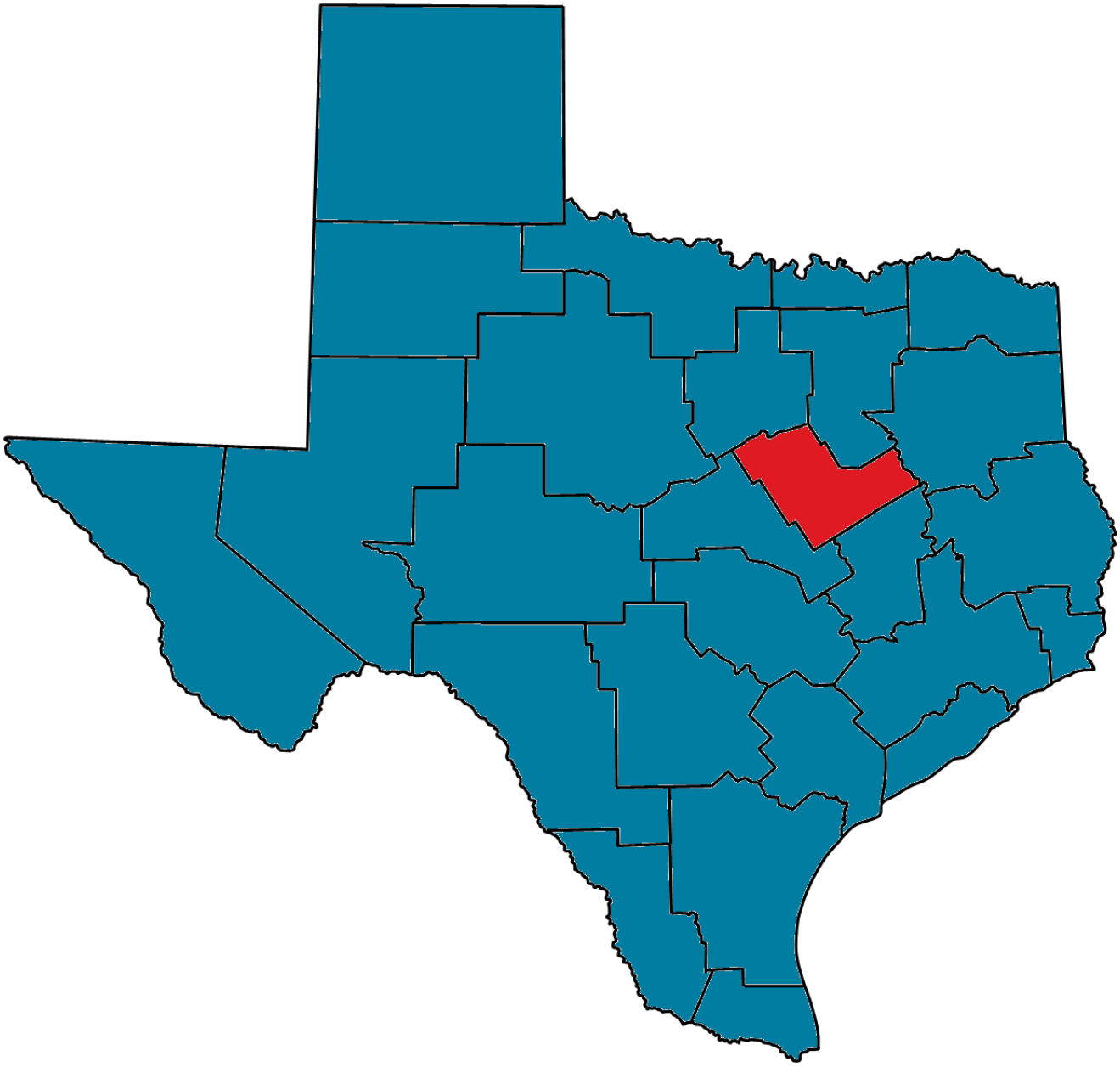
2018 HIV Continuum of Care

Waco HIV Service Delivery Area (HSDA)



achieving TOGETHER
A COMMUNITY PLAN TO END THE HIV EPIDEMIC IN TEXAS

www.achievingtogethertx.org

Data Sources

The data contained in this report is compiled by the Texas Department of State Health Services; HIV/STD Branch.

*Data sources include: Enhanced HIV AIDS Reporting System (as of July 2, 2017), Medicaid, ARIES (Ryan White Program database), ADAP (AIDS Drug Assistance Program), STD*MIS (Prevention and Public Health Follow Up database), the Texas Medical Monitoring Project and private insurance data.*

Terminology & Abbreviations

PLWH—People Living With HIV

HSDA—HIV Service Delivery Area (based on HIV Care & Treatment funding)

Mode of Exposure—How a person acquired HIV—a person's biological sex (i.e. sex assigned at birth) is used to determine mode of exposure

- **Male-Male Sexual Contact**—HIV acquisition most likely occurred due to sexual contact between two men
- **Injection Drug Use**—HIV acquisition most likely occurred due to injection drug use
- **Male-Female Sexual Contact**—HIV acquisition most likely occurred due to sexual contact between a man and a woman.

Priority Populations—Populations who are disparately and disproportionately impacted by HIV

Latinx—a gender neutral term used in place of Latino or Latina

Latinx MSM—Latino gay, bisexual and other cisgender Men who have Sex with Men

White MSM—White gay, bisexual and other cisgender Men who have Sex with Men

Black MSM—Black gay, bisexual and other cisgender Men who have Sex with Men

Black Women—Black cisgender Women who have sex with men

Transgender People –includes both transgender men and transgender women. A significant majority of Transgender PLWH are transgender women.

Latinx Women—Latina cisgender Women who have sex with men

PWID—People Who Inject Drugs

PrEP—Pre-Exposure Prophylaxis—HIV Prevention Medication

nPEP—non-occupational Post-Exposure Prophylaxis

Behavioral Interventions—interventions designed to change behaviors that make people more vulnerable to acquiring HIV. These can include individual, group and community level interventions.

Retention in Care—2 contacts with the care system, at least 3 months apart in the calendar year (contacts include a visit with a medical provider, HIV lab work, or and ART prescription)

Viral Suppression—a viral load <= 200 copies/ml

In-Care Viral Suppression—Viral Suppression among PLWH who have achieved Retention in Care

Waco HSDA

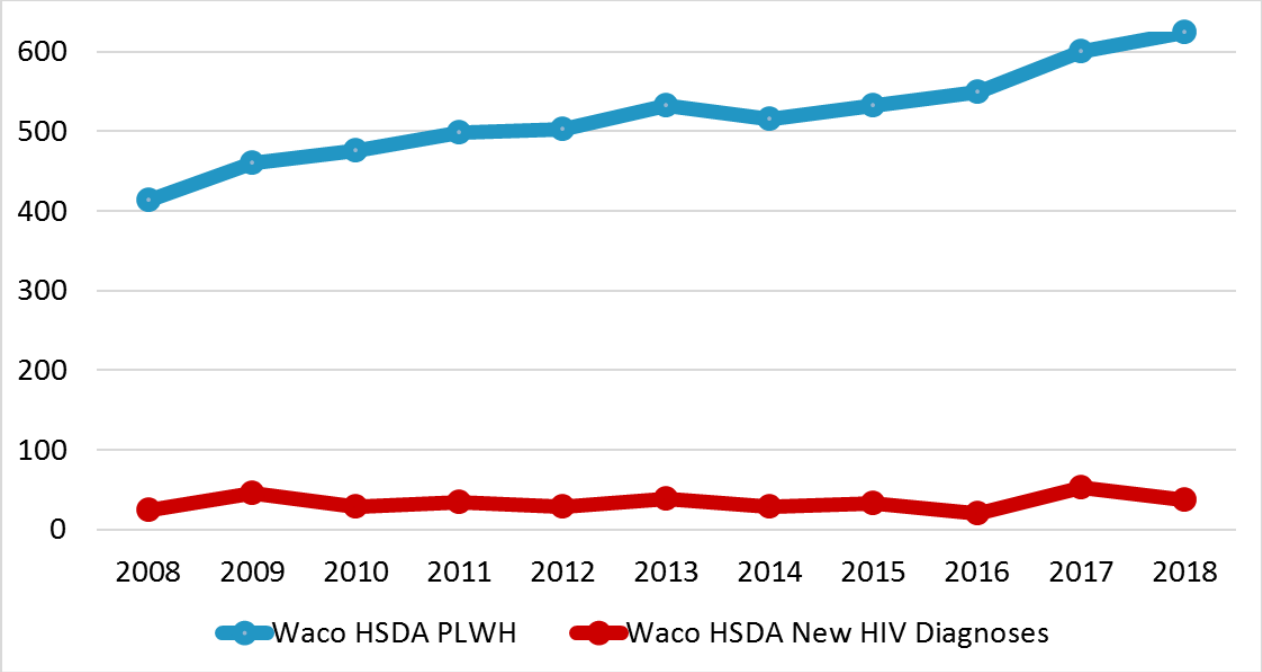
Waco HSDA Counties: Bosque, Falls, Freestone, Hill, Limestone, McLennan

Epi Profile

People Living With HIV (PLWH) and New HIV Diagnoses

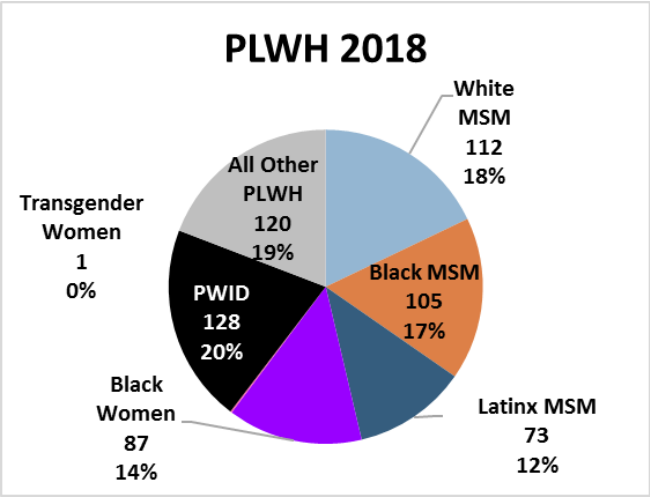
In the Waco HSDA, the number of new HIV diagnoses has remained flat and stable for the past several years.

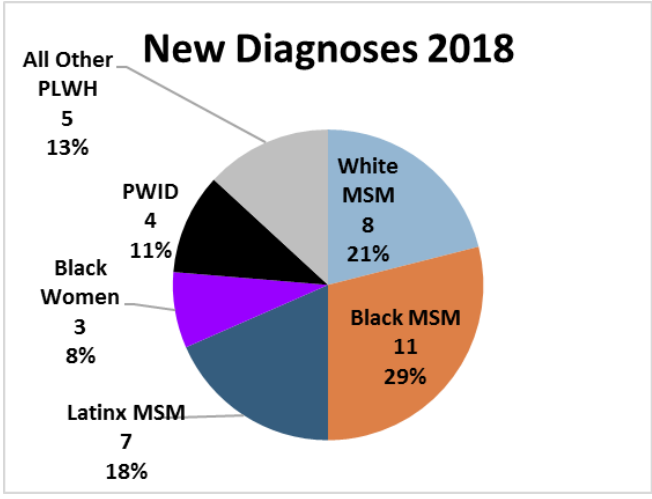
There were **625 people living with HIV (PLWH)** in this area as of the end of 2018. In 2018, **37 people were newly diagnosed with HIV**. This includes only people with diagnosed HIV with a current address in this area. People with undiagnosed HIV are not included.



Priority Populations (81% of PLWH, 87% of New HIV Diagnoses)

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



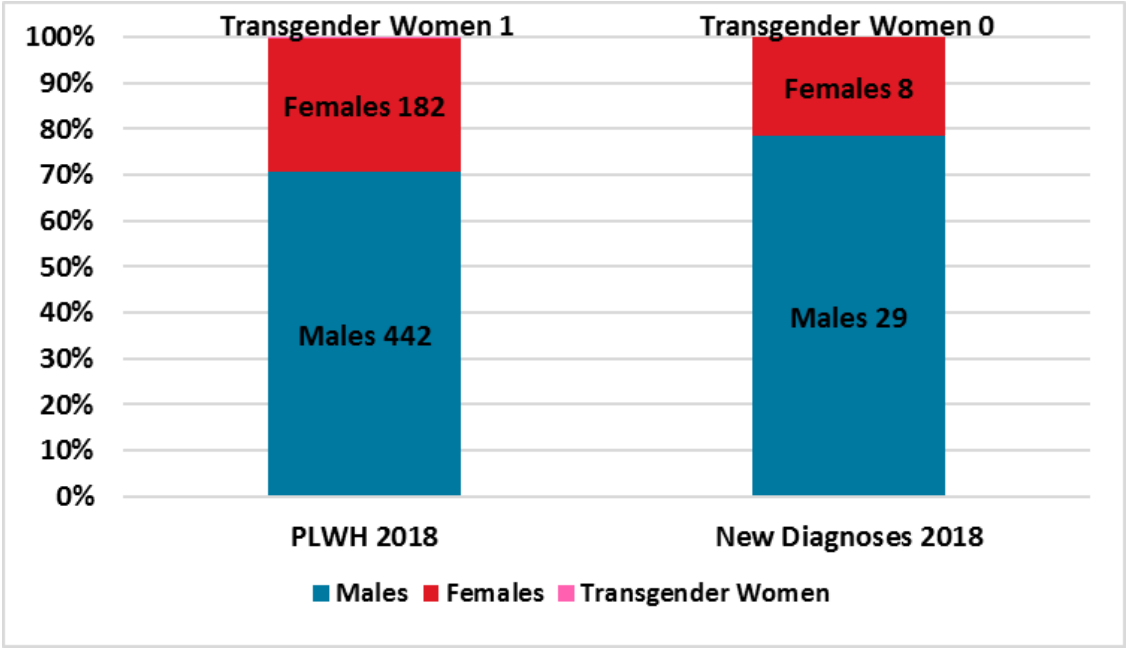


Gender

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

Note

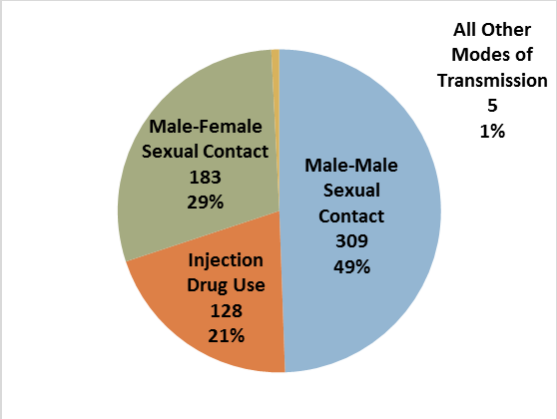
Due to current reporting methods, the number of transgender PLWH are most likely underreported.



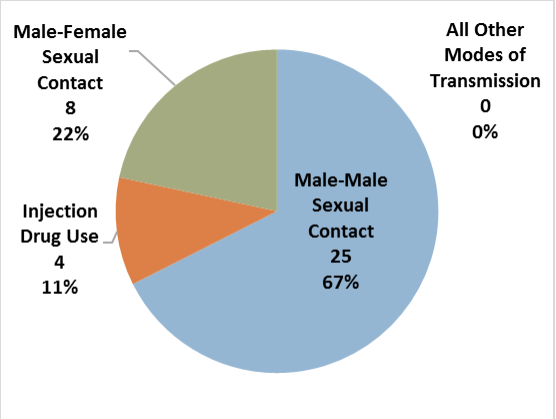
Mode of Exposure

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

PLWH

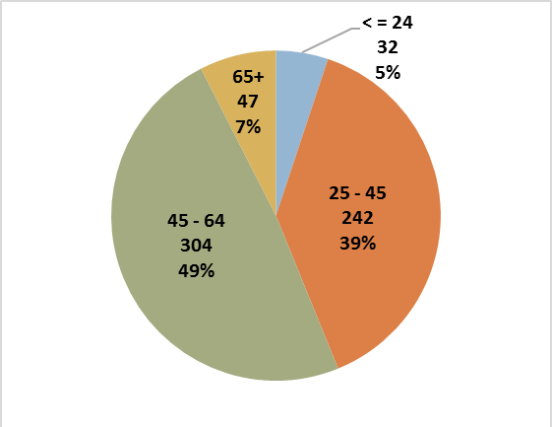


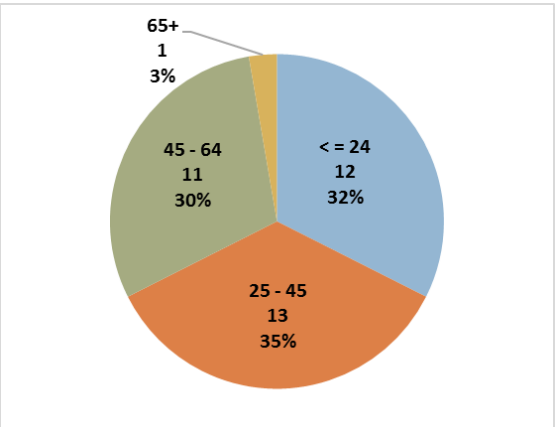
New Diagnoses



Age

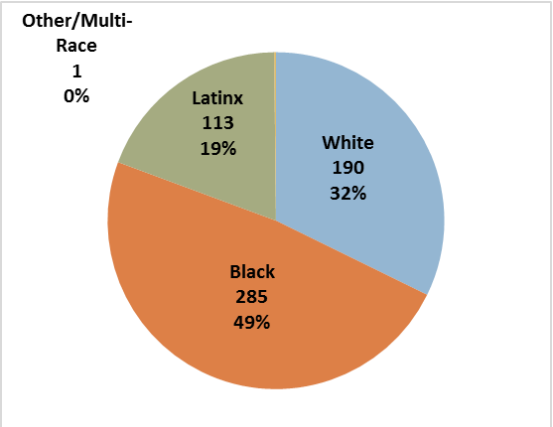
The majority of PLWH are 45-64; the majority of new diagnoses are among people 25-45.

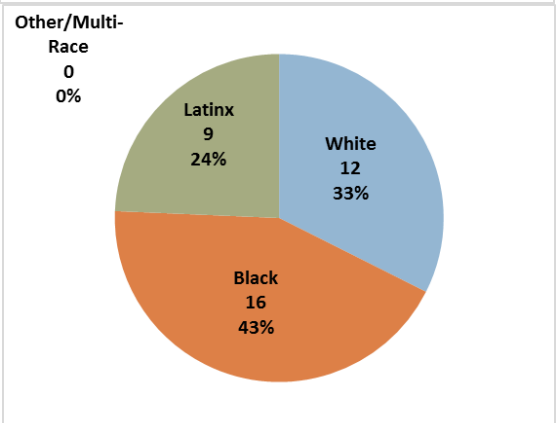




Race/Ethnicity

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





Focused Prevention

Focused Prevention involves ensuring that HIV prevention efforts are centered around those populations and communities where HIV is most heavily concentrated. These populations are often disparately impacted by HIV and any efforts to significantly reduce new HIV incidence must focus on meeting the needs of these groups. Focused Prevention interventions are based on the concept of Combination Prevention. Combination Prevention values client autonomy and includes Behavioral Interventions, Condoms/Lubricant, HIV/STI Testing, and Biomedical Interventions like PrEP, nPEP and Treatment as Prevention (TasP).

Texas' goal is that all people with increased vulnerabilities to acquiring HIV have equitable access to Combination Prevention.

Locally Relevant Populations for Prevention

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

White MSM | Black Women | Black Men who have sex with Women | Transgender People

Local Prevention Interventions—DSHS Funded *(see **Appendix A** for intervention descriptions)*

- *Core HIV Prevention*

Full Diagnosis

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

Primary Diagnosing Facilities 2013-2018

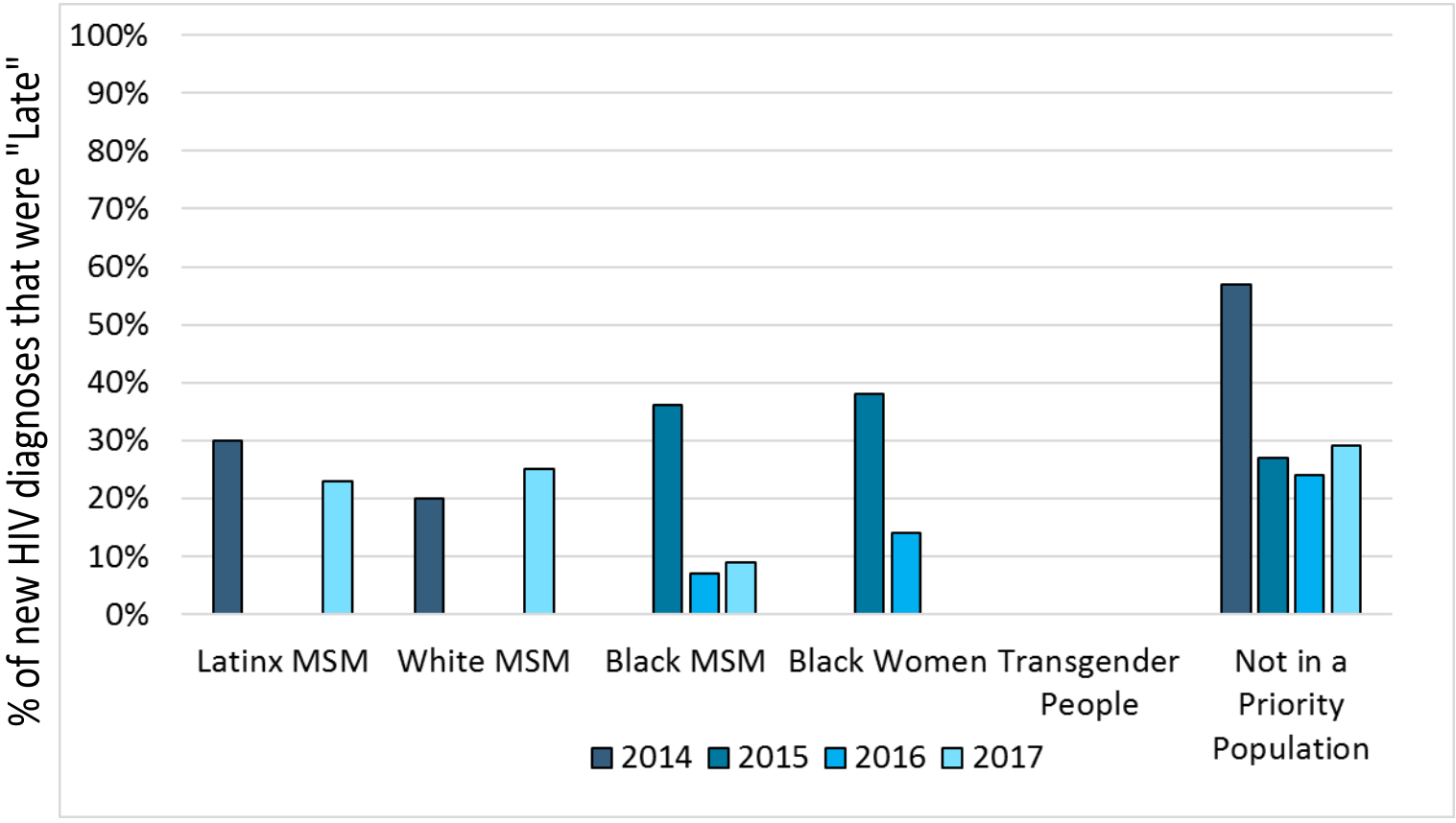
52% of HIV diagnoses in the Waco HSDA happen in these 5 facilities. Waco-McClennan County HD is the top diagnosing facility in the area.

Diagnosing Facility	Total # Diagnosed	% of Total Diagnoses	% Latinx MSM	% White MSM	% Black MSM	% Black Women	% Transgender People
Waco McClennan County HD	62	29%					
Providence Health Cecnter	18	8%					
Waco-McClennan Co HD—STD	12	6%					
Family Health Center—Waco	9	5%					
CSL Plasma	8	4%					

Late Diagnosis 2014—2017

A "late diagnosis" is when a person receives a Stage 3/AIDS diagnosis within 3 months of their initial HIV diagnosis. Studies have linked late HIV diagnoses to slower CD4 gains, faster disease progression and higher mortality.

There are no "late diagnosis" trends.



Successful Linkage

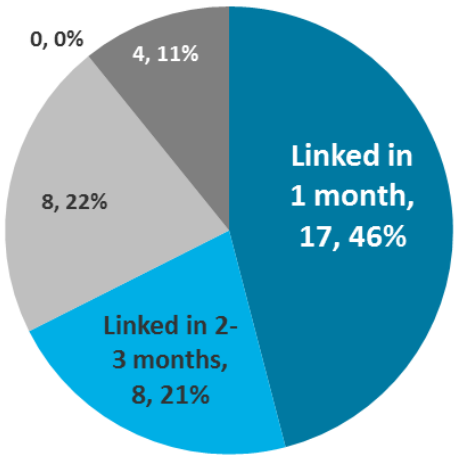
We know that treatment for HIV keeps PLWH healthier longer and reduces deaths, but it is most effective if treatment starts soon after the diagnosis is made. Linkage refers to the time it takes from the person's diagnosis to when they have their first episode of HIV medical care.

Texas' goal is for 90% of all people newly diagnosed with HIV to be linked to care within 3 months.

Timely Linkage—2018

67% of people diagnosed with HIV in the Waco HSDA in 2017 were linked to care within 3 months.

Linkage is a priority in the Waco HSDA



Linked in 1 month	17	46%
Linked in 2-3 months	8	21%
Linked in 4-12 months	8	22%
Linked in 12+ months	0	0%
No Evidence of Linkage	4	11%

Timely Linkage—Priority Populations—2012-2017

Coming Soon

Retention in Care. Viral Suppression

Retention in Care and Viral Suppression are two key measures that help us understand individual level health, efficacy of HIV care systems, and Community Viral Load. ***Retention in Care*** *is defined as at least 2 contacts with the care system during the year (either an HIV medical appointment, HIV lab work, or an ART prescription).* ***Viral Suppression*** *is defined as a viral load that's less than/equal to 200 copies/ml. For these purposes we're looking at the last viral load of the year.*

Studies have shown that PLWH who are able to maintain viral suppression (for at least 6 months) can not transmit HIV.

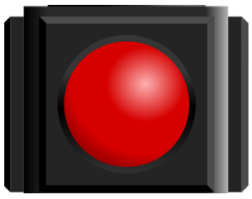
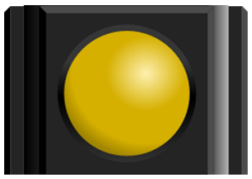
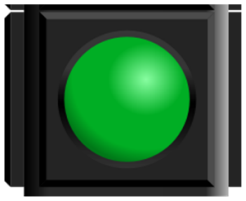
Health Outcomes—Stoplight System

Texas' goals by 2030 are:

90% PLWH retained in HIV care & treatment

90% of those retained achieve viral suppression

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

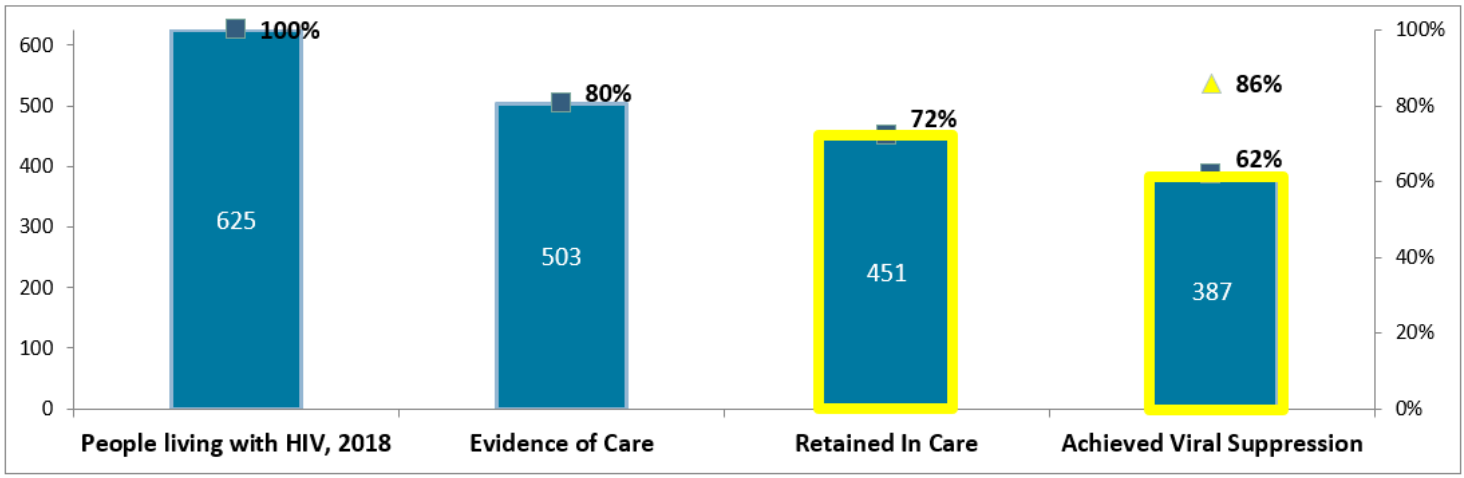
On ART / Retention In Care		On ART/In-Care Viral Suppression
< 69%	 Stop and examine further, May be a priority	< 84%
70% - 89%	 May need to examine further, May not be a priority	85% - 89%
90% <	 Maintain Current Activities, Look for Promising Practices	90% <

2018 Care Continuum

In the Waco HSDA, 72% of PLWH have achieved retention in care, 62% of total PLWH have achieved viral suppression, and 86% of PLWH who are retained in care achieved viral suppression.

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

HIV Treatment Cascade for Waco HSDA, 2018



80% of PLWH had at least 1 episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care

62% of PLWH achieved viral suppression (last viral load of the year was <200 copies/ml). This means roughly 6 out of 10 PLWH achieved viral suppression.

This is community viral suppression

72% of PLWH were retained in care (at least 2 episodes of HIV care & treatment across the year). This means roughly 7 out of 10 PLWH were retained in care.

Of those 7 out of 10 PLWH retained in care, 86% , or roughly 6 of those 7 achieved viral suppression.

This is in-care viral suppression.

2018 Continuum of Care, Parity Table

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

Most communities have few opportunities to achieve viral suppression, even when retained in care. People who acquired HIV through male-male sexual contact, specifically Black and Latinx MSM, have achieved In-Care Viral Suppression goals.

Retention in care and in-care viral suppression are both priorities.

90% PLWH retained in HIV care

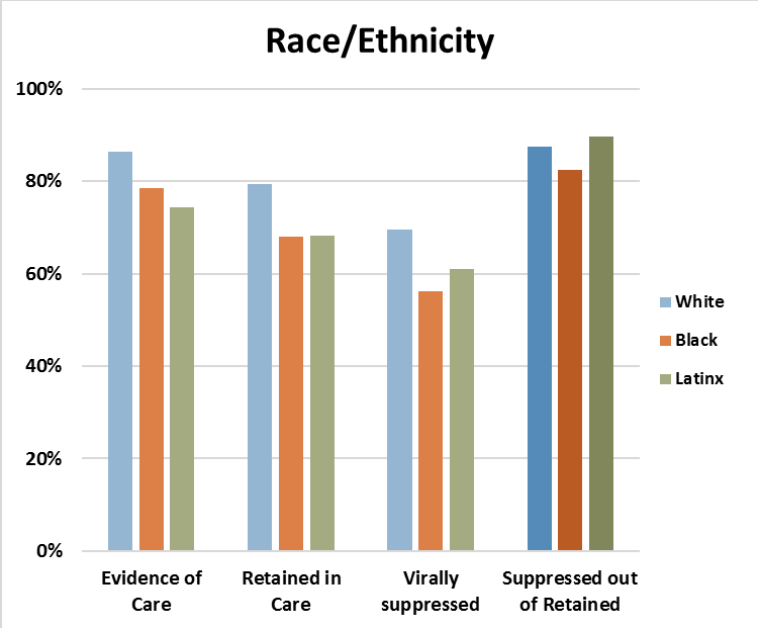
90% of those retained achieve viral suppression

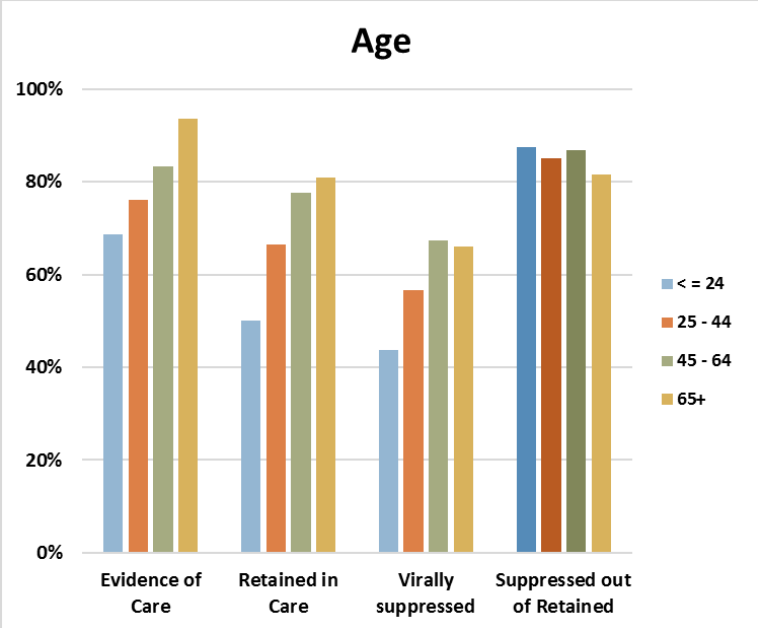
	PLWH		Evidence of Care (At least one visit)		Retained in Care		Suppressed		% suppressed of those retained
	#	%	#	%	#	%	#	%	%
All PLWH	**625**	**100%**	**503**	**80%**	**451**	**72%**	**387**	**62%**	**86%**
Women	182	29%	150	82%	139	76%	113	62%	81%
Men	442	71%	353	80%	312	71%	274	62	88%
Transgender Women	1	<1%	0	0%	0	0%	0	0%	0%
White	190	30%	164	86%	151	79%	132	69%	87%
Black	285	46%	224	79%	194	68%	160	56%	82%
Latinx	113	18%	84	74%	77	68%	69	61%	90%
<=24	32	5%	22	69%	16	50%	14	44%	88%
25 – 44	242	39%	184	76%	161	67%	137	57%	85%
45-64	304	49%	253	83%	136	78%	205	67%	87%
65+	47	8%	44	94%	38	81%	31	66%	82%
Male-Male Sexual Contact	309	49%	246	80%	216	70%	198	64%	92%
Injection Drug Use	128	20%	104	82%	94	74%	74	58%	78%
Male-Female Sexual Contact	183	29%	149	81%	137	75%	113	62%	83%
White MSM	112	18%	96	86%	87	77%	76	68%	87%
Black MSM	105	17%	83	79%	70	66%	64	61%	92%
Latinx MSM	73	12%	54	74%	48	66%	48	66%	100%
Black Women	87	14%	69	79%	63	73%	51	59%	80%
Transgender Women	1	<1%	0	0%	0	0%	0	0%	0%
PWID	128	20%	104	82%	94	74%	74	58%	78%

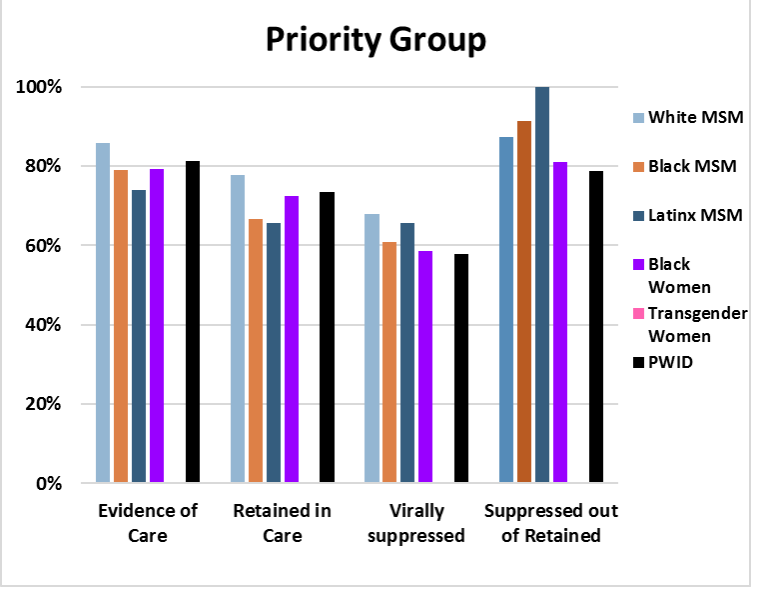
Note

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

2018 Continuum of Care, Parity Bar Charts







Note

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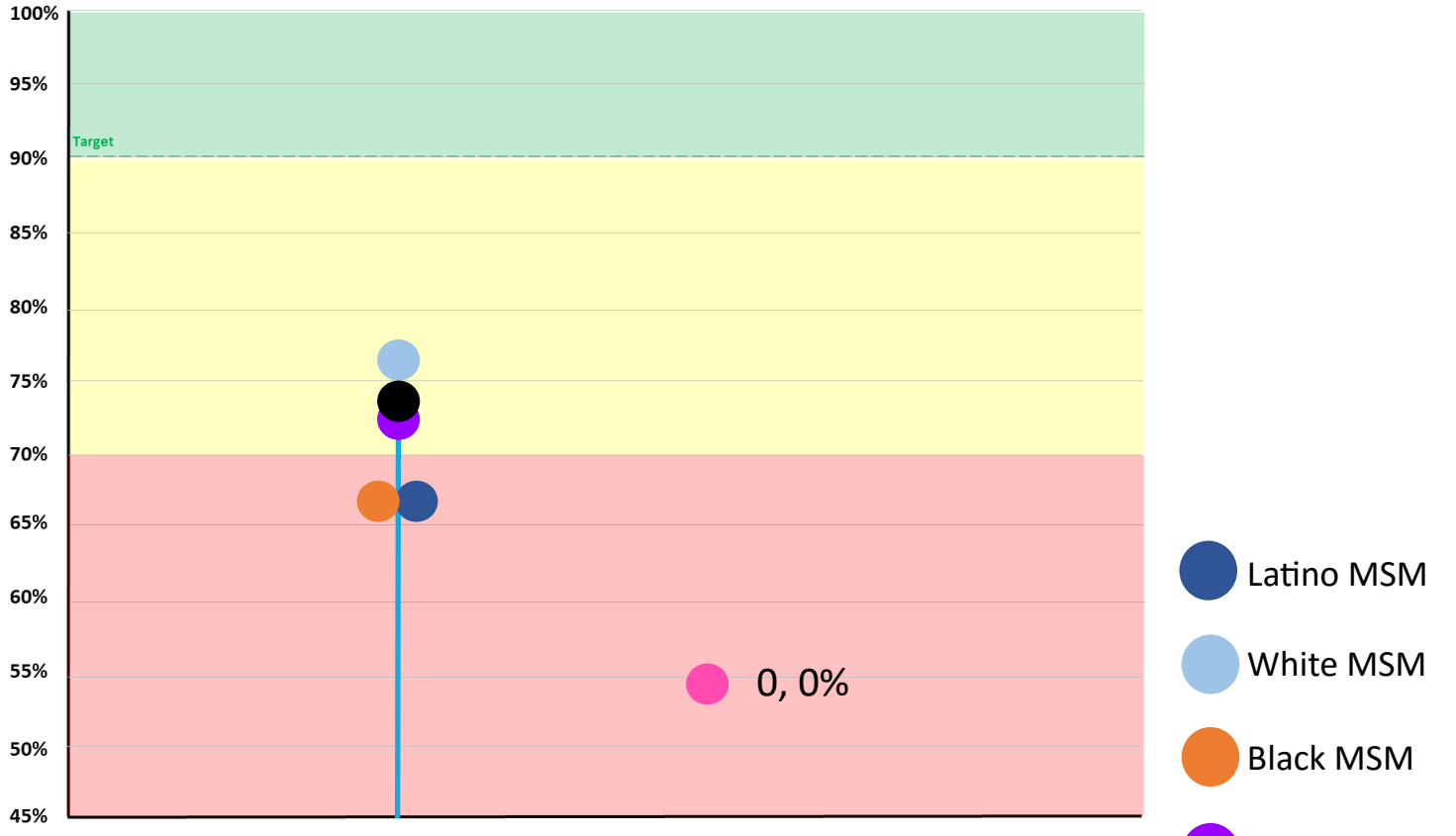
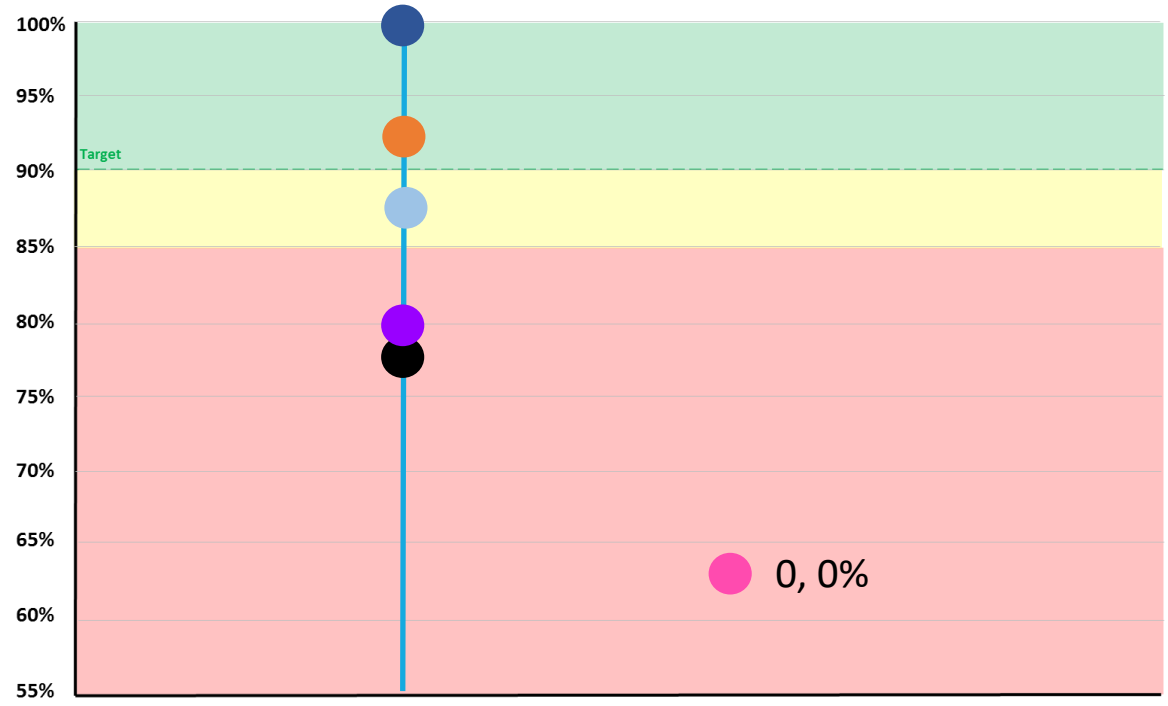
2017 Continuum of Care, Priority Populations, Stoplight System

Retention in Care, Priority Populations



In-Care Viral Suppression, Priority Populations



Note

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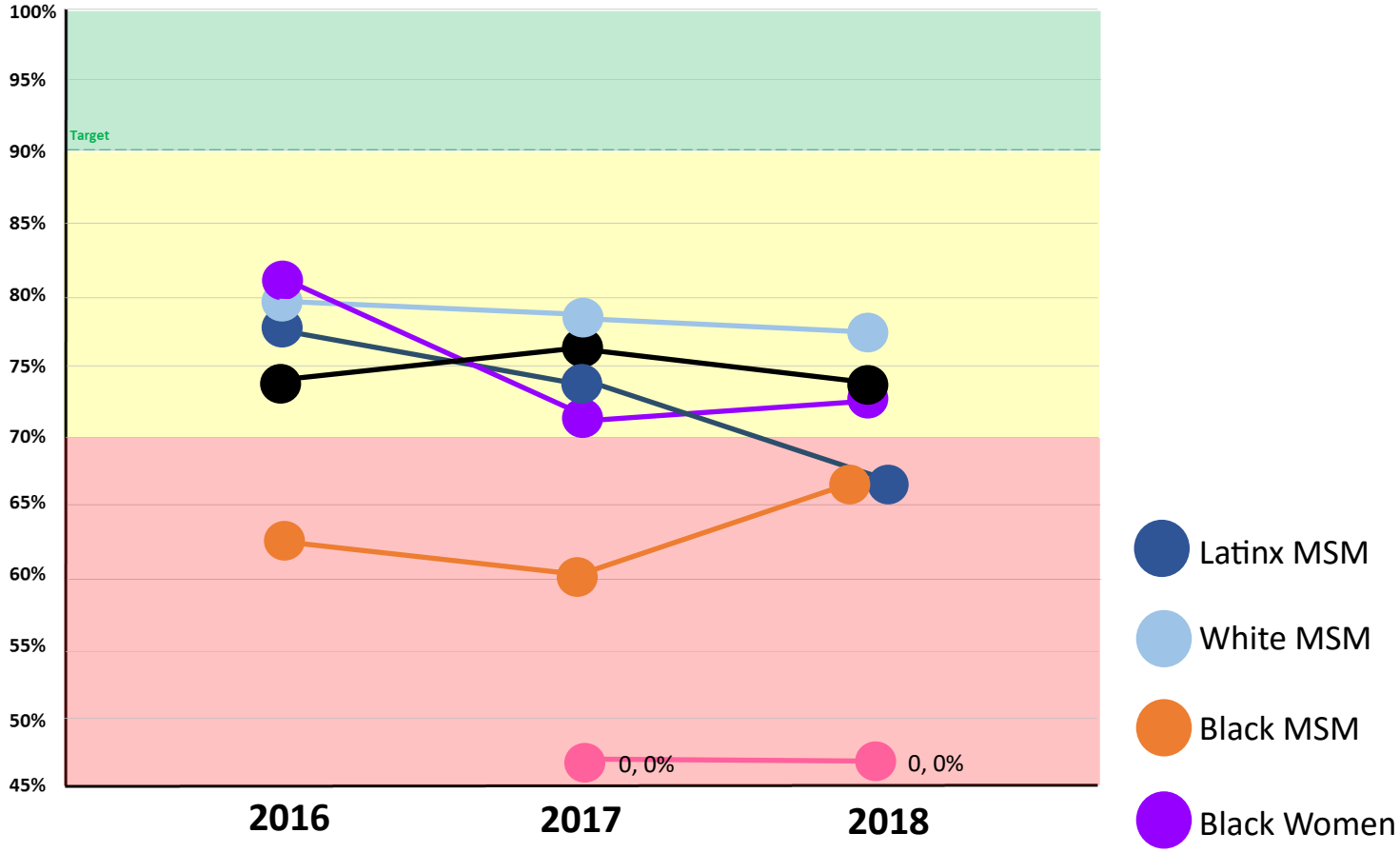
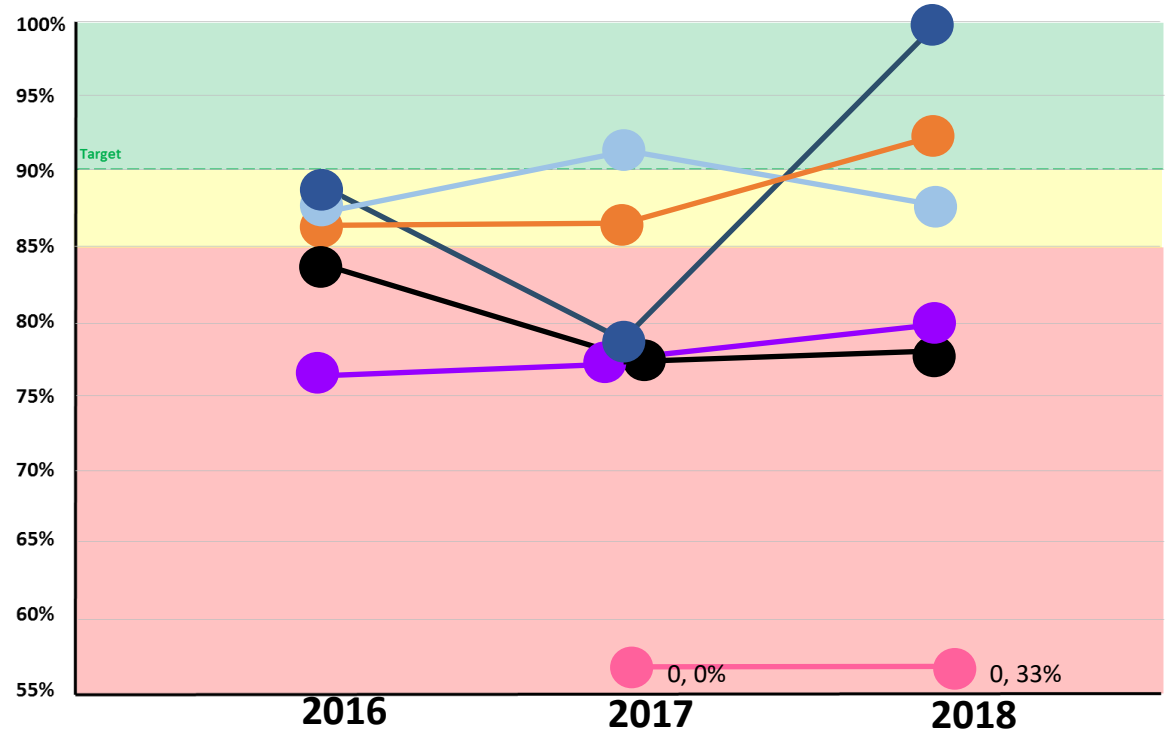
Continuum of Care, Priority Populations, Stoplight System 2016-2018

Retention in Care, Priority Populations



** no transgender data available for 2016*

In-Care Viral Suppression, Priority Populations



Note

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

Targets

The number of people who need to be able to access and engage with our systems in order to equitably meet our 90-90 goals (based on current number of PLWH who know their status).

90% PLWH retained in HIV care & treatment

90% of those retained achieve viral suppression

	PLWH		Retained in Care		*90% Retained goal*	Gap	Suppressed	*90% In-Care Viral Suppression goal*	Gap
	#	%	#	%	#	#	#	#	#
All PLWH	**601**	**100%**	**431**	**72%**	***541***	***110***	**356**	***487***	***131***
Women	176	29%	130	74%	*158*	*28*	103	*142*	*39*
Men	424	71%	301	71%	*382*	*81*	253	*344*	*91*
Transgender People	1	<1%	0	0%	*1*	*1*	0	*1*	*1*
White	180	30%	138	77%	*162*	*24*	122	*146*	*24*
Black	280	47%	187	67%	*252*	*65*	148	*227*	*79*
Latinx	107	18%	81	76%	*96*	*15*	65	*86*	*21*
<=24	28	5%	16	57%	*25*	*9*	12	*23*	*11*
25 – 44	239	40%	148	62%	*215*	*67*	118	*194*	*76*
45-64	291	48%	229	79%	*262*	*33*	190	*236*	*46*
65+	43	7%	38	88%	*39*	*1*	36	*35*	*-1*
Male-Male Sexual Contact	288	48%	205	71%	*259*	*54*	176	*233*	*57*
Injection Drug Use	132	22%	100	76%	*119*	*19*	77	*107*	*30*
Male-Female Sexual Contact	176	29%	122	70%	*158*	*36*	101	*142*	*42*
White MSM	103	17%	81	79%	*92*	*11*	73	*83*	*10*
Black MSM	98	16%	59	60%	*88*	*29*	51	*79*	*28*
Latino MSM	69	11%	51	74%	*62*	*11*	41	*56*	*15*
Black Women	88	15%	63	71%	*80*	*17*	48	*72*	*24*
Transgender Women	1	<1%	0	0%	*1*	*1*	0	*1*	*1*
PWID	132	22%	100	76%	*119*	*19*	77	*107*	*30*

Note

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

Appendix A: Prevention Interventions

The following are brief overviews of DSHS funded HIV prevention activities. With the exception of Routine HIV Screening in Health Care Settings, all prevention activities are focused on populations who have increased vulnerabilities to acquiring HIV. See the Focused Prevention section for locally relevant populations who are appropriate for Focused Prevention activities.

Routine Screening in Health Care Settings

The CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care and those with increased vulnerabilities to HIV (including gay, bisexual and other men who have sex with men) get tested more frequently. DSHS funded Routine Screening programs are opt-out testing programs and can be found in a variety of facilities, including hospital emergency departments, community health centers, and jail medical services.

Activities conducted in Routine Screening programs must include:

- Routine HIV screening and notification of HIV-positive results; and
- Linkage to and engagement in HIV medical care for people with HIV-positive test results

More information on evidence-based linkage programs can be found at the CDC in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention

Core HIV Prevention

Core HIV Prevention programs must include the following activities:

- Engaging populations with increased vulnerability to HIV
- Condom distribution
- Focused HIV and syphilis testing in non-clinical settings (emphasis on locations with high probability of encountering the locally relevant population for focused prevention)
- Linkage to and engagement in HIV medical care for people with HIV-positive test results; and
- Referral to PrEP, nPEP and other needed services for people with HIV-negative test results and increase vulnerabilities to acquiring HIV

More information on evidence-based linkage programs can be found at the CDC in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention

Appendix A: Prevention Interventions, continued

PrEP and nPEP

The CDC states that when taken daily, PrEP is highly effective for preventing HIV. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74% when taken daily.
PEP is also highly effective at preventing HIV. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure.

Activities conducted in PrEP and nPEP programs must include:

- Promotion and marketing of PrEP/nPEP through community education and awareness activities
- Promotion of adoption of PrEP/nPEP by local clinical providers; and
- Delivery of PrEP/nPEP clinical and client support services (this funding may not be used to pay for PrEP/nPEP medications, but it may be used for: navigation staff, clinical staff, initial and ongoing medical testing, adherence counseling and benefits counseling.

Client Level Interventions

Client Level Interventions are evidence-based or practice-based behavioral interventions delivered to individuals or groups that have shown effectiveness in preventing HIV transmission and acquisition. These interventions may be focused on both PLWH or HIV-negative people with increased vulnerabilities to acquiring HIV. Programs funded through DSHS may use approved “homegrown” interventions, or one of the CDC interventions listed in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention.

Currently funded interventions in Texas include:

- Healthy Relationships
- Personalized Cognitive Counseling
- CLEAR
- Many Men, Many Voices
- Behavioral Health
- Connect
- ¿ Y Ahora Que?
- VOICES/VOCES

Appendix A: Prevention Interventions, continued

Structural Interventions

Structural interventions are projects implemented at the community or system level in order to reduce the risk of HIV transmission and acquisition. These programs must work to reduce health inequities, and new HIV infections by directly addressing the social determinants of health such as stigma, lack of support, or policies or organizational practices that create barriers to prevention and treatment. Activities must be centered on one or more of the outcomes below:

- Strengthening community involvement in HIV prevention efforts by increasing a sense of community ownership, participation, and collaboration in HIV prevention activities;
- Increasing local coordination and collaboration among community members, groups, organizations, and sectors (e.g., private business, public institutions);
- Increasing community support, education, and dialogue;
- Creating an environment in which people of color, LGBTQ individuals, youth, and other marginalized populations are empowered to reduce the risk of HIV acquisition and barriers to accessing HIV prevention are reduced/eliminated;
- Elimination of structural, social, and economic barriers related to healthcare;
- Improved health outcomes for LGBTQ communities and people of color; and
- Increased participation in HIV-related care and PrEP\nPEP.

Programs may use 'traditional' community-level interventions as part of their structural intervention. Programs funded through DSHS may use approved "homegrown" interventions, or one of the CDC interventions listed in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention, or one of the Community and Structural-level interventions found on the CDC's Effective Interventions.

Currently funded interventions in Texas:

- MPowerment
- Stigma Reduction
- Community PROMISE
- Addressing Stigma