral Health, HIPCSA, and Food Bank clients; they are only 1% of OAHS, Mental Health, Outpatient Substance Use Treatment, and Emergency Financial Assistance clients.

Figure 11: Utilization of Selected Service Categories by Client Age, 2019 (Percent)



As with the other subpopulations, some of these differences are readily explained, while others would benefit from more information and analysis. For example, PWH who are over 65 are less likely to need OAHS and EIS (which provides bridge medications only) and more likely need HIPCSA because they are likely to be on Medicare, which provides their medical care but has some cost-sharing like deductibles and co-pays for which they may need assistance. A high level of use of Medical Nutrition Therapy may well reflect their need for nutrition supplements, which are provided through that service category. It would be useful to have more information about why they are unlikely to receive Mental Health services. Similarly, young PWH may have fewer Oral Health or Medical Nutrition Therapy Needs, but it would be useful to know why they are relatively unlikely to receive Outpatient Substance Use services.

Perceived service appropriateness: The 97 people interviewed for the analysis, including 33 consumers, provided considerable information about appropriateness of services:

- **Changing environment:** In the past few years, attention to issues of equity has increased. Both the City and subrecipients are perceived as placing a greater emphasis on LGBTQ issues and showing increased awareness of racial and ethnic inequities. However, a tradition of structural racism was described by many people from all stakeholder groups.
- **Transgender PWH:** Several people emphasized the challenges transgender PWH, both men and women, continue to face in obtaining respectful and appropriate services. A very few transgender men are identified in client statistics, and several consumers indicated that they do not yet have a "safe space." Some of the newer PrEP and PEP clinics provide gender-affirming care including hormones, primarily using 340B and private funding.
- **Lack of staff diversity:** There is a broadly shared recognition that lack of staff diversity is a major barrier to service appropriateness. While providers indicate that the proportion of LGBT staff has increased, most reported limited success in recruiting and retaining Black and Latinx staff, including clinicians, mental health counselors, and case managers. Subrecipients and other providers indicated that they have been particularly unsuccessful in recruiting Black staff. While many consumers value and respect the skills and commitment

of their service providers, they also emphasized the value of a case manager or counselor who understands their cultural experiences.

- **Service design:** Providers frequently described services as originally designed for "gay White men." Only one provider (not Ryan White funded) describes itself as targeting Black and Latinx people. The need for more services designed for Black women was also identified, as was the fact that Asians are "often ignored" since they are a small proportion of the population. In addition, there is a perceived need for more services and staff with training and experience in serving young men and older PWH.
- **Lack of bilingual staff:** Clients who speak limited English face considerable access challenges, and – as several providers noted – it is very difficult to provide mental health or case management services through an interpreter. Some providers use language lines to provide telephone interpretation. Since there is no Part A funding for Linguistic Services, providers may not have the resources for in-person interpreters. However, there was broad agreement that in a city that is 40% Latinx, providers should be able to hire staff who are bilingual in English and Spanish. Subrecipients Statements of Work indicate that providers comply with the Office of Management and Budget (OMB) Cultural and Linguistically Appropriate Services (CLAS) standards, but practices indicate that some subrecipients may not be fully compliant with Standards 5-8, which address language services.
- **Need for training:** Subrecipients and other providers emphasized the importance of cultural competence/cultural humility training. While most said they provide some training themselves, it is sometimes hard to find experienced trainers. The City sometimes offers sessions, but there is agreement on the need for more such training, focused on various subpopulations and issues.

System of Care Quality and Perceived Effectiveness

What is a "system of care"? A system of care involving health and/or social services has been described in the literature as "an approach that combines a broad array of services and supports with a set of guiding principles and core values" that are "organized into a coordinated network." Values often include being community-based, culturally and linguistically competent, individualized to address the needs of each client, and planned and guided by the community and consumers.[2] A system of care is designed to help accomplish specific outcomes, such as enabling people to maintain good health.

As the description suggests, analyzing the system of care involves looking at how services are organized and coordinated, perceived service quality and appropriateness, and outcomes achieved. For HIV services, this includes performance along the HIV continuum, including linkage, retention, and viral suppression. It also includes consumer satisfaction with services.

[2] See, for example, descriptions from Casey Family Programs, at https://www.casey.org/can-you-tell-us-about-a-few-agencies-that-have-systems-of-care/; and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, at https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf.

Overview: Overall, most people surveyed or interviewed believe that service quality in Austin is good. Some services, organizations, and individual staff are especially likely to be singled out for providing consistently helpful, respectful, competent care, and exceptional commitment to clients. Very few serious service failures were described.

HIV care continuum data: Limited data are available, but they identify some populations with delayed linkage to care or lower rates of viral suppression. For this analysis, the most useful information would be information about Ryan White clients rather than all PWH in the TGA, since Ryan White has limited influence on services and treatment outcomes for non-clients. Epidemiologic data for all PWH in the TGA indicate that in 2018, 75% of newly diagnosed PWH were linked to care within 3 months, but only 71% of Black MSM and 46% of Black women were linked within 3 months, compared to 88% of Latinx MSM. Eighty-four percent of PWH in the Austin TGA had at least one medical visit or laboratory test and 79% were retained in care (defined as at least 2 visits at least 3 months apart or virally suppressed at the end of the year). Overall viral suppression was 71%, but rates were lower for populations such as Black MSM (65%), Black women (66%), and Latinx MSM ages 13-34 (70%).

System strengths and weaknesses: Figures 12 and 13 summarize greatest strengths and weaknesses of the system of care, as identified in the survey. Some characteristics were described as both strengths and weaknesses. The most frequently identified strengths were the skills and commitment of service providers and their staff, stability of the system of care, and collaboration among service providers. The most frequently identified weaknesses were access to care on evenings and weekends, consumer input, and community involvement in planning (The last two are addressed in Topic-based Analyses).

Figure 12: Most Frequently Identified Strengths of the Austin System of HIV Care [N = 70]

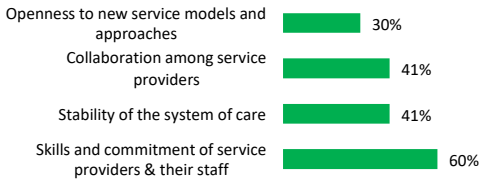
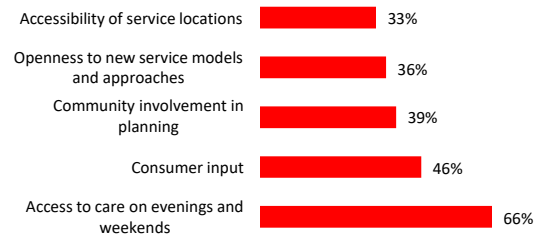


Figure 13: Most Frequently Identified Weaknesses of the Austin System of HIV Care [N = 70]



There were considerable variations by respondent group. Accessibility of service locations was seen as a weakness by 50% of PWH and 46% of FTC-affiliated respondents, but only 18% of Austin Public Health staff. Almost half (47%) of providers but only 30% of PWH, 27% of Fast Track Cities-affiliated respondents, and 9% of Austin Public Health staff identified collaboration among providers as a strength. In interviews, respondents often said that collaboration by

individual staff members across agencies is often very good, but more formal collaboration is less frequent, due to a combination of "'siloing,' competitiveness, and complacency" resulting in part from ten years without the self-reflection that typically occurs when there is a competitive procurement. Half (50%) of FTC-affiliated respondents and 45% of APH staff identified openness to new service models and approaches as a weakness, while 40% of PWH and 32% of providers identified it as a strength. In interviews, people pointed to the joint work led by FTC on Rapid Linkage to Care Program as an example of both innovation and collaboration. The effective use of 340B funds to develop PrEP and PEP services, support the development of additional sources of HIV care, and initiate gender affirming care was also cited as showing the potential for innovation, particularly among recently established entities.

Service-specific issues: Many people from all stakeholder groups identified some specific services that they feel need review and redesign, given their importance to the quality and effectiveness of the overall system of care.

- **Case management:** There is widespread concern that both Medical and Non-Medical Case Management in Austin need to be reviewed, requirements clarified, and changes in service models considered. The most frequently identified issues were these:
  - **Varying models and levels of assistance:** Different providers approach case management very differently. For example, some case managers travel to their clients, help clients with complicated intake for other services, and/or do "warm hand-offs" to ensure referrals are completed; others do not. Subrecipients reported using the Texas Department of State Health Services (DSHS) acuity scale in different ways, and at least one subrecipient has substituted its own scale, to avoid "graduating" clients who still need case management.
  - **Role of case management in the system of care:** In many Part A jurisdictions, a majority of clients receive case management, and case managers play a coordinating role, not only referring people to other services but also sometimes serving as gatekeepers who must provide a referrals, with client self-referrals not permitted. In Austin, only 27% of clients received case management services through RWHAP in 2019. According to its website, the only Food Bank funded by Part A is open *only* to clients who are enrolled in case management, and this is also a requirement for access to Medical Nutrition Therapy, which means that almost three-fourths of clients have no access to those services.
  - **Unclear distinction between Medical and Non-Medical Case Management:** Austin funds very little Medical Case Management; only 5% of clients receive it, and 22% receive Non-Medical Case Management. Nationally, many jurisdictions provide case management to a majority of clients, and often fund more Medical than Non-Medical Case Management. Several Austin Non-Medical Case Management providers said they are actually providing Medical Case Management, working not only to improve client access to needed services, but also health outcomes.
  - **High turnover:** Some agencies were described as having a hard time retaining case managers, and the learning curve for new case managers negatively affects the quality of case management services. Consumers "get tired of repeating their history to a new case manager."

- **Housing services:** Both Part A and HOPWA housing services would benefit from careful review and redesign, according to a number of providers and consumers. Among the issues identified: the need for housing plus social support, especially for consumers who were formerly homeless and have other co-occurring life situations; temporary housing units that are sometimes unsafe; and use of housing models that depend on case managers with limited housing expertise to locate housing units for clients.
- **Minority AIDS Initiative (MAI) services:** Austin is moving towards MAI services designed to improve medical outcomes for specific target groups, and away from providing funds that can be used to bill the costs of existing services when they are provided to Black and Latinx clients. Special targeted strategies are seen as essential to improve retention and viral suppression.
- **Mental Health services:** These services are seen as extremely important for positive medical outcomes, but insufficiently available. In addition, both providers and consumers described the lack of diverse mental health personnel as negatively affecting the use and the value of Mental Health Services for people of color.
- **Use of harm reduction techniques:** Increased use of harm reduction strategies are needed to "meet people where they are," and ensure that people are not denied other services because of co-occurring conditions like substance use.
- **Linguistic services:** Availability and quality of language services are a concern to providers, Planning Council members, consumers, and other stakeholders. This is a system of care concern because it involves both quality of and access to care – including the inability of consumers with limited English to learn about services, find their way to intake, and deal with complicated forms and requirements.

System of care: Many people from all stakeholder categories believe Austin currently has a variety of HIV medical-related and support services, but not a true *system* of care in the sense of *a coordinated, comprehensive network of services*. This was explained in many ways:

- **No consistent or coordinated intake and assessment process:** Austin has no centralized eligibility process to enable clients to provide their documents only once, at the first point of entry into care, and no consistent expectations or procedures for new client assessment or treatment planning. Everything can vary by subrecipient and by service category.
- **Insufficient support for high-need consumers:** Both consumers and providers identified a need for more client education about HIV and HIV medications, better understanding of available services and how to access them, and help in dealing with co-occurring life situations. This lack is given as one reason why Non-Medical Case Managers say they are actually providing Medical Case Management. It is also a frequent rationale for developing a peer navigation program.
- **Inconsistent cross-agency referrals:** Most consumers said they had not received help from a doctor, case manager, or other provider staff member in obtaining services from a different provider. Use of and methods for cross-provider referrals vary tremendously. Some case managers assist clients in completing very extensive intake forms for other services like Food Bank and Oral Health and do personal follow-up or even accompany clients to the first appointments; others provide contact information or perhaps make a

telephone call. Follow-up on referrals is challenging, especially since information may not be consistently or promptly uploaded into ARIES.

- **Limited collaboration on an organizational level:** Some cross-provider collaboration exists, but it is widely viewed as too limited. There has been cooperation during the pandemic, but many clients lack cross-agency treatment plans, and information sharing varies. The recipient does not hold regular meetings of subrecipient project managers/ Executive Directors, or regular case manager meetings or training. The only regular interaction among all subrecipients is at Clinical Quality Improvement (CQI) meetings, which have become an important informal mechanism for information sharing.
- **Lack of consumer choice:** With most services provided by only one subrecipient and only one provider located outside Travis County, consumers sometimes feel they cannot find a "good fit." More choice could improve retention.
- **Unnecessary, duplicative paperwork:** Everyone from consumers to case managers and administrators said that staff and clients spend far too much time on paperwork. The lack of a centralized eligibility system means multiple intakes and recertifications. Several administrators said that subrecipients sometimes include forms that are not actually required by either HRSA/HAB or the recipient, and urged them to simplify and streamline the processes, including a review of all intake "packages." Having several different eligibility levels for different services causes further complications; several providers suggested moving to 500% of FPL for all services.
- **Lack of motivation for change and innovation:** Several administrators and providers described services as being on "autopilot." The new clinics were described as extremely innovative, but there is concern that among subrecipients there is little ongoing evidence of growth in the system. It was suggested that motivation for active improvements requires more competition for funds through regular procurements, more comprehensive monitoring, other external pressures for accountability and change, and structured opportunities for joint problem solving.

Other Aspects of the System of Care

The analysis looked at several other aspects of the system of care, briefly summarized below and discussed in more detail in the Topic-based Analyses.

Technology: ARIES is widely viewed as problematic and burdensome. It was described as not user-friendly, very time-intensive, sometimes providing inaccurate data, and not allowing direct software bridges with electronic health records. Some subrecipients either don't enter all their data or don't do it in a timely fashion, partly because not enough frontline staff are trained to use the system. In addition, ARIES has laboratory and medical visits data from only one medical provider, making it impossible to accurately assess health outcomes on the care continuum for all clients or for subpopulations. These data gaps also make it harder to coordinate services. However, a new DSHS system is due in August 2021, and there is some hope that this will eventually improve the situation. Within APH, there are also data access issues, and staff indicated that systems would benefit from updating. There is no linkage between the HOPWA and ARIES systems, and ARIES data on housing services are incomplete. ARIES includes Ryan White Housing Services data, but HOPWA project sponsors are not required to report data into

ARIES and one project sponsor does not. This makes it very difficult for the recipient to determine the implications of HOPWA services on client outcomes.

Potential changes in the system of care: Given the number of new organizations, new clinics, and increased FQHC engagement in HIV services, it is likely that a competitive procurement will lead to funding applications from additional providers. In addition, some current providers are likely to seek funding for different or additional service categories. Some of the 340B clinics already provide or would like to expand HIV medical care; others may choose not to apply for Ryan White funding if they feel their very flexible 340B funding as Sexually Transmitted Infection (STI) clinics is likely to remain both secure and sufficient.

Multiple Planning Structures: Austin has two HIV planning bodies, the Part A Planning Council and the Fast Track Cities structure, linked because both are staffed within the same APH unit. Some Planning Council members serve on FTC committees and work groups, and there is a commitment to align the work, including new EHE funding for Travis County.

- **Planning Council:** This decision-making body now has more members than at any time over the past several years, includes active committees, and engages the full membership in the Priority Setting and Resource Allocation (PSRA) process. It has not yet reached the required 33% unaligned consumers and is considering ways to engage more consumers, including a possible Consumer Caucus. There is unusually low participation by subrecipients as either members or regular meeting attendees. It is important that a planning council not be dominated by subrecipients and that subrecipients not use the planning council as a way to advocate for funding for their organizations, but their engagement – appropriately managed – can enhance understanding of the system of care. The many new members and Support Staff have identified the need for training, and a growing number of sessions are being provided or are scheduled for 2021. The Council's 2017-2021 Integrated HIV Prevention and Care Plan is considered the "umbrella plan" for all HIV-related activities.
- **Fast Track Cities/EHE:** Austin established its FTC initiative in 2018; it has implemented a planning structure including a Core Coordinating Committee, Steering Committee, and four workgroups, and completed an action plan in May 2020. Participants have found its broad representation and planning efforts serious and important, praise the cooperative efforts that led to the development of the Rapid Linkage to Care Program that aims to link newly diagnosed people with HIV into care within 72 hours, and appreciate its focus on addressing complex health disparities issues. It has more subrecipient engagement than the Planning Council, but has faced challenges in obtaining consumer and high-need community involvement and involving frontline staff. A number of participants are eager to move from planning to more "action-oriented" discussion. Staff indicated that FTC has now done a "deeper dive" to prepare a more specific "menu of options," with objectives, strategies, inputs, and planned outcomes, which is expected to serve as the basis for determining how to use EHE program funding from HRSA/HAB.

Community and Consumer Engagement: There is wide agreement and concern over the low level of community and consumer engagement in HIV planning and programming. It was identified as a key weakness in the survey and in interviews. The Planning Council has found it very difficult to recruit and retain consumers, and some subrecipients reported difficulties in

establishing and maintaining active Community Advisory Boards (CABs). Some providers and other stakeholders described this as "a uniquely Austin problem." Among the many reasons given were the following: a local history of structural racism, health and other planning bodies that have not traditionally been diverse, a belief by consumers that they are not truly valued or treated as equals, community distrust of data gathering such as needs assessment processes. In addition, participation in planning bodies, especially a body like the Planning Council that has many complex roles and requirements, is hard, and people with HIV have other priorities. Stigma is also considered by consumers to be an important barrier.

Impact of the COVID-19 epidemic: Because of the pandemic, providers initially closed, then began opening with telehealth, often continuing to have decreased services. Some have received special grants to address pandemic-related needs. Many clients reportedly stayed safe by isolating themselves, and the epidemic caused some to become concerned enough to return to care. Many have done well at keeping telehealth appointments if they have appropriate computer or smartphone connectivity. However, some clients have been lost due to a lack of access to technology. There is concern about the pandemic's negative impact on mental health, significant job loss and economic difficulties for many clients, and a related loss of health insurance. Some consumers feel that service quality has declined due to telehealth, while others find it convenient and comfortable. The epidemic's long-term impact remains uncertain, although it is widely believed that telehealth will continue and expand far beyond pre-pandemic levels. Several providers are concerned about ensuring connectivity for all consumers. Some also fear that the epidemic may have as yet unknown long-term health and economic impact on clients.

Administration: HRAU manages three major HIV service grants: Ryan White Part A, Part C, and HOPWA. Under Part A, it works in partnership with the Planning Council. The relationship is good but complex. The analysis identified several areas for consideration, including the need to ensure that the Planning Council receives detailed information about services and client utilization, always provided by service category and without mention of subrecipient names or performance. It is expected that data will be shared even when there is only one service provider for a particular category, since the Planning Council needs such information to make informed, data-based decisions about priorities, allocations, directives, and service standards and otherwise partner with the recipient to improve the system of care.

Perhaps the most significant issue facing the recipient is the need to re-compete Part A services after a decade with no competitive procurement. HRSA generally expects funds to be openly competed every 3-5 years. This provides the opportunity for updating and innovation. This is necessary given the changes in the epidemic, treatments, and health care financing since 2011, as well as the many changes in federal requirements, from the new Policy Clarification Notice (PCN) #16-02 that describes and provides guidance on fundable service categories to the implementation of the National Monitoring Standards (NMS). New contracts will provide an opportunity to clarify expectations for subrecipients with regard to targeting, service strategies, access to care (including evening and weekend hours), and the level of services to be provided (e.g., minimum number of clients to be served and average number of service units per client). This information provides the basis for Austin-specific, service-category-specific monitoring,

including ongoing "desk" monitoring and annual monitoring during site visits. Interviews suggested that providers and other stakeholders would appreciate recipient leadership and guidance, including regular subrecipient meetings, training, and opportunities for information sharing.

Promising Models and Strategies

With guidance from the survey and interviews, EGMC explored four strategies and models in some detail; they are addressed in the Topic-based Analyses, and Appendix F provides detailed suggestions around peer navigation:

- **A centralized or coordinated eligibility system,** and perhaps adoption of common intake procedures and forms – action that has strong theoretical support and has been discussed and worked on extensively, but with no resolution to date. The report summarizes options in use by other jurisdictions.
- **Use of peer navigators,** including identification of key considerations and sound practices and documentation of several models that might be adaptable to Austin.
- **Long-term use of telehealth,** including current discussions about future reimbursement for telehealth for various purposes and by different third-party payers, as well as issues like connectivity that will need to be addressed.
- **Use of rideshare** as a transportation option that could help improve access to care, including how rideshare companies address HIPAA and other requirements and are used by other jurisdictions, and other privacy concerns.

Conclusions

- **This is not a system in crisis.** Austin provides a variety of core medical-related and support services for people with HIV in its five-county TGA. Services are considered to be generally good, seldom less than adequate, and in many cases excellent. Many consumers and other stakeholders identified subrecipients and specific staff – physicians, case managers, counselors, and others – who consistently provide extraordinary services and have earned the trust and respect of clients and colleagues.
- **There is not currently a coordinated, comprehensive network of services:** Many people said that Austin does not really have a "system" of care, due to a lack of consistent and collaborative procedures that can help clients enter care and move within and across providers to obtain needed services. Case management often provides the "glue," but in Austin only about a quarter of clients receive case management, and the models used are extremely varied.
- **Services do not yet fully reflect and address the needs of the diverse PWH population:** The system was frequently described as "developed largely by and for gay white men" and has not yet become fully diverse in staffing or in strategies or built trust with some high-need communities. Transgender, Black, Latinx, and female PWH are among the high-need subpopulations that need more providers and services that fit their needs and their culture. PWH with limited English face special challenges in obtaining and receiving care, especially since there is no Ryan White funding for Linguistic Services.

- **Austin does not meet the Ryan White goal of equal access for all regardless of who they are and where they live.** Clients who live outside Austin must often travel a long way for care, and can receive services such as OAHS and Oral Health only by going to Austin. Rural per-client costs are higher, which may further limit access to care.
- **Some services have long waiting periods,** because of low allocations or other factors. These include Mental Health and Oral Health.
- **The small number of providers means a lack of client choice.** Many services are provided by only one subrecipient.
- **Some innovations are occurring, but there few structured, system-wide efforts to continuously improve services.** Some efforts are being made by the Planning Council and FTC. Many stakeholders believe that the lack of a competitive procurement, contracts with expected levels of service and service delivery requirements, regular subrecipient meetings, and other direct and active guidance from HRAU has reduced the motivation for innovation by subrecipients. The greatest innovation in recent years has come from the new 340B clinics.

Recommendations for Strengthening the System of Care

Following are specific recommendations, primarily for the recipient but also for the Planning Council and other entities. Some of these would benefit from immediate action, while others can be addressed over several years. All are based on information from the analysis, and most were suggested by some of the many people interviewed or surveyed for this initiative.

HRAU should take the lead and work with the Planning Council, Fast Track Cities, EHE, subrecipients, and community representatives as appropriate, to accomplish the following:

1. **Strengthen services and processes that play a critical role in client access and coordination.** This includes the following:
    - **Carry out a comprehensive review of case management services,** with the involvement of both recipient and Planning Council and perhaps FTC as well. This should include exploring such issues as an appropriate mix of Medical and Non-Medical Case Management, including specialty case management (e.g., mental health or housing case management), the role of case managers in intake and initial client assessments, whether more clients may need to be in case management (which could require increased allocations), increased guidance on expectations for case managers in such areas as referrals and assistance to clients in filling out intake forms to access other services, and elimination of requirements that clients be enrolled in case management in order to quality for other services. The effort might result in a Planning Council directive, changes in service allocations, and/or changes in service standards.
    - **Require action to streamline eligibility determination.** Consider first-contact and centralized models, as described in the Models and Strategies Topic-based Analysis, or other approaches. The outcome should be a process ensuring that a client needs to provide eligibility information only once at intake and for each required recertification.
    - **Consider whether it is still necessary to have different income limits for different services in order to ensure access for those with the greatest need.** A single eligibility

limit of 500% of the federal poverty level would simplify eligibility determination and intake.

- **Review the variety of current approaches to intake and initial client assessment, and provide additional guidance or requirements to increase efficiency and ensure that all clients receive certain basic intake components,** such as a basic assessment, an opportunity to request case management, and immediate access to OAHS and medications. This might involve use of an approach similar to the Texas Department of State Health Services (DSHS) Part B practice of using State Services funds to support eligibility and intake specialists through the Referral to Health Care and Support Services category, since this makes it easier to establish consistent procedures.
- **Ensure that every person with HIV who enters care is aware of service choices.** This includes receiving both verbal information and a pocket directory or other easy-to-use listing and description of HIV services and providers, including Ryan White and other providers. The Planning Council's efforts related to a resource inventory and/or profile of provider capacity and capability could help create such a directory, and some providers may have resource information.
- **Review service category-specific intake requirements to eliminate unnecessary forms and other paperwork.** While subrecipients can take the lead, Part A, Part B, and Part C, administrative staff should play an active role, including setting and enforcing a timetable for the review and retaining the right of approval.

2. **Increase information sharing, coordination, and collaboration among subrecipients and with non-Ryan White funded providers.** Among the possible approaches:
   - **Provide clear guidance to subrecipients regarding cross-agency collaboration and referrals,** including expectations for written agreements, referral procedures and follow up, requirements for referral results to be entered into ARIES or its successor system, and some specific encouragement of sound practices like cross-agency treatment plans for high-need clients and use of cross-agency case reviews.
   - **Provide for regular meetings and information sharing opportunities that involve all subrecipients.** This should include regularly scheduled meetings of the recipient with subrecipient Executive Directors/Project Managers, periodic meetings and joint training of frontline staff such as case managers, and online meetings to share information. Where the focus is not on contract-related matters, include non-Ryan White providers, since this will strengthen relationships and increase collaboration.
3. **Continue to focus on increasing service appropriateness for disproportionately affected PWH subpopulations.** This should include efforts such as the following:
   - **Increase the diversity of clinicians, case managers, and other frontline staff.** This is primarily a subrecipient responsibility, but the recipient should consider requiring that applications provide information on staff racial/ethnic diversity, language skills, and inclusion of transgender staff. It could also provide incentives like extra points awarded to applicants who can show that they have the diverse staff needed to target particular subpopulations. Other actions might include encouragement of salaries and benefits sufficient to attract and retain personnel and salary supplements for staff with a second

language, and perhaps exploring how the recipient might assist subrecipients in recruiting diverse personnel.

- **Use the planned procurement to encourage applicants to propose MAI strategies designed to increase linkage, retention, treatment adherence, and viral suppression among minority populations.** While the RFA should specify the populations and provide parameters, it could encourage testing of innovative approaches.
- **Obtain community input on service appropriateness and needed changes,** through in-depth Planning Council needs assessment efforts that target key subpopulations and use data-gathering methods that involve people trusted by each subpopulation. Consider Planning Council or FTC-sponsored roundtables with subrecipients and other providers and with community activists, and other targeted efforts. Always summarize discussions and provide that information back to the community.

4. **Increase access to care for residents of the outer counties by increasing the number of services and locations outside Austin and outside Travis County.** This could involve Planning Council directives or simply inclusion of requirements in the new RFA, but might be accomplished by such efforts as:
   - **Requiring at least one OAHS provider to offer services in one or several of the outer counties,** through opening a new clinic, partnering with an FQHC or other provider located in at least one of those counties, providing services on a regularly scheduled basis at an existing subrecipient site (which has been done in the past), using a mobile health care van without HIV-specific signage, or some other mechanism.
   - **Funding certain services with the requirement that one provider must be located outside Travis County.** These might include Medical Case Management, Mental Health, and Outpatient Substance Use Treatment, including mental health and substance use counselors.
   - **Encouraging or requiring co-location of staff daily or on a scheduled basis in a subrecipient facility outside Travis County.** This might include mental health or substance use counselors.
   - **Make it financially feasible for personnel to travel to meet with clients outside central Austin and in the rural counties, given transportation issues.** This requires making the process financially feasible by allowing for a higher cost per unit of service due to the travel time and costs; it might also include providing Medical Transportation funds to these subrecipients and specifically allowing for use of their own or the organization's vehicles, with appropriate insurance.
5. **Increase client choice.** This means funding more than one provider of a service category wherever possible, and ensuring that providers make clients aware of their options, at intake or when they indicate a need for a particular service – including informing the client about services provided by a different subrecipient or a non-Ryan White provider. An updated list of providers should also be posted on the APH website.
6. **Rethink HOPWA services and design.** Consider whether the mix of HOPWA services and strategies may need refinement. Explore ways to address problems like unsafe or undesirable temporary housing, need for support services along with housing, need for

housing specialists to be responsible for identifying housing units, and the need to ensure that homeless PWH who receive temporary housing do not become homeless again due to a lack of priority for moving them into longer-term housing. Ryan White can never be a major source of HIV housing due to the other demands on its resources, so HOPWA is a particularly critical resource that needs to maximize its impact. New procurement is necessary to implement needed changes.

7. **Determine whether action may be needed to increase availability of services like Mental Health and Medical Case Management, given long wait times.** This may include action by the Planning Council to consider whether more data are needed to better understand PWH needs, and whether changes in priorities or resource allocations may be needed for such service categories. The subrecipient can support this process by ensuring that the Planning Council receives all available data on client needs, service utilization, and waiting lists, always by service category and without subrecipient names attached. As HRSA/HAB has long indicated, there is no problem with sharing data by service category even if there is only one provider, and it is appropriate to share aggregate quality assurance and quality improvement data.
8. **Consider funding a three-year pilot peer navigation program.** This will require a detailed review of models and options; Appendix F provides information to support this process. Based on available information, Austin may want to consider a centralized model like the ones used in Louisiana and Washington, DC to ensure consistent implementation, supervision and support, and regular training, while allowing for peers to be assigned to various subrecipients and locations. The use of such peers can increase service appropriateness and support full linkage and retention in care. The model should have performance monitoring and evaluation built in.
9. **Ensure that long-term use of telehealth benefits all clients.** There is considerable enthusiasm for its continuing use, but the recipient should work with subrecipients and seek consumer input to ensure that clients receive needed connectivity assistance, and to ensure that providers consider factors like whether a client has a safe and private place to participate in a telehealth appointment. The Planning Council will need to consider adjustments to service standards, and may want to consider encouraging efforts to help clients obtain smartphones or tablets, or to take advantage of federal programs like Lifeline, which provide phones or reduced-cost data plans to eligible low-income individuals.
10. **Rethink Medical Transportation in preparation for the RFA.** Consider allowing use of rideshare, with full HIPAA compliance and other privacy protections. Also consider making Medical Transportation funds available to providers of various services such as OAHS, Medical and Non-Medical Case Management, Mental Health, and allowing them to manage it while meeting service standards.
11. **Use the upcoming competitive procurement to refine and reshape the system of care,** increasing client choice and making services available in more locations. Provide a widely advertised competition with clearly defined expectations for service levels, opportunities for innovation within defined parameters, and a clear and user-friendly application process.

12. **Continue to strengthen the Planning Council's role in improving the system of care.** This includes efforts by the Council to:
    - **Continue providing training** for new members and updates for veteran members.
    - **Continue to engage consumers** both as members and in other less demanding ways, perhaps through establishment of a Consumer Caucus or Committee that offers useful information and training while providing ongoing consumer input to the planning process and can help build a critical mass of engaged consumers who may choose to become Planning Council members. Consider ways to make Planning Council and committee/caucus meeting attendance as convenient as possible for consumers, considering time, location, and transportation issues. Ensure that consumers feel welcome and valued and that their input is taken seriously.
    - **Explore and reach a decision about use of peer navigators,** including specific guidance to the recipient through a directive and perhaps a service model, and consider how a pilot project might be funded.
    - **Consider how to engage and learn from subrecipients and other providers,** while ensuring that there is no discussion of procurement or contracting.
    - **Have a committee review service utilization data**, including the data in this report, to better understand who is using (or not using) what services and why.
    - **Plan for an in-depth consumer-focused needs assessment** involving interviews or other data-gathering from a substantial number of diverse consumers. This will require use of incentives and should not be limited on completion of an unassisted online survey; more direct contact with potential respondents will be needed.
    - **Consider how best to address the need for language services for PWH with limited English,** which might involve funding for Linguistic Services and/or using a directive to encouraging hiring of more bilingual staff.
    - **Consider how to help ensure equitable access to care for PWH regardless of where they live in the TGA.** This might include a directive on geographic access to services or support for specific innovative service models to better serve PWH who do not live in Austin.

SECTION VII: LETTERS OF CONCURRENCE

To Whom It May Concern:

The EHE Planning Body concurs with reservations with the following submission by the Austin Public Health Department in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

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

- The EHE Planning Body will review the finalized Integrated HIV Prevention and Care Plan as it is made available.

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

Signature: *Aurelia Lopez* Date: 12/08/2022

EHE Planning Body Chair

To Whom It May Concern:

The Part B Council c***oncurs*** with the following submission by the Austin Public Health Department in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/ AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

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

Contributed to the integrated plan and voted on the approval of the integrated plan.

Funds may aid local agencies in their preventative care strategies and their access to care in their communities.

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

Signature: Sharon Zaldivar Alatorre & Jonathan Garcia 12/08/2022

Part B Planners

December 8, 2022,

To \\horn it may concern:

The Austin Arca HIV Planning Council *concurs* with the following submission by the Austin Public Health Department in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division ofHIV/AlDS Prevention (DHAP) and HRSA's HIV/ AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan. including the Statewide Coordinated Statement of Need (SCSN) for caJendar year (CY) 2022-2026.

TI1e Austin Area 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 gcographicaJ areas with high rates of HIV. The review and approval vote took place on December 1, 2022, with some recommended edits and comments from the Planning Council. The Planning Council *concurs* that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated H1V Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/ AIDS Program legislation and program guidance.

The Planning Council contributed to the Integrated Plans goals via recommendations within the full Business Committee and Strategic Planning/Needs Assessment subcommittee of the Planning Council.

Final recommendations, comments, and edits „..ere provided during the Special Called Business meeting that took place on December I, 2022. The Integrated Plan was approved via a unanin10us vote by all members present.

Planning Council members also participate on committees, in focus groups. and in leadership roles with Fast Track Cities and Ending the IJIV Epidemic's committee/ Stakeholder engagement groups.

Lastly the Planning Council is committed to recommending funds in the applicable and appropriate service categories to align \\ith the needs of those receiving Ryan White Part A services through the annual Priority Setting and Resource Allocations (PSRA) process.

the signature below confirms the concurrent of the planning body with the Integrated HIV Prevention and ~~care~~Care plan.

nature: Barry C. Waller Date: 13/12-J z_ z_

Austin Area Ill\' Planning Council Chair

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FAST-TRACK CITIES AUSTIN/TRAVIS CO.

To whom it may concern,

Fast-Track Cities ***concurs*** with the following submission by the Austin Public Health Department in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body (e.g. planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. Fast-Track Cities ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

- Fast-Track Cities contributed to the Integrated Plans goals via updates to its Action Plan presented to the Office of Support.
- Planning Council members also participate on committees, in focus groups, and in leadership roles with Fast Track Cities workgroups.
- Lastly, Fast-Track Cities has presented updates to its Action Plan as it relates to many of the intentions of the Ryan White Part A service categories and reviewed the integrated plan in support.

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

Signature: Date: 12/9/2022

Edgar Rodriguez
Fast-Track Cities Coordinator