

Centering Community to Strengthen the HIV Care System: Reflections from Dallas



2025 SUMMIT

September 15-17, 2025
New Orleans



Sonya M. Hughes-Galvan, EdD, MPH, CPH
Assistant Director, Ryan White Grants
Management Division
Dallas County Health and Human Services

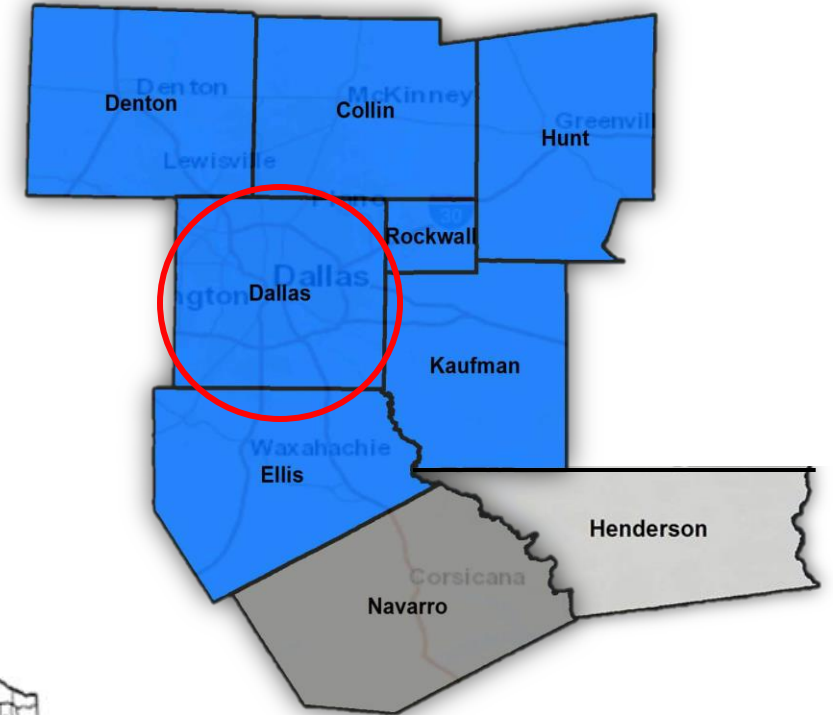


Dallas Regional Area

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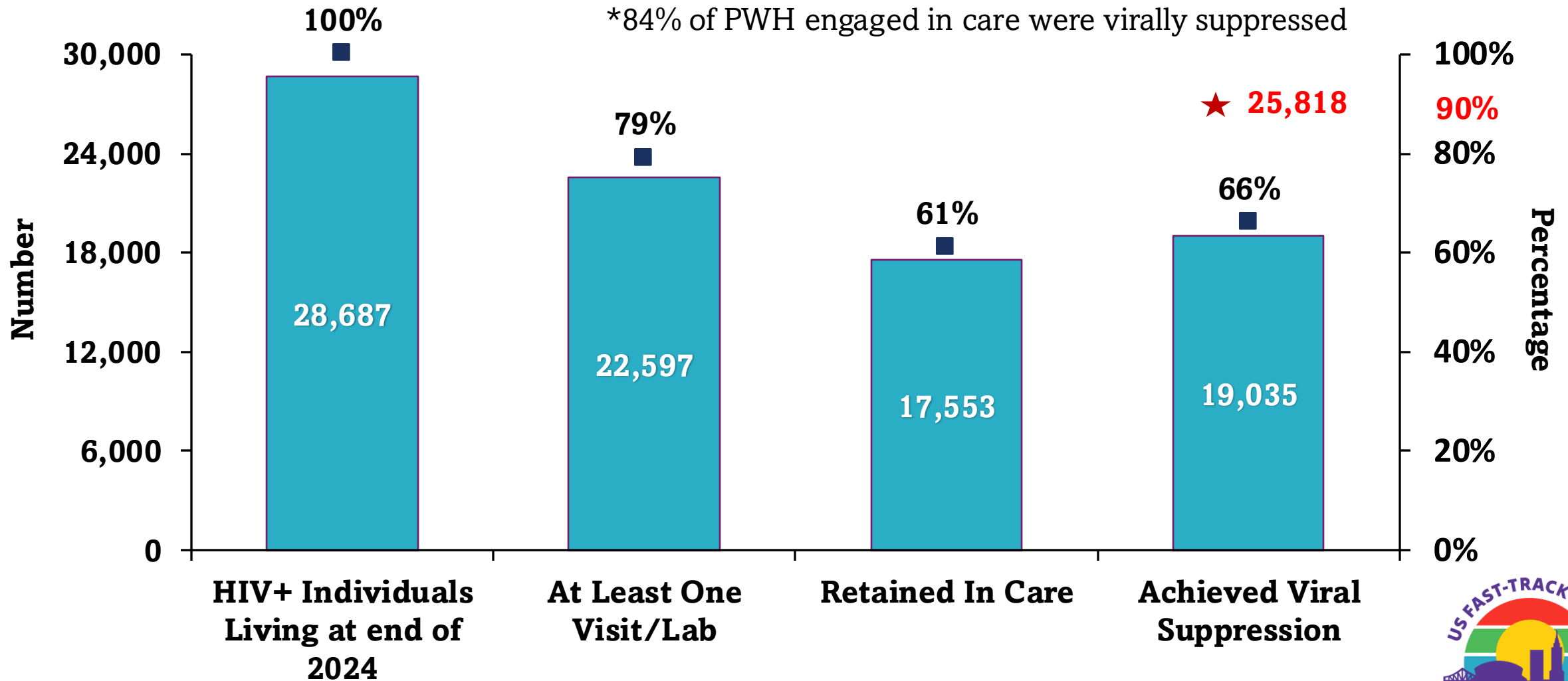
Dallas Eligible Metropolitan Area/ HIV Service Delivery Area

- 9-County Area in North Texas
 - Population ~5.6 million
 - (½ live in Dallas County)
 - 7,531 Square Miles



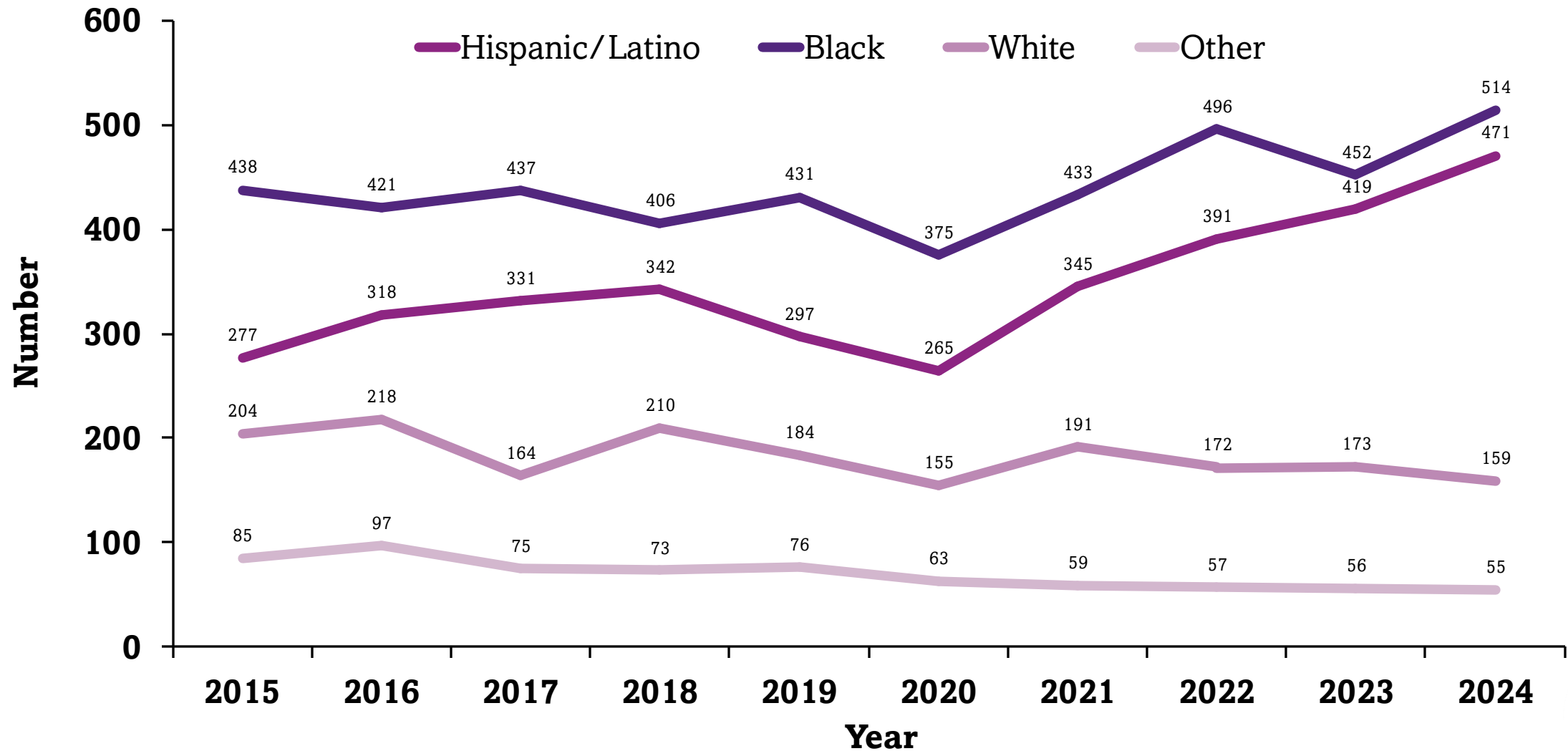
HIV Care Continuum: Dallas EMA/HSDA, 2024

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New HIV Diagnoses: Dallas EMA/HSDA by Race/Ethnicity, 2015-2024

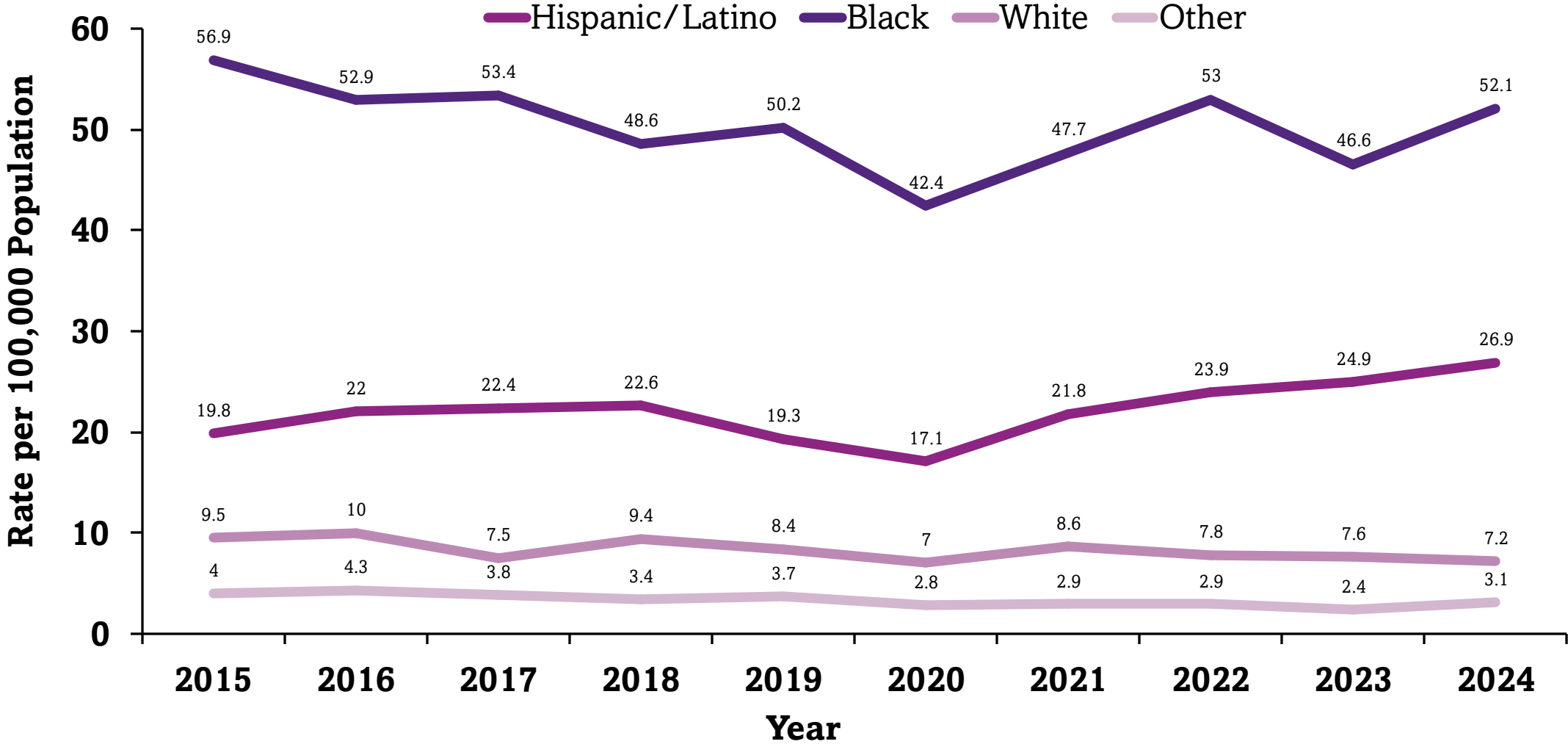
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New HIV Diagnoses Rates, Dallas EMA/HSDA by Race/Ethnicity, 2015-

September 15-17, 2025

2024



Dallas EMA/HSDA RWHAP – By the Numbers

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SERVED

10,774

Clients in
2024

**MORE
THAN**

38%

of people with
diagnosed HIV in the
Dallas EMA/HSDA

Ryan White Sub-recipient Agencies



**79% of Ryan White HIV/AIDS Program Clients
Virally Suppressed**

85%

were racial-
ethnic minorities



48%

were aged 45
years and older
2% were youth under 24



14%

had unstable
housing



The Dallas Fast Track County Initiative

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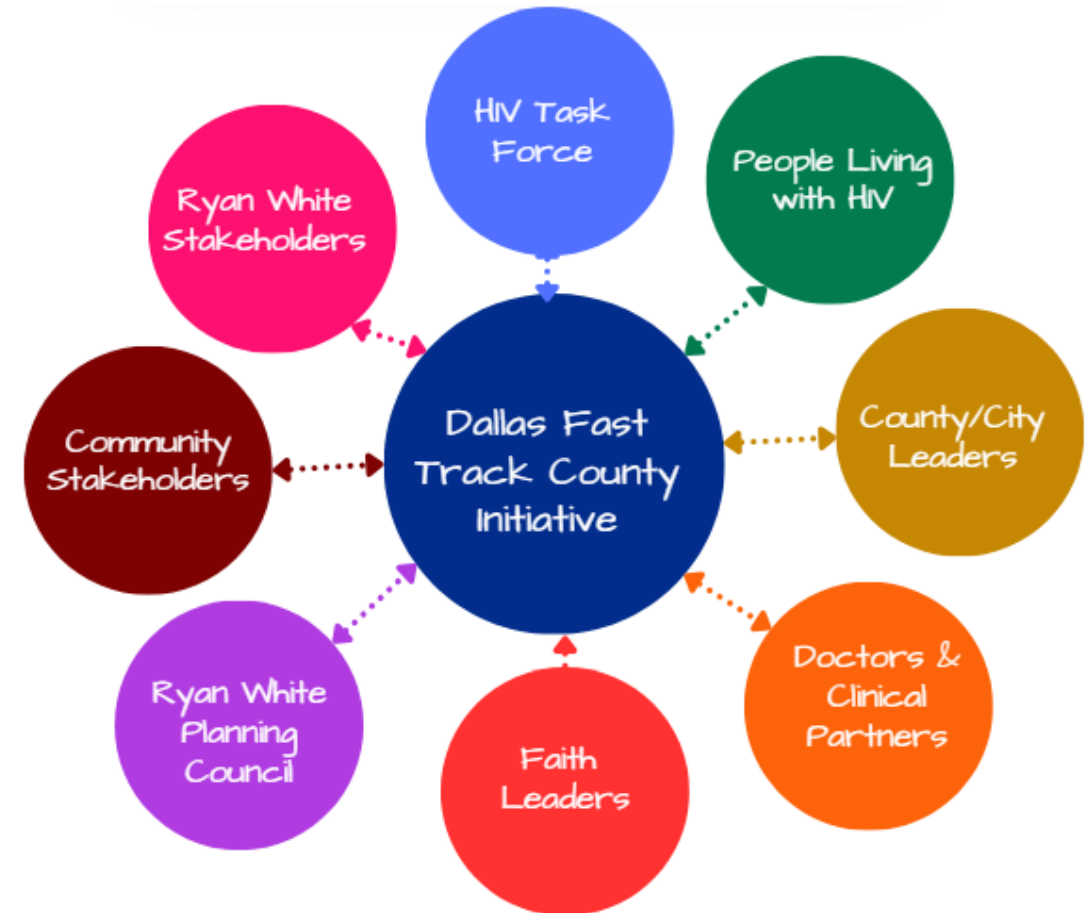
Centering Community

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- Quarterly working meetings (hybrid)
- EHE pillars framework
- Monitor progress, coordinate activities, and adapt strategies

Guiding Principle:

If someone is not at the table,
bring them!



The Goal is to Strengthen Our HIV Care System

- **Aligns with EHE pillars:** (Diagnose, Treat, Prevent, Respond) to drive one coordinated strategy across partners.
- **Improves Outcomes & Equity:** Faster linkage, sustained viral suppression, and focus on disproportionately impacted communities.
- **Strengthens System Performance:** Shared metrics, clear ownership, and faster course-correction.
- **Maximizes Resources:** Aligns county, state, and federal efforts; reduces duplication; scales what works.
- **Builds Preparedness:** Respond pillar tightens outbreak detection/response and community trust.



Successful Initiatives: FTCI

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- **Hepatitis Workgroup**: Established to address the intersection of HIV and Hepatitis, this workgroup strengthens screening, treatment, and linkage-to-care strategies.
- **Centralized Eligibility**: The development of a centralized eligibility system has streamlined client access to care and support services.
- **Ending the HIV Epidemic Request for Proposal Strategy**: Through a coordinated RFP process, the Initiative aligned federal EHE resources with local priorities.
- **Hospital Systems Implementing Opt-Out Testing**: Two major hospital systems implemented routine HIV opt-out testing, normalizing HIV screening and increasing early diagnosis opportunities.
- **Peer Navigation in Emergency Departments**: Peer navigators were embedded in hospital emergency departments to address link.



Special Projects of National Significance Awardee

- The aim of the SPNS Syndemic Approach Project is to improve HIV care outcomes for priority populations in Dallas County by addressing interconnected syndemic factors, HIV, mental health, food insecurity, and transportation

Our goals are to:

- Establish HIV primary care services at the DCHHS Sexual Health Clinic (SHC)
- Rapidly link newly diagnosed and out-of-care individuals to ART
- Integrate mental health screening and referral through partnerships
- Reduce social barriers to care (e.g., food insecurity and transportation)
- Improve care engagement, retention, and viral suppression rates through coordinated interventions

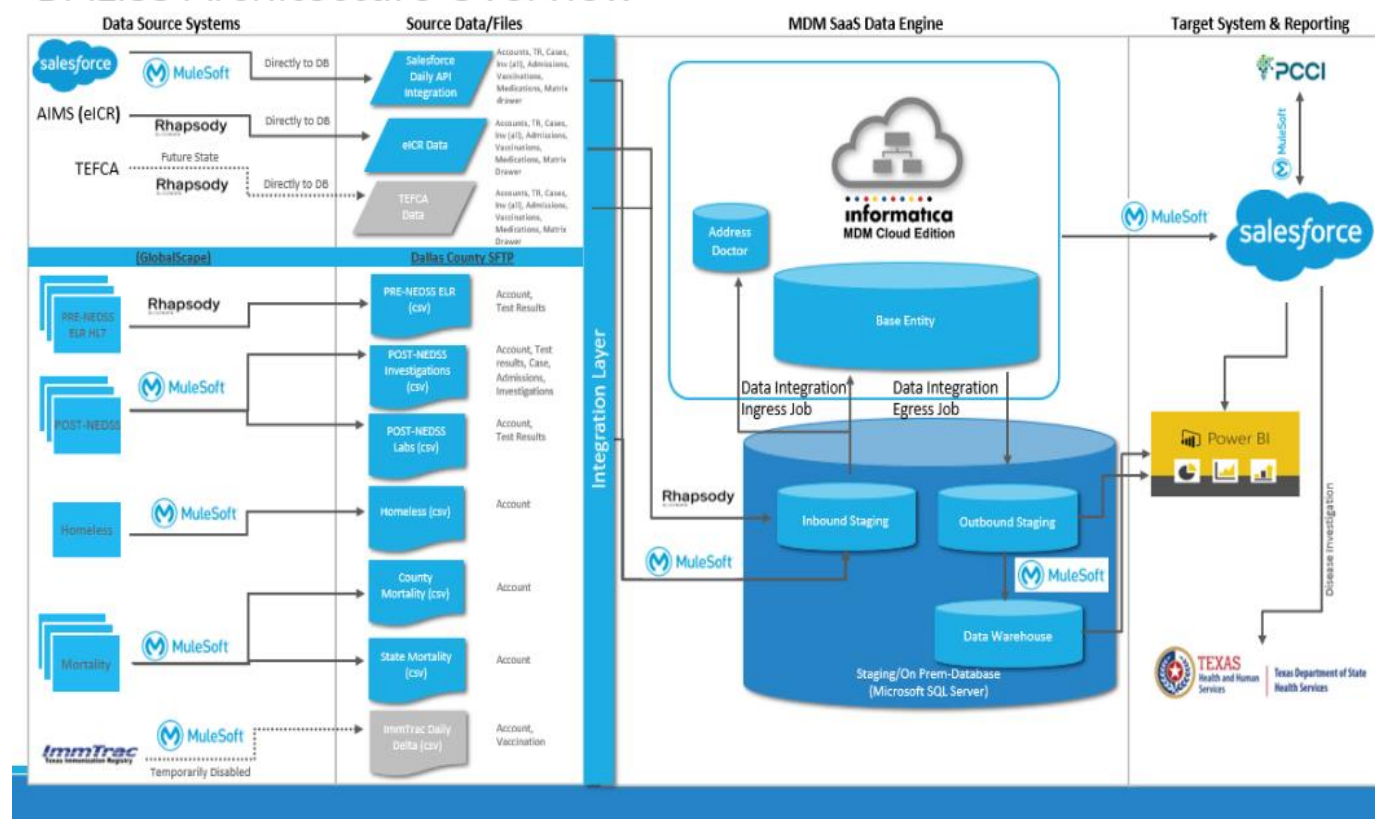


Salesforce Data Integration

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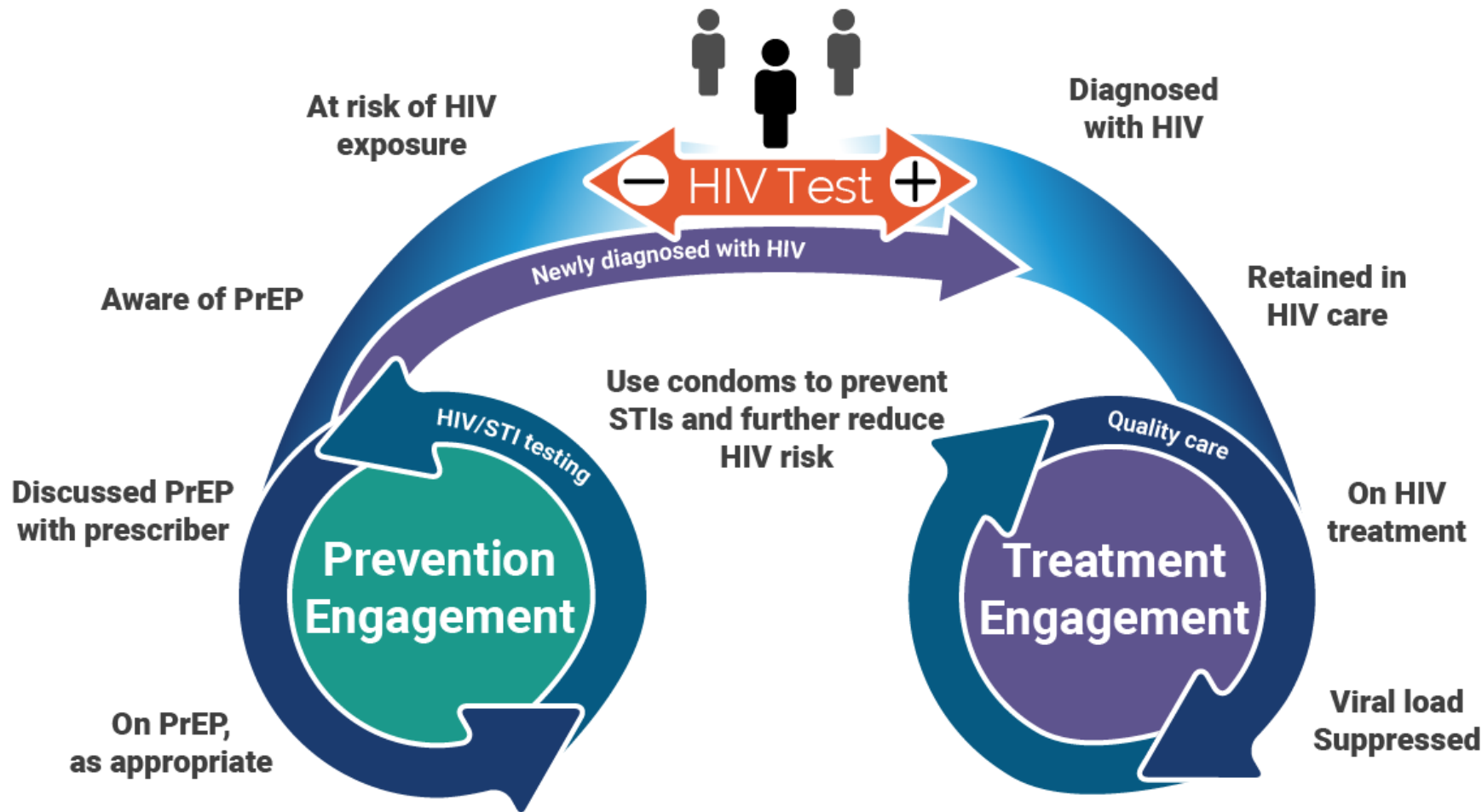
- Dallas County is undergoing a data modernization upgrade through Salesforce, streamlining public health reporting and analysis.
- Recipient of the HIMSS Davies Award of Excellence for COVID-19 response, Dallas is now expanding these capabilities to all reportable conditions.

DALISS Architecture Overview



Status Neutral Approach: EHE/RW Synergistic Relationship

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Question for the Audience:

What does that look like in your jurisdiction?

Centering the Voice of People Living with HIV

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Welcome to the Regional Ryan White Stakeholder Experience Evaluation (SEE) + Consumer Survey! Your feedback is crucial in improving care and services for people living with HIV. The Ryan White program is the nation's largest resource for HIV care, and your insights will help guide funding to meet the community's needs.

AK9. HIV STIGMA SCALE

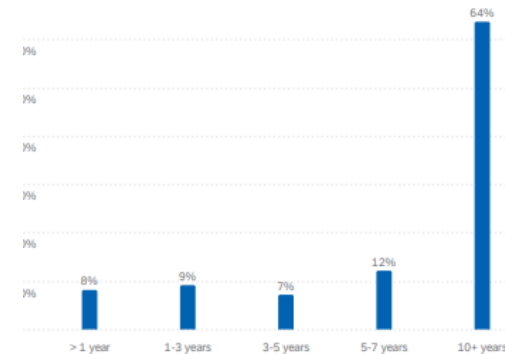
Negative attitudes					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. Families of people living with HIV AIDS should be ashamed.	1	2	3	4	5
2. People living with HIV AIDS should be ashamed.	1	2	3	4	5
3. *People who have HIV AIDS are cursed.	1	2	3	4	5
4. People who have AIDS are disgusting.	1	2	3	4	5
5. People living with HIV AIDS deserve to be punished.	1	2	3	4	5
6. It is reasonable for an employer to fire people who have AIDS.	1	2	3	4	5
7. People with AIDS should be isolated from other people.	1	2	3	4	5
8. People with HIV should not have the same freedoms as other people.	1	2	3	4	5
Perceived discrimination					
9. People living with HIV AIDS in this community face rejection from their peers.	1	2	3	4	5

Dallas Status Neutral Needs Assessment Survey



A Little About You

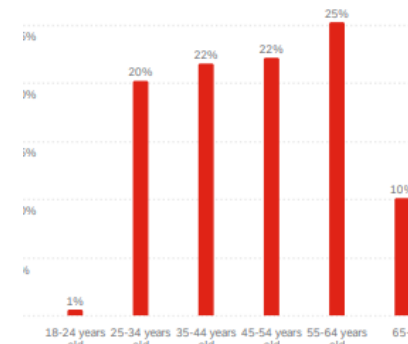
How long have you been living with HIV? 198



What is the zip code where you currently reside? 199



What is your age group? 198



What is your sexual identity or orientation? Select all that apply 198



FY 2024 RYAN WHITE
NEEDS ASSESSMENT
FOCUS GROUP

Black Cis Gender Women with Lived Experience

Eliminating Stigma & Discrimination in Health Settings Delivering HIV Services

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- Survey findings from 2018 across five Fast-Track Cities show that almost one in three PLWHA report feeling stigmatized by their community.
- Almost one in four, or 23%, report feelings of stigma in a healthcare setting, of which 78% identified a healthcare worker as the source of stigma.

Actionable Causes

- Ignorance about the harm of stigma
- Irrational fears
- Moral/value judgements

Approaches to Reducing Stigma/Discriminatory Behavior

- Measurement of stigma in health facilities
- Peer mobilization developed for & by PLWHA
- Engagement with community leaders
- Enabling workplace policies



Request for Proposal Scoring Criteria

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Criteria	Weight
Service Functionality, Comprehensive Service Delivery, and Work Plan	30%
Experience and Qualifications	20%
Budget	15%
Small Business Enterprise (SBE)	15%
* Innovation and Flexibility	10%
* Organizational Diversity Representative of the HIV Epidemic	10%

The External Review Committee includes subject matter experts, community stakeholders, and people with lived experience.



- Trauma-Informed Care (TIC): Agencies must integrate TIC principles into culture and services, including screening, client education, and skill-building to improve outcomes.
- Rapid StART: Sub-recipient shall join the learning collaborative to standardize rapid linkage and ART initiation for newly diagnosed individuals to increase viral suppression and retention.
- Integrated Planning & Needs Assessment: Participation in county-led planning and assessments ensures services are aligned with community needs and system priorities.

Why CAI for Your Trauma Informed Care Needs?

CAI's model of trauma informed implementation engages leadership to integrate trauma informed care into their agency's many systems. Based on the principles of implementation science, this approach includes integrating trauma informed care into the:

- Organizational culture
- Policies and protocols
- Tracking systems

Once organizational integration has begun, CAI offers individualized trainings for staff to deliver skills-based services to clients including how to:

- Screen for trauma
- Make effective referrals
- Provide trauma informed education and counseling

Integral to this model is support for agencies' staff to avoid burnout and other issues associated with secondary trauma.



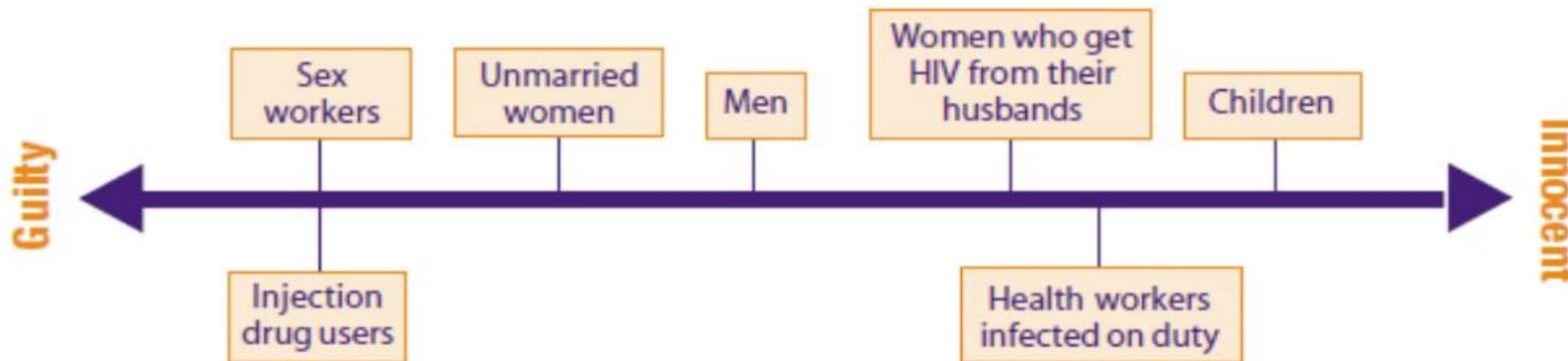
Contract Mandates

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- Client-Centered Care & Cultural Humility: Staff must complete cultural humility training to reduce bias and deliver inclusive, respectful, and client-focused care.
- Stigma Reduction: Agencies must engage in stigma-reduction activities that build trust, improve engagement, and strengthen the system of care.



Box 3: Schematic of “Innocence-to-Guilt” Continuum



HIV DOES NOT AFFECT ALL GROUPS EQUALLY

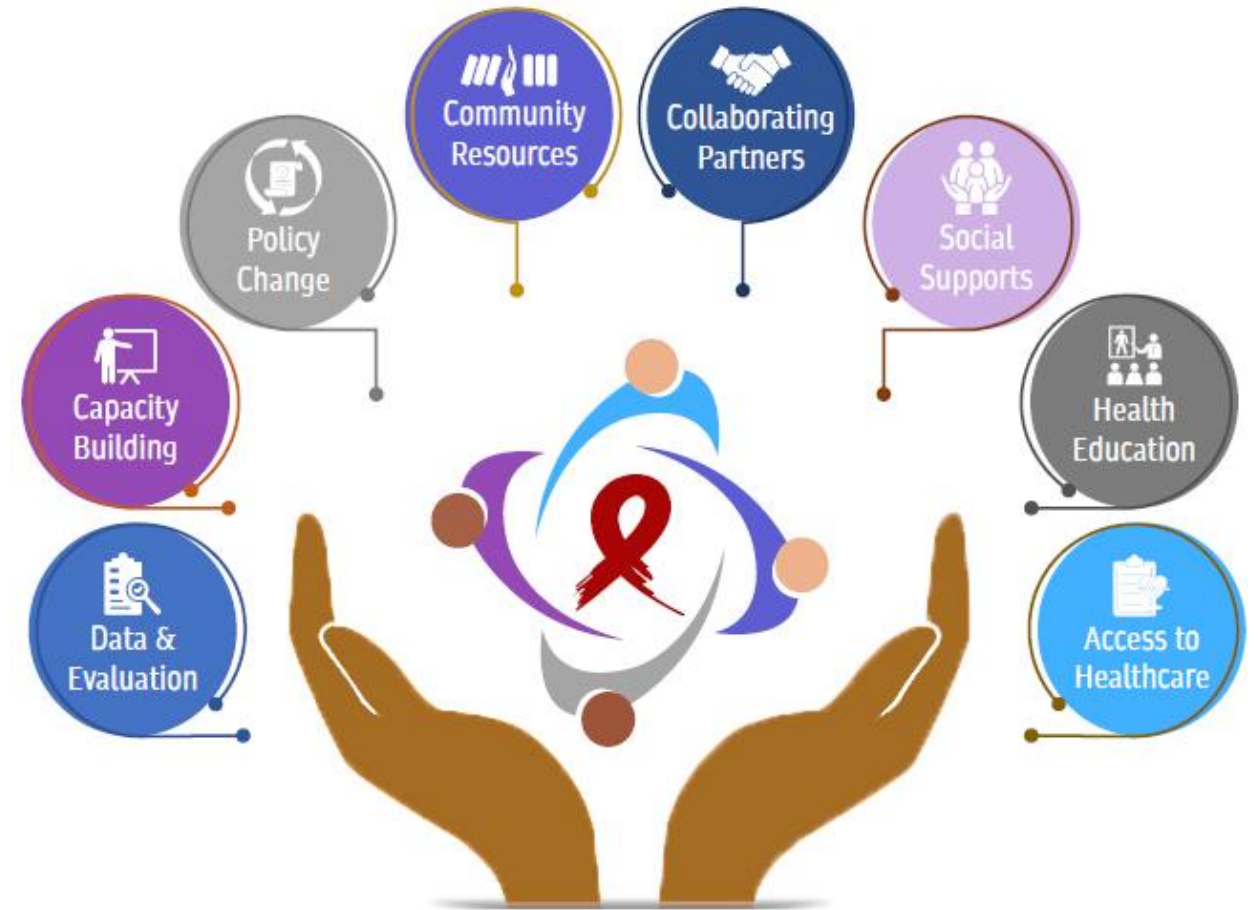
Black and Latino communities are **disproportionately** affected by HIV compared to other racial/ethnic groups.



Care Coordination: Community Health Workers

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- Community Health Workers (CHWs) are key partners in engagement and service identification, ensuring care aligns with client needs.
- Trusted Bridges: Build trust between clients and providers, reducing barriers to care.
- Access & Navigation: Help clients navigate complex healthcare systems and connect to essential services.



“People should not die from cancer because they are poor or Black. This is more than a medical and scientific issue. This is a moral issue.”

DR. HAROLD FREEMAN

PROFESSOR OF SURGERY EMERITUS,
COLUMBIA UNIVERSITY COLLEGE OF
PHYSICIANS AND SURGEONS




At its core, patient-centered care (PCC) refers to an approach in healthcare that respects and responds to the individual needs, preferences, and values of patients. Unlike the traditional model where the doctor makes decisions on behalf of the patient, PCC involves the patient as an active partner in their care.

[🏠 AIDS Patient Care and STDs](#) > [Vol. 33, No. 2](#)

Research Article | [🔒 NO ACCESS](#) | Published Online: 4 February 2019



Retention in HIV Care Among Participants in the Patient-Centered HIV Care Model: A Collaboration Between Community-Based Pharmacists and Primary Medical Providers

Authors: [Kathy K. Byrd](#) , [Felicia Hardnett](#), [Patrick G. Clay](#), [Ambrose Delpino](#), [Ron Hazen](#), [Michael D. Shankle](#), [Nasima M. Camp](#), [Sumihiro Suzuki](#), and [Paul J. Weidle](#) for the [Patient-Centered HIV Care Model Team](#) | [AUTHORS INFO & AFFILIATIONS](#)

Retention **improved 12.9%** (60.7–68.5%, $p = 0.002$). The largest improvement was seen among non-Hispanic black persons, **22.6% increase** (59.7–73.2%, $p < 0.001$)



Dallas County Approach - System of Care

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Flexible Service Models

- Video & phone visits available.
- Transportation supports: Uber Health rides, bus passes, Handi-Ride benefits and van rides.
- Multiple community clinic locations for easier access.
- Robust walk-in model:
 - CONNECT Clinic for those out of care, daily walk-ins across all services.

Serving Undocumented Clients

- Staff trained on responding to ICE activity and patient concerns.
- Legal department vetted and disseminated protocols.
- Commitment: safe, quality, and consistent care for all patients, regardless of immigration status.

Innovative Practices

- Walk-in reengagement clinic (Tues/Thurs 10–2) for patients out of care >6 months.
- Full service: financial clearance, labs, provider visit, and reentry into ongoing care.





Lessons Learned

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Value of Inclusive Engagement

- Broad coalitions (government, providers, hospitals, community groups, people with lived experience) are essential for meaningful impact.
- Ensuring all voices—including people with HIV—are at the table strengthens trust and creates more equitable solutions.

Importance of Relationship-Building

- Partnerships succeed when trust is nurtured through consistent communication and responsiveness.

Equity and Representation Matter

- Intentionally strengthens the system.
- Equity frameworks help ensure resources are distributed fairly, not just to the largest partners.

Data is a Unifying Tool

- Shared dashboards and outcome measures help align diverse stakeholders around evidence, not opinions.
- Transparency builds accountability across systems.

Flexibility in Coordination

- Urban environments are complex, with rapid policy shifts and funding freezes.
- Flexibility, innovation, and contingency planning help sustain progress when conditions change.



Lessons Learned

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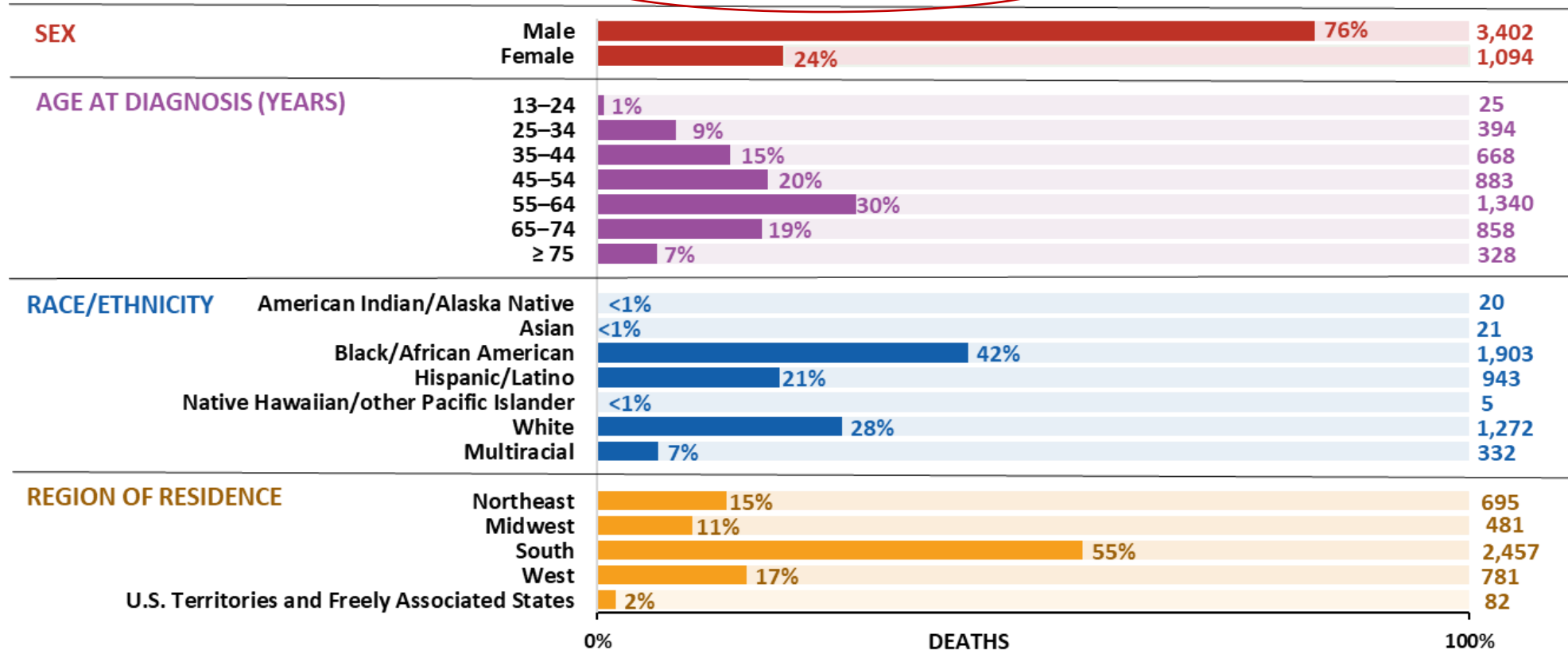
- **Partnership is the strategy:** The work cannot be done by one entity alone; it takes coordinated, cross-sector collaboration.
- **Progress is incremental:** Even small steps, like opt-out testing in hospitals or embedding peer navigators, can ripple into larger system transformation.
- **Challenges spark creativity:** Funding freezes, staffing turnover, or political barriers often push partners to innovate and find new pathways forward.



HIV-related Deaths of Persons with Diagnosed HIV, U.S. 2023

September 15-17, 2025

N= 4,496





“If you think you’re too small to make a difference, try spending the night with a mosquito.” - African Proverb



Sonya.Hughes@dallascounty.org



214-819-1841

