Panwest-West Texas

Panwest-West Texas
Ryan White Part B HIV Administrative Agency 2017-2020 Comprehensive HIV Services Plan

Revised May 2017

STARCARE

NEW SOLUTIONS, INC.

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ACRONYMS

ACA	Affordable Care Act
ART	Antiretroviral Treatment
BAS	Basin Assistance Services
C&T	Counseling and Testing
DIS	Disease Intervention Specialist
DSHS	Texas Department of State Health Services
ED	Emergency Department
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCC	HIV/AIDS Care Continuum
HEI	HIV Early Intervention
HERR	Health Education/Risk Reduction
HRSA	Health Resources and Services Administration
HSDA	HIV Service Delivery Area (Amarillo, El Paso, Lubbock and Permian Basin)
IAE	International AIDS Empowerment
IDU	Intravenous drug user
La Fe	La Fe Care Center
MHMR	Mental Health Mental Retardation
MAAS	Midland-Odessa Area AIDS Support
MSM	Men having sex with men
OSAR	Outreach, Screening, Assessment and Referral
PASO	Panhandle AIDS Support Organization
PCP	Primary Care Doctor/Practitioner
PDSA	Plan Do Study Act, Quality Management Cycle
PLWH	People/Person(s) Living with HIV or AIDS
PTSD	Post-Traumatic Stress Disorder
RHP	Regional Health Partnerships
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SPCAA	South Plains Community Action Association
STD	Sexually Transmitted Disease or Sexually Transmitted Infection
TTUHSC	Texas Tech University Health Sciences Center

EXECUTIVE SUMMARY

This 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan was designed to fulfill federal and state mandates and provide a road map for action over the next four years.

DESCRIPTION OF PANWEST AND WEST TEXAS PLANNING AREAS

- The PanWest Region includes three HIV Service Delivery Areas (HSDA):
- Amarillo HSDA
- Lubbock HSDA
- Permian Basin HSDA
- The West Texas area is also included in this analysis and is composed of one HSDA, El Paso.
- Together these four HSDAs comprise the 64 farthest west counties in Texas, ranging from the Panhandle to the Mexico border. The total population is approximately 2.14 million people.
- PanWest and West Texas HSDA counties have experienced significant growth between 2000 and 2014. Midland County grew 10.8%, Ector County 9.0%, Randall County 6.8%, and El Paso 6.7%.
- The counties with the lowest median incomes and the highest federal poverty levels include Potter, Hale, Lubbock, and El Paso Counties, all with incomes below $50,000.
- Randall County has the highest level of education of all HSDAs. Ector County and Hale County have high percentages without a high school diploma, 29% and 27%, respectively.

Regional Epidemic

By the end of 2015, the Pan West Region had a total of 1,539 PLWH. The three PanWest HSDAs have 497 PLWH in Amarillo, 547 PLWH in Lubbock, and 495 PLWH in Permian Basin. West Texas has 2,045 PLWH, almost all of whom live in El Paso County (99%).

PLWH race ethnicity varies across the region.

- The farther north the HSDA, the larger the percentage of White/Caucasian PLWH. This ranges from 34% in the Permian Basin HSDA to 8% in El Paso.
- The percentage of Black/African-American PLWHs are similar throughout the PanWest region, ranging from 16% in the Amarillo HSDA to 18% in the Permian Basin HSDA.
- The farther south the HSDA, the larger the percentage of Hispanic/Latino PLWH. This ranges from 86% in West Texas to 32% in the Amarillo region.

Men who have sex with men (MSM) is the most frequent transmission mode in all four HSDAs.

- The PanWest HSDAs have a smaller percentage with MSM than West Texas, ranging between 53% and 59% compared to 70% in in West Texas.
- IDU transmission mode is a relatively small percentage of infections. The rate, however, is higher in PanWest than West Texas.
- Heterosexual transmission mode ranges from 15% in Lubbock HSDA to 21% in the Amarillo and Permian Basin HSDAs.

Assessment of the Needs of People Living with HIV/AIDS

The 2017-2020 PanWest-West Texas Targeted Needs Assessment informs this comprehensive plan. It included an online survey of 268 consumers, 6 in-depth interviews with out-of-care consumers, 15 key informant interviews, 5 provider focus groups, and a resource inventory.[1]

Description of the Current Continuum of Care

The StarCare Specialty Health System HIV Services Administrative Agency (AA) is committed to meeting HRSA's goals of increasing access to care and decreasing health disparities, with particular emphasis on the needs of newly infected and disproportionately impacted populations. This is being effectively accomplished through one multi-service subcontractor in each of the PanWest HSDAs and two funded subcontractors in the El Paso HSDA.

- The three Ryan White Part B funded service subcontractors in the PanWest are located in the population centers of each HSDA. These providers assess, link and refer to non-Ryan White funded community resources throughout the region.
- In the West Texas HSDA, La Fe CARE Center and Project CHAMPS El Paso provide HIV medical care and medical case management.

In both the PanWest and West Texas regions, Subcontractors work with local community health care and social service providers to deliver services to encourage consumers' access to care, ensure the provision of appropriate HIV health care and meet client medical and supportive service needs.

Each subcontractor must establish, implement, and monitor a referral process to ensure follow-up with services that they don't directly provide. This approach fosters collaborative relationships and has enabled the subcontractors to explore the availability of community services, avoid duplication of services, and provide the service with minimal time lapses. It also ensures Ryan White Part B funding is used as the payer-of-last-resort.

Strengths and Challenges of the PanWest and West Texas Continuums of Care

The following strengths in service provision provide a foundation for this plan and achievement of its goals:

- Medical care is provided by specialty trained and experienced physicians in each HSDA.
- Ryan White core services are provided in each HSDA.

[1] PanWest-West Texas 2016 Comprehensive Needs Assessment can be found at www.panwest.org.

- Bilingual staff are widely available in West Texas organizations that serve PLWH.
- A variety of funding sources complements Ryan White funding.
- Well developed social service continuums of care in the population centers of the HSDAs.

Challenges include:

- Given Ryan White requirements to fund core medical services, funding for social services is limited. Collaboration with non-Ryan White funded community agencies is needed, but has been difficult to accomplish.
- Increasing numbers of newly diagnosed PLWH are stretching thin limited Ryan White funding, including funding for new services, despite the expansion of medical coverage through ACA.
- Shortages in the number of physician resources available to provide care to Ryan White patients persist.
- Location of Ryan White services in more urban centers creates access problems for PLWH in rural areas of all HSDAs.
- Stigma is an acute problem in the region limiting access to testing and the receipt of services due to consumer fear of disclosure.
- Decreases in outreach and prevention funding make it difficult to keep up with increasing numbers of at-risk populations.

Quality Management

The Administrative Agency established a joint Quality Management (QM) program for use in both the PanWest and West Texas regions. This program provides a documented, ongoing process to guide and continuously improve HIV/AIDS services. The primary purpose of the QM program is to enhance the quality of medical and other services provided to PLWH in the regions. It requires collaboration between all Ryan White funded subcontractors to ensure services are of the highest quality and provide efficiently and effectively in conformance with established standards of care and best practices.

- The cornerstone of the QM program is the Quality Management Plan.
- The QM Plan is developed and reviewed by the Quality Management Committee (QMC), which is comprised of representatives from the Administrative Agency (AA) and each funded PanWest and West Texas provider.
- Training is an important component of the QM program. The AA directly and indirectly offers training to contracted providers as part of the QM Plan.

COMPREHENSIVE HIV HEALTH SERVICES PLANNING PROCESS

Comprehensive HIV Health Services Plan

The 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. In May-July 2016, the AA staff participated in planning sessions that included a review of the previous mission, vision and shared values statements of the plan. These meetings also resulted in the development of draft goals, strategies, and required actions to be undertaken over the next four years. This information was developed into a draft plan that was presented and reviewed by the Texas Department of State Health Services (DSHS) staff.

Throughout the planning process AA staff considered the National HIV Strategy for the U.S., the *Texas HIV Plan* updated for 2014-2015, *Healthy People 2020*, and Ryan White Program requirements.

Mission, Vision and Core Values

The mission, vision and core values statements were included in the 2013 PanWest – West Texas Comprehensive Plan were adopted for the 2016 Comprehensive Plan. This mission statement is the foundation for the 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan.

Mission Statement

To support an effective, community-wide response to HIV/AIDS by focusing on high quality medical and support services and leveraging community resources.

The following ideal vision underpins the Plan.

Vision Statement

HIV care is accessible and effective.

All the work of the AA and its subcontractors is for the purpose of benefiting the health and well-being of PLWH. Recognizing the importance and complexity of this task, five values are shared by those who embrace this program.

Core Values

We believe all services build on the core values of: Dignity, Respecting Diversity, Professionalism and Quality, Availability and Accessibility, and Collaboration. These core values will encourage people living with HIV/AIDS to access treatment and be maintained in HIV medical care and support services.

- Dignity: All clients will be treated with dignity.
- Respect Diversity: Recognize and respect cultural and individual differences.
- Professionalism and Quality: Provide quality services in a professional manner.
- Availability and Accessibility: Health care services will be available and accessible.
- Collaboration: Work with community organizations to enhance access to the complete continuum of services, from HIV prevention to care and treatment.

PLAN GOALS AND RATIONALE

The 2017-2020 Comprehensive HIV Health Services Plan adopts three of the 2016 Texas Plan Priorities for AA and Subcontractor achievement. The goals reflect the findings of the 2016 PanWest-West Texas Targeted Needs Assessment which focused on barriers to linkage, retention and viral load suppression, and includes the updated epidemiologic profiles, regional demographics, and an assessment of access and health disparities in the region.

The three goals are to:

- Increase timely linkage to HIV-related treatment for those newly diagnosed with HIV.
- Increase continuous participation in systems of treatment among people living with HIV.
- Increase viral load suppression among people with HIV.

The goals for the 2017-2020 Comprehensive HIV Health Services Plan are outlined below along with the data and rationale to support the adoption of the goal.

GOAL 1: INCREASE TIMELY LINKAGE TO HIV RELATED TREATMENT FOR THOSE NEWLY DIAGNOSED WITH HIV.

Rationale

- Over a third of all new diagnoses were late stage, ranging from 46% in Amarillo to 30% in El Paso in 2014.
- From 2010-2014, new AIDS diagnoses increased by 14% across the entire region.
- Survey findings show that only 63% of current out-of-care consumers were linked to care within three months of their diagnosis.
- In 2014, across the PanWest-West Texas region, 72% of known PLWH were linked to care with at least one medical visit.
- When asked why they had not gotten into care for a timely manner the most frequent responses were “I was in denial” (48.5%), and “I wasn’t sick, so I didn’t think I needed medical care” (39.4%).

GOAL 2: INCREASE CONTINUOUS PARTICIPATION IN SYSTEMS OF TREATMENT AMONG PEOPLE LIVING WITH HIV.

Rationale

- In 2014, across all four HSDAs in the region, 66% of PLWH were retained in care with two or more medical visits. Amarillo had the highest rate (75%), and Permian Basin the lowest at 59%.
- PLWH in the region who are retained in care have viral suppression rates of 84%.
- Viral suppression levels not only improve long term health for PLWH, it also decreases their likelihood of infecting someone else.
- When asked reasons why they were not in medical care the top two reasons were, “I don’t feel sick,” and “I don’t have the money to pay for care.”
- The most often cited reasons that it was hard for consumers to get care included the paperwork required, the amount of time it takes at the clinic, and the time it takes to get an appointment.
- Sixteen percent of survey respondents reported dropping out-of-care within the last five years, and an additional 3% didn’t know/couldn’t remember.
- The most common reason for dropping out-of-care was “I was using drugs or alcohol“, “I was tired of taking medications”, and “I didn’t feel sick.”
- When asked, “What would have helped you stay in care,” the top 3 responses were:
  - ➢ “Having someone who understood what I was going through.”

- ➢ "Someone to guide me through the process of getting care, medication, and services."
- ➢ "Someone to talk to about being depressed/anxious."

GOAL 3: INCREASE VIRAL LOAD SUPPRESSION AMONG PEOPLE LIVING WITH HIV.

Rationale

- Across the entire PanWest-West Texas region, 55% of PLWH have achieved viral load suppression. The highest suppression rates were achieved in Amarillo (62%), and the lowest in Permian Basin (47%).
- Males have lower viral suppression rates than females, 54% compared to 57%.
- Hispanics had the lowest viral suppression rates (47%) compared to 61% of Whites and 51% of Blacks.
- Over 60% of respondents indicated they would like more information about their medications, and over 50% wanted information about their viral load.
  - ➢ Respondents were less likely to understand their viral load than their CD-4 levels, and had less understanding of what the viral loads meant.

MONITORING PROCESS

Monitoring Plan Results

The 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining completion dates, responsible parties and data indicators. Many of the objectives and actions should be monitored on a quarterly basis, but no less than semi-annually.

The AA is responsible for overseeing the implementation of the Plan in accordance with the stated timeframes. In addition:

- The AA works with funded providers to ensure a unified direction.
- The AA will review ARIES data quarterly to determine the number of new admissions and re-admissions of PLWH who are out of care as well as monitoring the units of service and expenditures.
- The quality management process supports monitoring and evaluation of Plan Goals.
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.

Evaluation

The AA monitors progress in achieving the goals and objectives of the plan. This, in turn, promotes evaluation of the Plan. Plan evaluation will include:

- Ability to implement stated action steps within the projected timeframes.
- Achievement of each strategy.
- Documented system improvements that support the three goals.

Each goal will be evaluated annually and upon completion of the plan using available data.

Impact on Priority Setting and Allocations

In developing the 2017-2020 PanWest-West Texas Comprehensive HIV Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system, but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement, but will not be a direct dollar cost. Finally, some of the strategies may result in increased costs for which additional funding sources may have to be identified.

I. INTRODUCTION

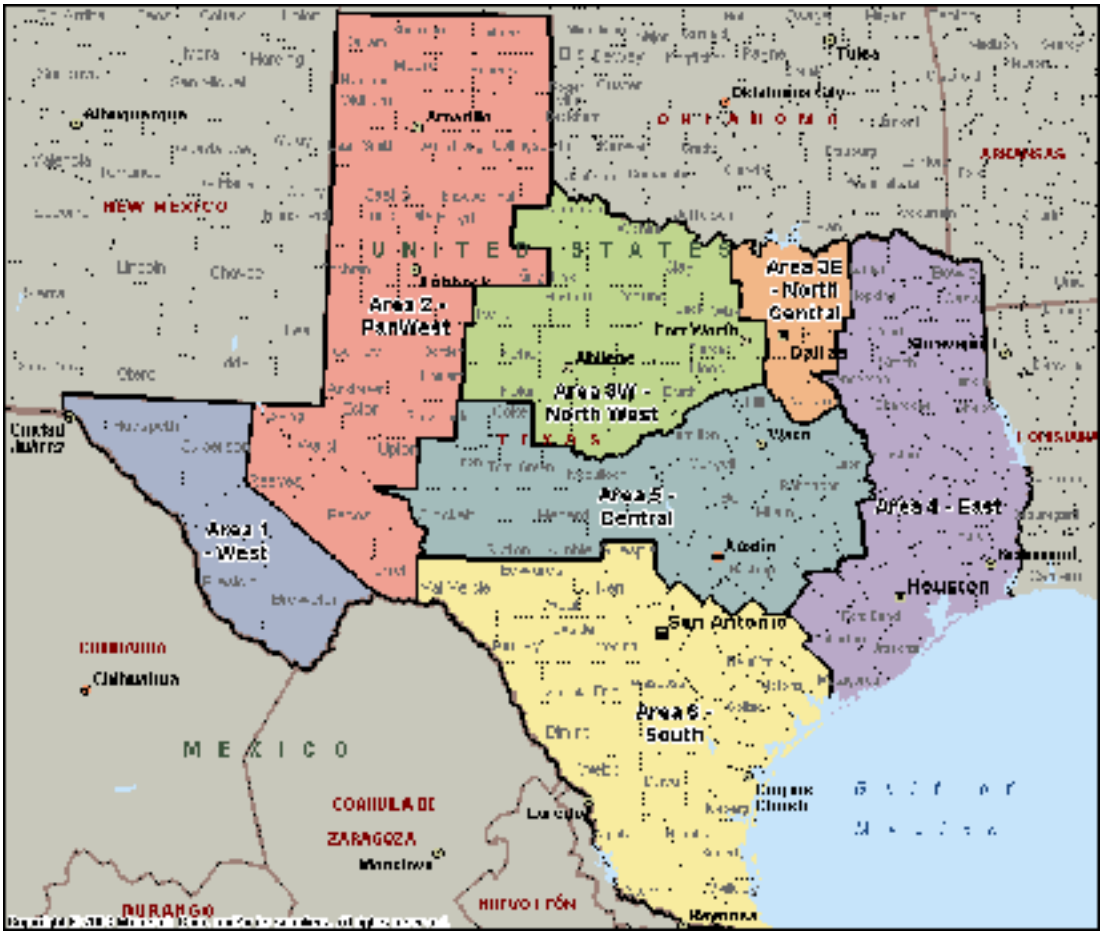
DESCRIPTION OF THE PANWEST AND WEST TEXAS PLANNING AREAS

Profile of the Four HIV Service Delivery Areas

This Comprehensive Plan includes the three PanWest HIV Service Delivery Areas (HSDA): Amarillo HSDA, Lubbock HSDA and Permian Basin HSDA and the El Paso HSDA (West Texas HASA). Together these four HSDAs comprise the 64 farthest west counties in Texas, ranging from the Panhandle to the Mexico border.

The map in Figure 1 presents the geography of the PanWest and West Texas regions.

Figure 1



The demographic profile is developed from U.S. Census Bureau data.[2] To provide the most relevant information, the one or two most populous counties from each HSDA are identified with detailed demographic data.

Table 1 combines the 64 counties making up the four HSDAs. The total population of the region was over 2.14 million in 2014. Each PanWest HSDA has one key Ryan White provider, which are listed in the table below. In West Texas, two organizations receive Ryan White Part B HIV medical care funds

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Table 1
PanWest and El Paso HSDAs
2014 Population and Key HIV/AIDS Providers

HSDAS AND COUNTIES	*2014 POPULATION*	*KEY PROVIDERS*
Amarillo HSDA--26 Counties Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Wheeler	**433,979**	Panhandle AIDS Support Organization (PASO)
Lubbock HSDA—15 Counties Bailey, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, Yoakum	**418,834**	SPCAA (Project CHAMPS) Lubbock
Permian Basin HSDA—17 Counties Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, Winkler	**439,107**	Basin Assistance Services (PBCC)
El Paso HSDA—6 Counties Brewster, El Paso, Hudspeth, Jeff Davis, Presidio	**848,562**	La Fe CARE; SPCAA (Project CHAMPS) El Paso
Total PanWest and West Texas Regions—64 Counties	**2,140,482**	

Population Data Source: U.S. Census Bureau State and County American Community Survey (ACS), 2014 Five-Year Estimates

The demographic analysis of the HSDAs finds:

- Both regions experienced significant growth between 2000 and 2014. Midland County grew 10.8%, Ector County 9.0%, Randall County 6.8%, and El Paso County 6.7%.
- The counties with the lowest median incomes and the highest federal poverty levels include Potter, Hale, Lubbock, and El Paso; all with median incomes below $50,000.
- Randall County has the highest level of education of all HSDAs while Ector County and Hale County have the highest percentages without a high school diploma, 29% and 27%, respectively.

[2]U.S. Census Bureau State and County American Community Survey 2015 Five-Year Estimates were selected for this profile to provide consistency with 2014 epidemiological data. Unless otherwise noted, all cited population statistics are from this source.

DESCRIPTION OF POPULATIONS LIVING WITH HIV BY RELEVENT CHARACTERISTICS

Epidemiology Overview

HIV Prevalence

In 2015, the PanWest Region had a total of 1,539[3] people living with HIV/AIDS (PLWH) and the West Texas region had 2,045.

- The number of PLWH varies among the PanWest HSDAs with 497 in the Amarillo HSDA, 547 in Lubbock HSDA, and 495 in the Permian Basin HSDA.
- This compares to 2,045 people living with HIV/AIDS in the West Texas region, almost all of whom live in El Paso County.
- PanWest and West Texas combined account for 5% of PLWH in the State of Texas.

Table 2
People Living with HIV/AIDS - 2014
Select Counties

HSDA/County	Number of PLWH	Percent of HSDA Total
Amarillo HSDA Total	**468**	
Potter County	251	53.6%
Randall County	113	24.1%
Lubbock HSDA Total	**528**	
Hale County	23	4.4%
Lubbock County	415	78.6%
Permian Basin HSDA Total	**616**	
Ector County	197	32.0%
Midland County	156	25.3%
El Paso HSDA Total	**2,050**	
El Paso County	2,030	99.0%
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch		

Race/Ethnicity

PLWH race ethnicity varies across the region.

- The farther north the HSDA, the larger the percentage of White/Caucasian PLWH. This ranges from 34% in the Permian Basin HSDA to 8% in El Paso.
- The percentage of Black/African-American PLWHs are similar throughout the PanWest region, ranging from 16% in the Amarillo HSDA to 18% in the Permian Basin HSDA.
- The farther south the HSDA, the larger the percentage of Hispanic/Latino PLWH. This ranges from 86% in West Texas to 32% in the Amarillo region.

[3] Unless otherwise stated, epidemiologic data are from Texas Department of State Health Services. Latest release is from 2015.

Gender
Differences are seen in PanWest and West Texas PLWH gender.

- PanWest has approximately 79% male and 21% female PLWH in all HSDAs.
- West Texas has 87% male and 13% female PLWH.

Age

- In all four HSDAs, prevalence increases with increasing age, beginning with 4% of PLWH in the 15-24 year age range and increasing to approximately 48% in the 25-45 year old group.
- The percentage increases in the 45+ group to more than 57%.

Transmission Mode
Men who have sex with men (MSM) is the most frequent transmission mode in all four HSDAs.

- The PanWest HSDAs have a smaller percentage with MSM than West Texas, ranging between 53% and 59% compared to 70% in in West Texas.
- IDU transmission mode is a relatively small percentage of infections. The rate, however, is higher in PanWest than West Texas.
- Heterosexual transmission mode ranges from 15% in Lubbock HSDA to 21% in the Amarillo and Permian Basin HSDAs.

HIV Incidence

- Between 2010 and 2014, new HIV diagnoses averaged between 82 and 86 in the PanWest HSDAs and 110 to 114 in the El Paso HSDA.
- The 2014 incidence rates ranged from 3.4/100,000 in Amarillo HSDA to 12.8/100,000 in El Paso HSDA and include 10.8/100,000 in Lubbock HSDA and 5.4/100,000 in Permian Basin HSDA.

Co-morbid Conditions
TDSHS reports co-morbid diagnoses of STI and TB for all newly diagnosed with HIV/AIDS. In 2014, 183 cases were reported of which 179 (98%) were STI related.

Syphilis is the most common co-morbid condition recorded with HIV infection.

- Syphilis diagnoses in persons living with HIV totaled 81 in 2014, 45% of all STI infections.
- Syphilis cases in El Paso HSDA (52) were nearly double the entire PanWest Region (29).
- In 2016, health departments reported a spike in STI diagnoses, especially new cases of syphilis:
    - ➢ TDSHS issued a syphilis alert April 28, 2016, reporting an increase of up to 267% for primary and secondary syphilis and 160% for early latent syphilis in Lubbock County. The
    - ➢ City of Lubbock issued a similar advisory with 24 newly identified cases compared to eight during the same period in 2015.
    - ➢ The City of Amarillo reported 31 cases since the beginning through April of 2016 and 47 cases in 2015.

DESCRIPTION OF THE AREA TREATMENT CASCADES

Texas DSHS developed the 2015 HIV/AIDS Care Continuum (HCC) for each of the PanWest and El Paso HSDAs.[4]Along with the Continuum or "cascade," a "Healthier Community" pictograph was developed to further depict engagement, retention and subsequent viral suppression for the PanWest and El Paso regions. The following presents the DSHS information.

Definitions used in the HCC:

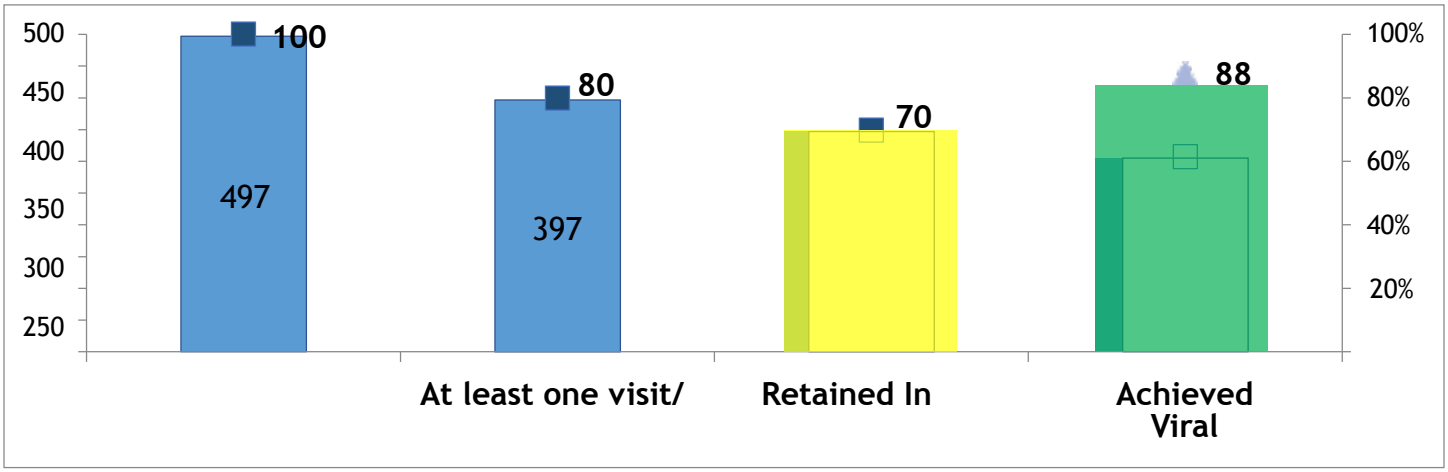
- HIV+ Individuals at end of 2015 = No. of HIV+ individuals (alive) residing in Texas at the end of 2015.
- At Least One Visit in 2015 = No. of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD-4 test) in 2015.
- Retained in Care = No. of PLWH with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2015.
- Achieved Viral Suppression at end of 2015 = No. of PLWH whose last viral load test value of 2015 was <= 200 copies/mL.

The HCC below present the status of these attributes for the PanWest and El Paso HSDAs. They can help guide each HSDA's efforts to link the HIV+ patients to medical care and maintain PLWH in care and treatment.

Amarillo HSDA

- Of 497 individuals living in the Amarillo HSDA in 2015, 397 (80%) were linked to care, 347 (70%) retained in care and 305 (61%) achieved viral suppression.
- Of the 397 who were linked to care, 347 (87%) were retained with at least two episodes of care and treatment, and 305 (61%) achieved viral suppression.
- Of 347 who were retained in care, 305 (88%) achieved viral suppression.

Figure 2
HIV Care Continuum Amarillo HSDA 2015

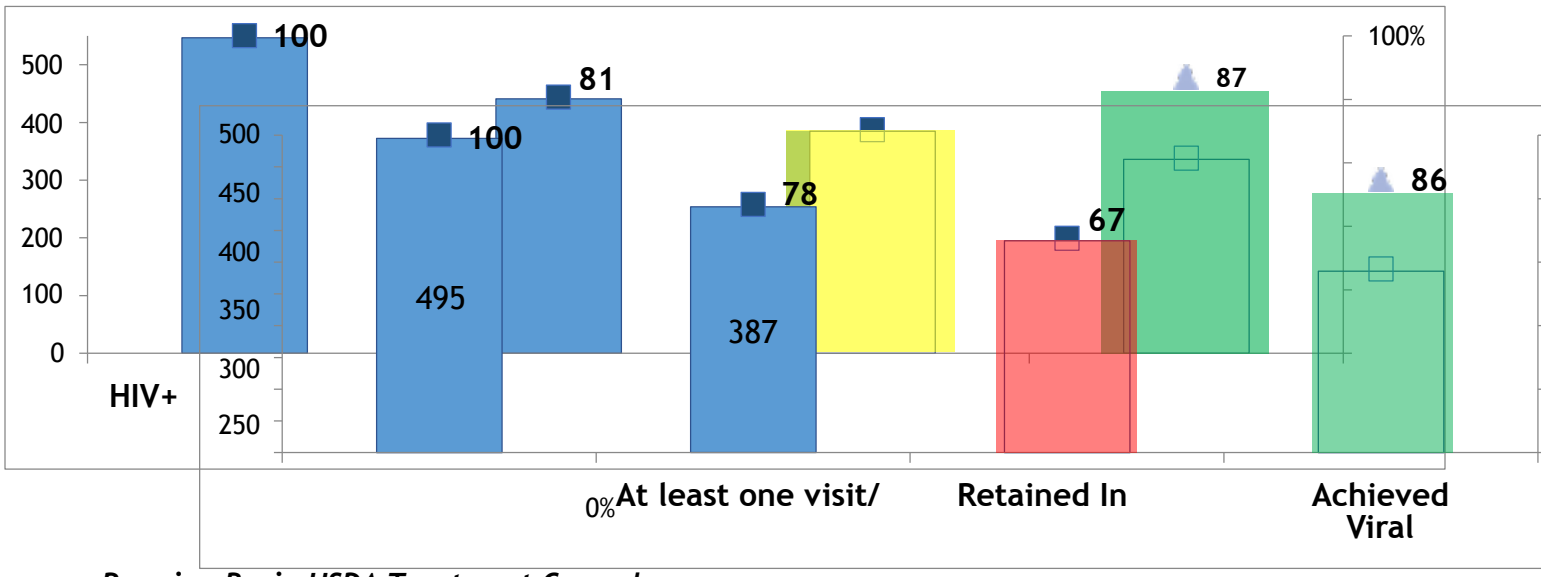


Lubbock HSDA

- Of 547 individuals living in the Lubbock HSDA in 2015, 441 (81%) were linked to care, 385 (70%) retained in care and 336 (61%) achieved viral suppression.
- Of the 441 who were linked to care, 385 (87%) were retained with at least two episodes of care and treatment, and 336 (76%) achieved viral suppression.
- Of 385 who were retained in care, 336 (87%) achieved viral suppression.

Figure 3
HIV Care Continuum Lubbock HSDA 2015

[4]Sources: Enhanced HIV AIDS Reporting System as of July 2, 2015, Medicaid, ARIES, ADAP, and private payers. All data and graphical depictions prepared by Program Planning and Evaluation Group, HIV/STD Branch at the Texas Department of State Health Services. August 2015 and April 2016.



Permian Basin HSDA Treatment Cascade

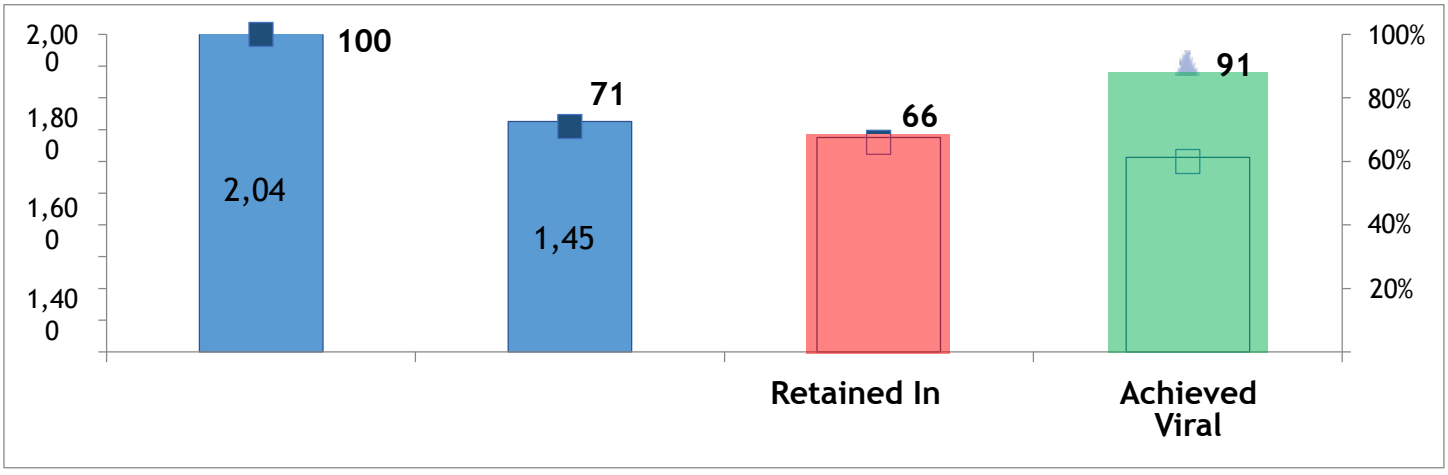
- Of 495 individuals living in the Permian Basin HSDA in 2015, 387(78%) were linked to care, 334 (67%) retained in care and 286 (58%) achieved viral suppression.
- Of the 387 who were linked to care, 334 (86%) were retained with at least two episodes of care and treatment, and 286 (74%) achieved viral suppression.
- Of 334 who were retained in care, 286 (86%) achieved viral suppression.

Figure 4
HIV Care Continuum Permian Basin HSDA 2015

El Paso HSDA/West Texas

- Of 2,045 individuals living in the El Paso HSDA in 2015, 1,452 (71%) were linked to care, 1,351 (66%) retained in care and 1,226 (60%) achieved viral suppression.
- Of the 1,452 who were linked to care, 1,351 (93%) were retained with at least two episodes of care and treatment, and 1,226 (84%) achieved viral suppression.
- Of 1,351 who were retained in care, 1,226 (91%) achieved viral suppression.

Figure 5
HIV Care Continuum El Paso HSDA 2015



DESCRIPTION OF ACCESS AND HEALTH DISPARITIES IDENTIFIED IN THE AREA

Health Disparities

In 2015, all four HSDAs reported relatively consistent performance for all four indicators of the HCC. PanWest region had higher linkage rates while El Paso/West Texas reported more favorable suppression rates. Retention rates were similar for both regions ranging from 66%-70%. Differences, however, were not significant. As a measure of favorable outcomes as a result of HIV care, viral suppression was achieved by at least 86% of all patients throughout the regions.

- Across the PanWest and West Texas regions, 71% of PLWH have been linked to care with at least one medical visit. Lubbock HSDA performed best with 81% linked to care. El Paso HSDA linked the lowest percentage into care with 71%.
- Sixty-six percent of PLWH were retained in care with two or more medical visits. Amarillo and Lubbock HSDAs achieved the highest percentage (70%) and Permian Basin achieved the lowest (67%).
- Across the entire PanWest/West Texas regions, 60% of PLWH have achieved viral suppression. Highest suppression rates were achieved in Amarillo and Lubbock (61%), and lowest in Permian Basin HSDA (58%).
- Of PLWH retained in medical care, 88% have achieved viral suppression in the PanWest/West Texas region. Highest suppression rates were achieved in El Paso HSDA (91%).

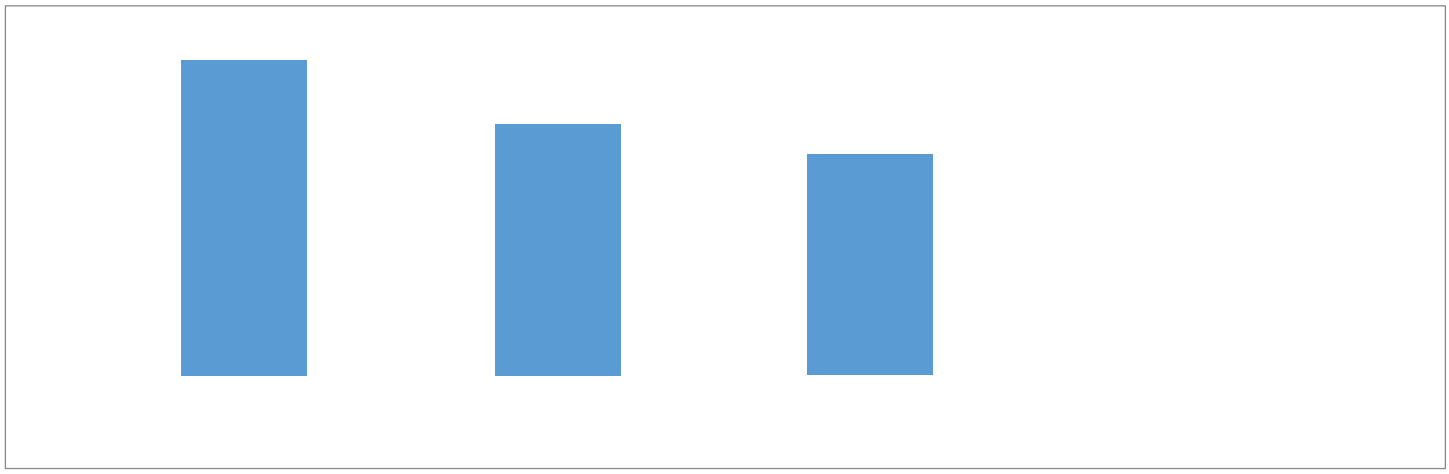
Table 3
HIV Care Continuum by Gender, Race/Ethnicity, Age and Transmission Category
PanWest and El Paso/West Texas Regions 2015

	PLWH		At Least One Visit		Retained in Care		Suppressed		% Suppressed of Those Retained
	#	%	#	%	#	%	#	%	%
Amarillo	497	100%	397	80%	347	70%	305	61%	88%
Lubbock	545	100%	441	81%	385	70%	336	61%	87%
Permian Basin	495	100%	387	78%	334	67%	286	58%	86%
PanWest	1,537	100%	1,225	80%	1,066	69%	927	60%	87%
El Paso/West Texas	2,045	100%	1,452	71%	1,351	66%	1,226	60%	91%
Total	3,582	100%	2,677	76%	2,417	68%	2,153	60%	89%

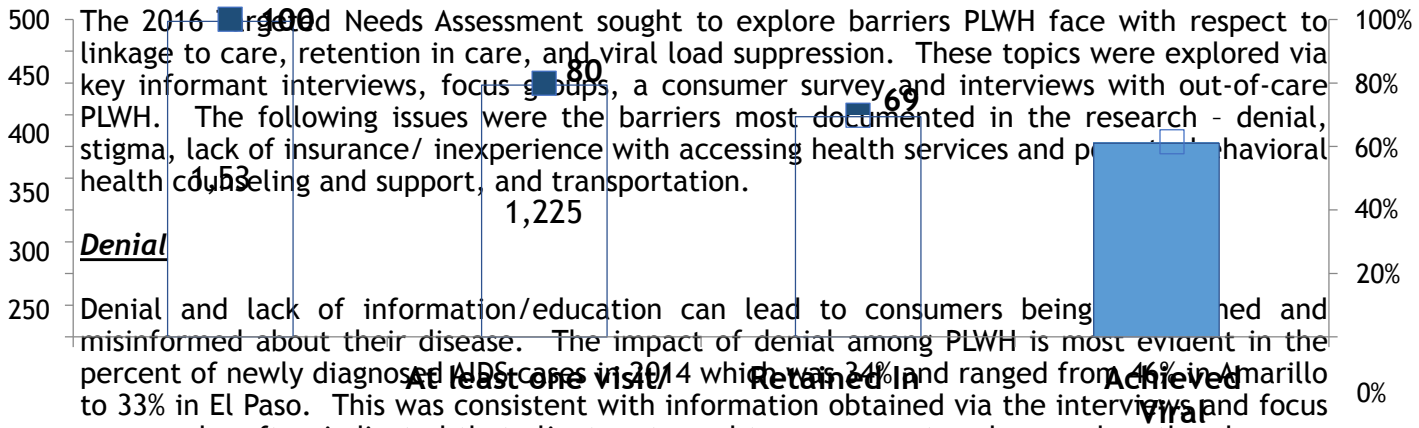
PanWest Region

- Of 1,537 individuals living in the PanWest Region in 2015, 1,225 (80%) were linked to care, 1,066 (69%) retained in care and 927 (60%) achieved viral suppression.
- Of the 1,225 who were linked to care, 1,066 (87%) were retained with at least two episodes of care and treatment, and 927 (76%) achieved viral suppression.
- Of 1,066 who were retained in care, 927 (87%) achieved viral suppression.

Figure 6
HIV Care Continuum PanWest 2015



ACCESS BARRIERS



The 2016 Integrated Needs Assessment sought to explore barriers PLWH face with respect to linkage to care, retention in care, and viral load suppression. These topics were explored via key informant interviews, focus groups, a consumer survey and interviews with out-of-care PLWH. The following issues were the barriers most documented in the research – denial, stigma, lack of insurance/ inexperience with accessing health services and p[illegible] behavioral health counseling and support, and transportation.

Denial

Denial and lack of information/education can lead to consumers being [illegible]ned and misinformed about their disease. The impact of denial among PLWH is most evident in the percent of newly diagnosed AIDS cases in 2014 which was 24% and ranged from 46% in Amarillo to 33% in El Paso. This was consistent with information obtained via the interviews and focus groups who often indicated that clients returned to care or entered care when they became ill or following a hospitalization, and by out-of-care individuals who indicated they were in denial because they didn't look or feel ill. Moreover, nearly 50% of consumer respondents who did not link to care in six months did so because of being in denial, and one-quarter of survey respondents dropped out-of-care because they didn't feel sick.

Stigma

Stigma is a significant barrier to HIV testing and care throughout the PanWest and West Texas region. In addition to HIV stigma, LGBT identity and behavioral health disorders can result in multiple stigmatizing factors faced by consumers. Stigma is particularly severe among some cultures and in small cities and rural towns as exists in the PanWest-West Texas region. Stigma impacts a person's willingness to be tested and their willingness to seek care and risk disclosure and disapproval. Most areas of West Texas and the PanWest area lack strong LGBT advocates and support networks for PLWH. Moreover, the number of LGBT-sensitive medical providers are scarce and proper protocols are not always followed when treating these patients. Additionally, medical education regarding LGBT health is often absent in medical school curriculums and the number of providers interested in HIV care is small. These issues have the potential to increase barriers to care for PLWH.

Key informants spoke of the cultural and religious beliefs and mores that keep people from seeking care due to fear of disclosure and of being disowned.

Focus group members identified being gay and being HIV+ as having to overcome two stigmatizing characteristics, being HIV+ and Black, as being a double minority.

A third of survey respondents who said stigma was a problem said they felt guilty and ashamed, and nearly 15% were afraid of rejection.

Lack of Insurance/Inexperience with Accessing Health Services, and Poverty

The PanWest-West Texas region is characterized by a high proportion of people who live below the federal poverty level, and who do not possess a high school diploma. Although thousands of PLWH have benefited from the reforms of ACA, the cost sharing (premiums, co-pays, and deductibles) of some plans leave them financially out of reach for many PanWest-West Texas PLWH. Moreover, the decision not to expand Medicaid in Texas has left many PLWH without insurance coverage and thus dependent solely on the Ryan White Program for medical and supportive services. As noted in the epidemiological section, the number of newly diagnosed PLWH has increased further, stretching already limited Ryan White funding. Nearly 50% of consumer survey respondents were without any type of insurance coverage.

In Texas, 1,205,174 consumers purchased, selected or were re-enrolled in a health plan through the Affordable Care Marketplace by February 2015. But many HIV patients in Texas live below the poverty line and are therefore ineligible for subsides on the exchange. In

addition, the decision not to expand Medicaid to cover poor adults, means that the bulk of low income HIV consumers have not benefited from expanded health care coverage. Texas Medicaid eligibility requirements are among the strictest in the country. For example, a family of six adults without a disability must earn less than $4,608 a year to qualify for Medicaid.

Katherine Record, a senior fellow at Harvard Law School's Center for Health Law & Policy Innovation, directed a study to model how ACA could affect HIV patients in Texas. The study found that approximately 65% of those receiving ADAP funds would be eligible for Medicaid if it were expanded.

The barriers to the uninsured, the lack of understanding and experience with accessing health care services, and poverty were documented throughout the Needs Assessment.

Key informants spoke of the problems consumers have encountered when they became insured for the first time as well as the fact that so few actually qualify for ACA coverage as barriers to poor PLWH seeking care.

Focus group members spoke of problems that occur because of the small number of participating specialists who accept ACA insurance products and the added paperwork burdens it places on clients. Focus group members also discussed the fact that many who qualify for Ryan White assistance shy away from care out of the belief that eventually they will be billed for treatment they cannot afford.

Poverty faced by PLWH is made clear by the fact that over 48% of consumer survey respondents had no insurance. This fact alone heightens the issues faced by Ryan White providers treating an increasing number of patients. More than 20% of consumer survey respondents indicated an inability to pay co-pays, deductibles or other costs of treatment as the reason for dropping out-of-care, and 27% of those who had not received medical care in the last year indicated the reason was because they did not have money to pay.

Behavioral Health Counseling and Support

Mental health and substance abuse have debilitating effects on consumers' ability to seek medical care and to adhere to treatment regimens. Behavioral health issues can range from needs for emotional support and encouragement, to dealing with mild depression and anxiety, to more serious mental health diagnoses, as well as alcohol and substance abuse. Access to these services for the uninsured is constrained by the overwhelming amount of need compared to available resources.

Key informant interviews and focus group members spoke of the need that many newly diagnosed had for emotional support because of the overwhelming amount of stigma these patients experience. Others spoke of the lack of mental health and substance abuse services available to the uninsured and of long waiting lists to get into substance abuse treatment centers.

Information derived from the consumer survey indicates that 35% of those who dropped out-of-care were using drugs and alcohol.

Transportation

Transportation is an issue that was raised often in the 2013 Needs Assessment and which continues to be a problem. Good public transportation is lacking throughout the region. All public transportation, when it exists, exist in major population centers and even then can involve multiple transfers to get to a care location or office. The rural areas which include most of the counties in the region are without transportation. In these areas, access to a car is a necessity.

The lack of transportation was highlighted in focus group discussions and by key informants, and by out-of-care consumers, and it was cited as a reason for dropping out-of-care for 19% of consumers.

Twenty-one percent identified transportation as a reason for not getting into care within six months of diagnosis. Twenty-one percent also identified it as a reason it is hard to get medical care. Of those who identified transportation as a problem, nearly 50% did not have a car or someone to drive them, and 26% didn't have money to pay for transportation.

The health disparities and access barriers have the most impact on the following target populations.

Target Populations

Men Who Have Sex with Men (MSM)

MSM is the predominant transmission mode in all the HSDAs, the issues facing these men shape their response to HIV status, access to HIV medical care, and compliance with treatment regimens.

Younger MSMs have grown up in an era of antiretroviral treatment (ART) and display less fear of HIV. They are more likely to use social media to engage in risky behaviors, but stigma remains a significant barrier to testing and linkage to care.

- Key informant interviewees were concerned that young MSM who are on their parent's insurance will frequently forgo treatment to prevent their parents from finding out they are HIV positive.
- Focus groups confirmed the concern that many young MSMs were engaging in anonymous sex with high number of contacts.
- Along with the rise in young MSMs testing positive for HIV, providers have seen an increasing number of syphilis cases.
- Young HIV+ MSMs face challenges of both having to come out and to admit their HIV status, a factor that often leads to denial and late diagnosis.

Hispanic PLWH

Issues that result in barriers to Hispanic PLWH include:

- A strong cultural taboo about talking about anything having to do with sex.
- Strong religious and cultural traditions leading to denial and guilt.
- Lack of support because of fear of disclosure.

Out-of-Care PLWH

Out-of-care consumers have a variety of reasons for not accessing HIV care. Key reasons include:

- A persistent belief that if they are unemployed and have no insurance they cannot afford to get care.
- Mental health and substance abuse issues that affect compliance and adherence.
- Stigma and anonymity.
- Transportation barriers for those living in more rural areas.

Strengths and Challenges of the PanWest and West Texas Continuums of Care

The following strengths in service provision provide a foundation for this plan and achievement of its goals:

- Medical care is provided by specialty trained and experienced physicians in each HSDA.
- Ryan White core services are provided in each HSDA.

- Bilingual staff are widely available in West Texas organizations that serve PLWH.
- A variety of funding sources complements Ryan White funding.
- Well developed social service continuums of care in the population centers of the HSDAs.

Challenges include:

- Given Ryan White requirements to fund core medical services, funding for social services is limited. Collaboration with non-Ryan White funded community agencies is needed, but has been difficult to accomplish.
- Increasing numbers of newly diagnosed PLWH are stretching thin limited Ryan White funding, including funding for new services, despite the expansion of medical coverage through ACA.
- Shortages in the number of physician resources available to provide care to Ryan White patients persist.
- Location of Ryan White services in more urban centers creates access problems for PLWH in rural areas of all HSDAs.
- Stigma is an acute problem in the region limiting access to testing and the receipt of services due to fear of disclosure.
- Decreases in outreach and prevention funding make it difficult to keep up with increasing numbers of at-risk populations.

DESCRIPTION OF THE AREA CARE AND TREATMENT SYSTEMS

Ryan White Funded Providers

Each of the three PanWest HSDAs has a Part B funded HIV/AIDS service subcontractor (provider). Each is located in the population center of the HSDA. Using a competitive request for proposal process, the subcontractors in the PanWest Region have been stable for many years. One of the West Texas HSDA subcontractors, however, changed in February 2015.

In 2015, the Providers served clients as follows:

- The Amarillo HSDA subcontractor served 285 unduplicated clients in a 26 county area.
- The Lubbock HSDA subcontractor served 360 unduplicated clients in a 15 county area.
- The Permian Basin HSDA subcontractor served 269 unduplicated clients in a 17 county area.
- The El Paso HSDA subcontractors served 1,145 unduplicated clients including 884 at La Fe CARE and 225 at Project CHAMPS El Paso.

All Subcontractors are required to provide culturally competent services without discrimination in any form.[5]

Linkage with Community Services

In both the PanWest and West Texas regions, subcontractors work with local community health care and social service providers to deliver services to encourage consumers' access to care, ensure the provision of appropriate HIV health care and meet client medical and supportive service needs. These include:

- HIV prevention and counseling and testing providers,

[5] The AA and all Subcontractors will comply with all federal and state non-discrimination statutes, regulations, and guidelines. Services shall be provided without discrimination on the basis of race, color, national origin, age, disability, ethnicity, gender, religion, or sexual orientation. Subcontractors are required to have policies and procedures in place to ensure services are accessible to the target population. Subcontractors must furnish evidence of having a plan to ensure the availability of bilingual staff and/or the services of an interpreter are available; general information and educational materials are available in the languages appropriate to the population served; and clients are educated and counseled according to individual needs and circumstances. Contracts established with Subcontractors require compliance with the Civil Rights Act of 1964, the Americans with Disabilities Act of 1991 and the Age Discrimination in Employment Act of 1967.

- Local health departments, including sexually transmitted disease clinics,
- Hospital systems and emergency rooms,
- Private and public clinics including family planning centers, community health centers, federally qualified health centers (FQHC),
- Substance abuse treatment providers, including HEI case managers,
- Mental health counseling programs,
- Food banks, churches, homeless shelters and other support organizations.

Subcontractors are required to provide the appropriate linkages[6] to ensure needed services are available for their clients.

Each subcontractor must establish, implement, and monitor a referral process to ensure follow-up with services that they don't directly provide. This approach fosters collaborative relationships and has enabled the subcontractors to explore the availability of community services, avoid duplication of services, and provide the service with minimal time lapses. It also ensures Part B funding is used as the payer-of-last-resort. It includes:

- Initial contact with the community agency to determine if the service is available.
- Provide the client with a written referral for the community service.
- When the service has been provided, the client will return with signed documentation for the case manager as proof of the service provision.
- If the client fails to bring the information to the case manager, the case manager will contact the referred agency to determine if the client attended the appointment/was provided with the requested service.
- The status of each referral is listed and tracked through an agency referral log to ensure follow-up and closure of all referrals.

The AA monitors this system during site reviews. The process also helps the AA identify potential barriers and gaps in service provision within the HSDA.

Outpatient/Ambulatory Medical Care

As a cornerstone of the Ryan White Program, all activities foster engagement and maintenance in outpatient/ambulatory medical care (OAMC). The following is a brief summary of the process by which clients access OAMC in each HSDA, and how each subcontractor assures that clients have access to a physician with HIV medical experience:

The **Amarillo HSDA** Subcontractor does not have a contract with any physician to provide medical care but does have an agreement with two local physicians: an infectious disease (ID) specialist and a local primary care physician with several years of experience treating HIV/AIDS who also does HIV/AIDS trainings for the AIDS Education and Training Center (AETC).

- The primary care physician sees the majority of HIV positive clients needing OAMC and works closely with the J.O. Wyatt indigent clinic to provide HIV/AIDS care as well as primary medical care.
- The ID physician currently does not accept new uninsured or insured HIV patients unless they are referred by the HSDA service Subcontractor.
- Once a client has been determined eligible for services, the case manager screens the client to determine all needs.
- If the client is in need of OAMC and does not have an alternate payer source, the client is referred to the J.O. Wyatt clinic to determine eligibility. Insured clients have the option of seeing a doctor of their choice based on their insurance network. Uninsured clients who are not eligible for J.O Wyatt services are referred to the ID physician and the Subcontractor will provide payment for the cost of the service if the client is eligible.
- The client may choose to see another physician but that physician must be willing to bill the Amarillo HSDA Subcontractor for services provided at an acceptable rate.

[6] Linkage may be through collaborative agreements, memoranda of understanding (MOU), other contractual relationships.

The service Subcontractor for the Amarillo HSDA is:

Panhandle AIDS Support Organization (PASO)
1501 SW 10th St.
Amarillo, TX 79101
Local 806-372-1050 or toll free 1-800-388-4879

The **Lubbock HSDA** Subcontractor contracts with the Texas Tech University Health Sciences Center (TTUHSC) to provide two weekly clinics at the TTUHSC facility to HIV positive clients.

- The clinic is called the Tech AIDS Clinic (TAC) and is under the direction of an Infectious Disease Specialist.
- One clinic is for clients who have Medicaid, Medicare or private insurance. The other clinic is for clients without insurance.
- The Lubbock HSDA Subcontractor's process to ensure that clients have access to ambulatory medical care is as follows:
  - ➢ Once a client has been determined eligible for services the Medical Case Manager schedules an appointment for the client at the TAC.
  - ➢ The Medical Case Manager also schedules the client an appointment for any necessary lab work to be completed before the initial doctor appointment.
  - ➢ Any services necessary to support the client with accessing medical care are offered as well, such as transportation and assistance with obtaining medications.
- Clients who have other payer sources, and choose not to use the TAC, can be seen by their primary care physician who may refer them to the Consultants in Infectious Disease practice.
- If clients are veterans, they are offered the choices listed above as well as an option for referral to the local Veterans Administration for services.

The Lubbock Subcontractor is part of a large health care organization, South Plains Community Action Association (SPCAA), which has WIC, Headstart, Family Planning Clinics, and Primary Health Clinics in the urban and rural areas of the Lubbock HSDA. The service Subcontractor for the Lubbock HSDA is:

Project CHAMPS – South Plains Community Action Association, Inc.
3307 Avenue X (34th & X)
Lubbock, TX 79411
Local 806-771-0736 or toll free 1-800-724-2677

The **Permian Basin HSDA** Subcontractor contracts with Texas Tech University Health Sciences Center Permian Basin (TTUHSC PB) for one weekly clinic in the city of Odessa.

- The clinic is run by a specialist ID doctor.
- The clinics are attended by resident physicians working with the ID doctor.
- Permian Basin has established the following process to ensure that clients have access to ambulatory medical care:
  - ➢ Once a client has been determined eligible for services, the client is scheduled for laboratory testing so that the results will be received by the first scheduled physician visit.
  - ➢ The clinic does not accept walk-ins. Appointments are required.
  - ➢ If the client has been receiving care elsewhere, a Release of Information form is signed so that prior history will be obtained by the time of the physician visit.
  - ➢ Clients without other payer sources and no physician are informed of the availability of medical services provided by the ID doctor at the weekly clinic.
  - ➢ Clients who have alternate funding sources are informed of their right to choose a doctor who will accept their alternate payer source.
  - ➢ Any supportive services necessary to help the client access medical care are offered as well, such as transportation and assistance with obtaining medications.

The Permian Basin HSDA Subcontractor, Basin Assistance Services (BAS), is moving to a new location effective March 1, 2014. The TTUHSC HIV clinic has moved to the TTUHSC PB campus. BAS's new contact information is as follows:

Basin Assistance Services (BAS)
Permian Basin Community Centers
1330 E. 8th St., Ste. 410
Odessa, TX 79761
Local 432-580-0713 or toll free 1-800-804-5418

The **El Paso HSDA** has two HIV medical care subcontractors, La Fe CARE and SPCAA Project CHAMPS El Paso. La Fe CARE is an established HIV clinic that operates five days per week with a schedule of infectious disease and primary care physicians experienced in the care of HIV disease. SPCAA Project CHAMPS El Paso has a nationally renowned infectious disease physician leading the program. He is also the head of medical informatics for TTUHSC.

- In addition to HIV medical care, La Fe CARE offers medical and non-medical case management, AIDS Pharmaceuticals, health insurance assistance, medical and non-medical transportation, oral health care, HIV prevention outreach, HIV counseling and testing. La Fe CARE is part of Centro De Salud Familiar La Fe, a community health care system and FQHC, providing linkage for clients needing to access other services in this system.
- SPCAA Project CHAMPS El Paso offers HIV medical care, medical and non-medical case management, health insurance, AIDS Pharmaceuticals, and medical transportation. Project CHAMPS El Paso may add services as the program expands as well as offering linkages with other service/programs available through their system of care.

Table 4
Services Provided by PanWest and West Texas Funded Subcontractors*

	Amarillo		Lubbock		Permian Basin		El Paso	
Service Category	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**
Outpatient/ Ambulatory/ Health Services		X		X		X	X La Fe CHAMPS	
Substance Abuse Outpatient Services		X		X		X		X
Mental Health Services		X		X		X	X	X
AIDS Pharmaceutical Assistance (local not ADAP)	X		X		X		X	
Medical Case Management Services	X		X		X		X	
Non-Medical Case Management Services	X		X		X		X	
Health Insurance	X		X		X		X	
Oral Health Care		X		X		X	X La Fe	X CHAMPS

	Amarillo		Lubbock		Permian Basin		El Paso	
Service Category	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**
Medical Transportation	X		X		X		X	
Non-Medical Transportation	X		X		X		X La Fe	X CHAMPS
Emergency Financial Assistance	X		X		X		NA	NA
Housing Services (plus HOPWA)	X		X		X			X
Food Bank (Food Vouchers)	X		X limit to ER+		NA	NA	NA	NA

* Service categories not listed are provided through linkage with non-Ryan White funded community agencies.
+ ER= very few vouchers limited to emergency situations for clients currently in medical services

Resource Inventory

The PanWest-West Texas 2017-2020 Comprehensive HIV Needs Assessment includes HSDA-specific resource inventories. They are found at www.panwest.org under Resources.

The majority of community resources are located in the urban localities of each HSDA – Amarillo, Lubbock, Midland, Odessa and El Paso. Each area uses the 211 system and local directories are also available.

Internet resources resulting in statewide or even national service access are essential in PanWest and West Texas. For example, due to the high cost of antiretrovirals, few community-level resources are available for pharmaceutical assistance for purchasing medications. Therefore, PLWH are linked with patient pharmaceutical companies' patient assistance programs whenever possible. The same is true for outpatient/ambulatory medical care and health insurance premiums and co-pays.

Another problem encountered in the HSDAs is that some community resources strive to be payers-of-last-resort, conflicting with the Ryan White policy of being the payer-of-last-resort. As a result, the organizations refer PLWH back to the local HIV service subcontractors for assistance. The table below provides an overview of available resources in each HSDA.

Table 5
Available Resources
PanWest and West Texas Regions
2016

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
AIDS Service Organization	1	1	2	6	10
Case Management	4	6	6	17	33

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
Dental Care	4	6	5	6	21
Emergency Assistance	4	8	11	5	28
Employment Assistance	1	2	5	6	14
Family Planning Services	5	4	6	3	18
Financial Assistance	0	0	5	2	7
Food Bank	11	16	11	8	46
HIV Counseling and Testing	11	13	7	12	43
HIV Medical Care	4	1	1	3	9
Home Healthcare	2	3	2	1	8
Hospice Care	3	2	2	3	10
Housing Services	6	13	7	17	43
Legal Services	1	4	3	3	11
LGBT Services	0	2	1	20	22
Medication Services	5	11	5	5	26
Mental Health Therapy and Counseling	3	10	10	17	40
OB/GYN Care	6	10	10	2	28
Primary Medical Care (not HIV-Specific)	13	14	16	8	51
Specialty Medical Care	5	6	10	6	27
STD Testing	6	10	6	3	25
Substance Abuse Treatment	8	12	10	7	37
Transportation Services	2	4	4	10	20

Administrative Agency Role and Responsibilities

StarCare Specialty Health System serves as the Administrative Agency for Ryan White Part B funding for the three HSDAs that make up the PanWest region and the West Texas HSDA. As such, it is responsible for administration, monitoring, fiscal disbursement, and planning for this HIV Administrative Service Area.

Quality Management Plan and Quality Management Committee

The Administrative Agency has established a Quality Management (QM) program for use in both the PanWest and West Texas regions. This program provides a documented, ongoing process to guide and continuously improve HIV/AIDS services. The primary purpose of the QM program is to enhance the quality of medical and other services provided to people living with HIV/AIDS in the region. It requires collaboration between all Ryan White funded

subcontractors to ensure services are of the highest quality and provided efficiently and effectively in conformance with established standards of care and best practices.

The cornerstone of the QM program is the Quality Management Plan.

- The QM Plan clearly outlines the necessary actions to improve service quality.
- The QM Plan outlines many topics, including the Tier 1 HAB Performance Measures and HAB Core Measures
- In late February 2010, DSHS asked AAs to begin combining the QM Plan with the area comprehensive plan. Please refer to Appendix A for the Annual Quality Management Plan.

The QM Plan is developed and reviewed by the Quality Management Committee (QMC) with input from the AA.

- The QMC is comprised of representatives of each Ryan White funded provider as well as AA staff, allowing collaboration and joint problem solving.
- The QMC meets quarterly, generally via conference call.
- Currently, the main focus of the QMC is to implement monitoring of the current HRSA HAB Core Measures: medical visit frequency, gap in medical visits, prescribed antiretroviral therapy, viral load suppression, and PCP prophylaxis.
- The QMC will continue to monitor Tier 1 HAB Measures and have providers maintain at least an 85% percent average for each measure.

Training is an important component of the QM program. The AA directly and indirectly offers training to contracted providers as part of the QM Plan.

- The AA informs the QMC of upcoming trainings, such as webcasts and teleconferences, conducted by the National Quality Center, the Texas Department of State Health Services (DSHS), and other agencies offering relevant trainings. The AA maintains a log of QM trainings and technical assistance.
- The AA will inform the QMC of upcoming Best Practices trainings provided by the AA and Texas Department of State Health Services (DSHS).
- The Data Manager will provide training to the QMC on monitoring the HRSA HAB Core Measures.

HAB Performance Measures

The HAB Performance Measures were implemented in the 2008-2009 contract period. The performance measures are:

Performance Measure I: Achieve a minimum of 85% percent of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year, with an ultimate goal of 90%-95%.

Performance Measure II: Achieve a minimum of 85% percent of clients with HIV infection who had 2 or more CD-4 T-cell counts performed in the measurement year, with an ultimate goal of 90%-95%.

Performance Measure III: Achieve 85% percent of clients with AIDS who are prescribed Anti-Retroviral Therapy (HAART), with an ultimate goal of 90%-95%.

Performance Measure IV: Achieve a minimum of 85% percent of clients with HIV infection and a CD-4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis, with an ultimate goal of 90%-95%.

Performance Measure V: Achieve a minimum of 85% percent of pregnant women with HIV infection who are prescribed antiretroviral therapy, with an ultimate goal of 90%-95%.

Table 6
HAB Performance Measures
Calendar Year 2016 Average Scores

	Amarillo	Lubbock	Permian Basin	La Fe	CHAMPS El Paso
Measure I:	72.54%	63.68%	72.79%	80.68%	28.57%
Measure II:	66.20%	70.66%	68.20%	85.44%	63.27%
Measure III:	100.00%	98.29%	97.14%	97.85%	97.18%
Measure IV:	86.21%	85.11%	82.05%	90.00%	72.73%
Measure V:	66.67%	0.00%	100.00%	100.00%	0.00%

Clinical and Case Management Monitoring

The AA conducts clinical and case management on-site monitoring at least once per year. This monitoring includes:

- Ensuring that Subcontractors of clinical services adopt and follow current nationally recognized clinical practice guidelines when providing clinical services.
- Evaluating and ensuring the quality of service delivery.
- Ensuring subcontractors develop, adhere to and maintain Physician Standing Delegation Orders when required to by law to provide clinical services.

Please refer to Appendix B for a full description of this process.

Utilization and Fiscal Monitoring

The AIDS Regional Information and Evaluation System (ARIES) allows Subcontractors to enter client-level data when services are accessed. The AA is then able to generate utilization, quality and fiscal monitoring reports. Procedures include:

- In order to track the number of clients served and the number of units of service provided, the Subcontractor is required to enter demographic, medical, risk factor and service delivery information by the fifth day after the service is provided.
- Subcontractors track the number of clients served and the number of units of service provided, and notify the AA and QMC of unusual numbers and patterns. They also check demographics for their HSDA.
- Subcontractors submit quarterly Ryan White Part B programmatic reports in the format provided by the AA. The reports are due on or before March 20, June 20, September 20 and December 20 of each year. Appropriate and timely completion is required for reimbursement.
- The Contracts Specialist compiles the subcontractor data and formulates an AA quarterly report for DSHS which are submitted on or before March 30, June 30, September 30 and December 30 of each year.
- The AA is able to track the demographics for each HSDA via ARIES.

Refer to Appendix C regarding details of the utilization and fiscal monitoring functions.

2017-2018 Priorities and Allocations

The AA receives Ryan White Service Delivery (RWSD) Part B and State Services funds from the Texas Department of State Health Services (DSHS), who receives Ryan White Part B funds from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The AA does not determine the amount of funds received but is responsible for setting service priorities and allocating these funds to service categories for each HSDA in the PanWest and West Texas regions.

- **Service categories** are the HIV related services that are eligible to receive Ryan White Service Delivery and State Services funds.
- Services are separated into **medical core** health care services (ex: ambulatory medical, dental, mental health, substance abuse, AIDS Pharmaceutical Assistance, etc.) and **support** services (ex: medical transportation, food pantry, housing, etc.).
  - ➢ At least 75% of Ryan White funds must be allocated to medical core services.
  - ➢ No more than 25% can be allocated to support services.
- **Priorities** refer to how service categories are ranked in order of need.
- **Allocations** refer to how the funds from Ryan White Service Delivery Part B and State Services are distributed to each service category.
- Ryan White Service Delivery Part B and State Services are the **payers-of-last-resort**, meaning all other funding sources and community resources must be tapped first.
- There are not sufficient funds to allocate to each service priority and meet every need.
- The full amount of the Part B and State Services does not always go into direct services as administrative indirect costs are included in several of the service categories.

Decisions about priorities and allocations are based on available data. This applies to both the process that DSHS uses to allocate funds to the HSDAs and to that used by the AA in prioritizing and allocating funds to each service category. Factors determining allocations include:

- Needs Assessment Findings—The 2016 PanWest-West Texas Comprehensive Needs Assessment served as guides in setting the 2017-2018 allocations and priorities.[7]
- Historical information based on expenditures, service provision, service barrier limitations, community resources, and stakeholder/community input.
- PanWest and West Texas Comprehensive Plans for HIV/AIDS Services.
- DSHS Priority Setting & Resource Allocation Principles and DSHS HIV Services Taxonomy.[8]

It is not unusual to see HSDAs with prioritized service categories that are not allocated funds or prioritized service categories receive minimal funds or even non-prioritized service categories that receive funds. Although priority ranking is considered, it is not the main indicator that a service category will be funded.

Allocations are done every year and every year they are different depending on the amount of funding the State receives.

- At the time the allocations are done, the AA generally does not know the actual funding amount it will receive from DSHS for each HSDA so the AA presents the allocations as percentages.
- Once the AA receives the funding amounts from DSHS, they are applied according to the allocated percentages.

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[7] It is important to note that service priorities chosen by the survey respondents are often not part of the medical core categories and cannot be fully funded.

[8] *Glossary of HIV Services (taxonomy)*: In January 2009, DSHS revised the taxonomy, now the Glossary of HIV Services. The taxonomy reflects the HRSA service definitions and specifies what services may be funded through Ryan White Service Delivery and which through State Services. It is accessible at www.dshs.state.tx.us.

- The allocations are generally determined at ninety-five percent (95%) of the previous year's allocations to allow for anticipated funding cuts, except for Medical Case Management and Non-Medical Case Management, which are generally allocated at 100%, since those categories include staff salaries.

Service priorities developed from the Targeted Needs Assessment are attached in **Appendix H**.

Because people's needs change, it is not possible to predict exactly how much money is needed in each service category.

- The AA monitors the spending rate of the service Subcontractors and works with the service Subcontractors to reallocate (shift funds) from one service category to another or, less frequently, from HSDA to HSDA, depending on the need in the area.
- Reallocations are most common in the final months of the fiscal year when there is enough expenditure data available to determine if a reallocation is necessary.
- Unexpended funds are not carried over to the next year but, instead, are returned to DSHS.

The Ryan White Service Delivery (RWSD) contract dates from April 1 through March 31. The State Services Contract runs September 1 through August 3. The AA also oversees a housing contract, Housing Opportunities for People With AIDS (HOPWA), whose funds are allocated by DSHS not the AA. The HOPWA contract runs February 1 through January 31. HOPWA funds are taken into consideration when allocating funds to housing services, but HOPWA is not part of the Priorities and Allocations process.

Core vs. Support Services

The Treatment Extension Act of 2009 requires states to allocate, at a minimum, 75% of RWSD funds to the medical core categories. To meet this requirement, DSHS requires each HIV Administrative Service Area (HASA) to fund a *minimum* of 75% of RWSD to the core medical services needed in the HSDA that are not provided through other resources. This leaves no more than 25% for social support services. (Refer to Appendix D for the list of medical core and social support services).

- At this time, the 75/25 percent requirement does not apply to State Services, just RWSD funds. This allows the AA to allocate to State Services certain social support services that are not allowable under RWSD.
  - ➢ For example, non-medical transportation can be allocated under State Services since it is critical in rural areas.
- A very notable impact from the 2009 Act is designation of Medical Case Management as one of the core medical services and Non-Medical Case Management as a social support service. DSHS developed new case management standards and a new case management model emerged to meet the requirement.
- For PanWest and West Texas, the AA requires that each area prioritize Outpatient/ Ambulatory Health Services, Oral Health Care, and Health Insurance Premium and Cost Sharing Assistance due to their medical urgency for maintaining client health. Subcontractors assure that community resources are used, that RW and States Services are payers of last resort and that funding is decreased in other categories as necessary to fund the three priority medical core categories.

Health Insurance Premium and Cost Sharing Assistance: In October 2008, DSHS gave Administrative Agencies a directive that clients should not be denied or put on waiting lists, without great justification, for AIDS Pharmaceuticals and Health Insurance services. The DSHS Health Insurance Policy was updated in 2009 and is available at the DSHS website at www.dshs.state.tx.us. The policy provides guidance on how to determine eligibility for health insurance and the limits on health insurance.

2017-2018 Allocations: **Appendix E** shows the amounts allocated to service categories in each of the four HSDAs. The AA continues to implement the Contingency Plan, developed by the

PanWest Planning Assembly in 2006, which reduces the funding amounts of non-core services in order to maintain funding of the core medical services.

In March 2016, the AA held public comment hearings in PanWest and West Texas to present the proposed 2016-2017 Priorities and Allocations. Community review and feedback about the service priorities and allocations are always welcome and are necessary to ensure they best meet the needs of people infected and affected by HIV/AIDS. Unfortunately, the forums are usually only attended by provider staff and seldom have clients or non-Ryan White funded agencies present. The allocation chart for each HSDA is posted at www.panwest.org under the Download Center of the menu.

Evaluation of 2014 Comprehensive Plan

The 2014-2017 Comprehensive Plan format included a timetable for review of each strategy and action that facilitated plan monitoring.

Key strategies that were accomplished include:

- Implemented HRSA HIV/AIDS Bureau (HAB) core measures for viral load suppression, PCP prophylaxis, and continued to monitor clinical measures for CD-4 count. To date, improvements have been noted and monitoring of HAB measures will continue as part of the Quality Management Program.
- The AA has continued to actively participate in the El Paso Community Mobilization Collaborative.
- Ryan White-funded agencies now have in place MUAs with local HIV prevention, outreach/counseling, and testing providers to effectively link newly diagnosed consumers to HIV medical care within three months of diagnosis, reducing barriers to care.
- Established integrated team of case managers and behavioral health providers.

Some actions are still in progress, including:

- Development of best practices for MCM related to frequency of medical visits, maintenance in medical care and medication delivery.
- Some progress has been made in organizing collaborative groups in each HSDA. These have been impacted by AA staffing changes and vacancies.
- Ensuring physician and mid-level practitioner availability in all HSDAs.

It also became evident that some actions in the 2014-2017 Plan were not realistic given our ability to influence their achievement. These included:

- Increasing the percentage of cervical cancer screenings and annual pap smears. While referrals were made, it was difficult to ensure compliance.
- The development of a new standard for behavioral health best practices.
- Establishing a plan for HEI case manager integration at BAS and CHAMPS El Paso.
- Implement a plan for all HIV clinic physicians and mid-level practitioners to develop the skills to diagnose and prescribe adult psychiatric medications for minor to moderate depression and anxiety.

SUMMARY PLAN GOALS AND RATIONALE

Mission, Vision and Core Values

The mission, vision and core values statements were included in the 2013 PanWest–West Texas Comprehensive Plan were adopted for the 2016 Comprehensive Plan. This mission statement is the foundation for the 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan.

Mission Statement

To support an effective, community-wide response to HIV/AIDS by focusing on high quality medical and support services and leveraging community resources.

The following ideal vision underpins the Plan.

Vision Statement

HIV care is accessible and effective.

All the work of the AA and its subcontractors is for the purpose of benefiting the health and well-being of PLWH. Recognizing the importance and complexity of this task, five values are shared by those who embrace this program.

Core Values

We believe all services build on the core values of: Dignity, Respecting Diversity, Professionalism and Quality, Availability and Accessibility, and Collaboration. These core values will encourage people living with HIV/AIDS to access treatment and be maintained in HIV medical care and support services.

- Dignity: All clients will be treated with dignity.
- Respect Diversity: Recognize and respect cultural and individual differences.
- Professionalism and Quality: Provide quality services in a professional manner.
- Availability and Accessibility: Health care services will be available and accessible.
- Collaboration: Work with community organizations to enhance access to the complete continuum of services, from HIV prevention to care and treatment.

Plan Goals and Rationale

The 2017-2020 Comprehensive HIV Health Services Plan adopts three of the 2016 Texas Plan Priorities for AA and Subcontractor achievement. The goals reflect the findings of the 2016 PanWest-West Texas Targeted Needs Assessment which focused on barriers to linkage, retention and viral load suppression, and includes the updated epidemiologic profiles, regional demographics, and an assessment of access and health disparities in the region.

The three goals are to:

- Increase timely linkage to HIV-related treatment for those newly diagnosed with HIV.
- Increase continuous participation in systems of treatment among people living with HIV.
- Increase viral load suppression among people with HIV.

The goals for the 2017-2020 Comprehensive HIV Health Services Plan are outlined below along with the data and rationale to support the adoption of the goal.

GOAL 1: INCREASE TIMELY LINKAGE TO HIV RELATED TREATMENT FOR THOSE NEWLY DIAGNOSED WITH HIV.

Rationale

- Over a third of all new diagnoses were late stage, ranging from 46% in Amarillo to 30% in El Paso in 2014.
- From 2010-2014, new AIDS diagnoses increased by 14% across the entire region.
- Survey findings show that only 63% of current out-of-care consumers were linked to care within three months of their diagnosis.
- In 2014, across the PanWest-West Texas region, 72% of known PLWH were linked to care with at least one medical visit.
- When asked why they had not gotten into care for a timely manner the most frequent responses were “I was in denial” (48.5%), and “I wasn’t sick, so I didn’t think I needed medical care” (39.4%).

GOAL 2: INCREASE CONTINUOUS PARTICIPATION IN SYSTEMS OF TREATMENT AMONG PEOPLE LIVING WITH HIV.

Rationale

- In 2014, across all four HSDAs in the region, 66% of PLWH were retained in care with two or more medical visits. Amarillo had the highest rate (75%), and Permian Basin the lowest at 59%.
- PLWH in the region who are retained in care have viral suppression rates of 84%.
- Viral suppression levels not only improve long term health for PLWH, it also decreases their likelihood of infecting someone else.
- When asked reasons why they were not in medical care the top two reasons were, “I don’t feel sick,” and “I don’t have the money to pay for care.”
- The most often cited reasons that it was hard for consumers to get care included the paperwork required, the amount of time it takes at the clinic, and the time it takes to get an appointment.
- Sixteen percent of survey respondents reported dropping out-of-care within the last five years, and an additional 3% didn’t know/couldn’t remember.
- The most comment reason for dropping out-of-care was “I was using drugs or alcohol“, “I was tired of taking medications”, and “I didn’t feel sick.”
- When asked, “What would have helped you stay in care,” the top 3 responses were:
  - “Having someone who understood what I was going through.”
  - “Someone to guide me through the process of getting care, medication, and services.”
  - “Someone to talk to about being depressed/anxious.”

GOAL 3: INCREASE VIRAL LOAD SUPPRESSION AMONG PEOPLE LIVING WITH HIV.

Rationale

- Across the entire PanWest-West Texas region, 55% of PLWH have achieved viral load suppression. The highest suppression rates were achieved in Amarillo (62%), and the lowest in Permian Basin (47%).
- Males have lower viral suppression rates than females, 54% compared to 57%.
- Hispanics had the lowest viral suppression rates (47%) compared to 61% of Whites and 51% of Blacks.
- Over 60% of respondents indicated they would like more information about their medications, and over 50% wanted information about their viral load.
    - ➢ Respondents were less likely to understand their viral load than their CD-4 levels, and had less understanding of what the viral loads meant.

II. TARGETED NEEDS ASSESSMENT

TARGETED ASSESSMENT OF NEEDS OF PEOPLE LIVING WITH HIV

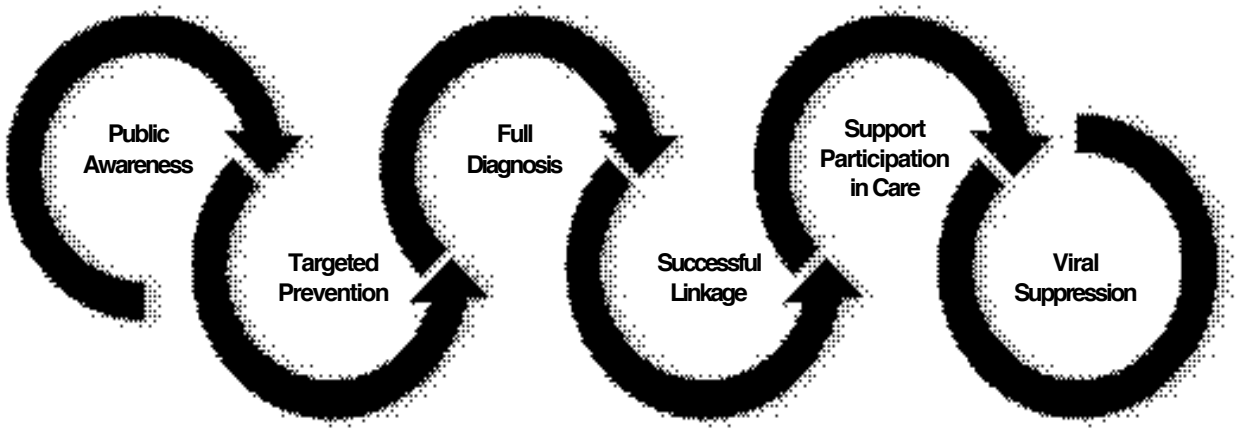
A Targeted Needs Assessments was conducted to direct and improve HIV care and treatment services and systems. Results are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity building, and help contracted providers improve the access to and quality of services delivered. In addition, by evaluating the service needs of severe need groups and other priority populations, targeted services can be developed/ funded.

The key findings and recommendations from the Targeted Needs Assessment are discussed within the context of the Texas Spectrum of HIV engagement. This comprehensive approach that includes six domains and is based on public health principles and the continuum of care developed by HRSA.

Domain 1: Increasing HIV awareness among members of the general public, community lenders and policy makers.
Domain 2: Increasing access to HIV prevention efforts for high risk groups.
Domain 3: Full diagnoses of everyone infected with HIV
Domain 4: Timely linkage to HIV related care and treatment.
Domain 5: Continuous participation in systems of care and treatment.
Domain 6: Increased viral load suppression.

The pictorial below depicts the interconnectedness of these domains.

Figure 8
Interconnectedness of the Domains of the Texas Spectrum of HIV Engagement



Findings and Recommendations

Domain 1 – Public Awareness

Key Finding

As noted in the 2014-2015 Texas HIV update, "only 40% of Americans report seeing, hearing or reading something about HIV. Lack of knowledge or awareness fuels the spread of new infections and HIV stigma." This statement is practically applicable to the entire PanWest-West Texas region. Qualitative information obtained through the needs assessment points to an overall lack of public awareness or interest in HIV or its risk factors which has fueled a new wave of HIV infections in young MSMs and the stigma of the diagnosis.

Recommendations

1.1 The information gathered from this needs assessment on the increase in new HIV infections by HSDA and by risk group and, as more recent epidemiologic data become available, should be disseminated to local media outlets, health departments, civic leaders, and policy makers with an emphasis on social determinants in an effort to increase HIV awareness and understanding.

1.2 Encourage cooperation among local health departments and school districts to ensure that high school age children are provided with evidence-based, age-appropriate information about HIV and other sexually transmitted diseases as part of a baseline of health education grounded in the benefits of abstinence and delaying or limiting sexual activity, while ensuring that young people who are sexually active have the information they need to protect themselves from Sexually Transmitted Infection (STI's) or other unintended consequences.

Domain 2 – Targeted Prevention

Key Finding

The increasing number of new HIV cases across the PanWest-West Texas regions must involve both efforts to increase education among the general public and policy makers as well as ensure that limited prevention dollars are targeted toward those at highest risk for the disease based upon epidemiological research.

Recommendations

2.1 Support best practice approaches to HIV outreach and testing of high risk populations.
- Investigate the use of PEER counselors to engage with at risk populations via social and sexual networks.
- Expand upon the success of El Paso's M factor program to build social networks in other PanWest regions to reduce the spread of HIV among young gay and bisexual men.

2.2 Encourage training of PrEP counselors through the AETC.

2.3 Promote sharing of information and strategies among Ryan White-funded providers seeking to find reliable, ongoing funding sources to support PrEP clinics.

Domain 3 – Full Diagnosis

Key Findings

A third of all PLWH in the PanWest and West Texas regions receive a late diagnosis of their disease. This may have severe consequences for the individual's long term health and increase the spread of new infections. It is estimated that undiagnosed individuals who have high viral loads and continue to engage in risky behaviors may be responsible for 50% to 70% of new infections. The reported expansion of anonymous sexual networks among young MSM raises serious concerns with regard to an ongoing increase in HIV infections and other associated infections among young MSMs.

Recommendations

1. Work with community health leaders and policy makers to encourage adoption of routine HIV testing as part of regular medical care.

3.2 Address issues of stigma that prevent high risk individuals from seeking testing, and encourage adoption of safe sexual practices

3.3 Work collaboratively with other advocates of the uninsured/underinsured to seek Medicaid expansion in Texas.

Domain 4 – Successful Linkage

Key Finding

Based upon the social, cultural and structural issues that exist in the PanWest and West Texas regions, issues of efficiency of operations which include lifting the paperwork burden for case management staff and clients, exploring the feasibility of a universal intake form and improved information technology systems will be essential.

Recommendations

4.1 Encourage the El Paso community mobilization collaborative to explore adoption of a universal intake form for Ryan White providers. If successful, encourage and use in the Pan West area.

4.2 Work with the AA to implement needed improvements to ARIES data entry and reporting.

4.3 Consider a patient navigator program to improve direct communication with HIV testing and efforts to link positives to an accessible care provider.

Key Finding

Cultural mores and religious conservatism drive many with or at risk of HIV underground and impacts the number and percentage of newly diagnosed persons who are willing to engage in early stage care and are willing to risk disclosure. To successfully engage and link the newly diagnosed into care requires a culturally competent and linguistically appropriate staff who understands these issues and the needs PLWH have for ongoing emotional support, confidentiality, and a safe non-judgmental environment.

Recommendation

4.4 Ensure that all Ryan White funded agencies provide ongoing training on cultural competency and on the HIPPA requirements for confidentiality to all employees including front office staff.

4.5 Encourage the use and employment of PEER counselors with responsibility for linking newly diagnosed PLWH to care and retaining them in care.

Domain 5 – Support Participation in Care

Key Finding

Physician manpower shortages for many medical specialists are documented throughout the PanWest and West Texas regions. The availability of HIV medical providers was discussed in the focus groups and key informant interviews, and concerns were raised with regard to the insufficient supply of practitioners, particularly those who service the uninsured. A clinic in one HSDA operates one day a week. In another clinic multiple providers are used staff the HIV clinic resulting in dissatisfaction among clients. In other HSDAs, the paucity of providers to serve the uninsured raises concerns with regard to succession plans for physicians who will seek to retire.

Recommendations

5.1 Support on-going education for physicians working in HIV clinics through the AETC.

5.2 Evaluate the potential of using physician extenders and group practice models to enhance clinic efficiency, reduce wait times for appointments and support consumers' participation in care.

5.3 Work with FQHCs to ensure access to primary care services for PLWH.

5.4 Provide funding to support clinician training and ability to treat mental health disorders including anxiety and mild depression.

5.5 Strengthen the bonds between HIV medical providers and drug and alcohol treatment providers in each HSDA.

5.6 Work with TTUHSC, AETC and the National Health Service Corps to ensure a continuing supply of HIV specialists available to support the coming shortages of physicians.

5.7 Support the work of quality management programs to monitor and improve quality of care for PLWH.

Key Finding

Transportation to medical care is a particular concern in the PanWest region which lacks a network of public transportation outside the metropolitan areas. At least one PanWest provider will be looking into expanding care to its rural counties via telemedicine support.

Recommendations

5.8 Investigate the use of telemedicine services to enhance physician manpower resources and to ease the burden of transportation for those in rural areas.

5.9 Continue funding for transportation services.

Domain 6 – Viral Suppression

Key Finding

While consumer respondents recognize that viral load suppression does not mean they can stop seeing the doctor or stop taking their medication, they do not always act upon this knowledge. People with chronic diseases suffer from treatment fatigue. PLWH, especially those who are poor, uninsured, or are otherwise marginalized experience additional barriers that interfere with treatment and medication adherence including co-morbid medical and social conditions that make it difficult for them to stay in care.

Recommendations

6.1 Increase efforts to educate consumers at the importance of viral suppression to their long term health.
- Ensure that medical/nursing professional actively engage consumers to ask questions about their disease.
- Provide nutritional counseling to PLWH.

6.2 Continue to provide funding to supplement locally available behavioral health and substance abuse services.

6.3 Support quality improvement initiatives sponsored by the National Quality Center to improve engagement, retention and viral suppression for PLWH.

THE 2017-2020 COMPREHENSIVE HIV HEALTH SERVICES PLAN ADDRESSES THE GOALS, STRATEGIES AND OBJECTIVES OF THE NATIONAL AND STATE POLICIES AND INITIATIVES

National HIV/AIDS Strategy for the United States Updated to 2020

The National HIV/AIDS Strategy first developed in 2010 led to changes in the way that people discussed HIV, prioritized and responded to HIV prevention and care services, and delivered medical, non-medical and support services to PLWH to remain in care and treatment. The 2015 update incorporates the changes that have occurred, lessons learned and scientific advances that have occurred and may one day lead to the elimination of HIV infections.

The strategy lays a foundation for building future efforts and contains a vision, four goals, action steps and indicators for measuring and monitoring progress to ensure that the nation moves forward to achieve its goals, which include:

1. Reducing new HIV Infections
2. Increasing Access to Care and Improving Health Outcomes for People Living with HIV
3. Reducing HIV-Related Disparities and Health Inequities
4. Achieving a More Coordinated National Response to the HIV Epidemic

As a guiding document, the Update is a National Plan which can only be achieved through the efforts at the national, state, tribal and local level, and across all sectors of society.

The NHAS strategy provided a framework and foundation for the Needs Assessment recommendations and for the goals of this Plan. Appendix F presents the NHAS strategies and the PanWest-West Texas goals that support these strategies.

More information can be found at:
https://www.aids.gov/federal-resources/national-hiv-aids-strategy/hhas-update.pdf

Since 2010, there have been a number of changes to the way in which HIV care is delivered. Two of the most important include: (1) the implementation of the Affordable Care Act, and (2) the introduction of PrEP and policies which support the use of Treatment as Prevention (TasP).

Treatment as Prevention (PrEP and the Use of Antiretroviral Treatment)

Treatment as Prevention refers to HIV prevention methods that use antiretroviral treatment to decrease the risk of HIV transmission. In 2011, the HPTN052 Study showed early initiation of antiretroviral treatment in PLWH with a CD-4 count between 350-550, reduced HIV transmission to HIV negative partners by 96%. A number of follow-up studies have shown similar results. This has led to the idea that “treatment as prevention” could be used as a strategy to decrease community viral load and reduce the rate of new HIV infections. Such an idea depends on increasing efforts to test and treat those who are HIV+. As a result, the U.S. Prevention Task Force now recommends that all people aged 15-65, and all pregnant women be screened for HIV.

New scientific breakthroughs in biomedical prevention have led to the development of Pre-Exposure Prophylaxis (PrEP), which uses antiretroviral drugs to protect HIV negative people from HIV before they are exposed. Clinical trials have shown PrEP to be very effective when used consistently and effectively. As a result, PrEP has potentially population-wide health benefits. However, if not taken routinely and consistently, PrEP is much less effective. Therefore, it is important that PrEP is offered as part of a package of prevention initiatives and not as a replacement for other more effective method like condoms.

The CDC has issued guidance to providers recommending PrEP be considered for those at risk for HIV and the Department of Health & Human Services now recommends that all persons with HIV be offered treatment not only for themselves but for others who may be at risk for HIV transmission.

One of the largest challenges in the PanWest-West Texas region is finding medical professionals who are knowledgeable and willing to dispense PrEP and finding an ongoing source of funding both for the medication and for the required laboratory testing that must be done as part of the prescribing regimen. PrEP is not covered under the Ryan White program as those using the drug are HIV negative individuals. Many providers in the region are looking into establishing PrEP clinics as a strategy to prevent the spread of HIV. Events should be monitored both at the local and state level in an effort to find a funding mechanism for this potential new tool in the fight against HIV.

Affordable Care Act

The implementation of the Affordable Care Act has improved access to prevention services like HIV testing by eliminating co-pays and deductibles, and expanded access to primary care services to eligible PLWH. No longer can PLWH be prevented from getting care due to their HIV status (pre-existing condition) and for some, new coverage options have become available through the Health Insurance Marketplace.

Unfortunately, benefits of the Health Insurance Marketplace have not benefited many PLWH in Texas because so many are living below the poverty line and cannot qualify for subsidies on the exchange. While 18% of Texans live below the poverty line, 40% of Ryan White clients in the PanWest-West Texas region are living below the poverty line. Forty-six percent of Ryan White clients have no insurance. Additionally, the state's decision to not expand Medicaid to cover poor adults, has meant the bulk of low income HIV patients do not qualify for expanded health coverage. Those who work but earn less than 100% of the poverty level cannot take advantage of the marketplace tax credits to enroll in health insurance.

Thus, the impact of ACA on medical providers in the PanWest-West Texas area has been minimal in terms of the numbers of newly insured under ACA as compared to the increasing numbers of newly diagnosed HIV+ consumers. The consumer survey found 4.5% of Ryan White clients had obtained insurance via the Affordable Care Act.

The Needs Assessment documented a number of problems consumers who have obtained coverage under ACA have experienced, including:

- Insufficient number of providers who accept plans PLWH can afford.
- Not understanding that their prior providers may not be in the plans they choose.
- Young adults who gained expanded coverage under parents' insurance are afraid to seek care out of fear their diagnosis will be disclosed to parents.
- Many drop coverage after a short time because they find they cannot afford coverage even with subsides.

Many believe that Texas will eventually expand Medicaid. If this becomes a reality, many more PLWH will become eligible for Medicaid benefits. This issue will need to continue to be monitored; for now the challenge seems to be ensuring that those who have obtained insurance through ACA are receiving the information they need to fully utilize these benefits.

How This Plan Addresses Healthy People 2020 Objectives

Healthy People 2020, launched in December 2010, is a 10-year agenda for improving the nation's health. *Healthy People 2020* is the result of a multi-year plan that includes input from diverse groups and organizations. The mission of the agenda is to:

- Identify national health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability, and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation and data collection needs.

There are 15 objectives related to HIV. Eleven are addressed in the 2017-2020 Comprehensive HIV Health Services Plan. The goals and strategies of the 2017-2020 Comprehensive HIV Health Services Plan that address *Healthy People 2020* objectives are in Appendix G.

More information can be found at:
https://www.healthypeople.gov/2020/topics-objectives/topic-HIV

Texas 2014-2015 Plan Update and Spectrum of HIV Engagement

At the time of development of the 2017-2020 Comprehensive HIV Health Services Plan, the Texas HIV Plan was under development. The most recent 2014-2015 Plan update was developed with a comprehensive approach based on public health principles and the Health Services & Resource Administration's (HRSA) continuum of care. Texas expanded the HRSA continuum into a framework known as the Texas Spectrum of HIV Engagement.

Figure 9
Interconnectedness of the Domains of the Texas Spectrum of HIV Engagement

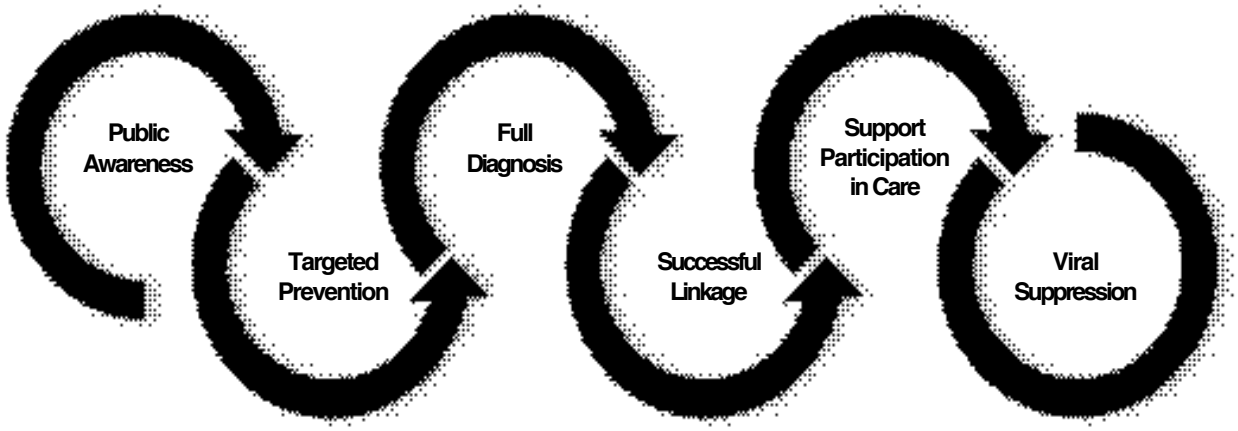


Figure 9 shows the interconnectedness of the strategies the state will employ in an effort to achieve the Plan's overarching goals which are to decrease the risk for populations and communities to HIV and reducing the amount of virus present in communities by reducing undiagnosed and untreated infections.

It is expected that the six domains of engagement will continue to figure prominently in the 2017-2020 Plan and that the six domains will form the basis for the 2017-2020 Plan strategies. These include:

1. Increase HIV awareness among members of the general public, community leaders, and policy makers.
2. Increase access to HIV prevention efforts for high risk groups.
3. Successfully diagnosis all HIV infections.
4. Increase timely linkage to HIV-related care and treatment.
5. Increase continuous participation in systems of care and treatment among people living with HIV.
6. Increase viral load suppression among people living with HIV.

The 2017-2020 Comprehensive HIV Health Services Plan proposes to adopt three of the six domain areas as the goals it will support and seek to achieve over the next three years.

More information about the 2014-2015 Plan Update can be found at:
https://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589987273

III. GOALS AND WORK PLANS

COMPREHENSIVE HIV HEALTH SERVICES PLAN

The 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. In May-July 2016, the AA staff participated in planning sessions that included a review of the previous mission, vision and shared values statements of the plan. These meetings also resulted in the development of draft goals, strategies, and required actions to be undertaken over the next three years. This information was developed into a draft plan that was presented and reviewed by the Texas Department of State Health Services (DSHS) staff.

Throughout the planning process AA staff considered the National HIV Strategy for the U.S., the *Texas HIV Plan* updated for 2014-2015, *Healthy People 2020*, and Ryan White Program requirements.

MISSION, VISION AND CORE VALUES

The mission, vision and core values statements were included in the 2013 PanWest–West Texas Comprehensive Plan were adopted for the 2017 Comprehensive Plan. This mission statement is the foundation for the 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan.

Mission Statement

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- Dignity: All clients will be treated with dignity.
- Respect Diversity: Recognize and respect cultural and individual differences.
- Professionalism and Quality: Provide quality services in a professional manner.
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- Collaboration: Work with community organizations to enhance access to the complete continuum of services, from HIV prevention to care and treatment.

GOALS AND RATIONALE

The 2017-2020 Comprehensive HIV Health Services Plan adopts three of the 2016 Texas Plan Priorities for AA and Subcontractor achievement. The goals reflect the findings of the 2016 PanWest-West Texas Targeted Needs Assessment which focused on barriers to linkage, retention and viral load suppression, and includes the updated epidemiologic profiles, regional demographics, and an assessment of access and health disparities in the region.

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- Increase continuous participation in systems of treatment among people living with HIV.
- Increase viral load suppression among people with HIV.

The goals for the 2017-2020 Comprehensive HIV Health Services Plan are outlined below along with the data and rationale to support the adoption of the goal.

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- When asked why they had not gotten into care for a timely manner the most frequent responses were “I was in denial” (48.5%), and “I wasn’t sick, so I didn’t think I needed medical care” (39.4%).

GOAL 2: INCREASE CONTINUOUS PARTICIPATION IN SYSTEMS OF TREATMENT AMONG PEOPLE LIVING WITH HIV.

Rationale

- In 2014, across all four HSDAs in the region, 66% of PLWH were retained in care with two or more medical visits. Amarillo had the highest rate (75%), and Permian Basin the lowest at 59%.
- PLWH in the region who are retained in care have viral suppression rates of 84%.
- Viral suppression levels not only improve long term health for PLWH, it also decreases their likelihood of infecting someone else.
- When asked reasons why they were not in medical care the top two reasons were, "I don't feel sick," and "I don't have the money to pay for care."
- The most often cited reasons that it was hard for consumers to get care included the paperwork required, the amount of time it takes at the clinic, and the time it takes to get an appointment.
- Sixteen percent of survey respondents reported dropping out-of-care within the last five years, and an additional 3% didn't know/couldn't remember.
- The most comment reason for dropping out-of-care was "I was using drugs or alcohol", "I was tired of taking medications", and "I didn't feel sick."
- When asked, "What would have helped you stay in care," the top 3 responses were:
  - ➢ "Having someone who understood what I was going through."
  - ➢ "Someone to guide me through the process of getting care, medication, and services."
  - ➢ "Someone to talk to about being depressed/anxious."

GOAL 3: INCREASE VIRAL LOAD SUPPRESSION AMONG PEOPLE LIVING WITH HIV.

Rationale

- Across the entire PanWest-West Texas region, 55% of PLWH have achieved viral load suppression. The highest suppression rates were achieved in Amarillo (62%), and the lowest in Permian Basin (47%).
- Males have lower viral suppression rates than females, 54% compared to 57%.
- Hispanics had the lowest viral suppression rates (47%) compared to 61% of Whites and 51% of Blacks.
- Over 60% of respondents indicated they would like more information about their medications, and over 50% wanted information about their viral load.
  - ➢ Respondents were less likely to understand their viral load than their CD-4 levels, and had less understanding of what the viral loads meant.

WORK PLANS

GOAL 1: **INCREASE TIMELY LINKAGE TO PARTICIPATION IN SYSTEMS OF TREATMENT AMONG PEOPLE LIVING WITH HIV.**

OBJECTIVE 1.1: By 2019, ensure that 90% of newly diagnosed PLWH are linked to care within 60-90 days of diagnosis.

STRATEGY: Increase cooperation and collaboration among prevention and treatment providers.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Planning Coordinator	The Administrative Agent (AA) supports collaboration with HIV Education, Outreach and HIV providers to ensure all cases are linked to care within three months of diagnosis. With this in mind, the AA will work with Disease Intervention Specialists and Health Department staff to review and address issues impacting delays between diagnosis and treatment.	Newly Diagnosed/ Those Returning to Care	Joint agreement on suggested improvement
By end of 2018	Planning Coordinator	The Planning Coordinator will contact Outreach and Disease Intervention Specialists to discuss shadowing their activities to gain a better understanding of all spectrums of care. Following these activities, the Planning Coordinator will meet with providers in each HSDA to present findings and review best practices.	Newly Diagnosed/ Those Returning to Care	Joint agreement on suggested improvements

OBJECTIVE 1.2: By 2019, increase the number of linked to care by 10%.

STRATEGY: Ensure that linkage systems are client-centered.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Program Administrator AA	Ensure that all agency staff receive at least annual training in cultural competency, HIPPA requirements, and confidentiality to tackle stigma, discrimination, and fears of disclosure among PLWH.	MSMs Hispanic MSMs Young MSMs	Number and types of training sessions provided

GOAL 2: **INCREASE CONTINUOUS PARTICIPATION IN SYSTEMS OF TREATMENT AMONG PEOPLE LIVING WITH HIV.**

OBJECTIVE 2.1: By 2019, increase the percentage of retained in care by 10%.

STRATEGY: Promote the development and implementation of models to improve retention.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Planning Coordinator Program Administrator	Identify the method, steps and processes that have resulted in the development of successful support structures (e.g., support groups) to enhance retention.	Those at high risk for dropping out-of-care	Identify best practices and disseminate information
By end of 2019	Planning Coordinator Program Administrator	Replicate the above process to create support group(s) in at least one other HSDA.	Those at high risk for dropping out-of-care	Support group(s) developed in at least one other HSDA

OBJECTIVE 2.2: By 2019, ensure 75% of newly diagnosed and returned to care PLWH have completed educational programs on benefits of early diagnosis and continuous treatment.

STRATEGY: Enhance efforts to engage and retain PLWH in care.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Program Administrator AA	Develop personalized, innovative, progressive, and ongoing educational program to educate consumers about the benefits of early diagnosis and treatment on their long term health and well-being (including viral load suppression). Ensure that programming is geared to individual clients' needs and desires.	Newly Diagnosed/ Those Returning to Care	Agreed upon program and pre- and post-test instrument
By end of 2019	Program Administrator	Implement the education program in each HSDA.	Newly Diagnosed/ Those Returning to Care	Pre- and post-test results Percent retained in care
By end of 2020	AA/DSHS Texas/ Louisiana Resource Center	Begin planning discussion regarding potential for Telemedicine Hub in the region.	Newly Diagnosed/ Those Returning to Care	Funding Availability

GOAL 3: **INCREASE VIRAL LOAD SUPPRESSION AMONG PEOPLE WITH HIV.**

OBJECTIVE 3.1: By 2019, increase the percent of PLWH who achieve viral suppression by 10%.

STRATEGY: Create a focus on clients, clinicians, and supportive services.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Program Administrator AA	Ensure case management staff utilize all available community resources and resource directories in assisting clients to meet their primary medical care, mental health, substance abuse, and other supportive service needs. Enhance case managers' awareness of new programs such as Healthy Texas Women's Program, Adult Safety Net Program, and encourage referrals to local FQHCs to meet clients' primary care and dental health needs.	Patients at high risk of dropping out-of-care	Percent retained in care
By end of 2018	Program Administrator	Ensure that case managers work with clients to ensure linkage to service providers (referrals and follow-up).	Patients at high risk of dropping out-of-care	Percent retained in care
By 2019	Program Administrators	Educate consumers about the meaning, benefits and implications of viral load suppression.	Patients at high risk for dropping out-of-care	Pre- and post-test scores Percent retained in care
By 2020	AA	Consider cost benefit of linking case managers to HIV care providers, EMR and having the capacity to enter screening data.	Patients at high risk for dropping out-of-care	Percent retained in care

OBJECTIVE 3.2: By 2019, increase the percent of HIV negative partners using PrEP to 25%.

STRATEGY: Enhance access to PrEP for HIV negative partners.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2017	Program Administrator AA	Educate interested clients and their partners about the purpose of PrEP, its use, and requirements.	MSMs	Number of clients requesting and receiving education
By end of 2017	Program Administrator AA	Develop a resource guide for PrEP to include prescribers' names, pharmacy, funding sources, and qualifications for pharmacy assistance programs. Ensure providers, case managers, and clients at high risk for other medical conditions are educated about the client's need to be closely monitored while on PrEP.	MSMs	Resource Inventory developed and available to consumers
By end of 2017	AA	Work with medical providers interested in developing PrEP clinics in the PanWest-West Texas Region.	MSMs	One clinic in place in region.

MONITORING PROGRESS

The 2017-2020 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining completion dates, responsible parties and data indicators. Many of the objectives and actions should be monitored on a quarterly basis, but no less than semi-annually.

The AA is responsible for overseeing the implementation of the Plan in accordance with the stated timeframes. In addition:

- The AA works with funded providers to ensure a unified direction.
- The AA will review ARIES data quarterly to determine the number of new admissions and re-admissions of PLWH who are out of care as well as monitoring the units of service and expenditures.
- The quality management process supports monitoring and evaluation of Plan Goals.
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.

EVALUATION

The AA monitors progress in achieving the goals and objectives of the plan. This, in turn, promotes evaluation of the plan. Plan evaluation will include:

- Ability to implement stated action steps within the projected timeframes.
- Achievement of each strategy,
- Documented system improvements that support the four goals.

Each goal will be evaluated annually and upon completion of the plan using available data.

- The actions that comprise each strategy are clearly outlined in the work plan. Successfully completing these actions with the designated timeframe will facilitate monitoring.
- By assigning responsible parties and monitoring intervals, any deviation in completion will be identified.

IMPACT ON PRIORITY SETTING AND ALLOCATIONS

In developing the 2017-2020 Comprehensive HIV Health Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system, but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement, but will not be a direct dollar cost. Finally, some of the strategies may result in increased costs during program initiation, but ongoing provision will increase cost to the system significantly.