ELEMENT 4: INITIAL EHE PLAN

The Houston EHE plan has a solid foundation in the two (2) existing jurisdictional HIV plans:

- *The Houston Area Comprehensive HIV Prevention and Care Plan*, expiring in 2021, and included as **Appendix 2**.
- *The Roadmap to Ending the HIV Epidemic in Houston*, expiring in 2021, and included as **Appendix 3**.

An extensive crosswalk between the two existing plans has been developed to identify areas of synergy and opportunities to develop in the future. The crosswalk has been used to develop current EHE plan goals where areas of synergy exist. The crosswalk is included as **Appendix 4**.

Since 2012, the Houston Health Department (HHD), the Houston HIV Prevention Community Planning Group (CPG), Harris County Public Health (HCPH), The Resource Group (TRG), and the Ryan White Planning Council (RWPC) have collaborated in integrated HIV prevention and care activities to meet requirements of both the Health Services and Resources Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). The Houston area is also fortunate to have been at the forefront of the Ending the HIV Epidemic (EHE) movement, developing and releasing a community-led plan to end HIV, known as the *Roadmap to Ending the HIV Epidemic in Houston*.

Utilizing federal funding to "Accelerate State and Local HIV Planning to End the HIV Epidemic", it is our intention to meet the grant requirements building upon the knowledge and work that exists within these existing plans. Ultimately, it is our goal to replace the two existing jurisdictional plans, both expiring in 2021, with one, new Ending the HIV Epidemic (EHE) plan to begin in 2022. This initial EHE plan will build upon the draft plan and will be innovative, responsive to local community needs and meet the requirements of the various federal funding partners.

Planning Jurisdiction

The jurisdiction for this EHE plan is Houston-Harris county. The EHE planning body will host additional listening sessions throughout the Houston Health Services Delivery Area (HSDA) to better inform prevention efforts within the Houston-Harris county jurisdiction. The HSDA is the geographic service area defined by the Texas DSHS which includes the six counties of the Houston EMA (Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller) plus four additional counties (Austin, Colorado, Walker and Wharton). This aligns with the approach taken by DSHS for the other four (4) EHE counties in Texas: Bexar, Dallas, Tarrant, and Travis.

Planning Structure

The Ending the HIV Epidemic planning structure was determined after presenting to all the local planning bodies in the first quarter of 2020. In this structure, the EHE Plan Steering Committee oversees all the subcommittees and provides guidance. The steering committee is composed of the representatives of the stakeholders including the Resource Group, END HIV Coalition, HIV Community Planning Group (CPG), Harris County Public Health (HCPH), Ryan White Planning Council, Ryan White Part A, Houston Health Department (HHD), and Texas Department of State Health Services (DSHS).

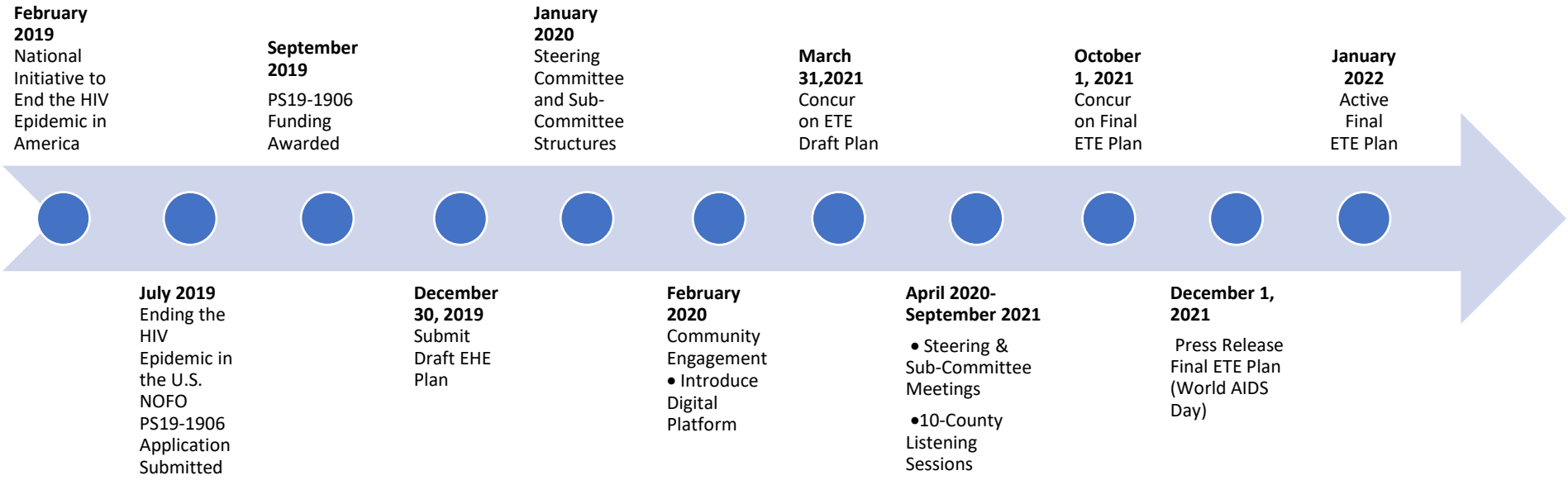
The ETE Champions serve as an executive resource committee providing community influence and support to the steering committee. This committee consists of chief executive representatives in a variety

of community settings including health systems, school districts, colleges/universities, community-based and nonprofit organizations.

The committees are structured using five founding themes: Status Neutral Systems, Research Data and Evaluation, Community Engagement, Education and Awareness, Policy and Social Determinants of Health (e.g. poverty, housing, racial and social justice, and mental health). These committees will frame their work around the four pillars of the Ending the HIV Epidemic Plan: Diagnose, Prevent, Treat and Respond. Each committee will have three (3) co-chairs representing 1) individuals providing/receiving HIV care and treatment services, 2) individuals providing/receiving HIV prevention services, 3) individuals representing administrative agencies. Each committee will be comprised of facilitators, subject matter experts (SME), support staff, and project assistants.

The organizational EHE planning structure is included as **Appendix 5**. This structure will be utilized to expand community engagement and merge the existing *Houston Area Comprehensive HIV Prevention and Care Plan* and the *Roadmap to Ending the HIV Epidemic in Houston* into one updated jurisdictional EHE plan.

Planning Timeline



- **April 2020-September 2021**: Meeting schedules and frequency will be developed based on Steering Committee and Pillar structures i.e. Monthly or Biweekly over the course of 6-months

Plan Goals and Activities

This initial EHE plan includes activities, strategies, and indicators for each EHE pillar using areas of intersection between the two (2) existing plans in the Houston area, e.g. these goals were drafted, when possible, where there were similarities in the two existing plans. These are indicated within the brackets in the key activities and strategies below. This is considered a "living" document, and it is anticipated that many more activities, strategies, and indicators will be added to each pillar as EHE planning and implementation continues.

Pillar 1: Diagnose

Goal: Increase individual knowledge of HIV status by diagnosing at least 90% of the estimated individuals who are unaware of their status within five (5) years.

Key Activities:

- Increase the number of HIV tests conducted in Houston and Harris County.
    - Increase HIV testing to achieve a **0.1%** new positivity rate by funding both the local community-based organizations and local hospital systems.
        - In 2017, the total number of publicly funded tests conducted in the Houston EMA in both routine and targeted settings is 112,581. Of these, 295 are identified as newly diagnosed positive tests corresponding to a new positivity rate of **0.3%**.
        - For 2017, an estimated 4,595 people were unaware of their HIV positive status in the EMA.
    - Collaborate with shelters, transitional housing centers and other community-based organizations (CBO), such as those that support and treat people with substance use disorders, to increase HIV testing in these settings.
    - Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings.
    - Routinize the offer of annual screenings for those at ongoing risk for HIV.
- Increase the accessibility of home HIV testing kits.
    - Promote rapid HIV self-test distribution programs
    - Implement a free home HIV test kit pilot project by 2021.
    - Organize community events to distribute HIV self-test kits to populations with higher risk but limited access to testing.
- Increase targeted outreach testing in non-traditional settings.
    - Mobile units will routinely serve specific vulnerable groups, such as African American and Hispanic MSM and transgender communities.
    - Offer routine services at least twice monthly and more frequently if more widespread HIV and syphilis identified with promotion through various communication platforms as "routine health screenings" to reduce stigma.
    - Extend mobile unit hours and capacity for testing and identify locations for HIV/STI self-test distribution.
    - Identify new non-traditional HIV screening sites (i.e. College campuses, apartment complexes, shopping centers, etc.).
    - Promote bundling of HIV testing with screening for other conditions relevant to the local population (e.g. STI testing, BMI assessment) at health fairs or pop-up testing events.
- Increase effectiveness of HIV partner services.
    - Increase HIV partner services to achieve the partner index benchmark of 2.0.

        - For 2018, the partner index in Houston/Harris County is 0.6. The partner positivity rate is 12.5% (36 new positives/287 partners notified).
    - Ensure 90% of reported new HIV cases are interviewed for partners, suspects and associates.
    - Ensure 90% of all partners initiated on a new HIV interview are tested for HIV.
    - Ensure 90% of all individuals interviewed who have been newly diagnosed with HIV. successfully compete their first HIV medical appointment.
    - Develop and implement technology-based partner services.
- Advocate for HIV policy change at the local, state and federal levels.
    - Collaborate with community leaders on policy initiatives to routinize testing.
    - Work to ensure all incarcerated persons receive mandatory HIV testing during initial processing upon arrival and release in correctional facilities.

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, community task force, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, local community members, local correctional institutions, local law enforcement, PWH, health departments, public health professionals, etc.
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Ryan White HIV/AIDS Program (RWHAP), State and/or Local Funding
Estimated Funding Allocation: $1.8 Million
Outcomes (reported annually, locally monitored more frequently): number of newly identified persons with HIV; Establishment of protocols for HIV/AIDS treatment under incarceration, number of cases linked to care under incarceration
Monitoring Data Source: EMR data, surveillance data, local protocols and reports
HIV Workforce Capacity: The Houston Area maintains approximately 486 full-time employees (FTEs) to direct HIV care and prevention services. In HIV service, there are about 72 FTEs for HIV medical care and 67 FTEs in linkage to HIV medical care. More support may be essential for executing these services and addressing these needs may prove difficult without expanding capacity. Individual organizations must also properly evaluate their own business structures and collaborate with other partners to ensure the workforce capacity is operating efficiently and effectively.

Pillar 2: Treat

Goal: Ensure 90% of clients are linked to care with a medical provider and started on ART within 72 hours of HIV diagnosis or return to care. Ensure 90% of clients are retained in care and virally suppressed.
Key Activities:

- Increase retention in medical care through rapid treatment initiation.
    - Implement immediate ART with a benchmark of 72 hours of HIV diagnosis for Test and Treat protocols. [*HCPH*]
    - Launch Rapid Start Treatment Program at HHD Health Centers by determining the feasibility of utilizing 340B funds to purchase ART "starter packs" for newly diagnosed clients and returning patients who have been out of care for greater than 12 months. DIS and Service Linkage staff will immediately initiate linkage services for persons diagnosed in the health centers by ensuring an appointment is made with a local Ryan White (RW) or private provider.
- Train more medical providers on the Ryan White care system. [*Comprehensive HIV Plan* and *Roadmap*]

- Conduct HIV treatment-focused public health detailing with 100 initial and another 100 follow-up visits to providers to improve treatment-related practices.
- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions. [*Comprehensive HIV Plan* and *Roadmap*]
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities. [*Comprehensive HIV Plan* and *Roadmap*]
- Implement a local viral suppression project promoting HIV re-engagement, retention, and treatment adherence by June 2021. Tangible reinforcements will be provided to PLWH served through the HHD's Service Linkage Program with the goal of increasing retention and viral suppression rates.
- Assess feasibility of expanding telemedicine services that are currently at the STD clinics to include HIV prevention support services (e.g., referrals to treatment adherence programs, mental health, and other ancillary services).

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, various professional health care associations, RWGA; TRG; HHD (Potential non-RP partners: RWPC), community task force
Potential Funding Resources: Ryan White HIV/AIDS Program (RWHAP), CDC HIV Prevention and Surveillance Programs, State Local Funding
Estimated Funding Allocation: $9,081,382
Outcomes (reported annually, locally monitored more frequently): Number of newly identified individuals with HIV linked to care; total number of people with HIV; Number of individuals with HIV identified as not in care relinked to care; Number of newly identified individuals with HIV linked to care and started on ART within 72 hours of diagnosis; Number of individuals with HIV identified as not in care relinked to care and started on ART within 72 hours. Dates will be collected by RWGA: first positive diagnostic test, test result disclosure, clinic referral, first outreach provider visit, first clinic medical provider visit, first ART prescription date, and ART start date
Monitoring Data Source: Surveillance, RWHAP, CPCDMS, CDC testing linkage data
HIV Workforce Capacity: There are about 80 full-time employees (FTEs) for HIV medical care (72 FTEs) and 67 FTEs for linkage to HIV medical care. The workforce categories with the fewest FTEs, with 1 FTE or less, total, were patient advocate, physical therapist, physician assistant, psychiatrist, public affairs specialist and translator. Additional support to execute these services and categories are essential for addressing community needs and providing adequate service delivery.

Pillar 3: Prevent

Goal: Achieve 50% reduction in new HIV cases by utilizing proven interventions, including PrEP, nPEP, and syringe services programs (SSPs).
Key Activities:

- Increase the percentage of eligible people successfully referred to PrEP provider to 50% in 5 years.
    - In 2018, the HHD PrEP program served the following:
        - 1,070 individuals were referred to PrEP (screened/eligible)
        - 203 were linked to PrEP provider (had a scheduled appointment)
        - 166 were prescribed PrEP (received at least one prescription)
        - Comparison of percentage of referrals linked to a provider between Jan-May 15, 2018 and Jan-May 15, 2019: 17.8% (~18%) vs. 15.8% (~16%)

- Expand access to same-day PrEP initiation for high-risk HIV negative individuals.
- Expand the availability and sustainability of PrEP and nPEP through education, referral, patient navigation, and cost effectiveness. [*Comprehensive HIV Plan* and *Roadmap*]
- Develop PrEP continuum of care to measure PrEP awareness, uptake, adherence and retention.
- Educate primary care providers on how to prescribe and follow up for PrEP and nPEP. [*Comprehensive HIV Plan* and *Roadmap*]
    - Educate providers on the importance of including PrEP and nPEP information as a routine part of screening for sexually transmitted infections (STIs). [*Comprehensive HIV Plan* and *Roadmap*]
    - Identify local healthcare providers to provide information, tools and training on PrEP-related practices, such as conducting a risk assessment, STI/HIV screenings/tests and PrEP education.
    - Conduct PrEP and nPEP-focused public health detailing with 100 initial and 100 follow-up visits to providers to improve PrEP-related practices including obtaining sexual history, sexually transmitted infection screening, HIV screening, and discussion of PrEP with patients.
    - Implement a nPEP 24-hour Hotline and Center of Excellence.
- Increase HHD PrEP clinic capacity.
    - Increase the number of PrEP clinical days at each HHD Health Center to 3 days per week.
    - Schedule monthly after hour PrEP clinics at each health center.
    - Expand PrEP services to provide access to hard to reach populations by extending mobile unit hours in targeted areas with high populations of African American and Hispanic MSM, transgender Latinx and African American women.
    - Host monthly PrEP clinic specifically for transgender clients with extended hours to provide a comfortable and safe space for patients to receive care absent of stigma.
    - Implement same-day PrEP initiation for high-risk HIV negative clients by providing a 30-day starter pack.
    - PrEP services will be extended to adolescents under the age of 18 years.
- Encourage the establishment of syringe services programs (SSPs) and other risk reduction strategies for persons who inject drugs (PWID).
    - Implement a Sharps Disposal Pilot Project: Sharp disposal kiosks will be installed in accessible and well-lit public park locations providing a secure, contained and accessible disposal sites for sharps to address the issue of discarded syringes in public spaces.
    - Educate public officials in Texas on the benefits of SSPs and encourage modification of governmental polices that create access barriers to these effective HIV prevention information and tools.

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, community task force, RWPC-OS *(Potential non-RP partners:* TDSHS; AETC; HHS)
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care, State and/or Local Funding, Minority AIDS Initiative (MAI), SAMHSA, HUD/ HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.
Estimated Funding Allocation: $500,000
Outcomes (reported annually, locally monitored more frequently): Number of providers trained; number of prescriptions for PrEP

Monitoring Data Source: Local databases, medical records data, pharmacy records
HIV Workforce Capacity: The HIV service with the most full-time employees (FTEs) is administration, with about 80 FTEs. The HIV services with the fewest FTEs, with 1 FTE or less, total, were capacity building for HIV services, condom distribution, health insurance premium and cost sharing assistance for PLWH individuals, HIV advocacy, insurance navigation for PLWH individuals, linkage to substance abuse/mental health services, patient navigation to any service regardless of HIV status, program promotion, research projects for PLWH persons, and translation services for PLWH persons. Expanding workforce capacity is necessary to enhance these services and categories in the Houston Area.

Pillar 4: Respond

Goal: Increase capacity to identify, investigate active HIV transmission clusters and respond to HIV outbreaks in 1 year.

As of August 2020, the HHD has been able to detect a total of 69 clusters within Houston/Harris County. To date, the HHD has responded to 14 clusters and 139 cluster cases within Houston/Harris County.

Key Activities:

- Increase HHD capacity for rapid detection and response to active HIV transmission clusters.
- Increase community engagement and input in response activities.
    - Actively involve members of local communities in planning, implementation, and evaluation.
    - Expand the cluster detection/response Community Advisory Board (CAB) to include additional external and internal stakeholders.
    - Host bi-annual community forums as a platform to analyze gaps and identify best practices to address the gaps.
- Implement both the cluster detection and response and time-space analysis to identify clusters.
- Increase molecular HIV sequence reporting to at least 60% of individuals with diagnosed HIV infection each year.
- Build contingency/surge capacity for cluster needs (such as venue-based screenings where directed for cluster response) into existing and/or new contracts with CBOs.
- Implement rapid ART linkage and same-day PrEP in cluster investigations.

Key Partners: Local community members, PWH, health departments, public health professionals
Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, Ryan White HIV/AIDS Program (RWHAP), State and/or Local Funding
Estimated Funding Allocation: $500,000
Outcomes (reported annually, locally monitored more frequently): Establishment of protocols for cluster detection and response procedures; number of clusters detected; number of cases linked to care in a cluster
Monitoring Data Source: Local protocols and reports
HIV Workforce Capacity
The Houston Area maintains approximately 19 individuals that comprise the Cluster Committee. The 80 full-time employees in administration also play vital roles in ongoing cluster detection and response efforts. Additional support is essential for seamless execution of response services, address barriers, and expand capacity.