PanWest-West Texas

2014-2017 Comprehensive HIV Health Services Plan

PART ONE:

Narrative

February 2014

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

STARCARE
SPECIALTY HEALTH SYSTEM

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ACRONYMS

AA	HIV Services Administrative Agency
ACA	Affordable Care Act
AETC	AIDS Education and Training Center
ARIES	AIDS Regional Information and Evaluation System
ART	Anti-Retroviral Therapy
BAS	Basin Assistance Services (Permian Basin HSDA)
DSHS	Texas Department of State Health Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GLBT	Gay/Lesbian/Bisexual/Transgender also listed as LGBT
HASA	HIV Administrative Service Area (i.e. PanWest, West Texas)
HERR	Health Education/Risk Reduction
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resources and Services Administration
HSDA	HIV Service Delivery Area (i.e. Amarillo, Lubbock, Permian Basin, and El Paso)
IDU	Injection drug use, injection drug user
ID	Infectious Disease physician or infectious disease specialist
MCM	Medical case management
MOA	Memoranda of Understanding
MSM	Men who have sex with men
OAMC	Outpatient/Ambulatory Medical Care
PASO	Panhandle AIDS Support Organization (Amarillo HSDA)
PDSA	Plan Do Study Act (quality management)
PLWHA	People/Person(s) Living with HIV/AIDS
QM & QMC	Quality Management and Quality Management Committee (QI: quality improvement)
RHP	Regional Health Partnerships
RWSD	Ryan White Service Delivery
SPCAA	South Plains Community Action Association (for Project CHAMPS in Lubbock HSDA)
STD	Sexually Transmitted Disease
TA	Technical Assistance
TAC	Tech AIDS Clinic through Texas Tech University Health Sciences Center in Lubbock
TTUHSC	Texas Tech University Health Sciences Center

EXECUTIVE SUMMARY

This 2014 - 2017 PanWest-West Texas Comprehensive HIV Health Services Plan was designed to fulfill federal and state mandates and provide a road map for action over the next three years.

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

- The PanWest HIV Administrative Service Area (HASA) includes three HIV Service Delivery Areas (HSDA):
  - Amarillo HSDA
  - Lubbock HSDA
  - Permian Basin HSDA
- The West Texas HASA has one HSDA, El Paso, and is also included in this analysis.
- Together these four HSDAs comprise the 64 farthest west counties in Texas, ranging from the Panhandle to the Mexico border. The total population is approximately 2.1 million people.
- PanWest and West Texas HSDA counties have experienced significant growth between 2000 and 2012. Midland County grew 26%, El Paso County 22%, Randall County 20%, Ector County 19%.
- The poorest counties, represented by the lowest median incomes and the highest federal poverty levels include Potter (Amarillo HSDA), Hale (Lubbock HSDA) and El Paso Counties.

<u>Regional Epidemic</u>

In 2012, the Pan West region had a total of 1,361 people living with HIV/AIDS (PLWHA). The three PanWest HSDAs have between 434 PLWHA (Amarillo) and 492 PLWHA (Permian Basin). West Texas has 1,843 PLWHA, almost all of whom live in El Paso County.

In the six years between 2007 and 2012, new HIV diagnoses averaged 23 in the Amarillo HSDA, 27 in the Lubbock HSDA, 30 in the Permian Basin HSDA and 103 in the El Paso HSDA.

PLWHA race ethnicity varies across the region.

- The farther north the HSDA, the larger the percentage of White/Caucasian PLWHA. This ranges from 51% in the Amarillo HSDA to 9% in the El Paso HSDA.
- Black/African American PLWHAs are similar percentages throughout the PanWest region, ranging from 13% in the Amarillo HSDA to 15% in the Lubbock HSDA.
- The farther south the HSDA, the larger the percentage of Hispanic/Latino PLWHA. This ranges from 85% in El Paso to 29% in Amarillo.

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

- The PanWest HSDAs have smaller percentages reporting MSM transmission mode than West Texas. PanWest HSDAs range between 51% and 55% MSM compared to 68% in West Texas.
- Injection Drug Use (IDU) transmission mode is higher in PanWest than West Texas.
- Heterosexual transmission mode ranges from 14% in Lubbock HSDA to 21% in Amarillo HSDA.

Assessment of the Needs of People Living with HIV/AIDS

The 2013 PanWest - West Texas Comprehensive Needs Assessments informs this comprehensive plan. It included an online survey of 328 consumers, 29 in-depth interviews with out-of-care consumers, key informant interviews, one case manager focus group, a behavioral health analysis, and a resource inventory.[1]

Description of the Current Continuum of Care

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

- The three Ryan White Part B funded service subcontractors in the PanWest are located in the population centers of each HSDA. These providers assess, link and refer to non-Ryan White funded community resources throughout the region.
- In the West Texas HASA, La Fe CARE Center and Texas Tech University Health Science Center (TTUHSC) provide HIV medical care and medical case management. Family Service of El Paso, Inc. provides mental health therapy and counseling.

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

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

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

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

- High quality medical care provided by experienced physicians in each HSDA.
- Availability of a full range of Ryan White core services.

[1] PanWest - West Texas 2013 Comprehensive Needs Assessment can be found at www.panwest.org.

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

Challenges include:

- Increasing demand for limited Ryan White funding, including funding for needed core services.
- Challenges in continuity of medical care at one West Texas provider.
- Changes in the Texas Ryan White case management system are challenging for all providers. Quality of case management services is uneven in the El Paso 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, limiting access to services due to consumer disclosure concerns.

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 and provide efficiently and effectively in conformance with established standards of care and best practices.

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

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

Comprehensive HIV Health Services Planning Process

The 2014 - 2017 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. In February 2014 the AA staff participated in a planning session that included a review of the previous mission, vision and shared values statements, making modifications. 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 the Texas Department of State Health Services (DSHS) staff.

Throughout the planning process AA staff considered the *Texas HIV Plan's Spectrum of HIV Engagement, the National HIV Strategy*, *Healthy People 2020*, and Ryan White Program requirements.

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 2014 – 2017 PanWest - West Texas Comprehensive HIV Health Services Plan.

Mission Statement

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

The following ideal vision underpins the Plan.

Vision Statement

HIV care is accessible and effective.

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

Core Values

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

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

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

The 2014 - 2017 Comprehensive HIV Health Services Plan establishes four goals for AA and Subcontractor achievement. All goals reflect the findings and recommendations of the 2013 PanWest-West Texas Comprehensive Needs Assessment, the updated epidemiological profiles and the Ryan White HIV/AIDS Program requirements. The Plan goals, their associated strategies, and actions:

- Improve the case management system in the HSDAs,
- Expand access to behavioral health services,
- Ensures access to high quality HIV medical care,
- Emphasize collaboration to provide the complete prevention and care continuum.

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 2014-2017 Comprehensive HIV Health Services Plan are outlined below.

GOAL I

Improve the Case Management System Throughout the PanWest and West Texas Regions.

As the first priority of the AA, the strategies of Goal I emphasize the importance of case management in supporting PLWHA in accessing medical care and needed supportive services. Effective case managers promote engagement and retention in HIV medical care, identify and support clients who are at risk for dropping out of care, and link them to non-Ryan White funded community services. The following strategies are associated with this goal:

- Implement the HRSA HIV/AIDS Bureau (HAB) medical case management (MCM) core performance measure "medical visit frequency" by July 2014. Monitor performance improvement related to this measure using the PDSA cycle through December 2017.
- Once the initial measure is successfully implemented and the quality management process (PDSA) is in place, expand the process to include the second core MCM performance measure "gap in medical visits," targeting implementation by December 2015.
- Develop regional best practices for (1) MCM performance measure medical visit frequency, (2) maintenance in medical care and (3) medication delivery at the June 2014 annual provider training. Develop measures demonstrating conformance to best practices for medication delivery by January 2015 and use the provider self-audit on an ongoing basis.

GOAL II

Expand Access to Behavioral Health Services (Mental Health and Substance Abuse Treatment) by Integration, Co-Location and/or Increased Collaboration Between Ryan White Funded Providers and Behavioral Health Organizations.

Goal II responds to the impact of mental health disorders and substance use on linkage and maintenance in HIV medical care. The strategies associated with this goal focus on improving case manager assessment and referral to behavioral health services, working with the HIV Early Intervention (HEI) case managers in each region and integrating them in the HIV treatment team, and expanding physician and clinician skills in diagnosing and treating minor to moderate anxiety and depression. The following strategies are associated with this goal:

- Establish medical case management (MCM) best practices to improve assessment, referral and utilization of behavioral health services by December 2015.
- Expand the treatment teams in each HSDA to include both mental health professionals and HEI case managers by December 2015.
- Develop and implement a plan for all HIV clinic physicians and mid-level practitioners to develop the necessary skills to diagnose and prescribe adult psychiatric medications for minor to moderate depression and anxiety by December 2017.

GOAL III

Ensure the Delivery of High Quality Medical Care Throughout the Region.

Goal III is central to the Ryan White Program and our mission—providing high quality HIV medical care. The strategies associated with this goal relate to core performance measures, adequate and consistent physician/clinician staffing which was identified as a challenge in the El Paso HSDA on the 2013 Comprehensive Needs Assessment, and increasing cervical cancer screening among female patients. Specific strategies include:

- Implement the HRSA HIV/AIDS Bureau (HAB) Core Performance Measures for viral load suppression and PCP prophylaxis by January 2015. Continue to monitor the clinical measure for CD4 cell count.
- Ensure physician and mid-level practitioner capacity in all HSDAs to provide timely patient access to high quality HIV medical care by January 2015.
- Increase the percentage of female Ryan White patients who receive cervical cancer screening to 50% in 2015, 60% in 2016 and 75% in 2017 per cervical cancer screening performance measure.

GOAL IV

Collaborate with Non-Ryan White Funded Providers to Expand Access to the HIV Prevention and Care Service Continuum.

Given budget constraints and Ryan White funding requirements, collaboration is essential in order to provide the complete continuum of HIV prevention, care and treatment to PLWHA in the regions. The Administrative Agency (AA) and Subcontractors have always worked collaboratively with other organizations to meet clients' needs. By adding this goal to the Comprehensive Plan, the AA is emphasizing these collaborations and expanding involvement with them. Specific strategies include:

- Encourage RW funded agencies to expand collaboration with local HIV prevention outreach/counseling and testing providers to effectively link newly diagnosed consumers to HIV medical care within three months of diagnosis, reducing barriers to care.
- Continue to actively participate in the El Paso Community Mobilization Collaborative through 2014.
- With the El Paso Community Mobilization Collaborative as an example, identify opportunities to support collaborative development in PanWest HSDA(s) in 2015 and beyond.

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

Monitoring Progress

The 2014 - 2017 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 semi-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 (QMC) and funded providers to ensure a unified direction.
- The AA will review ARIES data quarterly to determine the number of new admissions and re-admissions of 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 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.

Impact on Priority Setting and Allocations

In developing the 2014 – 2017 PanWest-West Texas Comprehensive HIV Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system, but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement, but will not be a direct dollar cost. Finally, some of the strategies may result in increased costs during program initiation, but ongoing provision should not increase costs to the system significantly.

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

SECTION 1-A: DESCRIPTION OF THE PANWEST AND WEST TEXAS PLANNING AREAS

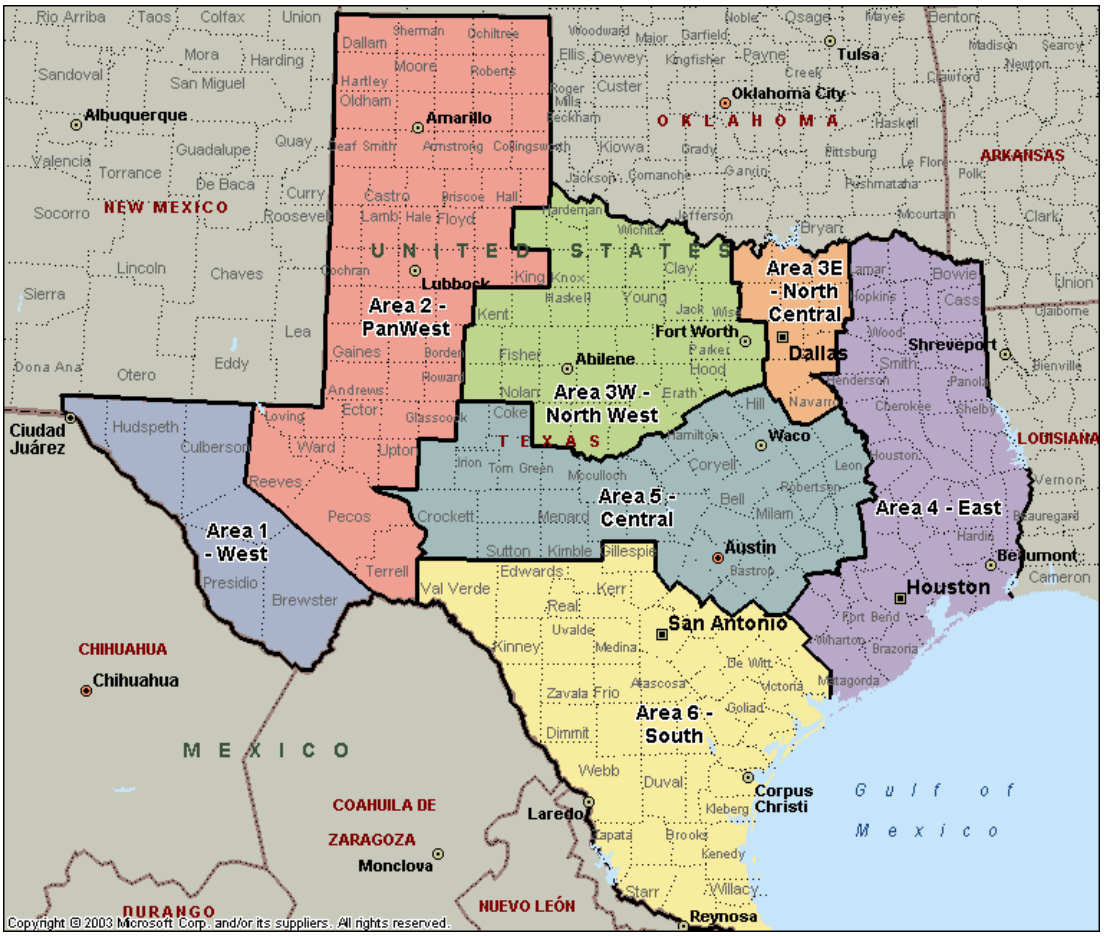
Profile of the Four HIV Service Delivery Areas

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

The PanWest and West Texas regions occupy 84,000 square miles with a total population of 2,144,059. El Paso County in the West Texas HASA has the greatest population density with nearly 800 people per square mile. Lubbock County, in the Lubbock HSDA, follows with 311 people per square mile. Potter, Midland and Ector counties, in the Amarillo and Permian Basin HSDAs, range between 138 and 146 people per square mile.

The map in Figure 1.1 presents the geography of the PanWest and West Texas regions.

Figure 1.1



Each PanWest HSDA has one key Ryan White provider, which are listed in the table below. In West Texas, two organizations receive Ryan White HIV medical care funds, and one receives funding for mental health therapy and counseling.

Table 1.1
PanWest and West Texas HSDAs
Counties, 2012 Population and Key Ryan White Providers

HSDAs AND COUNTIES	***2012 POPULATION***	***KEY PROVIDERS***
Amarillo HSDA--26 Counties Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Wheeler	435,408	Panhandle AIDS Support Organization (PASO)
Lubbock HSDA—15 Counties Bailey, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, Yoakum	418,578	SPCAA (Project CHAMPS)
Permian Basin HSDA—17 Counties Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, Winkler	437,899	Basin Assistance Services (BAS)
West Texas HSDA—6 Counties Brewster, El Paso, Hudspeth, Jeff Davis, Presidio	852,173	La Fe CARE, TTUHSC, & Family Service of El Paso, Inc.
Total PanWest and West Texas Regions—64 Counties	2,144,059	
Population Data Source: U.S. Census Bureau State and County QuickFacts, 2012		

The demographic analysis of the HSDAs finds:

- Both regions experienced significant growth between 2000 and 2012. Midland County grew 26%, El Paso County 22%, Randall County 20%, Ector County 19%.
- The counties with the lowest median incomes and the highest federal poverty levels include El Paso County with 25% of residents below federal poverty level (FPL), and Potter and Hale counties with 22% below FPL. To compare, 16% of Texas residents are below FPL.
- Randall County has the highest level of education of all HSDAs while Ector County and El Paso County have the highest percentages without a high school diploma, 28% and 26%, respectively.

Epidemiology Overview

HIV Prevalence

In 2012, the PanWest Region had a total of 1,361people living with HIV/AIDS (PLWHA) and the West Texas region had 1,843.

- The number of PLWHA does not vary significantly in the PanWest HSDAs with 434 PLWHA in the Amarillo HSDA, 435 in Lubbock HSDA, and 492 in the Permian Basin HSDA.

In West Texas, virtually all PLWHA live in El Paso County. The table below demonstrates the concentration of PLWHA in the most populous counties in each HSDA.

Table 1.2
People Living with HIV/AIDS - 2012
Select Counties

HSDA/County	Number of PLWHA	Percent of HSDA Total
Amarillo HSDA Total	**434**	
Potter County	256	59.0%
Randall County	86	19.8%
Lubbock HSDA Total	**435**	
Hale County	19	4.4%
Lubbock County	339	77.9%
Permian Basin HSDA Total	**492**	
Ector County	184	37.4%
Midland County	133	27.0%
El Paso HSDA Total	**1,843**	
El Paso County	1,824	99.0%
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch		

Race/Ethnicity

PLWHA race ethnicity varies across the region.

- The farther north the HSDA, the larger the percentage of White/Caucasian PLWHA. This ranges from 51% in the Amarillo HSDA to 9% in the El Paso HSDA.
- Similar percentages of Black/African American PLWHA are found throughout the PanWest region, ranging from 13% in the Amarillo HSDA to 15% in the Lubbock HSDA. In the El Paso HSDA, 6% of PLWHA are Black/African American.
- The farther south the HSDA, the larger the percentage of Hispanic/Latino PLWHA. This ranges from 85% in El Paso to 29% in Amarillo.

Gender

Differences are seen in PanWest and West Texas PLWHA gender.

- PanWest has approximately 80% male and 20% female PLWHA in all HSDAs.
- West Texas has 87% male and 13% female PLWHA.

Age

- In all four HSDAs, prevalence increases with increasing age, beginning with 5% of PLWHA in the 15 – 24 year age range and increasing to approximately 33% in the 45 to 54 year old group.
- The percentage decreases, however, in the 55+ group to less than 20%.

Transmission Mode

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

- The PanWest HSDAs have smaller percentages for MSM transmission than West Texas, between 51% and 55% compared to 68% in in West Texas.
- Injection drug use (IDU) transmission mode is higher in PanWest than West Texas.
- Heterosexual transmission mode ranges from 13.6% in Lubbock HSDA to 21% in Amarillo HSDA.

Unmet Need/Out-of-Care

Between 2007 and 2011, Texas Department of State Health Services (DSHS) calculated unmet need (percentage of PLWHA not receiving HIV medical care). Results found:

- Larger percentages of people with AIDS are in-care than out-of-care.
- In all HSDAs, except Permian Basin, women tend to be out-of-care to a greater extent than men.
- Younger PLWHA are more likely to be out-of-care than those in older age ranges.
- Heterosexual and IDU tend to be out-of-care to a greater extent than MSM.

HIV Incidence

- Between 2007 and 2012, new HIV diagnoses averaged between 23 and 30 in the PanWest HSDAs and 103 in the El Paso HSDA.
- The 2012 incidence rates ranged from 4.6/100,000 in Amarillo HSDA to 14.2/100,000 in El Paso HSDA and include 7.6/100,000 in Lubbock HSDA and 8.7/100,000 in Permian Basin HSDA.

Sexually Transmitted Diseases

Sexually transmitted diseases (STD) identify individuals at risk for acquiring HIV due to unprotected sexual activity.

- Chlamydia is the most prevalent sexually transmitted disease in both PanWest and West Texas, with increasing incidence between 2007 and 2011.
- Potter County has the highest 2011 chlamydia rate and the highest gonorrhea rate of all counties.
- Lubbock County had a significant increase in chlamydia cases and rates between 2007 and 2011, with cases increasing by 75% during this time. Lubbock also had an increase in gonorrhea cases and rates during this time.
- El Paso County had the highest total number of chlamydia and gonorrhea cases each year, but the 2011 incidence rates are below other counties.
- In 2011, Hale County has the highest syphilis rate of all key counties in the four HSDAs. This was followed by Lubbock County which had a historically high syphilis rate between 2008 and 2011.

Treatment Cascades

Texas DSHS developed a 2012 treatment cascade for each HSDA. The Cascades estimate both known and unknown PLWHA. The *Texas HIV Plan Update for 2014 – 2015* reports:

- Approximately 18% of those living with HIV have not been diagnosed.
- Models of the spread of HIV have estimated that undiagnosed persons may drive almost half of new HIV infections.
- In 2011, approximately one in three HIV diagnoses were made late in the course of the disease which affects prognosis and lifespan.
- Approximately two in five Texans were not receiving HIV medical care.
- About half who were in medical care had not achieved viral load suppression.[2]

The cascades below present the status of these attributes for the PanWest and El Paso HSDAs. They can help guide each HSDA's efforts to diagnose HIV, link the newly diagnosed to medical care and maintain PLWHA in care and treatment.

Amarillo HSDA Treatment Cascade

It is estimated that 530 people in the Amarillo HSDA are HIV positive. Of these, 434 are aware of their status.

- For 2012, DSHS finds 321 Amarillo HSDA PLWHA have a "met need"[3] for HIV medical care, with 224 (70%) achieving viral load suppression at the end of 2012.
- The met need translates to 74% of those who know their status accessing HIV medical in the previous 12 months, and an unmet need of 26%.

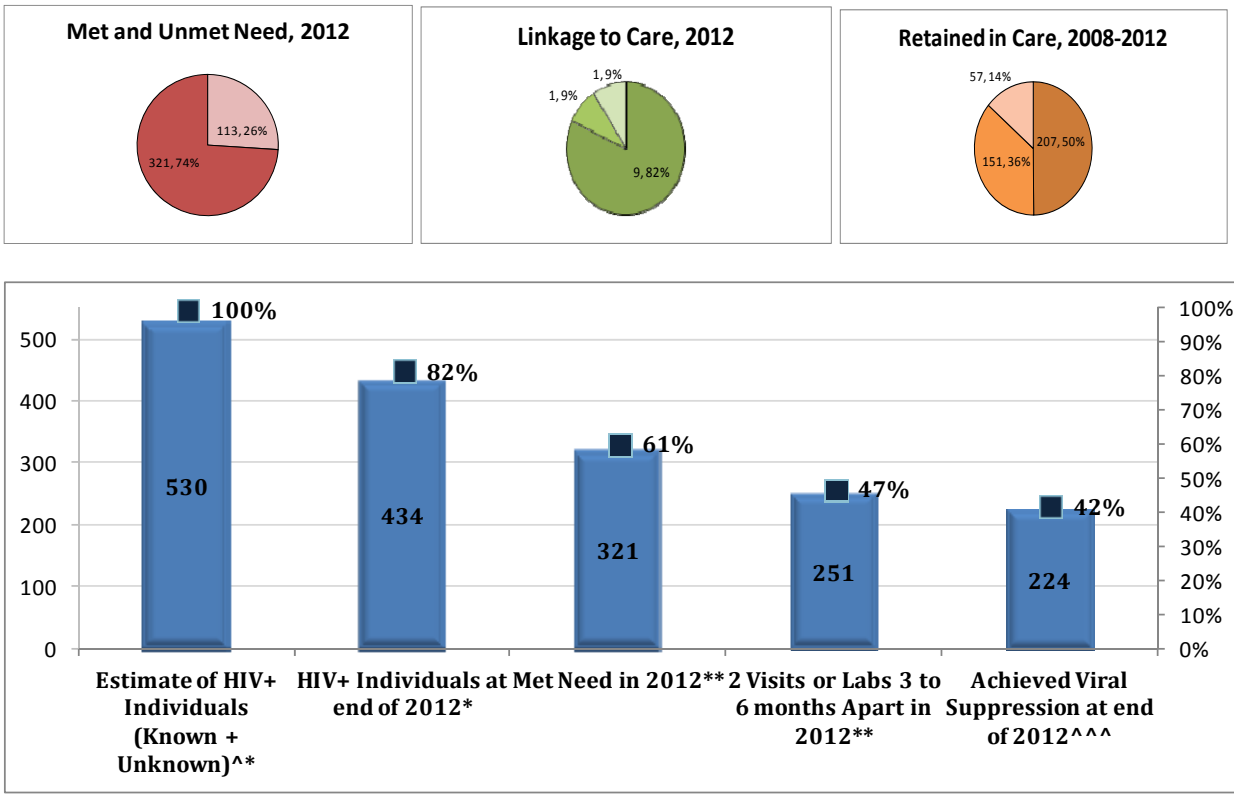
DSHS also identified that of the 11 consumers with new HIV diagnoses in the first nine months of 2012, nine (82%) linked to care within three months, one (9%) linked to care in four to 12 months, and one (9%) did not link at all.

Finally, DSHS provides data on consumers who were retained in care from 2008 through 2012.[4]

- 50% had a met need/were maintained in care every year.
- 36.5% were in and out of care between 2008 and 2012.
- 14% have no evidence of receiving HIV medical care during this time.

[2] *Texas HIV Plan, Update for 2014 – 2015, page 4.*
[3] A "met need" for HIV medical care uses the HRSA definition of having a CD4 or viral load test, antiretroviral medications or HIV medical care in the last 12 months.
[4] Those included in this calculation include those diagnosed with HIV on or before 2011.

Figure 1.2
Treatment Cascade for Amarillo HSDA 2012



Lubbock HSDA Treatment Cascade

It is estimated that 531 people in the Lubbock HSDA are HIV positive. Of these, 435 are aware of their status.

- For 2012, DSHS finds 319 Lubbock HSDA PLWHA have a "met need" for HIV medical care, with 235 (74%) achieving viral load suppression at the end of 2012.
- The met need translates to 73% of those who know their status accessing HIV medical in the previous 12 months, and an unmet need of 27%.

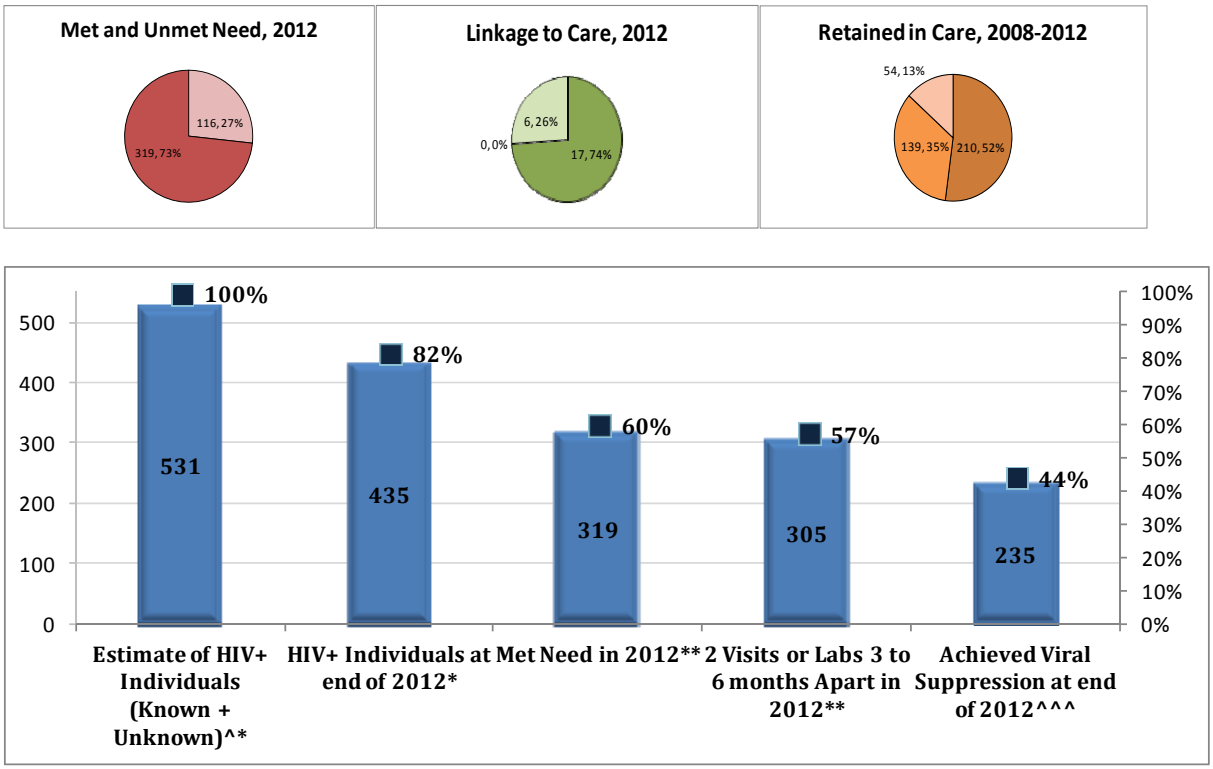
DSHS also identified that of the 23 consumers with new HIV diagnoses in the first nine months of 2012, 17 (74%) linked to care within three months, and six (26%) did not link at all.

Finally, DSHS provides data on consumers who were retained in care from 2008 through 2012.[5]

- 52% had a met need/were maintained in care every year.
- 35% were in and out of care between 2008 and 2012.
- 13% have no evidence of receiving HIV medical care during this time.

[5] Those included in this calculation include those diagnosed with HIV on or before 2011.

Figure 1.3
Treatment Cascade for Lubbock HSDA 2012



Permian Basin HSDA Treatment Cascade

It is estimated that 601 people in the Permian Basin HSDA are HIV positive. Of these, 492 are aware of their status.

- For 2012, DSHS finds 343 Permian Basin HSDA PLWHA have a "met need" for HIV medical care, with 230 (67%) achieving viral load suppression at the end of 2012.
- The met need translates to 70% of those who know their status accessing HIV medical in the previous 12 months, and an unmet need of 30%.

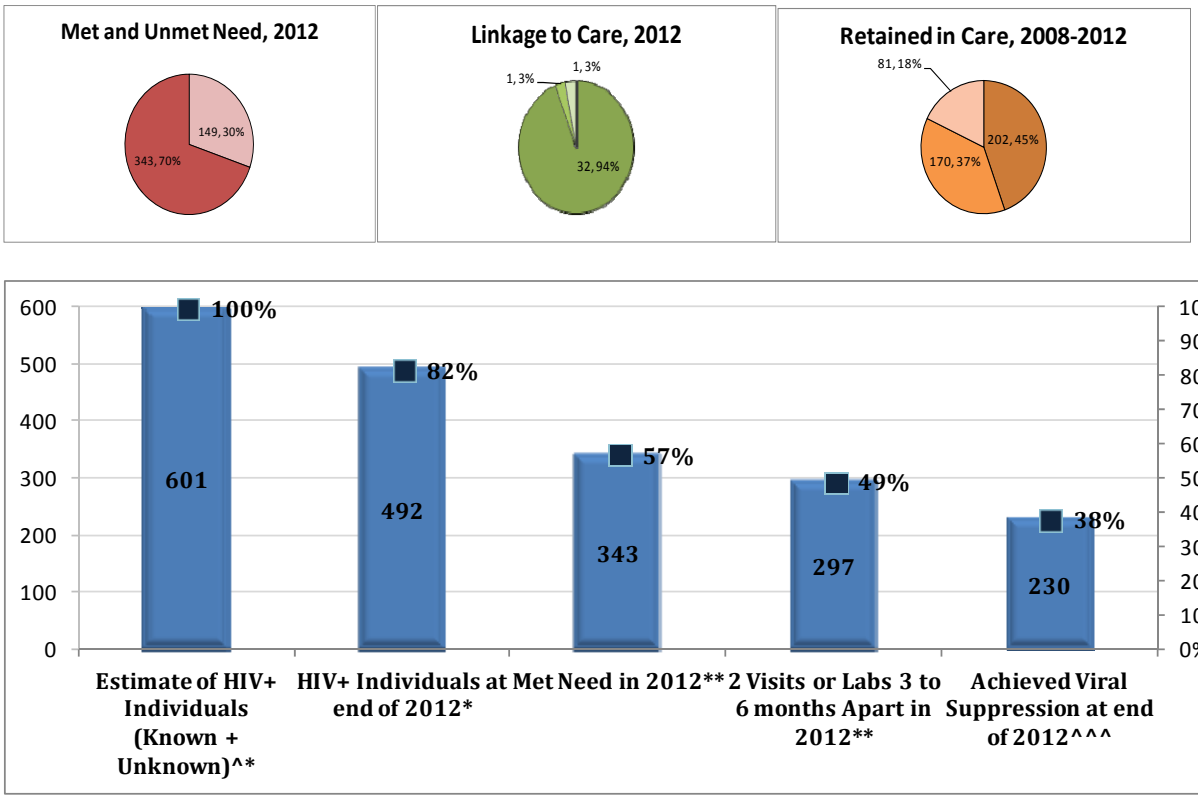
DSHS also identified that of the 34 consumers with new HIV diagnoses in the first nine months of 2012, 32 (94%) linked to care within three months, one (3%) linked to care within four to nine months, and one (3%) did not link at all.

DSHS provides data on consumers who were retained in care from 2008 through 2012.[6]

- 45% were maintained in care throughout this time period.
- 38% were in and out of care between 2008 and 2012.
- 18% have no evidence of receiving HIV medical care during this time.

[6] Those included in this calculation include those diagnosed with HIV on or before 2011.

Figure 1.4
Treatment Cascade for Permian Basin HSDA, 2012



El Paso HSDA Treatment Cascade

It is estimated that 2,250 people in the El Paso HSDA are HIV positive. Of these, 1,843 are aware of their status.

- For 2012, DSHS finds 1,256 El Paso HSDA PLWHA have a "met need" for HIV medical care, with 956 (76%) achieving viral load suppression at the end of 2012.
- The met need translates to 68% of those who know their status accessing HIV medical in the previous 12 months, and an unmet need of 32%.

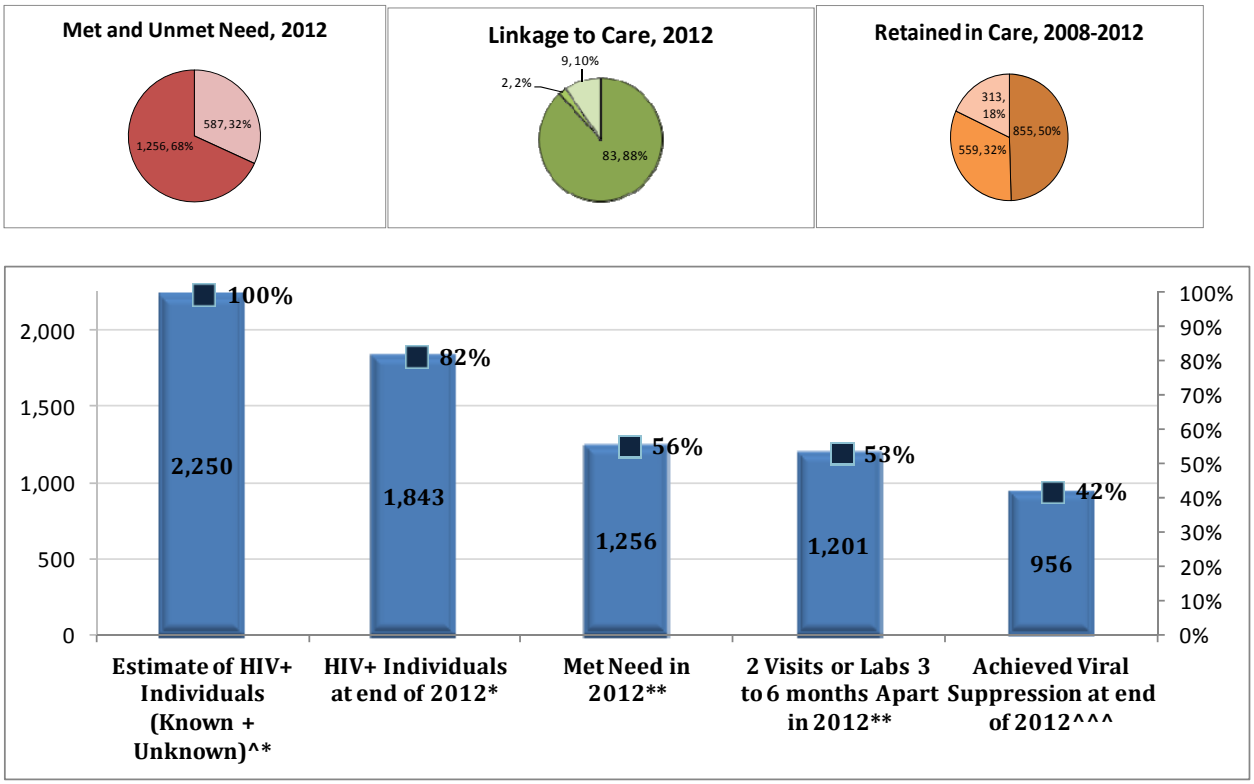
DSHS also identified that of the 94 consumers with new HIV diagnoses in the first nine months of 2012, 83 (88%) linked to care within three months, two linked to care within four to six months and nine (10%) did not link at all.

DSHS provides data on consumers who were retained in care from 2008 through 2012.[7]

- 50% (855PLWHA) had a met need/were maintained in care every year.
- 33% (559 PLWHA) were in and out of care between 2008 and 2012.
- 18% (313PLWHA) have no evidence of receiving HIV medical care during this time.

[7] Those included in this calculation include those diagnosed with HIV on or before 2011.

Figure 1.5
Treatment Cascade for El Paso HSDA, 2012



SECTION 1-B: DESCRIPTION OF THE CURRENT CARE SYSTEM

In 2009 significant changes occurred in the West Texas HASA—a large provider who was also the administrative agency abruptly closed its doors. Many patients were left without case management, medical or other essential services. The new administrative agency, Lubbock Regional MHMR Center (now StarCare Specialty Health System), was left to establish services for these consumers, contact them and make appropriate referrals to La Fe CARE.

Since that time, StarCare has made significant progress in the West Texas region while maintaining services in the PanWest region. Among other things, they:

- Established a second, highly regarded medical clinic at Texas Tech University Health Sciences Center (TTUHSC) in El Paso.
- Integrated La Fe CARE into the PanWest-West Texas administrative system.
- Funded mental health services through Family Service of El Paso, Inc.
- Expanded West Texas HOPWA services; conducted an El Paso housing study and participated in the El Paso Housing Coalition.
- Continued support of existing PanWest providers with strong core services.
- Established a sound quality management system in both regions.

- Are actively participating in and/or supporting regional collaboration.
- Ensure availability of bilingual staff at all Ryan White funded organizations.
- Expanded services with increasing numbers of clients at all HIV medical clinics.

Challenges include:

- Limited medical care options with two Ryan White funded organizations in the El Paso HSDA, and one Ryan White funded provider in each of the three PanWest HSDAs.
- Since losing the full time medical director in 2011, La Fe CARE has struggled with physician/clinician staffing.
- Case management services are uneven in the West Texas HSDA with both case management staffing and quality issues.
- Given Ryan White requirements to fund core medical services, funding for social services is limited. Collaboration with non-Ryan White funded community agencies is essential.
- In West Texas and other rural areas, the ongoing HIV stigma can be acute, limiting access to services due to consumer disclosure concerns.
- Increase in client numbers, but no increase in funds.
- Uncertainty about the impact of the Affordable Care Act especially regarding the Health Insurance Premium and Cost Sharing Assistance and AIDS Pharmaceuticals since Texas is not expanding Medicaid coverage.

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.

In 2013, the Providers served clients as follows:

- The Amarillo HSDA subcontractor served 267 unduplicated clients in a 26 county area.
- The Lubbock HSDA subcontractor served 301 unduplicated clients in a 15 county area.
- The Permian Basin HSDA subcontractor served 254 unduplicated clients in a 17 county area.
- The El Paso HSDA subcontractors served 1,145 unduplicated clients including 925 at La Fe CARE and 220 at TTUHSC.

All Subcontractors are required to provide culturally competent services without discrimination in any form.[8]

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

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, including HEI case managers,
- Mental health counseling programs,
- Food banks, churches, homeless shelters and other support organizations.

Subcontractors are required to provide the appropriate linkages[9] to ensure needed services are available for their clients.

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

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

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

Outpatient/Ambulatory Medical Care

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

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

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

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

The service Subcontractor for the Amarillo HSDA is:

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

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

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

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

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

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

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

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

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

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

- In addition to HIV medical care, La Fe CARE offers medical and non-medical case management, AIDS Pharmaceuticals, health insurance assistance, medical and non-medical transportation, oral health care, HIV prevention outreach, HIV counseling and testing. La Fe CARE is part of

Centro De Salud Familiar La Fe, a community health care system and FQHC, providing linkage for clients needing to access other services in this system.

- TTUHSC at El Paso offers HIV medical care, medical and non-medical case management, health insurance, AIDS Pharmaceuticals, and medical transportation. TTUHSC may add services as the program expands as well as offering linkages with other service/programs available through their system of care.

Table 1.3
Services Provided by PanWest and West Texas Funded Subcontractors*

	Amarillo		Lubbock		Permian Basin		El Paso	
Service Category	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**	**In-house**	**Contract Out / Refer Out**
Outpatient/Ambulatory/ Health Services		X		X		X	X La Fe TTUHSC	
Substance Abuse Outpatient Services		X		X		X		X
Mental Health Services		X		X		X	X	X
AIDS Pharmaceutical Assistance (local not ADAP)	X		X		X		X	
Medical Case Management Services	X		X		X		X	
Non-Medical Case Management Services	X		X		X		X	
Health Insurance	X		X		X		X	
Oral Health Care		X		X		X	X La Fe	X TTUHSC
Medical Transportation	X		X		X		X	
Non-Medical Transportation	X		X		X		X La Fe	X TTUHSC
Emergency Financial Assistance	X		X		X		NA	NA
Housing Services (plus HOPWA)	X		X		X			X SunCity
Food Bank (Food Vouchers)	X		X limit to ER+		NA	NA	NA	NA

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

Resource Inventory

The PanWest-West Texas 2013 Comprehensive HIV Needs Assessment includes HSDA-specific resource inventories. They are found at www.panwest.org under Resources.

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

Internet resources resulting in statewide or even national service access are essential in PanWest and West Texas. For example, due to the high cost of 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, the organizations refer PLWHA back to the local HIV service subcontractors for assistance. The table below provides an overview of available resources in each HSDA.

Table 1.4
Available Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
AIDS Service Organization	1	1	2	4	8
Case Management	4	3	5	14	26
Dental Care	4	5	4	8	21
Emergency Assistance	4	7	11	4	26
Employment Assistance	1	2	5	6	14
Family Planning Services	6	6	6	2	20
Financial Assistance	0	0	4	3	7
Food Bank	10	13	9	10	42
HIV Counseling and Testing	10	14	7	8	39
HIV Medical Care	3	1	1	3	8
Home Healthcare	2	4	2	3	11
Hospice Care	3	2	2	4	11
Housing Services	6	12	7	21	46
Legal Services	1	3	4	4	12
LGBT Services	1	1	1	1	4
Medication Services	5	9	5	6	25
Mental Health Therapy and Counseling	3	10	11	16	40
OB/GYN Care	7	9	8	6	30
Primary Medical Care (not HIV-Specific)	12	15	14	11	52
Specialty Medical Care	4	3	9	11	27
STD Testing	7	11	7	1	26
Substance Abuse Treatment	8	12	10	8	38
Transportation Services	1	3	2	9	15

SECTION 1-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.

A Comprehensive Needs Assessment was completed in the PanWest and West Texas regions in 2013 and provides the foundation for this Comprehensive HIV Health Services Plan. The needs assessment included an on-line survey of 328 consumers, in-depth interviews with 29 out-of-care/returned to care consumers, key informant interviews, a West Texas case manager focus group, resource inventories of each HSDA, a behavioral health assessment and review of Regional Health Plans.

Key findings and recommendations relating to PLWHA needs and medical services are presented below.

1. Sharing Best Practices Among the PanWest and West Texas HSDAs

Key Findings:
The organization of the PanWest and West Texas regions under a single administrative agency provides an opportunity for Ryan White funded providers to collaborate, share evidence-based best practices to build on successful programs, and respond effectively to challenges. This needs assessment presents similarities and differences between HSDAs. Effective programs should be documented and shared between providers. Implementation may include modifications based on HSDA differences.

Recommendation:
1.1. The administrative agent should build on current structures to document and share best practices, and evaluate each organization's progress in achieving identified outcomes based on implementation of those practices. Implementing the quality management PDSA cycle will promote continuous improvement in the services delivered throughout the region.

2. HIV Medical Care—Additional Clinical Staff, Increase Service Access

Key Findings:
The HIV medical clinics across PanWest and West Texas use a variety of medical staff and practice arrangements. Stability and quality of medical staff vary between these providers. The consumer survey and out-of-care interviews demonstrate that the quality and consistency of medical/clinical staff affects patient compliance and retention in care. The consumer survey identified specific dissatisfiers including long waits for appointments, inconsistency in clinicians seen at clinics, and cancelled appointments.

Physician manpower shortages are documented throughout the West Texas and PanWest regions. This is demonstrated in availability of medical staff for the HIV clinics and difficulty recruiting additional high quality physicians.

Only 25% of Pan West and West Texas women using Ryan White funded services report having a PAP smear in 2012. This ranges from one-third of the age appropriate female clients at PASO to 4% at TTUHSC. BAS also reports a small percentage, 11%.

Recommendations:
The following recommendations pertain to HIV clinic medical staff.

2.1. Support clinics operating with stable, high quality physicians to maintain those physicians.
- Evaluate workload. As appropriate provide funding for additional support such as nurse practitioner(s), data/administrative support.
- Evaluate succession planning requirements for physicians considering retirement or reducing hours.

2.2. Assist clinics in need of additional physicians/clinicians in recruiting dedicated, high quality physicians.
- Preceptorships through the Texas-Oklahoma AIDS Education and Training Center (AETC) are becoming available for family practice or internal medicine physicians to learn the skills needed for treating patients with HIV. Consider recruiting physicians dedicated to treating people with HIV and supporting them in gaining the HIV-specific skills necessary.

2.3. Encourage physician integration of medical care and mental health treatment at all Ryan White funded HIV medical care clinics.
- Support clinicians in expanding skills to treat mental health disorders, particularly mild to moderate depression. Preceptorships are available in this area through Texas-Oklahoma AETC.
- Develop a physician compensation structure that promotes obtaining this additional expertise.
- Work with the Regional Health Partnership (RHP) lead agency to identify opportunities for collaboration to integrate HIV medical care and behavioral health per the RHP Plans over the next three years.

2.4. Encourage integration of HIV medical care and women's health services, particularly cervical cancer screenings (PAP smears), at all Ryan White funded HIV medical care clinics. Provide needed funding for the PAP smears and other tests.
- For those providers not able to perform PAPs in the HIV clinic, funding should be available for appropriate referral. Follow-up and documentation in ARIES must follow.

The following recommendations pertain to HIV medical care providers' tactics to increase PLWHA service access.

2.5 HIV medical care clinics should employ all possible strategies to (1) ensure consumer access to care, (2) maintain consumers in care and (3) support in treatment compliance. These include:
- Provide appointment reminders via telephone, reminder card and text message to consumers with smart phones. The latter was of particular interest to out-of-care interview participants.
- Provide transportation to medical care for those not living near public transportation systems by collaboration with transportation providers and increasing transportation funding.

- Reduce appointment wait times and waiting room visibility, particularly for newly/recently diagnosed.
- Provide appropriate educational materials to support treatment compliance, written in both English and Spanish.

3. Primary Medical Care—Evaluate Need to Increase Access in Each HSDA

Key Findings:
Increasing co-morbidities, an aging PLWHA population and healthcare reform has increased the emphasis on PLWHA access to primary medical care for treatment of non-HIV conditions. Experts in healthcare reform and the Affordable Care Act also identified access to primary care treatment as important for PLWHA as new programs are implemented. Over half (56%) of consumer survey respondents do not have primary care physicians.

Recommendations

3.1. For those clinics that do not provide primary medical care for general medical conditions/non-HIV-related co-morbidities, identify local options, such as local federally qualified health centers (FQHC). Medical case managers and physicians should collaborate with the organization(s) and provide appropriate client referrals.
- When referrals to primary medical care are made, establish processes for follow-up to ensure the patient/client has received needed services.

3.2. Identify opportunities for Ryan White HIV medical providers or patients to participate in the Family Service of El Paso, Inc./Project Vida collaboration which will provide primary care and mental health services.

3.3. Identify Gay/Lesbian/Bisexual/Transgender (GLBT) "friendly" primary medical care services for use by GLBT consumers.
- Since this was identified as a need in El Paso, begin in the West Texas HSDA in collaboration with other regional partners.
- If successful, continue this process in other HSDAs.

4. Case Management—Continual Quality Improvement

Key Findings:
Ryan White medical and non-medical case managers are critical to supporting, encouraging and empowering clients to access needed care and services. Successful approaches identified include: development of a multidisciplinary treatment team to support a comprehensive treatment plan of care, co-locating as many needed services as possible at a single point of contact, sensitivity to client culture and needs, provision of support and empowerment.

Documenting and implementing the case management best practices in PanWest and West Texas can result in improved compliance with treatment regimes and increasing overall service satisfaction.

Recommendations:

4.1. Develop and implement medical case management best practices in all HSDAs per Recommendation 1. Once established, continue this process with non-medical case management best practices followed by housing case management best practices.
- Use a multi-disciplinary, team-centered approach to patient care with the case manager "managing" the process.

4.2. Provide targeted continuing education and training for case manager to support achievement of best practices.

4.3. Evaluate case management capacity, particularly at TTUHSC, to ensure appropriate case management staffing levels. Approve funding for hiring additional case manager/support staff as appropriate.

4.4. Additional case management staff should be culturally appropriate relative to targeted populations being served in the region.

4.5 Provide the on-line links for each of the 2013 Ryan White Resource Inventories. The appropriate regional inventory should be available at each Ryan Funded agency's website for use by both case managers and consumers. They should also be available on the Administrative Agency's website.

4.6. Educate and empower consumers to improve interactions with and the value received from their case managers. In order to achieve partnership relationships between providers and consumers, educate both parties about their roles and responsibilities.
- Consider developing a consumer Health Education/Risk Reduction (HERR) handbook for distribution with the resource directory.

5. Medications—Enhance Access

Key findings:

Difficulties in accessing medication and maintaining treatment regimens were identified as significant barriers for both in-care and out-of-care consumers.

Medication problems were identified as a reason for dropping out of care in the out-of-care interviews.

Recognizing the impact of medication issues on consumer compliance and satisfaction, medication was the first topic of discussion among the La Fe CARE case manager focus group participants.

Medication support was identified as necessary to take medication as prescribed. Specifically: assistance with obtaining medication and help with reminders to take the medications on schedule.

Recommendations:

5.1. Develop processes/systems at all providers to improve the ease of access to medication. Processes should be specific for each HSDA HIV medical care provider.

5.2. Support prescribing and/or dispensing medications for patients with mild to moderate depression

5.3. Advocate for maintenance of HIV formulary under the Affordable Care Act.

6. Linkage to Care After Diagnosis

Key Findings:
Out of care consumers that did not successfully link to care after diagnosis cite lack of support, poor communication, stigma and shame, denial and depression, misinformation about HIV, cost concerns and provider miscues.

One out-of-care consumer stated, "Once diagnosed they give you referrals; after that you are on your own. It is confusing… It would be wonderful to have peer navigator."

Recommendations:
6.1. Continue and/or expand collaborations between HIV medical care and HIV prevention outreach/counseling and testing to effectively link newly diagnosed consumers to HIV medical care, reducing barriers to care.
6.2. Evaluate developing a model peer support program for newly diagnosed in one HSDA in 2014. This may occur in a collaboration between Counseling &Testing and HIV medical care.

SECTION 1-D: DESCRIPTION OF BARRIERS TO CARE

The 2013 Comprehensive Needs Assessment also identified recommendations to overcome barriers to care in the areas of mental health therapy, substance abuse treatment, and the stigma of HIV. Collaborating with available services will be key to enhancing utilization of appropriate treatment services in 2014 – 2017.

Comprehensive Needs Assessment findings and recommendations in these areas are presented below:

1. Mental Health Therapy and Counseling—Integrate with Medical Care

Key Findings:
Mental health disorders can interfere with HIV medical treatment compliance. Appropriate mental health therapy is essential for positive patient outcomes. In many cases, however, client, system and cultural barriers prohibit timely and appropriate access.

- Ryan White funding for mental health therapy and counseling has been allocated throughout the PanWest and West Texas regions. Although this funding addressed an identified need, consumers are not completing referrals, not accessing services and funds are often unspent.

One-quarter of consumer survey respondents find it difficult to access medical care due to depression, emotional stress or mental disorder. In addition, among those who dropped out of care, 25% cite depression, emotional stress or mental disorder as a reason.

Co-located services, a variety of approaches and culturally competent counselors can improve access and compliance.

Recommendations

1.1. Develop mental health therapy best practices supported by case management staff.
1.2. Include a mental health counselor as part of the HIV medical care treatment team.
1.3. Evaluate the feasibility of providing on-site mental health counseling at each clinic site and/or each case management site.
1.4. Ensure mental health counselors are culturally appropriate/sensitive for the populations served.

2. Substance Abuse Treatment—HIV Early Intervention (HEI) Best Practices

Key Findings:

Substance abuse can interfere with HIV medical treatment compliance. Necessary substance abuse treatment is essential for positive patient outcomes. Substance abuse treatment services are reportedly accessible, but few consumers access them.

Most consumers who might be candidates for substance abuse treatment do not feel they need the service and are not willing to access it. Consumer survey respondents who considered getting substance abuse treatment cited lack of free treatment and unaware of treatment options as reasons.

Recommendations:

2.1. Include the HEI case manager in each HSDA as part of the clinical treatment team.
2.2. West Texas has a new HEI case manager and HIV services manager at Aliviane. Collaborate with these new employees to enhance the role of the HEI case manager in the region. Encourage Aliviane to expand the role to achieve HEI case management best practices established in PanWest or across the State.

3. Stigma

Key Findings:

HIV stigma is a significant barrier to care throughout the PanWest and West Texas HSDAs. It affects both in-care and out-of-care consumers. In addition to HIV stigma, GLBT identity, and mental health disorders can also be stigmatizing. Stigma can be particularly severe in small cities and rural towns.

Recommendations:

3.1. Develop an integrated plan to reduce stigma of HIV in all HSDAs. Initially work with the El Paso Community Mobilization Collaborative to accomplish this in West Texas.
- HRSA has outlined strategies for stigma reduction which include:
  - Provide knowledge and education to the public
  - Humanize the stigmatized population
  - Challenge the social acceptability of stigma
  - Help people affected by stigma develop tools to survive it—and combat it
  - Develop legal and regulatory responses to protect people from stigma and discrimination
  - Provide effective HIV/AIDS care and treatment.[10]

[10]Joan Holloway, et. al. "HIV/AIDS Stigma: Theory, Reality and Response." Health Resources Services Administration. August 2004. pgs 18-19.

For each of these strategies, HRSA identifies specific interventions that may be employed.

4. Provider Collaboration

Key Findings:
Collaboration is key to developing innovative approaches across the community, providing consumers with needed services, expanding available funds and supporting Ryan White as the payer of last resort.

Recommendations:

4.1. Continue to actively participate in the El Paso Community Mobilization Collaborative.
- Share information about the El Paso Community Mobilization Collaborative with West Texas Ryan White funded providers who are not participating.
- Identify opportunities to shift Ryan White funds from services provided by other collaborative partners to service gaps.
- Identify opportunities for Ryan White funded clients to access needed services through other sources provided by collaborative partners. Identify areas for Ryan White funds to support these services, i.e. client transportation.

4.2. With the El Paso Community Mobilization Collaborative as an example, identify opportunities to support collaborative development in PanWest HSDA(s) by 2015.

SECTION 1-E: 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 Quality Management Plan.
- The QM Plan clearly outlines the necessary actions to improve service quality.
- The QM Plan outlines many topics, including the Tier 1 HAB Performance Measures and the 2013 Core 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 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 QM Plan. Three meetings annually are conducted via teleconference and one is held in person.

- Currently, the main focus of the QMC is to implement monitoring of the current HRSA HAB Core Measures: medical visit frequency, gap in medical visits and viral load suppression and PCP prophylaxis.
- The QMC will continue to monitor Tier 1 HAB Measures and have providers maintain at least an 85% percent average for each measure.

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

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

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

HAB Performance Measures

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

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

Performance Measure II: Achieve a minimum of 85% percent of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year, with an ultimate goal of 90%-95%.

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

Performance Measure IV: Achieve a minimum of 85% 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%.

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

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. Since the HAB Performance Measures have been implemented, the Data Manager has worked closely with the providers to obtain all data necessary to

increase their percentages. Since training was provided on the HAB Tier 1 measures, the AA will implement a base line of 85% for the providers to achieve.

Table 1.5
HAB Performance Measures
Calendar Year 2013 Average Scores

	Amarillo	Lubbock	Permian Basin	El Paso	TTUHSC
Measure I:	76.81%	66.38%	74.15%	76.54%	70.45%
Measure II:	76.33%	65.94%	60.98%	83.22%	73.30%
Measure III:	75.00%	85.19%	97.85%	94.44%	77.78%
Measure IV:	93.60%	97.48%	100.00%	99.23%	92.94%
Measure V:	100.00%	50.00%	100.00%	100.00%	50.00%

When introducing the new HRSA HAB Core Measures, the AA will gather baselines for each Subcontractor. Once the subcontractor is at a minimum of 50% baseline, the AA will then require the Subcontractors to increase their baseline percentage by 10% annually. The HAB Core Measures will be monitored quarterly and be presented at each QMC.

According to DSHS, the new HAB Core Measures should be added to ARIES via an update in late April for Release 24.

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 Texas Department of State Health Services HIV Clinical and Case Management Services Standards. It includes:

- Monitoring of the care and treatment of persons with HIV in accordance with US Public Health Standards, Health Resources Services Agency-HIV/AIDS Bureau Measures, and Texas Department of State Health Services.

- Site visits to the clinics of the Subcontractors in Amarillo, 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
  - Compliance with client graduation, discharge, and termination policies and procedures
  - Compliance with other programmatic policies and procedures related to medical and non-medical case management

Other related activities of the AA Nurse Consultant include:

- 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 strategic samples of client charts are assessed for continuity of care as well as the completion and content of documentation.
- Providing feedback to the Subcontractors related to TA and site visits.

Utilization and Fiscal Monitoring

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

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

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, and cleaning, and generating various reports to find missing information or unknown data.

- After the AA completes the process, each Subcontractor's data manager receives statistical reports containing a list of clients with missing or unknown data on a bi- monthly basis. The missing data must be collected as soon as possible, preferably before the next data transmission begins.
- 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 at least annually 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 is at least one site visit per year at each Subcontractor location. This site visits may or may not be announced.
- 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 implemented 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 Premium and Cost Sharing, and Outpatient/Ambulatory Medical Care, and to prevent lapse of funds.
- The Contract Specialist monitors the contract expenses monthly to ensure that there is no lapse or overspending of funds. This is accomplished through analyzing the expenses reported monthly 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 1-F: 2013 – 2014 PRIORITIES AND ALLOCATIONS

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

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

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

- Needs Assessment Findings—The 2009 PanWest and 2010 West Texas Comprehensive Needs Assessments served as guides in setting the 2013-2014 allocations and priorities.[11]
- Historical information based on expenditures, service provision, service barrier limitations, community resources, and stakeholder/community input.
- PanWest and West Texas Comprehensive Plans for HIV/AIDS Services.
- DSHS Priority Setting & Resource Allocation Principles and DSHS HIV Services Taxonomy.[12]

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

[11] 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.

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

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

- At the time the allocations are done, the AA generally does not know the actual funding amount it will receive from DSHS for each HSDA so the AA presents the allocations as percentages.
- Once the AA receives the funding amounts from DSHS, they are applied according to the allocated percentages.
- The allocations are generally determined at ninety-five percent (95%) of the previous year's allocations to allow for anticipated funding cuts, except for Medical Case Management and Non-Medical Case Management, which are generally allocated at 100%, since those categories include staff salaries.

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

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

Around 2012 the State changed the Ryan White Service Delivery (RWSD) contract dates from April 1 through March 31 to September 1 through August 31 to run concurrent with the State Services contract. The AA also oversees a housing contract, Housing Opportunities for People With AIDS (HOPWA), whose funds are allocated by DSHS not the AA. The HOPWA contract runs February 1 through January 31. HOPWA funds are taken into consideration when allocating funds to housing services, but HOPWA is not part of the Priorities and Allocations process.

Core vs. Support Services

The Treatment Extension Act of 2009 requires states to allocate, at a minimum, 75% of RWSD funds to the medical core categories. To meet this requirement, DSHS requires each HIV Administrative Service Area (HASA) to fund a *minimum* of 75% of RWSD to the core medical services needed in the HSDA that are not provided through other resources. This leaves no more than 25% for social support services. (Refer to Appendix D for the list of medical 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 State Services certain social support services that are not allowable under RWSD.
    - For example, non-medical transportation can be allocated under State Services since it is critical in rural areas.
- A very notable impact from the 2009 Act is designation of Medical Case Management as one of the core medical services and Non-Medical Case Management as a social support service. DSHS developed new case management standards and a new case management model emerged to meet the requirement.
- For PanWest and West Texas, the AA requires that each area prioritize Outpatient/Ambulatory Medical Care, AIDS Pharmaceuticals, and Health Insurance Premium and Cost Sharing Assistance due to their medical urgency for maintaining client health. Subcontractors assure that

community resources are used, that RW and States Services are payers of last resort and that funding is decreased in other categories as necessary to fund the three priority medical core categories.

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

2013-2014 Allocations: Appendix E shows the amounts allocated to service categories in each of the four HSDAs. The AA continues to implement the Contingency Plan, developed by the PanWest Planning Assembly in 2006, which reduces the funding amounts of non-core services in order to maintain funding of the core medical services.

In November 2013, the AA held public comment hearings in PanWest and West Texas to present the proposed 2013-2014 Priorities and Allocations. Community review and feedback about the service priorities and allocations are always welcome and are necessary to ensure they best meet the needs of people infected and affected by HIV/AIDS. Unfortunately, the forums are usually only attended by provider staff and seldom have clients or non-Ryan White funded agencies present. The allocation chart for each HSDA is posted at www.panwest.org under the Download Center of the menu.

SECTION 1-G: EVALUATION OF 2010 COMPREHENSIVE PLAN

The 2010 – 2013 PanWest-West Texas Comprehensive HIV Services Plan was developed shortly after StarCare assumed responsibility for the El Paso HSDA. A 2010 Comprehensive HIV Needs Assessment was conducted in that region, supplementing the 2009 needs assessment conducted in PanWest.

The format for that plan included a timetable for review of each strategy and action that facilitated plan monitoring. Immediate achievement of a significant goal of that plan occurred when TTUHSC agreed to develop an HIV medical care clinic and offer case management services. This and other important strategies that were accomplished include:

- Establish a second medical care provider in West Texas by September 2010 with ancillary services and case management available by March 2011, increasing patient volume through March 2013.
- Provide medical services with expanded evening or weekend hours to meet client needs.
- Monitor service utilization and client satisfaction among disproportionately affected sub-populations.
- Implement the patient/client satisfaction survey throughout the PanWest and El Paso HSDAs, improving overall patient satisfaction annually.

Some of the strategies are being carried over to this 2014 – 2017 Comprehensive HIV Service Plan. These strategies may include new or additional actions going forward. These “carry over” strategies include:

- Optimize the medical and non-medical case management functions by March 2013.

- Evaluate and expand the mental health therapy and counseling services in West Texas to include funding for psychiatric consultations, co-location of mental health counseling with HIV medical care, development of multi-disciplinary treatment teams for patients with mental disorders.
- 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 adopted by Texas DSHS.

It also became evident that some strategies and actions of the 2010 – 2013 plan were not realistic given funding priorities. These include:

- Fund a medical home pilot project in either PanWest of West Texas by March 2013.
- Conduct annual assessments of clients' health literacy.
- Develop a peer mentor/peer navigator program for newly diagnosed PLWHA to encourage linkage to and maintenance in HIV medical care.

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

SECTION 2-A: COMPREHENSIVE HIV HEALTH SERVICES PLANNING PROCESS

The 2014-2017 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a planning process that included research, interactive discussion and plan development. The 2013 PanWest-West Texas Comprehensive Needs Assessment informed the Plan.

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 reviewed with Texas DSHS staff who offered input and support.

Mission and Vision

The previously developed mission and vision statements were reviewed for relevance in 2013. Modifications were made to both statements, expanding the focus on quality medical care and consumer health.

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

Vision Statement
HIV care is accessible and effective.

PanWest-West Texas Core Values

The PanWest-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 with community organizations to enhance access to the complete continuum of services, from HIV prevention to care and treatment.

The Continuum of Care

HRSA has 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 (operational) continuum of care 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 outpatient/ambulatory medical care, AIDS Pharmaceuticals, and Health Insurance Premium and Cost Sharing Assistance. Other PanWest and West Texas core services are HRSA's identified core services which include: oral health, mental health services, substance abuse services and medical case management.
- Critical Access Services provide information and connection to medical and psychosocial support services and include: case management (non-medical) transportation, interpretation services.
- 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 or HOPWA or they may be provided through community linkages. They include such things as: non-medical case management, housing services, food bank, emergency financial assistance for rent, mortgage or utilities and 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. This would result 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 individualized for target populations or even individual clients resulting in near perfect treatment adherence.

We 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. The operational continuum emphasizes the medical core categories, with the highest priorities placed on outpatient/ambulatory medical services, AIDS Pharmaceuticals, Health Insurance Premium and Cost Sharing Assistance and both medical and non-medical case management.

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. 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 PanWest and West Texas 2013 – 2014 Priorities and Allocations tables are available in Appendix E.

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 stable or decreasing in the face of increasing needs, effective linkage among community services can expand the system for all. 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.

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. One example is the El Paso Community Mobilization Collaborative, organized by the El Paso Department of Public Health. Begun in early 2013, this organization promotes networking, reduces service duplication and supports joint activities. The AA and El Paso Ryan White providers are participants in this collaborative.

SECTION 2-B: CHALLENGES FROM 2010 PLAN

This plan includes strategies from the 2010-2013 plan that were not completed, required additional time or actions to accomplish. These 2010 “carry over” strategies include:

- Optimize the medical and non-medical case management functions by March 2013. (2014 - 2017 Goal 1)
- Evaluate and expand the mental health therapy and counseling services in West Texas to include funding for psychiatric consultations, co-location of mental health counseling with HIV medical care, development of multi-disciplinary treatment teams for patients with mental disorders. (2014 – 2017 Goal 2)
- Implement the PanWest and West Texas regions’ annual quality improvement plan. (Ongoing and included in 2014 – 2017 Goal 3)

- Use data to determine progress toward the HIV/AIDS Bureau's HIV Core Clinical Performance Measures for Adult/Adolescent Clients Group 1 adopted by Texas DSHS. (Ongoing and included in 2014 – 2017 Goal 3)

The result of expanding/continuing these goals and strategies will be enhanced linkage to care, improved maintenance in care, and provision of the highest quality care for all PLWHA in the regions.

SECTION 2-C: 2012 PROPOSED CARE GOALS

GOAL 1: Improve the Case Management System Throughout the PanWest and West Texas Regions

GOAL 2: Expand Access to Behavioral Health Services (Mental Health and Substance Abuse Treatment) by Integration, Co-Location and/or Increased Collaboration Between Ryan White Funded Providers and Behavioral Health Organizations.

GOAL 3: Ensure the Delivery of High Quality Medical Care Throughout the Region.

GOAL 4: Collaborate with Non-Ryan White Funded Providers to Expand Access to the HIV Prevention and Care Service Continuum.

SECTION 2-D: GOALS REGARDING INDIVIDUALS AWARE OF THEIR HIV STATUS BUT NOT IN CARE AND GOALS REGARDING INDIVIDUALS UNAWARE OF THEIR HIV STATUS

Goal 4 fosters collaboration with prevention outreach, counseling and testing and linkage to care providers.

- In the El Paso HSDA, a collaborative formed in 2013 is supporting improved coordination of HIV outreach, prevention and linkage to care and treatment. The El Paso Department of Public Health is leading this collaborative with broad participation from providers, educators and the GLBT community. The AA and subcontractors actively participate in this collaborative.
- This collaborative may be a model for the region.
- In the Amarillo HSDA, the Department of Health provides on-site counseling and testing at PASO and PASO offers free space to other community agencies providing services to clients.
- In the Lubbock HSDA, Project CHAMPS staff works closely with the StarCare HIV Outreach Team, which provides counseling and free HIV and syphilis testing services, and with the Managed Care Center for Addiction/Other Disorders, Inc. HEI Program

SECTION 2-E: PROPOSED SOLUTIONS FOR CLOSING GAPS IN CARE AND ADDRESSING OVERLAPS IN CARE

With only one Ryan White funded provider in each PanWest HSDA and two Ryan White funded medical and case management providers in the El Paso HSDA, very little service overlap is found. Each organization works diligently to provide necessary services and meet their clients' needs.

Service gaps may exist, particularly due to funding limitations, but collaboration and referral help to reduce these. This plan addresses these gaps by enhancing available services.

- Improvements in the case management system will increase both efficiency and effectiveness and non-Ryan White funded service utilization.
- Expanding HIV medical care in El Paso will provide additional options for consumers.
- Integrating behavioral health professionals into the treatment team will enhance access to these services.
- Improving access to effective HEI case management services will allow medical and non-medical case managers to support and direct consumers in other ways.

SECTION 2-F: COORDINATION WITH OTHER FUNDING SOURCES

Ryan White is always the payer-of-last-resort. The AA and subcontractors work with consumers to ensure that all other insurance option are identified and used before Ryan White funds. These other options include Medicare, Medicaid, Veterans Administration, private insurance and now the Affordable Care Act (ACA) healthcare exchange.

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

SECTION 3-A: INTRODUCTION

The 2014 Comprehensive HIV Health Services Plan establishes four goals for the Administrative Agency. All goals reflect the findings and recommendations of:

- The 2013 PanWest-West Texas Comprehensive Needs Assessments
- Texas Department of State Health Services staff
- *Healthy People 2020* objectives
- *National HIV/AIDS Strategy*
- *2012 – 2014 Texas HIV Plan and Update for 2014 – 2015*
- Ryan White HIV/AIDS Program requirements.

These goals and associated strategies promote a high quality case management system, enhanced access to behavioral health services, delivery of quality HIV medical care and collaboration to provide a complete continuum of care and services.

The Administrative Agency staff feels confident that these goals support the mission of providing an effective community-wide response to HIV/AIDS by focusing on medical care and support services and leveraging community resources.

The goals and accompanying objectives of the PanWest-West Texas 2014 - 2017 Comprehensive HIV Health Services Plan are outlined below and detailed actions are found in Part Two.

SECTION 3-B: GOALS AND OBJECTIVES OF THE PLAN

Goal I

Improve the Case Management System Throughout the PanWest and West Texas Regions.

Case management is central to linkage with and maintenance in HIV medical care. The 2013 Comprehensive HIV Needs Assessment identified case management strengths and weaknesses in the four HSDAs. The strategies focus on providing a uniform level of case management at all Ryan White funded providers by adherence to HRSA HIV/AIDS Bureau performance measures and sharing best practices between providers in the region. Specific strategies include:

Strategies

2.1 Implement the HRSA HIV/AIDS Bureau medical case management (MCM) core performance measure “medical visit frequency” by July 2014. Monitor performance improvement related to this measure using the PDSA cycle through December 2017.

2.2 Once the initial measure is successfully implemented and the quality management process (PDSA) is in place, expand the process to include the second core MCM performance measure "gap in medical visits," targeting implementation by December 2016.

2.3 Develop regional best practices for (1) MCM performance measure medical visit frequency, (2) maintenance in medical care and (3) medication delivery at the June 2014 annual provider training. Develop measures demonstrating conformance to best practices for medication delivery by January 2015 and use the provider self-audit on an ongoing basis.

Goal II

Expand Access to Behavioral Health Services (Mental Health and Substance Abuse Treatment) by Integration, Co-Location and/or Increased Collaboration Between Ryan White Funded Providers and Behavioral Health Organizations.

Behavioral health was identified as a focus of the 2013 Comprehensive HIV Needs Assessment because the providers identified mental health and substance abuse treatment service needs, but consumers were frequently not accessing the service after receiving referrals. Findings suggest that expanded assessment, integration of mental health and substance abuse providers with the treatment team and possible co-location of services could improve consumer access. The strategies foster these approaches:

Strategies

2.1 Establish medical case management best practices to improve assessment, referral and utilization of behavioral health services by December 2015.

2.2 Expand the treatment teams in each HSDA to include both mental health professionals and HEI case managers by December 2015.

2.3 Develop and implement a plan for all HIV clinic physicians and mid-level practitioners to develop the necessary skills to diagnose and prescribe adult psychiatric medications for minor to moderate depression and anxiety by December 2017.

Goal III

Ensure the Delivery of High Quality Medical Care Throughout the Region.

Providing high quality HIV medical care is an essential use of Ryan White funds. Continual improvement of medical care in the four HSDAs is of paramount importance. The 2013 Comprehensive HIV Needs Assessment identified medical care barriers in West Texas related continuity of available clinicians. ARIES data identified low levels of female patients receiving cervical cancer screening in all four HSDAs. The 2014 - 2017 strategies address these concerns:

Strategies

3.1 Implement the HRSA HIV/AIDS Bureau Core Performance Measures for viral load suppression and PCP prophylaxis by January 2015. Continue to monitor clinical measure for CD4 cell count.

3.2 Ensure physician and mid-level practitioner capacity in all HSDAs to provide timely patient access to high quality HIV medical care by January 2015.

3.3 Increase the percentage of female Ryan White patients who receive cervical cancer screening to 50% in 2015, 60% in 2016 and 75% in 2017 per cervical cancer screening performance measure.

Goal IV

Collaborate with Non-Ryan White Funded Providers to Expand Access to the HIV Prevention and Care Service Continuum.

Providing a full continuum of client services requires collaboration between Ryan White funded providers and other community organizations. Working together, scarce resources are shared and outcomes are optimized. In 2013 El Paso Department of Public Health began a local HIV prevention and services collaborative with encouraging levels of participation. This Community Mobilization Collaborative may serve as a model for other HSDAS.

Strategies

4.1 Encourage RW funded agencies to expand collaboration with local HIV prevention outreach/counseling and testing providers to effectively link newly diagnosed consumers to HIV medical care within three months of diagnosis, reducing barriers to care.

4.2 Continue to actively participate in the El Paso Community Mobilization Collaborative through 2014.

4.3 With the El Paso Community Mobilization Collaborative as an example, identify opportunities to support collaborative development in PanWest HSDA(s) in 2015 and beyond.

SECTION 3-C: HOW THE PLAN ADDRESSES *HEALTHY PEOPLE 2020* OBJECTIVES

Healthy People 2020 was launched in December 2010 with the ten-year agenda for monitoring and improving the nation's health. It includes objectives with monitoring benchmarks in order to:

- Encourage collaborations across communities
- Empower individuals toward making informed health decisions
- Measure the impact of prevention activities

It is the result of a multi-year process that included input from diverse groups of individuals and organizations.[13] Eighteen objectives related to HIV prevention and care. Seventeen of these are addressed in the 2013 - 2017 PanWest-West Texas Comprehensive HIV/AIDS Services Plan. The goals and strategies of the 2014 – 2017 Comprehensive HIV/AIDS Services Plan that address *Health People 2020* Objectives are found in Appendix F.

SECTION 3-D: HOW THIS PLAN REFLECTS THE TEXAS STATE HEALTH PLAN

The 2012 – 2014 Texas HIV Plan was reviewed during development of the 2013 Comprehensive HIV Needs Assessment. It was discussed with Texas DSHS staff, and results used to plan and implement the out-of-care interviews for that assessment.

The Texas HIV Plan Update for 2014 – 2015 identified the Spectrum of HIV Engagement which is reflected in the Treatment Cascades.

The DSHS spectrum is organized around six domains:

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

This Comprehensive HIV Services Plan addresses all of these domains.

- Domains one through three are addressed via collaboration with community based prevention and counseling and testing providers (Goal 4).
- Domain 4, linkage to care after diagnosis, is supported by strong case management (Goal 1) and HIV medical care (Goal 3).
- Domains 5 and 6 are supported by Goals 1, 2 and 3 which focus on case management, medical care and behavioral health, all of which are critical to maintenance in medical care and treatment compliance.

[13] http://www.healthypeople.gov/2020/about/default.aspx. Retrieved 2-18-2014.

SECTION 3-E: HOW THIS PLAN IS COORDINATED WITH AND ADAPTS TO CHANGES THAT WILL OCCUR WITH THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT (ACA).

Many questions and concerns arose with the implementation of the Affordable Care Act. Texas did not expand Medicaid and this left a large gap for Texans at 135-138% and below Federal Poverty Limit (FPL) without insurance coverage, especially men and women without children or disabilities. Although people at 135-138% and lower FPL can access the marketplace, www.healthcare.gov, to determine eligibility they are not eligible for the subsidies to assist in paying the premiums.

Texas chose not to implement or partner with the federal government for the Marketplace Health Insurance Exchange so the federal government (through Center for Medicaid/Medicare Services – CMS) set up the Marketplace for Texas. The Marketplace, especially the federally implemented ones in various states, received negative media coverage due to many delays and unavailability of the website. But more impactful to the HSDAs was determining what plans were best for providing the most coverage for clients so that each client was covered for:

- Expensive HIV medications, prophylactic medications, chronic illness medications (i.e.: diabetes, hypertension, high cholesterol/triglycerides, etc), other medical conditions (i.e.: chemotherapy, hepatitis, gastro related, etc.) and medication for mental illness (i.e.: depression, anxiety, etc.).
- Infectious disease specialist (ID), primary medical care, and other medical specialties such as gynecology, radiology, oncology, ophthalmology, gastroenterology, dermatology, etc.
- Laboratory services, especially for CD4 and Viral Load which are crucial for HIV medication regiments.
- Hospitalization and ambulance that are not covered under Ryan White or State Services.
- Other medical concerns such as dental and substance abuse inpatient rehabilitation.

Another main concern is the cost of the health insurance, especially the insurance premiums, several very high even with the subsidy, and deductibles that the Ryan White and State Services pays for eligible clients.

The AA and subcontractors have been monitoring changes that will occur with the Affordable Care Act and preparing for them. Since Texas is not a Medicaid expansion state, it is estimated that 10% to 12% of Texas Ryan White clients will be impacted in 2014.

There are still many unanswered questions and concerns that cannot be answered for many months when enough data is gathered after more insurance plans are in effect and some for at least two years when enough national data is gathered to determine how to best use Ryan White and State Services.

Describe how the comprehensive plan addresses the goals of the National HIV/AIDS Strategy (NHAS), as well as which specific NHAS goals are addressed.

The Administrative Agency is fully supportive of the National HIV/AIDS Strategy (NHAS). The NHAS vision, goals and strategies have been translated to the regional priorities that will be enacted in this 2014 – 2017 Comprehensive HIV Health Services Plan.

The NHAS provides the framework and foundation for this Plan. The AA considered NHAS goals, strategies and outcomes during their deliberations. Table 3.1 presents the NHAS goals and strategies and PanWest-West Texas goals that support these.

Table 3.1
National HIV/AIDS Strategy Addressed
With the PanWest-West Texas 2014 Comprehensive HIV Services Plan

NHAS Strategies	***PanWest-West Texas CHSP***
Goal: Reduce New HIV Infections	
• Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.	These strategies are addressed collaboratively in Goal 4
• Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.	
• Educate all Americans about the threat of HIV and how to prevent it.	
Goal: Increase Access to Care and Improving Health Outcomes for PLWHA	
• Establish a seamless delivery system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.	These strategies are addressed in Goals 1, 2, and 3
• Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for PLWHA.	
• Support PLWHA with co-occurring health conditions and those who have challenges meeting basic needs, such as housing.	
Goal: Reduce HIV-Related Disparities and Health Inequities	
• Reduce HIV-related mortality in communities at high risk for infection.	These strategies are addressed collaboratively in Goal 4
• Adopt community-level approaches to reduce HIV infection in high-risk communities.	
• Reduce stigma and discrimination against people living with HIV.	

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

SECTION 4-A: MONITORING PROGRESS

The 2014-2017 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining start and completion dates, appropriate reporting intervals and status reports. Some strategies 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 once 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 4-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.

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

SECTION 4-C: IMPACT ON PRIORITY SETTING AND ALLOCATIONS

In developing the 2014 - 2017 Comprehensive HIV Health Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system, but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement, but will not be a direct dollar cost. Finally, some of the strategies, 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.