2022 to 2026

Integrated HIV Prevention and Care Plan

Fort Worth-Arlington Transitional Grant Area

DECEMBER 2022

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APPENDIX 1

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Doing our part to end the HIV epidemic

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SECTION 1: EXECUTIVE SUMMARY

SECTION 1a: APPROACH

The development of the 2022 to 2026 Integrated Plan for the Fort Worth-Arlington Transitional Grant Area (TGA) has been overseen by the North Central Texas HIV Planning Council (Planning Council), the planning body for the Ryan White HIV/AIDS Program (RWHAP) Part A Program and the Tarrant County HIV Administrative Agency (Administrative Agency). The Planning Council is a community group that has been appointed by Judge B. Glen Whitley of Tarrant County to plan the delivery of Ryan White Part A-funded HIV services and allocate federal resources to fund these services. The Administrative Agency is the recipient of Ryan White and other federal and state funding to provide medical care, supportive services, and housing to disadvantaged people with HIV.

Community assessment and evaluation activities are guided by the Planning Council's Comprehensive Planning Committee (CPC). The CPC established guiding principles for the development of the Plan**:**

- The Plan should be thoughtful, aspirational, innovative, and realistic
- Ending the HIV epidemic would require strong partnerships among public health programs, private sector entities, HIV providers, community-based organizations, and the public
- Each group listed above would have responsibilities for implementing the Plan
- Diverse and extensive stakeholder engagement would be required. People with HIV (PWH), community stakeholders, staff of community-based organizations, staff and leadership of public health programs, and others should have an equal voice in the development of the Plan
- Strategies and activities should improve performance across the entire local HIV continuum and establish parity of service delivery among prevention and care services

To develop this Integrated Plan, the Administrative Agency completed an exhaustive engagement and planning process that included three assessments of people with HIV (PWH) (a study of rural clients, youth transitioning to adult HIV care, and a client satisfactions survey), six virtual listening sessions with PWH from priority populations, and five in-person focus groups with clients of Ryan White-funded agencies. More than 400 PWH and at-risk HIV negative individuals participated in the planning process via these activities. The CPC was integrally involved in the process and had input throughout the development.

Additional stakeholder engagement was designed to be inclusive of everyone involved in HIV service delivery, program management, and planning. Community-based organizations (CBOs) and public health programs were asked to have their entire staffs take part and share their passion, perceptions, and expertise to inform the Plan. For many participants, such as front desk personnel, finance staff, and others not in managerial or leadership roles, this was the first time they had been engaged in local HIV planning.

More than 120 people took part in these planning sessions, representing the full staffs and leadership of:

- Six community-based organizations receiving Ryan White Part A funds (AIDS Outreach Center, CAN Community Health, JPS Healing Wings, Preventive Medicine Clinic, Salvation Army Fort Worth, and Samaritan House)
- The North Central Texas HIV Planning Council (Planning Council)

- The Tarrant County HIV Administrative Agency (Administrative Agency)
- Tarrant County Public Health Adult Health Services (TCPH Adult Health Services)
- Health Education Learning Project (HELP)
- The HIV Prevention Partnership (a local prevention planning body)

The planning process included:

- A review of Ending the HIV Epidemic (EHE) plans from 27 jurisdictions to identify commonalities among activities and strategies, evaluate the effectiveness of stakeholder engagement strategies, and inform performance and evaluation metrics.
- Evaluations of three assessments of PWH.
- A review of the most recent Texas EHE plan.
- An evaluation of the activities and progress of the 2020-2021 Tarrant County Public Health's HIV Taskforce's EHE Program Report.
- A review of the Ryan White Program's Continuous Quality Improvement (CQI) goals.
- Virtual listening sessions with PWH from priority populations, and in-person focus groups with PWH clients of Ryan White-funded community were-based organizations.
- Strategic planning activities with staff of CBOs, public health programs, the Planning Council, and the Prevention Partnership.
- An analysis of epidemiological data, prevention program data, Ryan White service utilization data, and other information.

Discussion topics, comments, and ideas generated during all the engagement activities were compiled and evaluated with the information gathered as part of the Pre-Planning Research and Review. Each strategic focus identified during the engagement process was then ranked as a high, moderate, or low priority based on how often they were mentioned.

Table 1: Ranking of Priorities by Strategic Focus

Strategic Focus	PWH and Community Stakeholders	HIV Leaders	Planning Council and Prevention Partnership	Administrative Agency, AHS, DIS staff	Pre-Planning Research and Review
Access to Care	High	High	High	High	High
Client-Centered Initiatives/Priority Populations	High	High	High	High	High
Collaboration/Relationships	NA	High	High	High	Moderate
Community Connection/Planning	Moderate	Moderate	Moderate	Moderate	Moderate
Condoms	Low	Low	Low	Moderate	Low
Cultural Humility and Competency	High	Moderate	Moderate	High	High
Faith Community Collaboration	Low	NA	Low	Moderate	Low
Funding	High	High	Moderate	High	High
Health Literacy	High	Moderate	Low	High	High
HIV Testing	High	High	High	High	High
Housing	High	High	High	High	Low
Innovation	NA	Moderate	Moderate	High	High
Social Media Initiatives	High	High	High	High	Moderate
Outreach	Moderate	NA	Moderate	Moderate	Low
Peer Mentoring	High	Moderate	Moderate	High	Moderate
Policy Revision	Low	Moderate	Moderate	Moderate	Moderate
PrEP/PEP	Moderate	High	High	High	High
Provider Education	Moderate	Moderate	Low	High	High
Rapid Start Linkage to Care	Low	High	High	High	High
Sex Ed Reform, Community HIV Education	High	High	High	High	High
Syringe Service Programs/Harm Reduction	NA	High	Low	High	Low
Stigma Reduction	High	High	High	High	High
Systems Improvement/ Data Collection & Use	Low	High	Moderate	High	Moderate
Undetectable=Untransmittable	Moderate	High	Moderate	High	High

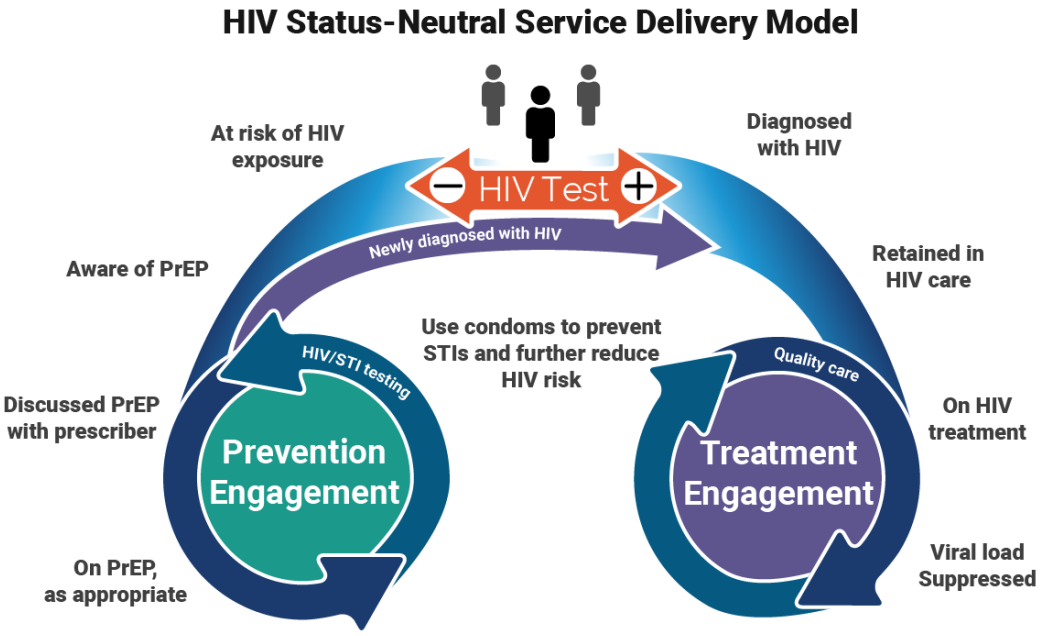
The CPC used these rankings to determine the final strategic priorities to address in the Integrated Plan.

PLOTTING STRATEGIES OF CBOs AND PUBLIC HEALTH PROGRAMS ALONG THE STATUS-NEUTRAL CONTINUUM

The HIV Status-Neutral Service Delivery Model establishes equity of care for people who have been tested for HIV, regardless of their testing results. The goal is to optimize a person's health through continuous engagement in either HIV treatment or prevention services. People who are diagnosed with

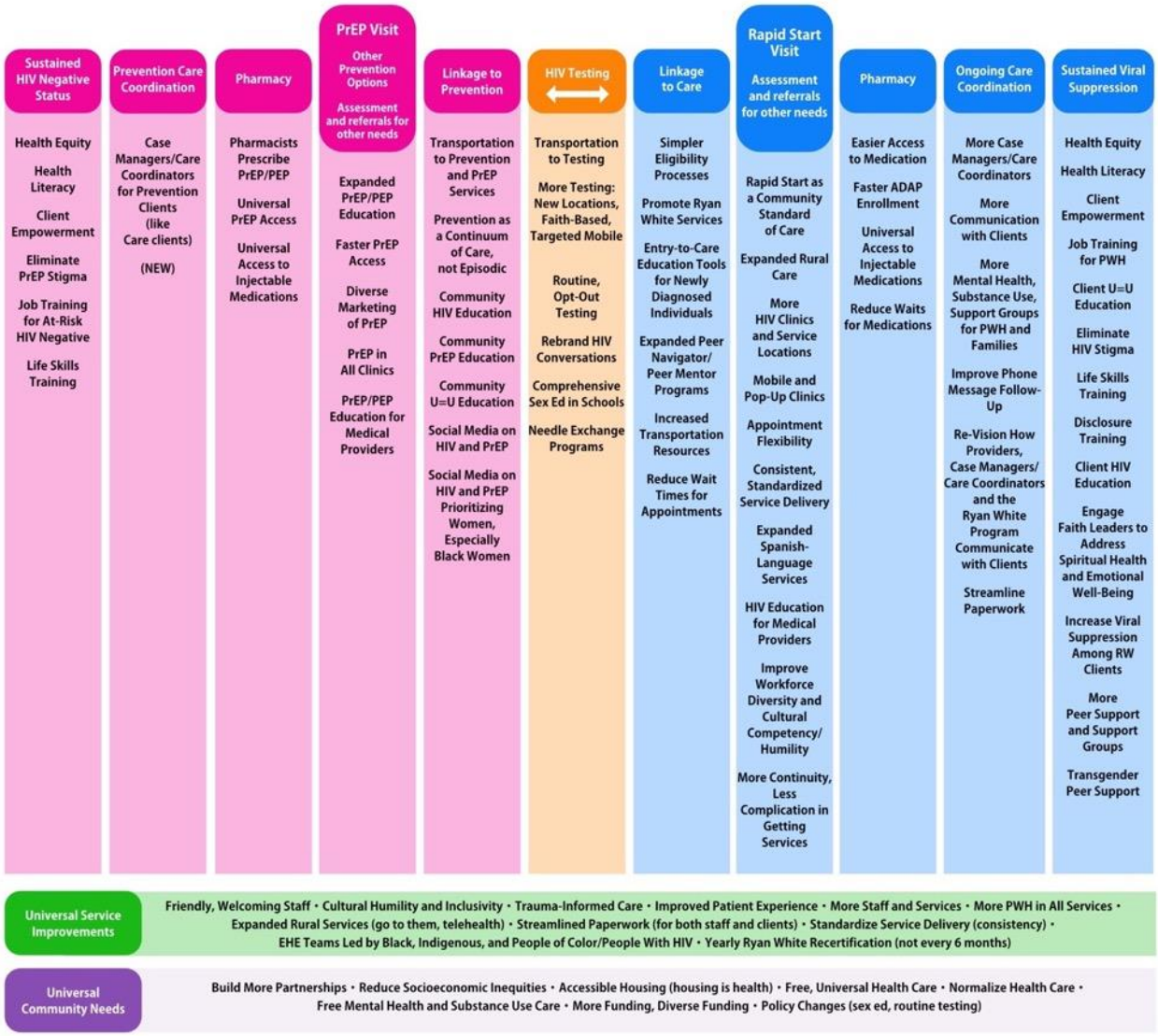
HIV enter the care continuum, which provides rapid linkage to medical care and initiation of HIV medications and ongoing support to remain engaged in care and achieve viral suppression. People who test negative for HIV enter a similar continuum, including rapid linkage to Pre-Exposure Prophylaxis (PrEP)/Post-Exposure Prophylaxis (PEP) and other prevention options, and support for treatment adherence, with the goal of maintaining an HIV negative status.

Figure 1: The HIV Status-Neutral Service Delivery Model



The Administrative Agency and TCPH Adult Health Services (AHS) have committed to adopting the status-neutral approach for future service delivery. Because of this, the results of all HIV planning activities have been plotted along the relevant steps along the status-neutral continuum of care. Universal service delivery improvements and community needs that would contribute to success along the entire prevention and care continuum are detailed below the continuum.

Figure 2: Combined Strategies from All Engagement Activities, Plotted Along the Status-Neutral Continuum of Care



Results of all engagement activities and draft Plan components were presented to the full Planning Council each month. After Council review, content was shared with the community for review and feedback.

The final goals, objectives, strategies, and activities developed for the Plan were approved by the Planning Council on November 1, 2022.

2022 to 2026 Integrated HIV Prevention and Care Plan

PRIORITY POPULATIONS

- Youth
- Black women
- Transgender women
- Men who have Sex with Men (MSM), especially Black and Hispanic MSM

OVERALL GOAL OF THE INTEGRATED PLAN

By December 2026, reduce new HIV infections in the Fort Worth-Arlington TGA, from approximately 325 cases in 2021 to less than 80 cases in 2026 (a 75% reduction).

Strategies are organized according to the goals of the National HIV/AIDS Strategy.

GOAL 1: PREVENT NEW INFECTIONS

OBJECTIVE: Create a high-performing status-neutral approach to HIV service delivery, in which HIV testing serves as an entry point for rapid linkage to, and engagement in prevention and care services. The status neutral approach will contribute to reducing the number of new HIV cases in the Fort Worth-Arlington TGA by 75%, from approximately 325 cases in 2021 to less than 80 cases in 2026.

Strategies led by the Tarrant County HIV Administrative Agency

- **Strategy 1.1:**
- Collaborate with the TCPH Adult Health Services to adopt the Status-Neutral Prevention and Treatment Cycle (SNPTC) as the jurisdiction's framework for HIV/STI/hepatitis screening, rapid linkage to HIV care, and rapid linkage to PrEP/PEP initiation and other prevention options.
- **Strategy 1.2:** Collaborate with community stakeholders and people with HIV to inform the development and implementation of a media initiative promoting HIV viral suppression as high-impact HIV prevention (known as Undetectable=Untransmittable, or U=U) to Ryan White clients.
- **Strategy 1.3:** Collaborate with community stakeholders and people with HIV to inform the development and implementation of a 3-year initiative promoting the availability of free or low-cost HIV services provided by the Ryan White Program.
- **Strategy 1.4:** Annually, complete detailing sessions with non-Ryan White providers to increase provider knowledge of the availability of free or low-cost Ryan White-funded medical care, supportive services, and linkage to care systems.
- **Strategy 1.5:** Collaborate with the TCPH Adult Health Services to establish routine, opt-out testing in hospital emergency departments, community clinics, urgent care centers, and other clinical settings, and provide support for linkage to Ryan White services.

Strategies led by the TCPH Adult Health Services

- **Strategy 1.6:** Annually, complete detailing sessions with medical providers to increase the number of providers offering routine HIV/STI/hepatitis screening and PrEP/PEP services, including tele-PrEP services, prioritizing geographic areas with high HIV incidence.

- **Strategy 1.7:** Increase the number of entities providing HIV/STI/hepatitis screening in geographic areas of high HIV incidence, including non-traditional partners such as walk-in labs, pharmacies, faith-based organizations, and mobile testing services.
- **Strategy 1.8:** Develop and implement a community-informed PrEP/PEP media initiative designed to decrease PrEP stigma and increase PrEP utilization, with specific messaging for young Black and Hispanic MSM, and Black women.
- **Strategy 1.9:** Increase the number of people in priority populations who use PrEP/PEP.
- **Strategy 1.10:** Establish transportation services to improve access to HIV/STI/hepatitis testing, and PrEP services.
- **Strategy 1.11:** Support policies that ensure universal access to PrEP/PEP medications, in pill and injectable forms.
- **Strategy 1.12:** Revise the delivery of HIV prevention services to mimic the Ryan White continuum of care (HIV screening, rapid linkage to PrEP/prevention options, prevention and PrEP/PEP case management/care coordination, and sustained HIV negative status).
- **Strategy 1.13:** Develop and implement a service delivery model for HIV prevention case management/care coordination services.
- **Strategy 1.14:** Promote policies that support allowing pharmacists to prescribe PrEP/PEP.
- **Strategy 1.15:** Lead community-driven activities to revision HIV messaging to reduce HIV stigma, change public perceptions of risk of exposure to HIV, and increase the acceptability of routine HIV/STI/hepatitis testing.

Strategies Led by Community Partners

- Increase the social media presence of CBOs offering HIV prevention and care services.
- Support policies that ensure universal access to PrEP/PEP medications, in pill and injectable forms.
- Support policies that support comprehensive, age-appropriate sex education in college.
- Promote policies that support needle exchange programs.
- Promote policies that support allowing pharmacists to prescribe PrEP/PEP.

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV

OBJECTIVE: Increase the number of PWH that achieve sustained viral suppression, from an estimated 78% to 95%.

Strategies Led by the Tarrant County HIV Administrative Agency

- **Strategy 2.1:** Conduct an annual analysis to contrast the service utilization of Ryan White clients that have achieved viral suppression to those who have not, to determine factors that are likely to support engagement in care and viral suppression. Based on this analysis, establish programmatic initiatives and quality activities to increase viral suppression among non-suppressed clients.
- **Strategy 2.2:** Increase the percentage of newly diagnosed and returning-to-care individuals that are successfully linked to care, ideally within seven business days, or less than 30 days, from an estimated 78% to 95%.
- **Strategy 2.3:** Increase the number of people with HIV that achieve sustained viral suppression, from an estimated 78% to 95%.
- **Strategy 2.4:** Increase the number of individuals who remain engaged in care 12 months from the date of their diagnosis/entry to care, from an estimated 51% to 95%.
- **Strategy 2.5:** Develop client education resources to educate PWH who are newly diagnosed, new to care, or out of care on the importance of rapid linkage to care, U=U, and other HIV-related information.
- **Strategy 2.6:** Increase the delivery of Ryan White medical care and support services in rural areas, utilizing telehealth and other service delivery methods preferred by clients.
- **Strategy 2.7:** Increase comprehensive use of the Provide Enterprise data system to improve provider-to-provider communication, management of clients' needs and referrals, data sharing, and quality evaluation and monitoring.
- **Strategy 2.8:** Expand peer navigation programming and diversify peer navigation staff.
- **Strategy 2.9:** Develop strategies for the Administrative Agency to communicate directly to Ryan White clients to promote the availability of services, and service changes.
- **Strategy 2.10:** Simplify Ryan White and AIDS Drug Assistance Program (ADAP) paperwork for clients and providers, including online completion of Ryan White and provider forms and the ability to digitally sign and submit documents.
- **Strategy 2.11:** Advocate for the Texas Department of State Health Services to implement policy changes that streamline eligibility and renewal certifications to significantly reduce wait times for ADAP-eligible clients to receive medication.

Strategies Led by the TCPH Adult Health Services

- **Strategy 2.12:** Develop and implement a revised service delivery model for Disease Investigation Services, focusing on providing compassionate, client-centric, trauma-informed services.

Strategies Led by Community Partners

- Advocate for policies that support universal access to injectable HIV medications, and other medications as they become available.
- Advocate for the expansion of Medicaid.

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HIV-RELATED STIGMA

OBJECTIVE: Reduce health disparities, HIV-related stigma, and other barriers to accessing care and providing services through improved service delivery and systems change.

Strategies Led by the Tarrant County HIV Administrative Agency

- **Strategy 3.1:** Develop a system-wide approach for HIV service delivery for those disproportionally impacted by HIV.
- **Strategy 3.2:** Engage Black faith leaders to educate their congregations and communities on HIV to increase awareness and reduce stigma and discrimination toward PWH.
- **Strategy 3.3:** Develop and implement an initiative to reduce stigma experienced by people with HIV.
- **Strategy 3.4:** Provide job training and personal or professional development opportunities to people with HIV, to prepare them to enter or return to the workforce, especially in public health programs, local community-based organizations, and HIV prevention and care programming.
- **Strategy 3.5:** Implement multi-agency case conferencing to monitor erratically-in-care clients.
- **Strategy 3.6:** Collaborate with the TCPH Adult Health Services to identify and address HIV-related disparities experienced by 1) clients accessing Ryan White services, and 2) individuals accessing HIV testing, PrEP/PEP, and other prevention services. Then design and implement effective, evidence-based, relevant interventions to improve health outcomes for those disproportionally impacted by HIV.

Strategies Led by the TCPH Adult Health Services

- **Strategy 3.7:** Evaluate the feasibility of increasing data-to-care/lost-to-care initiatives to identify erratically in-care and out-of-care people with HIV and return them to care.
- **Strategy 3.8:** Evaluate the feasibility of coordinating HIV/STI/hepatitis surveillance systems.
- **Strategy 3.9:** Collaborate with the Administrative Agency to evaluate the feasibility of establishing a multi-setting hepatitis screening program.

Strategies Led by Community Partners

- Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.
- Support policies that support comprehensive, age-appropriate sex education in college.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS

OBJECTIVE: Improve programmatic collaboration and performance by sharing innovations, best practices, and data to increase the competencies of staff and leadership to address the local epidemic.

Strategies Led by the Tarrant County HIV Administrative Agency

- **Strategy 4.1:** Present an annual, jurisdiction-wide training series that offers leadership and development opportunities, supports innovation in service delivery, addresses cultural humility and fosters dialogue about local issues that impede progress toward ending the HIV epidemic.
- **Strategy 4.2:** Train providers to expand their ability to offer high-quality, affirming medical care to priority populations which may include PrEP/PEP services and HIV, STI and hepatitis testing and treatment.
- **Strategy 4.3:** Work with the TCPH Adult Health Services and community partners to enhance collaboration among programs, providers, and the community to address policies and structural barriers that contribute to persistent HIV-related disparities.

Strategies Led by the TCPH Adult Health Services

- **Strategy 4.4:** Collaborate with the Tarrant County HIV Administrative Agency and community partners to identify geographic 'hotspots' to prioritize the coordinated, innovative use of resources to address HIV/STI/hepatitis prevention and care among disproportionally impacted populations.
- **Strategy 4.5:** Establish and maintain internet-based dashboards to report to the community on the status of the local HIV epidemic, the performance of HIV/STI/hepatitis prevention and care initiatives, linkage to care timeframes, and outreach/data to care activities.

Strategies Led by Community Partners

- Foster private-public-community partnerships to participate in HIV/STI/hepatitis prevention and care planning, service delivery, and evaluation, and initiatives to address social determinants of health.
- Facilitate the participation of traditional and non-traditional entities in geographic areas of concern to support prioritized HIV/STI/hepatis initiatives.

SECTION 1b: LIST OF SUPPORTING DOCUMENTS

To inform this Plan, the recommendations of five local assessments and plans that were evaluated:

- 2019 to 2021 Comprehensive Needs Assessment Study
- 2020 Improving Health Outcomes for Youth and Young Adults with HIV Study
- 2021 Study of HIV in Rural Areas
- 2021 Ryan White Part A Client Satisfaction Survey
- 2020-2021 Tarrant County HIV Taskforce's Ending the HIV Epidemic Program Report
- Achieving Together: A Community Plan to End HIV In Texas

Additionally, Ending the HIV Epidemic plans from 27 other jurisdictions were reviewed.

SECTION 2: COMMUNITY ENGAGEMENT AND DESCRIPTION OF JURISDICTIONAL PLANNING PROCESS

SECTION 2.1: JURISDICTIONAL PLANNING PROCESS

PRE-PLANNING REVIEW AND EVALUATION

Ending The HIV Epidemic Plans From Other Jurisdictions
Ending the HIV Epidemic plans from 27 jurisdictions were reviewed to identify commonalities among activities and strategies, evaluate the effectiveness of stakeholder engagement strategies, and inform performance and evaluation metrics.

Key Commonalities

- Nearly all the plans were organized to the match the well-ordered structure of the National HIV/AIDS Strategy (NHAS).
- Reducing new cases of HIV was the highest priority for many plans. Strategies for increasing HIV testing and prioritizing testing by geographic areas were common, as were 'test and treat' rapid linkage to care initiatives that would drive clients to earlier viral suppression and reduced sexually transmitted HIV.
- Addressing health disparities and reduce HIV-related stigma and discrimination.
- Plans with the greatest specificity of performance indicators tempered aspirational goals with realistic expectations.
- Comprehensive community engagement resulted in very specific strategies and activities that directly addressed local needs.

The review also revealed weaknesses. Some plans simply mirrored the goals and objectives of the NHAS, with little justification for local implementation or demonstrated ability to meet lofty goals. Several plans presented high-level, general recommendations with few if any specific activities. A small number of plans included expanding the use of Pre- and Post-Exposure Prophylaxis (PrEP/PEP).

The analysis was shared with the Comprehensive Planning Committee (CPC) of the North Central Texas HIV Planning Council (Planning Council) and the Tarrant County HIV Administrative Agency (Administrative Agency) to prepare them for leading the engagement and planning processes. Based on this analysis, guiding principles for the development of the Plan were established.

Guiding Principles for the Development of the Plan

- The Plan should be thoughtful, aspirational, innovative, and realistic.
- Ending the HIV epidemic would require strong partnerships among public health programs, private sector entities, HIV providers, community-based organizations, and the public.
- Each group listed above would have responsibilities for implementing the Plan.
- Diverse and extensive stakeholder engagement would be required. People with HIV (PWH), community stakeholders, staff of community-based organizations, staff and leadership of public health programs, and others should have an equal voice in the development of the Plan.
- Strategies and activities should improve performance across the entire local HIV continuum and establish parity of service delivery among prevention and care services.

REVIEW OF LOCAL ASSESSMENTS, PLANS, AND REPORTS

Achieving Together: A Community Plan To End HIV In Texas

Achieving Together was developed by community leaders, advocates, and people from across Texas. The Plan reflects the ideas, recommendations, and guidance of the Texas HIV Syndicate (Syndicate) and Achieving Together partners, and statewide community engagement efforts with people impacted by HIV, PWH, clinicians, and researchers. The Texas HIV Syndicate is the Texas integrated HIV prevention and care planning group. The Syndicate includes representation from PWH, community stakeholders, and leaders of HIV prevention and care organizations.

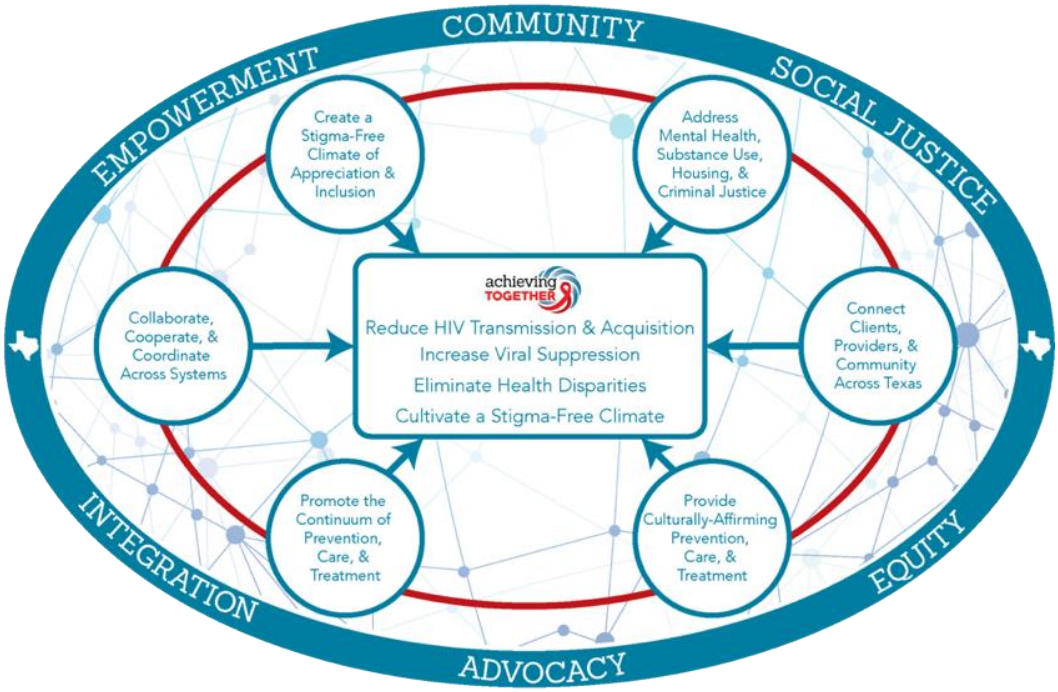
Achieving Together Goals

- Goal 1: Reduce HIV transmission and acquisition.
- Goal 2: Increase viral suppression among PWH.
- Goal 3: Eliminate health disparities.
- Goal 4: Cultivate a stigma-free climate.

Focus Areas

- Cultivate a stigma-free climate of appreciation and inclusion.
- Address mental health, substance use, housing, and criminal justice.
- Collaborate, cooperate, and coordinate across systems.
- Connect clients, providers, and communities across Texas.
- Provide culturally appropriate HIV prevention, care, and treatment.
- Promote the continuum of HIV prevention, care, and treatment.

Figure 3: Achieving Together Focus Areas and Goals



Achieving Together Performance Measures

- Overall: A 50% reduction in the annual number of Texans who acquire HIV, from 4,400 to 2,200 by 2030.
- 90% of PWH know their status, up from 80% in 2012.
- 90% of PWH who know their status are on antiretroviral therapy (ART), up from 68% in 2012.
- 90% of those on ART achieve viral suppression, up from 76% in 2012.

Interviews With Funded Ryan White Providers and Community Leaders: Capacity and Gap Analysis

A capacity and gap analysis for Ryan White-funded agencies was completed in 2021. Interviews were conducted with six agency leaders. During the planning process, these interviews were supplemented by conversations with 15 HIV community leaders in the TGA representing PWH, local planning body leadership, HIV prevention and care program leads, and leaders of other community-based organizations (CBOs). Participants were asked to share their thoughts on gaps and barriers that challenge service delivery. Responses are organized into the themes below.

- Providers need to increase capacity to offer compassionate, trauma-informed, culturally humble care, especially for Black and Hispanic individuals and people of trans experience.
- Technical assistance for agency-specific three-Year strategic planning is needed.
- Funding must diversify, and the Administrative Agency should create ways to ensure funding over multiple years so agencies can justify commitments to innovative programming.
- The Administrative Agency should provide technical assistance to train agency staff to offer more diverse services.
- HIV education needs to be increased, especially comprehensive, sex-positive, age-appropriate sex education in college.
- Media and marketing initiatives should be implemented promoting PrEP/PEP, HIV services, and Undetectable=Untransmittable.
- The state ADAP needs to dramatically decrease the time it takes for PWH to enroll in the program and receive medications.
- PWH desire job training to reenter the workforce/enter the HIV workforce.
- PWH who are erratically-in-care need financial incentives for adherence to HIV treatment and medications.
- Data sharing, and the use of data to drive service delivery needs to improve.
- More Peer Navigators are needed. A standardized service delivery model and training program needs to be established.
- Expand geographic parity of services by increasing the number of HIV providers
- Increase use of PrEP/PEP.
- Implement a self-guided PWH health care education program.
- Advocate for updated state HIV policies.

2019 to 2021 Comprehensive Needs Assessment Study

The Planning Council completed this assessment to inform their priority setting and resource allocations to address gaps in services and unmet needs in the TGA and develop directives for core medical and support services. More than 500 PWH who receive Ryan White-funded services participated.

Recommendations

- Decrease the amount of paperwork clients need to complete to receive services.
- Increase accessibility to care by providing services on weekends or evenings.
- Increase provider cultural humility.

- Expand provider capacity to offer multiple services at the same location.

2020 Improving Health Outcomes For Youth And Young Adults With HIV Study
The Administrative Agency commissioned this study to determine if there is opportunity to strengthen capacity to respond to the changing health care landscape and increase access to high quality youth- and young adult-centered care and services for low-income, uninsured, and underserved youth and young adults with HIV. Thirty youth/young adult client of the Ryan White program were interviewed.

Recommendations
- Entry-to-care education materials for newly-diagnosed youth.
- Create transitional Peer Mentor/Peer Navigation Programs.
- Establish formal offboarding/onboarding programs for youth transitioning from pediatric to adult HIV care.
- Implement rapid linkage to HIV medical care (first medical appointment and medication dose within seven business days from diagnosis or presentation for care).

2021 Study of HIV in Rural Areas
This study was completed to identify opportunities to strengthen services for clients residing in rural areas of the TGA. PWH were asked questions about access to care, barriers to care, stigma issues, and their experiences receiving care. The assessment included 16 client interviews, completion of 49 client satisfaction surveys, and four provider interviews.

Recommendations
- Ensure clients understand the Ryan White services that are available to them.
- Increase transportation resources for clients within rural areas.
- Establish peer mentor/peer navigation programs for rural clients.
- Initiate HIV media initiatives addressing stigma reduction, general HIV education, and U=U.
- Implement rapid linkage to care service delivery.
- Initiate a process for the Administrative Agency to communicate directly with the clients (rather than through providers).

2021 Ryan White Part A Client Satisfaction Survey
The client satisfaction survey assessed the individual-level, provider-level, and system-level services experienced by more than 330 people accessing Ryan White services in the TGA. Information from this survey informed strategies to increase the quality of services, reduce barriers to care and improve health outcomes for PWH.

Recommendations
- Increase viral suppression among Ryan White clients.
- Improve phone message follow-up.
- Revision how providers and the Administrative Agency communicate with clients.
- The Administrative Agency should promote Ryan White services, rather than expecting agencies to do so.
- Improve workforce competency and cultural humility.
- Engage faith leaders to address the spiritual health and emotional well-being of PWH
- Promote Covid-19 vaccinations to PWH.

2020-2021 Tarrant County HIV Taskforce's Ending the HIV Epidemic Program Report

The Tarrant County Public Health HIV Taskforce was responsible for advising the Tarrant County Public Health EHE program. The Taskforce was composed of DIAGNOSE, TREAT, PREVENT, and RESPOND work groups. These work groups reviewed the EHE Plan submission to TX DSHS and the CDC to verify that it describes how programmatic activities and resources should be allocated into the community, specifically to the most disproportionately affected populations and geographical areas that bear the greatest burden on HIV incidence. To further strengthen the community's input into the EHE Plan, key community leaders chaired each of the four work groups. The Program Report identified short-term, intermediate, and long-term outcomes.

Select Goals

- Identify and establish best practices relating to HIV testing within the community by 2025.
- Increase the number of youth/adolescents under 25 who are testing annually by 10% by 2025.
- Increase the number of sites that utilize and offer nontraditional testing by 2025.
- Establish mandatory HIV testing upon entry and release from prisons and detention facilities by 2025.
- Increase number of Tarrant County residents living with HIV who are receiving treatment to 90% by 2025.
- Decrease the time of availability to Rapid ART to 72 hours by 2023, and to same day by 2025 to 90% of newly diagnosed individuals.
- Improve patient care experience by addressing compassionate care, staff reflectiveness, burnout, and workforce capacity to better address the needs of people with HIV (baseline will be developed in 2021).
- Implement routine mental health screenings during HIV test/annual tests to establish a baseline mental health status by 2021.
- Increase visibility and accessibility of PrEP 10% by 2025.
- Utilize mobile testing units to target high-risk areas within Tarrant County four times a month by 2025.
- Increase access to education and training services relating to HIV cluster detection/ response to the Health Service Delivery Area/Tarrant County workforce by 2023.
- Develop and implement a status-neutral approach when identifying negative partners at risk of HIV exposure within clusters by 2023. Develop evaluation program and tools to be utilized alongside the implementation of the status-neutral approach.
- Increase and expand upon current HIV surveillance being utilized across the continuum of care within Tarrant County by 2025.

Table 2: Pre-Planning Review and Evaluation: Overarching Priorities
Information gathered from the Pre-Planning Review was evaluated and prioritized, as follows:

Strategy	Pre-Planning Review Priority
Access to Care	High
Client-Centered Initiatives/Priority Populations	High
Collaboration/Relationships	Moderate
Community Connection/Planning	Moderate
Condoms	Low
Cultural Humility and Competency	High
Faith Community Collaboration	Low
Funding	High
Health Literacy	High
HIV Testing	High
Housing	Low
Innovation	High
Media Initiatives	Moderate
Outreach	Low
Peer Mentoring	Moderate
Policy Revision	Moderate
PrEP/PEP	High
Provider Education	High
Rapid Start Linkage to Care	High
Sex Ed Reform, Community HIV Education	High
SSP/Harm Reduction	Low
Stigma Reduction	High
Systems Improvement/Data Collection & Use	Moderate
Undetectable=Untransmittable (U=U)	High

SECTION 2.1a: ENTITIES INVOLVED IN THE PLANNING PROCESS

Staff of Community-Based Organizations and Public Health Programs
The strategy used for stakeholder engagement was designed to be inclusive of everyone involved in HIV service delivery, program management, and planning. CBOs and public health programs were asked to have their entire staffs take part and share their passion, perceptions, and expertise to inform the Plan. For many participants, such as front desk personnel, finance staff, and others not in managerial or leadership roles, this was the first time they had been engaged in local HIV planning.

More than 120 people took part in these planning sessions, representing the full staffs and leadership of:

- Six community-based organizations receiving Ryan White Part A funds (AIDS Outreach Center, CAN Community Health, JPS Healing Wings, Preventive Medicine Clinic, Salvation Army Fort Worth, and Samaritan House)
- The North Central Texas HIV Planning Council
- The Tarrant County HIV Administrative Agency
- Tarrant County Public Health Adult Health Services (AHS)
- Disease Investigation Services (DIS)
- Health Education Learning Project (HELP)
- The HIV Prevention Partnership (a local prevention planning body)

Participants were asked to visualize the current continuum of care and what an ideal continuum of care would look like. Then, they were asked just one question:

"What needs to happen in the next five years that will result in the end of the HIV epidemic in Tarrant County?"

Participants generated ideas using a combination of individual brainstorming, two-member team review, and large group discussion. As ideas were shared, they were organized based on common themes. As the groupings became larger, strategies emerged. The result of each session was a unique array of strategies and activities that would contribute to ending the HIV epidemic. Figure 3 provides an example of completed agency planning activity.

Figure 4: Sample Planning Activity Completed by Staff of a Community-Based Organization

Early Prevention	Removing Stigma	Diversify Locations for Testing	Rapid Start (HIV and PrEP)	Client Support	Resources to Remove Barriers to Care	Increase Access Through Cultural Humility
Provide early education	More social media- prevention/care	Increase testing	faster PrEP access	More HIV support groups	Increase transportation	increase training for all staff
More HIV educational programs/schools	PrEP & HIV Increase social media and marketing	Increase mobile testing in rural areas	Rapid Start as a community standard	Input from family to help clients get into, and stay in care (momma and grandma, chosen family)	Increase access to housing, food, mental health	Increase confidentiality at clinics & orgs (H=HIV, A=AIDS)
Implementing more in depth sex ed in high schools w/PrEP	Normalize HIV as a health condition like diabetes, heart disease, etc.	More clinic hours/doctors	Immediate PrEP referrals when HIV-		Connecting RW agencies/resources	More clinic hours/doctors
More clinic location/mobile clinics	Develop an app that focuses on med reminders, access to counseling, etc.	More free testing sites	Faster ADAP		Easily accessible and free mental health services	
Educational outreach/events		Making routine testing more mainstream	Starting clients on HIV sooner (Rapid Start)			
Increase client health literacy and adherence- HIV care and prevention						
In-person outreach- prevention out of care						

EVALUATION

Combined, the CBO/Public Health Program planning activities resulted in 211 individual ideas. These ideas were organized into 20 overarching strategies.

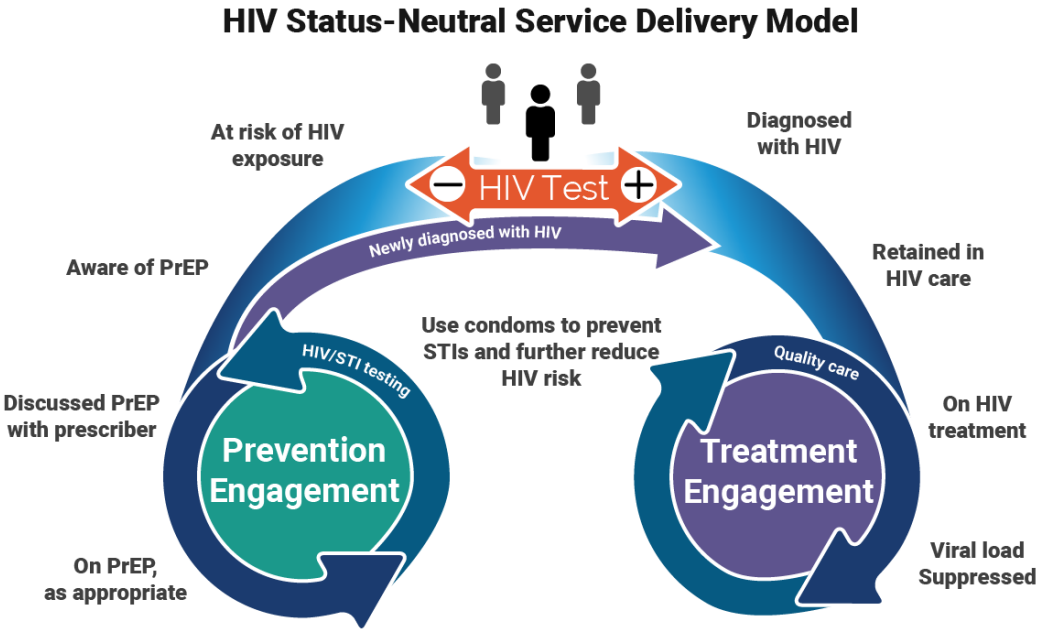
Social Media/Marketing (17 ideas)
HIV Testing (16 ideas)
PrEP/PEP (15 ideas)
Addressing Disparities (14 ideas)
Increased Support Services (14 ideas)
HIV Education (14 ideas)
Cultural Humility (13 ideas)
Decrease Administrative Burden (12 ideas)
Rapid Start Linkage to Care (9 ideas)
Improved Patient Experience (9 ideas)
Easier Access to Medications (8 ideas)
Expand Rural Care (7 ideas)
Diversify Funding (7 ideas)
Other HIV Prevention (7 ideas)
Client Life Skills (6 ideas)
Housing (5 ideas)
Health Literacy (4 ideas)
HIV and the Faith Community (2 ideas)
Stigma Reduction (2 ideas)
Increased Partnerships (1 idea)

PLOTTING THE STRATEGIES OF CBOs AND PUBLIC HEALTH PROGRAMS ALONG THE STATUS NEUTRAL CONTINUUM

The HIV Status-Neutral Service Delivery Model establishes equity of care for people who have been tested for HIV, regardless of their testing results. The goal is to optimize a person's health through continuous engagement in either HIV treatment or prevention services. People who are diagnosed with HIV enter the care continuum, which provides rapid linkage to medical care and initiation of HIV medications and ongoing support to remain engaged in care and achieve viral suppression. People who test negative for HIV enter a similar continuum, including rapid linkage to PrEP/PEP and other

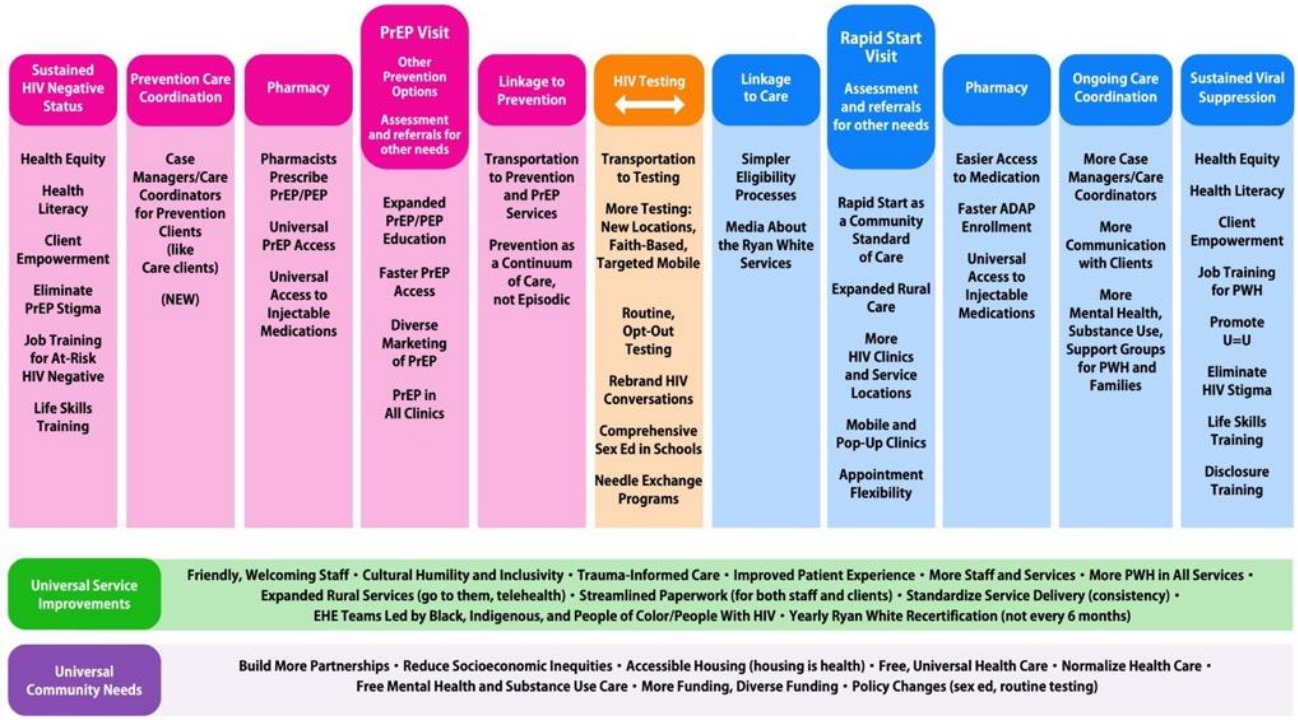
prevention options, and support for treatment adherence, with the goal of maintaining an HIV negative status.

Figure 5: The HIV Status Neutral Service Delivery Model



The Administrative Agency and TCPH Adult Health Services have committed to adopting the status-neutral approach for future service delivery. Because of this, the results of all HIV planning activities have been plotted along the relevant steps along the status-neutral continuum of care. Universal service delivery improvements and community needs that would contribute to success along the entire prevention and care continuum are detailed below the continuum.

Figure 6: CBO and Public Health Programs EHE Strategies Plotted Along the Status Neutral Continuum of Care



SECTION 2.1b: THE ROLE OF THE RYAN WHITE PART A PLANNING COUNCIL

The development of this Plan was overseen by the Tarrant County HIV Administrative Agency, Recipient, and the North Central Texas HIV Planning Council, the community group that has been appointed by Judge B. Glen Whitley to plan the delivery of Part A-funded HIV services and allocate federal resources to fund these services.

Community assessment and evaluation activities are guided by the Council's Comprehensive Planning Committee (CPC). For the development of this Plan, the CPC has evaluated input gathered from more than 120 stakeholders and 400 PWH and at-risk individuals.

SECTION 2.1c: ROLE OF OTHER PLANNING BODIES AND ENTITIES

The Prevention Partnership is a local planning body supported by TCPH Adult Health Services to inform and evaluate the delivery of HIV prevention services. Membership is diverse and includes representatives of Prevention Program-funded providers, community-based organizations, community groups, and others. The Partnership advises the TCPH Adult Health Services and has no authority to dictate service priorities or funding allocations.

The Prevention Partnership is the only other planning body in the jurisdiction.

SECTION 2.1d: COLLABORATION WITH RYAN WHITE HIV/AIDS PROGRAM PARTS

The Administrative Agency administers all Parts of the Ryan White HIV/AIDS Program (Parts A, B, C, D); the State of Texas Housing Opportunities for Persons With AIDS (HOPWA) funds, and the Texas HIV State

Services (SS) and Texas State Rebate (State R) funds, competitive Housing and Urban Development (HUD) HOPWA funds, and Ending the HIV Epidemic (EHE) funds. Providers that took part in the planning process receive funding from one or more Ryan White Parts.

There are no other Integrated Plans for the jurisdiction.

SECTION 2.1e: ENGAGEMENT OF PEOPLE WITH HIV

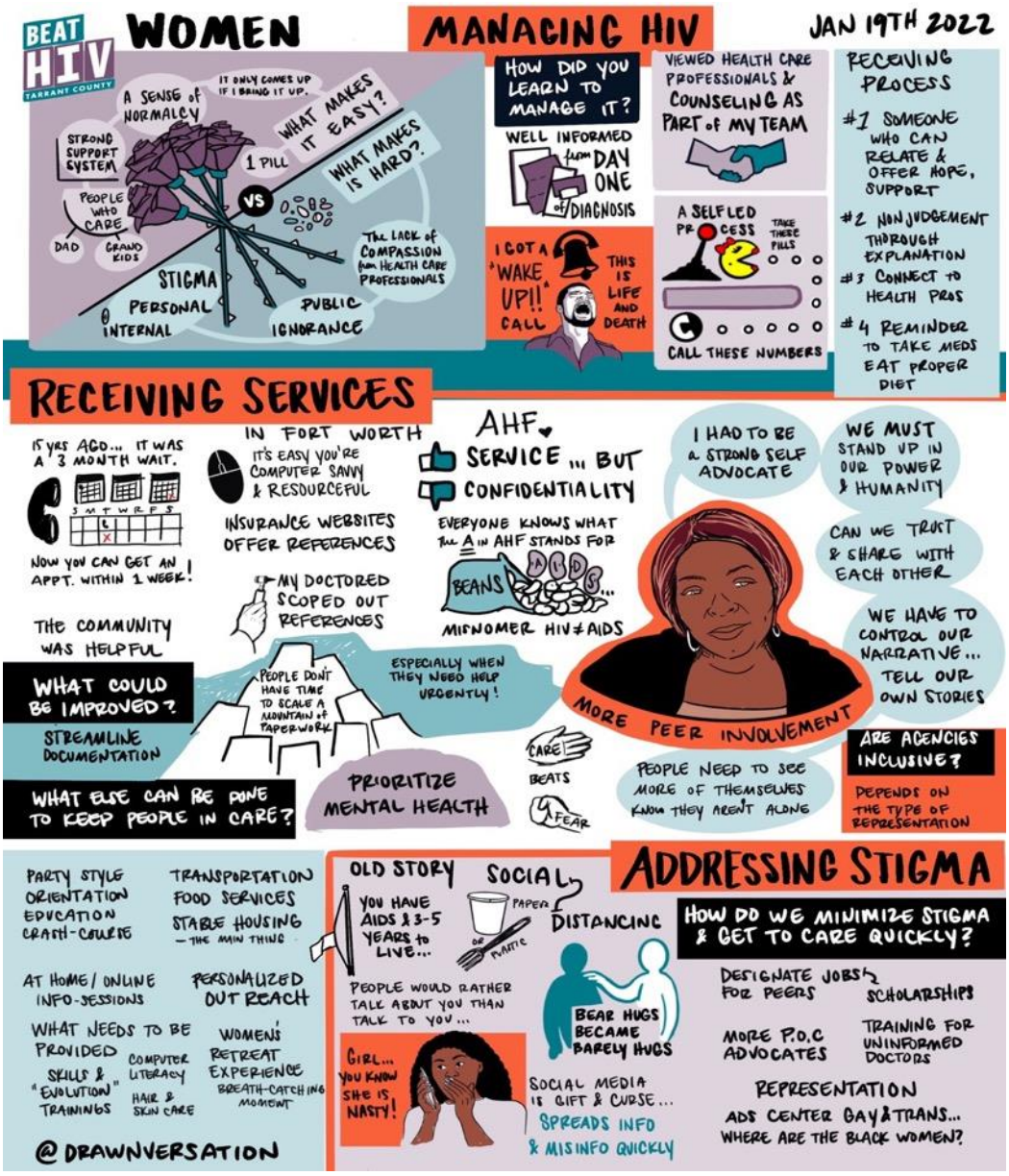
PWH were highly involved in the development of this Plan. Two assessments of PWH were completed immediately prior to the start of community engagement activities. As part of the engagement process of PWH and at-risk individuals, six virtual listening sessions were completed, followed by five in-person focus groups with clients of Ryan White-funded agencies. More than 400 PWH and at-risk HIV negative individuals participated in the planning process via these activities.

Listening Sessions with People with HIV

In early 2022, people with HIV were invited to take part in a series of virtual two-hour listening sessions to reflect on their entry into local HIV care, their experiences accessing services, and stigma and discrimination they may have faced. They were also encouraged to share their thoughts on what needed to be done to end the HIV epidemic. More than 60 people from priority populations participated in these robust conversations.

During these discussions, a graphic recorder created visualizations of the stories being told. The final discussion boards provide a captivating record of each engagement session, conveying emotion and intent better than a written report can. Participants saw their words come to life, and those viewing the boards have a greater sense of the tone and content of the meeting. The discussion boards have been displayed during Planning Council meetings and shared online.

Figure 7: 01.18.22 Listening Session With Black Women



Discussion Highlights

- Participants had faced internal and external stigma, and disclosure issues.
- Simply accessing services at an agency with 'AIDS' in the title was stigmatizing.
- Health department staff showed little empathy when conducting disease investigation interviews.
- People need ways to learn about services other than online content. Service availability and changes were not communicated well.
- Participants wanted to be visible in the community and be peer advocates to lift themselves up and show other women that there were others successfully living with HIV.
- Some had been provided comprehensive assistance when first accessing care. Others felt they had to navigate themselves. The level of care and cultural humility varies by agency.

- Newly diagnosed PWH should take advantage of case management and support services.
- The faith community needs to have a greater role in helping PWH.
- Priority needs: Transportation, skills/job training, support services specific to the needs of women, mental health services, peer navigation, and peer-led services.

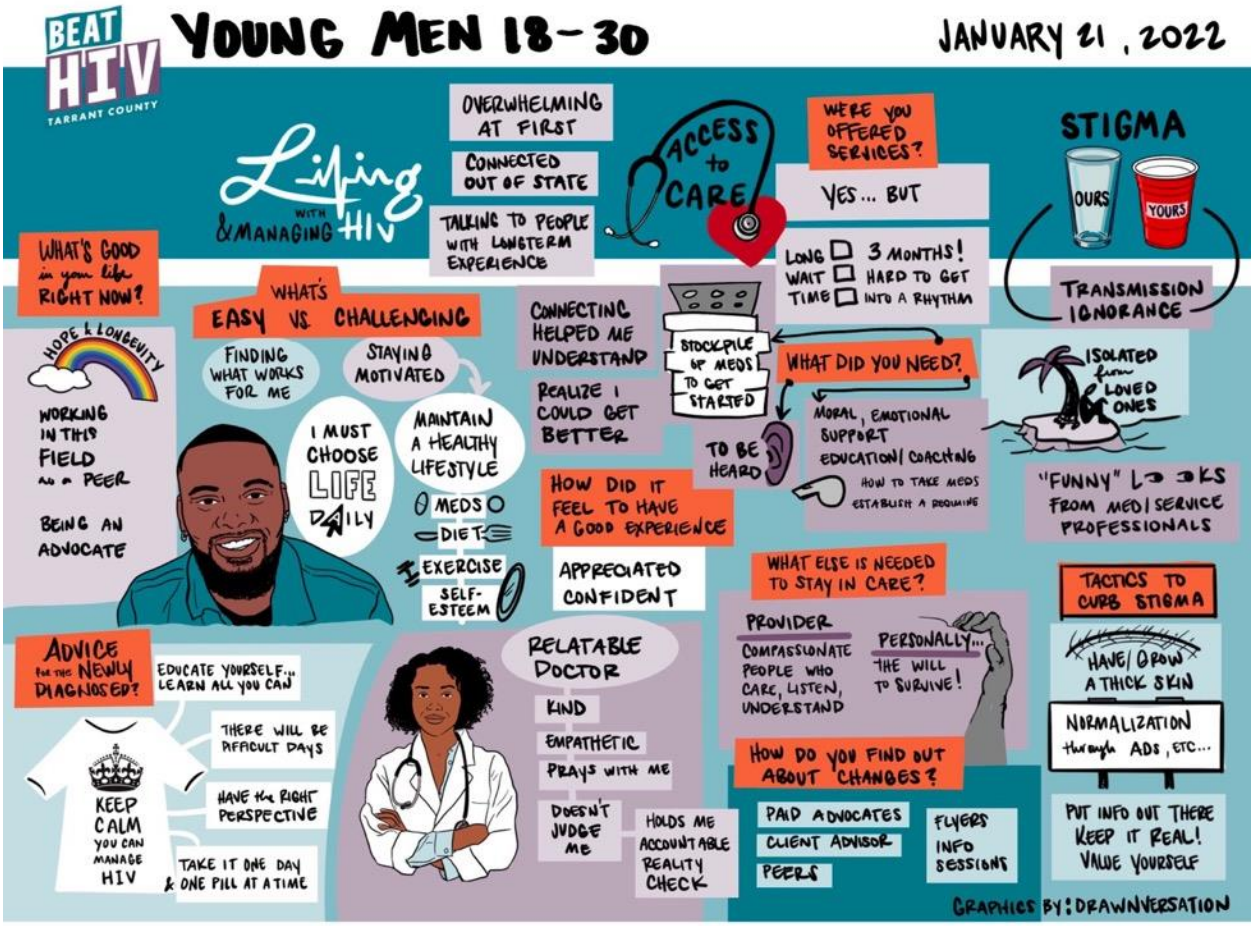
Figure 8: 01.20.22 Listening Session With People Aging with HIV

Discussion Highlights

- Telehealth and home-delivered medications made treatment adherence easy and offered flexibility around work schedules.
- Several participants discussed treatment fatigue and/or side effects from taking medications long-term.
- People need ways to learn about services other than online content. Service availability and changes were not communicated well. Some agency staff were not educated on the variety of programs offering assistance.
- Participants faced stigma from providers, the community, and the health department when linking to care after their initial diagnosis.
- Eligibility and enrollment for the Ryan White program, ADAP, and other services was daunting and took too much time.

- Undetectable=Untransmittable (U=U) should be promoted to PWH more. People have heard of U=U, but don't fully understand the concept.
- Most participants had been living with HIV for 15 years or more. Several participants recounted stories of feeling attacked or disrespected when contacted for partner services. DIS should show greater compassion and support.
- Stigma isn't as great an issue for PWH who have lived with HIV for a long time. "We've learned to develop coping strategies."
- The faith community could be more involved in HIV issues.
- The community has perceptions that drug users can't be compliant with their treatment, so providers won't prescribe to an active user.
- Priority needs: Peer support, transportation, more funds for gas cards ("five dollars can't get me anywhere"), training for case managers and peer navigators to better understand community services, and reduced paperwork/bureaucracy.

Figure 9: 01.21.22 Listening Session With Young Men with HIV Aged 18 to 30



Discussion Highlights

- Long wait times to get into care.
- Medical providers have been compassionate and empathetic.

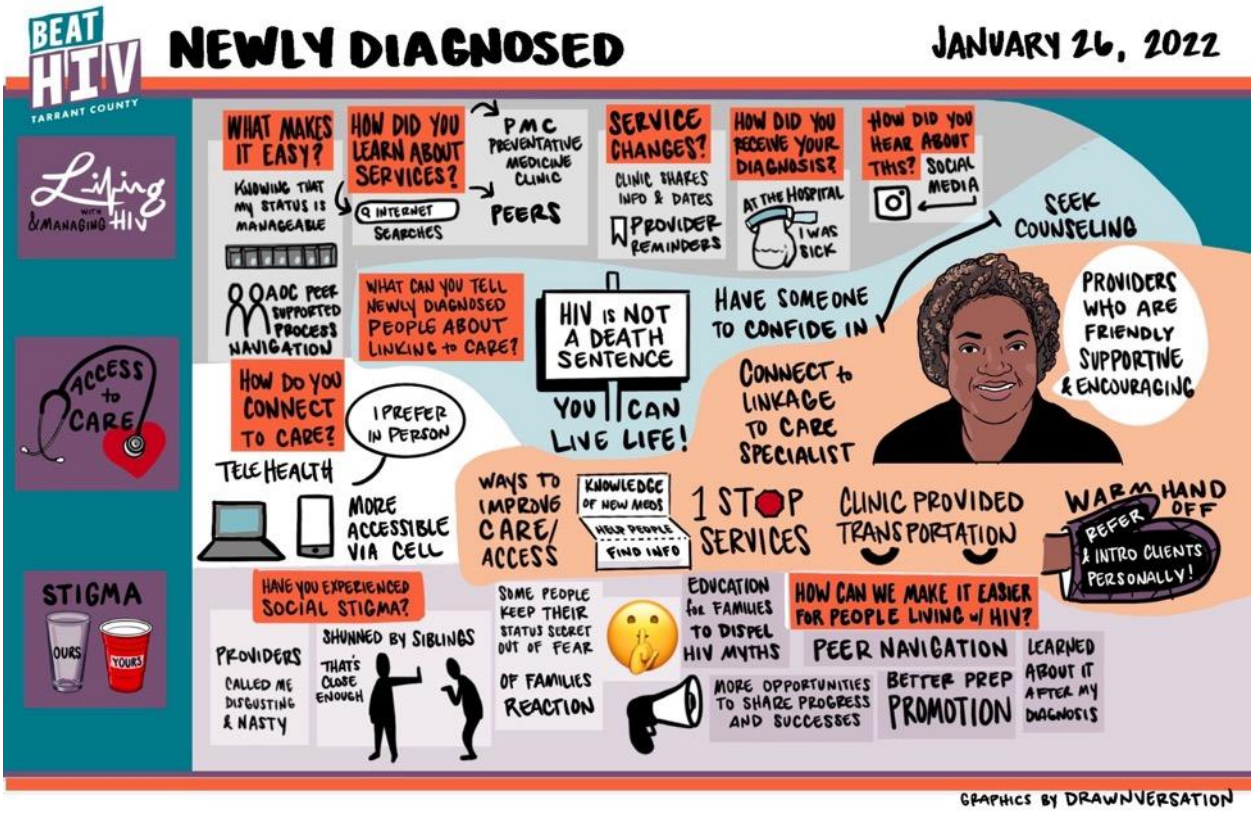
- Some participants had experienced depression due to having to manage a chronic illness ("I'm too young to be taking meds every day").
- Participants had experienced stigma from health care professionals outside of their HIV care system, and people who are not educated on HIV.
- Peer navigators were helpful with getting into care and dealing with other issues.
- Priority needs: Normalize HIV as a chronic disease, HIV education, and support groups/peer networking.

Figure 10: 01.25.22 Listening Session With Latino/a Individuals

Discussion Highlights

- It's difficult to get medications from ADAP. Participants discussed needing assistance completing paperwork and understanding the process.
- Primary ways to improve services: Kind, compassionate staff, eliminate bureaucracy and paperwork, and culturally humble services.
- Delays in care lead to depression and loneliness.
- Prioritized needs: Provider training on cultural humility, mental health services, housing, and reduced paperwork/bureaucracy.

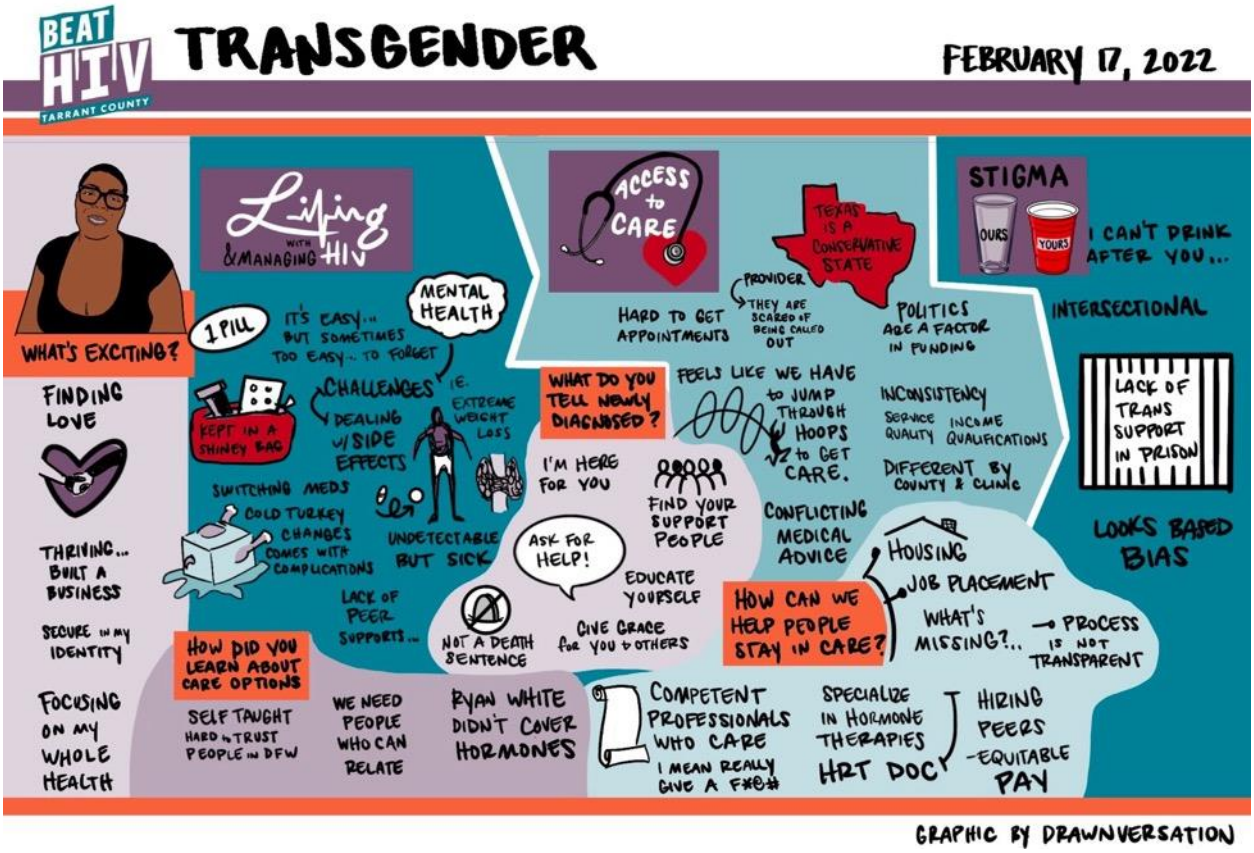
Figure 11: 01.26.22 Listening Session With Newly Diagnosed Individuals



Discussion Highlights

- Peer navigators and agency staff made entering care and treatment adherence manageable.
- Stigma experiences included being treated poorly by providers, and having family members distance themselves and their children—no physical contact, limited use of the home, etc.
- PrEP needs to be more promoted in the community. One participant shared they had never heard of PrEP until after they were diagnosed.
- Prioritized needs: Community HIV awareness, peer support, and mental health services.

Figure 12: 02.17.22 Listening Session With People of Trans Experience



Discussion Highlights

- Processes to enroll for HIV services are not clear.
- Treatment adherence can be challenged by achieving viral load suppression yet still feeling sick and experiencing side effects.
- Priority needs: Mental health and peer support services, housing, and job placement.

AGENCY-SPECIFIC CLIENT FOCUS GROUPS

PWH accessing services at AIDS Healthcare Foundation, AIDS Outreach Center, CAN Community Health, JPS Healing Wings, Preventive Medicine Clinic, Salvation Army Fort Worth, and Samaritan House were invited to participate in two-hour, in-person focus groups at each agency. Group size was limited to fifteen individuals who were recruited by case managers to reflect the diversity of each organization. Approximately 70 PWH participated.

Conversations focused on accessing HIV care in Tarrant County, living with HIV, and thoughts on what needed to be done to end the HIV epidemic.

Discussion Highlights

- For PWH moving to the jurisdiction, connecting to Ryan White services and ADAP was difficult.
- Clients would have liked more access to peers and support groups to cope with their diagnosis.
- Similar paperwork needs to be completed at multiple organizations.
- Services seemed rushed. Providers didn't take time to have in-depth conversations with clients.
- HIV stigma is prevalent throughout the community. Clients have a fear of letting people know their status. In multiple groups, participants shared they would never disclose their HIV status outside of their medical care—not even to children.
- Clients appreciate the services they receive and named specific case managers, peer navigators, or providers who had made a difference in their life.
- Navigating enrollment and ongoing eligibility for Ryan White services and ADAP is challenging.
- Clients are not sure what services are available to them. Additionally, when they discuss services needs with some case managers or peer navigators, they are not always referred to providers (concerns about staff awareness of available services).
- Priority needs: Housing, mental health services, substance use services, support groups, and services provided in Spanish.

Ending the HIV Epidemic

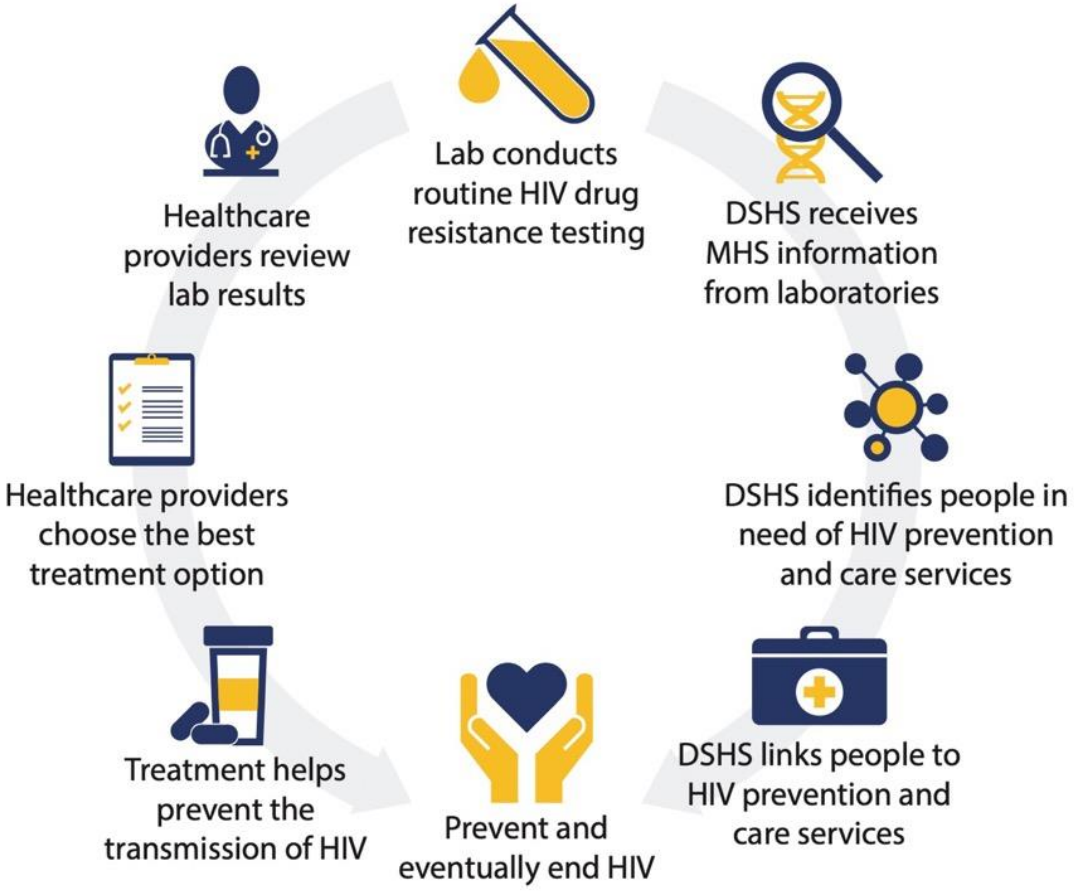
- Increase awareness and use of HIV testing and PrEP/PEP, especially among homeless people, substance users, and young adults.
- Increase community knowledge of basic HIV education and Undetectable=Untransmittable.
- Implement social media initiatives.
- Provide education in churches about HIV.

COMMUNITY ENGAGEMENT RELATED TO MOLECULAR HIV SURVEILLANCE

Molecular HIV Surveillance (MHS) is the routine collection of HIV genetic information by health departments from hospitals, medical providers, and laboratories. This information is collected during an HIV drug resistance test ordered by an HIV medical care provider. Testing requires a blood sample. The genetic information that is collected is not the genetic information of the person but the genetic information of HIV. This data helps to identify potential public health emergencies and monitor health conditions.

The Texas Department of State Health Services (TX DSHS) is responsible for developing statewide policies and procedures related to collecting, storing, and using MHS data to identify and respond to HIV clusters and outbreaks.

Figure 13: How TX DSHS Uses Molecular HIV Surveillance Data



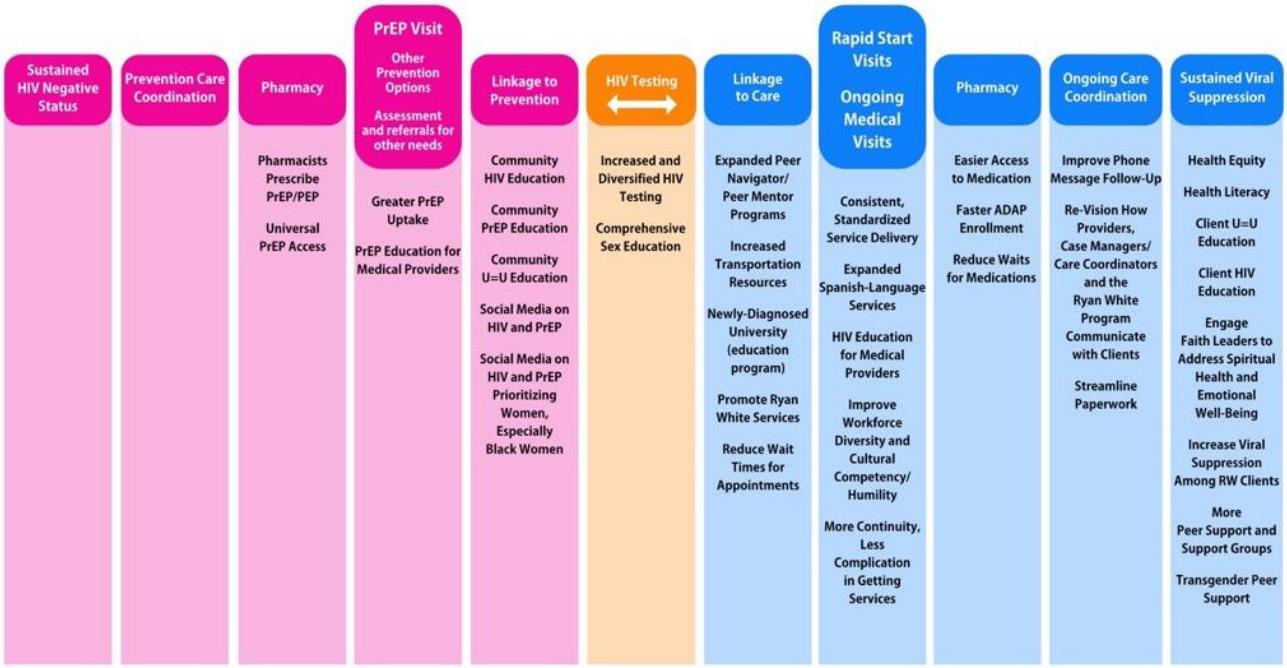
At the time of the release of this Plan, TX DSHS is working to establish a strategy to engage with communities statewide to inform of the MHS plan. The TCPH Adult Health Services is collaborating in this effort and will coordinate local engagement efforts on behalf of TX DSHS.

The Administrative Agency is working with Tarrant County Public Health Preparedness, the TCPH Adult Health Services, PWH, and the community to establish a programmatic plan to respond to HIV outbreaks, aligned to the existing county emergency plan.

EVALUATION

The results of the PWH engagements were compiled and evaluated. Strategies were then plotted along each step on the Status-Neutral Continuum of Care.

Figure 14: PWH EHE Strategies Plotted Along the Status-Neutral Continuum of Care

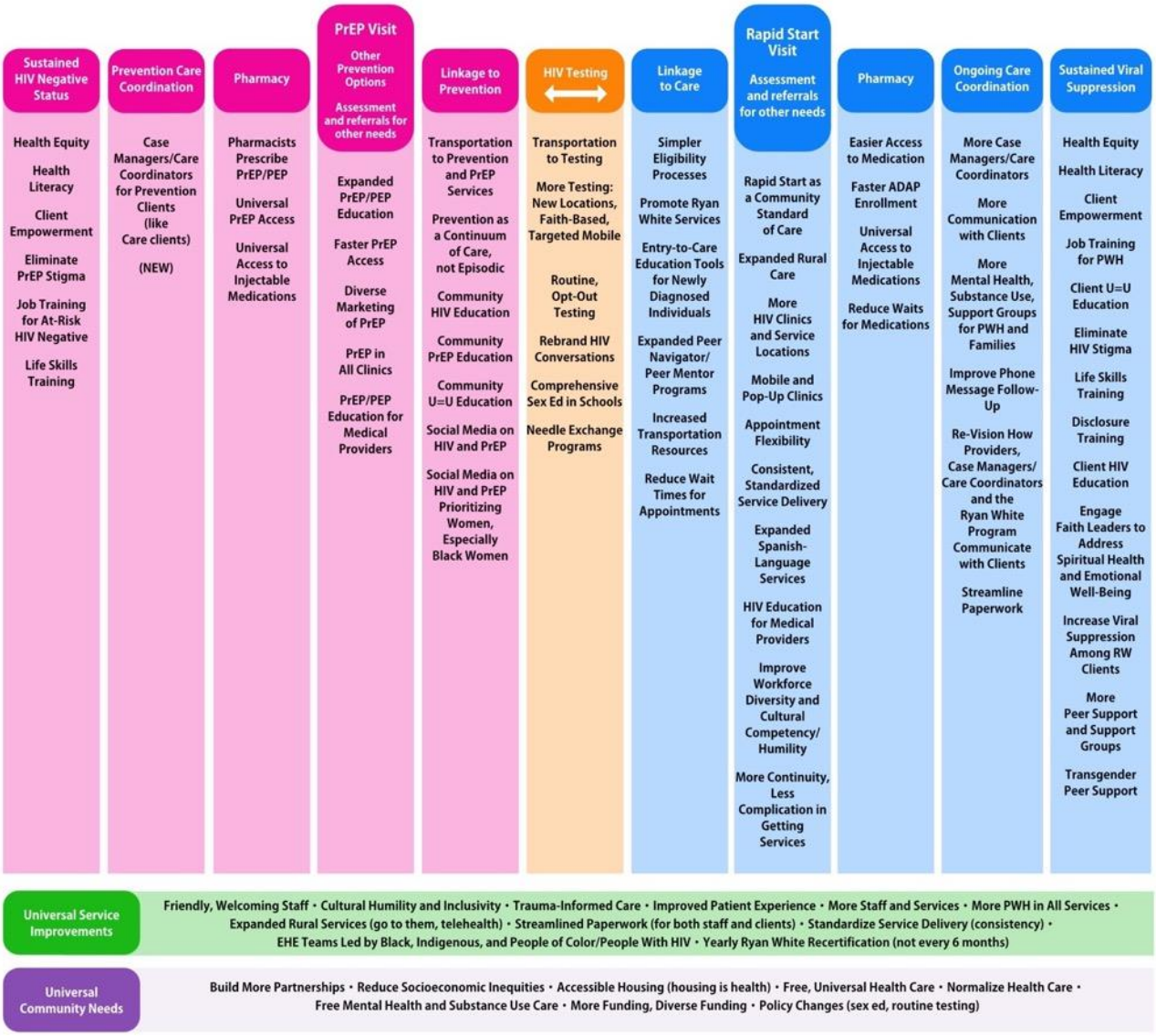


SECTION 2.1f: PRIORITIES

COMBINED STRATEGIES FROM ALL ENGAGEMENT ACTIVITIES

The strategies identified during engagement activities were plotted in relevant steps along the status-neutral continuum of care. Strategies that addressed universal service improvement and community needs were plotted along the entire continuum.

Figure 15: Combined Strategies from All Engagement Activities, Plotted Along the Status-Neutral Continuum of Care



EVALUATION AND DETERMINATION OF STRATEGIC PRIORITIES

Discussion topics, comments, and ideas generated during all the engagement activities and the Pre-Planning Research and Review were compiled and evaluated. Each strategic focus identified during engagement process was then ranked as a high, moderate, or low priority based on how often they were mentioned.

Table 3: Ranking of Priorities by Strategic Focus According to Input Group and Pre-Planning Research and Review

Strategic Focus	PWH and Community Stakeholders	HIV Leaders	Planning Council and Prevention Partnership	Administrative Agency, TCPH AHS	Pre-Planning Research and Review
Access to Care	High	High	High	High	High
Client-Centered Initiatives/Priority Populations	High	High	High	High	High
Collaboration/Relationships	NA	High	High	High	Moderate
Community Connection/Planning	Moderate	Moderate	Moderate	Moderate	Moderate
Condoms	Low	Low	Low	Moderate	Low
Cultural Humility and Competency	High	Moderate	Moderate	High	High
Faith Community Collaboration	Low	NA	Low	Moderate	Low
Funding	High	High	Moderate	High	High
Health Literacy	High	Moderate	Low	High	High
HIV Testing	High	High	High	High	High
Housing	High	High	High	High	Low
Innovation	NA	Moderate	Moderate	High	High
Social Media Initiatives	High	High	High	High	Moderate
Outreach	Moderate	NA	Moderate	Moderate	Low
Peer Mentoring	High	Moderate	Moderate	High	Moderate
Policy Revision	Low	Moderate	Moderate	Moderate	Moderate
PrEP/PEP	Moderate	High	High	High	High
Provider Education	Moderate	Moderate	Low	High	High
Rapid Start Linkage to Care	Low	High	High	High	High
Sex Ed Reform, Community HIV Education	High	High	High	High	High
Syringe Service Programs/Harm Reduction	NA	High	Low	High	Low
Stigma Reduction	High	High	High	High	High
Systems Improvement/ Data Collection & Use	Low	High	Moderate	High	Moderate
Undetectable=Untransmittable	Moderate	High	Moderate	High	High

The CPC used these rankings to determine the final strategic priorities to address in the Integrated Plan.

Results of all engagement activities and draft Plan components were presented to the full Planning Council each month. After Council review, content was shared with the community for review and feedback.

The final goals, objectives, strategies, and activities developed for the Plan were approved by the Planning Council on November 1, 2022.

HOW PEOPLE WITH HIV WILL BE INCLUDED IN THE IMPLEMENTATION, MONITORING, EVALUATION, AND IMPROVEMENT PROCESS OF THE INTEGRATED PLAN

This Plan was developed with extensive input from PWH. Comprehensive participation from PWH will continue as the Plan is implemented and evaluated.

The Planning Council is mandated to have reflective PWH representation, with at least 33% of its members identifying as living with HIV. The Administrative Agency will implement and evaluate the Plan's activities. PWH and others from the community are given time, as needed, to inform the work being completed as part of the Plan. Additionally, the community can provide feedback and comments via the Administrative Agency's website.

The **Integrated Plan Workgroup** meets at least three times per year and is tasked with guiding the implementation of the Plan. At each of its meetings, the Integrated Plan Workgroup reviews the progress toward completing activities defined in the Plan and evaluates the outcomes for each strategy. Time is provided on the agenda for PWH/public feedback.

The **Prevention Partnership** meets quarterly to complete a similar review of the activities that are being led by the TCPH Adult Health Services.

Annually, the Administrative Agency conducts **listening sessions, focus groups, and needs assessments of PWH** in the jurisdiction. Each of these initiatives will include components to gather feedback on the Plan's activities.

In 2018, the Administrative Agency's Continuous Quality Improvement program established a PWH quality consumer advisory board called the **Health Improvement Team (HIT HIV)**. Members complete comprehensive quality and leadership training and then meet regularly to inform the Ryan White Program's quality monitoring and evaluation. HIT HIV will meet monthly to review performance and outcome data collected during the implementation of the Plan to provide feedback and recommendations.

SECTION 2.1g: UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

The completed Texas Integrated Plan/SCSN is unavailable.

SECTION 3: CONTRIBUTING DATA SETS AND ASSESSMENTS

SECTION 3.1: DATA SHARING AND USE

LIST OF DATA USED TO INFORM THE DEVELOPMENT OF THIS PLAN

- HIV surveillance reports and data tables provided by TX DSHS.
- STI surveillance reports and data tables provided by TX DSHS.
- HIV testing program data provided by the Administrative Agency and TCPH Adult Health Services
- Ryan White Program service utilization and quality management data provided by the Administrative Agency.
- HOPWA utilization data provided by the Administrative Agency.
- Qualitative and quantitative data gathered from PWH, those at risk for acquiring HIV, and community stakeholders, including:
    - 2020 Improving Health Outcomes For Youth And Young Adults With HIV Study
    - 2021 Study of HIV in Rural Areas
    - 2021 Ryan White Part A Client Satisfaction Survey
    - 2020-2021 Tarrant County HIV Taskforce's Ending the HIV Epidemic Program Report
    - Achieving Together: A Community Plan To End HIV In Texas

Please refer to **Section 3.4: Needs Assessment** for a comprehensive summary of the findings and recommendations for these reports.

SUMMARY OF HOW DATA WAS ANALYZED AND USED TO SUPPORT PLANNING

Please refer to **Section 2: Community Engagement And Description Of Jurisdictional Planning Process** for a comprehensive summary of how data was analyzed and used to support planning.

DESCRIPTION OF DATA SHARING AGREEMENTS AND FOR WHAT PURPOSE

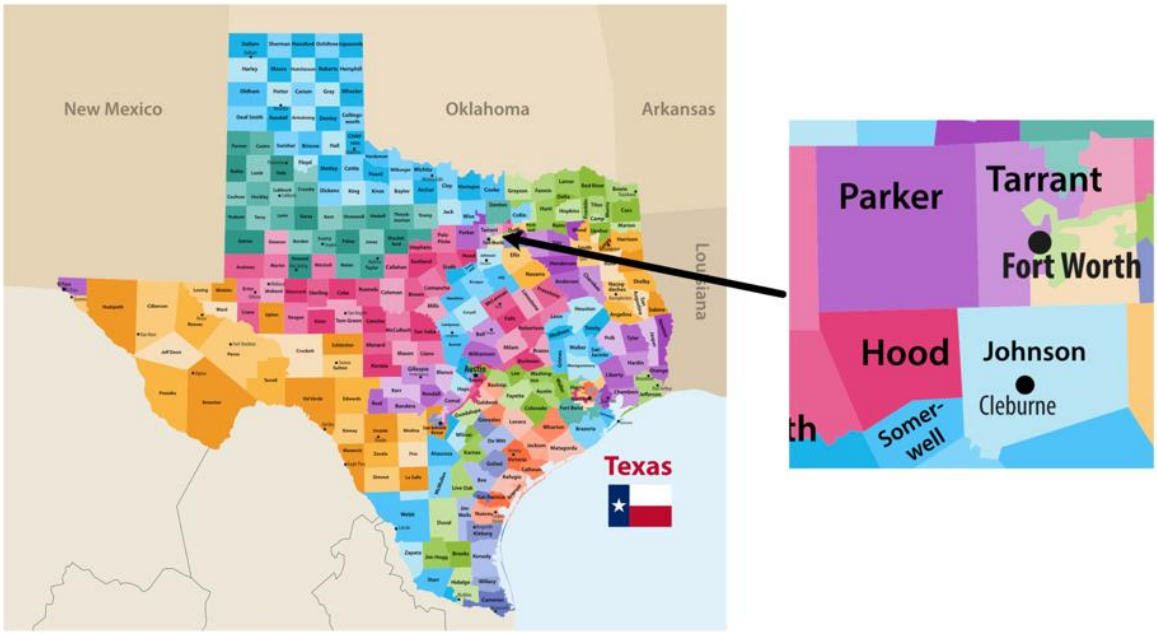
Ryan White Program Subrecipients are required to enter all client-level data into the Provide Enterprise system, which is a real-time, HIV/AIDS data management system including financial management and report writing features. The system has been highly customized for the Administrative Agency, and uses unique identifiers to record client information, service utilization, care plans, case notes, demographic, medical, and eligibility data. Provide Enterprise generates the Ryan White Services Report for federal data submissions. Subrecipients that are medical clinics also utilize their own electronic medical records and import clinical data into Provide Enterprise.

The Administrative Agency receives epidemiological data from the Texas Department of State Health Services (TX DSHS). This data set is typically provided on an annual basis for the preceding year.

A challenge exists related to requesting specific epidemiological and other prevention-related data for use in planning and evaluation. Currently, the Administrative Agency is unable to make unique data requests due to a conflict as to whether the local TCPH Adult Health Services or TX DSHS has the authority to enter into a data sharing agreement. This issue is currently under review.

SECTION 3.2: EPIDEMIOLOGICAL SNAPSHOT

Figure 16: Fort Worth-Arlington Transitional Grant Area



The Part A Fort Worth-Arlington TGA is comprised of Tarrant, Hood, Johnson, and Parker counties, located in north-central Texas. The TGA encompasses over 2,918 square miles with the service area inclusive of the urban areas of Fort Worth and Arlington as well as rural geographic areas. According to the U.S Census Bureau, the City of Fort Worth was the fastest-growing large city between 2010 and 2020 with a population increase of 177,000, or a nearly 19.3 percent increase during the ten years. Fort Worth is the 13th overall largest city in the United States.

In 2020, Fort Worth's population was 2,500,387 with 6,660 (TX DSHS 2019) people with HIV/AIDS. The TGA's population is 48.6% White, 28.4% Hispanic, and 16% Black/African American. The gender split is roughly 50% females and 50% males. The populations demonstrate disparities when comparing general U.S. Census data statistics and the state surveillance of newly diagnosed HIV cases. For example, Black/African Americans account for 16% of the general population, yet account for 45.8% of new HIV diagnoses. While the number of individuals who identify as MSM figures is not known, men make up 50% of the general population and account for 83.6% of new HIV diagnoses. Youth under 24 years of age make up a staggering 27.7% of newly diagnosed cases.

HIV incidence has averaged 316 cases annually over the last 5 years. Priority populations include youth under 24 years of age, MSM, and Black women.

The data utilized for this summary is compiled from the most currently available surveillance data provided by TX DSHS, which is calendar 2019. The total number of people with HIV in the TGA grew by 8.6% between 2017and 2019, from 6,086 to 6,660. The percentage of males increased by 8.2%; MSM increased by 9.5%, from 3,451 to 3,812. The group aged 25 to 34 increased by 12.2%; from 1,226 to 1,397. Overall, the population of people with HIV in the TGA was comprised of 76.2% male and 23.8% female. Men who have Sex with Men (MSM) made up 57.2% of people with HIV, with heterosexual men and women accounting for 24.2%. Blacks were 42.0%, Whites were 28.4%, and Hispanics were 23.5% of the overall HIV population. Those aged 45 to 54 made up the largest percentage of the overall HIV population, 25.1%.

Table 4: HIV and AIDS Incidence in the Fort Worth TGA, 2016 to 2020

	2016	2017	2018	2019	2020
Total	321	312	299	325	325
Sex at birth					
(M) Male	267	256	240	257	272
(F) Female	54	56	59	68	53
Gender identity					
Transgender women	7	1	1	2	1
Transgender men	1				
Cisgender Women	53	56	59	68	53
Cisgender Men	260	255	239	255	271
Age at diagnosis					
0-14	2			3	1
15-24	88	73	82	76	89
25-34	106	113	105	119	107
35-44	52	52	50	61	58
45-54	42	49	41	42	42
55-64	25	23	16	20	21
65+	6	2	5	4	7
Race/ethnicity					
American Indian/ Native Alaskan	2				
Asian	9	1	6	2	8
Black	147	148	124	154	149
Latino/a	81	83	89	94	82
Native Hawaiian/ Pacific Islander				1	
White	67	72	72	67	79
Multi-race	15	8	8	7	7
Mode of transmission groups*					
Gay and bisexual men and other men who have sex with men (MSM)	222	212	206	208	234
People who inject drugs (PWID)	13	12	16	25	17
Male PWID	7	6	4	10	7
Female PWID	6	6	12	15	10
MSM/PWID	11	10	9	15	12
Men who have sex with women (MSW) and Women who have sex with men (WSM)	74	77	69	74	61
MSW	26	27	22	23	18
WSM	48	50	47	51	43
Statewide priority populations					
Latino/a MSM	54	60	67	69	70
Black MSM	89	95	84	87	101
White MSM	52	49	44	40	52
Black WSM	32	33	21	34	28
Transgender people	8	1	1	2	1

Data Source: TX DSHS 2019

Table 5: HIV Incidence in the Fort Worth TGA, 2017 to 2019

	2017			2018			2019		
	Count	%	Rate	Count	%	Rate	Count	%	Rate
TOTAL	314	100	13	297	100	12.1	315	100	12.7
Sex at Birth									
(F) Female	56	17.83	4.6	59	19.87	4.7	67	21.27	5.3
(M) Male	258	82.17	21.8	238	80.13	19.8	248	78.73	20.4
Race									
(1) White, not Hispanic	75	23.89	6	72	24.24	5.8	68	21.59	5.5
(2) Black, not Hispanic	148	47.13	43	122	41.08	34.3	149	47.3	40.6
(3) Hispanic	82	26.11	12.6	90	30.3	13.4	90	28.57	13.1
(4) Other	1	0.32	0.8	6	2.02	4.5	3	0.95	2.2
(5) Multi-race	8	2.55	17.8	7	2.36	15.1	5	1.59	10.4
Age									
0-1	0	0	0	0	0	0	3	0.95	4.7
02-12	0	0	0	0	0	0	0	0	0
13-24	72	22.93	18	81	27.27	19.9	73	23.17	17.7
25-34	115	36.62	32.7	103	34.68	28.9	117	37.14	32.4
35-44	54	17.2	16.7	51	17.17	15.4	58	18.41	17.2
45-54	49	15.61	15.4	41	13.8	12.9	41	13.02	13
55-64	22	7.01	7.8	16	5.39	5.5	19	6.03	6.5
65+	2	0.64	0.7	5	1.68	1.7	4	1.27	1.3
Mode of Transmission									
MSM	214	68.18		204	68.75		202	64.1	
IDU	12	3.69		15	5.02		28	8.95	
MSM/IDU	10	3.28		8	2.83		14	4.6	
Heterosexual	78	24.84		70	23.4		67	21.4	
Pediatric	0	0		0	0		3	0.95	
Adult Other	0	0		0	0		0	0	

Data Source: TX DSHS 2019

Table 6: AIDS Incidence in the Fort Worth TGA, 2017 to 2019

	2017			2018			2019		
	Count	%	Rate	Count	%	Rate	Count	%	Rate
TOTAL	133	100	5.5	129	100	5.3	140	100	5.6
Sex at Birth									
(F) Female	33	24.81	2.7	26	20.16	2.1	28	20	2.2
(M) Male	100	75.19	8.4	103	79.84	8.6	112	80	9.2
Race									
(1) White, not Hispanic	38	28.57	3.1	30	23.26	2.4	30	21.43	2.4
(2) Black, not Hispanic	52	39.1	15.1	51	39.53	14.3	60	42.86	16.3
(3) Hispanic	36	27.07	5.5	37	28.68	5.5	47	33.57	6.9
(4) Other	0	0	0	6	4.65	4.5	2	1.43	1.5
(5) Multi-race	7	5.26	15.6	5	3.88	10.8	1	0.71	2.1
Age									
0-1	0	0	0	0	0	0	1	0.71	1.6
02-12	0	0	0	0	0	0	0	0	0
13-24	15	11.28	3.7	15	11.63	3.7	14	10	3.4
25-34	37	27.82	10.5	40	31.01	11.2	44	31.43	12.2
35-44	29	21.8	8.9	29	22.48	8.8	35	25	10.4
45-54	31	23.31	9.7	28	21.71	8.8	25	17.86	7.9
55-64	18	13.53	6.4	14	10.85	4.9	18	12.86	6.1
65+	3	2.26	1.1	3	2.33	1	3	2.14	1
Mode of Transmission									
MSM	72	54.44		84	65.04		81	57.79	
IDU	13	9.7		4	3.33		15	10.71	
MSM/IDU	7	5.26		4	3.02		12	8.43	
Heterosexual	41	30.6		36	27.83		30	21.64	
Pediatric	0	0		1	0.78		2	1.43	
Adult Other	0	0		0	0		0	0	

Data Source: TX DSHS 2019

Table 7: HIV Prevalence in the Fort Worth TGA, 2017 to 2019

	2017			2018			2019		
	Count	%	Rate	Count	%	Rate	Count	%	Rate
TOTAL	3055	100	126.5	3227	100	131.7	3458	100	139.3
Sex at Birth									
(F) Female	721	23.6	58.6	779	24.14	62.3	851	24.61	67.2
(M) Male	2334	76.4	197	2448	75.86	203.8	2607	75.39	214.2
Race									
(1) White, not Hispanic	831	27.2	66.8	862	26.71	69.2	898	25.97	72.1
(2) Black, not Hispanic	1345	44.03	390.3	1434	44.44	402.7	1562	45.17	425.6
(3) Hispanic	679	22.23	104.2	738	22.87	110.2	811	23.45	118.2
(4) Other	62	2.03	47.9	59	1.83	44.4	54	1.56	39.7
(5) Multi-race	138	4.52	307.2	134	4.15	288.9	133	3.85	276.7
Age									
0-1	0	0	0	0	0	0	2	0.06	3.1
02-12	17	0.56	4.4	16	0.5	4.1	11	0.32	2.8
13-24	267	8.74	66.6	261	8.09	64.2	254	7.35	61.7
25-34	888	29.07	252.7	924	28.63	259.1	1023	29.58	283
35-44	653	21.37	201.5	728	22.56	220.2	774	22.38	230.2
45-54	687	22.49	215.4	688	21.32	216.5	698	20.19	221
55-64	432	14.14	152.5	467	14.47	158.4	527	15.24	171.4
65+	111	3.63	0	143	4.43	0	169	4.89	0
Mode of Transmission									
MSM	1876	61.41		1962	60.8		2093	60.53	
IDU	229	7.51		237	7.35		267	7.72	
MSM/IDU	140	4.57		156	4.85		155	4.47	
Heterosexual	743	24.31		803	24.87		873	25.25	
Pediatric	63	2.06		65	2.01		66	1.91	
Adult Other	4	0.13		4	0.12		4	0.12	

Data Source: TX DSHS 2019

Table 8: AIDS Prevalence in the Fort Worth TGA, 2017 to 2019

	2017			2018			2019		
	Count	%	Rate	Count	%	Rate	Count	%	Rate
TOTAL	3060	100	126.7	3100	100	126.5	3202	100	129
Sex at Birth									
(F) Female	717	23.43	58.3	724	23.35	57.9	733	22.89	57.9
(M) Male	2343	76.57	197.8	2376	76.65	197.8	2469	77.11	202.9
Race									
(1) White, not Hispanic	992	32.42	79.7	972	31.35	78	993	31.01	79.7
(2) Black, not Hispanic	1172	38.3	340.1	1209	39	339.6	1237	38.63	337
(3) Hispanic	684	22.35	105	700	22.58	104.6	755	23.58	110.1
(4) Other	46	1.5	35.6	53	1.71	39.9	54	1.69	39.7
(5) Multi-race	166	5.42	369.5	166	5.35	357.8	163	5.09	339.2
Age									
0-1	0	0	0	0	0	0	1	0.03	1.6
02-12	3	0.1	0.8	3	0.1	0.8	2	0.06	0.5
13-24	52	1.7	13	39	1.26	9.6	34	1.06	8.3
25-34	352	11.5	100.2	373	12.03	104.6	374	11.68	103.5
35-44	603	19.71	186.1	602	19.42	182.1	612	19.11	182
45-54	1038	33.92	325.5	995	32.1	313	973	30.39	308.1
55-64	784	25.62	276.8	815	26.29	276.5	882	27.55	286.9
65+	228	7.45	0	273	8.81	0	324	10.12	0
Mode of Transmission									
MSM	1588	51.91		1645	53.08		1719	53.69	
IDU	451	14.72		439	14.17		446	13.93	
MSM/IDU	252	8.23		241	7.79		252	7.86	
Heterosexual	724	23.64		729	23.51		741	23.15	
Pediatric	31	1.01		32	1.03		32	1	
Adult Other	15	0.49		13	0.42		12	0.37	

Data Source: TX DSHS 2019

Table 9: Combined HIV and AIDS Prevalence in the Fort Worth TGA, 2015 to 2019

	2015		2016		2017		2018		2019	
	#	%	#	%	#	%	#	%	#	%
Total	5502	100	5834	100	6115	100	6327	100	6660	100
HIV	2610	47.4	2865	49.1	3055	50	3227	51	3458	51.9
AIDS	2892	52.6	2969	50.9	3060	50	3100	49	3202	48.1
(F) Female	1338	24.3	1394	23.9	1438	23.5	1503	23.8	1584	23.8
(M) Male	4164	75.7	4440	76.1	4677	76.5	4824	76.2	5076	76.2
(1) White, not Hispanic	1769	32.2	1809	31	1823	29.8	1834	29	1891	28.4
(2) Black, not Hispanic	2158	39.2	2341	40.1	2517	41.2	2643	41.8	2799	42
(3) Hispanic	1181	21.5	1273	21.8	1363	22.3	1438	22.7	1566	23.5
(4) Other	93	1.7	105	1.8	108	1.8	112	1.8	108	1.6
(5) Multi-race	301	5.5	306	5.2	304	5	300	4.7	296	4.4
0-1	0	0	0	0	0	0	0	0	3	0
02-12	23	0.4	23	0.4	20	0.3	19	0.3	13	0.2
13-24	319	5.8	322	5.5	319	5.2	300	4.7	288	4.3
25-34	996	18.1	1147	19.7	1240	20.3	1297	20.5	1397	21
35-44	1240	22.5	1228	21	1256	20.5	1330	21	1386	20.8
45-54	1681	30.6	1730	29.7	1725	28.2	1683	26.6	1671	25.1
55-64	993	18	1096	18.8	1216	19.9	1282	20.3	1409	21.2
65+	250	4.5	288	4.9	339	5.5	416	6.6	493	7.4
MSM	2987	54.3	3229	55.3	3464	56.7	3607	57	3812	57.2
IDU	683	12.4	689	11.8	680	11.1	676	10.7	713	10.7
MSM/IDU	416	7.6	415	7.1	391	6.4	398	6.3	407	6.1
Heterosexual	1309	23.8	1392	23.9	1466	24	1532	24.2	1615	24.2
Pediatric	89	1.6	90	1.5	94	1.5	97	1.5	98	1.5
Adult Other	18	0.3	19	0.3	19	0.3	17	0.3	16	0.2

Data Source: TX DSHS 2019

The prevalence of HIV within the jurisdiction has been increasing since 2013. Using TX DSHS prevalence data, the count of HIV positive individuals increased from 5,106 in 2013 to 6,660 in 2019. This growth is quadratic in nature (with R^2=0.9921). This means that the model selected for forecasting proceeding years should be accurate to a high degree. Without intervention, or strong and direct public health strategies, the jurisdiction may reach a critical point in which the population model may turn exponential. This would lead to a much higher burden on health care systems within the TGA in attempting to care for newly diagnosed and people with HIV.

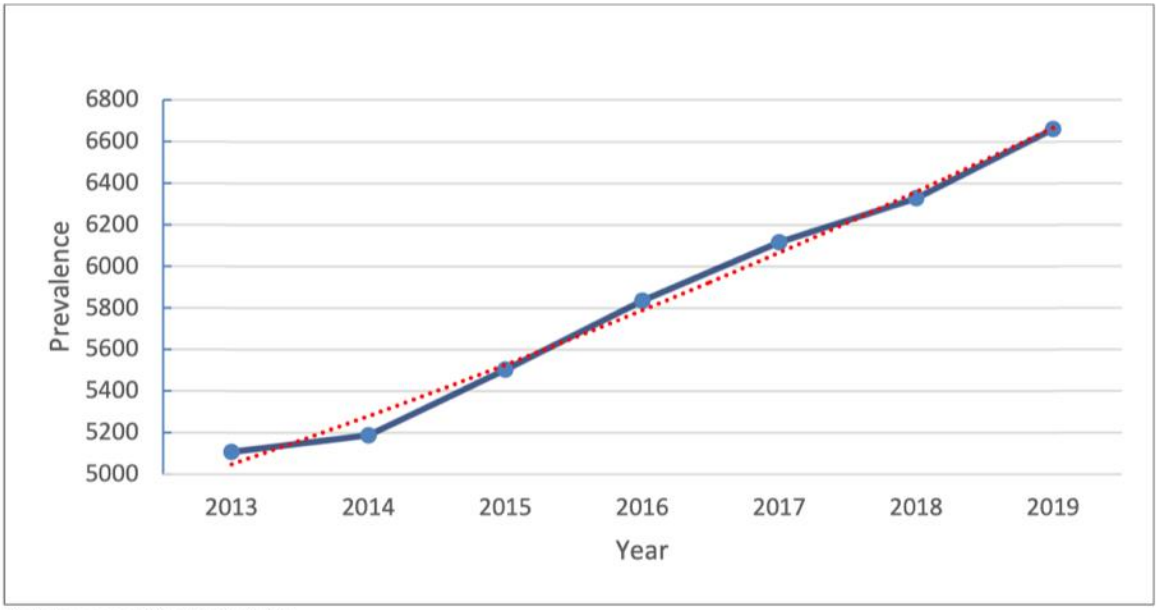
Table 10: HIV/AIDS Prevalence Over Time, 2013 to 2019, and Predicted Prevalence for 2020 and 2021

	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total	5106	5186	5502	5834	6115	6327	6660	6990	7328
HIV	2328	2395	2610	2865	3055	3227	3458	—	—
AIDS	2778	2791	2892	2969	3060	3100	3202	—	—
Female	1273	1313	1338	1394	1438	1503	1584	—	—
Male	3833	3873	4164	4440	4677	4824	5076	—	—

*Data Source: TX DSHS 2019; *Predicted increase for subsequent years computed by the Administrative Agency*

Using this model, prevalence for 2020 can be predicted to be close to 6,990, and by 2021 this could be as high as 7,328. Modeling is made significantly more difficult by the fact that 2020 was disrupted by COVID- 19. The consistent growth seen within the jurisdiction may be fully apparent two or three years after 2020.

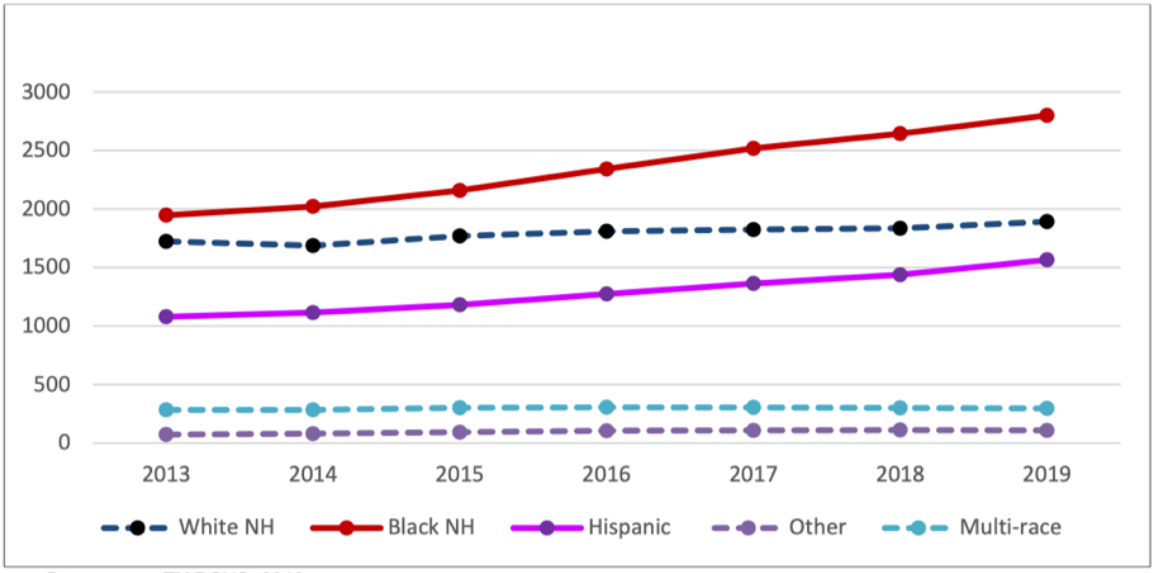
Figure 17: HIV/AIDS Prevalence, Fort Worth TGA, 2013 to 2019



Data Source: TX DSHS; 2019

While the total count of those living with HIV has steadily increased over time, this growth has not been seen equitably throughout the jurisdiction. Looking at the number of positive individuals categorized by sex at birth, males have been steadily linearly increasing since 2013, with nearly 220 males being added to the prevalence total per year. Females, on the other hand, have grown at about 25% of the rate that males have grown. This difference means that messaging, branding, outreach, intervention, prevention, and so many other internal items need to be able to reach a broader range of the population.

Figure 18: Prevalence by Race/Ethnicity, Fort Worth TGA, 2013 to 2019



Data source: TX DSHS; 2019

Incorporating race/ethnicity demonstrates how Black and Hispanic populations have seen a rise in the prevalence in HIV/AIDS yet other populations have either decreased or remained constant over time.

Table 11: Estimated Percentage of PWH in the Fort Worth TGA Who Are Living With Diagnosed HIV and the Estimated Number of Residents Living With Undiagnosed HIV, 2015 to 2019

	2015		2016		2017		2018		2019	
	Percent of PLWH with a diagnosis	People with undiagnosed HIV	Percent of PLWH with a diagnosis	People with undiagnosed HIV	Percent of PLWH with a diagnosis	People with undiagnosed HIV	Percent of PLWH with a diagnosis	People with undiagnosed HIV	Percent of PLWH with a diagnosis	People with undiagnosed HIV
Total	*80.9%*	*1,298*	*83.3%*	*1,166*	*84.9%*	*1,085*	*85.3%*	*1,092*	*87.3%*	*973*
Sex at birth										
Male	80.1%	1,036	82.2%	960	83.5%	923	84.2%	907	87.1%	750
Female	89.2%	162	87.1%	206	89.9%	162	92.7%	119	94.2%	98
Age group (yr.)										
13-24	43.7%	411	49.5%	328	54.1%	271	54.3%	252	56.0%	226
25-34	58.6%	704	60.4%	753	62.0%	760	61.4%	816	62.7%	830
35-44	77.5%	360	76.8%	372	78.5%	344	83.7%	259	88.0%	189
45-54	84.1%	319	86.5%	270	86.3%	275	81.9%	373	79.3%	435
>=55	88.8%	157	86.5%	216	91.5%	145	92.3%	141	96.0%	80
Race/ethnicity										
Black	79.9%	542	80.7%	559	83.9%	483	85.3%	457	87.2%	412
Latinx/Latino	78.7%	319	79.6%	327	80.2%	337	83.1%	293	90.7%	160
White	88.5%	231	86.1%	291	86.8%	277	85.7%	306	86.9%	286
Transmission group										
Gay and bisexual men and other men who have sex with men	76.6%	913	80.7%	771	82.5%	736	83.9%	693	84.7%	688

Estimated percentage of Fort Worth TGA PLWH who are living with diagnosed HIV and the estimated number of residents living with undiagnosed HIV

Estimates include PLWH 13+, and only groups with stable estimates are shown

Estimates are best available as of March 2021, and may change if estimation methods change or if data are updated

Note that subgroups may not add up to the total because of the way the estimates are produced. This is especially true of age groups.

Table 2. Estimated HIV prevalence among persons aged >=13 years, by selected characteristics, 2010-2017 — Fort Worth

Table 12 below includes available socio-demographic data for people with HIV in the TGA who are newly diagnosed and demonstrates which are at higher risk of HIV. This data includes 2019 statistics due to the prevalence data being available only through 2019 so the incidence and prevalence data sets align.

Table 12: People with HIV by Race/Ethnicity, Gender, and Age, Fort Worth TGA, FY2019

Characteristics	1) TGA Newly Diagnosed (n=315)	2) TGA People withHIV (n=6,660)	3) TGA People at HigherRisk of Contracting HIV
Race/Ethnicity			
White	21.6%	28.4%	**NEWLY DX BLACKS 47.3%**
Black	**47.3%**	42.0%	
Hispanic	28.6%	23.5%	
Gender			
Male	**78.7%**	76.2%	**MALES 78.7%**
Female	21.3%	23.8%	
Transgender	NDA	NDA	
Age			
Under 12	0.1%	0.2%	**AGES 25-44 55.0%**
13-24 years	23.2%	4.3%	
25-44 years	**55.0%**	41.7%	
45-54 years	13.2%	25.1%	
55+	7.0%	28.5%	
Mode of Transmission			
MSM IDU	**64.1%**	57.2%	**MSM 64.1%**
MSM/	9.0%	10.7%	
IDU	4.6%	6.1%	
Heterosexual	21.4%	24.2%	
Other Characteristics			
Homeless	NDA	**3.9%****	**HOMELESS 3.9%****
Formerly Incarcerated	NDA	1.7%**	
Federal Poverty Level			
100% and below	NDA	5.9%**	**Under 100% FPL****
101%-199%	NDA	15.0%**	
200%-399%	NDA	30.0%**	

*Data Sources: TX DSHS eHARS 2019; **TX DSHS eHARS 2018; NDA=no data available.*

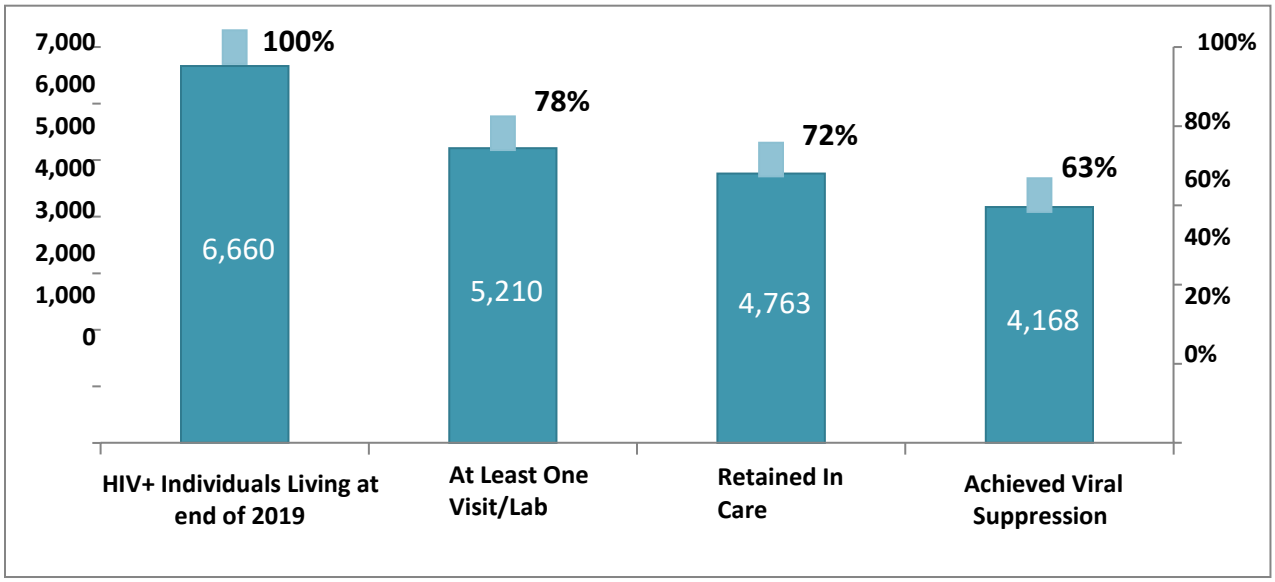
Overall, the number of new diagnoses in FY2017 to FY2019 increased by 9.0%. The percentage of Blacks being newly diagnosed was unchanged from 2017 to 2019, however, this is not reflective of the continually disproportionate impact of HIV on this subpopulation.

Table 13: Percentage Change of Newly Diagnosed Individuals, 2017 to 2019

Newly Diagnosed	2017	2018	2019	% Change
Total	312	298	315	9.0%
Black	149	125	149	0.0%
Hispanic	78	82	90	13.3%
13-24	71	82	73	2.7%
25-34	114	104	117	2.5%
MSM	213	206	202	-5.4%

Data Source: TX DSHS 2019

Figure 19: Fort Worth TGA HIV Care Continuum, 2019



DATA SOURCE: TX DSHS as described below:
HIV+ Individuals at end of 2019 - No. of HIV+ individuals (alive) at the end of 2019
At Least One Visit in 2019 - No. of people with HIV with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2019
Retained in Care is number of people with HIV with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2019
Achieved Viral Suppression at end of 2019 - No. of people with HIV whose last viral load test value of 2019 was <= 200 copies/m

PWH IN CARE, BUT NOT VIRALLY SUPPRESSED

The Fort Worth TGA is focusing efforts on addressing clients in care and not virally suppressed in an attempt to make significant viral load suppression (VLS) improvements. The overall VLS for clients in care but not virally suppressed is 20% in the within unmet need category. The three priority populations are demonstrating a large percentage of clients in care, but not virally suppressed need as reflected in the tables below. The TGA is going to maximize and leverage funding by focusing on improving VLS rates for clients in care and not virally suppressed. The in care and not virally suppressed portion of the unmet need framework has been ranked the highest priority by the Fort Worth TGA since the clients are already engaged in services. The approach is aimed at making the biggest impact in the shortest amount

of time. In addition, once the enhanced unmet need calculations are obtained services can be adjusted to meet client needs.

Table 14: PWH In Care, But Not Virally Suppressed Within Categories, 2021

	In Care, Not Virally Suppressed Within Categories	Need Identified	Intervention/ Programming	Outcomes/ Anticipated results
	11.2%			
Black MSM	19.0%	high	Rapid Start, Outpatient Ambulatory Health Services (OAHS), Stigma reduction campaigns and EIS - link clients into the RWHAP- implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need
Hispanic MSM	9.8%%	low	Rapid Start, Outpatient Ambulatory Health Services, Stigma reduction campaigns and EIS link clients into RWHAP implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need
Young Adults 18 to 30	13.7%	high	Rapid Start, Outpatient Ambulatory Health Services (OAHS), Stigma reduction campaigns and EIS link clients into RWHAP- implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need

Table 15: PWH In Care, But Not Virally Suppressed Across Categories, 2021

	In Care, Not Virally Suppressed Within Categories	Need Identified	Intervention/ Programming	Outcomes/ Anticipated results
	100%			
Black MSM	10.7%	high	Rapid Start, Outpatient Ambulatory Health Services (OAHS), Stigma reduction campaigns and EIS - link clients into the RWHAP - implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need
Hispanic MSM	19.2%	high	Rapid Start, Outpatient Ambulatory Health Services, Stigma reduction campaigns and EIS link clients into RWHAP - implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need
Young Adults 18 to 30	47.1%	high	Rapid Start, Outpatient Ambulatory Health Services (OAHS), Stigma Reduction campaigns and EIS link clients into RWHAP – implement VLS quality improvement (QI) projects at all sub-recipients	Reduce VLS rates by linking eligible clients into the RWHAP – Decrease VLS % of clients with an unmet need

Table 16: Co-Occurring Conditions Among PWH in the Fort Worth TGA, 2018

Co-Occurring Condition	% Among People with HIV in TGA 2018 (n=6,290)	
	n (=)	%
Chlamydia	120	1.9%
Gonorrhea	165	2.6%
Syphilis	267	4.2%
Hepatitis C	NDA	NDA
Homelessness/Unstably Housed	46	0.7%
Former Incarceration	106	1.7%
Mental Illness	NDA	NDA
Substance Use Disorder	NDA	NDA

CO-OCCURRING CONDITIONS

People with HIV are often vulnerable to co-occurring conditions such as sexually transmitted infections (STI), hepatitis C virus (HCV), and tuberculosis (TB). People with HIV may also struggle with co-occurring conditions such as mental health and/or substance use disorders, homelessness, and/or incarceration. Any of these conditions can complicate treatment, reduce its effectiveness, and hamper treatment adherence.

Sexually Transmitted Infection Rates, Including Syphilis, Gonorrhea, And Chlamydia

TX DSHS Sexually Transmitted Disease Management Information System (STD*MIS) reports that in 2018, chlamydia was still the most reported STI in the TGA, with 10,581 new reported diagnoses. The total number of people with HIV and co-occurring chlamydia increased from 92 to 120. Among people with HIV diagnosed with chlamydia, males represent the highest number at 107 or 90%; Blacks with chlamydia and HIV accounted for 44%, and MSM with both diagnoses were at 82%.

Among people with HIV in the TGA, gonorrhea rose to 6,125 or 97%. For people with HIV with co-occurring gonorrhea, males represent the highest count at 157 or 95%, ages 25-34 were 90 or 55%, and MSM were reported at 142 or 86%.

The number of overall syphilis diagnoses have increased in the TGA, from 502 to 540, and the number of people with HIV with co-occurring syphilis diagnoses increased from 142 to 267. Males represent 97% of these diagnoses; 42% were Black; 51% were between the ages of 25-34; and 88% identified as MSM.

Hepatitis C Virus

The HIV treatment guidelines that recommend screening for HCV, STI, and TB are not uniformly followed, and asymptomatic STIs and HCV infections may go undetected. Clinicians may not test for STI in the anus or throat, which also allows infections to go undetected. Finally, the way public health disease reporting is carried out can also affect the statistics of co-infections. For example, in Texas, only acute HCV infections are reported, not chronic infections. Without knowing how many infections are ongoing, it is not possible to get a clear idea of the number of people with HIV who also have HCV infections.

Homeless/Unstably Housed

The 2019 Tarrant County Homeless Coalition's (TCHC) "Point in Time Count" of people experiencing homelessness counted 2,028 individuals as homeless. 27 of those, or 1%, reported an HIV/AIDS diagnosis. The TGA's Ryan White clients have access to housing programs funded by both Housing and Urban Development (HUD) and HOPWA in response to identified needs. In addition, RWHAP Part A and CARES Act funding has been allocated to Housing.

Former Incarceration

Texas state prison inmates are typically released into the legal county of residence reported at intake. The most recent data from Texas Department of Criminal Justice (TDCJ) reports the total of HIV positive inmates released in FY2018 was 638, of which 34 (5%) were released to Tarrant County. Newly released HIV positive individuals have immediate needs, among which health care typically ranks very low in priority. Their need for housing, employment, and transportation tend to take precedence. Upon release in Tarrant County, TDCJ provides a referral to a local Ryan White service provider. Unless recently released individuals experience rapid linkage to OAHS and support services, they are likely to delay treatment, which causes them to present for care with higher acuity. It should be noted that incarceration information may not be collected during a Ryan White intake process. Although clients are

asked to report their living situation, unless a client self-identifies as being recently released from jail or prison, this information is not captured in client records.

Mental Illness

Mental health data is difficult to obtain, yet the economic burden of mental health treatment remains significant. In the most recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), the 2019 Texas Behavioral Health Barometer reports during 2017–2019, the annual average prevalence of past-year mental health service use among those with any mental illness in Texas was 39.5% (or 1.4 million), lower than both the regional average (41.2%) and the national average (43.6%). Further, it is reported that in a single-day count in March 2019, 35,995 people in Texas were enrolled in substance use treatment—an increase from 35,293 people in 2015.

In the Planning Council's 2019-2021 Needs Assessment, 41% of respondents stated they had depression; 38% had anxiety; and 19% indicated they had bipolar disorder. At the time of this writing, the Planning Council is exploring conducting a mental health study using American Rescue Plan Act (ARPA) funding to better understand mental health needs of people with HIV. There is concern that COVID-19 has increased mental health issues due to increased social isolation. In response, TGA CARES Act funding increased access to mental health services using telemedicine.

Substance Use Disorder

The National Institute on Drug Abuse describes how substance use and abuse reduces inhibition and alters judgement, which increases high-risk behaviors such as needle sharing or engaging in unprotected sex, thereby increasing the risk of obtaining or transmitting HIV. People with HIV who are active or former substance abusers pose significant challenges for Outpatient Ambulatory Health Services (OAHS) and Oral Health Care service providers. OAHS service providers must assess possible drug-to-drug interactions when prescribing medications that may interact with illicit drugs. RWHAP-funded oral health clinics screen clients for substance use to prevent interaction with medications administered during oral care visits. In the Planning Council's 2019-2021 Needs Assessment, 28% of respondents have indicated they have used non-prescription medications in the last six months with 23% using marijuana and 5% using methamphetamines.

SECTION 3.3: HIV PREVENTION, CARE, AND TREATMENT RESOURCE INVENTORY

HIV Service Delivery in the Fort Worth TGA

The Administrative Agency manages all federal funding for HIV care and supportive services for PWH in the north-central Texas area. The service region includes the Ryan White Part A Fort Worth-Arlington TGA and a Ryan White Part B Health Service Delivery Area (HSDA). PWH from four adjacent rural counties (Somervell, Wise, Erath, and Palo Pinto) access care in the TGA, even though these counties are part of the Part B HSDA. These counties add 3,100 square miles to the overall eight-county service area.

Table 17: HIV Services Offered in the TGA, By Funding Source

Service Category	Ryan White Part A	Ryan White Part B	Ryan White Part C	Ryan White Part D	Texas Department of State Health Services: State Services	Texas Department of State Health Services: State Rebate	Housing Opportunities for People with AIDS
Early Intervention Services (EIS)	X	X					
Emergency Financial Assistance (EFA)	X		X		X		
Food Bank/Home Delivered Meals	X	X			X		
Health Insurance Premium & Cost Sharing Assistance (HIPCSA)	X	X					
HIV Counseling & Testing			X				
Housing Services			X				X
Local AIDS Pharmaceutical Assistance (LPAP)	X		X		X		
Medical Case Management	X			X			
Medical Nutrition Therapy	X	X			X		
Medical Transportation	X	X	X	X	X		
Mental Health Services	X	X	X	X	X		
Non-Medical Case Management	X	X	X	X	X		
Oral Health Services	X	X	X				
Outpatient/Ambulatory Health Services	X	X	X	X			
Outreach Services	X	X			X		
Psychosocial Support Services	X	X		X	X		
Referral for Health Care and Support Services	X	X	X	X		X	
Substance Abuse Services-Outpatient	X	X	X		X		

Ryan White Priorities and Resource Allocations

Each year, the Planning Council reviews service utilization data, epidemiological data, information gathered from needs assessments, and other data to determine the service priorities for the TGA, and the Ryan White Part A funding allocations to provide those services. Additionally, the Administrative Agency prioritizes and allocates other Ryan White funding to complement the service delivery strategies of the Planning Council.

Ryan White Part A services are classified as either Core medical services (essential, direct health care services provided to PWH), or Supportive services ('wrap around' services that address disparities and support PWH to remain in care). For Part A funding, at least 75% of each year's grant funding must be allocated to Core services, with the remaining 25% allocated to Supportive Services.

Table 18: Grant Year 2021 to 2022 Ryan White Part A, B, and State Services Allocation Distribution

				Current Allocation Distribution				
Service Category	**Type of Service**	**Priority Setting**	**Per Allocations**	**Part A**	**Part A - MAI**	**Part B**	**State Services**	**Total Allocation**
AIDS Pharmaceutical Assistance (Local)	Core	3	79,727.00	79,727.00	-	-	-	79,727.00
Case Management (Non-Medical)	Support	11	228,000.00	228,000.00	-	-	-	228,000.00
Early Intervention Services	Core	9	515,204.00	250,350.00	264,854.00	-	-	515,204.00
Emergency Financial Assistance - Medication	Support	4	46,291.00	-	-	-	46,291.00	46,291.00
Emergency Financial Assistance - Other	Support	4	25,000.00	25,000.00	-	-	-	25,000.00
Food Bank / Home Delivered Meals (Congregate)	Support	16	78,694.00	78,694.00	-	-	-	78,694.00
Food Bank / Home Delivered Meals (Food Pantry)	Support	16	126,500.00	126,500.00	-	-	-	126,500.00
Health Insurance Premium & Cost Sharing Assistance	Core	2	800,000.00	-	-	743,676.00	56,324.00	800,000.00
Housing Services	Support	12	250,000.00	250,000.00	-	-	-	250,000.00
Linguistic Services	Support	19	15,000.00	-	15,000.00	-	-	15,000.00
Medical Case Management	Core	7	650,000.00	590,000.00	60,000.00	-	-	650,000.00
Medical Nutrition Therapy	Core	17	97,942.00	97,942.00	-	-	-	97,942.00
Medical Transportation	Support	10	150,000.00	-	-	-	150,000.00	150,000.00
Mental Health Services	Core	8	200,000.00	200,000.00	-	-	-	200,000.00
Oral Health Care	Core	1	300,000.00	300,000.00	-	-	-	300,000.00
Outpatient/Ambulatory Health Services	Core	5	1,451,221.00	1,451,221.00	-	-	-	1,451,221.00
Psychosocial Support Services	Support	13	37,950.00	-	-	37,950.00	-	37,950.00
Referral for Health Care & Support Services	Support	6	275,116.00	-	66,606.00	-	208,510.00	275,116.00
Substance Abuse Outpatient Care	Core	19	140,000.00	140,000.00	-	-	-	140,000.00
Grand Total			**5,466,645.00**	**3,817,434.00**	**406,460.00**	**781,626.00**	**461,125.00**	**5,466,645.00**
			Core	81%	80%	95%	12%	77%
			Support	19%	20%	5%	88%	23%

Prevention and Care Resource Inventory

The prevention and care resource inventory illustrates the comprehensive landscape of services available in the Fort Worth TGA. The resource inventory outlines the services maximizing public and private funding to address prevention and care service needs.

Table 19: Resource Inventory for Prevention and Care Services

Program/Services	Funder	Sites/Models
Routine HIV Testing	Private	AIDS Healthcare Foundation
	TX DSHS/CDC	AIDS Outreach Center
	Public	Tarrant County Hospital District, JPS Health Network-Healing Wings
	TX DSHS/CDC	TC Public Health Preventive Medicine Clinic

Program/Services	Funder	Sites/Models
Routine HIV Testing (cont.)	TX DSHS/CDC TX DSHS/CDC Public/Private Private Public Title X/Private Private Private Private Private	CAN Community Health Health Education Learning Project My Health My Resources of Tarrant County Collins Family Planning Clinic Urgent Care of Texas Hamid Burney Internal Medicine Prime Care Family Practice Lighthouse Family Medicine
Routine HIV Testing – ED's	Public/Private	Tarrant County Hospital District, JPS Health Network-Healing Wings
Routine HIV testing-Substance Use programs	Private	Integrated Outreach Services (Priority Populations Homeless, Substance Use and Youth priority populations)
Routine HIV Testing – Universities	Private	Integrated Outreach Services – Youth, TCU Health Education Learning Project
HIV Testing - mail	Public	Tarrant AA partnership with NASTAD/UCLA
HIV Testing pharmacy	Private	CVS Minute Clinics & Walgreens
Partner Services = DIS	TX DSHS/CDC	Tarrant County Public Health
Health Education Risk Reduction	TX DSHS/CDC	Tarrant County Public Health
Linkage to Care/Early Intervention Services	TX DSHS/CDC	Tarrant County Public Health
HIV Outreach services	CDC/TX DSHS/EHE Prevention	One Safe Place CAN Community Health Celebrate U Chris Howell Foundation-HIV Education
Data to Care – Surveillance data	CDC/TX DSHS/EHE Prevention	Tarrant County Public Health
PEP	Private Public	AIDS Outreach Center CAN Community Health Health Education Learning Project Texas Centers for Infectious Disease

Program/Services	Funder	Sites/Models
		Tarrant County Hospital District, JPS Health Network-Healing Wings
PrEP (prescribing)	Public Private	Tarrant County Hospital District, JPS Health Network-Healing Wings Health Education Learning Project AIDS Healthcare Foundation CAN Community Health Lighthouse Family Medicine Texas Centers for Infectious Disease Associates PrimeCare Family Practice Urgent Care of Texas Hamide Burney Internal Medicine
Tele PrEP	Private	CAN Community Health Health Education Learning Project
PrEP Navigation	Public	Health Education Learning Project
PrEP Assistance	Private	CAN Community Health Health Education Learning Project
Condon distribution	TX DSHS/CDC/ Public	Tarrant County Public Health AIDS Outreach Center Health Education Learning Project One Safe Place CAN Community Health Celebrate U Chris Howell Foundation-HIV Education
Evidence Based HIV Interventions	TX DSHS/CDC Public	Tarrant County Public Health
Prevention Case management/addressing social determinants of health (SDOH)	Public	Tarrant County Public Health HELP-LGBT/youth empowerment
Social marketing/ information distribution	TX DSHS/CDC/EHE	Tarrant County Public Health
STI Testing	TX DSHS/CDC	Tarrant County Public Health - Preventive Medicine Clinic Collins Family Planning Clinic

Program/Services	Funder	Sites/Models
	Public Title X/Private Private	Health Education Learning Project CAN Community Health Urgent Care of Texas Hamid Burney Internal Medicine Prime Care Family Practice Lighthouse Family Medicine
Outbreak Response		Department of State Health Services Tarrant County Public Health

LEVERAGING PUBLIC AND PRIVATE FUNDING SOURCES

Completing the resource inventory identified that while Ending the HIV Epidemic initiatives have supported the jurisdiction with increased funding, there are currently limited opportunities for new relationships or collaborations. The existing continuum of care and prevention services for PWH has had few new entities begin to offer services. The programs listed above tend to be very siloed, with limited engagement outside of their traditional partners.

Engaging non-traditional partners to take part in the development of this Plan did not result in any new entities taking action to begin or increase HIV prevention and care programming.

The Administrative Agency was recently awarded a competitive HOPWA grant. The Administrative Agency is also participating in a housing collaborative to build jurisdictional capacity for a readily accessible repository of housing resources. The collaborative is working to identify non-traditional housing partners.

Substance use prevention and treatment services receive partial funding from the TCPH Adult Health Services. Most providers within the HIV continuum of care provide referrals to these and other agencies.

SECTION 3.3a: STRENGTHS AND GAPS

Strengths, Gaps and Opportunities of the HIV Prevention System

Strengths

- There are many locations to obtain an HIV test in Fort Worth.
- Mail-order HIV testing initiative is available locally.
- The Administrative Agency is working with the Tarrant County Hospital District to establish routine testing in its Emergency Department.
- HIV testing occurs within substance use programs, along with risk reduction education.
- HIV testing occurs at universities.
- There are PrEP/PEP providers throughout the community to provide services for clients.
- Tele-PrEP services are available for clients providing additional access options.
- There are PrEP navigators to help clients access PrEP.
- There are multiple agencies funded for evidence-based HIV prevention programming.
- There is significant condom distribution, including condoms by mail.
- One local prevention provider is implementing prevention-based case management to address social determinants of health.
- The Disease Intervention Services program has adequate staffing to perform duties.
- Agencies have health educators for risk reduction counseling.
- Linkage to care specialists are guiding newly diagnosed clients into care quickly.
- Agencies are adapting non-local social media campaigns to address HIV education, provide PrEP/PEP information, and reduce HIV stigma.

Gaps

- Only one Emergency Department is conducting routine HIV screenings.
- There is not a lot of HIV testing being done outside of the Fort Worth urban area.
- Priority populations are unaware of PrEP as an HIV prevention tool.
- Non-HIV providers lack knowledge about PrEP/PEP.
- There are not enough local PrEP/PEP navigators.
- Emergency Department providers do not have education about the 72-hour time limitation for PEP initiation.
- Data sharing agreements are not in place to allow for program enhancements to be made so local funding can be maximized.
- Disease Intervention Services staff need training and development opportunities.
- Outreach programs need to be data-driven, with results shared with the community to ensure program coordination and to maximize resources.
- There is limited HIV testing in primary/OB care settings.
- School-based HIV education and outreach is limited, and difficult to revise without significant community effort.
- An HIV outbreak response plan is still in development.
- HIV criminalization laws are not science-based and need to be revised.
- There are no local harm reduction programs.

Opportunities

- Increase the number of hospitals, community clinics, and urgent care centers conducting routine HIV testing.
- Improve data sharing across the prevention and care systems to improve health equity and geographic disparities amongst priority populations.
- Enhance geographic data reporting and sharing so prevention and care service providers can develop targeted programming to enhance health outcomes and reduce barriers to care while addressing social determinants of health.
- Conduct quarterly meetings prevention and care to review where clients are testing positive and ensure these sites are linking clients into care.
- Conduct community meetings between testing sites, DIS, and other entry points to care to discuss the current system and what enhancements need to occur to ensure services are provided to clients.
- Increase PrEP awareness among priority populations.
- Fund more PrEP navigators.
- Expand PrEP services to include injectable antiretrovirals.
- Educate providers about PEP resources and the importance of starting PEPE within the 72 hours.
- Outreach to medical providers to increase the number of local PrEP providers.
- Ensure transportation resources are available to improve access to HIV/STI testing and PrEP/PEP services.
- Ensure DIS has enhanced training to improve the client experience related to partner services.
- Implement initiatives within the prevention system to promote a status-neutral approach to services.
- Ensure outreach coordination with local providers that submit positive HIV lab results.
- Enhance HIV testing in primary care settings throughout the TGA including the providers that submit other positive STI screens.
- Engage the faith community to increase HIV awareness and reduce stigma.
- Ensure Data to Care is coordinated with local HIV care providers to monitor clients erratically in care, quickly link clients into care, or get clients back into care quickly.
- Determine the feasibility of implementing harm reduction programs to improve outreach and HIV testing efforts to at-risk populations.
- Continue to fund social media campaigns aimed at reducing the stigma around HIV.

Strengths, Gaps and Opportunities of the HIV Care System

Strengths

- The Administrative Agency skillfully coordinates a variety of funding sources: Ryan White Part A, Part B and Part B rebates, Part C, Part D, EHE Care, and HOPWA funding to maximize care programming and resources for clients.
- There are robust services within the TGA to reduce potential barriers to care.
- The Administrative Agency intentionally funds programs in zip codes of high incidence that typically have lower health outcomes.
- Funding from the Minority AIDS Initiative focuses on clients that are disproportionately impacted by HIV to improve their health outcomes.
- Rapid Start is funded at the largest hospital system to ensure clients are quickly provided medications and access to ongoing HIV medical care.

- Rapid Start Linkage to Care within seven days of an HIV diagnosis or presenting for reentry to care is being established as a jurisdiction-wide standard of care.
- There is robust funding for Early Intervention Services (EIS) throughout the TGA to ensure that clients that are newly diagnosed, erratically-in-care, or out-of-care have the support needed to enter and engage in care.
- Early Intervention Services have been implemented with the local jail to ensure that PWH with an upcoming release date can be linked into care and supportive services before discharge.
- Medical Case Management is funded throughout the TGA to ensure clients have the supportive care to achieve positive health outcomes.
- Outpatient Ambulatory Health Services is funded throughout the TGA at large and small clinics to ensure clients have access to health care.
- The Administrative Agency has created a local medication program to address clients' medication needs that are not met by ADAP.
- There is a robustly funded Health Insurance Premium Costs Sharing Assistance program to support clients financially to obtain health insurance, and cover co-pays and deductibles.
- There are multiple choices for Oral Health services within the TGA.
- There are multiple choices for Mental Health Services throughout the TGA.
- Multiple housing programs have coordinated their funding to maximize local resources.
- Food services Medical Nutrition Therapy Services are available to clients within the TGA.
- Emergency Financial Assistance programming is available to support emergency medication and living needs.
- The Administrative Agency has developed a social media campaign focused on addressing HIV stigma.

Gaps

- Rapid linkage to HIV care is not available at all hospitals and clinics.
- Substance use programs are available, but accessibility is challenged by long wait times to enter services.
- The state ADIS Drug Assistance Program has extended enrollment timeframes and wait times for medication distribution.
- Affordable housing is in short supply.
- In-person support groups are a need for clients.
- Review health outcomes by service categories and work with providers to improve viral load suppression rates and improve health outcomes by adjusting programming as needed.
- Early Intervention Specialists, Case Managers, and Medical Case Managers need additional training on the availability of local programs and resources.
- Many agencies have experienced significant staff turnover, resulting in significant training needs.
- Subrecipient staff do not have comprehensive knowledge of what other grant resources are available through the TGA.
- Standards of care need to be consistent among providers and align with each funders' requirements.
- There is a lack of current epidemiological data to use for planning and service implementation.

Opportunities

- The Administrative Agency has prioritized contracting with additional substance use providers.
- The Administrative Agency continues to ramp up Rapid Start programming.

- Increase the number of in-person PWH support groups.
- Review service categories by viral load suppression rates to identify opportunities to improve health outcomes and service delivery.
- Ensure newly diagnosed, new-to-care, or returning-to-care clients understand the importance of rapid linkage to care and U=U information.
- Complete an ongoing training assessment for Subrecipient staff.
- Improve communications to promote the availability of Ryan White and other HIV services.
- Ensure Subrecipients are trained on the standards of care for services they provide.
- Require providers to implement clinical quality improvement projects, especially those focused on improving viral load suppression.
- Improving ADAP responsiveness and performance could allow for funding to be reallocated to other service needs.
- Implement data-sharing agreements between the Administrate Agency and the TCPH Adult Health Services so data can be shared for local program enhancements.
- Implement a Data to Care program using client-level data in coordination with local Subrecipients.
- Establish online TGA-specific dashboards for HIV services and epidemiological data.

SECTION 3.3b: APPROACHES AND PARTNERSHIPS

To complete the resource inventory, Administrative Agency and TCPH Adult Health Services staffs were interviewed about the jurisdiction's partners funded by the Health Services and Resources Administration, The Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, Housing Opportunities for Persons Living with AIDS, the National Institutes of Health, and Medicaid. Entities identified by the programs were contacted to gather further information.

SECTION 3.4: NEEDS ASSESSMENT

As part of the pre-planning review and evaluation, the following needs assessment activities and other information were used to inform goals and objectives in this submission.

2019 to 2021 Comprehensive Needs Assessment Study

The Planning Council completed this assessment to inform their priority setting and resource allocations to address gaps in services and unmet needs in the TGA and develop directives for core medical and support services. More than 500 PWH who receive Ryan White-funded services participated.

Goals of the Assessment

- Define the demographics and commonalities/differences of Ryan White clients.
- Gain a better understanding of the service needs and usage of clients who are virally suppressed, and those who are not virally suppressed.
- Collect data to inform service priorities, allocation of resources, and service directives.
- Identify gaps and barriers that keep clients from accessing services, or hinder engagement and retention in care.
- Assess client awareness of U=U and other HIV topics.
- Recommend service delivery strategies that would overcome client-identified issues engaging in care.

Key Findings

- Clients should be able to access multiple services at the same location and the ability to use insurance are important considerations for deciding where they access medical care.
- Hardest things about using HIV services: Too much paperwork or repetitive paperwork not wanting others to know they are getting HIV services, getting transportation, fear of being reported to immigration services, and services are not available on evenings or weekends.
- The most used services were Medical Care, Dental Care, Medication Assistance, Food Pantry or Meals, and Case Management
- Needed services included Dental Care, Housing, Emergency Financial Assistance, Support Groups, and Mental Health Services
- 68% of all respondents had their first medical appointment within 30 days of their HIV diagnosis.
- 92% of respondents reported they have received medical care within the past 6 months. Primary reasons others have not received medical care; no insurance, in jail, no transportation, can't afford medications, homeless, and just now getting into care.
- At some point in their life, 23% of participants reported they had stopped getting HIV care or taking meds for at least six months. Reasons included homelessness, being in prison, substance use, losing or not having a job, no transportation, and depression.

Recommendations

- Decrease the amount of paperwork clients need to complete to receive services.
- Increase accessibility to care by providing services on weekends or evenings.
- Increase provider cultural humility.
- Expand provider capacity to offer multiple services at the same location.
- Increase community awareness of the full range of services offered by the Ryan White Program.

2020 Improving Health Outcomes For Youth And Young Adults With HIV Study

The Administrative Agency commissioned this study to determine if there is opportunity to strengthen capacity to respond to the changing health care landscape and increase access to high quality youth- and young adult-centered care and services for low-income, uninsured, and underserved youth and young adults with HIV. Thirty youth/young adult client of the Ryan White program were interviewed.

Goals of the Assessment

- Evaluate the effectiveness of existing service delivery for youth and young adults with HIV.
- Evaluate client demographics and viral suppression data in the Provide Enterprise data system for youth aged 18 to 24.
- Conduct interviews with Ryan White clients aged 18 to 24 regarding their experiences transitioning to adult care or being diagnosed and entering HIV care as a youth. Other interview topics include accessing care, barriers to care, stigma, patient experiences, and other issues.
- Recommend service delivery strategies that would overcome client-identified issues engaging in care, to improve health outcomes for youth and young adults with HIV.

Key Findings

- Nearly all youth interviewed had strong, engaging, positive relationships with their pediatric medical providers.
- Participants felt that care providers for adults were not invested in creating patient/provider relationships like they had with their pediatric providers.
- Much of the "heavy work" of being a young person with HIV was managed for the individual by their provider or a family member (appointments, prescription fills, etc.).
- Many participants were concerned about the real or perceived lack of privacy at an adult provider.
- Youth providers offered simplified HIV education and messaging.
- Regardless of how the patient/provider relationships were perceived, participants believed the quality of care and the HIV knowledge of staff was consistent between youth and adult providers.
- Some newly diagnosed youth waited longer than expected to attend their first medical appointment.
- Case managers were viewed as caring, hard-working, and readily available when needed.
- While some parents remained involved in a participant's HIV care once they transitioned to an adult provider, other parents distanced themselves during the transition.

Recommendations

- Entry-to-care education materials for newly-diagnosed youth.
- Create transitional Peer Mentor/Peer Navigation Programs.
- Establish formal offboarding/onboarding programs for youth transitioning from pediatric to adult HIV care.
- Implement rapid linkage to HIV medical care (first medical appointment and medication dose within seven business days from diagnosis or presentation for care).

2021 Study of HIV in Rural Areas

This study was completed to identify opportunities to strengthen services for clients residing in rural areas of the TGA. PWH were asked questions about access to care, barriers to care, stigma issues, and their experiences receiving care. The assessment included 16 client interviews, completion of 49 client satisfaction surveys, and four provider interviews.

Goals of the Assessment

- Summary of demographics for rural clients and study participants.
- Interviews and surveys with rural HIV clients currently in HIV care, regarding access to care, barriers to care, stigma, patient/provider experiences, and other issues.
- Recommend service delivery strategies that would improve health outcomes for rural clients with HIV.

Key Findings

- Clients were satisfied with the service and care they received from their medical providers
- Participants did not have a good understanding of what Ryan White services they were receiving, or that were available to them.
- Clients needed more transportation resources.
- Peer mentor/peer navigation services would help clients remain engaged in care and address loneliness and mental health concerns.

- Media initiatives that focus on stigma reduction, general HIV education, and viral suppression are needed.

Recommendations

- Ensure clients understand the Ryan White services that are available to them.
- Increase transportation resources for clients within rural areas.
- Establish peer mentor/peer navigation programs for rural clients.
- Initiate HIV media initiatives addressing stigma reduction, general HIV education, and U=U.
- Implement rapid linkage to care service delivery.
- Initiate a process for the Administrative agency to communicate directly with the clients (rather than through providers).

2021 Ryan White Part A Client Satisfaction Survey

The client satisfaction survey assessed the individual-level, provider-level, and system-level services experienced by more than 330 people accessing Ryan White services in the TGA. Information from this survey informed strategies to increase the quality of services, reduce barriers to care and improve health outcomes for PWH.

Goals of the Assessment

- Comprehensively assess the level of satisfaction clients have with the services from agencies providing Ryan White-funded Primary Medical Care and Medical Case Management.
- Assess the overall level of satisfaction clients have with other Ryan White services.
- Assess the impact of the Covid-19 pandemic on the ability of clients to access services and remain engaged in care. Additionally, evaluate the financial impact clients experienced due to the pandemic.
- Develop recommendations for service delivery to increase client satisfaction with Ryan White services.

Key Findings

- Participants shared high levels of satisfaction with Ryan White services. Using a Likert scale of 1 (poor) to 5 (Excellent), all service categories were rated between 4.2 and 4.5.
- Services participants identified they needed but were unaware the service was available: Emergency Financial Assistance, Housing Assistance, Dental Services, Food Bank/Home-Delivered Meals, and Transportation, and Health Insurance Co-Pay Assistance.
- Top 10 services participants identified as most important for PWH, in order of ranking: Medical Care Services, Medications and Medication Assistance, Housing Assistance, Food Bank/Home-Delivered Meals, Mental Health Services and Support Groups, Transportation, Dental Services, Health Insurance Copay Assistance, Community Support for PWH, and Emergency Financial Assistance.
- Changes participants suggested for improving Ryan White services: better communication, expanded access to services, improved cultural humility, general service improvements, and streamlining programmatic processes.

Recommendations

- Increase viral suppression among Ryan White clients.
- Improve phone message follow-up.
- Revision how providers and the Administrative Agency communicate with clients.
- The Administrative Agency should promote Ryan White services, rather than expecting agencies to do so.
- Improve workforce cultural humility.
- Engage faith leaders to address the spiritual health and emotional well-being of PWH
- Promote Covid-19 vaccinations to PWH.

SECTION 3.4a: PRIORITIES

Priorities Identified by PWH assessment activities:

Listening Sessions with PWH

- Black Women: Transportation, skills/job training, support services specific to the needs of women, mental health services, peer navigation, and peer-led services.
- People Aging with HIV: Peer support, transportation, more funds for gas cards ("five dollars can't get me anywhere"), training for case managers and peer navigators to better understand community services, and reduced paperwork/bureaucracy.
- Young Men with HIV: Normalize HIV as a chronic disease, HIV education, and support groups/peer networking.
- Latino/a Individuals: Provider training on cultural humility, mental health services, housing, and reduced paperwork/bureaucracy.
- Newly Diagnosed Individuals: Community HIV awareness, peer support, and mental health services.
- People of Trans Experience: Mental health and peer support services, housing, and job placement.

Priorities Identified by Agency-Specific Client Focus Groups

- Housing.
- Mental health services.
- Substance use services.
- Support groups.
- Services provided in Spanish.
- Increase awareness and use of HIV testing, PrEP, and PEP, especially among people experiencing homelessness, substance users, and college-age individuals.
- Increase community knowledge of basic HIV education and Undetectable=Untransmittable.
- Implement social media initiatives.
- Provide education in churches about HIV.

2020 Improving Health Outcomes For Youth And Young Adults With HIV Study

- Streamline paperwork and bureaucracy.
- Increase accessibility to care by providing services on weekends or evenings.
- Increase provider cultural humility.
- Increase community awareness of the full range of services offered by the Ryan White Program.

2020 Improving Health Outcomes For Youth And Young Adults With HIV Study

- Education on transitioning from pediatric to adult care.
- Peer Mentors/Navigators to help adjust to adult care, especially the differences in client/provider relationships.
- Address privacy concerns.

2021 Study of HIV in Rural Areas

- Increase transportation resources.
- Expand peer mentor/navigation programs.
- Implement stigma reduction and HIV education media campaigns.
- Expand telehealth services.
- Initiate a process for the Administrative Agency to communicate directly with the clients.

2021 Ryan White Part A Client Satisfaction Survey

- Services participants identified as needed but were unaware were available to them: Emergency Financial Assistance, Housing Assistance, Dental Services, Food Bank/Home-Delivered Meals, and Transportation, and Health Insurance Co-Pay Assistance.
- Top 10 services participants identified as most important for PWH, in order of ranking: Medical Care Services, Medications and Medication Assistance, Housing Assistance, Food Bank/Home-Delivered Meals, Mental Health Services and Support Groups, Transportation, Dental Services, Health Insurance Copay Assistance, Community Support for PWH, and Emergency Financial Assistance.
- Most important changes participants would suggest for improving HIV services: better communication, expanded access to services, improved cultural humility, general service improvements, and streamlining programmatic processes.

SECTION 3.4b: ACTIONS TAKEN

In addition to informing the strategies and activities of this Plan, the needs assessment process informed a variety of initiatives. Recommendations for service delivery improvements were incorporated into the procurement language for 2022-2023 Ryan White Program services, requiring bid respondents to describe how their service delivery would address identified needs and barriers.

The recommendations of the 2021 Study of HIV in Rural Areas resulted in the HIT HIV group establishing quality improvement activities to address the issues of PWH in rural communities.

Information from the assessments supported the creation of a comprehensive HIV workforce training and development initiative, including the establishment of an annual HIV Symposium and the presentation of an ongoing training series. In 2022, these trainings included trauma-informed case management, cultural humility, medical mistrust, and HIV in the Black community, and peer navigator/care coordinator training. Participation in these training was required for staff and leadership of Ryan White-funded organizations.

Based on recommendations to improve linkages to HIV care, the Administrative Agency entered into formal agreements with local points of entry to HIV care (hospitals, urgent care clinics, etc.) to foster greater partnerships to support linking newly-diagnosed and out-of-care individuals with Early Intervention Specialists for rapid engagement in care and start of antiretroviral therapy.

SECTION 3.4c: APPROACH

The goal of completing needs assessments is to comprehensively evaluate the availability, accessibility, and acceptability of prevention and care services in the jurisdiction, including client experiences when accessing services, barriers and gaps in care, stigma and discrimination, and other issues. Assessment activities for the development of this Plan included one-to-one client interviews, online, phone, and paper surveys, virtual listening sessions, and in-person discussion groups. Depending on the focus, assessments also included provider interviews/surveys. Participants were recruited by random selection from the Ryan White client database, self-selection after seeing an email, poster, or flyer advertising the assessment, or through direct contact from a case manager or peer navigator.

An inclusive, collaborative process is used for the development, implementation, and analysis of needs assessments. The Administrative Agency, TCPH Adult Health Services, and the CPC collaborate to determine the focus of the assessment and priority population(s) to recruit. A timeline is established, as are parameters for sample size and recruitment strategies. Assessment tools are developed that asked both quantitative and qualitative questions and address programmatic and planning needs. Surveys, recruitment pieces and other materials are developed using language guided by the US Government Plain Language Guidelines, in compliance with Section 508 of the federal Rehabilitation Act that defines accessibility requirements for information and communication technology. PWH take part in test runs of the assessment, providing feedback on language, tone, comprehension, time needed to complete the assessment tool, etc.

Assessment materials are available in English and Spanish, with other language needs addressed through telephone interpreters. Assessment tools are typically designed to be completed in 15 minutes or less. A small incentive is typically provided to encourage participation.

Entities Engaged in the Process for Participant Recruitment

- Staff of community-based organizations receiving Ryan White Part A funds (AIDS Outreach Center, CAN Community Health, JPS Healing Wings, Preventive Medicine Clinic, Salvation Army Fort Worth, and Samaritan House)
- The North Central Texas HIV Planning Council
- The Tarrant County HIV Administrative Agency
- TCPH Adult Health Services
- The HIV Prevention Partnership (local prevention planning body)
- HIT HIV

SECTION 4: SITUATIONAL ANALYSIS

SECTION 4.1: SITUATIONAL ANALYSIS

Achieving Together: A Community Plan to End the HIV Epidemic in Texas discusses that local plans for must be flexible, adaptable, and actionable to fit the needs of the community. Guiding principles offer a tool for planning in complex and fast-changing times.

Stigma: Aim to remove barriers, eliminate stigma, and provide opportunities so that people from all communities can thrive and achieve optimal health and wellness.

Access: Focus on strategies that will create access to resources and services for all people and increase people's capacity to make decisions that affect themselves, their families, and their communities. Focus especially on those communities that face the biggest barriers affecting their access and ability to focus on HIV prevention, treatment, and care services.

Integration: Create an integrated system of HIV prevention, treatment, care, and advocacy across the state. Allow space for ideas and innovation to emerge and for each part of the system to function individually and collectively to their greatest capacity. Build bridges to connect people, groups, organizations, and systems to share data, resources, knowledge, funding, and support.

Empowerment: Support shared decision-making between people affected by HIV and providers and across systems. Recognize that people are experts in their own lives. Provide people with the skills, tools, and health literacy needed to navigate their health and wellbeing. Build capacity in the people and organizations working in the field so that they can be leaders and role models for the communities they serve.

Support: Promote and implement policies that will support the work in all areas of the Plan. We need supportive policies at the federal, state, local, and organizational levels. In addition to policy work by people who work within health and legislative systems, there is a role for advocates and community organizations outside of these established systems.

Community: Lasting change happens at the local level among people who are working together, without a partisan frame, to create a healthy community. To create movement around this Plan, start by strengthening existing relationships among people and organizations and reaching out to new ones. Listen and learn from multiple perspectives and build bridges with non-traditional partners and with people who have been left out of the conversation in the past. This creates opportunities to hear their stories and questions and to learn about what matters to them. Then, the work of this Plan will reflect all people who are affected by HIV.

The Fort Worth/Arlington TGA has aligned these guiding principles to the four Pillars of the Ending the HIV Epidemic Initiative:

DIAGNOSE All PWH as Early as Possible

Strengths

- Mail-order HIV testing initiative is available locally.
- HIV testing occurs within substance use programs, along with risk reduction education.
- HIV testing occurs at universities.

- The Administrative Agency has prioritized contracting with additional substance use providers.

Challenges

- Only one Emergency Department is conducting routine HIV screenings.
- There is not a lot of HIV testing being done outside of the Fort Worth urban area.
- There is limited HIV testing in primary/OB care settings.
- People in rural areas have limited HIV testing options and face significant stigma from the community.

Opportunities

- Increase the number of hospitals, community clinics, and urgent care centers conducting routine HIV testing.
- Ensure transportation resources are available to improve access to HIV/STI testing and PrEP/PEP services.
- Determine the feasibility of implementing harm reduction programs to improve outreach and HIV testing efforts to at-risk populations.
- Enhance geographic data reporting and sharing so prevention and care service providers can develop targeted programming to enhance health outcomes and reduce barriers to care while addressing social determinants of health.
- Conduct community meetings between testing sites, DIS, and other entry points to care to discuss the current system and what enhancements need to occur to ensure services are provided to clients.

TREAT PWH with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

Strengths

- The Administrative Agency intentionally funds programs in zip codes of high incidence that typically have lower health outcomes.
- Funding from the Minority AIDS Initiative focuses on clients that are disproportionately impacted by HIV to improve their health outcomes.
- There is robust funding for Early Intervention Services (EIS) throughout the TGA to ensure that clients that are newly diagnosed, erratically-in-care, or out-of-care have the support needed to enter and engage in care.
- Rapid Start is funded at the largest hospital system to ensure clients are quickly provided medications and access to ongoing HIV medical care.
- Rapid Start Linkage to Care within seven days of an HIV diagnosis or presenting for reentry to care is being established as a jurisdiction-wide standard of care.

Challenges

- Rapid linkage to HIV care is not available at all hospitals and clinics.
- The state ADIS Drug Assistance Program has extended enrollment timeframes and wait times for medication distribution.
- Many agencies have had significant staff turnover, resulting in substantial training needs.
- Clients desire to have better accessibility to HIV care—evening and weekend hours, more provider locations, more services offered by individual providers.
- Providers need to be more aware of social determinants of health and improve client satisfaction.

Opportunities

- Review health outcomes by service categories and work with providers to improve viral load suppression rates and improve health outcomes by adjusting programming as needed.
- Improve communications to promote the availability of Ryan White and other HIV services.
- Providers need to increase capacity to offer compassionate, trauma-informed, culturally humble care.
- Data sharing, and the use of data to drive service delivery needs to improve.
- Expand geographic parity of services by increasing the number of HIV providers.

PREVENT New HIV Transmissions by Using Proven Interventions, Including PrEP/PEP and Harm Reduction Programs

Strengths

- Tele-PrEP services are available for clients providing additional access options.
- Agencies are adapting non-local social media campaigns to address HIV education, provide PrEP/PEP information, and reduce HIV stigma.
- One local prevention provider is implementing prevention-based case management to address social determinants of health.

Challenges

- There is a lack of knowledge about PrEP/PEP among priority populations.
- There is a significant number of PWH who are not fully educated on viral suppression as a means of high-impact HIV Prevention (U=U).
- School-based HIV education and outreach is limited.

Opportunities

- Increase PrEP awareness among priority populations.
- Fund more PrEP navigators.
- Expand PrEP services to include injectable antiretrovirals.
- Educate providers about PEP resources and the importance of starting PEP within the 72 hours.
- Outreach to medical providers to increase the number of local PrEP providers.
- Ensure transportation resources are available to improve access to HIV/STI testing and PrEP/PEP services.
- Implement initiatives within the prevention system to promote a status-neutral approach to services.
- Increase promotion of U=U to PWH and those at-risk of acquiring HIV.
- Offer messages that promote overall health and wellness without stigma attached to mental health, substance use, and sexuality.

RESPOND Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People Who Need Them

Strengths

- TX DSHS is in the process of developing a statewide HIV outbreak response plan.
- The Administrative Agency is developing a program-specific response plan, modeling on the Tarrant County emergency response plan.

Challenges

- There is a lack of current epidemiological data to use for planning and service implementation.
- An HIV outbreak response plan is still in development.
- Data sharing agreements are not in place to allow for program enhancements that would contribute to focused geographic or population-specific initiatives for HIV testing, PrEP/PEP, and engagement/retention in care.
- There has been little engagement with the community to discuss and address issues related to Molecular HIV Surveillance.

Opportunities

- Implement data-sharing agreements between the Administrate Agency and the TCPH Adult Health Services so data can be shared for local program enhancements.
- Establish online TGA-specific dashboards for HIV services and epidemiological data.
- Implement a Data to Care program using client-level data in coordination with local Subrecipients.
- Engage community stakeholders to develop local best practices for molecular HIV surveillance.

SECTION 4.1a: SUBPOPULATIONS OF FOCUS

The Planning Council selected the following subpopulations of focus: Youth, aged 13 to 24; Black women, and Men who have Sex with Men (MSM). Justification for each selection is as follows:

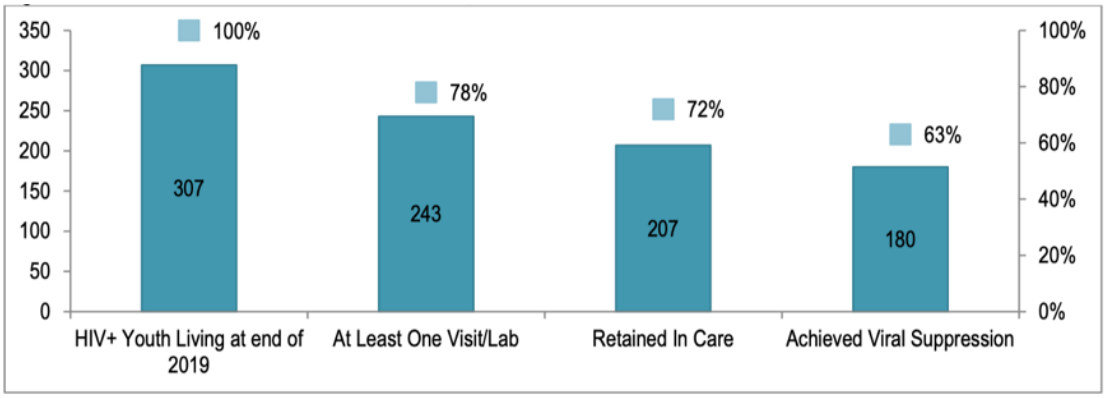
Youth aged 13 to 24

Youth, 13-24 comprise, 16.5% of the TGA population. Of all new HIV diagnosis in 2019, 23% were youth 13-24. In 2019, the most recent data available from TX DSHS, 59% of youth in the TGA were virally suppressed, and 67% were retained in care. Among the youth retained in care, 87% are virally suppressed. 79% of youth had evidence of care which indicates a single visit. TX DSHS reports that in 2018, 11% of youth had a late HIV diagnosis, and within three months of diagnosis had an AIDS diagnosis. Additionally, 17% of youth with a HIV diagnosis in 2018 were diagnosed with AIDS within 12 months (note, 2019 data on late diagnosis is not available currently). The data on the viral load suppression of youth retained in care supports the need to focus on youth engagement in care strategies along the continuum of care to increase viral load suppression and retention in care. Among youth, unmet need is at 21.5%.

According to the United States Agency for International Development, “Young people with HIV are a diverse group and their experiences and challenges vary, particularly between those infected as adolescents and those who were infected as infants and have survived with the help of increasingly effective antiretroviral therapies (ART).” Research suggests that young people find it difficult to accept an HIV diagnosis, adhere to treatment, and use HIV prevention practices. Common challenges include stigma, discrimination, and disclosure. Youth often do not place value on their health and may not see

the value in seeking treatment and remaining adherent. Youth face a myriad of social issues which impact their adherence. Housing is an important safety net for youth, yet some youths are put out of their homes when their status is known. There are limited housing options available for youth. A safe and stable place to live is critical to adhering to HIV care. Youth may have issues with disclosure and can need support and guidance on disclosing. Youth also need to feel respected and may have challenges trusting service providers. These contribute to youth of all races having the low viral load suppression.

Figure 20: Forth Worth TGA HIV Continuum for Youth, 2019



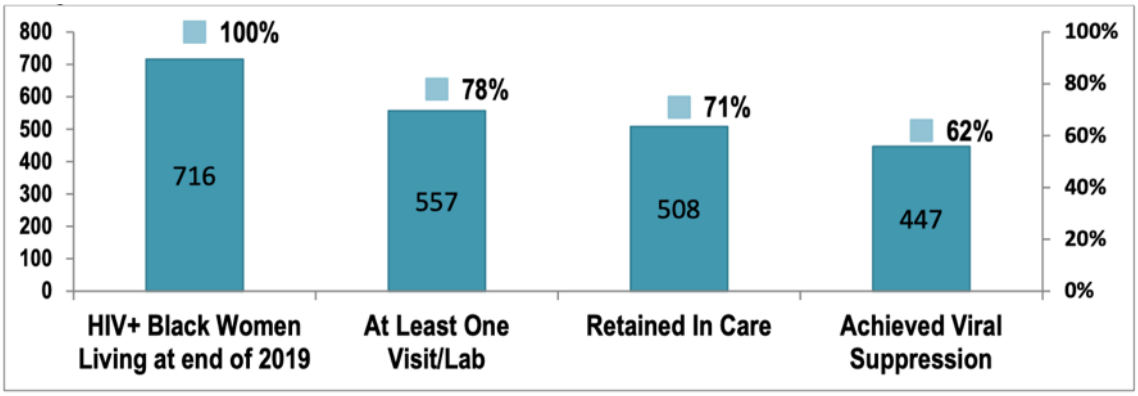
DATA SOURCE: TX DSHS as described below:
HIV+ Youth at end of 2019 - No. of HIV+ Youth (alive) at the end of 2019
At Least One Visit in 2019 - No. of Youth with HIV with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2019
Retained in Care is number of Youth with HIV with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2019
Achieved Viral Suppression at end of 2019 - No. of Youth with HIV whose last viral load test value of 2019 was <= 200 copies/mL

Black Women

Black women comprise nearly 11% of people with HIV in the TGA and represent the fourth largest population behind Black MSM (20%), White MSM (18%), and Hispanic MSM (15%). In 2019, the most recent data available from the TX DSHS, 62% of Black women in the TGA were virally suppressed, and 71% were retained in care. Among the Black women retained in care, 88% were virally suppressed. The unmet need for Black women is 22%. The needs for Black Women include linkage to care and retention in care, especially considering the social determinants of health including low income, lack of education, unstable housing, unemployment, and cultural stigma that increases Black women's risk of HIV.

In their study, African American Women and HIV/AIDS: A National Call for Health Communication Strategies to Address a Disparity, Dr. Monisha Arya, Dr. Heidi Behforouz, and Dr. Kasisomayajula Viswanath noted that, "this epidemic in African American women is fueled by many factors, including differential access to health information; disparate health care resources and exposure to prevention interventions; and gender-, societal-, and cultural-mediated barriers to prevention behaviors, initiatives to decrease the burden of HIV infection should take into account these factors and should use strategies that will reach African American communities." Black women who have HIV are likely to be living in poverty and are at risk of getting lost in the HIV system of care. Black women may be focused on basic needs such as housing, food, and employment, and HIV care is not a priority. Black women experience many other competing priorities which can undermine their ability to remain adherent to their HIV care. Another significant challenge when working with Black women is the stigma associated with having HIV. Black transgender women are more likely to deal with ongoing violence, experience marginalization, and are at a great risk of living in poverty.

Figure 21: Fort Worth TGA HIV Continuum for Black Women, 2019



DATA SOURCE: TX DSHS as described below:
HIV+ Black Women at end of 2019 - No. of HIV+ Black Women (alive) at the end of 2019
At Least One Visit in 2019 - No. of Black Women with HIV with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2019
Retained in Care is number of Black Women with HIV with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2019
Achieved Viral Suppression at end of 2019 - No. of Black Women with HIV whose last viral load test value of 2019 was <= 200 copies/mL

MSM

Based on 2019 TX DSHS data, MSM are the largest single group of people with HIV (57 %) and 64.1% of all people diagnosed with HIV in the TGA in 2018. However, the outcomes for MSM populations differ, see Figure 20 based on race. More than four out of five white individuals with HIV and three out of four Hispanics with HIV are MSM. MSM comprise more than four out of five new diagnoses in these groups. MSM are the largest group of Black individuals with HIV – they are almost half of Black individuals with HIV and three out of five newly diagnosed Blacks.

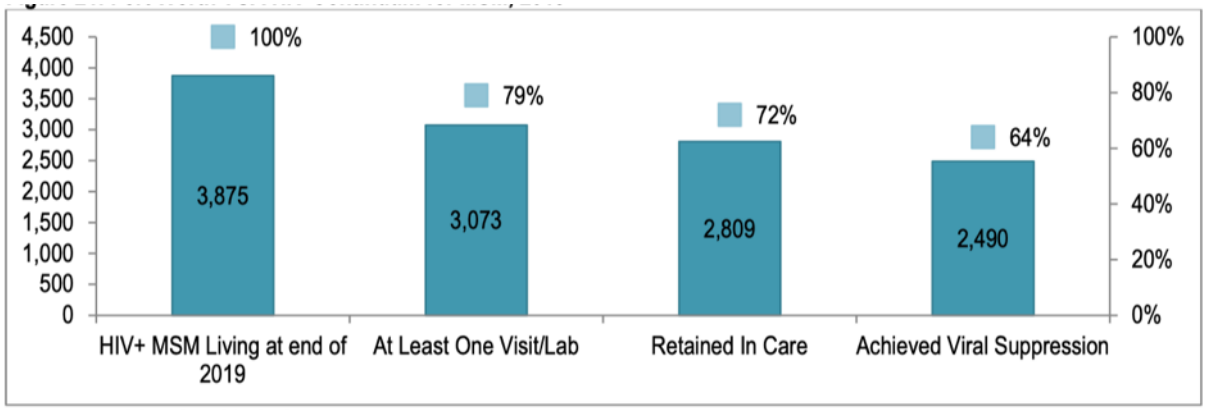
Table 22: Fort Worth TGA HIV Retention in Care for MSM by Ethnicity, 2019

MSM	Evidence of Care		Retained in Care		Suppressed		% Suppressed of Retained in Care
Black MSM	1337	76%	891	67%	745	56%	84%
Hispanic MSM	807	79%	743	73%	669	66%	90%
White MSM	1021	82%	960	77%	884	71%	92%

A key challenge for serving MSM populations is the system of care was developed to serve gay white men, and the HIV epidemic is disproportionately impacting Black males in the southern United States. The system of care needs to change to serve the growing Black population more effectively. There are disparities between the outcomes of white MSM and Black MSM populations, and new and innovative strategies are needed to improve health outcomes of the Black MSM population. Among the Hispanic MSM population, there are higher rates of late entry into care. This presents an opportunity for referring sex partners of MSM populations for PrEP services. Both viral suppression and PrEP can impact the transmission of HIV, which is critical to ending HIV.

For purposes of subpopulations, the white MSM will focus on the aging population of 65 and over. The 65+ age range has the highest unmet need at 27% among all MSM populations. Among all white MSM, the 65+ population, 34% are not virally suppressed. The white MSM population is aging, and services will need to be tailored to meet the needs of an aging population including isolation, multiple chronic illness, AIDS Survivor's Syndrome, and quality of life issues. The aging white MSM population likely didn't expect to live to be senior adults and may not be prepared for a future they didn't expect to see.

Figure 23: Fort Worth TGA HIV Continuum for MSM, 2019



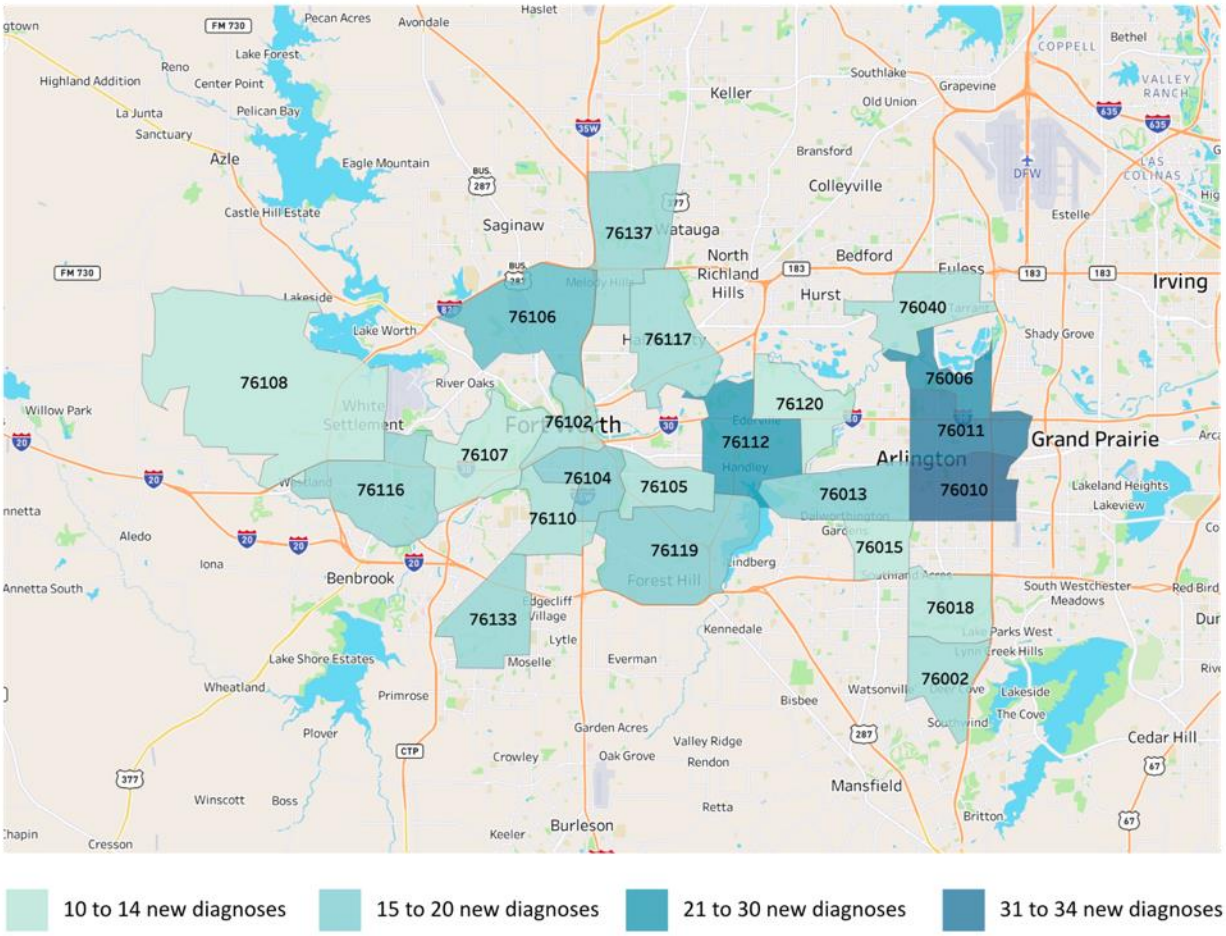
DATA SOURCE: TX DSHS as described below:
HIV+ MSM at end of 2019 - No. of HIV+ Black Women (alive) at the end of 2019
At Least One Visit in 2019 - No. of MSM with HIV with a met need (at least one: medical visit, ART prescription, VL test, or CD4 test) in 2019
Retained in Care is number of MSM with HIV with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2019
Achieved Viral Suppression at end of 2019 - No. of MSM with HIV whose last viral load test value of 2019 was <= 200 copies/mL

GEOGRAPHIC AREAS OF CONCERN

HIV/AIDS incidence data for 2018 and 2019 was combined and then mapped by zip code. Figure 22 details zip codes where ten or more newly diagnosed individuals resided at the time of their diagnosis.

Zip codes with 31 to 34 new diagnoses: 76010, 76011
Zip codes with 21 to 30 new diagnoses: 76006, 76112
Zip codes with 15 to 20 new diagnoses: 76106, 76013, 76104, 76119
Zip codes with 10 to 14 new diagnoses: 76116, 76133, 767137, 76002, 76117, 76040, 76102, 76105, 76110, 76018, 76015, 76107, 76108, 76120

Figure 24: Zip Codes With High HIV Incidence, 2018 and 2019 Data Combined



SECTION 5: 2022 TO 2026 GOALS AND OBJECTIVES

SECTION 5.1: GOALS AND OBJECTIVES DESCRIPTION

Definitions Used in This Section

- **Goals:** Broad aspirations that enable the Plan's vision to be realized
- **Objectives:** The changes, outcomes, and impact the Plan is trying to achieve
- **Strategies:** How to best to accomplish objectives
- **Activities:** Specific steps that will take place to implement the strategies
- **Performance Measures:** Measurable data used to track progress, successes, and challenges

The final goals, strategies, and activities for inclusion in this Plan were approved by the North Central Texas HIV Planning Council on November 1, 2022.

PRIORITY POPULATIONS

- Youth, aged 13 to 24
- Black women
- Men who have Sex with Men (MSM), especially Black and Hispanic MSM

OVERALL GOAL

By December 2026, reduce the number of new HIV cases in the Fort Worth-Arlington TGA, from approximately 325 cases in 2021 to less than 80 cases in 2026 (a 75% reduction).

Strategies are organized according to the goals of the National HIV/AIDS Strategy. Leadership responsibilities for strategies and activities are color-coded as follows:

The Tarrant County HIV Administrative Agency will be the lead entity for strategies in BLUE.
The TCPH Adult Health Services will be the lead entity for strategies in GREEN.
Community Partners (community-based organizations, elected and non-elected community leaders, people with HIV, etc.) will be the lead entities for strategies in YELLOW.

GOAL 1: PREVENT NEW HIV INFECTIONS

OBJECTIVE: Create a high-performing status neutral approach to HIV service delivery, in which HIV testing serves as an entry point for rapid linkage to, and engagement in prevention and care services. The status neutral approach will contribute to reducing the number of new HIV cases in the Fort Worth-Arlington TGA by 75%, from approximately 325 cases in 2021 to less than 80 cases in 2026.

Strategies Led by the Tarrant County HIV Administrative Agency

Strategy 1.1	**Collaborate with the TCPH Adult Health Services to adopt the Status-Neutral Prevention and Treatment Cycle as the jurisdiction's framework for HIV/STI/hepatitis screening, rapid linkage to HIV care, and rapid linkage to PrEP/PEP initiation and other prevention options.**	
	Activities	• 2022: Collaborate with community partners to identify how to align prevention and care services to support the SNPTC as an EMA-wide framework. • 2022: Complete a strengths/weaknesses/opportunities/threats analysis. Report findings to the community. • 2023: Collaborate with community partners to develop a transition plan. • 2024: Implement the transition plan.
	Performance Measures	• 2022, 2023: Activities completed. • 2024: Transition to the SNPTC model.

Strategy 1.2	**Collaborate with community stakeholders and people with HIV to inform the development and implementation of a media initiative promoting HIV viral suppression as high-impact HIV prevention (known as Undetectable=Untransmittable, or U=U) to Ryan White clients.**	
	Activities	• 2022: Evaluate existing U=U initiatives. • 2023: Conduct focus groups with people with HIV to inform content and design considerations. • 2023: Develop the media strategy and performance analytics. • 2023: Develop the campaign design and produce materials. • 2024: Implement the campaign. • 2024 to 2026: Evaluate the campaign performance and determination of future activities.
	Performance Measures	• 2024: Implementation of the campaign. • Annually: Actual performance analytics meet or exceed those established in the media strategy.

Strategy 1.3	**Collaborate with community stakeholders and people with HIV to inform the development and implementation of a 3-year initiative promoting the availability of free or low-cost HIV services provided by the Ryan White Program.**	
	Activities	• 2023: Conduct focus groups with people with HIV to inform content and design considerations. • 2023: Develop the media strategy and performance analytics. • 2024: Establish the campaign design and produce materials. • 2024: Implement the campaign. • Annually: Evaluate the campaign performance and determination of future activities. • Annually: Implement the revised campaign.
	Performance Measures	• 2024: Implementation of the campaign. • Annually: Actual performance analytics meet or exceed those established in the media strategy.

Strategy 1.4	**Annually, complete detailing sessions with non-Ryan White providers to increase provider knowledge of the availability of free or low-cost Ryan White-funded medical care, supportive services, and linkage to care systems.**	
	Activity	• Annually, complete five detailing sessions with non-Ryan White providers to educate them on the program's services.
	Performance Metric	• At least five detailing sessions are completed annually.

Strategy 1.5	**Collaborate with the TCPH Adult Health Services to establish routine, opt-out testing in hospital emergency departments, community clinics, urgent care centers, and other clinical settings, and provide support for linkage to Ryan White services.**	
	Activities	• 2022: Create a strategic plan to engage community entities. • 2023: Begin networking with community entities to engage buy-in and commitment from decision-makers. • 2024: Collaborate with community entities to identify needs related to staff training, data collection and reporting, peer mentoring, rapid start of HIV treatment, quality assurance, and other considerations. • 2024: Begin training/mentoring to address identified needs. • 2024: Implementation of routine, opt-out testing by collaborative partners.

	Performance Measures	• 2022: Strategic Plan completed. • 2023: At least three collaborative partners identified. • 2024: Capacity building and training needs fulfilled. • 2024: Implementation at three or more collaborative partners.

Strategies Led by the TCPH Adult Health Services

Strategy 1.6	**Annually, complete detailing sessions with medical providers to increase the number of providers offering routine HIV/STI/hepatitis screening and PrEP/PEP services, including tele-PrEP services, prioritizing geographic areas with high HIV incidence.**	
	Activity	• Annually, complete five detailing sessions with medical providers.
	Performance Metric	• At least five detailing sessions are completed annually.

Strategy 1.7	**Increase the number of entities providing HIV/STI/hepatitis screening in geographic areas of high HIV incidence, including non-traditional partners such as walk-in labs, pharmacies, faith-based organizations, and mobile testing services.**	
	Activities	• 2023: Research potential partner entities in geographic areas of concern. • 2023: Develop an action plan to contact and engage entities. • 2024: Begin outreach and secure potential entities. • 2024: Identify needs related to staff training, data collection and reporting, peer mentoring, rapid start of HIV treatment, quality assurance, and other considerations. • 2024: Provide training/mentoring to address identified needs. • 2025, 2026: Repeat Year 2 activities for the next rounds of potential partners.
	Performance Measures	• 2023: Action plan completed. • 2024: At least three collaborative partners identified in various geographic areas. • 2024: Capacity building and training needs fulfilled. • 2024, 2025: Implementation at three additional collaborative partners annually.

Strategy 1.8	Develop and implement a community-informed PrEP/PEP media initiative designed to decrease PrEP stigma and increase PrEP utilization, with specific messaging for young Black and Hispanic MSM, and Black women.	
	Activities	• 2023: Evaluate existing PrEP/PEP initiatives. • 2024: Conduct focus groups with community members to inform content and design considerations. • 2024: Develop the media strategy and performance analytics. • 2024: Develop the campaign design and produce materials. • 2025: Implement the campaign. • 2025: Evaluate the campaign performance and determination of future activities. • 2026: Implement the campaign as possible.
	Performance Measures	• Implementation of the campaign. • Actual performance analytics meet or exceed those established in the media strategy.

Strategy 1.9	Increase the number of people in priority populations who use PrEP/PEP.	
	Activities	• 2023: Engage community partners, PrEP medication manufacturers, and national entities to establish parameters to establish a baseline for needed PrEP use, and current PrEP use among priority populations. • 2023: Engage community partners to develop a strategic plan to increase PrEP use among priority populations. • 2024 to 2026: Implement the strategic plan, including an annual evaluation of performance.
	Performance Measures	• 2023: Determination of baseline and current PrEP use among priority populations. • 2024: Development and implementation of the strategic plan to increase PrEP use. • 2024 to 2026: Implementation and evaluation of the strategic plan.

Strategy 1.10	**Establish transportation services to improve access to HIV/STI/hepatitis testing, and PrEP services.**	
	Activities	• 2023: Assess the need, potential utilization, and resource availability for transportation services for testing and PrEP/PEP services. • 2024: If the assessment supports action, engage community stakeholders, funders, and other programs to develop a service delivery model and standards of care. • 2024: Secure a contractor to pilot service delivery. • 2025: Pilot and evaluate services. • 2026: Fully implement the service delivery model, if warranted.
	Performance Measures	• Completed assessment, implementation, and evaluation of the pilot of the service delivery model. • Standardization of the service, if fully implemented.

Strategy 1.11	**Support policies that ensure universal access to PrEP/PEP medications, in pill and injectable forms.**	
	Activity	• Ongoing: Establish dialog with community partners, state and local health programs, and community to promote universal comprehensive access to all forms of PrEP/PEP medications.
	Performance Metric	• Ongoing dialog as possible and appropriate.

Strategy 1.12	**Revise the delivery of HIV prevention services to mimic the Ryan White continuum of care (HIV screening, rapid linkage to PrEP/prevention options, prevention and PrEP/PEP case management/care coordination, and sustained HIV negative status).**	
	Activities	• 2023: Engage community stakeholders, funders, technical assistance providers, and other programs to inform revisions to the current continuum of care. • 2024: Finalize the revised continuum of care model and an implementation strategy • 2025 Pilot select components of the strategy and evaluate/revise the model • 2026: Fully implement the model.
	Performance Measures	• 2023: Completed stakeholder engagement. • 2025: Implementation of the pilot. • 2026: Revised Continuum of care model implemented.

Strategy 1.13	Develop and implement a service delivery model for HIV prevention case management/care coordination services.	
	Activities	• 2023: Evaluate existing service delivery models for implementation. • 2023: Engage community stakeholders, funders, technical assistance providers, and other programs to develop a service delivery model and standards of care. • 2024: Secure a contractor to pilot service delivery. • 2024: Pilot and evaluate services. • 2025: Fully implement the service deliver model.
	Performance Measures	• Completed assessment, implementation, and evaluation of the pilot of the service delivery model. • Full implementation of the service delivery model.

Strategy 1.14	Promote policies that support allowing pharmacists to prescribe PrEP/PEP.	
	Activity	• Ongoing: Establish dialog with community partners, state and local health programs, and community to promote the ability for pharmacists to prescribe all forms of PrEP/PEP medications.
	Performance Metric	• Ongoing dialog as possible and appropriate.

Strategy 1.15	Lead community-driven activities to revision HIV messaging to reduce HIV stigma, change public perceptions of risk of exposure to HIV, and increase the acceptability of routine HIV/STI/hepatitis testing.	
	Activities	• 2023: Engage community stakeholders, funders, technical assistance providers, and other programs to evaluate existing community activities and re-vision HIV prevention messaging. • 2023: Evaluate methods to communicate the revised messages/ways messages are delivered. • 2024: Identify opportunities and resources for implementation projects. • 2025: Implement projects.

	Performance Measures	• 2023: Completed community engagement and creation of implementation projects. • 2024: Completed evaluation of opportunities and resources for implementation of projects. • 2025: Implementation and evaluation of projects.

Strategies Led by Community Partners

- Increase the social media presence of CBOs offering HIV prevention and care services.
- Support policies that ensure universal access to PrEP/PEP medications, in pill and injectable forms.
- Support policies that support comprehensive, age-appropriate sex education in college.
- Promote policies that support needle exchange programs.
- Promote policies that support allowing pharmacists to prescribe PrEP/PEP.

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV.

OBJECTIVE: Increase the number of people with HIV that achieve sustained viral suppression, from an estimated 78% to 95%.

Strategies Led by the Tarrant County HIV Administrative Agency

Strategy 2.1	**Conduct an annual analysis to contrast the service utilization of Ryan White clients that have achieved viral suppression to those who have not, to determine factors that are likely to support engagement in care and viral suppression. Based on this analysis, establish programmatic initiatives and quality activities to increase viral suppression among non-suppressed clients.**	
	Activities	• 2023: Evaluate Ryan White client-level data to identify virally suppressed clients and their utilization of Ryan White services. Complete a similar evaluation of clients who are not virally suppressed. • 2023: Complete an analysis comparing linkage to care timeframes, treatment adherence, service utilization, and other factors to identify commonalities among suppressed and non-suppressed clients. • 2024: Develop and implement programmatic initiatives to support non-virally suppressed clients to receive a client-specific continuum of services to support them becoming virally suppressed. • 2024: Project evaluation and revision. • 2025 to 2026: Continued project implementation.
	Performance Measures	• 2023: Completion of data analysis and identification of commonalities supporting suppressed client to remain treatment adherent. • 2023: Development and implementation of programmatic initiatives and evaluation metrics. • 2024: Implementation and evaluation of programmatic initiatives • 2024 to 2026: Project evaluation.

Strategy 2.2	**Increase the percentage of newly diagnosed and returning-to-care individuals that are successfully linked to care, ideally within seven business days, or less than 30 days, from an estimated 78% to 95%.**	
Strategy 2.3	**Increase the number of PWH that achieve sustained viral suppression, from an estimated 78% to 95%.**	
Strategy 2.4	**Increase the number of individuals who remain engaged in care 12 months from the date of their diagnosis/entry to care, from an estimated 51% to 95%.**	
	Activities	• 2022: Complete a comprehensive analysis of linkage to care activities in the jurisdiction. • 2022: Engage stakeholders, funded providers, and other programs to re-vision linkage to care services to support rapid initiation of treatment and engagement in care within seven days of diagnosis (newly diagnosed individuals) or presentation for services (individuals returning to care), and comprehensive, consistent case management and coaching to remain engaged in care and achieve viral suppression. • 2023: Define a revised service delivery model for linkage to care services. Establish service standards, quality outcomes and Performance Measures. • 2024: Pilot the revised linkage to care model. • 2024: Evaluate the pilot project and revise as needed. • 2025 to 2026: Fully implement the revised service model.
	Performance Measures	• 2023: Completion of evaluation and stakeholder engagement activities. • 20231: Revised service delivery model created and piloted. • 2024 to 2026: Revised service model fully implemented and meeting or exceeding Performance Measures.

Strategy 2.5	**Develop client education resources to educate PWH who are newly diagnosed, new to care, or out of care on the importance of rapid linkage to care, U=U, and other HIV-related information.**	
	Activities	• 2022: Collaborate with community stakeholders, Ryan White clients, funded providers, and other programs to identify topics for client education, presented as a series of short motion graphic videos available in English and Spanish. • 2022: Produce the video series and make the content available online and via social media. • 2023: Develop and implement a strategy to promote the video series to Ryan White clients and the community. • 2023 to 2026: Continue to create and share new content.
	Performance Measures	• 2022: Determination of the initial content for the video series, and production of the motion graphic videos. • 2023 to 2026: Evaluation of online and social media analytics.

Strategy 2.6	**Increase the delivery of Ryan White medical care and support services in rural areas, utilizing telehealth and other service delivery methods preferred by clients.**	
	Activities	• 2023: Engage community stakeholders, Ryan White clients, funded providers, and other programs to identify opportunities to increase service delivery in rural areas. Compile this input with existing service assessments completed by the Ryan White Program to identify strategies for implementation and Performance Measures. • 2024: Develop and implement a pilot project to address identified needs. • 2024 to 2026: Evaluate the pilot project, revise as needed, and fully implement the service delivery model.
	Performance Measures	• 2024: Development and implementation of a pilot project. • 2024 to 2026: Actual performance meets or exceeds established Performance Measures.

Strategy 2.7	**Increase comprehensive use of the Provide Enterprise data system to improve provider-to-provider communication, management of clients' needs and referrals, data sharing, and quality evaluation and monitoring.**	
	Activities	• 2022: Collaborate with staff of Ryan White providers to identify and address barriers and challenges that hinder data collection and input into Provide Enterprise. • 2023: Develop and implement a quality improvement initiative to increase data collection and input into Provide Enterprise. • 2023: Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners. Set performance indicators. • 2024 to 2026: Monitor and evaluate progress toward performance goals, and address deficiencies as needed.
	Performance Measures	• 2023: Implementation of a quality improvement initiative to improve data collection and input. • 2023: Establish performance indicators. • 2024 to 2026: Actual performance meets or exceeds established performance indicators.

Strategy 2.8	**Expand peer navigation programming and diversify peer navigation staff.**	
	Activities	• 2022: Present a 1-day training for peer navigators, care coordinators, and agency leadership on best practices for peer navigation services. • 2023: Engage peer navigators, care coordinators, and agency leadership to inform revision to the existing service delivery model, standards of care, and Performance Measures. • 2023: Implement the revised service model and standards. • 2024 to 2026: Continue implementation of the service delivery model.
	Performance Measures	• 2022: Presentation of a 1-day training. • 2023: Development and implementation of a revised service delivery model, standards of care, and Performance Measures • 2024 to 2026: Evaluation of performance based on defined metrics.

Strategy 2.9	**Develop strategies for the Administrative Agency to communicate directly to Ryan White clients to promote the availability of services, and service changes.**	
	Activities	• 2022: Analyze how existing funded providers communicate with clients, especially related to service changes, eligibility changes, participation in needs assessments and client satisfaction services, etc. • 2022: Evaluate data sharing agreements, releases of information, etc. to determine if and how the Tarrant County HIV Administrative Agency can communicate with clients directly. • 2023: Revise data agreements, client forms, and other necessary documentation to support direct communication to clients by the Tarrant County HIV Administrative Agency. If direct communication is not possible, engage funded providers to identify and implement policies and procedures to communicate program changes and assessments to clients.
	Performance Measures	• 2022: Assessment of the ability of the Tarrant County HIV Administrative Agency to communicate directly to clients. • 2023: Completion of agreements and other needs to facilitate direct communication. If not possible, development of a communication protocol for funded providers.

Strategy 2.10	**Simplify Ryan White and AIDS Drug Assistance Program (ADAP) paperwork for clients and providers, including online completion of Ryan White and provider forms and the ability to digitally sign and submit documents.**	
Strategy 2.11	**Advocate for the Texas Department of State Health Services to implement policy changes that streamline eligibility and renewal certifications to significantly reduce wait times for ADAP-eligible clients to receive medication.**	
	Activity	• Ongoing: Establish dialog with community partners, state and local health programs, and community to promote policy, process, and form revisions to provide greater access to forms, digitally sign forms, and streamline eligibility and renewal certifications.
	Performance Metric	• Ongoing dialog as possible and appropriate.

Strategies Led by the TCPH Adult Health Services

Strategy 2.12	**Develop and implement a revised service delivery model for Disease Investigation Services, focusing on providing compassionate, client-centric, trauma-informed services.**	
	Activities	• 2023: Partner with a university system and technical assistance providers to engage stakeholders to inform the development of a revised DIS service delivery model. • 2024: Pilot the service delivery model and complete an evaluation. • 2025 to 2026: Adjust the service delivery model as needed, and fully implement it.
	Performance Measures	• 2023: Completion of engagement activities. • 2024: Development of revised service delivery model. • 2025: Completed pilot of the service delivery model. • 2026: Full implementation of the service delivery model.

Strategies Led by Community Partners

- Advocate for policies that support universal access to injectable medications, and other medications as they become available.
- Advocate for the expansion of Medicaid.

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HIV-RELATED STIGMA

OBJECTIVE: Reduce health disparities, HIV-related stigma, and other barriers to accessing care and providing services through improved service delivery and systems change.

Strategies Led by the Tarrant County HIV Administrative Agency

Strategy 3.1	**Develop a system-wide approach for HIV service delivery for those disproportionally impacted by HIV.**	
	Activities	• 2024: Research service models and identify technical assistance partners. • 2024: Engage community stakeholders, providers, and other programs to inform the development of a service delivery model for a system-wide, client-centered, trauma-informed approach to address the needs of marginalized populations. • 2025: Pilot the service delivery model and complete an evaluation. • 2025 to 2026: Adjust the service delivery model as needed, and fully implement it.
	Performance Measures	• 2024: Completion of research activities. • 2024: Development of service delivery model. • 2025: Completed pilot of the service delivery model. • 2026: Full implementation of the service delivery model.

Strategy 3.2	**Engage Black faith leaders to educate their congregations and communities on HIV to increase awareness and reduce stigma and discrimination toward PWH.**	
	Activities	• 2023: Present a half-day meeting for faith leaders to present the 'state of HIV' in the jurisdiction, share an overview of the Integrated Plan, and request engagement in ending the HIV epidemic. • 2023: Continue to engage with faith leaders to facilitate them to develop a one-year plan to engage their congregations and communities on HIV issues. • 2024: Facilitate implementation and evaluation of the plan, and next steps.
	Performance Measures	• 2023: Presentation of the half-day meeting. • 2023: Development and implementation of a one-year engagement plan. • 2024: The plan is implemented and evaluated.

Strategy 3.3	**Develop and implement an initiative to reduce stigma experienced by people with HIV.**	
	Activities	• 2024: Evaluate stigma assessment models and identify technical assistance providers. • 2024: Engage stakeholders, providers, and other programs to form a work group to guide the development and implementation of a client assessment of HIV stigma issues. • 2025: Implement the client assessment and analyze the results. • 2025: Engage the work group to use the assessment results to develop an action plan to reduce HIV stigma. • 2026: Implement the plan.
	Performance Measures	• 2024: Stigma assessment models are evaluated, and a technical assistance provider is secured. • 2024: The work group is formed and finalizes and implements the client assessment. • 2024: The work group completes an evaluation of the assessment. • 2025: An action plan is developed and implemented.

Strategy 3.4	**Provide job training and personal or professional development opportunities to people with HIV, to prepare them to enter or return to the workforce, especially in public health programs, local community-based organizations, and HIV prevention and care programming.**	
	Activities	• 2024: Research service models and identify technical assistance partners. • 2024: Engage community stakeholders, people with HIV, providers, and other programs to identify employment needs and issues among people with HIV, and opportunities and challenges they may face entering the general workforce or local HIV workforce. • 2025: Complete an assessment of the current state of the local HIV workforce, and the needs of people with HIV who wish to enter the workforce. • 2025: Evaluate the assessment to determine action steps. • 2026: Implement action steps.
	Performance Measures	• 2024: Engagement of a work group to oversee the project. • 2024: Completion of the HIV workforce assessment. • 2025: Evaluation of the assessment and development of an action plan. • 2026: Implementation of the action plan.

Strategy 3.5	Implement multi-agency case conferencing to monitor erratically-in-care clients.	
	Activities	• 2023: Engage staff of funded providers to participate in regular case conferencing to monitor erratically-in-care clients. • 2023: Monitoring protocols, tools, and timeframes are established. • 2024: Case conferencing begins.
	Performance Measures	• 2023: Establishment of the case conferencing initiative. • All Years: Evaluation of retention in care of erratically-in-care clients.

Strategy 3.6	Collaborate with the TCPH Adult Health Services to identify and address HIV-related disparities experienced by 1) clients accessing Ryan White services, and 2) individuals accessing HIV testing, PrEP/PEP, and other prevention services. Then design and implement effective, evidence-based, culturally relevant interventions to improve health outcomes among these individuals.	
	Activities	• 2024: Research service models and identify technical assistance partners. • 2024: Engage community stakeholders, providers, and other programs to inform the development of a service delivery model for a system-wide, client-centered, trauma-informed approach to HIV-related disparities. • 2025: Pilot the service delivery model and complete an evaluation. • 2025 to 2026: Adjust the service delivery model as needed, and fully implement it.
	Performance Measures	• 2024: Completion of research activities. • 2024: Development of service delivery model. • 2025: Completed pilot of the service delivery model. • 2025 to 2026: Full implementation of the service delivery model.

Strategies Led by the TCPH Adult Health Services

Strategy 3.7	**Evaluate the feasibility of increasing data-to-care/lost-to-care initiatives to identify erratically in-care and out-of-care people with HIV and return them to care.**	
	Activity	• 2024: Collaborate with the Tarrant County HIV Administrative Agency and public health programs to evaluate the feasibility of increase data-to-care/lost-to-care initiatives.
	Performance Metric	• 2024: The feasibility study is completed, and next steps are determined.

Strategy 3.8	**Evaluate the feasibility of coordinating HIV/STI/hepatitis surveillance systems.**	
	Activity	• 2024: Collaborate with the Tarrant County HIV Administrative Agency and public health programs to evaluate the feasibility of coordinating HIV/STI/hepatitis surveillance systems.
	Performance Metric	• 2024: The feasibility study is completed, and next steps are determined.

Strategy 3.9	**Collaborate with the Administrative Agency to evaluate the feasibility of establishing a multi-setting hepatitis screening program.**	
	Activity	• 2024: Engage community stakeholders, providers, and other programs to conduct feasibility study for establishing a multi-setting hepatitis screening program.
	Performance Metric	• 2024: The feasibility study is completed, and next steps are determined.

Strategies Led by Community Partners

- Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.
- Support policies that support comprehensive, age-appropriate sex education in college.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS.

OBJECTIVE: Improve programmatic collaboration and performance by sharing innovations, best practices, and data to increase the competencies of staff and leadership to address the local epidemic.

Strategies Led by the Tarrant County HIV Administrative Agency

Strategy 4.1	**Present an annual, jurisdiction-wide training series that offers leadership and development opportunities, supports innovation in service delivery, addresses cultural humility and fosters dialogue about local issues that impede progress toward ending the HIV epidemic.**	
	Activity	• Annually, convene a diverse planning body representing HIV/STI/hepatitis prevention programs, providers, and stakeholders to plan and present an annual one-day training event for up to 150 participants, and up to three specialized training sessions for up to 30 people.
	Performance Measures	Annually: • Implementation of an annual large-scale training event. • 85% of attendees rate the event as Excellent or Outstanding.

Strategy 4.2	**Train providers to expand their ability to offer high-quality, affirming medical care to priority populations which may include PrEP/PEP services and HIV, STI and hepatitis testing and treatment**	
	Activity	• Annually, present up to three one-day specialized training sessions for up to 30 participants, especially participants from providers in geographic areas of concern, addressing such topics as culturally humble service delivery, medical mistrust among people of color, innovations in treatment engagement and adherence, etc.
	Performance Measures	Annually: • Implementation of three one-day specialized training events. • 85% of attendees rate the event(s) as Excellent or Outstanding.

Strategy 4.3	**Work with the TCPH Adult Health Services and community partners to enhance collaboration among programs, providers, and the community to address policies and structural barriers that contribute to persistent HIV-related disparities.**	
	Activities	• Annually, convene a work group to develop and implement an action plan to address funding, policy, data, workforce capacity, and programmatic barriers to overcome to effectively address the epidemic. • 2023: Work group established. • 2024: Detailed 1-year action plan and high-level follow-up 3-year plan completed.
	Performance Measures	• 2023: Action plan implemented and evaluated. Next year's plan detailed. • 2024 to 2026: Follow up plans developed, implemented, and evaluated annually.

Strategies Led by the TCPH Adult Health Services

Strategy 4.4	**Collaborate with the Tarrant County HIV Administrative Agency and community partners to identify geographic 'hotspots' to prioritize the coordinated, innovative use of resources to address HIV/STI/hepatitis prevention and care among disproportionally impacted populations.**	
	Activity	• Annually, convene a work group to develop and implement an action plan to address tailored HIV/STI/hepatitis prevention and care activities in geographic areas of concern.
	Performance Measures	Annually: • Work group established. • Action plan developed. Lead entities and resources identified. • Action plan implemented. • Evaluation of the completed activities by the work group.

Strategy 4.5	**Establish and maintain internet-based dashboards to report to the community on the status of the local HIV epidemic, the performance of HIV/STI/hepatitis prevention and care initiatives, linkage to care timeframes, and outreach/data to care activities.**	
	Activities	• 2023: Assess the data needs and Performance Measures of programs, providers, and stakeholders in the jurisdiction. • 2023: Identify resources and other needs for the development of the dashboards. • 2023: Identify data sources and sharing needs for the collection and evaluation of data to create the dashboards. • 2024: Develop the framework for the dashboards. • 2024: Conduct trial imports and focus groups to assess performance and accuracy. • 2025: Launch the dashboards. • Annually: Seek community feedback for quality improvements.
	Performance Measures	• Public launch of the dashboards. • Annual quality review.

Strategies Led by Community Partners

- Foster private-public-community partnerships to participate in HIV/STI/hepatitis prevention and care planning, service delivery, and evaluation, and initiatives to address social determinants of health.
- Facilitate the participation of traditional and non-traditional entities in geographic areas of concern to support prioritized HIV/STI/hepatis initiatives.

SECTION 5.1a: UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

Not Applicable. No other Strategic Plans were used to meet the requirements for the submission of this Plan.

SECTION 6: 2022 TO 2026 INTEGRATED PLANNING IMPLEMENTATION, MONITORING AND JURISDICTIONAL FOLLOW UP

SECTION 6.1: 2022 TO 2026 INTEGRATED PLANNING IMPLEMENTATION APPROACH

SECTION 6.1a: IMPLEMENTATION

The Tarrant County HIV Administrative Agency, TCPH Adult Health Services, and Community Partners have been assigned as lead entities responsible for overseeing the implementation and evaluation of each strategy of the Plan. This oversight includes obtaining and allocating funding, recruiting community partners, private sector entities, and others for collaboration (especially non-traditional partners), data collection and reporting, and other aspects of implementation.

The Planning Council and Prevention Partnership will collaborate with these entities to engage participation from PWH and people at risk for acquiring HIV. Additionally, these planning bodies will complete assessment initiatives that measure the impact of the activities detailed in the plan related to increased service utilization, improved health outcomes, viral suppression, PrEP initiation, etc.

SECTION 6.1b: MONITORING

Accountability for the execution of the plan will be accomplished by regularly assessing progress, evaluating the effectiveness of implemented activities, reporting on progress, and evaluating quality improvement initiatives.

The Administrative Agency will collaborate to monitor progress toward achieving the goals and objectives of the Plan. The Administrative Agency and TCPH Adult Health Services will conduct ongoing data collection, evaluation of epidemiological and other data, and completion of other monitoring to support reporting requirements relevant to their funding sources and to keep local planning bodies and stakeholders informed. Information gathered from each Program's Subrecipients, collaborative partners, and other local and state entities will be used to assess service delivery and performance and improve health outcomes along the status-neutral HIV care continuum.

The Administrative Agency's Continuous Quality Improvement program establishes annual program activities to support the implementation, monitoring, and evaluation of the Plan's initiatives.

The Administrative Agency provides a comprehensive programmatic update at each Planning Council meeting. Information shared includes:

- Monitoring summaries and evaluations for the Plan's strategies and activities.
- Continuous Quality Improvement activities and performance.
- Service category utilization information.
- Performance toward meeting funding allocations.
- New and emerging trends in the jurisdiction.
- Other relevant information.

The Planning Council's Comprehensive Planning Committee meets at least six times per year and is tasked with reviewing the progress of implementing the Ryan White-led HIV care initiatives of the Integrated Plan. Additionally, work groups may be established for specific activities that require

additional participation by other Council members, specialized skills, or community collaboration. These work groups also provide updates during Planning Council meetings.

The Prevention Partnership meets quarterly to complete a similar review of prevention initiatives.

The Planning Council and Prevention Partnership will meet jointly at least once per year to collectively evaluate the Plan and make recommendations and decisions for revising the timeline or activities.

The Planning Council's annual priority setting and resource allocation process includes a one-day data presentation meeting. During this meeting, the Administrative Agency, TCPH Adult Health Services, state epidemiology program, local service providers, and others present a variety of data and monitoring information to inform the Council's priorities and funding for the next grant year.

SECTION 6.1c: EVALUATION

High-level performance measures are established for each activity detailed in the Plan, as described in **Section 5: 2022 to 2026 Goals and Objectives**. As each strategy is fully developed and implemented, more detailed performance measures and monitoring time frames will be created. As performance measures are defined, the Administrative Agency will modify its data systems to collect new data for specific evaluation measurements and to create reports.

The Administrative Agency monitors programmatic progress toward goals and objectives using surveillance and client-level data. To evaluate health outcomes, the Administrative Agency and TCPH Adult Health Services will collaborate with Subrecipients, the state HIV Surveillance Program, local stakeholders, and other health programs to assure that the most current, relevant data available is available for use to drive programmatic development, monitoring and evaluation. Surveillance, HIV testing, and Partner Services data will be used to monitor trends and positivity rates and track acute cases of HIV. Epidemiological data is provided by TX DSHS annually.

At each of its meetings, the CPC will review the progress toward completing activities defined in the Plan and evaluate the implementation and outcomes for each strategy. The committee will report on their efforts during each full Planning Council meeting.

The Administrative Agency will provide a comprehensive programmatic update at Planning Council meetings, which will include a progress and evaluation report for the components of the Integrated Plan the agency is leading. This update may also include Continuous Quality Improvement reporting, service category utilization information, and other information related to the Integrated Plan.

The Administrative Agency also convenes an annual jurisdictional meeting with Subrecipients, health programs, stakeholders, and PWH and will provide programmatic updates and evaluation of the progress of the Integrated Plan.

The Continuous Quality Improvement program will evaluate service delivery across the Ryan White-funded system of care to identify and quickly address health outcomes and disparities. Five EHE-specific quality goals have been established to evaluate the impact of the work done to fulfill the Integrated Plan:

- Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 87 percent.
- Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent.
- Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of diagnosis to at least 85 percent.
- Increase viral load suppression among Youth, Black MSM Youth, and Hispanic Youth by 20%.
- Grow the CQI Program and build capacity for providing technical assistance to Subrecipients focusing on creating a culture of continuous quality improvement by improving and supporting a CQM Committee, establishing a system to visualize and communicate performance measure data, and engaging and supporting subrecipients in implementing QI projects within their agencies.

In 2018, the Continuous Quality Improvement program established a PWH quality consumer advisory board (HIT HIV). Members are provided comprehensive quality and leadership training, and then meet regularly to inform Ryan White quality monitoring and evaluation. HIT HIV meets monthly to review performance and outcome data collected during the implementation of the Integrated Plan to provide feedback and recommendations.

SECTION 6.1d: IMPROVEMENT

As shared above, the Planning Council, Prevention Partnership, Administrative Agency, and TCPH Adult Health Services have a highly collaborative, methodical process for gathering, evaluating, and sharing data and information with the community at-large.

The Integrated Plan was created using an equally collaborative process that included PWH, people at risk for acquiring HIV, staffs and leadership of HIV service organizations and Disease Investigation Services, and other stakeholders. Community input guided the development of the Plan, and community input will inform revisions and improvements to the Plan.

The Planning Council is responsible for making annual revisions to the Plan, in collaboration with the Administrative Agency and TCPH Adult Health Services. In addition to the monitoring and evaluation activities detailed earlier, the Council completes a variety of activities to obtain community input. PWH and others are encouraged to attend Council meetings and become members of the Planning Council and/or HIT HIV advisory board. Time is allocated on all Planning Council agendas for public comment

The Comprehensive Planning Committee determines the scope and content for population-specific and large scale PWH needs assessments and client satisfaction surveys, and other assessment activities such as listening sessions or focus groups. All assessments are aligned with the goals and strategies of the Plan, and the performance measures established to evaluate progress.

The Planning Council is involved in the presentation of an annual HIV symposium, which includes program updates and presentations of activities implemented as part of the Plan. Stakeholders can provide written comments on Plan initiatives at any time via the PC's website.

SECTION 6.1e: REPORTING AND DISSEMINATION

The Administrative Agency and TCPH Adult Health Services will regularly update the Planning Council and Prevention Partnership on the on implementation, monitoring, evaluation, and improvements made to the Plan. Surveillance and epidemiological data will also be presented (as available) to assist in following trends and planning activities and initiatives. Each planning body will dedicate time on their meeting agendas to review the Plan implementation, solicit feedback from members, PWH, and stakeholders, and provide feedback to the Administrative Agency and TCPH Adult Health Services.

The Integrated Plan will be made available for download on the Planning Council and the Administrative Agency websites.

Each year, the Administrative Agency hosts an HIV symposium, a multi-session conference offering diverse presentations on such topics as innovative linkage to care models, trauma-informed care, Status Neutral Approach, etc. In addition to general stakeholder attendance, all staff of Ryan White Program Subrecipients are required to attend. More than 120 participants attend this free event. Updates on the progress of the Integrated Plan update is an established part of the agenda for this event.

SECTION 6.1f: UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

The completed Texas Integrated Plan/SCSN is unavailable.

SECTION 7: LETTER OF CONCURRENCE

North Central Texas
HIV Planning Council
Doing our part to end the HIV epidemic

Lisa Muttiah, Grant Manager
Tarrant County HIV Administrative Agency
2300 Circle Drive, Suite 2306
Fort Worth, TX 76119

Dear Ms. Muttiah:

The North Central Texas HIV Planning Council (PC) ***concurs*** with the following submission by the Tarrant County HIV Administrative Agency (TC AA) 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 PC 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 PC ***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.

The PC's Comprehensive Planning Committee (CPC) has been tasked with guiding the Integrated Plan development. Since 2021, the CPC has evaluated input gathered from more than four hundred people with HIV and at-risk individuals via needs assessments of Ryan White clients, virtual listening sessions, and in-person focus groups held at HIV service organizations. Additionally, the CPC analyzed the results of stakeholder planning activities attended by more than 120 people, including the full staffs and leadership of six community-based organizations, the Tarrant County HIV Administrative Agency, the HIV Prevention Program, Disease Investigation Services, and the HIV Prevention Partnership. Each month, the CPC evaluated and approved content for inclusion in the Integrated Plan. The CPC Chair provided monthly progress updates to the full Planning Council.

The Tarrant County HIV Administrative Agency has participated with Tx DSHS related to the development of the Statewide Plan. The Texas Department of State Health Services (DSHS) intended to release the Statewide plan by the middle of October 2022, but at the time of submission of this document, their plan has not been released.

The signature below confirms the ***concurrence*** of the North Central Texas HIV Planning Council with the CY 2022-2026 Integrated HIV Prevention and Care Plan.

Signature: Date: Friday, December 2, 2022

Wanda Harris-George
North Central Texas HIV Planning Council Chair

APPENDIX 1

TEXAS DEPARTMENT OF STATE HEALTH SERVICES DATA AVAILABILITY LETTER

TEXAS
Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

Sept 14, 2021

Dear Colleagues:

Every year, staff in the TB/HIV/STD Section of the Texas Department of State Health Services (DSHS) provide Ryan White HIV/AIDS Program (RWHAP) Part A grantees and administrators with information on HIV trends, participation in HIV treatment, and HIV health outcomes for use in their grant applications. As staff began preparing data for the 2021 applications, the latest HIV surveillance data available was from the calendar year 2019. The latest STD data, used in estimating co-morbidities, was from calendar year 2018. The 2020 HIV and STD data were delayed due to statewide COVID-19 activities. This is consistent with the national trends. The Centers for Disease Control and Prevention (CDC) extended the deadline for all final 2020 STD and HIV case data. STD 2020 data is due September 2021, and HIV 2020 data is due December 2021.

DSHS staff are working to get caught up with the 2021 HIV/STD data so that there are no delays. Additionally, DSHS is working to improve the overall quality and timeliness of data submissions at all levels, such as providers, labs, and public health entities, on DSHS systems.

Please let us know if you have questions or concerns. We appreciate your understanding.

Felipe Rocha, Director
TB/HIV/STD Section