PanWest-West Texas

2013 Ryan White Part B Comprehensive Needs Assessment

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ACRONYMS

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

EXECUTIVE SUMMARY

This 2013 PanWest-West Texas Ryan White Comprehensive Needs Assessment was designed to fulfill federal and state mandates and provide critical information for priority-setting and decision-making.

- The PanWest Region includes three HIV Service Delivery Areas (HSDA):
  - Amarillo HSDA
  - Lubbock HSDA
  - Permian Basin HSDA
- The West Texas area is also included in this analysis and is composed of one HSDA, El Paso.
- Together these four HSDAs comprise the 64 farthest west counties in Texas, ranging from the Panhandle to the Mexico border. The total population is approximately 2.1 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 counties with the lowest median incomes and the highest federal poverty levels include Potter, Hale and El Paso Counties.
- Randall County has the highest level of education of all HSDAs. Ector County and El Paso County also have high percentages without a high school diploma, 28% and 26%, respectively.

Regional Epidemic

In 2012, the Pan West Region had a total of 1,361 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 West Texas 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 West Texas.
- 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 West Texas 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 a smaller percentage with MSM than West Texas, ranging between 51% and 55% compared to 68% in in West Texas.
- IDU transmission mode is a relatively small percentage of infections. The rate, however, is higher in PanWest than West Texas.
- Heterosexual transmission mode ranges from 13.6% in Lubbock HSDA to 21% in Amarillo HSDA.

Special Populations

Men Who Have Sex with Men

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

- Younger (under age 30) MSM face a different environment than older MSM and long term survivors. While MSM identity is becoming less closeted, it is still very difficult for some MSM to accept.
    - MFactor focus groups, through the City El Paso Department of Public Health, provided detail on the struggles associated with "coming out" to family.
    - Out-of-care interviews highlighted difficulties accepting HIV status, when MSM learn of partners' infidelities upon diagnosis.
    - Out-of-care consumers and MFactor focus groups also discussed misunderstanding the implications of an HIV diagnosis and resultant risk behaviors.
    - Young MSM use of technology can support access to care.

Hispanic PLWHA

- Issues that result in barriers to Hispanic PLWHA accessing care continue:
    - Machismo resulting in closeted status and denial
    - Religious dogma leading to denial and guilt
    - Lack of support due to closeted status with family and friends
    - Needed education in the community to understand HIV transmission
    - Less acceptance among lower income population

Out-of-Care PLWHA

- Out-of-care consumers have many reasons for not accessing HIV medical care. They are as varied as the individuals themselves.
    - Disclosure concerns, particularly at the time of diagnosis
    - Conflicting demands on time, particularly for the working poor and women
    - Financial issues due to lack of insurance
- Individual, personalized access/treatment plans should be developed for each consumer at the time of diagnosis and revised as his/her situation/acceptance of the diagnosis changes.

Key Findings and Recommendations

The following presents Comprehensive Needs Assessment key findings and associated recommendations. They are comprehensive and should be prioritized in light of available personnel, resources and funding.

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 my 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 one West Texas clinic's 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 women 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/clinician 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 HIV positive patients. Consider recruiting physicians dedicated to treating HIV positive people 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 PAP smears, at all Ryan White funded HIV medical care clinics. Provide needed funding for the PAP 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 should 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 system 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/Project Vida collaboration which will provide primary care and mental health services.

3.3. Identify GLBT "informed" 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 demonstrated 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 HSDA's 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 needed 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 of medication access. 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. 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

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

7. Substance Abuse Treatment—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:
7.1. Include the HEI case manager in each HSDA as part of the clinical treatment team.
7.2. 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.

8. 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:
8.1. 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.
8.2. 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.

9. 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:
9.1. Continue to actively participate in the **El Paso Community Mobilization Collaborative.**
- Share information about the 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.

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

10. 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, LGBT identity, and mental health disorders can also be stigmatizing.

Stigma can be particularly severe in small cities and rural towns.

Recommendations:
10.1. 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.[1]

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

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

1. INTRODUCTION

Needs assessment is an essential tool for Ryan White Programs. Legislative mandates and the Health Services Resources Administration (HRSA) HIV/AIDS Bureau expect assessments of persons living with HIV/AIDS (PLWHA) service needs to be determined through: (1) consulting with PLWHA using both structured, quantitative surveys and qualitative focus groups or interviews; (2) identification of populations with severe needs and co-morbidities as indicated from epidemiological data; and (3) evaluation of the effectiveness of available resources and services in meeting needs. In addition, identification and engagement of PLWHA who know their status and are not receiving primary medical care ("out-of-care") is an essential task. This 2013 PanWest-West Texas Ryan White Comprehensive Needs Assessment was designed to fulfill federal and state mandates and provide critical information for priority-setting and decision-making.

The PanWest Region includes three HIV Service Delivery Areas (HSDA): Amarillo HSDA, Lubbock HSDA and Permian Basin HSDA. The West Texas HSDA is also included in this analysis. Together these four HSDAs comprise the farthest west counties in Texas, ranging from the Panhandle to the Mexico border.

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

Figure 1.1

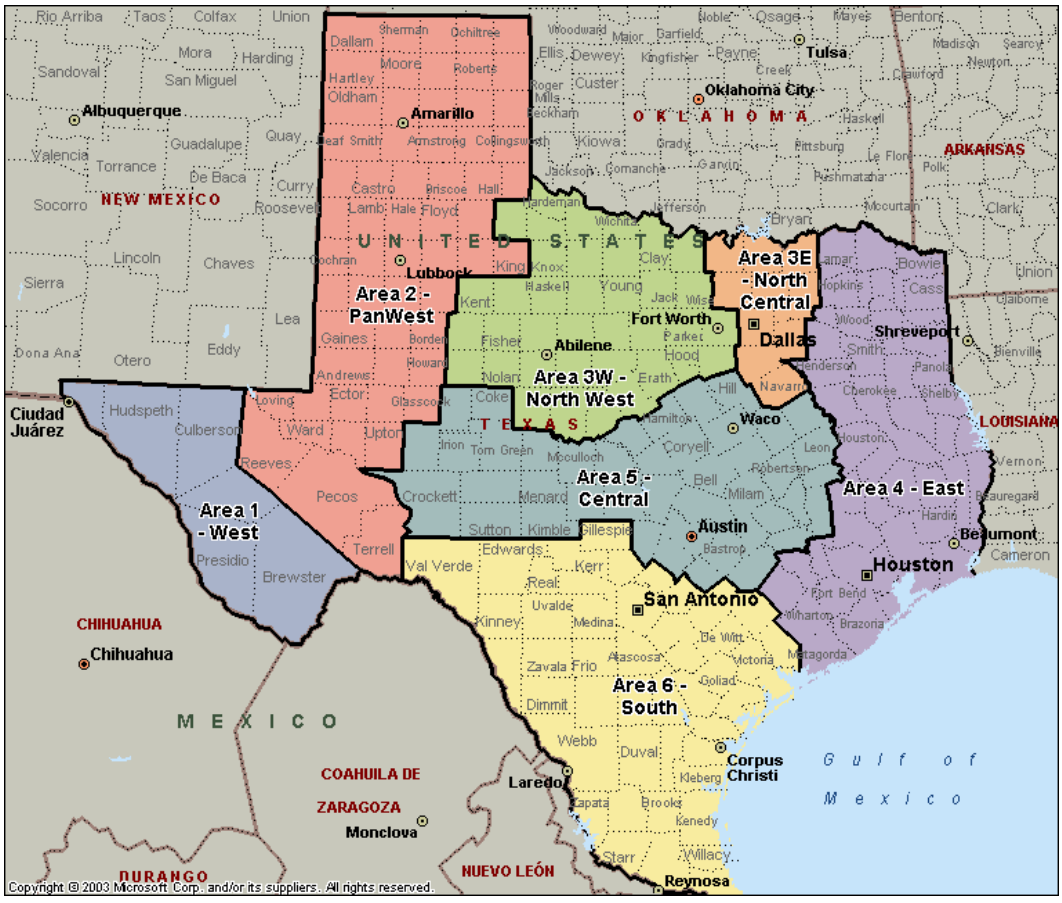


Table 1.1 presents the 64 counties making up the four HSDAs. The total population of the region was over 2.1 million in 2012. Each PanWest HSDA has one key Ryan White provider, which are listed in the table below. In West Texas, the two organizations receiving Ryan White Part B HIV medical care funds are also presented.

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 & Texas Tech Care Clinic (TTUHSC)
Total PanWest and West Texas Regions—64 Counties	2,144,059	

Population Data Source: U.S. Census Bureau State and County QuickFacts, 2012

2. METHODOLOGY

DEMOGRAPHIC PROFILE

The demographic profile is developed from U.S. Census Bureau data. A population overview of all 64 counties is found in **Appendix A.** To provide the most relevant information, the one or two most populous counties in each HSDA are identified with detailed demographic data.

EPIDEMIOLOGIAL PROFILE

The Texas Department of State Health Services (DSHS) has recently finalized the 2012 surveillance data, and it was used for this profile. The specific components of the epidemiological profile include:

- People living with HIV/AIDS (prevalence). Includes age, gender, race/ethnicity and transmission mode. Absolute numbers and rates provide a basis for comparison. In addition, trend data allows identification of changes in the epidemic.
- People recently diagnosed with HIV/AIDS (incidence). Includes age, gender, race/ethnicity and transmission mode. Infection rates and trends are identified.
    - DSHS provided "late to care" data which identifies consumers who delayed HIV diagnosis. It includes those who converted from HIV to AIDS within one month and within one year of initial diagnosis. DSHS has recently enhanced their methodology resulting in increases in some areas.
- Treatment Cascade. DSHS has developed treatment cascades for each HSDA. These estimate the breadth of the HIV epidemic, document the number of PLWHA receiving HIV medical care (met need), identify the number not receiving HIV medical care (unmet need), document linked to HIV medical care after diagnosis as well as maintenance in care over time.
- Sexually Transmitted Diseases. Include number, rate and trend data for the sexually transmitted diseases of chlamydia, gonorrhea and syphilis.

KEY INFORMANT INTERVIEWS

Twenty-six key informant interviews were conducted during project initiation as well throughout the course of the needs assessment. Interviews included

- Ryan White funded providers including agency directors, case managers and physicians
- Prevention, outreach and counseling/testing staff in each HSDA
- Leadership of non-Ryan White funded organizations that address the needs of PLWHA
- Leadership and case managers at behavioral health organizations in the region
- Texas Department of State Health Services (DSHS) staff, particularly in relation to healthcare reform and the Affordable Care Act (ACA).

These interviews provided insight throughout the needs assessment. Specifically, interviews with:

- Ryan White funded providers laid the foundation for developing the consumer survey.
- Behavioral health providers were critical in the behavioral health service assessment.
- AIDS Service Organizations/non-Ryan White funded service providers confirmed information for Ryan White personnel, identified additional needs and areas to explore.

- Prevention, outreach and counseling and testing provided insight into the needs of the newly diagnosed, issues related to linkage to care after diagnosis, insight into out-of-care issues, and risk factors present in the region.
- Expectations regarding the impact of healthcare reform.

FOCUS GROUP

One focus group was conducted with seven case managers from La Fe CARE Center. Perceptions of clients' most significant needs, access barriers and service delivery issue were discussed.

IN-CARE CONSUMER SURVEY

A total of 328 consumer surveys were conducted at PanWest and West Texas provider locations.

- Survey Monkey ™ was used for both administration and analysis. Availability of computers and method of survey administration varied by agency as follows:
  - La Fe CARE Center has a computer lab with 16 computers and a tutor available. All of their surveys were conducted in the computer lab with the tutor assisting as necessary.
  - TTUHSC case manager assisted clients in completing the survey via computer.
  - On-site BAS clients completed a paper survey with volunteer or case manager assistance. These surveys were entered into the electronic file. Case managers also conducted surveys by telephone.
  - Project CHAMPS case managers conducted surveys on-site or via telephone. The paper surveys used were entered into the electronic file.
  - PASO conducted most surveys during a three day on-site event. Some were paper and others were electronic. Translators were provided for Asian/Burmese clients in efforts to include their input.
- The survey was available in English and Spanish.
- A $10 WalMart gift card was provided as an incentive for survey completion.

Consumers completing surveys at PanWest HSDA providers range from 40 at BA to 81 at Project CHAMPS. West Texas respondents included 47 at TTUHSC and 96 at La Fe CARE. Table2.1 presents the number of and percentage of survey participants in each HSDA. This table demonstrates that although West Texas has the largest number of completed surveys, this is less than the percentages of both Ryan White clients and 2012 PLWHA in other HSDAs.

Table 2.1
Number and Percentage of Survey Participants from each HSDA

	Completed Surveys		Ryan White Clients (per 2012 ARIES)		2012 PLWHA (per DSHS Epidemiology)	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
West Texas HSDA	143	44.6%	1,073	56.3%	1,619	58%
Permian Basin HSDA	40	12.2%	269	14.1%	404	14%
Lubbock HSDA	81	24.7%	296	15.5%	394	14%
Amarillo HSDA	64	19.5%	269	14.1%	389	14%
Total	**328**	**100.0%**	**1,907**	**100.0%**	**2,806**	**100.0%**

It should be noted that the analysis of some of the consumer survey responses cannot be performed at the HSDA level due to cell sizes of five respondents or less.

OUT OF CARE CONSUMER INTERVIEWS

The "2012 – 2014 Texas HIV Plan" provides an overview of out-of-care consumers' access barriers. This information provided a basis for in-depth telephone interviews which were designed to expand on available information by identifying motivation, barriers and reasons for eventual linkage to care.

Both providers and outreach workers were asked to identify and refer consumers that met the following expanded out-of-care definition:

1. Traditional HRSA definition: no CD4 or viral load tests, no antiretroviral medication and no HIV medical care for the last 12 months.
2. Having been diagnosed between 2010 and 2013, consumers who did not link to care within six months of diagnosis. These consumers may currently be in care.
3. Having been diagnosed between 2010 and 2013, consumers who initially linked to care but dropped out of care for at least six months. These consumers may now be back in care.
4. Consumers who dropped out of care for at least 12 months but are now back in care with preference for consumers who have been back in care for no more than 18 months.

Consumers received a $25 WalMart gift card for completing the interview.

The goal was to conduct 40 out-of-care interviews, but only 29 were completed.

- Ryan White funded providers referred 25 of these consumers from their case load. Four referred consumers did not complete the interview.
- Non-Ryan White funded outreach workers, prevention/counseling and testing service providers were offered a personal incentive of $50 for each out-of-care consumers referred. Despite this incentive, only four additional consumers were referred.

BEHAVIORAL HEALTH ANALYSIS

Mental health disorders and substance abuse can interfere with HIV medical treatment compliance. Therefore, appropriate mental health therapy and necessary substance abuse treatment are 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.
- Similarly, substance abuse treatment services are reportedly accessible, but few consumers access them.
    - In the Lubbock HSDA, case managers reported that 75% of clients need mental health and/or substance abuse treatment, but most refuse.
    - PASO staff estimates that 25% of their clients are using mental health services and another 25% more need it.
    - Another Amarillo provider remarked, "A lot of PLWHA have a substance abuse issue…everyone is using some type of substance."
    - El Paso providers report making referrals, but clients often do not access services.

The administrative agency is interested in developing services that meet behavioral health needs and are appropriately utilized.

REGIONAL HEALTH PLAN ANALYSIS

The Medicaid 1115 waiver refers to a section of the Social Security Act that allows the Secretary of the Department of Health and Human Services to waive some or all of these requirements for: 'experimental, pilot, or demonstration projects which are likely to assist in promoting objectives of the act.' [2]" In Texas, the Medicaid1115 waiver is a "demonstration project to expand coverage." States have some flexibility in designing and running their Medicaid programs, but they have to comply with a range of federal standards.

A component of Texas' Medicaid 1115 waiver required the development of Regional Health Partnerships (RHP) throughout the state. These RHPs were required to conduct a need assessment for their region and develop plans to increase access to needed services. Acute care hospitals led these partnerships, and they often included psychiatric hospitals, large community providers and city/county health departments.

Because the RHP five year plans will impact access to care and services, they have been reviewed for this needs assessment. Planned programs that will impact PLWHA are outlined below. Please note: the regional boundaries for the RHPs are different from the boundaries of the HSDAs.

EL PASO DEPARTMENT OF PUBLIC HEALTH MSM FOCUS GROUPS

In winter 2012 and spring 2013 the El Paso Department of Public Health HIV Surveillance and MFactor Programs conducted five focus groups with gay/bisexual men and transgendered individuals. HIV status was not a determinant of participation. Groups included:

Table 2.2
Focus Groups

Group	Number	Date
Spanish speaking	7	October 15, 2012
Twenty-nine years of age and younger	3	November 8, 2012
Thirty years of age and older	2	November 10, 2012
Transgender	3	December 4, 2012
Twenty-nine years of age and younger	12	March 12, 2013

The written notes from these groups have been provided for this needs assessment. As appropriate and informative, finding are integrated into this report.

[2] Texas State Report page 28.

3. REGIONAL DEMOGRAPHIC PROFILE

POPULATION CHANGE AND DENSITY

The 64 counties of the PanWest and West Texas regions occupy 84,000 square miles with a total population of 2,144,059. Due to the large number of rural counties, this needs assessment will focus on the counties with largest populations and largest number of PLWHA.

Considering the HSDAs of the PanWest region:

- Lubbock County is the most populous in the PanWest region with 311.3 people per square mile in 2010.
- Potter, Midland and Ector counties range between 138 and 146 people per square mile.
- The six county West Texas region abuts the Mexico border and is 23,458 square miles with El Paso County being the most populous, with 790.6 residents per sq. mile.

Table 3.1
Population Change 2000-2012
Population Density 2012
Key Counties

	2000 Population	2012 Population	% Change	2010 Population Density*
Amarillo HSDA				
Potter County	113,546	122,335	7.74%	133.3
Randall County	104,312	125,082	19.91%	132.4
Lubbock HSDA				
Hale County	36,602	36,385	0.59%	36.1
Lubbock County	242,628	285,760	17.78%	311.3
Permian Basin HSDA				
Ector County	121,123	144,325	19.16%	152.8
Midland County	116,009	146,645	26.41%	152
West Texas HSDA				
El Paso County	679,622	827,398	21.74%	790.6

Source: U.S. Census Bureau State and County QuickFacts, 2012; Census 2000 Summary File
**Population Density is persons per square mile*

GENDER

Considering gender, little variation exists in key counties. Males range from 52.4% in Hale County to 48.7% in Randall and El Paso counties.

Table 3.2
Population Gender
Key Counties
2011

	Male	Female
Amarillo HSDA		
Potter County	51.3%	48.7%
Randall County	48.7%	51.3%
Lubbock HSDA		
Hale County	52.4%	47.6%
Lubbock County	49.3%	50.7%
Permian Basin HSDA		
Ector County	49.6%	50.4%
Midland County	49.2%	50.8%
West Texas HSDA		
El Paso County	48.7%	51.3%

Source: U.S. Census Bureau ACS 2011
**Hale County:2009-2011 ACS 3-year estimate*

AGE

Age does not vary significantly across the regions.

- The under 20 age range varies for 33% in El Paso County to 28% in Randall County
- The 20 – 24 age range is highest in Lubbock County at 13% and lowest in Midland County at 7%. This could be related to the presence of Texas Tech University in Lubbock County.
- The 25 to 34, 35 to 44 and 45 to 54 age ranges are all similar.
- The 55 and older age range varies from 20% in El Paso County to 24.5% in Randall County.

Table 3.3
Population Age
Key Counties
2011

Age						
	Under 20	**20-24**	**25-34**	**35-44**	**45-54**	**55+**
Amarillo HSDA						
Potter County	30.9%	7.2%	14.8%	12.8%	13.0%	21.1%
Randall County	28.0%	7.9%	13.3%	12.7%	13.5%	24.5%
Lubbock HSDA						
Hale County	32.1%	7.8%	13.5%	12.0%	12.9%	21.7%
Lubbock County	29.1%	12.8%	14.1%	11.2%	11.7%	21.2%
Permian Basin HSDA						
Ector County	32.3%	8.0%	14.9%	11.5%	13.1%	20.3%
Midland County	30.2%	6.9%	15.5%	11.8%	13.7%	22.0%
West Texas HSDA						
El Paso County	33.0%	8.1%	13.6%	12.9%	12.4%	19.8%

Source: U.S. Census Bureau ACS 2011.
**Hale County:2009-2011 ACS 3-year estimate*

INCOME AND POVERTY

The counties with the lowest median household incomes have the highest percentages of residents below the federal poverty level (FPL).

- These counties include Potter County, Hale County and El Paso County.
- These counties have median incomes below the Texas and U.S. average and FPL above the State and Randall and Midland counties have median household incomes above the Texas and U.S. averages and lower percentages below the FPL than found in the State and the U.S.

Table 3.4
Median Household Income and
Population Below Federal Poverty Level
Key Counties, Texas and U.S.
2011

County	Median Household Income	Below Federal Poverty Level
Amarillo HSDA		
Potter County	$35,956	22.1%
Randall County	$57,183	9.8%
Lubbock HSDA		
Hale County	$36,669	22.3%
Lubbock County	$43,716	20.6%
Permian Basin HSDA		
Ector County	$49,967	14.0%
Midland County	$54,330	11.7%
West Texas HSDA		
El Paso County	$39,573	24.7%
Texas and U.S.		
Texas	$49,392	15.9%
U.S.	$50,502	18.5%

Source: U.S. Census Bureau ACS 2011
**Hale County:2009-2011 ACS 3-year estimate*

EDUCATIONAL ATTAINMENT

Educational attainment varies widely throughout the region.

- Randall County has the highest level of education of all HSDAs. They have the lowest percentage without a high school diploma (7%) and the highest percentage with a college degree or higher (31%).
- Hale County has the highest percentage without a high school diploma (31%) and the lowest percentage with a college degree (12%).
- Ector County and El Paso County also have high percentages without a high school diploma, 28% and 26%, respectively.
- This compares to Texas with 19% without a high school diploma and 26% with a college degree, and the U.S. with 14% without a high school diploma and 28.5% with a college degree.

Table 3.5
Educational Attainment
Key Counties, Texas and U.S.
2011

	No High School Diploma	High School Graduate/GED	Some College, Associate's Degree	Bachelor's Professional, or Graduate Degree
Amarillo HSDA				
Potter County	23.1%	28.2%	33.1%	15.6%
Randall County	7.1%	22.0%	39.7%	31.1%
Lubbock HSDA				
Hale County	31.3%	29.6%	27.0%	12.0%
Lubbock County	16.0%	26.2%	30.0%	27.8%
Permian Basin HSDA				
Ector County	27.6%	27.9%	31.6%	15.0%
Midland County	19.5%	24.0%	33.3%	23.2%
West Texas HSDA				
El Paso County	26.3%	23.8%	29.3%	20.7%
Texas and U.S.				
Texas	18.9%	25.5%	29.1%	26.4%
U.S.	14.1%	28.4%	29.0%	28.5%

Source: U.S. Census Bureau ACS 2011
**Hale County:2009-2011 ACS 3-year estimate*

4. EPIDEMIOLOGICAL PROFILE

In 2012, the PanWest Region had a total of 1,361 PLWHA.

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

This compares to 1,843 people living with HIV/AIDS in the West Texas region, almost all of whom live in El Paso County.

For a detailed breakdown of PLWHA and HIV infection rate by county, refer to Appendix B.

Table 4.1
Total People Living with HIV/AIDS
By HSDA and Region
2012

HSDA/Region	Number	% of Total
Amarillo	434	13.5%
Lubbock	435	13.6%
Permian Basin	492	15.4%
PanWest Region	**1,361**	**42.5%**
West Texas	1,843	57.5%
Total	**3,204**	**100.0%**
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch		

Table 4.2
People Living with HIV/AIDS
Select Counties
2012

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%
West Texas HSDA Total	**1,843**	
El Paso County	1,824	99.0%
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch		

HIV INCIDENCE

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 West Texas HSDA.

- The Amarillo HSDA has the fewest new cases and the lowest rate per 100,000 residents in 2009 through 2012. In the latter year, this HSDA has 20 new diagnoses and a rate of 4.6/100,000.
- The Lubbock HSDA had 32 new diagnoses in 2012, and a rate of 7.6/100,000. This was the second highest number of diagnoses in the past six years, surpassed by 2009 when 37 new PLWHA were diagnosed.
- Permian Basin has the highest number of new diagnoses in the past six years in 2010 and 2012 with 38. The rate per 100,000 declined in 2012 due to population increases.
- West Texas had increasing diagnoses between 2008 and 2012, with 121 new cases in the latter year for a rate of 14.2/100,000.

Table 4.3
New HIV Diagnoses
2007-2012

	2007		2008		2009		2010		2011		2012	
HSDA/Region	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**
Amarillo	23	5.52	25	5.96	22	5.19	21	4.91	25	5.78	20	4.59
Lubbock	20	5.03	19	4.75	37	9.10	23	5.59	28	6.72	32	7.64
Permian Basin	17	4.29	29	7.16	25	6.01	38	9.10	31	7.30	38	8.68
West Texas	118	15.12	79	9.94	82	10.10	114	13.80	106	12.57	121	14.20

Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch
Rates are per 100,000 population.

PLWHA 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 West Texas.
- Black/African-American PLWHA are similar percentages throughout the PanWest region, ranging from 13% in the Amarillo HSDA to 15% in the Lubbock HSDA.
- In West Texas, 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 West Texas to 29% in Amarillo.

Table 4.4
People Living with HIV/AIDS by Race/Ethnicity
HSDA and Region
2012

HSDA/Region	White/ Caucasian		Black/African-American		Hispanic/ Latino		Other/ Unknown		Total
	#	%	#	%	#	%	#	%	#
Amarillo	221	50.9%	56	12.9%	125	28.8%	32	7.4%	434
Lubbock	177	40.7%	66	15.2%	179	41.1%	13	3.0%	435
Permian Basin	152	30.9%	68	13.8%	248	50.4%	24	4.9%	492
PanWest Region	550	40.4%	190	14.0%	552	40.6%	69	5.1%	1,361
West Texas	160	8.7%	110	6.0%	1,557	84.5%	16	0.9%	1,843
Total	710	22.2%	300	9.4%	2,109	65.8%	85	2.7%	3,204

Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch

PLWHA 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.

Table 4.5
People Living with HIV/AIDS by Gender
HSDA and Region
2012

HSDA/Region	Female		Male		Total
	#	%	#	%	#
Amarillo	96	22.1%	338	77.9%	434
Lubbock HSDA	84	19.3%	351	80.7%	435
Permian Basin	99	20.1%	393	79.9%	492
PanWest Region	279	20.5%	1,082	79.5%	1,361
West Texas	235	12.8%	1,608	87.2%	1,843

Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch

PLWHA AGE

Considering PLWH by age, the age group percentages demonstrate limited variation across the four HSDAs.

- The 15 to 24 age group percentages range from 3.0% in the Amarillo HSDA to 6.9% in the Lubbock HSDA.
- The 25 to 34 age group percentages range from 14.5% in the Amarillo HSDA to 18.3% in the Permian Basin HSDA.
- The 35 to 44 age group percentages range from 27.1% in the Lubbock HSDA to 31.7% in the Permian Basin HSDA.
- The 45 to 54 age group percentages range from 30.5% in the Permian Basin HSDA to 33.5% in West Texas.
- The 55 and older age group percentages range from 15.4% in the Permian Basin HSDA to 19.4% in the Amarillo HSDA.

Table 4.6
People Living with HIV/AIDS by Age
HSDA and Region
2012

HSDA/Region	15 - 24 Years		25 - 34 Years		35 - 44 Years		45 - 54 Years		55+ Years	
	#	%	#	%	#	%	#	%	#	%
Amarillo	13	3.0%	63	14.5%	134	30.9%	139	32.0%	84	19.4%
Lubbock	30	6.9%	74	17.0%	118	27.1%	135	31.0%	78	17.9%
Permian Basin	17	3.5%	90	18.3%	156	31.7%	150	30.5%	76	15.4%
PanWest Region	60	4.4%	227	16.7%	408	30.0%	424	31.2%	238	17.5%
West Texas	92	5.0%	268	14.5%	504	27.3%	617	33.5%	354	19.2%
Total	152	4.7%	495	15.4%	912	28.5%	1041	32.5%	592	18.5%

Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch

PLWHA TRANSMISSION MODE

MSM is the most frequent transmission mode in all four HSDAs.

- The PanWest HSDAs have a smaller percentage with MSM than West Texas, with between 51% and 55% compared to 68% in in West Texas.
- 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.

Table 4.7
People Living with HIV/AIDS by Transmission Category
HSDA and Region
2012

HSDA/Region	MSM		IDU		MSM/IDU		Heterosexual		Pediatric		Total
	#	%	#	%	#	%	#	%	#	%	#
Amarillo	228	52.6%	71	16.4%	42	9.6%	91	20.9%	2	0.5%	434
Lubbock	243	55.9%	75	17.1%	55	12.6%	59	13.6%	2	0.5%	435
Permian Basin	250	50.8%	77	15.7%	45	9.2%	115	23.3%	4	0.8%	492
PanWest Region	**722**	**53.0%**	**223**	**16.4%**	**142**	**10.4%**	**265**	**19.4%**	**8**	**0.6%**	**1,361**
West Texas	1,252	67.9%	147	8.0%	93	5.0%	327	17.8%	14	0.8%	1,843
Total	**1,973**	**61.6%**	**370**	**11.6%**	**235**	**7.3%**	**592**	**18.5%**	**22**	**0.7%**	**3,204**
Texas	**41,434**	**56.8%**	**8,889**	**12.2%**	**4,346**	**6.0%**	**17,389**	**23.8%**	**745**	**1.0%**	**72,932**

Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch

Between 2007 and 2011, DSHS calculated unmet need (percentage of PLWHA not receiving HIV medical care) by HSDA with detail by disease status, gender, race/ethnicity, age and exposure mode.

- Larger percentages of people with AIDS are in-care than out-of-care. Conversely, more people with HIV have an unmet need for medical 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.

Table 4.8
Unmet Need
PanWest and West Texas HSDAs
2007-2011

	Amarillo		Lubbock HSDA		Permian Basin HSDA		El Paso HSDA	
	#	%	#	%	#	%	#	%
TOTAL	116	28	108	28	145	33	545	31
DISEASE STATUS								
HIV	69	41	61	31	70	41	257	36
AIDS	47	19	47	26	75	28	288	28
GENDER								
Female	23	26	24	31	17	20	70	30
Male	93	29	84	27	128	36	475	31
RACE/ETHNICITY								
White	68	30	42	25	36	22	56	33
Black	16	30	16	26	19	28	43	40
Hispanic	27	25	48	33	87	42	445	31
AGE								
13 to 24	5	45	6	38	3	19	24	32
25 to 34	21	33	22	33	29	36	101	37
35 to 44	38	32	38	34	44	32	178	35
45 to 54	29	20	24	20	46	36	158	27
55+	23	29	18	26	23	29	79	25
EXPOSURE CATEGORY								
MSM	44.7	21	50.8	25	70.2	31	351.5	30
IDU	24.7	36	17.9	28	28.6	39	59.2	41
MSM/IDU	20.4	47	16.6	29	15.8	35	24.2	28
Heterosexual	26.2	30	21.7	38	30.4	31	101.1	31

Source: Texas DSHS

SEXUALLY TRANSMITTED DISEASE EPIDEMIOLOGY

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

Chlamydia

Chlamydia is the most prevalent sexually transmitted disease in both PanWest and West Texas, and increases in incidence are seen in many of the key counties between 2007 and 2011.

- Potter County has the highest 2011 chlamydia rate, 756.4/100,000. Total Potter County cases over the last five years ranged from 876 in 2007 to 1,105 in 2010.
- Lubbock County had a significant increase in chlamydia cases and rates between 2007 and 2011, with cases increasing by 75% during this time. The 2011 rate of 719.5/100,000 was the second highest among the key counties of the region.
- Both Ector and Midland counties also experienced steady increases between 2007 and 2011. The former increased by 55% and the latter by 70%.
- El Paso County had the highest total number of cases each year, with increases form 2,954 cases in 2007 to 4,512 in 2011. This is a 53% increase. The incidence rate is below other counties at 576.6/100,000 in 2011.

Table 4.9
Chlamydia Cases and Rates
Key Counties
2007 through 2011

HSDA/County	2007		2008		2009		2010		2011	
	Cases	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***
Amarillo HSDA										
Potter	876	720.2	1103	904.9	1043	834.3	1105	874.5	966	756.4
Randall	219	189.4	265	227.3	379	318.8	346	287.6	314	257.9
Lubbock HSDA										
Hale	197	554.7	192	542.9	188	505.7	217	584	200	538.6
Lubbock	1106	425.0	1411	534.9	1687	634.3	1834	684.6	1940	719.5
Permian Basin HSDA										
Ector	522	407.1	632	483	676	513.9	830	624.9	813	606.3
Midland	476	378.7	710	551.6	727	567.5	823	634.5	812	618.2
West Texas HSDA										
El Paso	2954	395.2	3344	446.7	3421	447.9	4356	563.4	4512	576.6

* Rates represent cases per 100,000 population
Source: TDSHS, TB/HIV/STD Epidemiology and Surveillance Branch 2013

Gonorrhea

Key counties with high chlamydia rates, also tend to have high gonorrhea rates.

- Potter County had the highest gonorrhea rate in 2011 with 214.5 cases/100,000 population. This represents a declining trend from 2007 when the incidence rate was 382.3/100,000.
- Lubbock County had a steady increase in gonorrhea cases and rates between 2007 and 2011, with 688 cases and a rate of 255.1/100,000 in the latter year.
- Ector and Midland counties had similar numbers of cases and rates which varied during the five year period. In 2011 the cases and rates were lower than all other years except 2007.
- El Paso County had more gonorrhea cases than other key counties in 2011, but a relatively low rate of 95.5/100,000.

Table 4.10
Gonorrhea Cases and Rates
Key Counties
2007 through 2011

HSDA/County	2007		2008		2009		2010		2011	
	Cases	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***
Amarillo HSDA										
Potter	465	382.3	412	338	383	306.4	377	298.4	274	214.5
Randall	78	67.5	89	76.3	89	74.9	69	57.4	52	42.7
Lubbock HSDA										
Hale	41	115.4	31	87.7	23	61.9	39	105	38	102.3
Lubbock	389	149.5	429	162.6	488	183.5	618	230.7	688	255.1
Permian Basin HSDA										
Ector	164	127.9	220	168.1	201	152.8	214	161.1	188	140.2
Midland	162	128.9	231	179.5	228	178.0	248	191.2	190	144.7
West Texas HSDA										
El Paso	395	52.8	539	72	503	65.9	803	103.9	747	95.5

* Rates represent cases per 100,000 population
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch 2013

Syphilis

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.
Potter County had a high syphilis rate in 2007 and 2008, but it declined significantly in 2009 through 2011.

West Texas has the largest number of syphilis cases, but the rate is not as high as other counties.

Table 4.11
Syphilis Cases and Rates
Key Counties
2007 through 2011

HSDA/County	2007		2008		2009		2010		2011	
	Cases	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***
Amarillo HSDA										
Potter	7	5.8	5	4.1	1	0.8	1	0.8	0	0
Randall	3	2.6	1	0.9	0	0	2	1.7	1	0.8
Lubbock HSDA										
Hale	0	0	0	0	0	0	1	2.7	3	8.1
Lubbock	5	1.9	20	7.6	20	7.5	13	4.9	12	4.5
Permian Basin HSDA										
Ector	1	0.8	0	0	5	3.8	3	2.3	2	1.5
Midland	0	0	0	0	1	0.8	0	0	1	0.8
West Texas HSDA										
El Paso	10	1.3	7	0.9	13	1.7	16	2.1	14	1.8

* Rates represent cases per 100,000 population.
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch 2013

SPECIAL POPULATIONS

In-Care Consumers

ARIES data, in-care consumer survey responses and key informant insights, provides profiles of in-care consumers in each of the four HSDAs.

Amarillo HSDA

Overview
Amarillo HSDA has one Ryan White funded provider, Panhandle AIDS Support Organization (PASO). They provide a wide range of funded and collaborative services for PLWHA in the region. A profile of in-care consumers using ARIES and consumer survey data finds:

- In 2012 Paso provided services to 62% of PLWHA in the HSDA.
- PASO reported 45 new clients in 2012, and surveillance reported 20 newly diagnosed with HIV in the region. Therefore, other new clients may be attributable to consumer moving into the region or returning to care.
- PLWHA tend to be male, white/Caucasian, and English speaking. More than half are 45 years of age or older.
- PASO provides services to both recently diagnosed (11%) and long term survivors (25% diagnosed 1995 or earlier)

- Educational levels vary widely from 9% with less than a ninth grade education to 45% with at least some college.

Detailed Data

A comparison between the Amarillo HSDA epidemiology, ARIES data and consumer survey respondents is presented below.

- Approximately 75% of PASO clients are men, compared to 78% of the epidemic and 79% of those who completed the survey. Nearly 3% of those completing the survey were transgender.

Table 4.12
Amarillo HSDA PLWHA Gender

Gender	*Epidemiology n=434*	*ARIES n=269*	*Consumer Survey n=64*
Female	22.1%	24.9%	22%
Male	77.9%	74.2%	77%
Transgender	na	0.4%	2%

- Over half of those living in the Amarillo HSDA who are HIV positive are 45 years of age or older. Only 3% are "youth," ages 15 to 24 years. Those accessing services at PASO have a similar age profile, and those completing the consumer survey tended to be somewhat older, with 62.5% in the 45+ age range.

Table 4.13
Amarillo HSDA PLWHA Age

Age	*Epidemiology n=434*	*ARIES n=269*	*Consumer Survey n=64*
15 – 24 Years	3.0%	2.2%*	4.7%**
25 – 44 Years	45.4%	48.7%	32.8%
45 + Years	51.4%	49.1%	62.5%
* ARIES uses 13 to 24 age range ** Consumer Survey used 18 to 24 age range.			

- White/Caucasians are approximately 50% of the regional epidemic, and a slightly smaller percentage of those identified in ARIES as receiving Ryan White services.
- Hispanic/Latinos are 29% of the epidemic and 30.5% of those receiving Ryan White services.
- Asians are not differentiated in the epidemiology data, but are 7.8% of those receiving Ryan White services and 9% of those completing the survey.

Table 4.14
Amarillo HSDA PLWHA Race/Ethnicity

Race/Ethnicity	*Epidemiology n=434*	*ARIES n=269*	*Consumer Survey n=64*
Black/African-American	12.9%	13.4%	14.1%
White/Caucasian	50.9%	46.5%	46.9%
Hispanic/Latino	28.8%	30.5%	26.6%
Asian		7.8%	9.4%
Multi-Race/Other	7.4%	1.9%	3.1%

Amarillo HSDA 2012 transmission mode data is available from Texas DSHS and from the ARIES system.

- MSM is the predominant transmission mode with DSHS data documenting 63% of PLWHA
- IDU is the transmission mode for 26%.
- 21% of Amarillo HSDA PLWHA had a heterosexual transmission mode.
- ARIES percentages are skewed by 16% who report they do not know their transmission mode.

Table 4.15
Amarillo HSDA PLWHA Transmission Mode
2012

	Epidemiology n=434		**ARIES n=269**
	#	**%**	**%**
MSM	228	52.6%	42.4%
IDU	71	16.4%	12.6%
MSM/IDU	42	9.6%	7.8%
Heterosexual	91	20.9%	16.0%
Pediatric	2	0.5%	0.4%
Other	na	na	16.0%

Over 87% of Amarillo HSDA survey respondents are most comfortable speaking English. Six percent are most comfortable with Spanish and 6% with Burmese.

- PASO was interested in identifying the needs of the Burmese immigrants accessing their services, and obtained a translator to allow six Burmese consumers to complete the survey. Specific results for this population are found in **Appendix D.**

The consumer survey found over half (52%) of Amarillo HSDA respondents received their HIV diagnosis in 2000 or before. This included 8% diagnosed before 1990.

- On the other hand, 11% of consumer survey respondents were diagnosed between 2011 and July 2013.

Amarillo HSDA in-care survey respondents had varying levels of educational attainment.

- 45% had at least some college
- While 29% had less than a high school diploma including 9.5% with less than a ninth grade education.

This diversity presents challenges for staff in providing services on an educationally appropriate level.

Lubbock HSDA

Overview

Lubbock HSDA has one Ryan White funded provider, Project CHAMPS, which is part of the South Plains Community Action Association (SPCAA). Lubbock is also home to StarCare, which provides a wide range of mental health, HIV prevention and other services including the PanWest and West Texas Ryan White administrative agency. They provide an anchor for wide range of funded and collaborative services for PLWHA in the region. A profile of in-care consumers using ARIES and consumer survey data finds:

- In 2012 Project CHAMPS provided services to 75% of PLWHA in the HSDA.
- Project CHAMPS reported 47 new clients in 2012, and surveillance reported 35 newly diagnosed with HIV in the region. Therefore, other new clients may be attributable to consumer moving into the region or returning to care.
- Lubbock HSDA PLWHA tend to be male, white/Caucasian, and English speaking. Seven percent are 15 to 24 years of age, and 49% are 45 years of age or older.
- MSM is the most frequent Lubbock HSDA transmission mode, followed by injecting drug use and heterosexual contact.
- Project CHAMPS consumer survey respondents include 21% diagnosed between 2011 and 2013 and 43% before 2001.
- One third of Lubbock HSDA consumer survey respondents are high school graduates and 38% have education beyond high school.

Detailed Data

A comparison between the Lubbock HSDA epidemiology, ARIES data and consumer survey respondents is presented below.

- Approximately 80% of Project CHAMPS clients are men, compared to 81% of the epidemic and 78% of those who completed the survey. Nearly 3% of those completing the survey were transgender.

Table 4.16
Lubbock HSDA PLWHA Gender

Gender	*Epidemiology n=435*	*ARIES n=296*	*Consumer Survey n=81*
Female	19.3%	19.6%	22.2%
Male	80.7%	80.4%	77.8%
Transgender	na	0.0%	0.0%

- DSHS surveillance, ARIES data and the consumer survey all have similar age profiles.
  - 6% of PLWHA are in the 15 to 24 age range.
  - Between 44% and 48% of consumers were in the 25 to 44 years of age.
  - Between 46% and 49% of consumers were 45 years of age or older.

Table 4.17
Lubbock HSDA PLWHA Age

Age	*Epidemiology n=434*	*ARIES n=269*	*Consumer Survey n=81*
15 – 24 Years	6.9%	6.1%*	6.3%**
25 – 44 Years	44.1%	45.3%	47.6%
45 + Years	48.9%	48.0%	46.3%
* ARIES uses 13 to 24 age range ** Consumer Survey used 18 to 24 age range.			

- White/Caucasians are approximately 41% of the Lubbock HSD regional epidemic and Ryan White service users. The consumer survey included 31% white/Caucasian respondents.
- Hispanic/Latinos are 41% of the epidemic, 36.5% of those receiving Ryan White services and 42% of consumer survey respondents.
- Black/African-Americans are 15% of the Lubbock HSDA regional epidemic, but 21% of Ryan White service users and 23.5% of consumer survey respondents.

Table 4.18
Lubbock HSDA PLWHA Race/Ethnicity

Race/Ethnicity	*Epidemiology n=435*	*ARIES n=296*	*Consumer Survey n=81*
Black/African-American	15.2%	21.0%	23.5%
White/Caucasian	40.7%	41.6%	30.9%
Hispanic/Latino	41.1%	36.5%	42.0%
Asian		0.0%	1.2%
Multi-Race/Other	0.0%	1.0%	2.5%

Lubbock HSDA 2012 transmission mode data is available from Texas DSHS. ARIES client reported data, with 13.1% of clients reporting either an "other" or "unknown" transmission mode, presents discrepancies with the DSHS surveillance data.

- MSM is the predominant transmission mode with DSHS data documenting 56% of PLWHA
- IDU is the transmission mode for 17 % and MSM/IDU for 13%.
- 14% of Lubbock HSDA PLWHA had a heterosexual transmission mode.

Table 4.19
Lubbock HSDA PLWHA Transmission Mode
2012

	Epidemiology n=435		ARIES n=296
	#	%	%
MSM	243	55.9%	49.7%
IDU	77	17.1%	10.5%
MSM/IDU	45	12.6%	8.5%
Heterosexual	115	13.6%	16.9%
Pediatric	4	0.5%	1.4%
Other/Unknown	na	na	13.1%

- Over 96% of Lubbock HSDA survey respondents are most comfortable speaking English.
- Lubbock HSDA consumer survey respondents included 21% diagnosed with HIV between 2011 and 2013, 37% diagnosed between 2001 and 2010, and 43% diagnosed before 2001.
- Lubbock HSDA consumer survey respondents educational attainment include one third who are high school graduates; 38% have some college or more, and 28% have less than a high school diploma, including 4% with less than a ninth grade education.

Permian Basin HSDA

Overview
Permian Basin HSDA has one Ryan White funded provider, BAS, with 269 clients according to 2012 ARIES data. BAS provides funded and collaborative services for PLWHA in the region. A profile of Permian Basin HSDA in-care consumers using ARIES and consumer survey data finds:

- In 2012 BAS provided services to 55% of PLWHA in the HSDA.
- BAS reported 55 new clients in 2012, and surveillance reported 38 newly diagnosed with HIV in the region. Some of these new clients may be attributable to increasing population moving into the region due to the oil boom or to consumers returning to care.
- Permian Basin HSDA PLWHAs tend to be male, although there is a larger percentage of females accessing services than in other PanWest and West Texas HSDAs.
- Over half of Permian Basin HSDA people living with HIV/AIDS are Hispanic/Latino. This is followed by white/Caucasian. According to ARIES data, however, white/Caucasian are accessing Ryan White services to a greater extent than Hispanic/Latinos.
- Despite the high percentage of Hispanic/Latino consumers, 85% of consumer survey respondents report being most comfortable speaking English and 15% speaking Spanish.
- Seven percent are 15 to 24 years of age, and 49% are 45 years of age or older.
- MSM is the most frequent Permian Basin HSDA transmission mode, followed by heterosexual contact and injecting drug use. The latter group has a lower percentage represented in the ARIES data than found in the 2012 surveillance data.

- Ten percent (10%) of BAS consumer survey respondents were diagnosed with HIV between 2011 and 2013, while 15% were diagnosed in 1995 or before. For each five year interval from 1996 to 2011, survey respondents' year of diagnosis were evenly distributed.
- Permian Basin HSDA consumer survey respondents have high levels of educational attainment, with only 7.5% not graduating from high school. The remainder are either high school graduates (47.5%) or have college level education.

Data Detail

A comparison between the Permian Basin HSDA epidemiology, ARIES data and consumer survey respondents is presented below.

- Nearly three-quarters of BAS clients are men, compared to 80% of the epidemic and 65% of those who completed the survey. 2.5% of those completing the survey were transgender.

Table 4.20
Permian Basin HSDA PLWHA Gender

Gender	*Epidemiology n=492*	*ARIES n=269*	*Consumer Survey n=40*
Female	20.1%	26.0%	32.5%
Male	79.9%	74.0%	65.0%
Transgender	na	0.0%	2.5%

- DSHS surveillance and ARIES data have similar age profiles. The consumer survey has a higher percentage of those 45 years of age and older.
    - 6% of PLWHA are in the 15 to 24 age range.
    - Between 48% and 54% of consumers were 45 years of age or older.

Table 4.21
Permian Basin HSDA PLWHA Age

Age	*Epidemiology n=492*	*ARIES n=269*	*Consumer Survey n=40*
15 – 24 Years	6.9%	5.5%*	5.5%**
25 – 44 Years	44.1%	45.3%	40.7%
45 + Years	48.9%	48.0%	53.5%
*ARIES uses 13 to 24 age range ** Consumer Survey used 18 to 24 age range.			

- Hispanic/Latinos are 50% of the Permian Basin HSDA epidemic, 36.5% of those receiving Ryan White services and 42.5% of consumer survey respondents.
- White/Caucasians are 31% of the regional epidemic, and are 42% of the Ryan White service users. The consumer survey included 37.5% white/Caucasian respondents.
- Black/African-Americans are 14% of the Permian Basin HSDA regional epidemic, but 21% of Ryan White service users and 17.5% of consumer survey respondents.

Table 4.22
Permian Basin HSDA PLWHA Race/Ethnicity

Race/Ethnicity	*Epidemiology n=492*	*ARIES n=269*	*Consumer Survey n=40*
Black/African-American	13.8%	18.5%	17.5%
White/Caucasian	30.9%	37.9%	37.5%
Hispanic/Latino	50.4%	42.5%	42.5%
Asian	0.0%	0.7%	0.0%
Multi-Race/Other	0.0%	1.5%	2.5%

Permian Basin HSDA 2012 transmission mode data is available from Texas DSHS. ARIES client reported data, with 12% of clients reporting either an "other" or "unknown" transmission mode, presents discrepancies with the DSHS surveillance data.

- MSM is the predominant transmission mode with DSHS data documenting 53% of PLWHA.
- IDU is the transmission mode for 17 % and MSM/IDU for 9%. Consumers accessing Ryan White services report lower IDU transmission mode percentages.
- DSHS identified 23% with a heterosexual transmission mode compared to 27.5% of those accessing Ryan White services.

Table 4.23
Permian Basin HSDA PLWHA Transmission Mode
2012

	Epidemiology n=492		**ARIES n=269**
	#	**%**	**%**
MSM	228	52.6%	45.0%
IDU	75	17.1%	8.2%
MSM/IDU	45	9.2%	5.2%
Heterosexual	115	23.3%	27.5%
Pediatric	4	0.8%	2.2%
Other/Unknown	na	na	11.9%

WEST TEXAS HSDA

West Texas HSDA has three Ryan White funded providers located in El Paso. Two of these organizations provide HIV medical care, and the third provides mental health therapy and counseling.

The consumer survey was conducted with the support of the two West Texas HSDA medical care providers, La Fe CARE Center (La Fe) and Texas Tech University Health Sciences Center (TTUHSC). The former has been an established HIV service provider while TTUHSC was developed in 2010 and has been increasing patient volume steadily since that time.

A wide range of services supporting PLWHA and providing services to those at-risk for contracting the disease are available in El Paso County. Ryan White funds mental health therapy and counseling at Family Service El Paso, Inc. HOPWA services are also provided by Sun City Behavioral Health and the City of El Paso.

Provider collaboration is increasing in the region. A recent initiative, El Paso Community Mobilization being led by the El Paso Department of Public Health, has expanded provider collaboration.

Overview
A profile of in-care consumers using DSHS surveillance, ARIES and consumer survey data finds:

- 121PLWHA were newly diagnosed in the West Texas region in 2013. The two El Paso Ryan White HIV medical care providers report 184 new patients. The difference may be due to patients switching providers, patients relocating to the region, out-of-care patients returning to care.
- In 2012 La Fe and TTUHSC provided services to 58% of PLWHA in the HSDA.
- The West Texas HSDA epidemic is 87% male. This is a larger percentage than found in any of the PanWest HSDAs. Ryan White clients and survey respondents are predominantly male.
- The West Texas epidemic is also predominantly (85%) Hispanic with 40% most comfortable speaking Spanish.
- A wide variation in educational attainment is found in the West Texas HSDA, which must be translated to a range of communication styles and educational materials.
- Over half of consumer survey respondents were diagnosed with HIV since 2006, including 31% diagnosed between 2011 and 2013.

A comparison between the West Texas HSDA epidemiology, ARIES data and consumer survey respondents is presented below.

- Approximately 85% of West Texas Ryan White HIV medical care clients are men, compared to 87% of the epidemic and 79% of those who completed the survey. Nearly 3% of those completing the survey were transgender.

Table 4.24
West Texas HSDA PLWHA Gender
2012

Gender	*Epidemiology n=1,843*	*ARIES n=1,073*	*Consumer Survey n=143*
Female	12.8%	13.7%	18.2%
Male	87.2%	85.7%	79.0%
Transgender	na	0.6%	2.8%
Note: Epidemiology does not include transgender – only gender at birth.			

- DSHS surveillance, ARIES data and the consumer survey all have similar age profiles.
  - Between 5% and 7% of PLWHA are in the 15 to 24 age range.
  - Between 39% and 42.5%of consumers were in the 25 to 44 years of age.
  - Between 52% and 53% of consumers were 45 years of age or older.

Table 4.25
West Texas HSDA PLWHA Age

Age	*2012 Epidemiology n=1,843*	*2012 ARIES n=1,073*	*2013 Consumer Survey n=143*
15 – 24 Years	5.0%	5.8%*	7.0%**
25 – 44 Years	41.8%	42.5%	39.2%
45 + Years	52.7%	51.6%	53.3%
* ARIES uses 13 to 24 age range ** Consumer Survey used 18 to 24 age range.			

- Hispanic/Latinos are 85% of the epidemic, 89% of those receiving Ryan White services and 85% of consumer survey respondents.
- White/Caucasians are approximately 9% of the regional epidemic. The consumer survey included 8% white/Caucasian respondents.
- Black/African-Americans are 6% of the Lubbock HSDA regional epidemic, but 4% of Ryan White service users and 5% of consumer survey respondents.

Table 4.26
West Texas HSDA PLWHA Race/Ethnicity

Race/Ethnicity	*2012 Epidemiology n=1,843*	*2012 ARIES n=1,073*	*2013 Consumer Survey n=143*
Black/African-American	6.0%	4.3%	4.9%
White/Caucasian	8.7%	6.1%	7.7%
Hispanic/Latino	84.5%	88.8%	85.3%
Asian		0.0%	0.0%
Multi-Race/Other	0.9%	0.8%	2.1%

West Texas HSDA 2012 transmission mode data is available from Texas DSHS. ARIES client reported data, with 13.1% of clients reporting either an "other" or "unknown" transmission mode, presents discrepancies with the DSHS surveillance data.

- MSM is the predominant transmission mode with DSHS data documenting 68% of PLWHA
- IDU is the transmission mode for 8% and MSM/IDU for 5%.
- 18% of West Texas HSDA PLWHA had a heterosexual transmission mode. ARIES data documents 23% of Ryan White clients are women.

Table 4.27
West Texas HSDA PLWHA Transmission Mode
2012

	Epidemiology n=1,843		**ARIES n=1,073**
	#	**%**	**%**
MSM	1,252	67.9%	64.4%
IDU	147	8.0%	3.2%
MSM/IDU	93	5.0%	1.1%
Heterosexual	327	17.8%	23.2%
Pediatric	14	0.8%	0.4%
Other/Unknown	na	na	7.7%

Nearly 40% of West Texas HSDA survey respondents are most comfortable speaking Spanish.

Of the four HSDAs under study, West Texas has the largest percentage of recently diagnosed consumers.

- 31% were diagnosed between 2011 and 2013
- 20% were diagnosed between 2006 and 2010.

The West Texas HSDA consumer survey respondents have a wide range of educational attainment.

- Twelve percent report less than a ninth grade education.
- On the other end of the spectrum, 10% have a more than a college degree, such as a masters degree.

Out-of-Care Interviews Respondents Profile

A total of 29 in-depth interviews provide insight into the needs, motivations, barriers and risk factors of consumers who are currently not receiving HIV medical care or who have recently been "out-of-care."

Consumers identified for out-of-care interviews must meet at least one of the following criteria:

- Not currently receiving HIV medical care. These people may or may not be receiving other Ryan White or HIV services
- Diagnosed between 2010 and 2013 and failed to link to care within six months of diagnosis. These consumers may currently be in care.
- Diagnosed between 2010 and 2013, initially linked to care, but dropped out of care for at least six months. These consumers may now be back in care.
- Dropped out of care for 12 months but are now back in care. We prefer to include consumers who have been back in care for no more than 18 months.

This section presents a profile of these consumers overall and by HSDA as well as the HSDA-specific Treatment Cascade developed by Texas DSHS. Appendix E.

Overall Profile

The 29 consumers participating in the out-of-care interviews include eight (28%) who are not currently receiving HIV medical care and 21 (72%) who are currently receiving HIV medical care, but meet the out-of-care criteria.

- HSDA of residence includes: 21% are from the Amarillo HSDA, 24% from the Lubbock HSDA, 10% from the Permian Basin HSDA, and 45% from the West Texas HSDA.
- Race/ethnicity includes: 65.5% of participants are Hispanic, 27.6% are white/Caucasian and 6.9% are black/African-American.
- Gender: 79% male and 21% female.
- Employment status:
    - Eight participants (28%) are working full time. One of these respondents is working two part time jobs.
    - Six participants (21%) are working part time. Two report also going to school.
    - Of the nine employed respondents answering the question about whether they have disclosed their HIV status to co-workers, two thirds have not disclosed while one third have.
    - More than half (51%) are not currently working. One reports going to school, and two report being disabled.

Technology Use

Out-of-care consumers were asked about use of computers, smart phones and social media. Consumers are more likely to have access to smart phones than computers.

- Less than 48% have access to computers, and only 14% report using the computer to obtain information about HIV.
- Two thirds have a smart phone and all of the consumers use their phones to access information about HIV.
- Most consumers with smart phones would like to receive appointment reminders via text message.
- Nearly half of out-of-care consumers access Facebook via computer or smart phone.
- Adam4Adam and Poz were mentioned by a limited number of interviewees.

Amarillo HSDA

Amarillo HSDA providers recruited six consumers (20.7%) that participated in the out-of-care interviews. Their profile includes:

- All live in Amarillo. Three not currently receiving HIV medical care.
- Two women and four men;
- Two Hispanic/Latino and four white/Caucasian;
- All age groups represented ranging from 18 – 24 to 55+;
- Two are not employed. Of those working, two have not told their employer of their HIV status.
- Half have not told the people they live with of their HIV infection.

Amarillo HSDA Treatment Cascade

Texas DSHS developed a 2012 treatment cascade for Amarillo HSDA that estimates both known and unknown PLWHA. It is estimated that 530 people in the Amarillo HSDA are HIV positive. Of these, 434 are aware of their status.

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.

- For 2012, DSHS finds 321 Amarillo HSDA PLWHA have a "met need" 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.

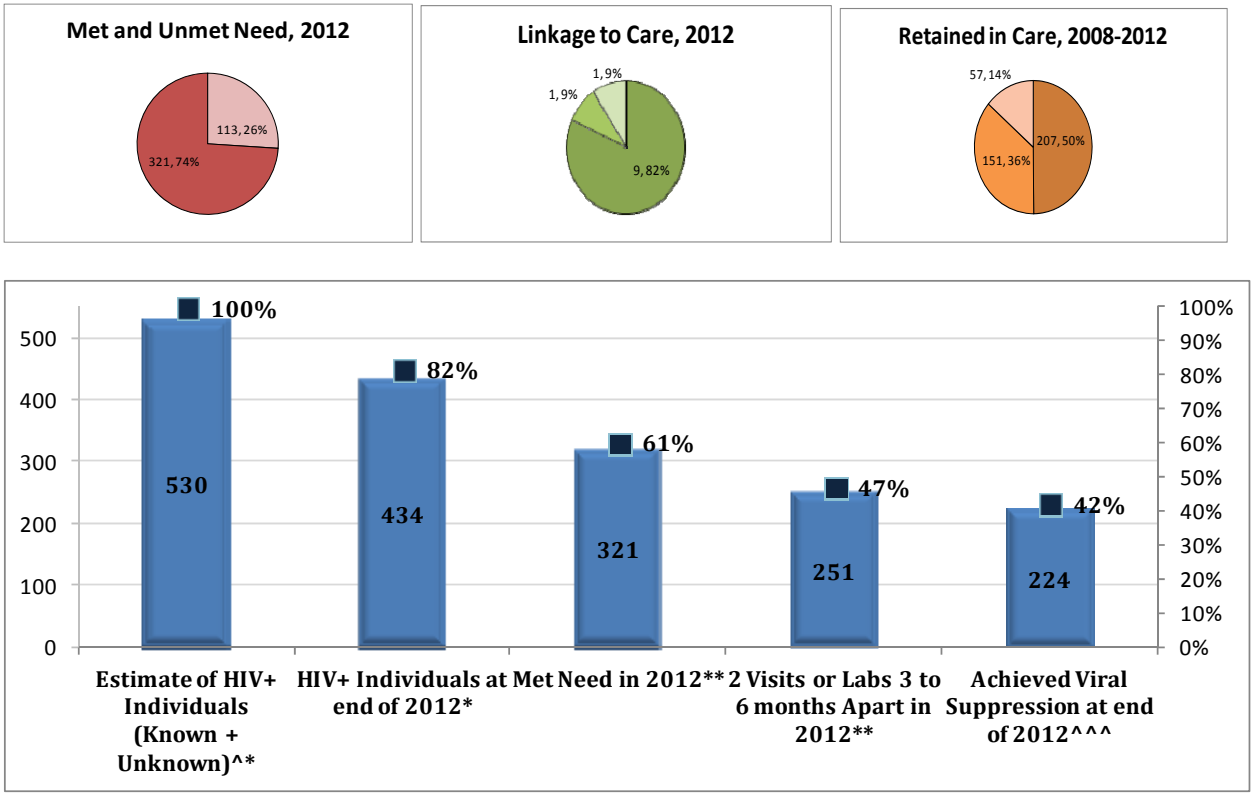
Finally, DSHS provides data on consumers who were retained in care from 2008 through 2012.[3]

- 50% had a met need/were maintained in care every year.

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

- 36.5% were in and out of care between 2008 and 2012.
- Fifty seven people (14%) have no evidence of receiving HIV medical care during this time.

Figure 4.1
Treatment Cascade for Amarillo HSDA 2012[4]



Lubbock HSDA

Lubbock HSDA providers recruited seven consumers (24.1%) that participated in the out-of-care interviews. Their profile includes:

- Five live in Lubbock, one in Wolfforth, and one in Essington.
- Four are not currently receiving HIV medical care.
- Three women and four men.
- Four Hispanic/Latino, two white/Caucasian, and one black/African-American. All were interviewed in English.
- Three were "youth," between the ages of 18 and 24. Two were 54 years of age or older, and the remaining two were in the 35 to 44 age group.
- Three are employed, and two have not told their employers of their HIV status. Of those working, two have not told their employer of their HIV status. Of those not working, one is disabled.
- Five have told those they live with about their HIV status. One of the female respondents has not told her children, but her spouse is aware.

[4] Detailed information about DSHS development of these graphs and charts can be found in **Appendix F.**

Lubbock HSDA Treatment Cascade

Texas DSHS developed a 2012 treatment cascade for Lubbock HSDA that estimates both known and unknown PLWHA. It is estimated that 531 people in the Lubbock HSDA are HIV positive. Of these, 435 are aware of their status.

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.

- 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%.

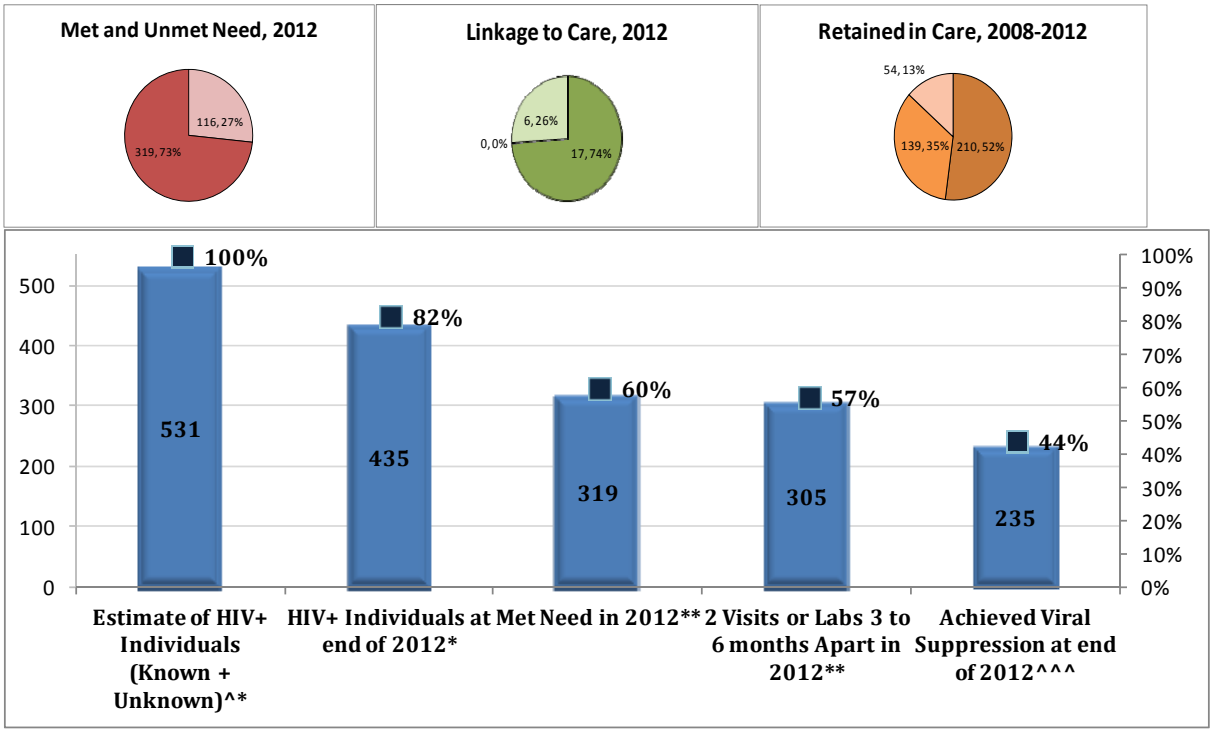
DSHS also identified that of the 23 consumers with new HIV diagnoses in the first nine months of 2012, 17 (74%) linked to care within three months, and six (26%) did not link at all.

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.

Fifty-four people (13%) have no evidence of receiving HIV medical care during this time.

Figure 4.2
Treatment Cascade for Lubbock HSDA 2012



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

Permian Basin HSDA

Permian Basin HSDA providers recruited three consumers that participated in the out-of-care interviews. Their profile includes:

- Two live in Odessa and one lives in Stanton.
- All are currently receiving HIV medical care.
- One woman and two men;
- Two white/Caucasian and one black/African-American.
- Age categories include 18 – 24 through 35 - 44 years.
- Two are employed, and they have not told their employers of their HIV status
- All have told those they live with about their HIV status.

Permian Basin HSDA Treatment Cascade

Texas DSHS developed a 2012 treatment cascade for the Permian Basin HSDA that estimates both known and unknown PLWHA. It is estimated that 601 people in the Permian Basin HSDA are HIV positive. Of these, 492 are aware of their status.

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.

- 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.

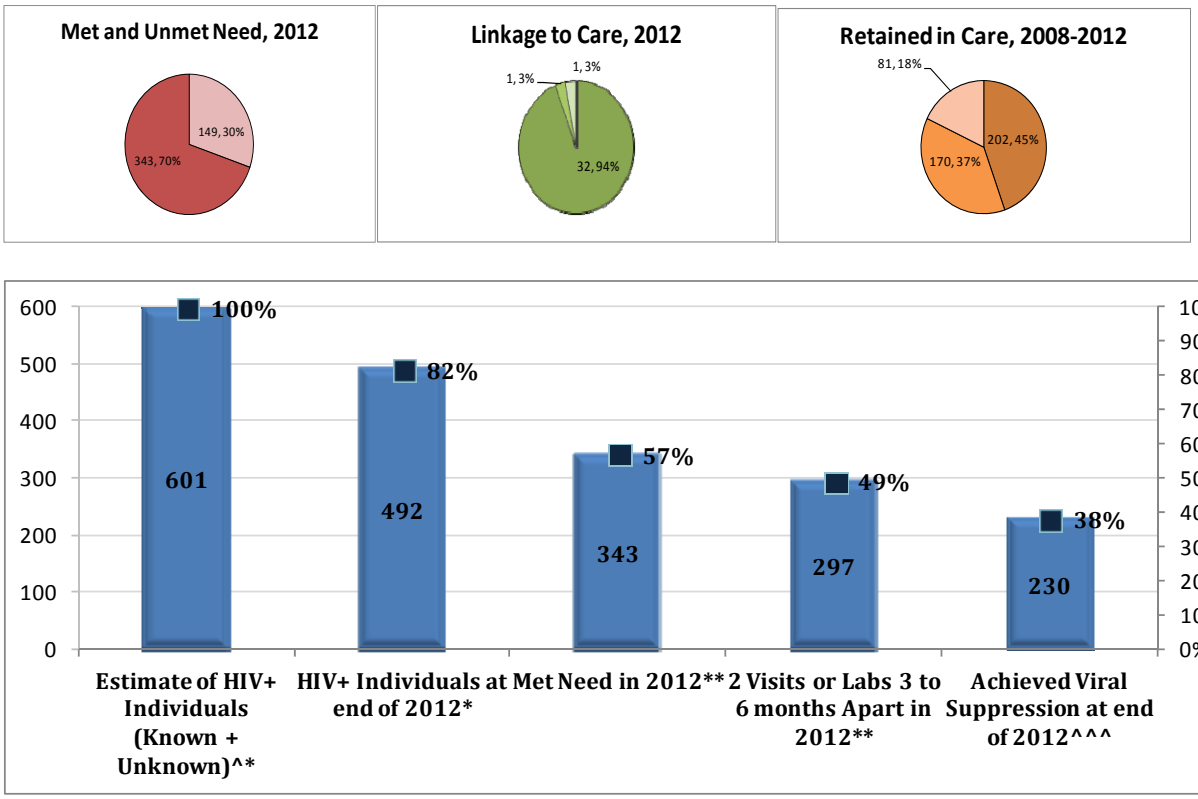
DSHS provides data on consumers who were retained in care from 2008 through 2012.[6]

- 45% were maintained in care throughout this time period.
- 38% were in and out of care between 2008 and 2012.

Eighty-one (18%) people 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 4.3
Treatment Cascade for Permian Basin HSDA, 2012



El Paso HSDA

El Paso HSDA providers recruited nine consumers and an outreach worker recruited four consumers for a total of 13 El Paso HSDA consumers that participated in the out-of-care interviews. They have the following similarities:

- All are from El Paso; all are male, and all are Hispanic/Latino.
- Twelve are currently receiving HIV medical care.
- One is under 25 years of age, four are 25 – 34 years, five are 35 – 44, and three are 45 -54 years.
- Eight are not working, three are working full time, and two are working part time. One of those who is working full time has not disclosed his HIV status to co-workers.
- Four have not told those they live with about their HIV status. One has an unstable living situation and has only told his wife, not others he/they live with. Two live alone.

El Paso HSDA Treatment Cascade

Texas DSHS developed a 2012 treatment cascade for the El Paso HSDA that estimates both known and unknown PLWHA. It is estimated that 2,250 people in the West Texas HSDA are HIV positive. Of these, 1,843 are aware of their status.

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.

- 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%.

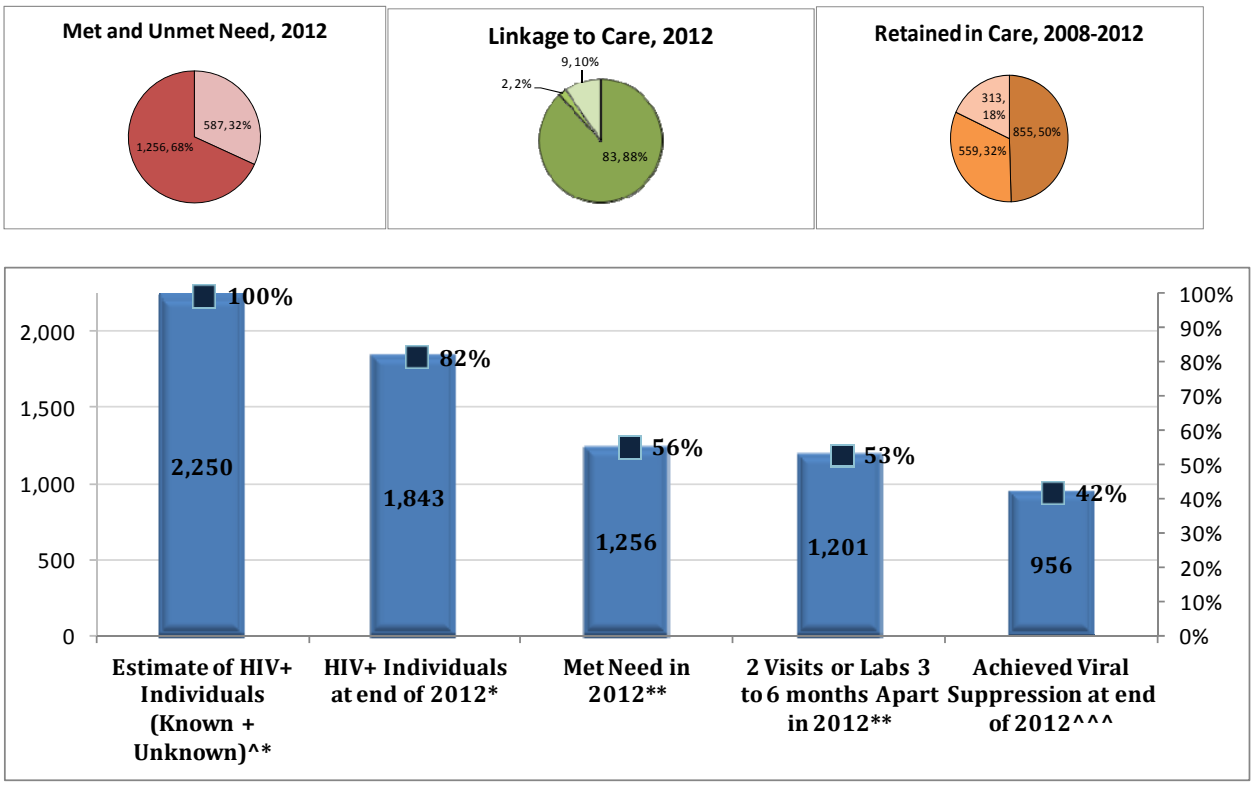
DSHS also identified that of the 94 consumers with new HIV diagnoses in the first nine months of 2012, 83 (88%) linked to care within three months, two linked to care within four to six months and nine (10%) did not link at all.

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.

Eighteen percent (313PLWHA) have no evidence of receiving HIV medical care during this time.

Figure 4.4
Treatment Cascade for El Paso HSDA, 2012



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

5. SERVICES

HIV MEDICAL CARE

HRSA Definition

The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

2012 ARIES Utilization

Based on ARIES unduplicated data, 83.8% of Ryan White funded agency clients accessed outpatient ambulatory medical care for infectious disease in 2012.

- Percentage of clients accessing this service range from 77.7% at Project CHAMPS to 88.9% at BAS.
- Consumers may have used other sources to access HIV medical care not reflected in these figures.

Table 5.1
Outpatient Ambulatory Medical Care
Infectious Disease Utilization
2012 Unduplicated Clients

	PASO		Project CHAMPS		BAS		La Fe Care		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
HIV Medical Care	214	79.6	230	77.7	239	88.9	767	85.0	148	86.1	1,598	83.8
Source: ARIES 2012												

HIV Medical Care Use and Barriers

Consumer Survey

Ninety-six percent of survey participants reported having a CD4 or viral load test in the last year. Ten respondents (3%) have not had these tests, and three people didn't know if they had these tests.

Table 5.2
CD4 or a Viral Load Test in the Last Year

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	7	4.9%	0	0.0%	2	2.5%	1	1.6%	10	3.0%
Yes	133	93.0%	40	100.0%	79	97.5%	63	98.4%	315	96.0%
Don't Know	3	2.1%	0	0.0%	0	0.0%	0	0.0%	3	0.9%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

Nearly 90% of survey respondents report receiving HIV medical care in the last year.

- Amarillo respondents were the largest percentage reporting not accessing medical care in the last year (14%) followed by those from West Texas (12%).

Table 5.3
HIV Medical Care in the Last Year

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	17	11.9%	3	7.5%	3	3.7%	9	14.1%	32	9.8%
Yes	124	86.7%	37	92.5%	78	96.3%	55	85.9%	294	89.6%
Don't Know	2	1.4%	0	0.0%	0	0.0%	0	0.0%	2	0.6%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

Three consumer survey respondents fulfilled the HRSA definition for out of care. This definition requires consumers have no CD4 count, no viral load test, no antiretroviral medication, no medical care in the last twelve months.

Consumers accessing medical care were asked if it is ever hard to get HIV medical care.

- Sixteen percent (48 PLWHA) report that it can be hard to get HIV medical care.
- The highest percentage, 27% (or 33 consumers), was found in West Texas followed by 16% in the Permian Basin.

Table 5.4
Is it ever hard to get HIV medical care?

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 292	#	%	#	%	#	%	#	%	#	%
No	91	73.4%	31	83.8%	72	93.5%	50	92.6%	244	83.6%
Yes	33	26.6%	6	16.2%	5	6.5%	4	7.4%	48	16.4%
HSDA Totals	124	100%	37	100%	77	100%	54	100%	292	100%

Those who reported it hard to get medical care were asked the reasons.

- Transportation is a barrier for over half of those finding accessing HIV medical care hard.
  - This includes 75% of West Texas clients that find it hard to get HIV medical care.
- Costs of treatment and depression or other mental health disorder were each cited by nearly a quarter of those with barriers.
- Disclosure concerns and lack of health insurance were each identified by 20% of respondents.
- "Other" reasons were identified by 36% of respondents,
  - This includes two thirds of West Texas respondents that find it hard to get medical care.
  - The most frequent "other" barriers included:
    - Changing doctors,
    - Limited clinic hours (although the response "the hours the clinic is open" may not have been identified),
    - Difficulty getting appointments.
  - Specific comments relating to "other" included:
    - "They switch me from doctor to doctor"
    - "The constant change of physicians"
    - "Availability of doctors to schedule appointments"
    - "They have many doctors resigning and I had to wait five months to finally have an appointment with one"
    - "HIV doctor only available Tuesdays"
    - "Hard to see my doctor, always booked"

Table 5.5
Reasons It Is Hard to Get HIV Medical Care

Barrier	**Total**	
n = 45	**#**	**%**
No transportation	24	53.3%
The co-pays, deductibles or other costs of treatment	11	24.4%
Depression or other mental health disorder	11	24.4%
You worry about seeing someone you know there	9	20.0%
You don't have health insurance, Medicaid or Medicare	9	20.0%
Taking time off work for appointments	5	11.1%
The hours the agency is open	5	11.1%
Alcohol or drug use	3	6.7%
The doctor/staff don't speak my language	1	2.2%
The doctor/staff don't understand my culture	1	2.2%
Immigration concerns	0	0.0%
Other	16	35.6%
HSDA Totals	95	
Note: Multiple responses were allowed.		

Twenty-seven (55%) of these respondents report these barriers have caused them to miss an HIV medical appointment in the last year.

Table 5.6
Have any of these things caused you to miss an HIV medical care appointment in the past year?

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 49	#	%	#	%	#	%	#	%	#	%
No	14	42.4%	2	33.3%	2	40.0%	4	80.0%	22	44.9%
Yes	19	57.6%	4	66.7%	3	60.0%	1	20.0%	27	55.1%
HSDA Totals	33	100%	6	100%	5	100%	5	100%	49	100%

Key Informant Interviews

Two significant medical care issues in West Texas were highlighted by key informants and reiterate the barriers identified by consumer survey respondents.

1. Long waits for appointments.
2. Physician turnover and shortages.

Specific comments include:

- "Waiting time at the clinics to get the first appointment can be two months or more."
- "Clients are not comfortable being seen by different doctors."
- "___ (clinic) has disjointed care."
- "(Limited) Availability of doctors and appointments is an access barrier."
- "Continuity of care is not being met—appointments are canceled and rescheduled."

In Lubbock, key informants' comments focused on improvements to the care process including:

- "We engage with clients the most at the clinic, so we have switched gears to make referrals while at the clinic."
- "We have developed a treatment team approach to better engage them--they have a lot of people talking to them and the medical case manager is the last one at the end of the day."
- "Clinic hours, two mornings a week, make it difficult for people who are working. Most patients are working in places that don't offer sick time." (Note: consumers did not identify this as an access barrier.)

In Odessa, key informant remarks about access barriers focused on "no shows." BAS sends reminder cards followed by telephone calls, but the no show rate is high.

- The oil boom was one factor cited, "Old patients move, new come in. Since the town is booming, people are moving out of town. They live far away and it is difficult to travel…We see five new patients a month."
- One key informant stated, "10% to 20% of indigent patient are non-compliant, this is a higher percentage than found among private patients."

Out-of-Care Interviews

Overview of out-of-care consumers currently receiving HIV medical care:

- Two-thirds of out-of-care consumers qualifying for interviews are currently receiving medical care.
- These consumers have continued to miss medical appointments since returning to care, with 55% reporting missing appointments in the last year. Reasons for missing appointments include:
  - "I forgot the last appointment. I have appointments every six months, so I will not have seen the doctor for a year. I have maintained my medication due to refills."
  - "I have fallen through the cracks. They gave me an appointment without telling me; then I missed it."
  - "I get scatterbrained, and I don't have transportation."
  - "I was not able to function on the medicine, so I stopped going."
  - "I was 15 minutes late (because of transportation/bus problems) and they insisted on rescheduling. It made me wonder if it was worth it."
- Suggestions to improve access to medical appointments include:
  - Transportation including bus passes and gas vouchers identified by five consumers
    - "I need transportation—I can take the bus. Right now I am using my parents' vehicles, so that makes it difficult during the day, since they are not aware of status."
    - "I need transportation. I work all day and my boss is not aware of my status so it can be hard to get to appointments."
    - "I was supposed to be in care, but I have not had a ride."
  - Reminder phone calls or reminder text.
  - Better doctors who will spend more time.

Dropping Out of HIV Medical Care

Consumer Survey

Twelve percent of consumer survey respondents report dropping out of medical care for six months or more in the last five years.

- Responses by HSDA ranged from 17% in Amarillo HSDA to 13% in West Texas HSDA and 5% in Permian Basin HSDA.

Table 5.7
Dropped Out of Care

HRSA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	124	86.7%	38	95.0%	74	91.4%	53	82.8%	289	88.1%
Yes	19	13.3%	2	5.0%	7	8.6%	11	17.2%	39	11.9%
HSDA Totals	143	100%	40	100.0%	81	100%	64	100%	328	100%

Frequent reasons for dropping out of care cited by consumer survey respondents included:

- Lack of health insurance, Medicare or Medicaid, cited by 43%.
- Depression, emotional stress or mental disorder, cited by nearly a quarter of those who dropped out of care.
- Moving/relocating was cited by 22% of those who dropped out of care.

Table 5.8
Reasons for Dropped Out of Care

Barriers	**Total**	
n = 37	**#**	**%**
You didn't have health insurance, Medicaid or Medicare	16	43.2%
Depression, emotional stress or mental disorder	9	24.3%
You moved/relocated	8	21.6%
You were not sick	7	18.9%
It was hard for you to keep appointments	7	18.9%
Co-pays, deductibles, or other costs of treatment	6	16.2%
You were using drugs or alcohol	6	16.2%
You were not ready to follow the treatment	5	13.5%
Appointments took too long	5	13.5%
You were tired of following the treatment	5	13.5%
You didn't like the way you were treated by the people there	4	10.8%
It was too hard to get there (transportation)	4	10.8%
They weren't open when you could get there (convenient hours)	4	10.8%
You were worried someone might find out you are HIV-positive if you went there	3	8.1%
Other	5	13.5%
HSDA Totals	94	

Participants were asked, “What could have been done to keep you in care or get you back into care sooner?” Verbatim responses included:

- Transportation was identified by three respondents.
  The following were identified by two respondents:
  - Substance abuse treatment
  - Insurance
  - More doctors at the clinic
  - More “one-on-one” support from case manager or other staff

Out-of-Care Interviews

Out-of-care consumers were asked why they are not receiving HIV medical care. Responses were varied and included:

- Medication issues were the reason for dropping out of care for four out-of-care consumers.
- Feeling well, so didn't need treatment was identified by two consumers.
    - I didn't need meds--they did all kinds of blood work. I don't like doctors. I will need to go some day when I get sick, but I have not been sick.
- Paperwork.
    - I filled out paperwork for Ryan White, but I don't know what happened.
- Didn't know where to go for care
    - I relocated from Las Cruces. In El Paso it has been a disaster. At first I didn't know where to go. Went to ____ (clinic), everything was lost. Went to _____(clinic) but took six months to get appointment
- Personal issues including death in the family, death of partner
- Financial issues including no insurance and the cost of treatment
- Denial, depression and/or disclosure concerns identified by four consumers
- Misunderstanding of educational materials
    - Paperwork freaked me out because it said the virus attacks the body. Got it from ____(agency)—It said HIV does this to your cells…so I backed off from everything.

Consumers were asked what could be done to help them get into medical care. Responses included:

- Increased access to doctors and ease in getting an appointment were identified by two consumers.
- **Empower the consumer to be part of the treatment team/plan. Comments included:**
    - **I could not make the doctor understand I did not want medicine. I told them my mind was mad up and I can't waste my time on it.**
    - Get everyone into a little meeting and plan it out--get everyone to explain--that would help a lot.
- Three reported returning to care for personal reasons:
    - My (partner) passed away a month ago. I know I have to get treatment.
    - Sometimes I feel like giving up; I know I have to try because it is the only thing that will keep me alive.
    - Decided to come back to care for her children and grand baby

Resources

HIV medical care is offered by eight providers in the PanWest and West Texas regions.

- The Amarillo HSDA and the El Paso HSDA each report three providers.
- Lubbock HSDA and Permian Basin each have one provider.

Table 5.9
HIV Medical Care Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
HIV Medical Care	3	1	1	3	8

MEDICATION ASSISTANCE; AIDS DRUG ASSISTANCE PROGRAM AND AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

HRSA Definition

AIDS pharmaceutical assistance includes local pharmacy assistance programs implemented by Part A or Part B grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are NOT funded with ADAP earmark funding.

2012 ARIES Utilization

Based on 2012 ARIES unduplicated data, 29% of regional clients accessed AIDS pharmaceutical assistance (local). In addition, 5.5% accessed AIDS pharmaceutical assistance for co-pays.

- PASO, La Fe CARE and TTUHSC all had one-third or more of clients accessing AIDS pharmaceutical assistance (local)
- PASO and Project CHAMPS had the largest percentage accessing co-pay assistance.

Table 5.10
AIDS Pharmaceutical Assistance (Local)
2012 Unduplicated Clients

	PASO		Project CHAMPS		BAS		La Fe Care		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
AIDS Pharm. Assistance (local)	99	37.7	56	18.9	49	18.2	301	33.3	56	33.0	561	29.4
AIDS Pharm. Assistance Co-Pay	39	14.5	30	10.1	0	0.0	27	3.0	8	4.7	104	5.5
Source: ARIES 2012												

Medication Assistance Use and Barriers

Consumer Survey

Ask about whether they had taken HIV medication in the last year, 91.5% responded positively.

- Twenty-eight respondents have not taken medication.
- The largest number and percentage of those not taking medication were in the El Paso HSDA.

Table 5.11
HIV Medication in the Last Year

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	22	15.4%	2	5.0%	3	3.7%	1	1.6%	28	8.5%
Yes	121	84.6%	38	95.0%	78	96.3%	63	98.4%	300	91.5%
HSDA Totals	143	100.0%	40	100%	81	100%	64	100%	328	100%

Treatment/Medication Compliance

Consumers who are taking HIV medication were asked if they always take their medication on time and as prescribed, and 88% report following their prescribed medication regimen.

- Amarillo and Lubbock HSDAs had the largest percentages not taking their medication on time and as prescribed, 16% and 13%, respectively.

Table 5.12
Do you always take your HIV medication on time and as prescribed?

HSDA	West Texas		Permian Basin		Lubbock		Amarillo		Total	
n = 300	#	%	#	%	#	%	#	%	#	%
No	11	9.1%	4	10.5%	10	12.8%	10	15.9%	35	11.7%
Yes	110	90.9%	34	89.5%	68	87.2%	53	84.1%	265	88.3%
HSDA Totals	121	100%	38	100%	78	100%	63	100%	300	100%

Consumers who do not take their medication on time and as prescribed were asked about barriers to compliance.

- The most frequent response was “I forget,” cited by more than half of those that do not always follow their regimens.
- “I run out” was identified by over a quarter of respondents.
- Side effects are a barrier for seven (21%) of those who do not follow the medication regimen.
- Other issues included: depression, work schedule conflicts, and not caring.

Table 5.13
Reasons for Not Taking Medication On Time and As Prescribed

Barrier	Total	
n = 34	**#**	**% (of respondents)**
I forget	19	55.9%
I run out	9	26.5%
I do not like the side effects	7	20.6%
I sometimes get the directions mixed up	4	11.8%
I don't like to take pills every day	3	8.8%
I can't afford it	3	8.8%
I don't like to take it when I am out in public	2	5.9%
I do not feel sick	2	5.9%
Other	7	20.6%
Total	57	

Seventeen percent of survey respondents stated that there are services they need to make it easier to keep their doctors appointment and/or take their prescribed medication.

- El Paso HSDA had the largest number and percentage of respondents reporting these services, 25% and 35 consumers.

Table 5.14
Are there services that you need that would make it easier for you to keep your doctor appointments and take your prescribed medicine?

Attribute/ Response	El Paso HSDA		Permian Basin HSDA		Lubbock HSDA		Amarillo HSDA		Totals by Response	
n = 328	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
No	108	75.5%	38	95.0%	71	87.7%	55	85.9%	272	82.9%
Yes	35	24.5%	2	5.0%	10	12.3%	9	14.1%	56	17.1%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

Needed services include:

- Transportation, identified by 24 respondents. Four specifically requested gas vouchers.
- Medication support was identified by four respondents, including assistance with obtaining medication and help with reminders to take the medications on schedule.
- Insurance, identified by three.
- Dental care, identify by two.
- Suggestions for clinic scheduling included extended hours (identified by two), reminder calls, and additional clinics.
- Having one doctor instead of changing providers.

- Limit canceling and rescheduling established appointments.

Key Informant Interviews and Focus Groups

Accessing medication was the first topic of conversation among the La Fe Care case manager focus group participants. Specific issues included:

- La Fe physicians will not write a prescription for a patient they have not seen, whether that is a prescription continuation from prison, a re-script for a psychiatric medication from Sun City Behavioral Health or another source. This often causes a lapse in treatment for these patients.
- It was stated that halfway house/prison inmates are not given an adequate supply of HIV medication prior to transfer, and once in El Paso, they do not have the ability to pick up prescriptions when they are ready.
    - Case managers report that transportation from the El Paso halfway house is very limited and regulated, resulting in access barriers.

A Permian Basin HSDA key informant stated, "Meds are the top need, but it is being filled."

- Another key informant stated that sometimes refills are not filled on a timely basis because of pharmacy, patient forgetfulness or other issues.
- "Clients don't know what questions to ask--doctors assume they know the treatment. They will instruct the newer ones more but not the older ones. They all need a clear explanation of what's going on with labs and meds."

A Lubbock HSDA key informant reported that their treatment team approach includes a pharmacist. Specific comments included:

- "The pharmacist reviews all client meds that are brought to the clinic to identify possible interactions."
- "We will fund medication initially until they are able to get a program to cover it."
- "We are doing swallowing evals with speech therapist. We found that if swallowing causes discomfort, the client may not take the medication as directed."

Out-of-Care Interviews

These issues identified by the case managers and key informants were supported by out-of-care consumer responses.

- Has a problem with the pharmacy—they have to order it, so he goes back to get it, and they have to reorder—why can't they keep it in stock, especially when they know I am up for a refill
- Getting medications is a hassle. I have to ride on the bus across town to the pharmacy, but there are no bus passes.
- I forgot to turn in the medication application renewal at ___ (clinic). So I didn't go back.
- I ran out of medication; I tried to leave message but they never called back; now trying to get into the doctor so he can get on medication.
- I am not comfortable with the medication—a lot of side effects—itchy skin, sores, blurring vision, hallucinations, high sugar… He might have continued medical care if he felt that the treatment team was understanding and supportive of his decision not to take meds.

Resources

Twenty-five organizations provide medication services in the PanWest and West Texas regions.

- The Lubbock HSDA has the most with nine providers, followed by West Texas with six.

Table 5.15
Medication Services
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
Medication Services	5	9	5	6	25

SPECIALTY MEDICAL CARE

Specialty Care Use and Barriers

Key Informant Interviews

Both El Paso HSDA and Lubbock HSDA key informants identified a need for improved access to physician specialists. Specifically: "Specialists for medical problems that affect HIV treatment."

Permian Basin key informants stated if they have a patient with a co-morbidity, requiring a specialists, they have not had issues finding a doctor

Resources

El Paso HSDA, with a medical school and many acute care hospitals, has the largest number of specialty medical care resources, eleven.

Although the Lubbock HSDA has a medical school, only three specialty medical care resources have been identified.

Table 5.16
Specialty Medical Care Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Specialty Medical Care	4	3	9	11	27

PRIMARY MEDICAL CARE

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.

- Ryan White funded medical care providers and case managers identified this as an area to assess on the consumer survey.
- 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.

Therefore, the consumer survey included information about primary care access and utilization.

Primary Medical Care Use and Barriers

Consumer Survey

Participants were asked, "Other than your HIV doctor, do you have a doctor/clinic that you go to for treatment of general medical conditions, such as coughs and colds, diabetes, high blood pressure, etc.?"

- Over half (56%) do not have a primary care doctor/practitioner (PCP).
- This ranges from nearly two thirds of respondents in the El Paso HSDA to one-third in the Lubbock HSDA.

Table 5.17
Other than your HIV doctor, do you have a doctor/clinic that you go to for treatment of general medical conditions, such as coughs and colds, diabetes, high blood pressure, etc.?

Attribute/ Response	El Paso HSDA		Permian Basin HSDA		Lubbock HSDA		Amarillo HSDA		Totals by Response	
n = 327	#	%	#	%	#	%	#	%	#	%
No	94	65.7%	21	52.5%	27	33.8%	41	64.1%	183	56.0%
Yes	49	34.3%	19	47.5%	53	66.3%	23	35.9%	144	44.0%
HSDA Totals	143	100%	40	100%	80	100%	64	100%	327	100%

Respondent that do not have a PCP were asked the reasons. (Appendix G) Three responses were cited by 32% or more of participants:

1. Getting all medical care from the HIV doctor/clinic (50%).
    - 70% of Amarillo HSDA respondents and 60% of West Texas HSDA respondents cited this reason.
    - Only 11% of Lubbock HSDA respondents cited it.
2. Not needing a PCP (40%).
    - Percentages of respondents were similar across all four HSDAs.
3. Using the Emergency Room when additional care is necessary (32%).
    - Responses by HSDA: 37% West Texas, 32% Amarillo, 29% Permian Basin, 19% Lubbock.
4. No insurance was a concern for 14 respondents. These were all included as "other," so this is a top of mind concern for primary care access.

Table 5.18
Reasons for Not Having Primary Care Physician

Barrier	Total	
n = 177	#	#
I get all my care from my HIV doctor/at the HIV clinic	92	50.3%
I have not needed one	73	39.9%
I go to the Emergency Room when necessary	59	32.2%
No insurance (derived from other)	14	7.7%
I don't want to tell my HIV status to another doctor/nurse	13	7.1%
Transportation	13	7.1%
There is too much paperwork/hassle at another doctor/clinic	11	6.2%
It takes too much time to go to another doctor/clinic	7	3.8%
Financial concerns (derived from other)	7	3.8%
Immigration concerns	6	3.3%
Other (with insurance responses removed)	7	3.8%

Key Informant Interviews

Ryan White funded providers identified concerns about adequate funding and the need to refer and support consumers in accessing primary medical care. Comments included:

- Providers need to know more about how to get consumers engaged in primary care.
- With Part B, we only have enough money to provide HIV care.
- We refer to primary medical care for general medical care including co-morbidities of diabetes, and high blood pressure. We have clinic at their site and a federally qualified health center (FQHC) for uninsured.
- Ryan White Part B funds and the clinic hours are not sufficient to provide primary care in addition to HIV medical care.
- We will treat high blood pressure or diabetes at the clinic. If necessary due to funding, he will give them a referral to a primary care clinic.
    - For something like thyroid that is not directly attributable to HIV, we cannot use Ryan White funding.
- For those who can't afford primary care, their doctors will take care of one issue. If they have more than one, they will be referred to a primary care doctor or specialist.

Providers in some HSDAs were not familiar with the FQHC available to provide primary care to their clients. FQHCs are available through the PanWest and West Texas regions, although all sites may not operate on a full time basis.

- El Paso HSDA has three FQHCs with 14 locations. La Fe Care is part of an FQHC organization.
- Permian Basin HSDA has an FQHC in Midland and another in Odessa
- Lubbock HSDA has a FQHC in Lubbock and another in Levelland as well as in Hale County

- Amarillo HSDA has several FQHC sites.

It is expected that primary care providers will be increasingly important as health care reform is initiated. Clinician and case manager understanding of available resources and appropriate referrals will support appropriate PLWHA utilization

Resources

Fifty-two organizations provide primary medical care in the PanWest and West Texas regions. A map of primary medical services in El Paso County developed by the Department of Public Health can be found in Appendix H.

Table 5.19
Primary Medical Care
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	El Paso	Total
Primary Medical Care (not HIV-Specific)	12	15	14	11	52

WOMEN'S HEALTH SERVICES

2012 ARIES Utilization

Twenty-five percent 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 women clients at PASO to 4% at TTUHSC.
- BAS also reports a small percentage, 11%.

Table 5.20
Female Clients Receiving PAP Smear
2012

Received PAP Smear	PASO n=68		Project CHAMPS n=70		BAS n=58		La Fe CARE n=129		TTUHSC n=24		Total n=349	
	#	%	#	%	#	%	#	%	#	%	#	%
Yes	23	33.8	18	31.0	8	11.4	37	28.7	1	4.2	87	24.9
No	45	66.2	40	69.0	62	88.6	92	71.3	23	95.8	262	75.1

Source: ARIES 2012

Women's Health Services Use and Barriers

Consumer Survey

Female respondents were asked if they have a doctor or clinic that they go to for PAP smears and treatment of women's health conditions.

- Of the 71 women that responded, 78% report having a women's health physician/clinic.

Table 5.21
Doctor/Clinic for PAP Smears and Treatment of Women's Health Conditions

HSDA	El Paso		Permian Basin		Lubbock		Amarillo		Total	
n = 71	#	%	#	%	#	%	#	%	#	%
No	5	19.2%	4	30.8%	4	22.2%	3	20.0%	15	22.2%
Yes	21	80.8%	9	69.2%	14	77.8%	12	80.0%	56	77.8%
HSDA Total	26	100%	13	100.0%	18	100%	15	100%	71	100%

Respondents without a women's health physician/clinic were asked the reasons. None of the responses had significant numbers. Responses are presented in Table 5.22.

Table 5.22
Reasons for not having a Doctor/Clinic for Women's Health Issues

Barriers	Total	
n = 12	#	%
I get all my care from my HIV doctor/at the HIV clinic	4	33.3%
I go to the Emergency Room when necessary	3	25.0%
No insurance	3	25.0%
I don't want to disclose my HIV status to another doctor/nurse	2	16.7%
Transportation	2	16.7%

Key Informant Interviews

Ryan White providers stated that they need to better engage their female clients in women's health services.

- Issues center on educating and supporting women to access services
- Unpredictable funding and for women's health services. Previously patients went to Planned Parenthood, but that service has closed in both El Paso and Odessa.
    - BAS clinic provides a voucher to the gynecology clinic. It was reported that they "do about 20 to 30 female PAPs via the voucher."
- One provider reports that they have an OB/GYN clinic, but HIV patients do not schedule their women check-ups.

Resources

A total of 30 OB/GYN providers are identified in the PanWest and West Texas region. A map of women's health services in El Paso County developed by El Paso Department of Public Health can be found in Appendix I.

Table 5.23
OB/GYN Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
OB/GYN Care	7	9	8	6	30

Table 5.24
Available Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Family Planning Services	6	6	6	2	20

EARLY INTERVENTION SERVICES

HRSA Definition

The provision of counseling to individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals for other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Early Intervention Services Use and Barriers

Key Informant Interviews

Key informants from AIDS service organizations, departments of health and Ryan White funded organizations provided detail counseling and testing, diagnosis and linkage to care:

Amarillo HSDA

The Amarillo Department of Public Health employs two people for HIV/STD outreach, C&T and linkage to care. They have an office at PASO, that is staffed two half days per week.

- Anyone with a positive test is tracked for 90 days or until after their first medical appointment.
- The close collaboration with PASO allows them to providing ongoing follow-up as necessary.
- The outreach team has close ties with influence leaders in the high risk communities including homeless and commercial sex workers.

Lubbock HSDA

Much of the counseling and testing in the Lubbock HSDA is provided through StarCare Specialty Health Systems. StarCare staff report that reduced funding has resulted in reduction in staff and no testing for chlamydia. Other organizations include:

- Managed Care Center for Addictive/Other Disorders, Inc. which is a substance abuse treatment program that also does rapid testing.
- The Lubbock Department of Health provides HIV and STD testing along with a STD treatment clinic. The latter operates on a low cost fee for service basis.

El Paso HSDA

The El Paso HSDA has a range of organizations providing C&T and linkage to care. These include the El Paso Department of Public Health, La Fe Care Center, International AIDS Empowerment, and Aliviane (substance abuse treatment). The Department of Public Health has developed innovative programs including:

- MFactor which provides a safe environment for the LGBT community, 18 - 39 years of age. Among other things services include health education, risk reduction, social support.
- CLEAR uses an evidence- based one-on-one skill building program with weekly meetings. Five core modules can be supplemented with additional focused modules based on client needs and interests.
- Community Mobilization brings together representatives of El Paso community organizations that support people at risk of or living with HIV/AIDS. This program seeks to provide networking opportunities and develop synergies between providers to reduce HIV risk behaviors, expand C&T, enhance linkage to and maintenance in HIV medical care.

Out-of-Care Interviews

Providers requested that out-of-care consumers be asked if they requested the HIV test be run a second time after receiving their diagnosis. Five consumers reported requesting a ”re-test.”

Barriers to Care after Diagnosis

Barriers to linkage to care identified include: lack of support, communication problems, depression, denial, misinformation about HIV, cost concerns, provider miscues. Verbatim remarks about each are provided below.

Lack of Support

- After diagnosis, I went through the process alone. It would have helped to have case worker to help. Having some personal help and support would have made a difference.
- Once diagnosed they give you referrals; after that you are on your own. It is confusing. It would be wonderful to have peer navigator. I would volunteer to be a peer navigator.
- The girl from the ____ (counseling and testing agency) told me. I broke down. She said, 'I'll give you a few minutes.' She came back in 30 minutes! She made an appointment with ____ (clinic), gave me a note with the appointment and left. I didn't go to the appointment.
- The doctor and the social worker from ___ (clinic) helped him a lot... I have always been positive and happy.
- ___(outreach worker) from ____ (clinic) helped me by giving advice and understanding. Also, the support from my friends and my partner at the time.
- My family (provides support). My parents were present when the doctor told me about my status and they along with my sister and partner (who also is HIV positive) were very supportive since day one. That helped me to accept my HIV status and start moving on right away.
- Therapy. This would have helped-- to understand that is like another disease and I should not be ashamed.

Communication

- There should be better communication with newly infected people. People to call for comfort or coach.
- Should be a little more communicative because communication gets lost.

Stigma and Shame

- I felt ashamed, but it did not affect my regular activities or work.
- The person who ran the HIV test encouraged me to start treatment. It would have been easier to have private medical appointments. I did not want to see people in the waiting room.
- I was afraid of seeing someone there and having it get all around town. The waiting area is a little too open.
- My partner didn't tell me he was positive until after we had been together for a year. There is a BIG stigma with HIV. When I was diagnosed, it spread through my family like wildfire. They are looking out for me now. I am willing to educate my family now, but I was not ready to do that right away.
- When you live in a small town, everyone knows everyone else's business, so I didn't want anyone to know.

Depression

- Felt depressed for about six months.
- At the beginning, I was just waiting for my time to go. For three months I just laid there.
- It is a process--denial, anger, grief stages. A little depression. Then you come to terms with it. Finding something I could do helped--I took up cooking Make it easier; friendly, understanding.
- Get some counseling to help the person get around the idea, when I first found out wanted to die. Maybe counseling could help.

Denial

- Just beginning now; which is 8 months later. I got it from my partner who was cheating. Freaked out, got depressed…I was referred to a counselor, but didn't go. Blew if off because I didn't want to think about it. I wanted to get it out of his mind, but it didn't.
- I waited out of denial and fear. Finally I decided I needed to take care of myself—I said, "just get up and do it."
- I was diagnosed when pregnant. The baby is positive. The baby is living with her grandmother and getting treatment. The baby's father recently died of AIDS. This is causing me to think about getting it (treatment).

Misinformation about HIV

- Friend told him once on meds you can't miss one which made him not want to begin.
- Would have liked more treatment information and resources. I was worried about gaining weight from medications so I didn't get treatment. Then I saw a magazine and read the story of a professional HIV positive skater with same fears. Then I started treatment.

Cost Concerns

- The cost was too expensive. He did not and does not have insurance through work. He is eligible for Ryan White and that is also how he gets his meds.
- Moneywise it is hard to get. Still thinks the cost will be a problem. No one told him it was free of charge so he worried about the cost.

Provider Miscues

- He was told he would be contacted for an appointment, but he was never contacted. He contacted them again. "They left him hanging."
- Got right into care--it was rocky—transportation problems; had to talk to a lot of people; had a problem with pharmacist.

Suggested Advice to Newly Diagnosed

Out-of-care consumers were asked to give advice to newly diagnosed PLWHA. Responses fall into two categories: (1) Accessing and following HIV medical treatment; (2) Having a positive outlook on life. Specific comments are illuminating:

Accessing and following medical treatment

- Do not waste any time, seek treatment as soon as possible. Lot of people are sick and should not be embarrassed.
- Have patience with the paperwork and seek treatment.
- Get under a doctor's care and take care of yourself. It is a disease you can live with. Treatment is much better and much easier to follow.
- Get care for it--get on meds
- Make doctors visits, stay on medication, if you have severe side effects, check with the doctors If you are going to play, play safe. It's not easy to be rejected, but it is a whole lot worse to know you are the cause of their infection
- Keep doctor's appointments, take medication on time
- They should get tested ASAP to get on meds soon.

- Take care of your health--it gets better. He feels much better about his diagnosis now.

Positive outlook

- Don't think about death--live life to the fullest--this is not a terminal illness anymore
- Stay positive, you're going to make it
- Don't give up--after diagnosis she was making plans for burial. As the years go by, she is healthier than a lot of people.
- The only thing that takes you out of depression and motivates to act is self-love, is not enough that other people love you, if you don't love yourself. Accept yourself and your situation.
- Move on, do your life not worrying about what others may think or say, worry about yourself, take your meds and move on having a normal life.
- To throw forward, keep moving and consider the condition as any other (diabetes, cancer, etc.). It is very controllable nowadays, take your meds, do exercise and eat well.
- Don't let it ruin your life. It happens and it happens to a lot of people. Take care of yourself.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

HRSA Definition

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, co-payments, and deductibles.

This is one of three service categories that the Texas Department of State Health Services required to be funded.

2012 ARIES Utilization

Across PanWest and West Texas regions, few 2012 funds were distributed for health insurance premium and cost sharing assistance. This may due, in part, to the fact that these regions have among the highest rates of uninsured in the country, and few consumers have health insurance for continuation.

- Other categories with minimal utilization included Medicare premium assistance, Medicare Part D assistance, Medicare co-payment assistance and "other" insurance assistance.

Table 5.25
Health Insurance Premium Assistance
2012 Unduplicated Clients

	PASO		Project CHAMPS		BAS		La Fe Care		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Insurance Premium Assistance	5	1.9	5	1.7	12	4.5	3	0.33	0	0.0	25	1.3
Source: ARIES 2012												

Health Insurance Premiums and Cost Sharing Assistance Use and Barriers

Consumers Without Health Insurance

The ARIES system allows clients to provide multiple insurance sources. To simplify, Table 5.26 presents the number and percentage of consumers without any type of insurance.

- BAS and PASO have the lowest percentages of uninsured clients, 34% and 35% respectively.
- West Texas providers have the highest percentages. TTUHSC reports 72% and La Fe 60% without insurance.

Table 5.26
Consumers Without Health Insurance

Insurance	PASO		Project CHAMPS		BAS		La FE		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
None	95	35.3	130	43.9	92	34.2	543	60.1	123	72.4	983	50
Source: ARIES 2012												

Key Informants

Key informant comments related to insurance continuation include:

- A lot of money is going to insurance cost sharing.
- Health insurance assistance is also out of funds.
- Need insurance support. If they are employed, the premium may be too high.
- Services need to help patients access insurance.

ORAL HEALTH SERVICES

HRSA Definition

Diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

2012 ARIES Utilization

Ryan White funded oral health use was limited in 2012. ARIES data finds:

- The largest number and percentage using oral health services were La Fe Care clients. Half (50%) accessed prophylaxis or routine treatment, and 17% accessed specialty care.
- 31% of BAS clients accessed these services
    - BAS refers to a contracted dentist.
- 15% of PASO clients accessed prophylaxis and routine treatment.
    - PASO has agreement with dentist for “basics,” (rarely dentures).
- Other resources are used for Project CHAMPS and TUHSC clients.
- CHAMPS gets patients into available FQHC dental clinics and uses a private dentist for specialty services in Lubbock.

- TTUHSC provides oral surgery but uses Tooth Angels for dental care. Contracting for dental services though the TTUHSC has reportedly been stalled.

Table 5.27
Oral Health Services
2012 Unduplicated Clients

	PASO		Project CHAMPS		BAS		La Fe Care		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Prophylaxis	23	8.6	1	0.3	66	24.5	213	23.6	0	0.0	303	15.9
Routine Treatment	18	6.7	2	0.7	18	6.7	241	26.7	0	0.0	279	14.6
Specialty	2	0.7	13	4.8	3	1.0	155	17.1	0	0.0	173	9.1
Source: ARIES 2012												

Oral Health Services Use and Barriers

Out of Care Interviews

Out-of-care consumers are not aware of the services available through Ryan White. Dental care is a service that might encourage consumers to access the service system.

- One out-of-care consumer who has recently begun treatment after being out of care for several years stated, "I wasn't aware of the services available. I have gone to the dentist several times, but have paid out-of-pocket every time."

Resources

Twenty-one organizations provide dental care in the PanWest and West Texas regions. This includes eight in El Paso HSDA, five in Lubbock HSDA, and four in each of the Amarillo and Permian Basin HSDAs.

Table 5.28
Dental Care Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Dental Care	4	5	4	8	21

HOUSING

HRSA Definition

The provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services included assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

2012 ARIES Utilization

Housing services funded by Ryan White/State Services and HOPWA in the PanWest HSDAs include:

- Housing Assistance - Emergency
- Housing Assistance – Short Term
- Housing Referral/Housing Related Services
- Short Term Housing Assistance, Mortgage Assistance, Rental Assistance, Utility Assistance
- Tenant-Based Rental Assistance
- Permanent Facility-Based Housing

In 2012 PASO had 85 clients accessing these services, Project CHAMPS had 25 clients and BAS had 29 clients.

West Texas clients access these services through two agencies:

1. Sun City Behavioral Health, which is administered by El Paso Essential Health Network
2. International AIDS Empowerment (IAE) which is administered by the City of El Paso Housing Department

2012 Housing Profile

ARIES provides 2012 housing status for PLWHA

- PASO had the largest percentage of clients with stable housing (75.5%). TTUHSC has the lowest percentage, 40%. The other three agencies have between 52% and 56% with stable housing.
- Homeless is a small percentage. The West Texas region has nine clients who are homeless while PASO has two.

Table 5.29
Housing Status
Ryan White Consumers by Agency
2012

	PASO		Project CHAMPS		BAS		La Fe CARE		TTUHSC	
	#	%	#	%	#	%	#	%	#	%
Stable/Permanent	203	75.5%	165	55.7%	150	55.8%	418	46.3%	68	40.0%
Temporary	61	22.7%	130	43.9%	118	43.9%	472	52.3%	97	57.1%
Unstable (Homeless)	2	0.7%	0	0.0%	0	0.0%	8	0.9%	4	2.4%
Unknown	3	1.1%	1	0.3%	1	0.4%	5	0.6%	1	0.6%
Source: ARIES 2012										

Housing Use and Barriers

Key Informant Interviews

Amarillo HSDA

- Need help to get into own place. State services money is available to help with deposit. HOPWA does not help get into housing without income
- No HOPWA waiting list--Section 8 is still open. Assist with HOPWA until get Section 8 approval—8 months for women with children and two years for men

Permian Basin HSDA

- The oil boom has caused a severe housing shortage in the region. Low income people have been pushed out of the cities to lower priced, more rural areas.
- Housing is a big need. She (case manager) gives them the apartment list and they contact the apartments. Some have waiting lists. I f they can't get an apartment, HOPWA has a prioritized list. Currently three or four on the list. Women with children are first priority.

El Paso HSDA

- Section 8 is not an option since the waiting list has not been open for over two years. Most clients are single and the housing authority has a hierarchy making options very limited.
- Undocumented have a hard time accessing housing. There are three or four places (housing complexes) that do not require documentation.
- If they want to begin HOPWA, consumer have to go through IAE (International AIDS Empowerment) or Sun City, both of which maintain waiting lists. They may refer to Project Bravo or general assistance.

Out of Care Interviews

When consumers are not meeting basic needs, such as housing, it is difficult for them to access or be compliant with HIV medical care.

- Nearly half (48%) of out-of-care consumers meet the definition of stable housing, living in an apartment or house that they own or rent. However, one of these consumers has not told her children of her HIV status.
- Ten (34.5%) have temporary housing situations.
- Three are homeless and one reports receiving an eviction notice.
- Nearly 30% have not told those they live with of their HIV status.

Table 5.30
Out-of-Care Consumers
Housing Status

Current Housing	Total Number	Disclosed HIV Status To Living Companions		
Living in:		**Yes**	**No**	**Lives Alone**
Home or apartment that is owned or rented	14	12	1	1
With Family	9	4	5	
Group home	1		1	
Homeless or Couch to couch	3	2	1	
Apartment but received eviction notice	1			1
TOTAL	**28**	**18**	**8**	**2**

Comments from out-of-care consumers with unstable housing or housing situations that interfere with accessing HIV medical care include:

- They (family members) take my money so I don't have the apartment I want. I live far away in low rent housing and I don't have a car.
- I need housing—"if not for my mother, I would be homeless."
- Housing is the biggest issue in the area (Permian Basin). More funding is needed for housing.
- I am looking for a place right now. I have talked to ___ (provider) about housing (currently homeless).
- I am living couch to couch. Going through this alone.
- I live alone and am about to get evicted.
- It (housing) is unstable—sometimes I'm with parents, sometimes in Mexico with family, sometime I rent.

Resources

The PanWest and West Texas regions have 46 organizations providing housing services.

- El Paso HSDA has 21 housing providers.
- Lubbock HSDA has 12 providers.

Table 5.31
Available Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Housing Services	6	12	7	21	46

MEDICAL CASE MANAGEMENT (INCLUDING TREATMENT ADHERENCE)

HRSA Definition
Provision of services focused on maintaining HIV-infected persons in systems of primary medical care to improve HIV-related health outcomes. Medical Case Managers act as part of a multidisciplinary medical team, with a specific role of assisting clients in following their medical treatment plan. Medical Case Managers should not serve as gatekeepers or access points into medical care as the goal of this service is the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the Medical Case Manager. Medical Case Management must include a comprehensive assessment of need, the development of a service plan to address client needs, client referral to appropriate providers based on need and service plan, interventions to address client issues such as medication compliance, adherence and risk reduction as well as patient education.

CASE MANAGEMENT (NON-MEDICAL)

HRSA Definition
Non-Medical Case Management is a collaborative process that assesses, educates, plans, implements, coordinated, monitors and evaluates the options and services required to meet the client's health and human service needs. Case Management is seen as an encounter that involves assessment and care planning with the goal of independence for the client.

2012 ARIES Utilization

In 2012, nearly 82% of PanWest and West Texas clients access medical case management services.

- This ranges from 57% at BAS to 100% at TTUHSC.
- Two thirds of PASO clients accessed medical case management
- 88% of Project CHAMPS and La Fe clients used medical case management

Nearly three-quarters (73%) accessed non-medical case management.

- Organizations with lower percentages using medical case management tended to have larger percentages accessing non-medical care management.
- 93% of BAS clients accessed non-medical case management and none of TTUHSC clients accessed it.

Table 5.32
Accessing Medical and Non-Medical Case Management

Insurance	PASO		Project CHAMPS		BAS		La FE		TTUHSC		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Medical Case Management	178	66.5	262	88.9	154	57.3	796	88.2	170	100.0	1,560	81.8
Non-Medical Case Mgt.	225	83.6	256	86.5	250	92.9	666	73.8	0	0.0	1,397	73.3

Source: ARIES 2012

Ryan White medical and non-medical case managers play a critical role in supporting, encouraging and empowering clients to access needed care and services. Using best practices, case managers improved compliance with treatment regimes, reduced clients' time required for appointments and increased overall service satisfaction.

Successful approaches identified include:

- Development of a multidisciplinary treatment team to develop a comprehensive treatment plan of care.
- Provide as many needed services as possible at a single point of contact.
- Be sensitive to client needs, including both support and empowerment.

Medical and Non-Medical Case Management Use and Barriers

Key Informant Interviews

Non-Ryan White key informants provided suggestions related to support and cultural sensitivity:

- Case managers need to empower and support patients in understanding their rights. Clients drop out of care instead of confronting issues and concerns with medical provider.
- Consumers must be able to talk to providers and understand how to be assertive.
- "Need more culturally sensitive staff. Staff are not aware of MSM issues, staff and even doctors are uncomfortable with MSM."

Out-of-Care Interviews

Positive comments from out-of-care consumers relate to receiving needed services because they are "working with case manager."

Negative comments include

- Long waits for a scheduled appointment when no one else was there.
- Out-of-care often do not like to be seen in HIV providers' large, open waiting areas due to disclosure concerns. Case managers should be sensitive to this.
- Communication is important. Some recently out-of-care would like" better communication with their case workers."

- Patients need to understand and be a partner in their treatment plan. One consumer stated, "It is rare to see a case worker. They should get everyone (including client) into a little meeting and plan it (his treatment) out. Get everyone to explain. That would help a lot."
- Miscommunication related to prescription refills resulted in missed medication for two recently out-of-care consumers in two different HSDAs.

Resources

Twenty-six organizations provide case management services in the PanWest and West Texas HSDAs. More than half (54%) of these are in the West Texas region.

Table 5.33
Case Management
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Case Management	4	3	5	14	26

FOOD SERVICES

HRSA Definition

The provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Also includes vouchers to purchase food.

2012 ARIES Utilization

According to 2012 ARIES data, Amarillo is the only HSDA providing Ryan White funded food services to a significant number of consumers.

- PASO provided 113 consumers with food services in 2012.
- No consumers in El Paso HSDA received Ryan White funded food services, but an El Paso ASO has a food pantry that provides food specifically to PLWHA.

Key Informant Interviews

Access to health food continues to be a client need throughout PanWest and West Texas. Key informants in each area cited the reduced availability of food from the community food banks as a concern for their clients. Specific comments include:

Amarillo HSDA

- Waiting lists for food. One client saw food stamps decrease significantly. Food pantries are struggling. Need nutritious food.
- Client struggle with food and are stretched thin.

Lubbock HSDA

- Clients always feel the need for food bank, EFA, etc.

Permian Basin HSDA

- The local food banks are getting less funding and more people with growth in the area. Food stamps have been cut.

El Paso HSDA

- International AIDS empowerment offers a food bank for PLWHA. Recently the donations have been low.

Resources

PanWest and West Texas regions have 42 organizations providing food bank services.

Table 5.34
Food Bank
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Food Bank	10	13	9	10	42

TRANSPORTATION

HRSA Definition

Transportation: (through State Services only): Transportation services include the conveyance services provided, directly or through voucher, to a client so that he or she may access support services.

Medical Transportation: (through State Services and Part B): services include the conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Transportation Use and Barriers

Key Informant Interviews

The need for transportation varies by HSDA.

Lubbock HSDA

- Transportation is the case managers' top of mind need. In the past they have had bus passes, but they recently ran out
- A Lubbock case manager stated, "Transportation is the main reason for missing appointments." When bus passes are available, they not only supported HIV medical care appointments, but also oral health, mental health therapy and substance abuse treatment visits.

Permian Basin HSDA

- The most significant need for transportation is from Midland to Odessa. Tracks don't run (between these cities).
- In town people are more the issue. If someone has to go from Midland to Odessa for dental work, buses are not effective.
- Tracks serve outlying counties and are inexpensive.

West Texas

Key informant opinions about the need for transportation assistance in El Paso vary.

- A West Texas case manager stated that "This need (transportation) is being met."
- On the other hand, an agency administrator said, "Transportation is a major need. For $10 per person per month, they can get an unlimited bus pass."
- A counselor confirmed the need for transportation saying, "Transportation; is a need. It results in missed appointments. Aside from bus tokens, there is no other transportation…I will go to client homes (30% of time).
-

Out-of-Care Interviews

Transportation is a barrier to accessing HIV medical care, and is a reason some consumers dropped out of care.

- I am using my parents' vehicles, so that makes it difficult during the day, since they are not aware of my HIV status. This consumer also said he can take the bus, but the bus does not go everywhere or it takes several connections.
- He does not have reliable transportation. He has not gotten bus passes.
- He has transportation issues. He has not gotten bus passes--was told there were none available, but has gotten a disability card for reduced rate.
- Most significant need is transportation. He works all day and boss is not aware of his status, so need extended clinic hours and transportation to get there in time.
- She quit medical care because of transportation. It was a pharmacy/medication issue. They said prescription would be ready so she got transportation to pick it up and it was not ready. It was a big hassle.
- Need transportation. When taking the bus, it is hard to get to the clinic on time. You can't always reschedule if late.
- Transportation is a service need. ____ (provider) has helped with everything else.
- Transportation--there should be a better relationship with Sun Metro. He has a car but because he is not working, he doesn't always have the money for gas--would like to see gas vouchers.

Table 5.35
Available Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Transportation Services	1	3	2	9	15

HIV PREVENTION/COUNSELING AND TESTING

Key informant interviews, out-of-care consumer interview and MFactor focus groups provided information on HIV prevention, outreach and counseling and testing (C&T).

Resources

With 39 agencies in the region providing HIV C&T and 26 providing STD testing, all HSDAs except Permian Basin have more organizations providing HIV C&T.

- Lubbock HSDA has the most agencies providing these services.
- West Texas has the least, which is interesting because it has the most people living there.

Table 5.36
HIV Counseling and Testing
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
HIV C&T	10	14	7	8	39

5.37
STD Testing
PanWest and West Texas Regions
2013

	Amarillo	Lubbock	Permian Basin	West Texas	Total
STD Testing	7	11	7	1	26

Risk Factors

HIV risk continues in all HSDAs. Consumers in the out-of-care interviews and MFactor focus groups discussed details of high risk behaviors among MSM. Findings include:

- "High risk behaviors are everywhere."

- "They (his friends) go out and have a 'fast experience' by having sex with people they don't even know, some use protections and others don't. They go out to have an 'adventure.'
- Young MSM demonstrate the most high risk behavior. Risk factors reported by these men include:
  - "They (young men) don't fear it--there is a lack of information out there. Not enough people doing education.
  - Unwilling to disclose HIV status due to potential rejection.
    - "Hiding status is more common among the 18 - 25 year olds."
    - "If you are honest and tell possible partners you are HIV, they want nothing to do with you—so there is no chance of being with somebody."
  - Prefer sex without protection
    - "Younger men are more willing to make the choice (not to use condom)."
  - People who are "newly out" (of the closet) don't know about risk factors including sexual risks, STDs and don't know where to get education about these things. No "gay handbook."
- Promiscuity/multiple partners
- Sex while high on drugs or alcohol
  - "I have has seen lately the younger people using drugs, alcohol, experimenting, unprotected sex."
    - Over 30 MFactor focus group included participants with previous heavy drug use including injecting drugs. For these men moderate drug use continues although no reports of current IDU.
- "Nobody has oral sex with condoms, and that is high risk."
- "Bug chasers" seeking to become positive to obtain benefits
  - "People want to get infected…They think they can get financial assistance."
  - "Here in El Paso it is very rare."
- Some focus group participants made the case that protection is an individual's responsibility.
  - "What I have learned is that people don't infect you, you infect yourself because of how you want to see it or excuse to use, whether you were drunk, because you were drugged, for promiscuous, for being a dummy, because you fell in love, because you confided in someone, but nobody obligated or forced you not to wear protection."

On-line sites make increase hook-ups

- Adam4Adam, Craig's List
- Advertise preferences

Key informants from all HSDAs confirm these findings and provide varying perspectives on interventions.

- "It is getting worse because the younger generation is not caring."
- A lot of "complacency" resulting in not testing—bring back urgency (in this epidemic).
- "In general people are aware of the risks. Young Hispanics are a high risk group."
- "Condoms are very 1990s. Current science is viral load of the community. People who are undetectable are highly uncontagious. "
- "There is a misconception about sex between two positive partners—think they don't need protection."

BEHAVIORAL HEALTH ANALYSIS

An epidemic of mental health disorders is occurring among American adults.

- One in four adults currently carry a psychiatric diagnosis
- One in five adults take psychiatric medication regularly,[8]

Based on key informant interview responses, it can be expected that PLWHA have these disorders at the same or greater rates.

The negative effects of mental health disorders on physical health are well-documented. Mental health disorders can lead to non-compliance with treatment regimens, self-medicating through substance use, and other negative consequences.

Mental health disorders and substance abuse can interfere with HIV medical treatment compliance. Therefore, appropriate mental health therapy and necessary substance abuse treatment are 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.
- Similarly, substance abuse treatment services are reportedly accessible, but few consumers access them.
    - In the Lubbock HSDA, case managers reported that 75% of clients need mental health and/or substance abuse treatment, but most refuse.
    - PASO staff estimates that 25% of their clients are using mental health services, and another 25% more need it.
    - Another Amarillo provider remarked, "A lot of PLWHA have a substance abuse issue…everyone is using some type of substance."
    - El Paso providers report making referrals, but clients often do not access services.

The administrative agency is interested in developing services that meet behavioral health needs and are appropriately utilized.

Shifts in the Delivery of Behavioral Health Services

Key Considerations

This problem is pervasive in Texas and nationally. To begin to address it, DSHS commissioned a 2010 study entitled, "Capacity Building Project: Serving the Mental Health and Substance Abuse Needs of HIV Infected Persons in Texas."[9] The major themes emerging from this study provide a foundation for the behavioral health evaluation of this CHNA. These themes with key regional information are outlined below:

[8] Based on the National Institute for Mental Health and a 2011 Wall Street Journal analysis of pharmaceutical claims data.
[9] Rountree, Michele, et. al., Executive Summary, July 2010.

- Stigma – The stigma relating to HIV status, mental health or substance abuse status were all noted as affecting access to and maintenance of mental health and substance abuse services;
    - The stigma associated with mental health treatment is a significant access barrier in both the PanWest and West Texas regions.
        - Among the Mexican-American community, the stigma of mental health treatment is well documented. It was discussed by El Paso key informants.
        - A key informant stated, "Mental health has a stigma for all groups. It is viewed as a weakness."
        - Among the rural PanWest and West Texas communities, stigmas surrounding LGBT identity, HIV status and mental health treatment were discussed by both consumers and key informants.
- Assessment tools and assessment skills - all groups stressed the importance of utilizing standardized mental health and substance abuse assessment tools and having the proper training to utilize these tools to refer clients to providers;
    - SAMISS is the standard mental health and substance abuse assessment tool used by PanWest and West Texas Ryan White case managers. SAMISS provides a very broad evaluation of mental health and substance abuse issues.
        - A key informant stated, "Our is not trained in mental health and substance abuse issues--SAMISS assessment does not do enough--it is too general."
- Training - Recommended specifically on the diagnosis and treatment of mental health disorders (particularly for HIV/AIDS physicians), dual diagnosis, post-traumatic stress disorder (PTSD), and cultural competence in the area of LGBT issues.
    - Physicians are critical to linking patients with mental health and substance abuse treatment, so appropriate training is needed.
        - The "Capacity Building Project" stated, "A referral by a primary care physician is values above other sources."
        - This was reiterated by key informants.
    - Mfactor staff identified a need in West Texas for "LGBT-friendly" healthcare services, such as general primary care. Their clients are seeking providers who understand and can address MSM health issues.
- Client issues and Readiness - All groups in the study discussed client motivation and readiness as impacting access and maintenance of treatment.
    - PanWest and West Texas providers recognize the importance of client readiness to service linkage and to successful outcomes.
        - "You need client buy-in for both mental health and substance abuse treatment to be successful."
        - "(Mental health and substance abuse treatment) Services are available and easy to get, it is the commitment from the client."
        - "The issue is getting them to acknowledge it and be ready to go."
    - "Capacity Building Project" found that case managers linked success to (1) their encouragement and follow-up with the client, and (2) client rapport with the staff. It also found that clients were motivated by (1) rapport with the provider, (2) effective therapeutic techniques and models, (3) personal decision to change/internal drive to get well. For successful substance abuse treatment, it was also considered important to separate the client from the drug addiction environment.

- This report also suggested using support groups to move the client toward other types of treatment. This was explored during both provider key informants and out-of-care consumer interviews. Family Service has a successful male support group that has been operational for seven years. However, it is the exception. When asked about support groups, most providers stated their clients would not attend support groups. The following issues were identified:
    - One West Texas provider states, "Their (mental health) diagnoses prevent them from understanding."
    - Clients with severe mental health disorders, including major depression, bipolar disorder and schizophrenia, often do not like the side effects associated with taking psychotropic medications. This can be a significant access barrier.
    - Clients are reportedly referred to mental health services due to non-compliance with medical/medication regimen. "A client can be very cautious about what he takes. He can spend two hours with the psychologist and leaves fine, then doesn't take the meds."
    - When out-of-care consumers were asked about interest in support groups, all expressed disclosure concerns in a group setting. Comments focused on small towns/rural areas.
    - Only ten in-care consumer survey respondents report a need for a support group, including eight in El Paso HSDA and two in Lubbock HSDA. This is one third of consumers reporting a need for mental health support services.

- Integrated Care - factors related to integrated care include integrated mental health/substance abuse models of treatment, the utilization of multi-disciplinary teams, and service provision within the context of medical care. Integrating medical care and behavioral health issues is increasingly being viewed as a key to improving health. It has been estimated that among the general population, as much as 70% of primary care visits are the result of psychosocial issues.[10]
    - Primary care is now the sole form of health care used by over one-third of all patients with a mental disorder accessing the health care system.[11] Key informants estimated that PLWHA have higher needs for mental health treatment than the general population.
    - In PanWest and West Texas, physicians who have the skills to treat both HIV and mental health issues, such as anxiety and depression, have been successful in addressing these co-morbid conditions during HIV medical care visits.
    - Family Services in partnership with Project Vida (FQHC) is trying to integrate primary care, substance abuse and mental health treatment at their Surety Drive location. Project Vida will provide care at Family Service that include psychiatric service and medication prescriptions.
    - The Regional Health Partnership Plans throughout the PanWest and West Texas regions include new models of care that integrate primary care and mental health treatment. This is increasingly viewed as an essential model of care for individuals with co-occurring medical and behavioral health disorders.

[10] Robinson and Reiter (2007). Behavioral Consultation and Primary Care: a Guide to Integrating Services, Chapter 15, "Evaluating your service".

[11] Russell, Lesley, Mental Health Care Services In Primary Care: Tackling the Issues in the Context of Health Care Reform, Center for American Progress, October 2010. Page 1.

  - Essential to these integrated models is the availability of psychiatric services for more severe disorders.
- Resources and Networking—all groups reported a need for more substance abuse treatment and mental health services throughout the state, as well as emphasizing a greater value on networking between providers.

Roles and Definitions

Mental Health Services HRSA Definition
Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Outpatient Substance Abuse Services HRSA Definition
Outpatient substance abuse treatment is the provision of medical treatment or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel

HIV Early Intervention (HEI) Case Management

HIV Early Intervention (HEI) case management provides outreach and support to PLWHA who are substance users. HEI case managers may:

1. Provide intensive case management, based on referral, for PLWHA with substance abuse issues;
2. Conduct case finding in the community in collaboration with an outreach team;
3. Receive referrals from PLWHA's medical or social case managers when the client is ready to access substance abuse treatment;
4. Provide ongoing follow-up, education and support after the client is in recovery.

HEI case managers are funded through the Texas DSHS Division of Mental Health and Substance Abuse.

Outreach, Screening, Assessment and Referral (OSAR)

Outreach, screening, assessment and referral centers (OSARs) are the first point of contact for those seeking substance abuse treatment services. Regardless of ability to pay, Texas residents who are seeking substance abuse services and information may qualify for services based on need.
OSARS in the PanWest and West Texas HSDAs include:

StarCare Specialty Services (covers most of Amarillo and Lubbock HSDAs)
3804 I-27, Lubbock 79412
806-767-1716
Permian Basin Regional Council on Alcohol and Drug Abuse
120 East Second Street, Odessa 79761
432-580-5100

El Paso Hospital District

5959 Gateway West, Suite 520, El Paso 79925
915-521-7818

Statewide HIV Residential Substance Abuse Treatment

Homeward Bound operates a 60 to 90 day statewide, PLWHA-specific residential substance abuse treatment program located in Dallas, Texas. The 12-bed PLWHA unit is part of a much larger facility, so patients are able to access a variety of services, including such things as acupuncture. Homeward Bound also operates Trinity Detox and Behavioral Health Center in El Paso.

The Dallas-based Homeward Bound treatment team includes medical doctors, bilingual/bicultural LCDCs, LPCs, and LVNs. Collaborative educational programs are provided by University of Texas Southwest Medical College staff and the Greater Dallas Council on Alcohol and Drug Abuse. A family program is provided on the weekends.

While this specialized PLWHA program is available to PanWest and West Texas PLWHA, barriers include (1) the distance to Dallas, (2) cumbersome paperwork requirements that may delay entry into treatment, (3) limited bed availability.

Behavioral Health Analysis Use and Barriers – Substance Abuse Treatment

Consumer Survey

Substance Abuse Treatment

The survey asked participants if they considered getting substance abuse treatment in the last 12 months.

- Nearly 91% said they did not consider getting it.
- Fifteen (4.6%) participants said they got substance abuse treatment
- Another 15 participants said they considered it, but did not get it.

Table 5.38
Considered getting substance abuse treatment in the last 12 months

HSDA	El Paso		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	126	88.1%	40	100.0%	76	93.8%	56	87.5%	298	90.9%
Yes, but I didn't get it	11	7.7%	0	0.0%	3	3.7%	1	1.6%	15	4.6%
Yes, and I got it	6	4.2%	0	0.0%	2	2.5%	7	10.9%	15	4.6%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

The fifteen respondents who considered substance abuse treatment but didn't get it were asked the reasons.

- The most frequent answer, cited by seven respondents, was the need for free treatment.
- This was followed by six who did not know where to go to get substance abuse treatment.
- Transportation to treatment was identified as a barrier by three respondents.
- None of the respondents didn't get treatment because "it takes too long to get in—I need to get in immediately when I am ready."

Table 5.39
Reasons for Not Getting Substance Abuse Treatment

HSDA	El Paso	Permian Basin	Lubbock	Amarillo	Total
n = 15	#	#	#	#	#
I need free treatment	5	0	1	1	7
I didn't know where to go	4	0	1	1	6
I need transportation to treatment	1	0	1	1	3
I need a program with an understanding counselor	1	0	0	1	2
It takes too long to get in—I need to get in immediately when I am ready	0	0	0	0	0
Other	1	0	0	0	1
HSDA Totals	12	0	3	4	19

Mental Health Services

Approximately three-quarters of survey participants have not used mental health services in the past year.

- The HSDA with the largest percentage using mental health services was El Paso with 30% accessing these services.
- The HSDA with the smallest percentage using mental health services was Lubbock HSDA with 18.5% of participants reporting using these services.

Table 5.40
Mental Health Support Services Used in the Past Year

HSDA	El Paso		Permian Basin		Lubbock		Amarillo		Total	
	#	%	#	%	#	%	#	%	#	%
No	100	69.9%	32	80.0%	66	81.5%	51	79.7%	249	75.9%
Yes	43	30.1%	8	20.0%	15	18.5%	13	20.3%	79	24.1%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

Nine percent of respondents said there are mental health services they need now but are not getting.

- This includes 11% in both El Paso and Lubbock HSDAs.

Table 5.41
Are there Mental Health Support Services Needed Now but Not Getting?

HSDA	El Paso		Permian Basin		Lubbock		Amarillo		Total	
n = 328	#	%	#	%	#	%	#	%	#	%
No	127	88.8%	36	90.0%	72	88.9%	63	98.4%	298	90.9%
Yes	16	11.2%	4	10.0%	9	11.1%	1	1.6%	30	9.1%
HSDA Totals	143	100%	40	100%	81	100%	64	100%	328	100%

Those needing mental health services were asked what services would help them now.

- The most frequent response was outpatient counseling, identified by 14 consumers including 8 in El Paso HSDA. This is half of the El Paso consumers with a need, three-quarters of the of Permian Basin consumers with a need and a third of Lubbock HSDA consumers with a need.
- Psychiatric medications and psychiatrist services were identified by 11 participants including more than half of those needing services in the Lubbock HSDA.
- The one consumer in Amarillo HSDA identifying a need for mental health services identified a need for psychiatric medication and psychiatrist services.
- Support groups were identified as needed by ten consumers, eight of whom are in the El Paso HSDA and two in Lubbock HSDA.
- The remaining services: dual diagnosis program, day treatment, crisis management and residential treatment were identified by between two and four consumers each.

Table 5.42
Services That Would Help You Now

HSDA	El Paso	Permian Basin	Lubbock	Amarillo	Total
n = 29	#	#	#	#	#
Outpatient counseling	8	3	3	0	14
Psychiatric medications and psychiatrist services	4	1	5	1	11
Support groups	8	0	2	0	10
Dual diagnosis treatment (mental health and substance abuse treatment)	2	0	2	0	4
Day treatment	3	0	0	0	3
Crisis management	2	1	0	0	3
Residential treatment	2	0	0	0	2
Other	3	0	2	0	5
HSDA Totals	32	5	14	1	52

Key Informant Interviews

Amarillo HSDA

Free/low-cost mental health counseling options are available to Ryan White clients:

1. PASO staff report that mental health services are high quality in Amarillo. The difficulty arises with "getting client to enroll."
2. Texas Panhandle Centers is available for mental health treatment with little or no wait for outpatient counseling.
3. PASO provides support groups by a licensed professional counselor. It was reported that funding is an issue for support groups.
4. The indigent clinic counselors reportedly have a one week wait.

In the Amarillo HSDA, psychiatric medication can be difficult to access:

1. The indigent clinic has an excellent psychiatrist, but they have an eight month wait.
2. Inpatient psychiatric services are provided by The Pavilion Hospital.

PASO staff estimates that 30% of their clients are in need of substance abuse treatment services.

1. For substance abuse treatment, Managed Care Center for Addictive/Other Disorders, Inc. has a satellite office in Amarillo with the HEI case manager.
2. PASO has a monthly meeting that also includes the HEI case manager and the Amarillo Department of Health HIV prevention representative.

3. No low/no cost residential substance abuse treatment in Amarillo. Patients are sent to Lubbock or Homeward Bound in Dallas.
    a. A key informant stated, "Have Managed Care and HEI case manager who do a good job. If clients need residential treatment, they must go to Homeward Bound in Dallas.

Lubbock HSDA

Four free/low-cost mental health counseling options are available to Ryan White clients:

1. Current contract with Covenant Health System, which is a Catholic organization. Reportedly some clients are "uncomfortable" with faith-based providers.
2. General therapist, Diane Soucy, LPC, is another counseling option.
3. Negotiating a contract with Texas Tech (Lubbock) for a wide range of treatments. They have "more appropriate" counselors that have a LGBT focus.
4. Star Care Specialty Health System, formerly Lubbock Mental Health/Mental Retardation (MHMR) center

Psychiatric medication can be difficult to access:

1. According to Project CHAMPS staff, StarCare Specialty Health System has a "multi-year" wait for psychiatric treatment of schizophrenia, bipolar disorder or major depression.
2. Ryan White providers report sending clients to a private psychiatrist due to the StarCare waiting list. The initial evaluation is reportedly $300.
3. Ryan White provider reported paying for the psychotropic medication until they "figure out what patient assistance is available."

Support Groups

1. Support groups have been offered in the past, but "they don't seem to last."
2. Providers and consumers identify the stigma of HIV as a key reason that support groups have not been successful.
3. Managed Care has started a support group

Newly Diagnosed

1. StarCare staff report referring newly diagnosed to Managed Care for individual support.
2. Offering individual counseling after diagnosis may help avoid a crisis, lets the newly diagnosed understand "there is life after being positive," and provides support in telling partners and other family members.

Limited resources for low/no cost substance abuse treatment are available in the Lubbock HSDA.

1. Managed Care is the only free service locally.
2. Managed Care provides inpatient and outpatient substance abuse treatment and is the only low/no cost service locally.
3. Managed Care employs the HEI case managers for Amarillo and Lubbock
4. Key informants discussed weaknesses of the Managed Care program including high staff turnover rate, client dissatisfaction, waits of 24 to 72 hours for a spot resulting in loss of client to care.
5. Detox was a top of mind need identified by a Lubbock HSDA case manager.
6. Other residential substance abuse treatment providers are for-profit and require clients to have insurance. They will occasionally take someone without insurance, but "you can't count on it."

Permian Basin HSDA

Free/low cost mental health counseling and substance abuse treatment is available through Permian Basin Community Centers.

1. This is the MHMR provider and offers free residential substance abuse treatment.
2. Ryan White case managers state the waiting list is not long, clients can be see within a day or same day.
3. Clients, however, don't take advantage of mental health services. It was stated, "If they agree, they often back out."
4. Refer to Alternative Life Solutions Counseling for individual counseling and MHMR for psychiatric medications.
5. BAS case managers' state, "Accessing substance abuse services is not the problem. It is about the clients being ready."

Support groups have not been successful in the Permian Basin:

1. BAS has offered support groups, but they have not gotten good participation.
2. Midland-Odessa Area AIDS Support (MAAS) offers support groups, but BAS staff reports, "they are not as strong as they need to be."

El Paso West Texas HSDA

Free/low cost mental health counseling options:

1. Family Service Executive Director reports they treat two types of clients
    a. Employed, medically compliant but have depression or anxiety. These clients require six to ten counseling sessions,
    b. Clients with more serious mental illness such as major depression, bipolar, borderline personality. This is a longer term client and may be treated at Emergence Health Network with psychiatry services.
2. In addition to Family Service, La Fe case managers refer to Sun City Behavioral Health. If patients do not attend their appointments, the case managers are alerted and ensures the patient complies.
3. Texas Tech case management reports few patients have sought either counseling or support group despite the fact that counseling is encouraged.

Severe shortage of psychiatrists continues in the region, resulting in difficulty accessing psychiatric medications.

1. Emergence Health Network, previously MHMR, is expanding services. Sun City Behavioral Health is affiliated with Emergence.
2. Key informants stated that accessing Emergence services required paperwork and other system-specific barriers.
3. System issues may be exacerbated in the future: Medicare and Medicaid billing requirements will result in lower reimbursement and more hoops for the client to jump through to get service. Currently Family Service has eight therapists who are Medicaid/Medicare credentialed out of 40 therapists. This will lessen the pool of available therapists.
4. Texas Tech HIV case manager can provide internal referrals to psychiatry within their system. It normally takes one to two months to be seen.

5. TTUHSC can also easily refer to Family Service, and they are working on a contract with Sun City Behavioral Health.

Support groups:

1. Family Service has an going HIV support group that has been operating 6 – 7 years.
2. International AIDS Empowerment provides substance abuse and mental health support groups. This is a collaborative program between IAE, Family Service and Recovery Alliance to provide both one-on-one and group interventions.

Key informants report both residential and outpatient substance abuse treatment services can be difficult to access in El Paso.

1. Currently two substance abuse treatment providers addressing the needs of El Paso PLWHA: Aliviane and Recovery Alliance. Aliviane has reportedly had a reduction in services due to funding issues.
2. Aliviane employs the West Texas HEI case manager as well as two HIV prevention outreach workers. The HEI case manager reportedly works with 35 clients, five of whom are receiving substance abuse treatment services. Education, support and transportation are among the services provided.
3. A Ryan White funded case manager reports that patients disclose they are using but don't want help. She refers to the HEI case manager at Aliviane, but “only a handful have gone.”
4. The Aliviane key informant reported they have a COPSD program for the co-occurrence of mental health and substance abuse issues. She stated that LLPCs are available to address these co-occurring disorders.
5. Family Service is interested in integrating substance abuse treatment into their service mix.
6. Key informants reported that El Paso substance abuse treatment providers operate in silos. Clients must go through the OSAR which refers to the best provider after screening.

Resources

The 40 mental health therapy and counseling providers in the Pan West and West Texas regions and 38 substance abuse treatment providers vary in their distribution.

- Amarillo HSDA has only three mental health agencies but eight substance abuse treatment providers.
- El Paso HSDA has 16 mental health therapy providers and eight substance abuse treatment organizations. Aliviane, with the HEI case management program, has a variety of programs targeting various populations.
- Lubbock and Permian Basin HSDAs have similar number of mental health and substance abuse treatment providers.

Table 5.43
Mental Health Therapy and Counseling Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Mental Health Therapy	3	10	11	16	40

Table 5.44
Substance Abuse Treatment and Counseling Resources
PanWest and West Texas Regions
2013

Service	Amarillo	Lubbock	Permian Basin	West Texas	Total
Substance Abuse Treatment	8	12	10	8	38

REGIONAL HEALTH PARTNERSHIP PLANS

A 1115 waiver is a "demonstration project to expand coverage. States have some flexibility in designing and running their Medicaid programs, but they have to comply with a range of federal standards. The 1115 waiver refers to a section of the Social Security Act that allows the Secretary of the Department of Health and Human Services to waive some or all of these requirements for: 'experimental, pilot, or demonstration projects which are likely to assist in promoting objectives of the act.' [12]"

A component of Texas' Medicaid 1115 waiver required the development of Regional Health Partnerships (RHP) throughout the state. These RHPs were required to conduct a need assessment for their region and develop plans to increase access to needed services. Acute care hospitals led these partnerships, and they often included psychiatric hospitals, large community providers and city/county health departments.

Because the RHP five year plans will impact access to care and services, they have been reviewed for this needs assessment. Planned programs that will impact PLWHA are outlined below. Please note: the regional boundaries for the RHPs are different from the boundaries of the HSDAs.

[12] Texas State Report page 28.

Table 5.45
Planned Programs That Will Impact PLWHA

Region	Anchor Facility	Counties	Key Cities
12	Lubbock County Hospital District dba University Medical Center	47	Lubbock. Amarillo, Plainview, Childress
14	Ector County Hospital District dba Medical Center Health System	16	Midland, Odessa
15	University Medical Center	2	El Paso
Note: Region 13 has two counties in the Permian Basin HSDA, Pecos and Terrell. Pecos County has a general hospital and the RHP 13 plan includes increased primary care access in Terrell County with the development of a part time clinic.			
Source: Texas Health and Human Service Commission			

Regional Health Partnership 12

RHP 12 covers a vast geography in the Texas panhandle with many rural and frontier counties along with the cities of Amarillo and Lubbock. Given this, the RHP 12 Plan states, "There are major healthcare provider shortages, multiple counties with no acute care hospitals and significant transportation issues to access primary care services." The region has a large minority population, limited English proficient population, and education levels below state and national levels. "To address these issues the RHP 12 Plan ranked issues in three "tiers" according to the documented level of need.

- Tier one included the two more pressing needs:
    1. A severe lack of primary care access including provider shortages, financial barriers, wait times and length of time to get an appointment;
    2. Lack of mental health services including lack of available appointments, insurance coverage and emergency room usage for mental health issues.
- Tier two are other priority issues
    1. Uninsured and underinsured;
    2. High incidence of obesity, diabetes, and heart disease;
    3. The need for specialty care;
    4. Need for cancer screenings;
    5. Insufficient maternal and prenatal care.

Specific projects of interest to the Ryan White program include:

- City of Lubbock Public Health Department—Increase, expand and enhance dental services including services for older adults.
- Helen Farabee Center, Wichita Falls —Enhance service availability to appropriate levels of behavioral health care; expanding the number of community based settings where behavioral health services may be delivered in underserved areas.

- Starcare Specialty Health System, Lubbock—Development of behavioral health crisis stabilization services as alternatives to hospitalization.
- Texas Panhandle Centers, Amarillo — (1) Development of behavioral health crisis stabilization services as alternatives to hospitalization. (2) Design, implement, and evaluate research-supported and evidence-based interventions for a targeted behavioral health population to prevent unnecessary use of services in a targeted population. (3) Integrate primary and behavioral healthcare services. (3) Recruit, train, and support consumers of mental health services to provide peer support services.
- Central Plains Center, Plainview—Design, implement and evaluate whole health peer support for individuals with mental health and/or substance abuse disorders.
- City of Amarillo Department of Public Health—Design, implement, and evaluate research-supported and evidence-based interventions for a targeted behavioral health population to prevent unnecessary use of services in the criminal justice system.
- Texas Tech University Health Sciences Center, Lubbock—Establish/expand a patient care navigation program to targeted patients who are at high risk to disconnect from institutionalized health care (e.g. patients with multiple chronic conditions, cognitive impairments and disabilities, limited English proficiency, recent immigrants, the uninsured, frequent visitors to the E.D.)

Regional Health Partnership 14

The RHP 14 Plan is introduced with the following statement, "Due to our size, many of our patients are traveling great distances to get specialty services and in some cases even primary care…We don't have a large (healthcare) system like you see in East Texas or more urban areas. We are a collection of independent entities that have operated in silos."

- Consequently, one goal of the RHP 14 Plan is to identify ways the partners can collaborate and streamline care.

Key health challenges identified in the Plan include:

- Rapid Population Growth: RHP 14 is a very rapidly growing segment of Texas with Midland and Odessa identified as the two fastest growing cities in the U.S. by many reports. This rapidly changing environment strains already limited resources and space leading to improper utilization of healthcare resources, particularly emergency services.
- Limited Housing Availability: It is estimated that 20,000 to 30,000 people are living in hotels waiting for housing.
- Provider Shortages: An aging physician base with difficulty recruiting to the region, particularly frontier communities.

The RHP 14 Plan proposes to enact projects to realize the RHP's five-year vision:

- Primary Care Expansion: Almost every healthcare provider in RHP 14 has dedicated a project or segment of a project to meet this need.
- Improved Health Literacy: Numerous education and interpretation projects aimed at eliminating this barrier to care are included in the Plan.
- Collaborative Community Projects: By bringing together all supportive constituents within each county, it is expected that projects will have a greater impact.

Specific projects of interest to the Ryan White program include:

- West Odessa Family Health Clinic—Establish a primary care medical home in the underserved area of West Odessa focusing on pediatrics, family practice, optometry and OB/Gyn.
- Expansion of Behavior Health Sciences through Texas Tech University Health Science Center, Permian Basin—Improved access to psychiatric care and services through recruitment of new physicians.
- Permian Basin Community Centers—(1) increase behavioral health care capacity, primarily psychiatric and counseling services, to patients who do not meet the DSHS definition of "target population." (2) Increase capacity of detox and residential substance abuse facility from 22 to 42 beds to enhance access to intensive residential treatment and detox services while reducing the need for local emergency departments to address crisis situations that are substance abuse related. PBCC will treat these patients in a less restrictive environment. (3) Integration of behavioral and primary care by including primary care into PBCC's two largest behavioral healthcare clinics. The goal is to have primary care physicians, case management and support staff embedded in PBCC's public mental health clinics.
- Wide range of primary care expansion project including new clinics, physician recruitment and a mobile clinic.

Regional Health Partnership 15

Region 15 faces the challenge of providing healthcare services to a high volume of indigent and immigrant patients. The RHP 15 Plan states, "While the population of the region is 800,000, its healthcare providers serve and estimated population of 2.6 million residents in a multi-national region. ..In addition to El Paso and Hudspeth County residents, a large number of non-residents patients travel across the Mexico border to receive care. Providers in the region bear the burden of this increased usage which is neither compensated, nor recognized by State or Federal programs for the uninsured or Medicaid eligible populations."

Region 15 healthcare infrastructure includes 10 acute care hospitals and two psychiatric hospitals. Ambulatory care providers include three FQHCs with 14 locations and numerous private and public primary care providers. Despite these facilities, Region 15 has a **significant physician manpower shortage**, with only 58% of the required number of physicians needed for the population. Uninsured, indigent and immigrant populations use El Paso County emergency departments as primary access points into the healthcare system.

The RHP 15 Plan proposes to address the most severe access needs as follows:

- Increase access to primary care through the expansion of medical homes, primary care clinics and more effective care navigation upon discharge.
- Provide the full continuum of healthcare services with a focus on primary care, specialty care and behavioral health.
- Better manage patients with chronic diseases, such as diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease, epilepsy, dementia, and renal disease to help prevent unnecessary readmission and get patients the care they need to prevent, self-manage and address in an appropriate setting.
- Provide patient education to ensure the population accesses the right care in the right setting.
- Overcome language, socio-economic, and monetary barriers to accessing healthcare resources in the region.

- Increase the number of specialists and scope of services available in the community.
- Address the issues of diabetes and obesity.
- Increase patient satisfaction through the delivery of high quality, effective healthcare services.

Specific projects of interest to the Ryan White program include:

- University Medical Center of El Paso—(1) establish more primary care clinics and urgent care services including a new one serving the Westside of El Paso, relocation and expansion of the Montwood Clinic in East El Paso, expansion of two existing Neighborhood Health Centers at Yselta and Fabens; (2) insert behavioral health trained practitioners into non-behavioral health settings.
- Texas Tech University Health Sciences Center—increase access to ocular care by recruiting two ophthalmologists and two therapeutic optometrists linked electronically to TTUHSC primary care physicians.
- Emergence Health Network—(1) develop an Extended Observation Unit as an alternative to inappropriate systems of psychiatric emergency care, (2) expand the capacity of and access to behavioral healthcare by increasing the number of providers in the community, (3) expand behavioral health training for the workforce including Dialectical Behavioral Therapy, Cognitive Processing Therapy, and “Recovery Innovations” curriculum.

6. RECOMMENDATIONS

The following recommendations incorporate information from all components of this needs assessment. They are comprehensive and should be prioritized in light of available personnel, resources and funding.

1. Sharing Best Practices with the Four HSDAs

The organization of the PanWest and West Texas regions under a single administrative agency provides an opportunity to collaborate, share evidence-based best practices to build on successful programs, and respond effectively to challenges.

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

The HIV medical clinics across the Permian Basin and West Texas use a variety of medical staff and practice arrangements. 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 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/clinician 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 HIV positive patients. Consider recruiting physicians dedicated to treating HIV positive people 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 each 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 PAP smears, at all Ryan White funded HIV medical care clinics. Provide needed funding for the PAP 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 should 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 system 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

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/Project Vida collaboration which will provide primary care and mental health services.

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

4. Case Management

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.

4.6 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 of their roles and responsibilities.

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

5. Medications

5.1. Develop processes/systems at all providers to improve the ease of access of medication access. 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. Behavioral Health—Mental Health Therapy and Counseling

6.1. Develop mental health therapy best practices supported by case management staff.

6.2. Include a mental health counselor as part of the HIV medical care treatment team.

6.3. Evaluate the feasibility of providing on-site mental health counseling at each clinic site and/or each case management site.

6.4. Ensure mental health counselors are culturally appropriate/sensitive for the populations served.

7. Behavioral Health—Substance Abuse Treatment

7.1. Include the HEI case manager in each HSDA as part of the clinical treatment team.

7.2. 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.

8. Linkage to Care After Diagnosis

8.1. 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.

8.2. 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.

9. Provider Collaboration

9.1. 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. Continue to actively participate in the El Paso Community Mobilization Collaborative.

- Share information about the 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.

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

10. Stigma

10.1. Develop an integrated plan to reduce stigma of HIV in all HSDAs. Initially work with the 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.[13]

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

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