HIV/AIDS SERVICE AREAS
West Texas, Area 1 & PanWest, Area 2
Ryan White Part B Program

2010-2013 COMPREHENSIVE HIV HEALTH SERVICES PLAN

REVISION MAY 2012

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Initial Comprehensive Plan developed 2010 by:

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TRANSFORM HEALTH CARE INFORMATION TO VALUE

EXECUTIVE SUMMARY

The 2010-2013 Comprehensive HIV Services Plan was the first joint plan between the PanWest and West Texas regions. The Plan was revised March 2011, April 2011, and April 2012.

The PanWest region encompasses three HIV Service Delivery Areas (HSDA) and 58 counties, and the West Texas HSDA includes six counties. The PanWest's three HSDAs have a strong history of joint administration with the Administrative Agent (AA) Lubbock MHMR. The West Texas area came under the AA as of summer 2009. In July 2009, a change occurred in the West Texas HSDA resulting in Lubbock Regional MHMR Center (LRMHMRC) assuming HIV Service Administrative Agency (AA) responsibilities for this HSDA. Planned Parenthood of El Paso, the West Texas HSDA AA and large HIV multi-service provider, unexpectedly closed its doors. LRMHMRC was enlisted to become the AA. Although this was a difficult transition for West Texas consumers, subcontractors, and the AA staff, the challenges are being addressed, and the change is ultimately positive for all parties.

This joint PanWest-West Texas Comprehensive HIV Services Plan emphasizes high quality HIV medical care and funded services as well as a consumer-centric approach to planning, care and treatment. It also demonstrates the economies of scale being attained by consolidating AA services for the two regions.

1. WHERE WE ARE NOW: WHAT IS IN OUR CURRENT SYSTEM OF CARE?

The PanWest and West Texas regions comprise 64 counties and over 84,000 square miles. Most of the counties are very rural, but cities exist within each HSDA.

- Lubbock County is the most populous in the PanWest with 296 people per square mile.
- Potter, Midland and Ector counties range between 138 and 146 people per square mile.
- The six county West Texas region abuts the Mexico border and is 23,458 square miles with El Paso County being the most populous, with 754 residents per sq. mile.

Considering race and ethnicity, the two regions have diverse populations.

- The northern most HSDA, Amarillo, is predominantly White (64%), followed by 29% Hispanic and 5% Black.
- The demographics gradually change moving south through the western portion of the state. West Texas, which is the southern most HSDA, has a Hispanic majority (83%), followed by White (12%) and Black (3%).

The 2008 Texas median household income was $50,049. The only PanWest or West Texas County that exceeds this is Midland County with a median household income of $56,320.

- The West Texas HSDA, El Paso County and Potter County have the lowest median 2008 household incomes, ranging between $36,300 and $37,000.
- Most other HSDAs and population centers have median incomes in the range of $42,000 to $48,000.

Similarly, in 2008 in Texas, 15.8% of residents lived below the poverty level. In the PanWest and West Texas regions, between 15% and 25% of residents were living below the poverty level.

The PanWest and West Texas Regional HIV/AIDS Epidemics

Over 1.2 million people reside in the PanWest region, and 1,163 of these are infected with HIV/AIDS for an infection rate of 94.2/100,000.

- Each of the PanWest HSDAs has a similar number of residents, approximately 400,000. The number of PLWHA in these HSDAs ranges between 356 in Permian Basin and 417 in Amarillo, thus the infection rates are similar, ranging from 90/100,000 to 99/100,000.
- Most PLWHA reside in the population centers of the HSDAs.
  - Seventy five percent of the 417 PLWHA in the Amarillo HSDA reside in Potter County, home of the city of Amarillo
  - The Lubbock HSDA has 358 PLWHA, with 85% residing in Lubbock County;
  - The Permian Basin HSDA has 356 PLWHA, and 75% residing in Midland County and Ector County which is home to Odessa.

The six counties comprising West Texas have a total population of over 790,000.

- El Paso County, with 1,569 PLWHA, is home to 99.5% of those living with HIV/AIDS in this HSDA. The HIV infection rate in West Texas is 200.8/100,000.

While men comprise the vast majority of infections, women are an increasing percentage of the epidemic in the PanWest HSDAs. West Texas has been stable in the proportion of infections by gender beween 2002 and 2008 with 87% male.

In the PanWest region, White residents are a slightly decreasing percentage of the HIV epidemic and Hispanic residents are an increasing proportion. The percentage of infected Blacks/African-Americans in the PanWest region was stable during this time period at approximately 16%. In West Texas, the epidemic is concentrated in the Hispanic community (84%), with little change in the proportion between 2002 and 2008.

PLWHA in the PanWest tend to be diagnosed on a more timely basis than those in West Texas. In the PanWest, 22% of people diagnosed with HIV between 2005 and 2008 received an AIDS diagnosis within one month, and 7% more received that diagnosis within one year. In West Texas, 36% of all new diagnoses received an AIDS diagnosis within one month of the HIV diagnosis. Further, 43% of all new diagnoses received HIV and AIDS diagnoses within one year.

Assessment of the Needs of People Living with HIV/AIDS

Comprehensive Needs Assessments were conducted in the PanWest region in 2009 and in West Texas in 2010. Both needs assessments included consumer surveys and resource inventories. The West Texas needs assessment included key informant interviews and focus group

discussions. Results from these studies were used to inform the comprehensive planning process.[1]

Description of the Current Continuum of Care

The Administrative Agency 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 three Part B funded subcontractors in the West Texas HSDA.

- The three Part B funded service Subcontractors in the PanWest are located in the population centers of each HSDA – Amarillo, Lubbock, Odessa. These subcontractors assess, link and refer to non-Ryan White funded community resources throughout the region.
- In the West Texas HSDA, there are two HIV medical care subcontractors, La Fe CARE, and Texas Tech University Health Science Center (TTUHSC). In addition, Family Service of El Paso is funded for mental health therapy/ counseling in this region.

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 Part B and State Services funding is used as the payer of last resort.

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

The following strengths and challenges are provide a foundation for this plan and achievement of its goals as well as help explain why the goals can be difficult to meet or meet timely:

- High quality medical care provided by experienced physicians in each HSDA. However, the number of infectious disease (ID) specialists are limited. This is was noted in the Permian Basin area in late 2011 when the ID retired in December 2011 and there were no other IDs in the area to take his place. Fortunately, Texas Tech University Health Sciences Center was able to enter into a contract with Basin Assistance Services (BAS), the Permian Basin HSDA HIV Service Provider, to provide a clinic. Due to space limitations, the clinic had to be conducted at the BAS location.
- Increasing demand for limited Ryan White funding, including medical core services. Each HSDA is experiencing an increase in new clients. In West Texas, the Texas Tech University Health Sciences Center HIV clinic went from approximately 60 patients in summer 2011 to 110 by end of April 2012 and the majority of those clients are new to services and several are coming in late into care and quickly progressing to AIDS.

[1] 2009 PanWest Comprehensive Needs Assessment and 2010 West Texas Comprehensive Needs Assessment results can be found at www.panwest.org.

PanWest-West Texas Ryan White Part B Programs

- Availability of a full range of Ryan White medical core services. The AA strives to allocate funds to four main medical core categories Ambulatory Outpatient Medical Care (AOMC), Health AIDS Pharmaceuticals, Health Insurance and Medical Case Management. The AA has a no denial policy for AOMC, Health Insurance, and AIDS Pharmaceuticals due to the urgency and immediate impact the three services can have on client health outcomes. Unfortunately, this can limit availability of funds to other core services such as oral health but especially to non-medical support services such as housing and food bank.
- Service providers with several years of HIV service experience in the areas.
- Spanish/English bilingual staff are widely available in West Texas organizations that serve PLWHA. In PanWest, each service provider has at least one Spanish speaking case manager.
- A variety of funding sources complements Ryan White funding and service providers have resourceful case managers who know how to navigate the system.
- Well developed social service continuums of care in the population centers of the HSDAs. With the growing number of clients and the lessening of funds for community agencies, resource requirements are becoming more stringent. Several agencies are also following a payer of last resort policy.
- Changes in the Texas Ryan White case management system. DSHS released the new case management standards in January 2011. The new standards include new challenges such as extensive training for case managers, six month updates, and increased supervisory overview.
- 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 may be time-consuming and difficult to accomplish.
- In West Texas and other rural areas, the ongoing HIV stigma can be acute, limiting access to services due to consumer disclosure concerns.

In March 2012, TX DSHS held a meeting in Austin for Ryan White providers to discuss changes and challenges in HIV Services. The main focus was as follows:

- Expand the capacity of existing providers. Providers have to be ready to bill Medicaid and code correctly. Providers have to be ready to bill private insurance.
- Expand the network of existing providers. There are more PLWHA and they are outgrowing the current RW system. We can no longer expect Ryan White to be the only resource. We have to know our resources and use them. We need more medical providers – need more primary care providers to manage chronic care for HIV.
- Expand client knowledge especially on the Affordable Care Act (ACA) and changes they will be seeing if they become eligible for Medicaid under the expanded Medicaid program: What is the client perspective of 2014? How much do clients understand about insurance? For example, what is a premium?, what is a co-pay?, what is a deductible?, what is a provider? If you've never had insurance, how would you know these things?
- Health Reform Overview: The ACA went before the Supreme Court March 26, 2012. The Court is expected to rule on the ACA in late June or early July. They can accept the ACA as is, change parts of it or they can throw out the whole thing. Because of this it is difficult to make concrete plans. The US Health and Human Services, CMS, HRSA, DSHS are all making plans but nothing is definite because there are still several unknowns. Parts of the ACA have rolled out such as no denial for pre-existing conditions for children. Other parts

such as young adults able to stay on their parent's insurance up to age 26 and the expanded Medicaid have not.

- A big issue is the Medicaid primary care reimbursement rate. There is a big push for it to increase to the level of the Medicare rate.
- The uncertainty of the US Supreme Court's ruling on the ACA makes it difficult to plan when it is unknown what will be required and allowable.
- Federally Qualified Health Centers (FQHCs) must be responsive to community health care needs providing primary care services and preventive services. They are open to everyone regardless of ability to pay. However, the FQHCs are not intended to be free clinics and they have a sliding scale free/cost sharing fee based on the Federal Poverty Limit.
- In Texas, two main things stand out, the number of people at the poverty level add the number of people without insurance.
- Ryan White Treatment Act is due for reauthorization in 2013. How will it change? Will the funds go into ACA? There is talk that RW will be different but that it will be a safety net for those clients who cannot get into the expanded Medicaid or one of the insurance programs, such as undocumented individuals.
- What about Medicaid? Medicaid is an entitlement program. It is not a discretionary program and cannot have a waiting list. If you are eligible then it has to be provided to you. It is a jointly funded program between the State and the Federal government. Medicaid Delivery Models are managed care organizations (MCO) or fee for services (FFS): MCOs (Star, Star Plus, NorthStar) are paid a capitalized rate to cover all the mandatory medical services. Beginning March 2012 MCOs must provide prescription drugs based on preferred drug list (HHC). MCOs must provide HIV prevention screening, counseling, diagnostic and treatment. Its members must be able to access HIV diagnostic services without a referral or approval from PCP. 1115 Waiver (Healthcare Transformation) is managed care expansion statewide. It has a carved-in dental managed care as well as prescriptions on a preferred drug list. For more information visit The Medicaid Managed Care Initiative www.hhsc.state.tx.us.medicaid/mmc.shtml or www.hhsc.state.tx.us/1115-waiver.shtml. If expanded Medicaid rolls out it will be at the modified adjusted gross income (MAGI) of 133% FPL not 100% so this will allow more people to be eligible for Medicaid. The actual percentage will be 138%. The big deal about this is that people will not have to prove disability, just 133% of the FPL.
- People who do not qualify for Medicaid because they fall into the 138% - 400% FPL can participate in the insurance exchange program (extra money to help buy insurance).
- The 2011 State Healtcare Access Research Project (SHARP) Texas State Report[2] examines the State's capacity to meet the healthcare needs of PLWHA. Over half the PLWHA in TX live in Dallas and Houston areas. DSHS estimates that about 50% (maybe as high as 70%) of 35,000 people who receive RW services will be eligible for the expanded Medicaid in 2014 (this is assuming that it passes the Supreme Court). This still leaves approximately 50% (or 25%) who will be without Medicaid. Of those, approximately 13% will be eligible for subsidies to purchase insurance (exchange). Challenges for expanded Medicaid include: A) lack of providers especially in health professional shortage areas (HPSA) like rural areas. A) the Medicaid Application and Enrollment process can be long and difficult, C) overburdened

[2] SHARP Texas State Report by Amy Killelea, Devin Cohen, Robert Greenwald 2011, prepared by Health Law and Policy Clinic of Harvard Law School & the Treatment Access Expansion Project

case managers who do not have time to explain or assist with the enrollment or who may not have the knowledge to assist with enrollment – there is a disconnect between the information needed and the people who need it. Visit www.texashiv.org if you are interested in receiving updates and alerts.

- Texas Jurisdictional Plan (Public Health Perspective): The number of new HIV diagnoses and deaths remain stable, so why is the number of people living with HIV/AIDS increasing? Containment. Treatment works and people live longer. Research shows that a PLWHA who is treatment adherent is less likely, the rate is about 96%, to transmit the HIV to someone else. Because of this, it is important to a) increase the diagnoses rate, and, b) increase access to care. The National HIV Strategy has four goals and one of them is to coordinate. Texas plans to enhance coordination between planning and resource allocation, which are often split in a way that separates prevention and care. The Texas plan has to focus on the full socio-ecological frame from the TX CPG Prevention Plan. The goal is to reduce new HIV infections in Texas. The guiding principles are:
  - It must be comprehensive: a coordinated response
  - Allocations need to be founded on a shared understanding of who is at risk in TX based on epidemiological data
  - Multiple levels of action: individuals, environment, systems (institutions, structure)

  The plan has to be effective in quality and quantity. Priority – Feasibility – Bang for your buck: Narrow the priorities to a few good, workable ones. Prioritize what must be done first – start with a few, such as three, priorities to work toward. How feasible is it to meet the priorities? (Is it easy to do or so difficult it is not worth the time and money?) Is it worth the expense (if it's effective but it will only help 20 people in one year, how economical is it? Is it more effective to move to something that will cover many more people?)?

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 PLWHA in the regions. It requires collaboration between all Ryan White funded subcontractors to ensure services are of the highest quality as well as provided efficiently and effectively in conformance with established standards of care and best practices.

- The cornerstone of the QM program is the Annual Quality Management Plan that encompasses the Annual Quality Improvement (QI) Plan.
- The QM/QI Plan is developed and reviewed by the Quality Management Committee (QMC), which is comprised of representatives from the AA and each funded PanWest and West Texas subcontractors.
- Training is an important component of the QM program. The AA directly and indirectly offers training to subcontractors as part of the QM program.

2. WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

Comprehensive HIV Health Services Planning Process

The 2010 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. The "2010 PanWest—HIV Service Area 2 Comprehensive Plan for HIV Services with Quality Management Plan and Quality Improvement Plan" (Comprehensive Plan) provided the basis for this plan. In July 2010, the AA staff participated in a planning session that included a review of the mission, vision and shared values to ensure they applied to both the PanWest and West Texas. They outlined draft goals and strategies with discussion of required actions over the next three years. This information was developed into a draft plan that was presented and reviewed by West Texas subcontractors in early October 2010. Their input revealed that many of the actions were already under way in that region, and this information was added to the plan. Throughout the planning process, AA staff considered and incorporated Texas Department of State Health Services (DSHS) initiatives and requirements. These are reflected in the goals, strategies and actions.

Mission, Vision and Core Values

The mission, vision and core values statements were included in the 2010 PanWest Comprehensive Plan, and slightly revised for this joint Plan. This mission statement is the foundation for the PanWest and West Texas 2010 Comprehensive HIV Health Services Plan.

Mission Statement

To develop and coordinate an effective, comprehensive, community-wide response to HIV/AIDS in the PanWest and West Texas regions by providing high quality medical and support services that optimize Ryan White funds and leverage community resources.

The following ideal vision underpins the Plan.

Vision Statement

The PanWest and West Texas Administrative Agency visualizes a system of HIV care that is accessible and effective so PLWHA may enjoy improved health and an enhanced quality of life.

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

Core Values

The PanWest and West Texas Administrative Agency (AA) takes pride in its commitment to public service and its responsibility to continuously improve HIV health service delivery. The AA believes that all services require a basic foundation of the core values of: Dignity, Respecting Diversity, Professionalism and Quality, Availability and Accessibility, and Collaboration. The AA believes 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 within the community to enhance PLWHA access to all available services.

3. HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

The 2010-2013 Comprehensive HIV Health Services Plan establishes four goals for AA and Subcontractor achievement. It also includes the goals of the 2012 Annual Quality Management (QM) Plan and Annual Quality Improvement (QI) Plan.

- All four Comprehensive Plan goals reflect the findings and recommendations of the 2009 and 2010 Comprehensive Needs Assessments, the epidemiological profiles and the Ryan White HIV/AIDS Program requirements.
- The 2012-2013 Annual Quality Improvement Plan outlines strategies and actions necessary to achieve five quality performance measures.

These Plan goals, their associated strategies and actions promote access to quality HIV medical care and supportive services for all PLWHA; ensure culturally sensitive service provision; link and engage PLWHA outside the medical care system; and ensure services are of the highest quality. The AA feels confident that these goals promote a system of care that will promote the health and well-being of people living with HIV/AIDS in the region.

The goals and accompanying objectives of the 2010-2013 Comprehensive Health Services Plan are outlined below. See Part II, Section III Action Plan of this Plan for strategy updates.

GOAL I
Provide a quality continuum of HIV medical care that encourages engagement and retention in treatment.

As the first priority of the AA, the strategies of Goal I are intended to support a quality Continuum of Care to promote engagement and retention in HIV medical care. The following strategies are associated with this goal:

- Establish a second medical care subcontractor in West Texas by September 1, 2010 with ancillary services and medical case management available by March 2011, increasing patient volume through March 2013. 3-2011 NOTE: TTUHSC was established as the second subcontractor in August 2010. **4-2012 NOTE**: TTUHSC patient volume has increased about 50% and is currently at approximately 65 or more patients.
- Provide medical services with expanded evening and/or weekend hours to meet client needs by March 2011. 3-2011 NOTE: La Fe CARE began one weekday evening clinic and one monthly Saturday morning clinic. **4-2012 NOTE**: La Fe is in the process of evaluating the evening and Saturday clinics.
- Evaluate co-located gynecology services at La Fe Care, Inc. by June 2011, identifying the need to modify, improve and/or promote this service to encourage utilization. Establish a service plan based on results of the evaluation by September 2011. 3-2011 NOTE: La Fe CARE provides ob/gyn services through a nurse practitioner (NP). Whatever treatments the La Fe CARE NP cannot provide, such as laser treatment, are provided by a NP in Vinton, TX.
- Optimize the medical and non-medical case management functions in PanWest and West Texas regions by March 2013.
- Evaluate and expand the mental health therapy and counseling services in the West Texas region to include: funding for psychiatric consultations in 2011, co-location of mental health counseling with HIV medical care by 2012, and development of multi-disciplinary treatment teams for patients with mental disorders by 2013.
- Develop standards/policies to prioritize PanWest and West Texas clients who will qualify for medication co-pay assistance, insurance assistance, oral health procedures and vision care by June 2011, extended from March 2011, evaluating the impact through March 2013.
- Fund a medical home pilot project in either PanWest or West Texas HSDA by March 2013. **4-2012 NOTE**: This strategy is pending indefinitely mainly due to uncertainties with the Affordable Care Act awaiting a decision from the U.S. Supreme Court and funding availability.

GOAL II
Provide all funded services in a culturally sensitive manner that recognizes the regional stigma of HIV disease and works to reduce it.

Goal II responds to the ongoing need to enhance access to and retention of care, particularly focusing on the diverse populations found in both the PanWest and West Texas regions. The

strategies associated with this goal focus on developing services at multi-service subcontractors, improving health literacy, and providing appropriate bilingual educational materials.

- In West Texas, increase access to core medical and support services by contracting with a least one medical care subcontractor at an organization that combined HIV and non-HIV services by March 2011. 3-2011 NOTE: This goal was met by contracting with TTUHSC.
- Monitor service utilization and client satisfaction among disproportionately affected sub-populations semi-annually through 2013, identifying reasons if declining utilization occurs.
- Review English and Spanish patient and family education materials annually, improving and expanding health literacy resources as necessary through March 2013.
- Conduct an annual assessment of clients' HIV health literacy including such topics as understanding of their HIV treatment, importance of adherence, risk reduction strategies and HIV prevention.

GOAL III
Identify, engage and retain people who know their status and are not receiving HIV medical care.

Goal III recognizes the ongoing emphasis in identifying PLWHA who are diagnosed but not receiving HIV medical care. It reiterates the commitment to identifying and engaging those who are not accessing care. To accomplish this goal, the strategies draw on programs that have been successful in other parts of the state and nation, such as return to care/lost to care programs and peer navigators. In addition, a focus on health literacy is emphasized. Specifically:

- Establish comprehensive "Return to Care" programs at one PanWest HIV medical care subcontractor and one West Texas medical care subcontractor by March 2012.
- Ensure appropriate materials are available to educate clients on the benefits of remaining in care and the health consequences of not adhering to treatment including how HIV is spread and how to disclose the information to current/future partners by September 2011 with annual updates.
- Develop a peer mentor/navigator program for newly diagnosed people living with HIV/AIDS and other appropriate populations to encourage linkage and maintenance in HIV medical care by March 2013.

GOAL IV
Ensure all funded services are of the highest quality, conforming to measurable standards of care and service outcomes including clinical quality measures and client satisfaction.

The Administrative Agency, the Quality Management Committee (QMC) and all subcontractors consistently strive to deliver the highest quality services to PLWHA. Their ongoing commitment to quality care is recognized through the shared values. Goal IV builds upon and incorporates the quality improvement plan with the following objectives:

- Implement the PanWest and West Texas Regions' Annual Quality Improvement Plan.
- Use data to determine progress toward the HIV/AIDS Bureau's HIV Core Clinical Performance Measures for Adult/Adolescent Clients Group 1 (Tier 1) adopted by the Texas Department of State Health Services.
- Implement the annual patient/client satisfaction survey throughout the PanWest and West Texas HSDAs, improving overall patient/client satisfaction annually.

4. HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?

Monitoring Progress

The 2010-2013 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining start and completion dates, appropriate reporting intervals and status reports. Some objectives and actions require monthly review while other long term objectives will be reviewed less often, but no less than annually. The AA is responsible for overseeing the implementation of the 2010-2013 Comprehensive HIV Health Services Plan (hereinafter the Plan) in accordance with the stated timeframes. Specifically:

- The AA delegates tasks to the Quality Management Committee (QMC) and funded subcontractors to ensure a unified direction.
- The AA will review ARIES data quarterly to determine the number of new admissions and re-admissions of PLWHA who are out of care as well as monitoring the units of service and expenditures.
- The quality management process supports monitoring and evaluation of strategies and activities.
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from the surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.

Evaluation

The AA, supported by the QMC, 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 as follows:

- Goal I, focusing on an accessible and engaging Continuum of Care that retains clients, will be evaluated through ARIES utilization data which should be monitored at least quarterly. The development of successful new providers and programs will be evaluated with both ARIES data and consumer satisfaction surveys.

- Goal II, focusing on providing services in a culturally sensitive manner and reducing the stigma of HIV disease will be evaluated with ARIES data, client satisfaction data as well as consumer and provider input into educational needs and the available educational materials.
- Goal III, targeting consumers who know their status but are not receiving HIV medical care, will be evaluated using annual unmet need estimates and data from developing returned to care programs.
- Goal IV, focusing on quality care, will be evaluated through improved clinical outcomes and improved client satisfaction. The Annual Quality Improvement Plan incorporates evaluation benchmarks which will support the evaluation of this goal.

Impact on Priority Setting and Allocations

In developing the 2010-2013 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, particularly those that center on identifying new service providers may result in increased costs during program initiation, but ongoing provision should not increase costs to the system significantly. However, the increasing number of uninsured clients in both PanWest and West Texas have caused an increase in medical services plus unexpected events in each area have forced the AA and the subcontractors to delay implementation of several strategies.

TABLE OF CONTENTS

Page

LIST OF TABLES AND FIGURES

ACRONYMS

AA: Administrative Agency

AA MSM: African American men who have sex with men

ACA: Affordable Care Act - federal health reform under the Obama Administration

ADAP: AIDS Drug Assistance Program through the TX HIV Medication Program

AIDS: Acquired Immunodeficiency Syndrome diagnosed (caused by HIV)

AOMC: Outpatient/Ambulatory Medical Care- HIV core medical service category, includes labs, infectious disease specialist, other specialities etc… (also seen as OAMC)

ARIES: AIDS Regional Information and Evaluation System (HIV database for TXDSHS)

ART: Antiretroviral therapy medication for treatment of HIV disease (formerly HAART)

CARE: Comprehensive AIDS Resources Emergency Act

CDC: Centers for Disease Control and Prevention

COC: Continuum of Care

DSHS or TX DSHS: Texas Department of State Health Services (answers to HRSA for Part B)

ELR: Electronic Lab Reporting

EMA: Eligible Metropolitan Area

FMS: Female/Male Sex

FPL: Federal Poverty Limit – income table used by many agencies to determine eligibility and fees for certain programs, especially those geared toward low income individuals

FQHC: Federally Qualified Health Center (to provide primary and preventive care to all people on a sliding scale or fee per service scale based on the Federal Poverty Limit)

HAB: HIV/AIDS Bureau (part of HRSA)

HARS: HIV/AIDS Reporting System (through the CDC)

HASA: HIV/AIDS Administrative Service Area (ex: PanWest and West Texas)

HERR: Health Education/Risk Reduction

HET Male or **HET Female**: Heterosexual male or Heterosexual female

HIV: Human Immunodeficiency Virus

HOPWA: Housing Opportunities for Persons with AIDS

HRSA: Health Resources and Services Administration (under the USDHHS)

HSDA: HIV Service Delivery Area (Amarillo, El Paso, Lubbock, and Permian Basin)

ID: Infectious disease specialist - doctor

IDU: Injection Drug Use(r)

I/RR: Incarcerated/Recently Released

IV: Intravenous

LRMHMRC: Lubbock Regional Mental Health Mental Retardation Center (AA for TX DSHS)

MOU: Memorandum of Understanding

MSM or **MMS**: Men who have Sex with Men (AA MSM=African American MSM, HIS MSM= Hispanic MSM, MSM/IDU =MSM who also inject drugs)

OAMC: Outpatient/Ambulatory Medical Care- HIV medical core service category that includes labs, infectious disease specialist, other medical specialties, etc… (also seen as AOMC)

OB/GYN: Obstetrical/Gynecological services for women

OOC: Out of Care – a person with an HIV diagnosis who is not receiving medical care

PLWHA: People/Person(s) Living with HIV or AIDS

QI: Quality Improvement

QM and **QMC**: Quality Management and Quality Management Committee

RW or **RW Part B** or **RW II**: Ryan White, Ryan White Part B (formerly Title II)

RWSD: Ryan White Service Delivery – base grant for Part B

SA: Substance Abuse(r)

SNG: Severe Need Group(s)

SSDI: Social Security Disability Insurance

STD or **STI**: Sexually Transmitted Disease or Sexually Transmitted Infection

TA: Technical Assistance

TANF: Temporary Assistance for Needy Families (formerly AFDC)

TDCJ: Texas Department of Criminal Justice

TxCPG: Texas Community Planning Group – representatives across State working with DSHS to develop the Texas HIV/STD Prevention Plan 2011

TXSCSN or **SCSN**: Texas Statewide Coordinated Statement of Need

USDHHS: U.S. Department of Health and Human Services

WCB: Women of childbearing age (ages 15 – 44)

INTRODUCTION

The initial 2010-2013 Comprehensive HIV Services Plan is the first joint plan between the PanWest and West Texas regions. The PanWest region encompasses three HIV Service Delivery Areas (HSDA) and 58 counties, and the West Texas HSDA includes six counties. In July 2009, Planned Parenthood of El Paso, the West Texas HSDA Administrative Agency (AA) and large HIV multi-service provider, unexpectedly closed its doors. The regional AA responsibilities were assumed by Lubbock Regional MHMR Center, the PanWest AA, and medical and other subcontracted services were absorbed by the remaining HIV medical care provider, La Fe CARE. Although this was a difficult transition for West Texas consumers, providers, and the AA staff, the challenges are being addressed. This joint PanWest-West Texas Comprehensive HIV Services Plan demonstrates the focus on high quality HIV medical care and other funded services; a consumer-centric approach to planning, care and treatment; and the economies of scale being attained by consolidating AA services.

HISTORY OF THE RYAN WHITE HIV/AIDS PROGRAM[3]

Since enactment in 1990, the purpose of the Ryan White HIV/AIDS Program has been to improve the life and health of poor and disenfranchised people living with HIV/AIDS (PLWHA). As the epidemic changed, the health focus increased and the focus on disproportionately affected populations continued, targeting un- or under-insured, people who are impoverished, and people who may have lost the capacity to provide for themselves because of their illness. The history of the legislation mirrors the evolution of the epidemic:

- The original legislation, the **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act**, provided for care, services, research and demonstration programs aimed at reducing the morbidity and mortality from the disease.
- In 2000 the Ryan White CARE Act was reauthorized, and due to improved medical treatment, the legislation focused on maintaining PLWHA in medical care and identifying "out-of-care" PLWHA and bringing them into the care system.
- In 2006, the **Ryan White Treatment Modernization Act (TMA)** was passed to accommodate changes in the epidemic as well as treatment advances. It reinforced the Ryan White HIV/AIDS Program as a health care rather than social services program, requiring that at least 75% of funds are allocated to 13 medical-related core services.
- In 2009, the Modernization Act was due to expire and was reauthorized as the **Ryan White HIV/AIDS Treatment Extension Act of 2009** (Extension Act of 2009). Maintaining most components of the Modernization Act, the services authorized under the Extension Act of 2009 are intended to:
  - Reduce the use of more costly inpatient care,
  - Increase access to care for underserved populations,
  - Improve quality of life for those affected by the HIV epidemic.

[3] A detailed history of the Ryan White Program and associated terminology can be found in Appendix A.

The Extension Act of 2009 works toward these goals by funding local and State programs that provide primary medical care and support services; health care provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues.

- The Extension Act of 2009 is scheduled to expire (sunset) around October 2013. It is unknown if the Extension Act of 2009 will be reauthorized. There is much speculation surrounding its reauthorization including concern that Ryan White will not be reauthorized to it will be reauthorized as a safety net to cover those PLWHA who will not be covered under the Affordable Care Act, assuming it passes.

The Affordable Care Act went before the U.S. Supreme Court in late March 2012. The Court will either completely void the whole Act or accept it as is, or somewhere in between. The Court's decision is expected to be announced in June or July 2012.

COMPREHENSIVE HIV HEALTH SERVICES PLANNING

The Ryan White Program requires development of a comprehensive HIV health services plans for Part A and Part B grantees to direct coordination and provision of care and services to PLWHA. The importance of developing an actionable comprehensive HIV services plan has been consistently emphasized by the leadership of the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) and the Texas Department of State Health Services (DSHS). Specific requirements for Comprehensive HIV Services Plans have been outlined and should reflect a system that:

1. **Ensures the availability and quality of all core medical services.**

2. **Eliminates disparities** in access to core medical services and support services among disproportionately affected sub-populations and historically underserved communities;

3. **Specifies strategies for identifying individuals who know their HIV status but are not in care**, informing them about available treatment and services, and assisting them in the use of those services;

4. **Includes a discussion of clinical quality measures;**

5. **Includes strategies that address the primary health care and treatment needs** of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system;

6. **Provides goals, objectives, timelines, and appropriate allocation of funds;**

7. **Includes strategies to coordinate the provision of service programs for HIV prevention**, including outreach and early intervention services, and;

8. **Includes strategies for the prevention and treatment of substance abuse**.

How to Use this Plan

This document consists of two parts which comprise the PanWest and West Texas 2010 Comprehensive HIV Health Services Plan. Part One is the narrative portion and contains four sections, including:

1. A situational analysis of the current system of care;
2. A description of the planning process and the overarching principles guiding the directions established in the Plan;
3. An overview of each goal and objective contained within the Plan; and
4. A framework for monitoring and evaluating success.

The second part presents the Plan. It begins with the Mission, Vision and Shared Values statements and follows with the Goals and Strategies. Each strategy is presented with a detailed action plan delineating actions, responsibilities, and timeframes.

The Plan concludes with a timeline, identifying the projected start and completion date for each objective and action step. This tool will allow monitoring the progress of implementation and in guiding the work of those who are charged with carrying out the Plan.

HIV Services and Prevention Programs and the National HIV Strategy

In July 2010 the National HIV/AIDS Strategy for the United States was released. Its vision was for HIV infections to be rare and when they do occur that access to care would be easy, fast and of the highest quality. The National Strategy consists of three main goals:

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

The National Strategy states that in order to meet those three goals, the USA must achieve a more coordinated national response to the HIV epidemic. The Texas Community Planning Group (TxCPG) and TX DSHS are asking Texas HIV service providers and prevention and outreach programs to increase their coordination by working closely together.

While this Plan is geared specifically for HIV services in the PanWest and West Texas areas, it hopes to reflect the goals of the National HIV/AIDS Strategy and the 2011 Texas HIV/STD Prevention Plan, developed by the Texas HIV/STD Prevention Community Planning Group (TxCPG). The State of Texas is looking at different ways of better coordinating HIV services and prevention/outreach programs in order to bring PLWHA who are aware of their diagnosis into medical services, keep PLWHA in medical services, and locate those PLWHA who do not know their diagnosis and bring them into medical care.

Concerns are voiced by service and prevention/outreach programs about the limitations on how the two programs can work together more closely when they are two very different programs funded by two different grants. Concerns include the following: How are case managers supposed to work with PLWHA who are in services and also get out into the community to find

people who are not in services? How are service providers supposed to find people who are not aware of their diagnosis? How can prevention programs afford to spend time working with services when there is not enough time, funds or staff to test and educate those people who are infected but don't know it? How will the Affordable Care Act help us or limit us in treating PLWHA? How will the Affordable Care Act help us or limit us in testing and educating people who do not know their diagnosis and people who do know their diagnosis but are not in care?

The concerns are valid but it is necessary to begin by communicating with each other, knowing each other's programs, and willing to work with each other. Show a united front to the community. For example, in the Amarillo HSDA the HIV service provider, Panhandle AIDS Support Organization (PASO) has a good working relationship with the City Health Department who does outreach and prevention. Each agency knows what the other agency does. The directors and staff know each other by name. They call each other if a client needs special assistance or education. The City has workers go to the service provider building once weekly to provide testing for STD for current clients and HIV/STD testing to client partners and the community as a whole. PASO and the City also work closely with a local HEI agency, Managed Care Center for Addiction, who assists clients with a co-diagnosis of HIV and substance abuse. In the Lubbock HSDA, the service provider, SPCAA Project CHAMPS works closely with the Lubbock Regional MHMR Center Outreach Team. The outreach workers contact Project CHAMPS when they have a newly diagnosed or returning client so that Project CHAMPS will be expecting the client. If needed, the outreach worker will accompany the client to Project CHAMPS to introduce the case manager and help as needed with the initial appointment. The outreach workers also work closely with the local TX DSHS office on partner solicitation. And it is not unusual to find the three agencies working together at community events to assure people are tested and educated and given information about services. These examples are promising for areas such as the PanWest where prevention/outreach programs are scarce. The areas are geographically very large and difficult to cover. So for these areas, collaboration and coordination is not just important in one HSDA but across HSDAs.

PanWest - West Texas
Ryan White Part B Programs

PART ONE:

2010-2013 COMPREHENSIVE HIV HEALTH SERVICES PLAN
May 2012 Revision

NARRATIVE

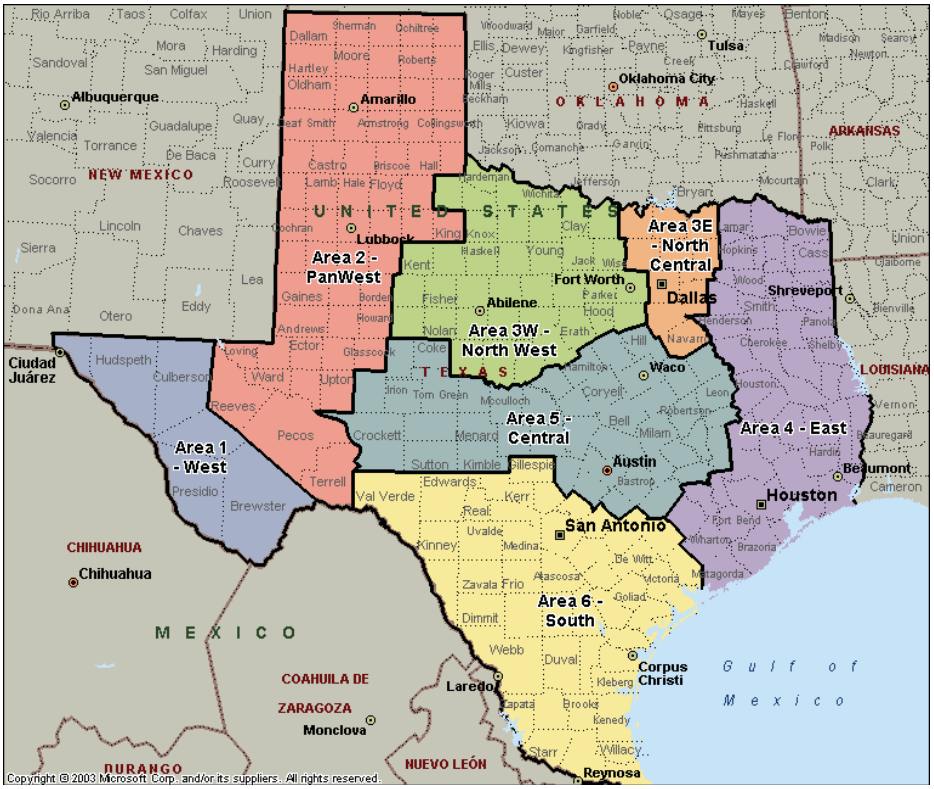
SECTION I
WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

SECTION I A: DESCRIPTION OF THE PANWEST AND WEST TEXAS PLANNING AREAS

GEOGRAPHY OF THE PANWEST AND WEST TEXAS REGIONS

The PanWest Area (Area 2) encompasses Texas Public Health Region 1 and part of Region 9 (Permian Basin). The PanWest is made up of fifty-eight (58) counties divided into three (3) HIV Service Delivery Areas (HSDAs): Amarillo, Lubbock, and Permian Basin (Midland-Odessa). West Texas is made up of six counties that comprise one HSDA, El Paso. The Map below depicts the PanWest Planning Area 2 and West Texas Area 1:

Figure I A-1
Service Area Map



The counties of each HSDA are as follows:

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.

Lubbock HSDA (15 counties): Bailey; Cochran; Crosby; Dickens; Floyd; Garza; Hale; Hockley; King; Lamb; Lubbock; Lynn; Motley; Terry; Yoakum.

Permian Basin HSDA (17 counties): Andrews; Borden; Crane; Dawson; Ector; Gaines; Glasscock; Howard; Loving; Martin; Midland; Pecos; Reeves; Terrell; Upton; Ward; Winker.

West Texas HSDA (6 counties) Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio.

The two regions comprise 64 counties and over 84,000 square miles. Most of the counties are very rural, but cities exist within each HSDA.

- The PanWest region encompasses 58 counties with a total land area of 62,887 square miles.
- PanWest averages 20 people per square mile with Lubbock County being the most populous with 296 people per square mile.
- Potter, Midland and Ector counties range between 138 and 146 people per square mile.
- The six county West Texas region abuts the Mexico border and is 23,458 square miles.
- El Paso County is the most populous in the two regions, with 754 residents per sq. mile.

Foreign Born and Language

The number and percentage of foreign born residents varies throughout the four HSDAs.

- Lubbock HSDA and Lubbock County have the smallest percentage of foreign born residents, 4.7% and 3.3% respectively.
- This compares to West Texas HSDA and El Paso County with more than a quarter of residents (27%) born outside the U.S.
- Differences exist in the Permian Basin HSDA. Overall 9.6% of HSDA residents are foreign born including 7.6% of Midland County residents and 10.6% of Ector County residents.

Moving south from Amarillo, the percentage of the population that speaks a language other than English at home increases.

- In the Amarillo HSDA, 20% speak a language other than English at home. This increases to 73% in the West Texas HSDA.
- In the state of Texas, 31.2% of the population five years of age and older speak a language other than English in their homes.

Socioeconomic Factors

The 2008 Texas median household income was $50,049. Considering the HSDAs and the most populous counties, the only one that exceeds this is Midland County with a median household income of $56,320.

- The West Texas HSDA, El Paso County and Potter County have the lowest median 2008 household incomes, ranging between $36,300 and $37,000.

- Most other HSDAs and population centers have median incomes in the range of $42,000 to $48,000.

In 2008 in Texas, 15.8% of residents lived below the poverty level.[4] In the PanWest and West Texas regions, between 15% and 25% of residents were living below the poverty level.

- West Texas and El Paso County had a quarter of their residents living below the poverty level. This is nearly 200,000 people.
- The Permian Basin had the smallest percentage, 15%. Midland County had 10% of residents living below the poverty level and Ector County had 15.5%.
- While the Amarillo HSDA had an overall percentage of 15.2% living below the poverty level, Potter County had 22.5% of residents living in poverty.

Considering adults age 25 and over, between two-thirds and three-quarters of HSDA residents are high school graduates. Overall, the 76% of Texas residents are high school graduates.[5]

- Over three-quarters of residents of Amarillo HSDA are high school graduates.
- In the Lubbock HSDA, Lubbock County has a higher percentage of high school graduates, 78.4%, compared to the HSDA overall.
- In the Permian Basin, Midland County has 79% of residents over 25 years of age with a high school degree. This compares to the neighboring county of Ector with 68% with high school degrees.
- West Texas HSDA and El Paso County have the lowest percentage of adults age 25 and older with a high school degree, with fewer than 66%.

SECTION I B: THE PANWEST AND WEST TEXAS HIV EPIDEMIC

The data on the epidemic was obtained from the Texas Department of State Health Services (DSHS) HIV/STD Prevention and Care Branch.

The 2010 Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning, reporting period January 1 to December 31, 2010, Publication Number E13-11937 (Revised January 31, 2012) is located at the following link: www.dshs.state.tx.us/hivstd/reports/HIVandAIDSinTexas.pdf. In Appendix B of the Profile, beginning with page 152, there are tables for the PanWest and West Texas that lists characteristics from 2006 – 2010 of people living with HIV and people newly diagnosed with HIV. The Profile notes that "The case numbers and rates are listed by county for each HSDA as well. Five years worth of data are provided so trends can be identified. All data in this appendix were extracted from the eHARS database and are current as of July 1, 2011. Rates are calculated using data from the Texas State Data Center population estimates. One technical note to keep in mind when interpreting these data concerns the number of cases involved in some of the table cells. If there are a small number of cases, the rate associated with the number is considered

[4] Ibid.
[5] Ibid.

statistically unstable. This is because with so few cases, the rate can fluctuate from year to year. For example, if there are two new diagnoses for a particular county in 2009 with a rate of 25 cases per 100,000 but in 2010 there was one new diagnosis with a case rate of 12 per 100,000, it would be tempting to conclude HIV is becoming less of a concern in this county. A more accurate interpretation of these rates would be that with such a small number of cases, the rate will continue to fluctuate and so a multi-year trend for the county will be ambiguous. The CDC recommends that the rate of any cell with less than four cases should be considered statistically unstable and should be interpreted with caution.[*]" ([*] Klein, R.J. et al. 2002. Healthy People 2010 Criteria for Data Suppression. Healthy People 2010 Statistical Notes, 24, Centers for Disease Control and Prevention)

OVERALL PREVALENCE

Based on the 2010 Profile cited above, between 2006 and 2010, the number of people living with HIV/AIDS (PLWHA) in the PanWest and West Texas regions steadily increased.

- Amarillo HSDA: In 2006 the number of PLWHA was 345 and in 2010 the number was 377 (rate 84.0 to 86.4). The largest numbers/rates were in Potter County with a small number in and Randall County.
- Lubbock HSDA: In 2006 the number of PLWHA was 318 and in 2010 the number was 366 (rate 81.8 to 97.7). The overwhelming number of PLWHA are in Lubbock County. The Hispanic PLWHA number is slowly increasing and the rates are higher but still comparable to the rates of White PLWHA.
- Permian Basin HSDA: In 2006 the number of PLWHA was 310 and in 2010 the number was 394 (rate 83.0 to 90.8). In 2008, the number/rate of Hispanic PLWHA (78.0) exceeds those of White PLWHA (71.6) and in 2010 there is a significant increase (White rate 80.1, Hispanic rate 95.3). The largest number of PLWHA are in Ector County and Midland County with a small, but increasing, number Howard and Reeves Counties.
- El Paso HSDA: In 2006 the number of PLWHA was 1,304 and in 2010 the number was 1,617 (rate 173.4 to 202.0). In PanWest, the number of people living with AIDS was fairly similar to those living with HIV. However, in West Texas, the number of people living with AIDS exceeds those living with HIV by at 300 in number (rate difference is at least 40 points more than that of HIV, except in 2010 when it drops to 39.8). The majority of the PLWHA were males. The main race/ethnicity was Hispanic. The largest numbers/rates were in El Paso County with numbers ranging from 1 -3 in the other five counties of the West Texas area.

In all HSDAs the majority of the PLWHA were male and main mode of exposure was MSM. In each HSDA the rate of Black PLWHA are disproportionate and the number is slowly increasing, except in Amarillo where the number of Black PLWHA is generally the same from 2006-2010.

CONCURRENT DIAGNOSES

Once infected with HIV, people typically have five to ten years without symptoms before they progress to AIDS.[6]

- Early testing is critical in preventing the further spread of HIV/AIDS. Those unaware of their status are more likely to transmit the disease to others, resulting in missed opportunities for the prevention of new HIV infections.
- Early HIV/AIDS diagnosis allows HIV infected people to benefit from life-saving medication and treatment.
- Late diagnosis increases the cost of care and is associated with poorer prognosis and decreased long-term survival.

PLWHA in the PanWest tend to be diagnosed on a more timely basis than those in West Texas. In the PanWest, 22% of people diagnosed with HIV received an AIDS diagnosis within one month, and 7% more received that diagnosis within one year.

- The Permian Basin HSDA has the largest percentage with late diagnosis with 30% converting to AIDS within one month and an additional 4% converting within one year.
- Older adults in PanWest have a higher percentage of late diagnoses, with 32% of those 45 to 54 years converting within one month, and 27% of those 55+ converting within that time frame.
- Blacks also have a higher percentage of late diagnoses compared with other races/ethnicities with 30% converting within one month and an additional 6% converting within on year.

GENDER

While men comprise the vast majority of infections, women are an increasing percentage of the epidemic in the PanWest and West Texas HSDAs.

Table I B-3

PLWHA by Gender PanWest and West Texas Regions Comparison 2006 and 2010													
		2006						2010					
		Male			Female			Male			Female		
		#		Rate	#		Rate	#		Rate	#		Rate
HSDA	Amarillo	288		139.5	57		27.9	301		137.5	76		34.9
	Lubbock	251		132.2	67		34.7	283		141.0	83		41.0
	Permian Basin	243		128.2	67		35.4	319		158.0	75		37.2
HSDA	West Texas	1,134		309.5	170		44.1	1,410		359.0	207		50.7

[6] http://www.dshs.state.tx.us/hivstd/reports/HIVandAIDSinTexas.pdf. Page 11. Retrieved May 6, 2010.

INCIDENCE—NEW DIAGNOSES

The number of new diagnoses has steadily increased in West Texas and PanWest, especially in the Permian Basin HSDA who had 24 new diagnoses in 2006, 16 in 2007, 28 in 2008, 25 in 2009 and jumped to 44 in 2010.

Table IB-9

Incidence—New Diagnoses
PanWest and West Texas Regions 2010

	Amarillo HSDA		Lubbock HSDA		Permian Basin HSDA		West Texas HSDA	
	#	Rate	#	Rate	#	Rate	#	Rate
Total	15	3.4	23	5.7	44	10.9	119	14.9
Male	10	4.6	17	8.5	38	18.8	108	27.5
Female	5	2.3	6	3.0	6	3.0	11	2.7
White	9	3.3	11	5.2	7	3.8	8	8.5
Black	1	4.7	6	21.15	3	14.3	9	41.3
Hispanic	4	3.1	5	3.2	33	17.4	102	15.2
***Other/Unknown**	1	9.5	1	-	0	0.0		
13 - 24	1	1.3	4	5.2	8	11.5	29	20.3
25 - 34	5	8.0	9	14.0	12	20.4	41	32.2
35 - 44	5	9.2	2	4.3	17	37.2	19	18.4
45 - 54	4	6.8	4	8.3	5	9.4	20	20.7
55+	0	0.0	4	4.5	2	2.1	8	6.6
MSM	9	58.0	13	57.4	19	43.9	92	77.6
IDU	3	18.7	3	13.0	7	16.8	4	3.5
MSM/IDU	0	0.0	1	6.1	5	11.6	2	1.3
Hetero	4	23.3	5	23.5	12	27.7	21	17.6

Data Source: 2010 TX Integrated Epidemiologic Profile for HIV/AIDS Prevention & Services Planning rev. 1-31-12

*Combined Asian/Pacific Islander, Native American Multi-Racial and unknown cases

For Amarillo, there is a growing Burmese population

MORTALITY

Mortality in PanWest declined between 2003 and 2007, but increased in 2008. In 2008, deaths were evenly distributed among PanWest HSDAs. Mortality in West Texas peaked in 2005 at 38 and has been on a declining trend since that time. HSDA deaths in 2008 totaled 21.

Table I B-10

Mortality: PanWest and West Texas Regions and Texas 2003 - 2008							
		2003	**2004**	**2005**	**2006**	**2007**	**2008**
HSDA	Amarillo	8	6	11	7	7	11
	Lubbock	14	13	9	7	6	12
	Permian Basin	14	9	7	6	6	10
Regional	PanWest	36	28	27	20	19	33
HSDA	West Texas	25	36	38	30	19	21
Statewide	Texas	1,215	1,238	1,241	1,518	1,449	1,279

Note: Death match has not been done. Deaths from 2009 incomplete.
Source: eHARS 2010 midyear file

UNMET NEED

The HRSA definition of unmet need for HIV-related medical care requires 12 months with no evidence of:

- CD4 count
- Viral load test
- Antiretroviral therapy

DSHS produced these estimates for January 1, 2007 through December 31, 2007 by matching HIV/AIDS cases in the Texas HIV/AIDS Reporting System (HARS) against names, personal identifiers (e.g. data of birth), unique record codes and limited data elements from the following data sources:

- HIV/AIDS Reporting System (HARS)
- Texas AIDS Drug Assistance Program (ADAP)
- Electronic Lab Reporting (ELR), Uniform Reporting System (URS)
- Medicaid
- Large private insurers

Sources not included in this analysis include Medicare, Veteran's Administration, Texas Department of Criminal Justice and some private insurers.[7]

[7] Refer to DSHS for detailed information on the matching methodology, HRSA's Unmet Need Framework and additional data limitations.

Findings

- People living with AIDS (PLWA) are slightly more likely to be in care than those with HIV. This may be because these individuals are sicker and need medical care and/or because the lab tests for AIDS diagnosis are well documented.
- Females are more likely to be in care than males.
- Blacks have a much higher unmet need than other racial/ethnic groups, followed by Whites then Hispanics.

The 2010 TX Epidemiologic Profile lists Unmet Need for Medical Care as follows:

Amarillo HSDA: unmet need number 125 (33%), 77 HIV and 48 AIDS, 99 male
West Texas HSDA: unmet need number 571 (35%), 258 HIV and 313 AIDS, 501 male
Lubbock HSDA: unmet need number 118 (32%), 60 HIV and 58 AIDS, 94 male
Permian Basin HSDA: unmet need number 151 (38%), 82 HIV and 69 AIDS, 131 male

See the Profile tables, Appendix B, for more details.

SECTION I C: ASSESSMENT OF THE NEEDS OF PEOPLE LIVING WITH HIV/AIDS

Comprehensive Needs Assessments are conducted to determine priority service needs and gaps in the continuum of care for PLWHA. 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. Comprehensive Needs Assessments were conducted in the PanWest region in 2009 and in West Texas in 2010. Both needs assessments included consumer surveys and resource inventories, and the West Texas needs assessment included key informant interviews and focus group discussions. This section presents a summary of the key findings from these two needs assessments.

PANWEST NEEDS ASSESSMENT FINDINGS

The PanWest Comprehensive Needs Assessment included two surveys, one for "in care" consumers with 144 conducted, and another for "out of care" consumers with a sample size of 38. The out of care definition used in PanWest allowed consumers not receiving medical care for six months or more to complete the survey.[8]

Six severe need groups were identified as priority populations in this needs assessment: (1) African American Males having Sex with Males (MSM), (2) Anglo MSM, (3) Hispanic MSM,

[8] Out of care PLWHA were recruited by Ryan White agency staff, through advertisements placed in the local newspapers and flyers posted in local service agencies.

(4) Women of Childbearing Age (with special emphasis on women of color), (5) Heterosexual Males and (6) Aged/45+ PLWHA.

IN CARE CONSUMER SURVEY RESULTS

Each in care consumer ranked his/her top core medical and social support service needs "to keep me in medical care." In addition participants also identified services gaps/ barriers[9] to care.

Top 10 Core Medical Service Needs included:

1. HIV Primary Medical Care
2 &3. Laboratory Services-CD4 cell counts and Viral Load Testing
4. HIV Medications
5. General Primary Medical Care (for treatment of co-morbidities)
6. Oral Health Care-Preventive Dental Care
7. Specialty Medical Care: Ophthalmology
8. Health Insurance/Co-pay Assistance
9. Medical Case Management
10. Non-HIV Medications

Top 10 Social Support Service Needs included:

1. Social Services Case Management
2. Emergency Financial Assistance
3. Food Bank/Nutrition Services
4. Housing-Help Paying Utilities
5. Housing-Finding Housing
6. Housing-Help Paying Rent or Mortgage
7. Transportation to Other than Primary Medical Care Appointment
8. Legal Services
9. Psychosocial Support Services
10. Physical Therapy/Occupational Therapy/Speech Therapy

The Top Service Gaps included:

1. Housing Assistance (rent, mortgage and utility assistance)
2. Oral Health Care/Dental Care (primarily dental 2 & 3 services)
3. Emergency Financial Assistance (non-HIV medications, utilities assistance)
4. Vision Care (eye exams, eye care)
4. Food Bank/Nutrition Services
4. Legal Services
4. Psychosocial Support Groups

Other service gaps included:

- Transportation
- Primary Medical Care,

[9] Gaps/barriers were the sum of survey respondents who answered "Can't get this service" or service is "Hard to Get" along with reasons for their reasons.

- Medical Nutrition Specialist, Laboratory services (CD4),
- Clothing voucher,
- Health Insurance/Disability Assistance,
- Home Repair/Maintenance
- Respite Care.

The most frequently cited reasons for these service gaps included:

1. There was no agency that provided the service I needed.
2. I didn't have information I needed about the service,
2. I didn't qualify for services because of income, residence, age, etc
4. I had no insurance, or Medicaid, or Medicare.
5. I am not comfortable with the agency staff
5. I was embarrassed to ask for the service.

Consumers were able to identify more than one service gap. The second Core Medical and Social Support Service Gaps/Barriers included:

1. Housing Assistance (rent and utility assistance)
2. Psychosocial Support/Support Groups
3. Oral Health Care/Dental Care
3. Medical Specialty Care: Gastroenterologist
3. Legal Services
3. Medical Nutritionist
3. Emergency Financial Assistance
3. Medical Transportation

The most frequently cited reasons for the second service gaps included:

1. I didn't have the information I needed about the service.
2. I didn't qualify for services because of income, residence, age, etc.
3. There was no agency that provided the service I needed.
4. I had no insurance, or Medicaid, or Medicare.
5. I could not take off from work to get to the service.

OUT OF CARE SURVEY RESULTS

The out of care (OOC) evaluated:

- Current reasons for being OOC
- Reasons for delays in accessing care after diagnosis
- Factors which prompted getting into primary medical care

Reasons for Out of Care Status

The primary reasons for not seeking primary medical care included:

1. Don't feel sick (72%)
2. Worried that others will find out (69%)
3. No money for Doctors/Meds (58%)
3. Don't want to/not ready to deal with it (58%)
5. Stigma of HIV disease (56%)

6. Don't want to take HIV meds (36%)
7. Don't want to see Doctor for HIV (33%)
8. Too much paperwork (31%)

Referral Into and Linkage to HIV Primary Medical Care

While more than 70% of the Out of Care (OOC) respondents report receiving an active referral into HIV primary medical care, almost 30% did not receive this important referral.

A total of 65% of the OOC sample entered HIV primary care within one year of learning their HIV status.

- Approximately 43% of the OOC report entering primary medical care within the gold standard three month time frame.
- Another 16% entered HIV primary care within the first six months following diagnosis
- More than 5% report entering HIV treatment and care within the first 7-12 months following their HIV diagnosis.

Among the 35% who did not enter medical care within on year of diagnosis, reasons include:

- Denial—reported by 50% as their primary reason for delaying entry into care.
- Disclosure Concerns, described as "fear of others finding out/didn't want anyone to know their HIV status" was reported by 25%.
- Feeling well/didn't feel sick was cited by 17% of the OOC who delayed accessing treatment.
- Scared to start meds was identified by 13%.
- Almost 17% report 'feeling well/didn't feel sick' and 13% of the OOC

Factors Which Prompted Getting Into HIV Primary Medical Care

OOC consumers identified reasons for entering HIV medical care including:

- Getting real about their HIV disease
- Getting sick enough to be hospitalized
- Fears about the consequences of further delay
- Encouragement from their case manager to enter care
- "Other' reasons included: sickness, encouragement from the prison system or others, and desire to access care for treatment of other health issues (e.g., high blood pressure).

Suggestions to Encourage Earlier Entry Into Care

When asked what might have encouraged them to enter care sooner, the OOC respondents suggested:

- More information about HIV and the benefits of treatment (and consequences of non-treatment)
- Use of peer mentors to assist in adjusting to the diagnosis, navigating the systems of care and providing emotional support
- Financial assistance
- Eligibility assistance

With approximately one third of the OOC sample recently incarcerated, these consumers suggested greater assistance with the transition from jail/prison to the community.

OOC Gaps/Barriers to Care

Many of the reasons offered by the OOC PLWHA to explain their perceptions of the service Gaps and Barriers in the PanWest service delivery area relate to:

- Lack of insurance, ineligibility for disability and/or lack of perceived affordability of the services.
- Not previously aware of the Ryan White funded services for support in accessing primary medical care and medications.
- Transportation is perceived as a substantial access-to-care barrier.

Based upon these findings, it is evident that the strategic dissemination of information about all of the Ryan White services available in the PanWest service delivery area should contribute to the reduction of unmet need.

WEST TEXAS NEEDS ASSESSMENT FINDINGS

The following overarching recommendations are designed to build upon strengths, reduce consumer barriers to care, and limit system challenges.

SERVICES

1. Expand the System of Care

Consumer needs consistently exceed available Ryan White funding. Both the Administrative Agency and the three Ryan White funded providers strive to maximize the value received from all funds. A key recommendation of thisneeds assessment is to identify opportunities to augment Ryan White funds with other funding sources as follows:

1.1. Identify innovative approaches to stretch Ryan White funds in order to provide hard to fund medical and social services.

- Expand the number of organizations awarded Ryan White funds in order to increase PLWHA access to all these agencies' services.
- Support collaboration between agencies receiving Ryan White funds, Texas Department of State Health Services (DSHS) funds and Centers for Disease Control and Prevention (CDC) funds in order to benefit PLWHA.

Although the El Paso social service continuum is well developed, HIV-specific services are limited. Key informants advocated enhanced networking and collaboration between providers in order to improve service access as follows:

1.2. Establish a provider network/consortium to increase collaboration and networking. Consider beginning with quarterly meetings that include education and networking.

- Encourage collaboration among community organizations and key stakeholders to identify opportunities to meet basic consumer needs with non-Ryan White funds including food, housing, emergency financial assistance.

2. *HIV Medical Care*

The quality of medical care available in the West Texas HSDA is highly regarded. Medical care issues include: (1) concerns about disclosure of HIV status, (2) lack of agency choice, (3) requirements for out-of-pocket payments for co-pays and deductibles, and (4) the availability of other medical services and specialty care. Recommendations included:

2.1. *Expand HIV primary medical care by adding another provider.*

- The ideal organization will treat a range of medical conditions, be easily accessible and geographically distant from La Fe Care Center.

2.2. *Expand financial assistance for medical care and medication co-pays and deductibles.*

- This was the "biggest problem" consumers encountered when using HIV medical care over the past year. Three quarters of consumer survey respondents are unemployed and almost all have very low income levels. Therefore, payments for co-pays and deductibles can be significant barriers to care.

2.3. *Evaluate the feasibility of providing co-located ob/gyn care at HIV medical clinic(s) or providing transportation to the physician office.*

- The closure of Planned Parenthood reduced access to ob/gyn care. Many women are currently using a physician located in Vinton which is approximately 25 miles away. Consider options to enhance access to this important service.

2.4. *Identify resources for low cost vision care, including optometry and eyeglasses.*

- This was a top need of in-care consumers and was highly ranked by those 55 and older.

2.5. *Support development of a model medical home pilot project over the next three years.*

- Work with funded providers to research medical home model programs and provide funding for a successful model in either 2011 or 2012.

3. *Case Management*

Skilled case managers are essential to enhance linkage with HIV medical care and support access to the non-Ryan White funded social service system. Consumer survey respondents and focus group participants expressed concerns about case manager turnover, expertise and empathy, resulting in the following recommendations:

3.1. *Evaluate and improve the HIV medical and social case management functions throughout the West Texas HSDA.*

- Provide intensive training, supervision and oversight for all case managers.
- Work with local agencies to expand the number of medical case management providers.

- Identify issues resulting in high case manager turnover and support their resolution.
- Implement a case management acuity system to ensure adequate resources are available to those with the highest requirements.
- Implement clearly defined medical and social case management standards of care.
- Monitor client satisfaction at least quarterly, requiring intervention plans to address low levels of client satisfaction.

Educate and Empower Consumers

A goal of case management is to move clients to self sufficiency so they need minimal case management support. Most consumers would like to achieve this, but systems, tools and training must be in place to promote client self-management.

3.2. Educate and empower consumers.

- In order to achieve partnership relationships between providers and consumers, educate both parties about of their roles and responsibilities.

One tool developed during this needs assessment is the Resource Directory. This is available in both English and Spanish with indices by service category and geographic locations. Consumers and case managers can use this tool to identify available services, eligibility, intake procedure and other organizational information. Therefore, it is recommended to:

3.3. Distribute the 2010 Ryan White Resource Directory to case managers and consumers. Consider making the directory available on-line.

- Consider developing a consumer Health Education/Risk Reduction (HERR) handbook for distribution with the resource directory.

4. Housing

Meeting the basic need for housing is critical to maintaining PLWHA in HIV medical care as exemplified by the differences in housing situations between in-care and out-of-care consumers.

- The most frequent living situation reported by over 57% of consumers was an apartment, house or mobile home that they own or rent. This, however, varies between 63% of in-care and 26% of out-of-care respondents.
- The most frequent housing situation for out-of-care consumers was living at someone else's apartment, house or mobile home with 29% of the out-of-care providing this response. Over 17% of out-of-care consumers are homeless, either living on the street or in homeless shelters.
- Sixty percent of respondents indicated an interest in living in housing for PLWHA, but 45% of these consumers would only want such an arrangement if their HIV status remained confidential.

Therefore, housing-related recommendations include:

4.1. Evaluate the El Paso housing system and the current availability of housing for PLWHA. Support funding for additional housing options for PLWHA.

- Consider medical foster homes, designated apartments for PLWHA, other permanent, stable housing options.

March 2011 NOTE: The AA contracted with New Solutions, Inc. to conduct a housing evaluation of the El Paso area. On April 27, 2011 the evaluation report will be presented to the West Texas Ryan White and HOPWA providers and other area housing agencies. Primary housing agencies will be invited to present information on their agencies as part of increasing case manager knowledge of resources and to increase collaboration.

4.2. Enhance case managers' understanding of the housing system and housing options for PLWHA in order to increase the number of PLWHA with permanent, stable housing.

- Provide case manager training in order to improve access and referral to housing in the region.

4.3. In 2011, evaluate the impact of changes in administration of the Housing Opportunities for People with AIDS (HOPWA) program in access to and availability of housing.

5. Oral Health Care

Oral health/dental care is a top consumer need, and the service with the most access barriers identified. The most frequent barrier to preventive dental care and dental procedures was "limited funding." In the focus groups, consumers discussed beginning a dental procedure followed by a delay in completion when "funds ran out." Therefore, it is recommended to:

5.1. Increase funding for oral health care, both preventive care and procedures.

6. Mental Health Therapy and Counseling

Over 55% of all consumer survey respondents have been diagnosed with a mental health disorder with 90% diagnosed with depression and two-thirds diagnosed with anxiety. More than half of those with a mental health diagnosis received mental health counseling or counseling for emotional stress in the last two years. The greatest barrier to accessing mental health therapy and counseling care was "didn't want to use this service—wanted to handle it myself."

The availability of psychiatric care had declined in El Paso, with one key informant reporting that the number of psychiatrists has decreased from 30 to 13 in the region. HIV medical care providers and Ryan White funded mental health counseling must collaborate with other organizations to enhance access to psychiatric services and to provide needed mental health counseling. Therefore, it is recommended:

6.1. In collaboration with El Paso Mental Health Mental Retardation (MHMR) and Family Service, expand funding for mental health therapy and counseling including funding for psychiatric treatment.

6.2 For difficult clients, integrate mental health counseling services with HIV medical care and medical case management to provide a holistic, multi-disciplinary treatment team.

- Begin as a pilot project and expand if successful.

6.3 Consider offering short term informational support groups that include HIV education and treatment adherence.

PRIORITY POPULATIONS

7. In-care Consumers

In care consumers fall into three groups including: (1) those who have overcome barriers, understand the care system and have made it work for them, (2) those who enter and exit the system based on their personal situations, or (3) those who have recently begun care and need to be retained. The care system must recognize all these consumers, and strive to retain them.

Providing quality care and ensuring patient satisfaction are critical to maintaining consumers in the care system. In addition, monitoring utilization provides early warning signals of patients dropping out of care. The administrative agency and medical care providers must diligently monitor these three indicators to ensure PLWHA are maintained in-care, with the recommendation as follows:

7.1. To retain in-care consumers, continue to evaluate client satisfaction with the quality of medical care and medical case management.

7.2. Establish a "return to care program" that monitors patient's retention in HIV medical care and provides intensive case management for those who drop out or are at risk of dropping out.

8. Recently Diagnosed

Providing effective post-test counseling for newly diagnosed PLWHA is critical to appropriate linkage with HIV medical care and other services. Some recently diagnosed consumer focus group participants discussed less than satisfactory experiences with the post-test counseling received. Collaboration among those providing counseling and testing (C&T) as well as education for C&T and outreach staffs could improve the patient experience and promote movement into HIV medical care.

8.1. Require medical care providers to collaborate with counseling and testing organizations to develop multiple approaches to engage and retain consumers in-care.

8.2. Provide training of post-test counselors to optimize clients' experiences and improve linkages with HIV medical care.

An effective intervention for newly diagnosed is providing a peer navigator to educate and inform them about the available services and the care system. Currently, some long-term survivors informally counsel the newly diagnosed. Over the next two to three years, consideration should be given to developing a peer navigator program based on best practices across the state and nation.

8.3 Consider development of a peer navigator program to train peers to work with newly diagnosed to support them in navigating the service system.

9. Monolingual Spanish

Close to half of West Texas consumer survey respondents are most comfortable speaking Spanish. In the Spanish language focus groups, participants requested additional Spanish brochures to help educate their family members. Therefore, it is suggested to:

9.1. Conduct a detailed review of Spanish language brochures and teaching tools currently in use in the HSDA. Ensure that appropriate tools are available for both PLWHA and their family members.

- These should be appropriate for low-literacy levels in Spanish.
- As necessary, conduct a statewide or national search of available materials and screen for use in the West Texas region.

10. Other Populations

Small changes tailoring the service delivery system to priority populations' needs will pay dividends as consumers feel more comfortable accessing treatment and services. Therefore, having "specialists" who understand and advocate for tailored programs/services for priority populations will promote service utilization and maintenance in-care. The following recommendation recognizes this need:

10.1 Support program development for priority populations including previously incarcerated, women, older adults, Hispanic MSM, substance users. As possible, case managers should specialize in understanding, advocating for, and meeting the service needs of these populations.

- Consider: co-locating ob/gyn services for women, providing outreach and education to previously incarcerated at the halfway house and through parole officers, working with Aliviane NO/AD and the HEI case manager to appropriately screen and refer substance users, offering specialty care for older adults with co-morbidities, etc.

OTHER ISSUES

11. Reduce Late Diagnoses

11.1. Collaborate with prevention outreach to reduce high-risk behavior and enourage HIV counseling and testing.

The large number of "Late to Care" PLWHA has significant implications for HIV prevention, HIV care and the community overall.

- HIV prevention and outreach is critical to curb the epidemic.
- Collaborate with prevention providers to support prevention outreach and early counseling and testing.
- Support community education related to HIV/AIDS prevention and early counseling and testing.

12. Reduce the Stigma

One reason for delayed testing is the stigma of HIV throughout the region. The continuing stigma of HIV was apparent in all populations. Focus group participants discussed the stigma's impact on their lives, including being ostracized by family and friends. Therefore, it is recommended to:

12.1 Work with consumers and providers to develop an integrated plan to reduce the stigma of HIV/AIDS throughout El Paso and the West Texas region over the next three to five years.

- Collaborate with prevention and care providers throughout the region.
- Include targeted community education with a specific emphasis on youth education.
- Consider stigma reduction strategies put forward by HRSA.

SECTION I D: DESCRIPTION OF THE CURRENT CARE SYSTEM

In 2009, Planned Parenthood of El Paso unexpectedly closed its doors with only one week notice to clients/patients. This organization was serving as both the West Texas HSDA administrative agency and an integrated medical care and social services provider.[10] This significantly impacted the delivery of treatment, support services and Ryan White program administration in the region. In order to establish the foundation for service planning and delivery, the new administrative agency, Lubbock Regional MHMR Center, took three immediate actions:

1. Contracted with one organization to provide Housing Opportunities for People with AIDS (HOPWA) services,

[10] Planned Parenthood of El Paso services included: HIV medical care, HIV case management, PLWHA support groups, prevention outreach and HIV counseling and testing.

2. Consolidated medical care and case management at the remaining provider, La Fe CARE, directing all Planned Parenthood clients to that organization
3. Contracted for a comprehensive needs assessment in order to understand both consumer needs, provider opinions and the non-Ryan White continuum of care in the region.

2009 brought significant changes to the Ryan White program. The 2009 provider and administrative agency changes present an opportunity to improve the service delivery system for PLWHA. Three agencies receive Ryan White funding so the continuum of care must rely on and link with the West Texas/El Paso social service system. The following strengths were identified in this needs assessment and provide a foundation for the future:

- High quality medical care provided by experienced physicians.
- Availability of a full range of Ryan White core services.
- A variety of funding sources complements Ryan White funding.
- Bilingual staff are widely available at organizations serving PLWHA.
- A well developed social service continuum of care in El Paso.

Challenges include:

- Only three Ryan White funded organizations in the West Texas HSDA, and one Ryan White funded provider in each of the three PanWest HSDAs.
- Two West Texas organizations provide housing funding through Housing Opportunities for People with AIDS (HOPWA).
- In West Texas, funding for some core and social services is inconsistent, resulting in delays in completing procedures. This has been a particular concern for oral health (dental) procedures.
- Quality of case management services is uneven in the West Texas HSDA.
- 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 may be time-consuming and difficult to accomplish.
- In West Texas and other rural areas, the ongoing HIV stigma can be acute, limited access to services due to consumer disclosure concerns.

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 Amarillo and Permian Basin HSDAs have been stable for many years. The Lubbock HSDA subcontractor, however, changed in February 2008.

- The Amarillo HSDA Subcontractor serves approximately 263 clients in a 26 county area.
- The Lubbock HSDA Subcontractor serves approximately 270 clients in a 15 county area.
- The Permian Basin HSDA Subcontractor serves approximately 227 clients in a seventeen (17) county area.

All Subcontractors are required to provide culturally competent services without discrimination in any form.[11]

In 2009, the West Texas HSDA experienced a significant change in the HIV care system that resulted in severe capacity constraints and consumer access barriers.

- In July 2009, Planned Parenthood Center of El Paso, a large HIV services provider with approximately 500 patients, abruptly closed its doors. Planned Parenthood provided a range of services including: HIV medical care, HIV case management, PLWHA support groups, prevention outreach and HIV counseling and testing.
- The remaining HIV medical care provider, La Fe CARE Center, did its best to absorb Planned Parenthood's patients, but the transition was challenging for both patients and staff. Currently, La Fe CARE serves about 900 clients.
- In April 2010, the AA issued a Request For Proposals (RFP) for an additional medical care provider and in August 2010, Texas Tech University Health Science Center (TTUHSC) began treating PLWHA and providing medical case management. Currently, TTUHSC serves approximately 118 clients.
- Family Service of El Paso provides mental health therapy and counseling in West Texas and serves approximately 235 clients
- SunCity, through El Paso Emergence Health Network (formerly El Paso MHMR), is the AA HOPWA provider and serves approximately 61 PLWHA.

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,
- 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,
- Mental health counseling programs,

[11] 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 American with Disabilities Act of 1991 and the Age Discrimination in Employment Act of 1967.

- Food banks, churches, homeless shelters and other support organizations.

The Subcontractors are required to provide the appropriate linkages[12] 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.

AMBULATORY OUTPATIENT MEDICAL CARE

As a cornerstone of the Ryan White Part B Program, all activities foster engagement and maintenance in ambulatory outpatient medical care (AOMC). The following is a brief summary of the process by which clients access AOMC 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 AETC.

- The primary care physician sees the majority of HIV positive clients needing AOMC and works closely with the J.O. Wyatt Clinic to provide HIV/AIDS care as well as primary medical care.
- The ID physician currently does not accept new 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.

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

- If the client is in need of AOMC and does not have an alternate payer source, the client is informed that he/she may see one of the two physicians 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.

The service Subcontractor for the Amarillo HSDA is:

Panhandle AIDS Support Organization (PASO)
1523 South Taylor
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 that 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 off University Avenue)
Lubbock, TX 79411
Local 806-771-0736 or toll free 1-800-724-2677

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

- 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 which is usually within two weeks of the eligibility determination.
  - 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 service Subcontractor for the Permian Basin HSDA is:

Basin Assistance Services (BAS)
Permian Basin Community Centers for MHMR
1118 B. W. 12th Street
Odessa, TX 79763
Local 432-580-0713 or toll free 1-800-804-5418

The **West Texas HSDA** has two HIV medical care subcontractors. La Fe CARE Center 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. Texas University Health Science Center (TTUHSC) began treating patients in August 2010.

- In addition to HIV medical care, La Fe CARE Center offers medical and non-medical case management, health insurance premium assistance, AIDS pharmaceuticals, 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, providing easy linkage for clients needing to access other services in this system. Contact information is:

La Fe CARE
1505 Mescalero
El Paso, TX 79925
Phone: 915-772-3366

- TTUHSC offers HIV medical care, AIDS pharmaceuticals, medical and non-medical case management, health insurance premium assistance, and medical transportation. TTUHSC offers linkages with other service/programs available through their system of care. TTUSHC may add services as the program expands. Contact information is:

  Texas Tech University Health Sciences Center
  Internal Medicine
  4801 Alberta
  El Paso, TX 79905
  Phone: 915-545-6640

RESOURCE INVENTORY

Both the 2009 PanWest and the 2010 West Texas comprehensive needs assessments included region-wide resource inventories. In the West Texas HSDA, the resource inventory is available in English and Spanish for use by consumers, case managers and other health care providers. It can be found at www.panwest.org. The PanWest resource inventory is also available 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 most have local directories (Amarillo, United Way Community Resource Directory, Lubbock Red Book, Odessa Odessa Links,

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 anti-retrovirals, few community-level resources are available for pharmaceutical assistance for purchasing medications. Therefore, PLWHA 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, several organizations refer PLWHA back to the local HIV service Subcontractors for assistance.

SECTION I E: 2012-2013 QUALITY MANAGEMENT PROGRAM

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 regions. 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 Annual Quality Management Plan (QM Plan) / Annual Quality Improvement Plan (QI Plan).

- The QM/QI Plan clearly outlines the necessary actions to improve service quality.
- The QM Plan outlines many topics, with the main focus on the Tier 1 and Tier 2 HAB Performance Measures
- In late February 2010, DSHS asked AAs to begin combining the QM Plan with the area comprehensive plan. The new QM Plan is discussed in more detail in Appendix B.

The QM/QI 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 convenes quarterly to review the QI Plan. Two meetings annually are conducted via teleconference and two are held in person in Lubbock.
- The new QM Plan and QI Plan that are included in the 2010-2013 Comprehensive HIV Health Services Plan, May 2012 Revision, were initially reviewed and approved by the QMC in May 2010 and will be reviewed again June 2012 when the QMC convenes in Lubbock.
- Currently, the main focus of the QMC is to review the Tier 1 and Tier 2HAB Performance Measures which are explained in more detail in Appendix C.

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 and the Texas Department of State Health Services (DSHS). The AA maintains a log of QM trainings and technical assistance.
- In 2010 the AA hired a Quality Manager to oversee the QM program.

Please refer to Appendix B for the Annual Quality Management Plan.

HAB PERFORMANCE MEASURES

The Tier 1 HAB Performance Measures were implemented in the 2008-2009 contract period. The performance measures are:

Tier 1 Performance Measure I: Achieve a minimum of 60% 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%.

Tier 1Performance Measure II: Achieve a minimum of 60% percent of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year, with an ultimate goal of 90%-95%.

Tier 1Performance Measure III: Achieve 60% percent of clients with AIDS who are prescribed Anti-Retroviral Therapy (ART), with an ultimate goal of 90%-95%.

Tier 1Performance Measure IV: Achieve a minimum of 60% percent of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis, with an ultimate goal of 90%-95%.

Tier 1Performance Measure V: Achieve a minimum of 70% percent (increased from 60% to 70% in May 2012) of pregnant women with HIV infection who are prescribed antiretroviral therapy, with an ultimate goal of 90%-95%.

When the performance measures were implemented, there were many unknown factors with data entry and retrieval which caused targets to be low. To attempt to get all Subcontractors to a similar level, the AA implemented a baseline target of 60% for each performance measure. Several of the concerns have been corrected and Subcontractors, as well as the AA, have learned the nuances of data entry resulting in more accurate reporting. For example, pregnant women must be captured during the first trimester so this easily skews data if a pregnant woman enters services in her second or third trimester.

There is variation in the percentages due to the three month difference in the reporting periods. The Subcontractors typically met or exceeded the 60% baseline target. For measures where the percentage was below 60%, the AA Data Manager worked closely with the Subcontractor to help determine the reason especially since the targets will increase for 2011-2012.

Table I E-1

TIER 1 HAB PERFORMANCE MEASURES *FISCAL YEAR 2011 AVERAGE SCORES					
MEASURE	**Permian Basin**	**West TX - La Fe CARE**	**Lubbock**	**West TX - TTUHSC**	**Amarillo**
Tier 1, 1	74.64	83.00	75.00	73.17	62.80
Tier 1, 2	72.25	85.14	75.48	69.51	67.15
Tier 1, 3	95.45	94.67	89.66	95.45	81.48
Tier 1, 4	98.98	99.75	98.29	94.87	97.64
Tier 1, 5	100.00	100.00	0.00	50.00	100.00

* Ryan White Fiscal Year is April 1, 2011 through March 31, 2012.

In 2011, the AA implemented the Tier 2 HAB Performance Measures. The performance measures are:

Tier 2, Performance Measure 1: Achieve a minimum of 60% percent of clients with HIV infection on ARVs who were assessed and counseled for adherence two or more times in the measurement year

Tier 2, Performance Measure 2: Achieve a minimum of 60% percent of women with HIV infection who have a Pap screening in the measurement year

Tier 2, Performance Measure 3: Achieve a minimum of 60% percent of clients with HIV infection who completed the vaccination series for Hepatitis B

Tier 2, Performance Measure 4: Achieve a minimum of 60% percent of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection

Tier 2, Performance Measure 5: Achieve a minimum of 60% percent of clients with HIV infection who received HIV risk counseling within the measurement year

Tier 2, Performance Measure 6: Achieve a minimum of 60% percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year

Tier 2, Performance Measure 7: Achieve a minimum of 60% percent of adult clients with HIV infection who had a test for syphilis performed within the measurement year

Tier 2, Performance Measure 8: Achieve a minimum of 60% percent of clients with HIV infection who received testing with results documented for latent tuberculosis infection (LTBI) since HIV diagnosis

As when the Tier 1 Performance Measures were implemented, with Tier 2 there are also many unknown factors with data entry and retrieval which cause targets to be low. To attempt to get all Subcontractors to a similar level, the AA implemented a baseline target of 60% for each performance measure. However, there are still too many nuances of data entry that prevent accurate reporting.

Table I E-2

TIER 2 HAB PERFORMANCE MEASURES FISCAL YEAR 2011* AVERAGE SCORES

MEASURE	Permian Basin	West TX - La Fe CARE	Lubbock	West TX - TTUHSC	Amarillo
1	50.26	9.06	2.16	1.75	1.11
2	30.36	31.82	12.50	9.09	39.22
3	16.50	43.15	2.46	4.00	28.29
4	75.12	92.95	50.48	95.12	87.92
5	79.43	46.73	58.65	76.83	2.90
6	37.32	39.17	5.77	10.98	15.94
7	52.63	77.96	14.42	56.10	66.67
8	92.82	52.52	73.56	89.59	80.68

* Ryan White Fiscal Year is April 1, 2011 through March 31, 2012.

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.

In order to ensure that quality management is maintained, the URS Data Manager and Contract Specialist provide technical assistance (TA) to subcontractors regarding data collection, submission, and data integrity.

- Requests for TA from Subcontractors receive a response within one (1) business day of receiving the request in ninety-five percent (95%) of requests.
- TA is provided in a format that best meets the needs of Subcontractors and may be provided on-site, via telephone, or electronic mail.

Monitoring for clinical and case management services, conducted by the AA (Registered) Nurse Consultant, is performed in accordance with HV Clinical and Case Management Services Standards. It includes:

- Monitoring of the care and treatment of persons with HIV according to the US Public Health Standards.
- Site visits to the clinics of the Subcontractors in Lubbock, Odessa and El Paso to assure the medical needs of the clients are being met.
- Regular desktop monitoring of the documentation in ARIES for:
  - Timeliness and content of case notes
  - Subcontractors' adherence to payer of last resort and emergency medication policies
  - Completion of needs assessments
  - Implementation and updating of care plans
  - Updating of medication and lab results specifically CD4 counts and viral loads
  - Assessing the need for specialty referrals and ensuring follow-up on referrals
  - Conformance to discharge and termination policies and procedures
  - Conformance to all other policies and procedures related to medical and non-medical case management

Other related activities of the Nurse Consultant include:

- Regular communication with Subcontractors via telephone, e-mail and on site for clarification of any identified issues.
- Provision of TA as requested or as determined necessary to ensure clients are receiving quality services.

- Participation in site reviews for each Subcontractor where random samples of client charts are assessed for continuity of care as well as the completion and content of documentation.
- Completion of required reports and documentation and
- Providing feedback to the Subcontractors related to TA and site visits.

In January 2012, TX DSHS released the new Case Management Standards and the Nurse Consultant works with the DSHS Nurse Consultant and Case Management Trainer for clarification on the standards as well as monitoring the subcontractor training on the new standards.

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. They also check demographics for their HSDA and notify the AA and QMC of unusual numbers and patterns.
- Subcontractors submit quarterly Ryan White Part B programmatic reports in the format provided by the AA. The reports are due on or before April 20, July 20, October 20 and January 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 April 30, July 30, October 30 and January 30 of each year.
- The AA also checks ARIES data at least quarterly and notifies DSHS of the demographics per HSDA via the Quarterly Report.

After the data entry process is performed at the Subcontractor level, the AA Data Manager performs bi-monthly data quality checks.

- The process includes checking for record duplication, cleaning, and generating various reports to find missing information or unknown data.
- After the AA completes the process, the Subcontractors' data manager receives statistical reports containing a list of clients with missing or unknown data on a monthly basis. The missing data must be collected as soon as possible; preferably before the next data transmission begins in the following month.
- The Subcontractors' data managers are encouraged to share information with the case managers in order to complete this process.

Quality assurance checks are conducted through site visits on a quarterly basis at each subcontractor location. The review process ensures accuracy of the ARIES data in focus areas, such as demographics, medical history, service delivery, etc.

- There are three announced and at least one unannounced site visit per year at each Subcontractor location.
- Subcontractors are notified at least two weeks in advance for scheduling of the announced visits.
- An audit tool is used to conduct the review. During the check, clients are randomly selected and the AA's data manager crosswalks the data in ARIES with the information as presented in the client's profile.
- Physical reviews of client and service data are evaluated. The reports are shared with the Subcontractors.
- As of April 1, 2010, TX DSHS will implement a new policy, Documenting Case Management Actions in ARIES, "to assist in the improvement of the quality of documentation as well make data input more uniform." The new policy requires Subcontractors to use ARIES to the maximum extent possible to include entering case notes, adherence assessments, mental health/substance abuse screenings, and risk reduction notes.

Expenditure Monitoring

Another major quality management function is the monitoring of Subcontractor expenditures.

- The AA monitors expenditures at least quarterly through ARIES data and Subcontractor billing data and notifies DSHS of the expenditures via the Quarterly Report.
- The Contract Specialist discusses reallocations as needed to assure adequate funding for medical core services especially to avoid denial of services, waiting lists and delay of services for AIDS Pharmaceuticals, Health Insurance, and Ambulatory Outpatient Medical and to prevent lapse of funds.
- The Contract Specialist monitors the contract expenses to ensure that there is no lapse or overspending of funds at least every quarter through analyzing the expenses reported in the quarterly report by the subcontractors.
- If expenditures do not appear to be on target, Subcontractors are contacted and required to submit a plan to ensure funds are expended appropriately. If it is determined that the Subcontractor is unable to expend funds within the contract term, the AA initiates necessary steps following the DSHS reallocation policy.

SECTION I F: 2012-2013 PRIORITIES AND ALLOCATIONS

The AA receives Ryan White Service Delivery (RWSD) and State Services funds from the Texas Department of State Health Services. DSHS receives the RWSD 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.

- **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 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 and State Services, are distributed to each service category.
- Ryan White Service Delivery and State Services are the **payers-of-last resort**, meaning all other funding sources must be tapped first.
- There are not sufficient funds to allocate to each service priority and meet every need.

Decisions about priorities and allocations are based on available data. This applies both to 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 PanWest 2009 Needs Assessment and the West Texas 2010 Needs Assessment serve as guides in setting the service priorities.[13]
- Historical information based on expenditures, service provision, gaps analysis, 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.[14]

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 to 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 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.
- 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

[13] 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.

[14] *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. The January 2009 Glossary of HIV Services can be viewed at www.dshs.state.tx.us.

Management and Social Case Management, which are generally allocated at 100%, since those categories include staff salaries.

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 the DSHS.

The AA also oversees a housing contract, Housing Opportunities for People With AIDS (HOPWA), whose funds are allocated by DSHS not the AA. HOPWA funds are taken into consideration when allocating funds to housing but HOPWA is not part of the Priorities and Allocations process.

Historically, the Ryan White Service Delivery (RWSD) contract ran from April 1 to March 31 and the State Services contract from September 1 to August 31. In April 2012, DSHS initiated a new contract period of September 1 – August 31 for each of the three contracts, Part B, State Services and HOPWA, to begin September 1, 2012.

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. This leaves no more than 25% for social support services. (Refer to Appendix D for the list of medical care 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 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 is designation of Medical Case Management as one of the core medical services and Non-Medical Case Management as a social support service. In PanWest and West Texas a new case management model is emerging since this service has historically focused on social/support service referrals.

DSHS Health Insurance Policy: 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.

Appendix E shows the service priority and amounts allocated to service categories in each of the four HSDAs. The Contingency Plan developed by the PanWest Planning Assembly in 2006 has been implemented annually since then. It reduces the funding amounts of non-core services in order to maintain funding of the core medical services.

In February and March 2012, the AA held public comment hearings in each PanWest HSDA and in West Texas to present the proposed 2012-2013 Priorities and Allocations (P&A). 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. The P&A charts are attached in Part III of this Plan as Appendix E and can also be viewed at www.panwest.org under the Download Center.

SECTION II
WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

SECTION II A: COMPREHENSIVE HIV HEALTH SERVICES PLANNING PROCESS

The 2010-2013 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a planning process that included research, interactive discussion and plan development. The 2009 PanWest Comprehensive Needs Assessment, the 2010 PanWest Comprehensive Plan and the 2010 West Texas Comprehensive Needs Assessment were used to inform the Plan. The West Texas Needs Assessment was completed in June 2010 and the planning process began in July 2010.

The AA staff planning session provided the basis for the draft plan. The mission, vision and shared values were reviewed and edited. The goals and strategies were outlined with discussion of actions needed to successfully accomplish them over the next three years. This information was developed into a draft plan that was presented and reviewed by the QMC and providers in early October 2010.

Throughout the planning process, AA staff considered and incorporated Texas Department of State Health Services (DSHS) initiatives and requirements. These are reflected in the goals, strategies and actions.

MISSION AND VISION

The previously developed mission and vision statements were reviewed for relevance in 2010. Limited modifications were made to both statements, expanding the focus on quality medical care and consumer health.

Mission Statement

To develop and coordinate an effective, comprehensive, community-wide response to HIV/AIDS in the PanWest and West Texas regions by providing high quality medical and support services that optimize Ryan White funds and leverage community resources.

Vision Statement

The PanWest and West Texas Administrative Agency visualizes a system of HIV care that is accessible and effective so PLWHA may enjoy improved health and an enhanced quality of life.

PANWEST-WEST TEXAS CORE VALUES

The PanWest and West Texas Administrative Agency (AA) takes pride in its commitment to public service and its responsibility to continuously improve HIV health service delivery. The AA believes that all services require a basic foundation of the core values of: Dignity, Respecting Diversity, Professionalism and Quality, Availability and Accessibility, and Collaboration. The AA believes these core values will encourage people living with HIV/AIDS to access treatment and be maintained in HIV medical care and support services.

Core Values

- 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 within the community to enhance PLWHA access to all available services.

THE CONTINUUM OF CARE

HRSA defined the continuum of care as "a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV Infection to meet their health care needs and psychosocial service needs throughout all stages of illness." In planning for services, HRSA suggests comparing the ideal continuum with the existing continuum since the ideal continuum guides the development of the operational continuum.

1. Ideal - A service "wish list" and the corresponding mechanisms for linking these services. In this scenario, resources are unlimited.

2. Operational - The set of services and linking mechanisms currently available to PLWHA in their communities, given the realities of funding constraints and environmental barriers that prevent achievement of the ideal continuum. These consist of Ryan White funded services, volunteer services and services funded by other sources.
   - Core Services. Operationally, the AA places the highest priority on provision of ambulatory outpatient medical care, AIDS pharmaceuticals, and health insurance premium and cost sharing assistance. Other PanWest and West Texas core services include HRSA's identified core services which include: oral health, mental health services, substance abuse services, medical case management, medical nutritional therapy, hospice, home health care, home and community based health services, and early intervention (for Part B, only counseling, testing and referral)

- Critical Access Services provide information and connection to medical and psychosocial support services and include: non-medical case management, medical transportation, interpretation services, health education/risk reduction, etc…
- Supportive Services allow PLWHA to meet basic needs and enhance their quality of life. These services vary between the four HSDAs, and may be funded by the Ryan White Program, State Services or HOPWA or they may be provided through community linkages. They include such things as: housing services, food bank, emergency financial assistance for rent, mortgage or utilities and non-medical transportation.

IDEAL CONTINUUM OF CARE

In an ideal care continuum there is unlimited funding, endless community resources, and abundant coordination and cooperation between and among service providers that results in:

- All people living with HIV/AIDs receiving needed services and achieving high level wellness.
- No unmet need.
- Availability of all necessary tools and teaching strategies resulting in near perfect treatment adherence.

Envision one agency that coordinates all key points of access and all services, regardless of funding source. Coordination is facilitated because there is cooperation among all HIV and non-HIV service providers and prevention agencies. With the high level of treatment adherence and improved prevention strategies, the ultimate goal of eliminating HIV/AIDS is not only possible but also probable. The AA uses the ideal continuum of care as a guide to developing a realistic, feasible and operational continuum.

OPERATIONAL CONTINUUM OF CARE

The AA is committed to working with regional providers to realize a comprehensive continuum as consistent with the ideal as possible. Funding, community resources, and cooperation and coordination among community resources are vital to an effective continuum of care. Shared responsibility between Subcontractors and PLWHA is increasing with subcontractors educating, referring and linking clients to services. Clients must provide required documentation, following up with appointments and following through with program requirements. With limited resources, the PanWest and West Texas areas may eventually experience waiting lists for HIV services. To limit and avoid waiting lists for medical services, funding priority is given to medical core service categories. With rare exceptions, reallocations cannot go to social service categories if a medical core category needs funding.

The AA realizes that reduced funding and certain environmental factors limit the attainment of an ideal continuum of care. However, it should not limit the ability to form and maintain relationships with community agencies, especially those that are considered key points-of-entry into the health care system for PLWHA. Although funding and community resources have been decreasing in the face of increasing needs, effective linkage among community services can expand the system for all. Throughout the PanWest and West Texas regions, the Ryan White

funded providers strive to network and develop a system of care that optimizes available resources. In all cases, they maintain Ryan White Part B as the payer of last resort as mandated by HRSA. Other community resources also strive to be payers of last resort and Ryan White funded providers must educate as they collaborate with these organizations.

Subcontractor Resource Inventory

PanWest has one HIV service Subcontractor per HSDA so all services are either provided by the HIV Service Subcontractor or the HIV Service Subcontractor contracts or works with another agency to provide the service. The three PanWest HIV/AIDS service Subcontractors receive HOPWA, RWSD and State Services funds to provide services as part of the continuum of care in their communities for the 2011-2012 contract year. In West Texas, La Fe CARE receives RWSD and State Services. Texas Tech University Health Sciences System (TTUHSC) receives RWSD. Family Service receives RWSD. El Paso Emergence Health Network (formerly EPMHMR) Sun City Behavioral Health Care receives HOPWA. In the table below, each HSDA is listed and by each service an X is marked to indicate if the service is provided in-house (done at the Subcontractor site), or contracted out/referred out to an external agency with which the Part B Subcontractor has a contract, memorandum of understanding or oral agreement.

Table II A-1

Services Provided by PanWest and West Texas Funded Subcontractors*								
	Amarillo		**Lubbock**		**Permian Basin**		**West Texas**	
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**
Ambulatory/ Outpatient Health Svc.		X		X		X	La Fe TTU	
Substance Abuse Outpatient Services		X		X		X		X
Mental Health Svcs.		X		X		X	Family Svc	
AIDS Pharmaceutical Assist. (not ADAP)	X		X		X		La Fe TTU	
Medical Case Management Services	X		X		X		La Fe TTU	
Non-Medical Case Management Services	X		X		X		La Fe	
Health Insurance	X		X		X		La Fe TTU	
Oral Health Care		X		X		X	La Fe	TTUHSC
Medical Transportation	X		X		X		La Fe TTU	
Non-Medical Transp.	X		X		X		La Fe	TTUHSC
Emergency Financial Assistance	X		X		X		NA	NA
Housing Svc/HOPWA	X		X		X			Sun City
Food Bank/ Vouchers	X		X		NA	NA	NA	NA

***** Service categories not listed are provided through linkage with non-Ryan White funded community agencies.

SECTION III
HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

SECTION III A: INTRODUCTION

The 2010-2013 Comprehensive HIV Health Services Plan establishes four goals for the Administrative Agency. All four goals reflect the findings and recommendations of the 2009 PanWest and 2010 West Texas Comprehensive Needs Assessments, information from the integrated Quality Management Plan, the proposed Healthy People 2020 objectives, and the 2008-2010 Texas Statewide Coordinated Statement of Need and Ryan White HIV/AIDS Program requirements. These goals and associated strategies promote access to quality HIV medical care and supportive services for all PLWHA; require culturally sensitive service provision; link and engage PLWHA outside the medical care system; and ensure services are of the highest quality. The Administrative Agency feels confident that these goals foster a system of care that will promote the health and well-being of people living with HIV/AIDS in the region.

The goals and accompanying objectives of the PanWest-West Texas 2010 - 2013 Comprehensive HIV Health Services Plan, revised May 2012, are outlined below.

SECTION III B: GOALS AND OBJECTIVES OF THE PLAN

GOAL I:
Provide a quality continuum of HIV medical care that encourages engagement and retention in treatment.

As the first priority, the strategies of Goal I are intended to provide a quality Continuum of Care to support engagement and retention in HIV medical care. This will be accomplished by the following strategies:

Strategies

- Establish second medical care provider in West Texas by September 1, 2010 with ancillary services and medical case management available by March, 2011, increasing patient volume through March 2013. (**August 2010: This was done in El Paso.)**
- Provide medical services with expanded evening and/or weekend hours to meet client needs by March 2011. (**Fall 2011: This was done in El Paso.)**
- Evaluate co-located gynecology services at La Fe Care, Inc. by March 2011, identifying the need to modify, improve and/or promote this service to encourage utilization. Establish a service plan based on results of the evaluation by September 2011.

- Optimize the medical and non-medical case management functions in PanWest and West Texas regions by March 2013.
- Evaluate and expand the mental health therapy and counseling services in the West Texas region to include: funding for psychiatric consultations in 2011, co-location of mental health counseling with HIV medical care by 2012, and development of multi-disciplinary treatment teams for patients with mental disorders by 2013.
- Develop standards/policies to prioritize PanWest and West Texas clients who will qualify for medication co-pay assistance, insurance assistance, oral health procedures and vision care by June 2011, evaluating the impact through March 2013.
- Fund a medical home pilot project in either PanWest or West Texas HDSA by March 2013.

A key recommendation of the 2010 West Texas Comprehensive Needs Assessment was to add one HIV outpatient ambulatory medical care provider. The sudden closure of Planned Parenthood in July 2009 resulted in a significant gap in the care continuum. Since that needs assessment, the AA has contracted with Texas Tech University Health Care System to begin offering this service in August 2010.

The 2009 PanWest and 2010 West Texas Comprehensive Needs Assessments identified needs to expand the hours of operation for HIV outpatient ambulatory medical care and other key services in order to accommodate clients' work and personal schedules. In order to increase consumer access and maintenance in care, services must be offered to meet consumers' needs and schedules. Beginning the Fall of 2010, La Fe CARE began a weekly evening clinic plus one monthly Saturday clinic.

The closure of Planned Parenthood reduced options for gynecology services for HIV positive women. La Fe CARE has a nurse practitioner providing primary care gynecology services one day per week, but patients do not complete referrals and often miss appointments. At the same time, many needs assessment participants reported traveling to Vinton to a more specialized gynecology practice. This strategy evaluates the reasons for limited use of the co-located primary care nurse practitioner service in order to provide a service that is convenient, meets patients' needs and is well utilized.

Increasing consumer needs coupled with limited funding require increasing expertise to appropriately refer and link clients to available services. This is coupled with changing medical and non-medical case managers' roles. Therefore, this strategy focuses on preparing PanWest and West Texas providers to best meet clients needs with high quality case management services.

Recent changes in West Texas psychiatric and mental health services are resulting gaps in the continuum. During the 2010 needs assessment, it was reported that the number of available psychiatrists had declined significantly. In September 2010, MHMR of El Paso (now El Paso Emergence Health Network) reduced the service provided, particularly to low-income and indigent patients. In 2011 Sun City Behavioral Health Care began offering psychiatric evaluations and services and La Fe CARE and TTUHSC have begun using the Sun City service. Ryan White Part B funds mental health therapy and counseling in West Texas, this

strategy expands that funding and evaluates options to optimize its use. Currently, the Subcontractor in West Texas is Family Service of El Paso, Inc. and they provide individual and group counseling for HIV positive individuals.

Core services including assistance with medical and medication co-pays, insurance assistance, oral health procedures and vision care were identified as consumer needs. Standards to prioritize these high cost needs are needed to maximize use of available funds.

Medical Homes is a new approach for providing or linking patients with necessary medical and social services for chronic conditions. The AA believes PanWest and/or West Texas ambulatory outpatient medical care providers are uniquely suited to develop a medical home pilot program to improve overall patient health outcomes. However, due to the pending outcome of the Affordable Care Act, the Medical Home strategy is also pending.

Goal I and its accompanying objectives and action plans support the "Healthy People 2020" objectives of (1) reduce the time interval between diagnosis and treatment to increase PLWHA longevity, (2) reduce AIDS cases, and (3) reduce AIDS mortality, (4) increase the proportion of persons surviving more than three years after diagnosis with AIDS.

The 2008-2010 Texas Statewide Coordinated Statement of Need identified the transition to medical case management as an emerging trend in the State. Enhancements of the case management system are being implemented in the PanWest and West Texas regions and will support the DSHS recommendations. In January 2012, DSHS released the new Case Management Standards of Care and Subcontractors are completing training, drafting policies and beginning to implement new processes as dictated by the new standards.

GOAL II:
Provide all funded services in a culturally sensitive manner that recognizes the regional stigma of HIV disease and works to reduce it.

Strategies

- In West Texas, increase access to core medical and support services by contracting with a least one medical care provider at an organization that combined HIV and non-HIV services by March 2011. (August 2011: TTUHSC began seeing HIV patients.)
- Monitor service utilization and client satisfaction among disproportionately affected sub-populations semi-annually through 2013, identifying reasons if declining utilization occurs.
- Review English and Spanish patient and family education materials annually, improving and expanding health literacy resources as necessary through March 2013.
- Conduct an annual assessment of clients' HIV health literacy including such topics as understanding of their HIV treatment, importance of adherence, risk reduction strategies and HIV prevention.

Goal II addresses the needs of diverse populations in the 64 counties of the PanWest and West Texas regions. Ranging from rural areas, to urban towns to border communities, services throughout the region must be delivered to meet the needs of all people living with HIV/AIDS.

The stigma of HIV can be a significant deterrent to accessing care throughout these regions. The 2010 West Texas Comprehensive Needs Assessment found some consumers did not access HIV services due to the stigma associated with HIV-specific organizations. Therefore, providing services at a multi-service organization will increase access for these consumers.

Regular monitoring of ARIES trend data and expansion of this data to include information about disproportionately affected populations will allow monitoring and evaluation of service utilization. As necessary, early action can be taken if changes in utilization issues are identified.

Monolingual Spanish speaking consumers require appropriate educational materials for themselves and their families. This was discussed during the West Texas monolingual Spanish focus groups in which participants asked for educational materials not only for themselves but also for their family members. This strategy requires periodic review of available Spanish materials to ensure adequate and appropriate information is available.

By eliminating disparities in access and retention among disproportionately affected subpopulations, this goal and its accompanying objectives and action plans support the "Healthy People 2020" proposed objectives of (1) reducing the time between diagnosis and initiation of care, and (2) increasing the percentage of PLWHA receiving HIV medical care.

The 2008–2010 Texas SCSN provides strategies to address the disproportionate impact of HIV/AIDS on African-American and border communities. It also addresses the impact of HIV stigma on accessing services. The strategy to expand services to multi-service providers is specifically suggested in the SCSN.

GOAL III:
Identify, engage and retain people who know their status and are not receiving HIV medical care.

With enhanced treatment options and improving medical outcomes, the Ryan White Program emphasizes identifying and linking PLWHA who are not receiving HIV medical care with the care system. Once receiving treatment, their maintenance in care is essential. This goal directly addresses that requirement.

Strategies

- Establish comprehensive "Return to Care" programs at one PanWest HIV medical care provider and one West Texas medical care provider by March 2012.
- Ensure appropriate materials available to educate clients on the benefits of remaining in care and the health consequences of not adhering to treatment including how HIV is spread and how to disclose the information to current/future partners by September 2011 with updates on an annual basis.

- Develop a peer mentor/navigator program for newly diagnosed people living with HIV/AIDS and other appropriate populations to encourage linkage and maintenance in HIV medical care by March 2013.

"Return to care" programs have been successfully implemented by statewide and national providers. They identify and follow-up with patients who drop out of care and encourage their return. This strategy includes developing early identification systems for missed appointments; researching successful return to care programs and modifying for regional implementation; and monitoring the success of the programs once established.

Health literacy and treatment adherence education are critical to maintain PLWHA in the care system. Patients must understand the benefits of following their treatment as well as the consequences of lapses in care. Appropriate collateral materials will support providers as they instruct patients about these critical issues.

A peer counselor pilot program should be designed to support newly diagnosed consumers as they move from post test counseling into care. Providing funding for a well-researched model program will provide an opportunity to evaluate the impact of this approach in the PanWest and/or West Texas regions.

Improving health literacy has been shown to increase adherence and improve care outcomes. To that end, this objective will expand information available to consumers. The 2008–2010 Texas SCSN has identified poor health literacy as a barrier to care, and this objective will reduce that barrier.

Linkage with and maintenance of PLWHA in HIV medical care is central to the proposed "Healthy People 2020" strategies of: (1) increasing the percentage of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards; (2) reducing deaths from HIV infection; (3) extending the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase the years of life of an individual infected with HIV; and (4) reducing new cases of perinatally acquired HIV infection. It also supports the Healthy People 2010 goal of increasing the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling and support to 70%.

GOAL IV:
Ensure all funded services are of the highest quality, conforming to measurable standards of care and service outcomes including clinical quality measures and client satisfaction.

The AA consistently strives to deliver the highest quality services to PLWHA. Their ongoing commitment to quality care is recognized through the mission, vision and shared values. Goal IV builds upon and enhances the quality management plan with the following objectives:

Strategies

- Implement the PanWest and West Texas Regions' Annual Quality Improvement Plan.

- Use data to determine progress toward the HIV/AIDS Bureau's HIV Core Clinical Performance Measures for Adult/Adolescent Clients Group 1 (Tier 1) adopted by the Texas Department of State Health Services.
- Implement the patient/client satisfaction survey throughout the PanWest and West Texas HSDAs, improving overall patient/client satisfaction annually.

Quality is a critical focus of the AA and the foundation for every service funded by the Ryan White and State Health Services programs. Quality is the attainment of performance excellence through established standards, accountability, and consumer satisfaction and it supports attainment of optimal health outcomes for PLWHA.

The AA recognizes that quality improvement is a continual process. This plan supports this process through ongoing review and improvement. It builds on and expands the consumer satisfaction survey using a quality improvement process will enhance service quality and promote PLWHA retention in care.

The Public Health Services treatment guidelines provide the basis for the delivery of quality HIV medical care. Reducing the number of new AIDS cases among the general population and disproportionately affected subpopulations results from providing high quality care, and this is consistent with proposed "Healthy People 2020" proposed objectives.

The 2008–2010 SCSN clearly states that local and state administrative systems should facilitate consumer entry and maintenance in high-quality care that meets or exceeds minimum public health standards. The AA and PanWest and West Texas service providers support that goal as reflected in this comprehensive plan.

SECTION IV
HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT AND LONG TERM GOALS?

SECTION IV A: MONITORING PROGRESS

The 2010-2013 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining start and completion dates, appropriate reporting intervals and status reports. Some objectives and actions require frequent review while other long term objectives will be reviewed less often, but no less than annually.

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

- The AA delegates tasks to the Quality Management Committee and funded providers to ensure a unified direction.
  - The Quality Management Committee will review reports on the progress of each strategy and the committee's input will be solicited to assist in determining the effectiveness of the strategies and activities.
  - Annual site reviews will also be used to evaluate the overall progress of each strategy and to determine what updates are needed.
- The AA will review ARIES data quarterly to determine the number of new admissions and re-admissions of PLWHA who are out of care as well as monitoring the units of service and expenditures.
- The quality management process, discussed in Section I, supports monitoring and evaluation of strategies and activities
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from the surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.
  - Client satisfaction surveys are conducted annually by the AA to gauge the level of service satisfaction and determine what areas need improvement.
  - Provider (Subcontractor) Satisfaction Surveys are conducted annually.
  - At least twice annually, the AA will notify clients of the AA's role and request input from clients to assist in evaluating quality of services and requesting client input and participation.

SECTION IV B: EVALUATION

The AA, supported by the QMC, 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 as follows:

- Goal I, focusing on an accessible and engaging Continuum of Care that retains clients, will be evaluated through ARIES utilization data which should be monitored at least quarterly. The development of successful new providers and programs will be evaluated with both ARIES data and consumer satisfaction surveys.
- Goal II, focusing on providing services in a culturally sensitive manner and reducing the stigma of HIV disease will be evaluated with ARIES data, client satisfaction data as well as consumer and provider input into educational needs and the available educational materials.
- Goal III, targeting consumers who know their status but are not receiving HIV medical care, will be evaluated using annual unmet need estimates and data from returned to care programs.
- Goal IV, focusing on quality care, will be evaluated through improved clinical outcomes and improved client satisfaction. The quality management program incorporates evaluation benchmarks which will support the evaluation of this goal.

SECTION IV C: IMPACT ON PRIORITY SETTING AND ALLOCATIONS

In developing the 2010-2013 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, particularly those that center on identifying new service providers may result in increase costs during program initiation, but ongoing provision will not increase costs to the system significantly. As previously stated, some of the strategies are pending awaiting the outcome of the Affordable Care Act since its review by the US Supreme Court in March 2012.