PanWest-West Texas

2020-2025 Comprehensive HIV Health Services Plan

JUNE
2020

STARCARE
SPECIALTY HEALTH SYSTEM

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

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ACRONYMS

AA	Administrative Agency
ACA	Affordable Care Act
ART	Antiretroviral Treatment
BAS	Basin Assistance Services
DIS	Disease Intervention Specialist
DSHS	Texas Department of State Health Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HAB	HIV/AIDS Bureau
HCC	HIV/AIDS Care Continuum
HEI	HIV Early Intervention
HERR	Health Education/Risk Reduction
HOPWA	Housing Opportunities for Persons Living with AIDS
HRSA	Health Resources and Services Administration
HSDA	HIV Service Delivery Area (Amarillo, El Paso, Lubbock and Permian Basin
IDU	Intravenous drug user
La Fe	La Fe Care Center
MSM	Men having sex with men
OSAR	Outreach, Screening, Assessment and Referral
PASO	Panhandle AIDS Support Organization
PCP	Primary Care Doctor/Practitioner
PDSA	Plan Do Study Act, Quality Management Cycle
PLWH	People/Person(s) Living with HIV or AIDS
PrEP	Pre-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RHP	Regional Health Partnerships
RWHAP	Ryan White HIV/AIDS Program
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SPCAA	South Plains Community Action Association
STD	Sexually Transmitted Disease or Sexually Transmitted Infection

EXECUTIVE SUMMARY

This 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan was designed to fulfill federal and state mandates and provide a road map for action over the next five years.

DESCRIPTION OF PANWEST AND WEST TEXAS PLANNING AREAS

- The PanWest Region includes three HIV Service Delivery Areas (HSDA):
- Amarillo HSDA
- Lubbock HSDA
- Permian Basin HSDA
- The West Texas area is also included in this analysis and is composed of one HSDA, El Paso.
- Together these four HSDAs comprise the 64 farthest west counties in Texas, ranging from the Panhandle to the Mexico border. The total population is approximately 2.23 million people.
- PanWest and West Texas HSDA counties have experienced significant growth between 2000 and 2014. Midland County grew 10.8%, Ector County 9.0%, Randall County 6.8%, and El Paso 6.7%.
- The counties with the lowest median incomes and the highest federal poverty levels include Potter, Hale, Lubbock, and El Paso Counties, all with incomes below $50,000.
- Randall County has the highest level of education of all HSDAs. Ector County and Hale County have high percentages without a high school diploma, 29% and 27%, respectively.

Regional Epidemic

In 2018, the Pan West Region had a total of 1,836 PLWH. The three PanWest HSDAs have 550 PLWH (Amarillo) and 609 PLWH (Permian Basin). West Texas has 2,274 PLWH, almost all of whom live in El Paso County (99%).

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

- The PanWest HSDAs have a smaller percentage with MSM than West Texas, ranging between 53% and 61% compared to 70% in in West Texas.
- IDU transmission mode is a relatively small percentage of infections. The rate, however, is higher in PanWest (19-25%) than West Texas (12%).
- Heterosexual transmission mode ranges among the HSDA's; from 15% in Lubbock to 20% in Amarillo, 22% in the Permian Basin, and 17% in the El Paso HSDA.

Assessment of the Needs of People Living with HIV/AIDS

The 2019-2025 PanWest-West Texas Targeted Needs Assessment informs this comprehensive plan. It included an online survey of 181 clients, 22 out-of-care clients and 8 newly diagnosed. 87 respondents participated in focus groups and key informant interviews .[1]

Description of the Current Continuum of Care

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

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

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

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

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

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

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

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

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

Challenges include:

- Given Ryan White requirements to fund core medical services, funding for social services is limited. Collaboration with non-Ryan White funded community agencies is needed but has been difficult to accomplish.
- Increasing numbers of newly diagnosed PLWH are stretching thin limited Ryan White funding, including funding for new services, despite the expansion of medical coverage through ACA.
- Shortages in the number of physician resources available to provide care to Ryan White patients persist.
- Location of Ryan White services in more urban centers creates access problems for PLWH in rural areas of all HSDAs.
- Stigma is an acute problem in the region limiting access to testing and the receipt of services due to consumer fear of disclosure.
- Decreases in outreach and prevention funding make it difficult to keep up with increasing numbers of at-risk populations.
- COVID-19 has led to increasing challenges, such working from home and the use of telehealth.

Quality Management

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

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

**Please see Appendix A for the complete 2020 Quality Management Plan

COMPREHENSIVE HIV HEALTH SERVICES PLANNING PROCESS

Comprehensive HIV Health Services Plan

The 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. The 2019 Needs Assessment results were evaluated to ensure the Comprehensive Plan fulfilled the mission, vision, and shared goals of not only the AA, but the State requirements and the clients we serve.

This information is developed into a draft plan that will be presented to and reviewed by the Texas Department of State Health Services (DSHS) staff.

Throughout the planning process AA staff considered the National HIV Strategy for the U.S., the *Texas HIV Plan* updated for 2017-2021, *Healthy People 2020*, and Ryan White Program requirements.

Mission, Vision and Core Values

The mission, vision and core values statements were included in the 2016 PanWest – West Texas Comprehensive Plan were adopted for the 2020 Comprehensive Plan. This mission statement is the foundation for the 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan.

Mission Statement

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

The following ideal vision underpins the Plan.

Vision Statement

HIV care is accessible and effective.

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

Core Values

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

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

PLAN GOALS AND RATIONALE

The 2020-2025 Comprehensive HIV Health Services Plan adopts three of the 2016 Texas Plan Priorities for AA and Subcontractor achievement. The goals reflect the findings of the 2016 PanWest-West Texas Targeted Needs Assessment which focused on barriers to linkage, retention and viral load suppression, and includes the updated epidemiologic profiles, regional demographics, and an assessment of access and health disparities in the region.

The three goals are to:

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

The goals for the 2020-2025 Comprehensive HIV Health Services Plan are outlined below along with the data and rationale to support the adoption of the goal.

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

Rationale

- Although "late" stage diagnosis is trending downward, it is still a very present issue. For instance, in El Paso in 2014 just over 30% of newly diagnosed individuals were considered late stage. This is compared to 2017 in which there were less than 20% that were newly diagnosed in the late stage.
- From 2014-2018, new AIDS diagnoses increased by 13% across the entire region.
- Survey findings show that the percentage of current out-of-care consumers were linked to care within three months of their diagnosis range from 94% in the Permian Basin HSDA to 68% in the Lubbock HSDA
- In 2018, across the PanWest-West Texas region, the percentage of known PLWH were linked to care within one month range from 83% (Permian Basin HSDA), 62% (Amarillo HSDA), 49% EL Paso HSDA), and 48% (Lubbock HSDA),
- In the Achieving Together, A plan to end the HIV epidemic in Texas Plan, it is stated that, we know that treatment for HIV keeps PLWH healthier longer and reduces deaths, but it is most effective if treatment starts soon after the diagnosis is made. Linkage refers to the time it takes from the person's diagnosis to when they have their first episode of HIV medical care. Texas' goal is for 90% of all people newly diagnosed with HIV to be linked to care within 3 months.[2]
- Focus group respondents reported the need for increased advocacy in the communities that can provide awareness to the public regarding HIV, prevention, among other topics.

[2]Achieving Together, A Plan to End the HIV Epidemic in Texas, 2019

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

Rationale

- The 2018 retained in care data reflects the percentage of PLWH that are retained in care:
  - Amarillo: 75%
  - El Paso: 67%
  - Lubbock: 72%
  - Permian Basin: 70%
- Of the 181 survey respondents, 12% (22) reported they are out of care.
- 58% (15 of 26) Amarillo HSDA survey respondents reported that they cannot afford private insurance/premiums.
- According to the 2019-2024 Needs Assessment, many respondents reported being adherent to their medical care appointments. However, retention rates for the priority populations continue to struggle.
- "High ART costs are among many structural barriers that lead to poor treatment access and adherence." Costs can range between $25,000 to $36,000 a year.[3]
- Viral suppression levels not only improve long term health for PLWH, it also decreases their likelihood of infecting someone else.
- If left untreated, HIV attacks the immune system and can allow different types of life-threatening infections and cancers to develop.[4]
- HIV continues to have a disproportionate impact on certain populations, namely ethnic, minority, and gay/bi-sexual men.

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

Rationale

- 2018 Viral Suppression rates per HSDA are as follows:
  - Amarillo: 67%
  - El Paso: 63%
  - Lubbock: 61%
  - Permian Basin: 60%
- The Achieving Together, A Plan to End the HIV Epidemic in Texas maintains a goal of 90% of PLWH on ART treatment have a 90% viral suppression rate by 2030.
- Focus groups and key informants indicated that they were aware of their primary HIV treatment needs but had a difficult time in accessing or being informed of additional services. This includes other services offered and not offered by RWHAP funds.
- Viral Suppression rates vary between HSDA's. For instance, in Amarillo viral suppression rates are 71% for Hispanic MSM. This is compared to Hispanic MSM in El Paso at 64%.
- There is also a major prevention benefit. People living with HIV who take HIV medication daily as prescribed and get and keep an undetectable viral load have effectively no risk of sexually transmitting HIV to their HIV-negative partners.[5]
- The use of PrEP taken daily may significantly reduce a high-risk HIV negative individuals' risk of acquiring disease. PrEP is one additional effort in the plan to end the HIV epidemic.

[3]Cost of HIV Treatment Rising, https://www.amfar.org/cost-of-hiv-rising/, February 18, 2020
[4/5]HIV Treatment Plan, www.hiv.gov, March 29, 2019

MONITORING PROCESS

Monitoring Plan Results

The 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining completion dates, responsible parties and data indicators. Many of the objectives and actions should be monitored on a quarterly basis, but no less than semi-annually.

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

- The AA works with funded providers to ensure a unified direction.
- The AA will review ARIES data quarterly.
- The quality management process supports monitoring and evaluation of Plan Goals.
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.

Evaluation

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

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

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

Impact on Priority Setting and Allocations

In developing the 2020-2025 PanWest-West Texas Comprehensive HIV Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement but will not be a direct dollar cost. Finally, some of the strategies may result in increased costs for which additional funding sources may have to be identified.

COVID-19 Challenges

The COVID-19 Pandemic has led to several challenges to the AA. The typical methods to effectively function became altered due to StarCare's work from home policy mid-March. Travel restrictions were also placed on all StarCare staff. For this reason, the Public Community forums discussing Priorities and Allocations were held virtually through the Zoom platform for the first time. The feedback received through surveys emailed post-forum through Survey Monkey was positive, however some participants missed the personal face-to-face communication.

Additionally, the Comprehensive Plan Update was delayed as the need arose to manage the current day-to-day issues that arose regarding RWHAP and COVID-19. It was necessary to locate resources such as food, housing, rent/utility assistance, etc. on a regular basis for the providers to share with clients in need of those vital services. A priority also arose with the addition of the CARES Act funds that were allocated to the RWHAP and HOPWA.

I. INTRODUCTION

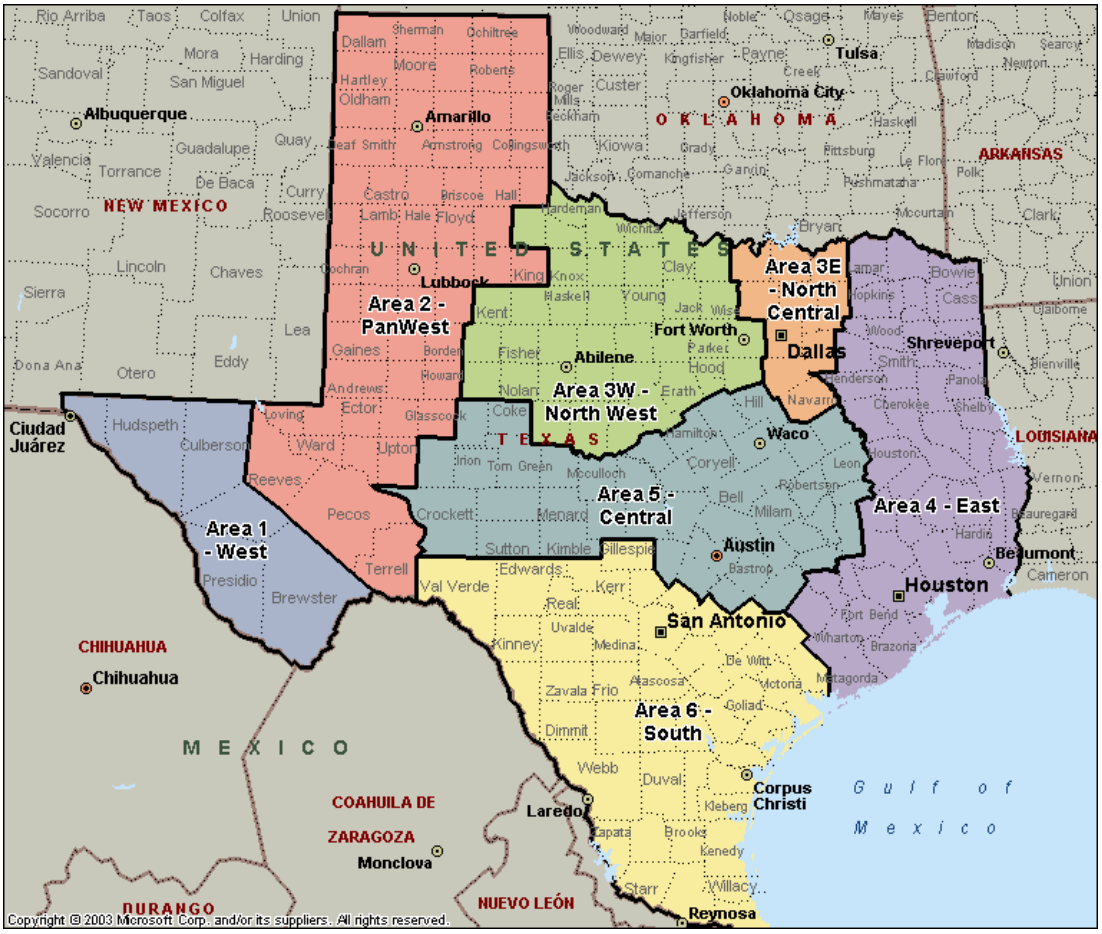
DESCRIPTION OF THE PANWEST AND WEST TEXAS PLANNING AREAS

Profile of the Four HIV Service Delivery Areas

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

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

Figure 1



The demographic profile is developed from U.S. Census Bureau data.[6] To provide the most relevant information, the one or two most populous counties from each HSDA are identified with detailed demographic data.

Table 1 combines the 64 counties making up the four HSDAs. The total population of the region was over 2.2 million in 2018. Each PanWest HSDA has one key Ryan White provider, which are listed in the table below. In West Texas, two organizations receive Ryan White Part B HIV medical care funds
.

Table 1
PanWest and El Paso HSDAs
2018 Population and Key HIV/AIDS Providers

HSDAS AND COUNTIES	*2018 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	**436,974**	Panhandle AIDS Support Organization (PASO)
Lubbock HSDA—15 Counties Bailey, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, Yoakum	**435,952**	SPCAA (Project CHAMPS) Lubbock
Permian Basin HSDA—17 Counties Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, Winkler	**490,846**	Basin Assistance Services (PBCC)
El Paso HSDA—6 Counties Brewster, El Paso, Hudspeth, Jeff Davis, Presidio	**866,224**	La Fe CARE; SPCAA (Project CHAMPS) El Paso
Total PanWest and West Texas Regions—64 Counties	**2,229,996**	
Population Data Source: U.S. Census Bureau State and County American Community Survey (ACS), 2018 Five-Year Estimates[6]		

The demographic analysis of the HSDAs finds:

- The counties with the lowest median incomes and the highest federal poverty levels include Potter, Hale, and El Paso; all with median incomes below $50,000.
- Randall and Lubbock Counties have the highest level of education of all HSDA's (91.9% and 85.8%, respectively). Potter County and El Paso County have the highest percentages without a high school diploma, 23% and 22%, respectively.

[6]U.S. Census Bureau, 2018 Population Estimate of Texas, by County, American Fact Finder Advanced Search, July 1, 2018

DESCRIPTION OF POPULATIONS LIVING WITH HIV BY RELEVENT CHARACTERISTICS

Epidemiology Overview

HIV Prevalence

In 2018, the PanWest Region had a total of 1,836[3] people living with HIV/AIDS (PLWH) and the West Texas region had 2,274.

- The number of PLWH varies among the PanWest HSDAs with 550 in the Amarillo HSDA, 677 in Lubbock HSDA, and 609 in the Permian Basin HSDA.
- This compares to 2,274 people living with HIV/AIDS in the West Texas region, almost all of whom live in El Paso County.
- PanWest and West Texas combined account for 4.37% of PLWH in the State of Texas.

Table 2
People Living with HIV/AIDS - 2018
Select Counties

HSDA/County	Number of PLWH	Percent of HSDA Total
Amarillo HSDA Total	**550**	
Potter County	280	51.0%
Randall County	157	28.5%
Lubbock HSDA Total	**677**	
Hale County	27	4.0%
Lubbock County	557	82.3%
Permian Basin HSDA Total	**609**	
Ector County	256	42.03%
Midland County	215	35.3%
El Paso HSDA Total	**2,274**	
El Paso County	2,249	99.0%
Source: Texas DSHS, TB/HIV/STD Epidemiology and Surveillance Branch		

[7] Unless otherwise stated, epidemiologic data are from Texas Department of State Health Services. Latest release is from 2018.

Uninsured

The number of uninsured PLWH varies across the HSDA's. Based on 2017 U.S. Census Bureau data:

- Amarillo: 33 PLWH are uninsured
- El Paso: 425 PLWH are uninsured
- Lubbock: 91 PLWH are uninsured
- Permian Basin: 26 PLWH are uninsured[4]

Race

- Amarillo: White (45%), Black (15%), Hispanic (36%), other (4%)
- El Paso: White (6%), Black (4%), Hispanic (89%), other (<1%)
- Lubbock: White (39%), Black (16%), Hispanic (45%)
- Permian Basin: white (32%), Black (16%), Hispanic (49%), other (2%)

[8] U.S. Census Bureau, 2018 Population Estimate of Texas, by County, American Fact Finder Advanced Search, July 1, 2018

Gender

PanWest and West Texas PLWH gender distinctions.

- PanWest: 1,452 male and 376 female, and 8 Transgender PLWH in all HSDAs.
- West Texas: 1,970 male and 291 female, and 13 Transgender PLWH.

Age

- In all four HSDAs, prevalence increases with increasing age, beginning with 4 % of PLWH in the <24-year age range and increasing to approximately 54% in the 45 to 64-year-old group.
- The percentage decreases, however, in the >65 group from 1-6%.

Transmission Mode

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

- The PanWest HSDAs have smaller percentages for MSM transmission than West Texas, between 53% and 61% compared to 70% in in West Texas.
- Injection drug use (IDU) transmission mode is higher in PanWest (19-25%) than West Texas (12%).
- Heterosexual transmission mode ranges from 15% in the Lubbock HSDA, 20% in the Amarillo HSDA, 22% in the Permian Basin HSDA, and 17% in the EL Paso HSDA.

HIV Incidence

- In 2018 there were 113 new HIV diagnoses in the PanWest HSDAs and 134 in the El Paso HSDA.

Co-morbid Conditions

TDSHS reports co-morbid diagnoses of STD and TB for PLWH. From 2011 to 2018 STD infection rates in Texas for PLWH are as follows:

- Chlamydia: 792 (2011) and 2,829 (2018)
- Gonorrhea: 934 (2011) and 3,377 (2018)
- P & S Syphilis: 329 (2011) and 775 (2018)
- TB: 1, 489 (1993-2018) and 59 (2018)
- The rate of Tuberculosis (TB) in Texas PLWH is 15.7 times higher than in the general population (4.0/100,000). However, TB is still relatively rare in PLWH–less than 2% of the Texans living with HIV in 2018 had been diagnosed with TB in the years following their HIV diagnosis. PLWH who also have latent TB infections are more likely to develop TB disease because their immune system is weakened.
- PLWH carry a much higher burden of STD than the general population.
- In 2018, rate of CT in PLWH was 6 times higher than the overall population rate, the GC rate was 22 times higher, and the P&S Syphilis rate was 94 times higher.
- In general, STD rates are higher in transgender women and in non-transgender men; in Black PLWH; in PLWH between 15 and 34 years old; and in MSM living with HIV, especially Black MSM. [5]

[9]STD and HIV surveillance data are from Texas Department of State Health Services. Latest release is from 2018.

The HIV TREATMENT CASCADE

The 2018 HIV Treatment Cascade, developed by the Texas DSHS, provided data to reflect the disparities in accessing care, retention in care, and those that achieve viral suppression. The cascade is a visible model of the Continuum of Care for PLWH in Texas.

Priority populations are also defined within the cascade.

The following presents the DSHS information.

Indicators utilized in the HCC:

- HIV+ Individuals at end of 2014 = No. of HIV+ individuals (alive) residing in Texas at the end of 2018
- At Least One Visit in 2018 = No. of PLWH with a met need (at least one: medical visit, ART prescription, VL test, or CD-4 test, or CD4 test in 2018).
- Retained in Care = No. of PLWH with at least 2 visits or labs, at least 3 months apart or suppressed at end of 2018.
- Achieved Viral Suppression at end of 2018 = No. of PLWH whose last viral load test value of 2018 was <= 200 copies/mL.

The HIV Care Continuum below present the status of these indicators for the PanWest and El Paso HSDAs.
This data should be a guide and foundation for each of the HSDA's efforts to link the HIV+ patients to medical care and maintain PLWH in care and treatment. [4]

<u>Amarillo HSDA</u>

Of the 550 PLWH in the Amarillo HSDA in 2018:

- 414 (75%) retained in care.
- 371 (67%) achieved viral suppression.
- 450 (82%) had at least one visit/lab.

Figure 2
HIV Care Continuum Amarillo HSDA 2018

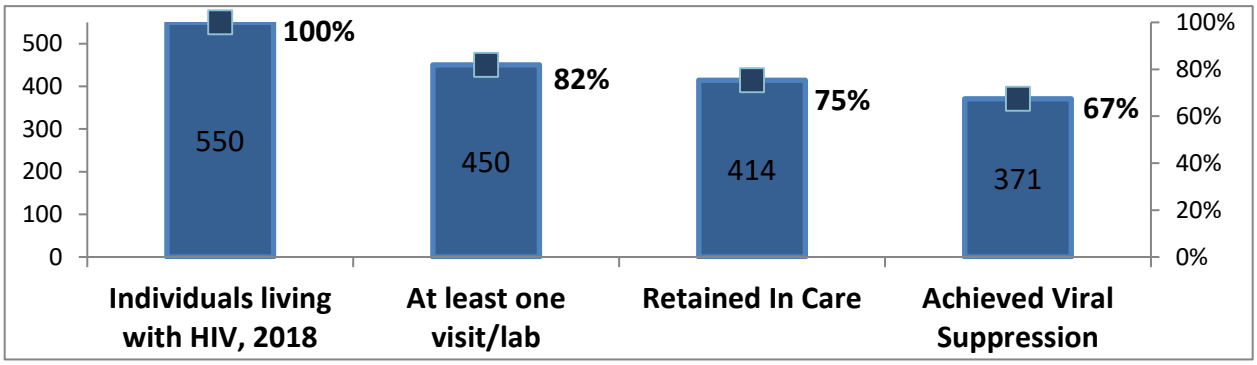


Figure 3

Priority Populations Amarillo HSDA 2018

Priority Groups Amarillo HSDA	White MSM	Black MSM	Hispanic MSM	Black Women	Transgender Women
At least one visit/lab	87%	69%	87%	84%	100%
Retained in Care	82%	58%	82%	74%	100%
Virally suppressed	78%	46%	71%	68%	100%
Suppressed out of Retained	95%	80%	87%	93%	100%

Lubbock HSDA

Of the 677 PLWH in the Lubbock HSDA in 2018:

- 485 (72%) retained in care.
- 414 (61%) achieved viral.
- 541 (80%) had at least one visit/lab.

Figure 4
HIV Care Continuum Lubbock HSDA 2018

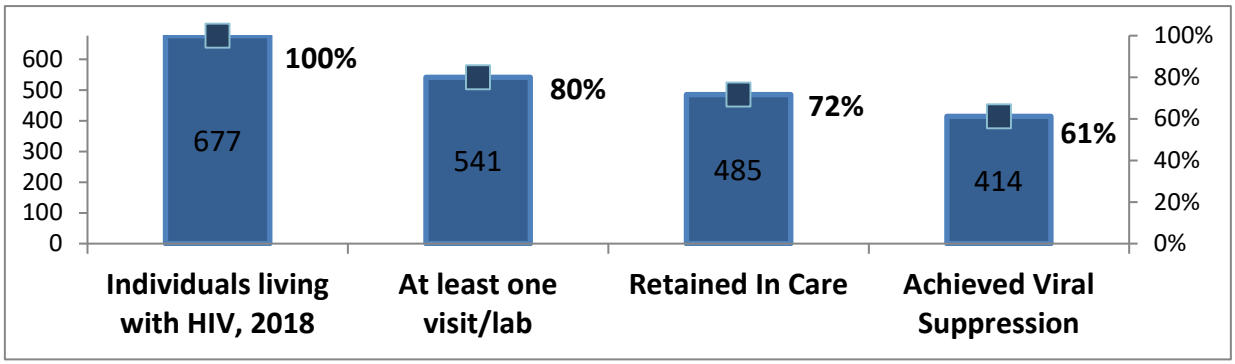


Figure 5
Priority Populations Lubbock HSDA 2018

Priority Groups Lubbock HSDA	White MSM	Black MSM	Hispanic MSM	Black Women	Transgender Women
At least one visit/lab	83%	73%	81%	83%	100%
Retained in Care	77%	63%	72%	71%	100%
Virally suppressed	69%	53%	66%	63%	50%
Suppressed out of Retained	90%	84%	92%	88%	50%

Permian Basin HSDA

Of the 609 PLWH in the Permian Basin HSDA in 2018:

- 428 (70%) retained in care.
- 366 (60%) achieved viral suppression.
- 484 (79%) had at least one visit/lab.

Figure 6
HIV Care Continuum Permian Basin HSDA 2018

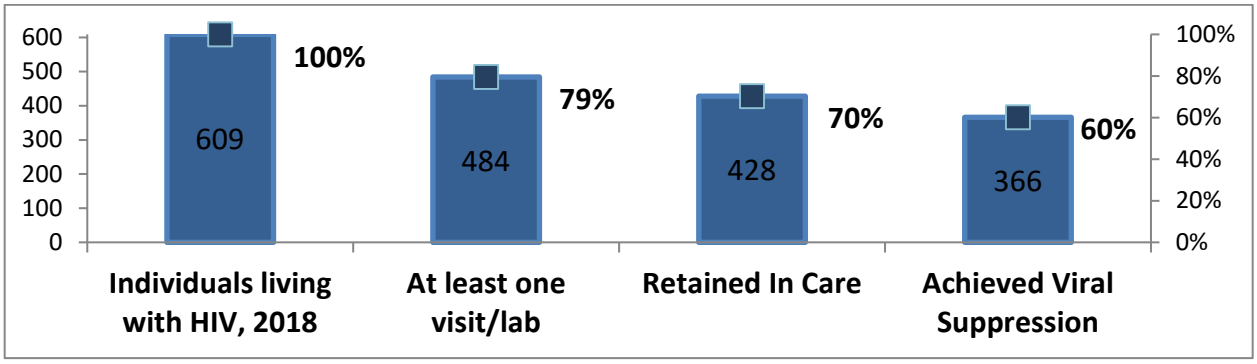


Figure 7
Priority Populations Permian Basin HSDA 2018

Priority Groups Permian Basin HSDA	White MSM	Black MSM	Hispanic MSM	Black Women	Transgender Women
At least one visit/lab	80%	71%	79%	78%	100%
Retained in Care	68%	59%	70%	65%	100%
Virally suppressed	63%	41%	59%	52%	100%
Suppressed out of Retained	92%	70%	84%	80%	100%

El Paso HSDA/West Texas

Of the 2,274 PLWH in the EL Paso/ West Texas HSDA in 2018:

- 1,524 (67%) retained in care.
- 1,426 (63%) achieved viral suppression.
- 1,602 (70%) had at least one visit/lab.

Figure 8
HIV Care Continuum El Paso HSDA 2014

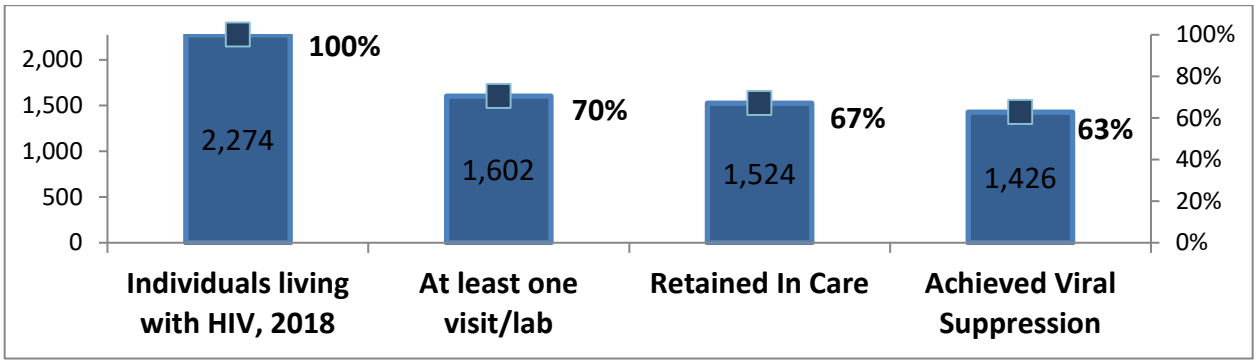


Figure 9
Priority Populations El Paso HSDA

Priority Groups El Paso HSDA	White MSM	Black MSM	Hispanic MSM	Black Women	Transgender Women
At least one visit/lab	75%	69%	72%	47%	69%
Retained in Care	74%	62%	68%	47%	69%
Virally suppressed	70%	56%	64%	37%	69%
Suppressed out of Retained	95%	51%	94%	78%	100%

DESCRIPTION OF ACCESS AND HEALTH DISPARITIES IDENTIFIED IN THE AREA

Health Disparities

The 2017-2021 Texas HIV Plan discusses the harsh disparities that Texans with HIV face. More than two thirds of new infections, as well as more than half of persons living with HIV, are gay men. Between 2010 and 2014, Black and Hispanic Texans accounted for roughly 75 percent of new diagnoses. Hispanics continue to have a disproportionate number of late diagnoses. The rate of late diagnosis among Hispanics in 2014 was about 1.4 times higher than in Whites or Blacks. [6]

Health disparities among PLWH are not only based on sexual orientation, but also race, gender, access to care and socioeconomic status. These issues will be discussed below.

[10]2017-2021 Texas HIV Plan, A Blueprint for Fighting HIV In Texas, August 2017

The following charts reflect the breakdown of the Panwest/ West Texas Comprehensive Needs Assessment Survey Respondent's race, age, and sexual orientation:

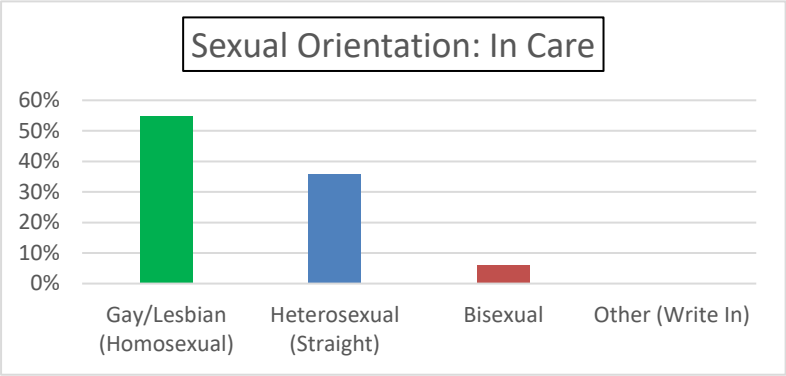
Figure 10
HIV Care Continuum by Race/Ethnicity
PanWest and El Paso/West Texas Regions 2018

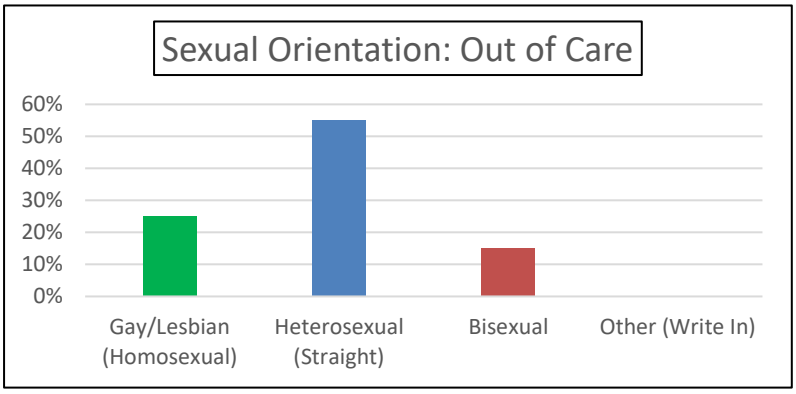
Race	In Care #	In Care %	Out of Care #	Out of Care %
White, not Hispanic	60	45%	11	58%
Black or African American, not Hispanic	26	19%	3	16%
Asian	0	0%	1	5%
Native American or Alaska Native	8	6%	0	0%
Native Hawaiian or other Pacific Islander	1	1%	1	5%
Hispanic (Latino/a)	82	58%	8	40%

Figure 11
HIV Care Continuum by Age
PanWest and El Paso/West Texas Regions 2018

Age	In Care	Out of Care
<-24 years	5	1
25-44 years	41	10
45+ years	99	8

Figure 12
HIV Care Continuum Sexual Orientation (In and out of care)
PanWest and El Paso/West Texas Regions 2018





Needs, Gaps, and Barriers

The PanWest and West Texas HSDA's each have their own unique set of issues that create needs, gaps, and barriers to client's receiving the services they need. The information that follows discusses the needs, gaps, and barriers in more detail and outlines the combined needs, gaps, and barriers for the Panwest and West Texas HSDA's.

- Need: Number of **in care** client survey respondents who stated, "I am not currently receiving services".
- Gap: Sum of **in care** client survey respondents who answered, "This service is unavailable in the area".
- Barrier: Number of **in care** client survey respondents who indicated that a service "Is hard to get".

**The survey questions related to but were not specific to available Ryan White Part B service categories.

Figure 13
PanWest and El Paso/West Texas HASA
2018 Needs, Gaps, and Barriers

Needs	Gaps	Barriers
Insurance	Health Education/Risk Reduction	Transportation
Dental	Outreach	Housing
Financial Assistance		
Support Groups		

Survey respondents had various concerns based on the survey results regarding the needs, gaps, and barriers.

Survey respondents' responses (one was selected per HSDA):

NEEDS

Insurance: "Do you have private insurance?"

- Amarillo: 58% (15 of 26) "I cannot afford private insurance/premiums."
- El Paso (La Fe):84% (26 of 31) "I do not have the money to pay for co-pays."
- El Paso (CHAMPS): 43% (13 of 30) "I need assistance paying for medications"."
- Lubbock: 44% (7 of 16) "I have difficulty accessing medical services due my lack of insurance."
- Permian Basin: 30% (3 of 10) "I do not have medical insurance, so services are hard to obtain."

Dental: "In the past 12 months have you seen a dentist?'

- Amarillo: 47% (17 of 36) "I don't have the money to pay."
- El Paso (La Fe): 77% (24 of 31) "Oral health issues do not affect food intake or nutrition."
- El Paso (CHAMPS): 23% (7 of 30) "I have oral health issues that affect food intake or nutrition."
- Lubbock: 43% (13 of 30) "I don't have money to pay."
- Permian Basin: N/A

Financial Assistance: "If you went for a medical visit today, would you have the money to pay any of the co-pays?"

- Amarillo: 36% (14 of 39) Money issues are a problem faced in keeping housing.
- El Paso (La Fe): 50% (15 of 30) "I need help paying for utilities."
- El Paso (CHAMPS): 84% (21 of 25) reported they earn less than $16, 240/year.
- Lubbock: 44% (14 of 32) reported not having money to pay for counseling.
- Permian Basin: 30% (7 of 23) reported money issues as a problem keeping housing.

Behavioral Health: "Would you be interested in participating in a support group with other people who are living with HIV?"

- Amarillo: 23% (9 of 39) reported being unable to pay for counseling.
- El Paso (La Fe): 74% (23 of 31) indicated they had not participated in a support group in the past.
- EL Paso (CHAMPS): 39% (11 of 28) reported yes, when asked if counseling, therapy, or medication has helped in the past.
- Lubbock: 23% (7 of 30) reported the need for outpatient support groups.
- Permian Basin: 37% (10 of 27) reported trouble remembering or concentrating in the past 30 days.

GAPS:

Health Education/Risk Reduction: "How often do you use condoms during sex?" and/or "Does your main sex partner take PrEP?"

- Amarillo: 55% (6 of 11) out of care respondents reported rarely or never.
- El Paso (La Fe): Regarding PrEP-47% (8 of 17) reported no.
- El Paso (CHAMPS): Regarding PrEP-58% (15 of 26) in care respondents report no.
- Lubbock: Regarding PrEP-32% (10 of 31) have not heard of people taking medication like Truvada as PrEP.
- Permian Basin: Regarding PrEP-54% (13 of 24) reported no.

Outreach: "Is awareness of available services a barrier to accessing care for mental health services?"

- Amarillo: 28% (7 of 25) in care respondents reported not having the information about the service.
- El Paso (La Fe): 24% (7 of 29) reported unawareness of available services as a barrier to accessing mental health care.
- El Paso (CHAMPS): 21% (6 of 29) reported being embarrassed, ashamed, or judges to ask for help.
- Lubbock: 29% (9 of 31) reported not having the information needed about the service.
- Permian Basin: N/A

BARRIERS

Transportation: "What mode of transportation available through Ryan White funding would be most helpful for you to keep your appointments?"

**Based on the responses, the means to pay for gas for their personal vehicle was a larger need.

- Amarillo: 67% (18 of 27) reported the need for agas card for their personal vehicle.
- El Paso (La Fe0: 34% (10 of 29) reported public transportation as their main source of transportation.
- El Paso (CHAMPS): 33% (8 of 24) reported the need for bus/public transportation.
- Lubbock: 55% (18 of 23) reported using their own vehicle as their main mode of transportation.
- Permian Basin: 65% (13 of 20) reported the need for a gas card for their personal vehicle.

Housing: "In the past 6 months, what problems have you faced in keeping housing?"

- Amarillo: N/A
- El Paso (La Fe): N/A
- El Paso (CHAMPS): N/A
- Lubbock: N/A
- Permian Basin: 33% (7 of 21) reported money issues as a problem in keeping housing.

- Based on respondent survey results, 95% (21 of 22) males reported to be out of care while only 5% (1 of 1) female reported being out of care.
- Among the181 respondents, 87% (158 of 181) reported to be in care.
- Among the 181 respondents IN CARE:
  - 47% (67) are White
  - 20% (29) are Black
  - 56% (86) are Hispanic
  - 6% (8) are Native American or Alaska Native
  - <1% (1) is Native Hawaiian or another Pacific Islander
- Among the 181 respondents IN CARE, the 45+ age group has the highest percentage of in care clients (107), while the lowest is in the <24 age group (5).
- Among the 181 respondents IN CARE, 54 % (84) reported to be homosexual, while 29% (6) out of care clients reported to be homosexual.

ACCESS BARRIERS

The 2019 Targeted Needs Assessment sought to explore barriers PLWH face with respect to linkage to care, retention in care, and viral load suppression. These topics were explored via key informant interviews, focus groups, a consumer survey and interviews with out-of-care PLWH. The following issues were the barriers most documented in the research: stigma, advocacy/outreach, lack of insurance/ difficulties accessing health services, behavioral health counseling and support, and transportation.

Stigma and Advocacy

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

Key informants discussed difficulties in accessing support groups, even when offered, due to stigma.

The key informants mentioned that PLWH would like to have a community setting that helps them "feel" the sense of a social support system. They would also like the opportunity to advocate for their peers.

The key informants also mentioned that other than PRIDE evets, there are few opportunities for HIV advocacy, awareness, or prevention in the communities. They stated that this was reflective of the issue with stigma and that some PLWH may be "ashamed" to participate.

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

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

Consumers can purchase, select or were re-enroll in a health plan through the Affordable Care Marketplace on a yearly basis. But many HIV patients in Texas live below the poverty line and are therefore ineligible for subsides on the exchange. In addition, the decision not to expand Medicaid to cover poor adults, means that the bulk of low-income HIV consumers have not benefited from expanded health care coverage.

Survey respondents reported both a need and barrier in regarding financial assistance, dental care, health insurance copays/premiums and housing assistance (specifically utility assistance).

The number of PLWH surviving below the Federal Poverty Level (FPL) range from 77 PLWH in Amarillo to 106 PLWH in Lubbock.

Respondents discussed outside resources providers suggest may be scarce or difficult for PLWH to qualify for additional assistance.

Poverty faced by PLWH is made clear by the fact that over between 65-88% of survey respondents had no insurance. This fact alone heightens the issues faced by Ryan White providers treating an increasing number of patients.

Behavioral Health Counseling and Support

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

Depression is one of the most common mental health conditions experienced by people living with HIV, just as it is in the general population. In addition, some antiretroviral medications may cause symptoms of depression, anxiety, and sleep disturbance, and may make some mental health issues worse.[7]

32-66% of Key informant interviews and focus group members reported feelings of depression, anxiety, nervousness or too much stress and/or pressure in the last 30 days.

Focus group participants voiced challenges with accessing support groups, even when offered, due to stigma. They also reported that past support groups felt more like a "match session" instead of a secure setting to discuss their issues they are going through.

Survey results indicate that approximately 60% of respondents use alcohol and approximately 70% use some type of drug.

Transportation

Transportation is an issue that was addressed in the 2019 Needs Assessment. Good public transportation is lacking throughout the region. All public transportation, when it exists, exist in major population centers and even then, can involve multiple transfers to get to a care location or office. The rural areas which include most of the counties in the region are without transportation. In these areas, access to a car is a necessity.

[7]HIV/AIDS and Mental Health, National Institute of Mental Health, https://www.nimh.nih.gov/health/topics/hiv-aids/index.shtml#:~:text=Depression%20is%20one%20of%20the,some%20mental%20health%20issues%20worse. 2016

As many as 63% of respondents reported using their own personal vehicle for transportation. Roughly 50% indicated the need for gas cards for their personal vehicles.

The COVID-19 Pandemic has led to an decrease in transportation as there are less bus routes and Uber drivers available.

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

Target Populations

Men Who Have Sex with Men (MSM)

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

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

- Young HIV+ MSMs face challenges of both having to come out and to admit their HIV status, a factor that often leads to denial and late diagnosis.

Hispanic PLWH

Issues that result in barriers to Hispanic PLWH include:

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

Out-of-Care PLWH

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

- Focus groups reported that they have difficulty accessing services that may aid in general financial assistance and other services not offered through the RWHAP.
- Mental health and substance abuse issues that affect compliance and adherence.
- Stigma and anonymity.
- Transportation barriers.

DESCRIPTION OF THE AREA CARE AND TREATMENT SYSTEMS

Ryan White Funded Providers

Each of the three PanWest HSDAs has a Part B funded HIV/AIDS service subcontractor (provider). Each is located in the population center of the HSDA. Using a competitive request for proposal process, the subcontractors in the PanWest Region have been stable for many years. There is the potential to add an additional provider in the El Paso region. Contract negotiations are currently underway.

In 2018, the Providers served clients as follows:

- The Amarillo HSDA subcontractor served 550 unduplicated clients in a 26-county area.
- The Lubbock HSDA subcontractor served 677 unduplicated clients in a 15-county area.
- The Permian Basin HSDA subcontractor served 609 unduplicated clients in a 17-county area.
- The El Paso HSDA subcontractors served 2,274 unduplicated clients in a 6-county area.

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

** Please refer to the Texas map on page 1 of the Introduction.

Linkage with Community Services

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

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

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

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

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

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

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

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

Outpatient/Ambulatory Medical Care

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

The **Amarillo HSDA** Subcontractor has a contract with any physician to provide medical with two local physicians. Both physicians see clients for primary HIV care and ID care. The majority of HIV positive clients needing OAHS and works closely with the J.O. Wyatt indigent clinic to provide HIV/AIDS care as well as primary medical care.

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

The service Subcontractor for the Amarillo HSDA is:

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

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

- The clinic is called the Tech AIDS Clinic (TAC) and is under the direction of an Infectious Disease Specialist.
- One clinic is for clients who have Medicaid, Medicare or private insurance. The other clinic is for clients without insurance.
- The Lubbock HSDA Subcontractor's process to ensure that clients have access to ambulatory medical care is as follows:
    - Once a client has been determined eligible for services the Medical Case Manager schedules an appointment for the client at the TAC.

  - The Medical Case Manager also schedules the client an appointment for any necessary lab work to be completed before the initial doctor appointment.
  - Any services necessary to support the client with accessing medical care are offered as well, such as transportation and assistance with obtaining medications.
- Clients who have other payer sources, and choose not to use the TAC, can be seen by their primary care physician who may refer them to the Consultants in Infectious Disease practice.
- If clients are veterans, they are offered the choices listed above as well as an option for referral to the local Veterans Administration for services.

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

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

The **Permian Basin HSDA** Subcontractor contracts with Texas Tech University Health Sciences Center Permian Basin (TTUHSC PB) for one weekly clinic in the city of Odessa. They have established the use of telemedicine, which has provided an additional ID physician.

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

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

Basin Assistance Services (BAS)
Permian Basin Community Centers
1330 E. 8th St., Ste. 315
Odessa, TX 79761
Local 432-580-0713 or toll free 1-800-804-5418

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

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

Resource Inventory

The PanWest-West Texas 2019-2024 Comprehensive HIV Needs Assessment includes HSDA-specific resource inventories. They are found at www.panwest.org under Resources. The resource inventory includes services available ranging from food and utility assistance to substance abuse and recovery assistance.

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

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

An additional concern is encountered in the HSDAs, as some community resources strive to be payers-of- last-resort, conflicting with the Ryan White policy of being the payer-of-last-resort. As a result, the organizations refer PLWH back to the local HIV service subcontractors for assistance.

Please note that the resource inventory is a fluid document. This is especially true with the current COVID-19 Pandemic. The Planner monitors resources daily and ensures that the providers are made aware of any new resources as well as any that are no longer available. The resource inventory will be updated as needed to provide the clients with the services that meet their specific needs.

Administrative Agency Role and Responsibilities

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

Quality Management Plan and Quality Management Committee

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

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

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

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

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

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

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

HAB Performance Measures

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

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

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

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

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

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

Table 3
HAB Performance Measures
June 2020 Average Scores

	Amarillo	**Lubbock**	**Permian Basin**	**La Fe**	**CHAMPS El Paso**
Measure I:	92.2%	90.5%	92.8%	97.0%	96.5%
Measure II:	58.8%	0.0%*	52.2%	62.0%	24.4%
Measure III:	99.1%	97.4%	96.7%	96.0%	98.5%
Measure IV:	31.3%	26.3%	32.1%	3.4%	16.7%
Measure V:	69.2%	75.0%	96.2%	83.3%	100.0%

- Measures 1, 3, 4 Taken from HAB QM Report
- Measure 2 Taken from Data Service Entry 2.0 Report
- Measure 5 Taken from Crosstab Report

**The 0% is likely due to data entry discrepancies. CHAMPS is working to correct this.

Clinical and Case Management Monitoring

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

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

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

Utilization and Fiscal Monitoring

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

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

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

2020-2021 Priorities and Allocations

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

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

Core vs. Support Services

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

- The 75/25 percent requirement does not apply to State Services, only RW Part B funds. This allows the AA to allocate to State Services to social support services that are not allowable under RW Part B. For example, non-medical transportation can be allocated under State Services since it is critical in rural areas.

The AA requires the Panwest and West Texas regions to prioritize Outpatient/Ambulatory Medical Care, AIDS Pharmaceuticals, and Health Insurance Premium and Cost Sharing Assistance due to their medical urgency for maintaining client health. Subcontractors assure that community resources are used, that RW and States Services are payers of last resort and that funding is decreased in other categories as necessary to fund the three priority medical core categories

Please refer to Appendix D for the list of Core and Support services.

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

- Needs Assessment Findings—The 2019-2024 PanWest-West Texas Comprehensive Needs Assessment served as guides in setting the 2020-2021 allocations and priorities.[7]
- Historical information based on expenditures, service provision, service barrier limitations, community resources, and stakeholder/community input.
- PanWest and West Texas Comprehensive Plans for HIV/AIDS Services.
- DSHS Priority Setting & Resource Allocation Principles and DSHS HIV Services Taxonomy.[8]
- The allocations are often set prior to DSHS funding amounts are available. For this reason, the allocations may be based on a percentage.
- Once the funds become available, they are applied according to the allocated percentages.
- The allocations are generally determined at ninety-five percent (95%) of the previous year's allocations to allow for anticipated funding cuts, except for Medical Case Management and Non-Medical Case Management, which are generally allocated at 100%, since those categories include staff salaries.

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

Although funds are allocated every year, they may not be the same from year to year. It will be based on the funds received from the State as well as the current Needs Assessment and historical expenditures. Every effort is made to ensure the client's needs are evaluated first and foremost.

Client's needs may change, making it a challenge to predict the exact funding allocations for each service category. For example, the COVID-19 Pandemic has led to a shift in client's needs with a large number requesting assistance with food, rent, and utilities.

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

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

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

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

Health Insurance Premium and Cost Sharing Assistance: In October 2008, DSHS gave Administrative Agencies a directive that clients should not be denied or put on waiting lists, without great justification, for AIDS Pharmaceuticals and Health Insurance services. The DSHS Health Insurance Assistance Policy, 260.002, was updated in 2015 and is available at the DSHS website at www.dshs.state.tx.us. The policy provides guidance on how to determine eligibility for health insurance and the limits on health insurance.

2020-2021 Allocations: **Appendix E** reflects the funds allocated to the service categories in the 4 HSDA's.

In May 2020, the AA held public comment hearings in PanWest and West Texas to present the proposed 2020-2021 Priorities and Allocations. Community review and feedback about the service priorities and allocations are always welcome and are necessary to ensure they best meet the needs of people infected and affected by HIV/AIDS. The forums were held virtually due to the COVID-19 Pandemic restricting travel of all StarCare employees. Providers, clients, as well as community organizations were invited to the public forums. The allocation chart for each HSDA is posted at www.panwest.org under the Download Center of the menu.

Evaluation of 2017-2020 Comprehensive Plan

The 2017-2020 Comprehensive Plan format included a timetable for review of each strategy and action that facilitated plan monitoring.

Key strategies that were accomplished include:

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

Some actions are still in progress, including:

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

It also became evident that some actions in the 2017-2020 Plan were not realistic given our ability to influence their achievement. These included:

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

II. TARGETED NEEDS ASSESSMENT

TARGETED ASSESSMENT OF NEEDS OF PEOPLE LIVING WITH HIV

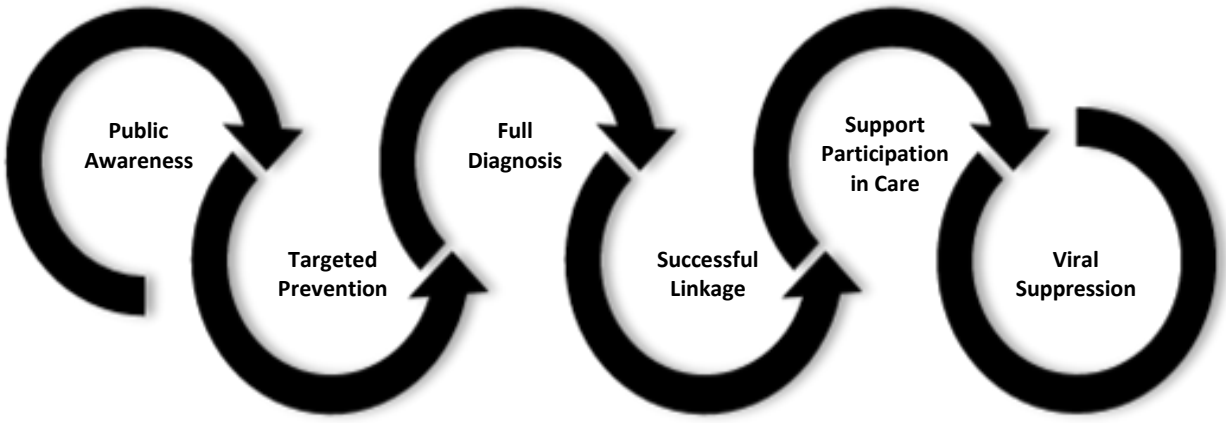
A Targeted Needs Assessments was conducted to direct and improve HIV care and treatment services and systems. Results are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity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

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

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

The pictorial below depicts the interconnectedness of these domains.

Figure 14
Interconnectedness of the Domains of the Texas Spectrum of HIV Engagement



Findings and Recommendations

Domain 1 – Public Awareness

Key Finding

Lack of knowledge or awareness fuels the spread of new infections and HIV stigma." This statement is practically applicable to the entire PanWest-West Texas region. Qualitative information obtained through the need's assessment points to an overall lack of public awareness or interest in HIV or its risk factors which has fueled a new wave of HIV infections in young MSMs and the stigma of the diagnosis.

Recommendations

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

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

Domain 2 – Targeted Prevention

Key Finding

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

Recommendations

2.1 Support best practice approaches to HIV outreach and testing of high risk populations.

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

2.2 Encourage training of PrEP counselors through the AETC.

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

Domain 3 – Full Diagnosis

Key Findings

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

Recommendations

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

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

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

Domain 4 – Successful Linkage

Key Finding

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

Recommendations

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

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

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

Key Finding

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

Recommendation

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

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

Domain 5 – Support Participation in Care

Key Finding

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

Recommendations

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

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

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

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

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

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

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

Key Finding

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

Recommendations

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

5.9 Continue funding for transportation services.

Domain 6 – Viral Suppression

Key Finding

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

Recommendations

6.1 Increase efforts to educate consumers at the importance of viral suppression to their long-term health.

- Ensure that medical/nursing professional actively engage consumers to ask questions about their disease.
- Provide nutritional counseling to PLWH.

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

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

THE 2017-2021 COMPREHENSIVE HIV HEALTH SERVICES PLAN ADDRESSES THE GOALS, STRATEGIES AND OBJECTIVES OF THE NATIONAL AND STATE POLICIES AND INITIATIVES

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

The National HIV/AIDS Strategy first developed in 2010 led to changes in the way that people discussed HIV, prioritized and responded to HIV prevention and care services, and delivered medical, non-medical and support services to PLWH to remain in care and treatment. The 2020 update incorporates the changes that have occurred, lessons learned and scientific advances that have occurred and may one day lead to the elimination of HIV infections.

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

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

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

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

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

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

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

Treatment as Prevention refers to HIV prevention methods that use antiretroviral treatment to decrease the risk of HIV transmission. In 2011, the HPTN052 Study showed early initiation of antiretroviral treatment in PLWH with a CD-4 count between 350-550, reduced HIV transmission to HIV negative partners by 96%. This has led to the idea that "treatment as prevention" could be used as a strategy to decrease community viral load and reduce the rate of new HIV infections.

There are health and prevention benefits to getting the viral load as low as possible. Health benefits mean PLWH live longer and healthier lives. The prevention benefit means that they have effectively no risk of transmitting HIV to negative partners. Such an idea depends on increasing efforts to test and treat those who are HIV+. As a result, the U.S. Prevention Task Force now recommends that all people aged 15-65, and all pregnant women be screened for HIV.

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

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

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

There are several medication assistance programs which can provide these vital medications at little to no cost. This is including a new program through the Department of Health and Human Services. It is called, Ending the Epidemic: Ready, Set, PrEP.There are two FDA approved medications available through this program, Truvada and Descovy. There are criteria that must be met to utilize this program. More information can be found at https://www.getyourprep.com/

Affordable Care Act

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

Unfortunately, benefits of the Health Insurance Marketplace have not benefited many PLWH in Texas because so many are living below the poverty line and cannot qualify for subsidies on the exchange. While 15% of Texans live below the poverty line, 736 of Ryan White clients in the PanWest-West Texas region are living below the poverty line. Additionally, the state's decision to not expand Medicaid to cover poor adults, has meant the bulk of low-income HIV patients do not qualify for expanded health coverage. Those who work but earn less than 100% of the poverty level cannot take advantage of the marketplace tax credits to enroll in health insurance.

Thus, the impact of ACA on medical providers in the PanWest-West Texas area has been minimal in terms of the numbers of newly insured under ACA as compared to the increasing numbers of newly diagnosed HIV+ consumers.

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

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

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

How This Plan Addresses Healthy People 2020 Objectives

Healthy People 2020, launched in December 2010, is a 10-year agenda for improving the nation's health. *Healthy People 2020* is the result of a multi-year plan that includes input from diverse groups and organizations. Healthy People 2030 is currently working on the 5th edition. The mission of the agenda is to:

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

Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

There are 16 objectives related to HIV. These objectives are addressed in the 2020-2025 Comprehensive HIV Health Services Plan. The goals and strategies of the 2020-2025 Comprehensive HIV Health Services Plan that address *Healthy People 2020* objectives are in Appendix G.

More information can be found at:

https://www.healthypeople.gov/2020/topics-objectives/topic-HIV

GOALS AND WORK PLANS

COMPREHENSIVE HIV HEALTH SERVICES PLAN

The 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan is the result of a collaborative planning process that included research, interactive discussion and plan development. This information was developed into a draft plan that was presented and reviewed by the Texas Department of State Health Services (DSHS) staff.

Throughout the planning process AA staff considered the National HIV Strategy for the U.S., the *Texas HIV Plan* updated for 2017-2021, *Healthy People 2020*, and Ryan White Program requirements.

GOALS AND RATIONALE

The 2020-2025 Comprehensive HIV Health Services Plan adopts three of the 2019 Texas Plan Priorities for AA and Subcontractor achievement. The goals reflect the findings of the 2019 PanWest-West Texas Targeted Needs Assessment which focused on barriers to linkage, retention and viral load suppression, and includes the updated epidemiologic profiles, regional demographics, and an assessment of access and health disparities in the region.

The three goals are to:

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

Please see the Executive Summary, (Pages ES-5 and ES-6) for the goals and rationale for the 2020-2024 Comprehensive HIV Health Services Plan.

The Work Plans below contain the goals, objectives, and strategies to encompass the findings from the 2019-2024 Comprehensive Needs Assessment.

The Work Plans are meant to be a fluid document as the client's needs may change prior to the next years Comprehensive Plan is introduced. The same is true for the current COVID-19 Pandemic. This has led to a shift in the needs of clients compared to prior to the pandemic.

The Work Plans will be monitored by the Planning Coordinator on a quarterly basis. If there is any adjustment that needs to be made due to lack of movement in a goal, the AA will discuss methods to ensure that the plan is re-evaluated to fit the current client needs.

The previous Comprehensive Plan goal, objectives, strategies, and activities are an on-going process as there have been staff turnovers and vacancies throughout the plan year. The COVID-19 Epidemic has also led to a shift in AA activities.

WORK PLANS

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

OBJECTIVE 1.1: By 2021, ensure that 90% of newly diagnosed PLWH are linked to care within 60 days of diagnosis.

STRATEGY: Increase communication with Providers to monitor linkage rates.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By 2021	Program Administrator Data Manager	• The Program Administrator and Data Manager will monitor the Providers on a consistent basis every month to determine the number of newly diagnosed clients and if they have been linked to care. • If there is no link to care within the 60-days, follow-up and an action plan to ensure linkage will occur.	Newly Diagnosed/ Those Returning to Care	Joint agreement on suggested improvement
By end of 2020	Planning Coordinator	• The Planning Coordinator will coordinate with Provider staff on a quarterly basis to determine any needs that are unmet regarding linking clients to services.	Newly Diagnosed/ Those Returning to Care	Joint agreement on suggested improvements

OBJECTIVE 1.2: By 2021, mobilize a Community Advisory Board in each HSDA.

STRATEGY: Ensure the Board is a diverse group consisting of PLWH, Social and Community Organizations, Peers, and the general public.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2021	Planning Coordinator/ Program Administrator AA	• Increase community awareness through education and outreach to reach the priority populations as well all PLWH. Mobilize the community to help end the epidemic in Texas using the Achieving Together Plan. • Utilize social media as the AA is currently under travel restrictions due to COVID-19. • Educate the community regarding the newly FDA approved at home HIV test kits. • Develop best practices for those that test positive at home to be linked to care.	PLWH	Identify best practices and disseminate information

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

OBJECTIVE 2.1: By 2021, increase the percentage of retained in care by 10%.

STRATEGY: Determine methods to encourage PLWH to engage in care.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By 2021	Planning Coordinator Program Administrator	• Identify Support mechanisms to encourage clients to engage in their care. • Determine the model necessary to reach and assist clients in finding the support groups that will allow them to participate without stigma and shame.	Those at high risk for dropping out-of-care	Identify best practices and disseminate information
By the end of 2020	Program Administrator	• Increase the use of Telemedicine for PLWH to engage in care without barriers, such as transportation or fear of stigma.	Those at high risk for dropping out-of-care	Identify best practices and disseminate information

OBJECTIVE 2.2: By 2021, ensure that 80% of new clients and those returning to care receive education and training on the method to obtain resources in each HSDA.

STRATEGY: Ensure and encourage PLWH to attend and participate.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2020	Program Administrator/ Planning Coordinator	• Create an educational program that reflects the resources available and how exactly to access them in each HSDA. Instruct the Providers to become trained to provide the information. • Topics may include, but not limited to budget development, nutrition needs, and healthy living. • The Planning Coordinator will ensure the resource Inventory is updated and re-evaluated at least 2 times per month.	Newly Diagnosed/ Those Returning to Care	Agreed upon program and pre- and post-test instrument

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

OBJECTIVE 3.1: By 2021, increase the viral suppression rates by 15%.

STRATEGY: Focus on reducing the disparities in viral suppression among priority populations

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By end of 2020	Program Administrator AA/ Planning Coordinator	• Ensure that the priority populations are receiving educational support regarding viral suppression and treatment adherence.	Priority Populations Patients at high risk of dropping out-of-care	Percent retained in care
By end of 2020	Program Administrator	• Case Managers should ensure that client's in the priority populations are monitored more frequently to not allow a client to "slip through the cracks".	Priority Populations/ Patients at high risk of dropping out-of-care	Percent retained in care
By end of 2020	Program Administrators/ Planning Coordinator	• Ensure the PLWH find the support systems that can assist in maintain viral suppression.	Patients at high risk for dropping out-of-care	Pre- and post-test scores Percent retained in care
By 2021	AA	• Determine the barriers to adherence in treatment, such as stigma, poverty, poor health literacy, and lack of knowledge on accessing resources. • Assist clients with these needs and follow-up to ensure the client's needs were met.	Priority Populations/ Patients at high risk for dropping out-of-care	Percent retained in care

OBJECTIVE 3.2: By 2021, increase the percent of HIV negative partners using PrEP to 30%

STRATEGY: Ensure PLWH are educated about PrEP and the benefits to HIV negative partners.

Timeframe	Responsible Party	Activity	Target Population	Data Indicators
By 2021	Program Administrator AA/Planning Coordinator	• Ensure clients are educated regarding PrEP and the benefits to their HIV negative partners. Ensure there are resources available for the client (pamphlets, website access, etc.).	MSMs	Number of clients requesting and receiving education
By end of 2020	Program Administrator AA	• Ensure that clients understand this is available to HIV negative individuals. • Provide the clients with resources regarding medication assistance, such as the new Ready, Set, PrEP program through the Department of HHS. • https://www.getyourprep.com/	MSMs	Resource Inventory developed and available to consumers.
By 2021	AA	• Encourage medical providers to create PrEP clinics in the PanWest-West Texas Region.	MSMs	One clinic in place in region.

MONITORING PROGRESS

The 2020-2025 PanWest-West Texas Comprehensive HIV Health Services Plan includes a detailed timeline outlining completion dates, responsible parties and data indicators. Many of the objectives and actions should be monitored on a quarterly basis, but no less than semi-annually.

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

- The AA works with funded providers to ensure a unified direction.
- The AA will review ARIES data.
- The quality management process supports monitoring and evaluation of Plan Goals.
- The AA prepares a quarterly report for DSHS that includes HSDA activities and expenditures.
- Input gathered from surveys, letters, website, phone calls, and public meetings will also be used as a means of evaluation.

EVALUATION

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

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

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

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

IMPACT ON PRIORITY SETTING AND ALLOCATIONS

In developing the 2020–2025 Comprehensive HIV Health Services Plan, the AA staff was aware of each strategy's potential impact on priority setting and allocations. Many of the strategies will not increase costs to the system but will provide alternative and cost-effective uses of funds. Some of the strategies will require staff or subcontractor time to implement but will not be a direct dollar cost. Finally, some of the strategies may result in increased costs during program initiation, but ongoing provision will not increase costs to the system significantly.

III. APPENDICES

APPENDIX A
PANWEST AND WEST TEXAS QUALITY MANAGEMENT PLAN 2016

The Quality Management (QM) Program of the StarCare Specialty Health System HIV Services Administrative Agency (AA) for PanWest (Area 2) and West Texas (Area 1) consists of the following components:

I. Quality Statement

The Quality Management Committee accepts the responsibility of overseeing progress toward achieving organizational and regional goals for quality of care for all clients. The Quality Management Committee will ensure that the establishment and review of improvement goals and quality indicators shall be regular components of the Committee's agenda. All of the Committee's activities are in support of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009).

II. Quality Infrastructure: Quality Management Committee (QMC)

The Quality Management Committee (QMC) monitors and assesses Subcontractor and AA activities, brainstorms methods to better implement standards of care, measures progress by reviewing performance measures specifically regarding medical care and case management, reviews results of client and provider (Subcontractor) satisfaction surveys, reviews needs assessments, discusses complaints and concerns, and shares best practices.

Committee Membership: The AA will maintain a QMC that is composed of internal and external stakeholders to include the site administrator of each HIV service Subcontractor, a senior data/case manager, a medical professional, and the Administrative Agency's Quality Manager and Program Supervisor. The QMC membership is composed of the following:

- Amarillo HSDA HIV Service Subcontractor: Panhandle AIDS Support Organization (PASO) - Executive Director
- Permian Basin HSDA HIV Service Subcontractor: Permian Basin Community Centers for MHMR Basin Assistance Services (BAS) – 1) Team Lead, and 2) Quality Management Coordinator
- Lubbock HSDA HIV Service Subcontractor: South Plains Community Action Association, Inc. Project CHAMPS - Program Director
- El Paso HSDA HIV Service Subcontractor: Centro de Salud Familiar La Fe, Inc. (La Fe CARE) – Program Director and Data Manager
- El Paso HSDA HIV Service Subcontractor: South Plains Community Action Association, Inc. Project CHAMPS - Program Director and Medical Case Manager
- Medical Professional: Ogechika Alozie, MD, MPH, AAHIVS
- AA Quality/Data Management Coordinator
- AA HIV Services Program Supervisor
- DSHS Consultant
- StarCare Compliance Director

Please note: Those who are designated to sit in for someone are responsible in communicating the information shared during the meeting to their committee member.

Participant Roles: The QMC, as a whole, will 1) annually, and as needed, review and update the QM Plan, 2) quarterly, and as needed, review and update the QM Annual Quality Improvement Plan, 3) review new and existing DSHS policies to include Case Management and Clinical guidelines, 4) discuss adverse events and consumer concerns/complaints, 5) review and update consumer surveys, review consumer survey data and action plans to address survey concerns, 6) review provider (Subcontractor) surveys and action plans to address survey concerns, and 7) review performance measure percentages to assure progress is made toward meeting the goals, strategies and activities of the Comprehensive Plan for HIV Services, Quality Management Plan and Annual Quality Improvement Plan.

In addition, the QMC participants have the following responsibilities:

A. The Contract Specialist reviews quarterly expenses and discusses needed reallocations.
B. The Quality/Data Management Coordinator conducts the following processes: i. Review service utilization data to identify patterns

i. Completes data quality checks as described in Section IX below
ii. Leads the QMC, schedules QMC meetings, updates the QM Plan and Annual Quality Improvement Plan, maintains meeting minutes, and provides training.

C. The Planning Coordinator works with the QM Coordinator on updating the Comprehensive Plan for HIV Services and at least quarterly monitoring and updating the goals, strategies and activities.
D. The HSDA service Subcontractors conduct and present to the QMC the following processes: i. Run report on items in performance measurement (See IV below) and share results

i. Run HAB Core Measures: will run report and present on percentages after Core Measures are uploaded in ARIES
ii. Present information on objectives/activities from the Comprehensive Plan/QM Plan
iii. Share individual agency QM activities as well as quality improvement activities implemented and piloted to improve the HAB measures and services in general (ex: new forms to streamline intakes, changes in personnel roles, policies, etc.…)

E. The physician provides medical insight and educates the QMC on issues that affect HIV treatment such as co-morbidities and their effect on HIV/AIDS and other medical topics.

Meetings: The QMC meets quarterly, generally via conference call. Other meetings are scheduled as needed. The AA provides an agenda to the QMC as well as updates the QM Plan and the Annual Quality Improvement Plan. The AA keeps meeting minutes and provides them to the QMC within ten (10) workdays of the QMC meeting.

Resources:

III. HIV Administration Agency

The Administrative Agency as a whole will monitor all aspects of eligibility for both Ryan White and the AIDS Pharmaceutical Assistance Program, ensuring that eligibility documents are continually updated and all eligibility criteria are met in accordance with Texas DSHS policy. The Administrative Agency will provide technical assistance where needed to ensure that all Providers maintain current eligibility documentation.
IV. Annual Quality Improvement Plan

The StarCare Specialty Health System established an Annual Quality Improvement Plan (QI Plan), in conjunction with the Comprehensive Plan for HIV Services, to identify the goals and strategies of the Quality Management Program. The Annual Quality Improvement Plan addresses the strategies during the year and also identifies the target date of completion. A new Annual Quality Improvement Plan is created in December approved by the Quality Management Committee. The plan is driven by the Comprehensive Plan and results of site reviews and Client/Provider Satisfactions Surveys. The plan identifies all the major activities of the committee and is the vehicle for examining how well the system is working in executing the program's priorities and strategies. The Annual Quality Improvement Plan lists the quality assurance and quality improvement activities for the contract year and is aligned with DSHS Quality Management objectives. The QI Plan is updated after each QMC meeting. The QM Plan is incorporated as an attachment in the Comprehensive Plan for HIV Services.

V. Performance Measure

One of the key characteristics of the Quality Management Program is to use data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. The QMC will follow the HIV/AIDS Bureau's HIV Core Clinical Performance Measures for Adult/Adolescent Clients. The QMC will abide by the core performance measures listed below:

1. Viral Load Suppression
2. CD4 cell count
3. Prescribed Antiretroviral Therapy
4. Medical Visits Frequency
5. Gap in Medical Visits
6. PCP Prophylaxis

VI. Plan to Identify, Correct, and Monitor Adverse Outcomes

A. The current system to identify potential adverse outcomes includes use of random review of client records, data review from ARIES, media releases, complaints, subcontractor monitoring, notification from DSHS, and any other communication mechanism. Specifically:

i. The Quality/Data Management Coordinator is responsible for collecting and analyzing data as directed by the QMC
ii. The Program Supervisor is responsible for reviewing complaints and notifications from DSHS

B. When a potential adverse outcome is identified, the following process is followed:

i. The staff identifying the outcome notifies all Administrative Agency staff, and the Administrative Agency staff consults to research and verify the information.
ii. The Administrative Agency staff works together to develop the corrective action applicable to the issue.
iii. Depending on the adverse outcome, the Contracts Specialist then notifies the Subcontractors first by phone, depending on the urgency of the outcome, and followed up in writing by e-mail and/or certified mail.
iv. Subcontractors will notify clients of the adverse outcome by phone, mail, e-mail, flyers, media, website, face-to-face contacts, during visits, etc... For emergency outcomes, clients will be notified within 24 hours by phone, home visit or other face-to-face contact. Subcontractors will document their efforts and at least three attempts must be made to contact the client.
v. For emergency adverse outcomes, the Administrative Agency will assist the Subcontractors to assess immediate needs of the clients and to facilitate access to services. Depending on the adverse outcome, the attached Texas Rapid Public Health Needs Assessment Instrument (TX DSHS) and/or the attached CASPER Questionnaire will be implemented.

vi. Non-emergency adverse outcomes will be addressed on a case-by-case basis with priority given according to client need.
vii. The final results of the corrective action to the adverse outcome are reported by The Program Supervisor to the Director of Contracts Management and to the Quality Management Committee.
viii. The Administrative Agency staff works together to perform follow up monitoring and reports to the Director of Contracts Management and to the Quality Management Committee.

C. The Administrative Agency also has a Contingency Plan for Lapse of HIV Services. This plan is located in the policies and procedures under Section 15 (AA) and Section 14B (Subcontractor) – Contingency Plan for Lapse of HIV Services. This plan includes general guidance to address a significant change or situation that may occur and result in a lapse of HIV services. The primary focus of this plan is core medical services.

VII. Capacity Building

The AA informs the QMC of upcoming trainings, such as webcasts and teleconferences, conducted by the National Quality Center and the Texas Department of State Health Services (DSHS). The AA will maintain a log of QM trainings and technical assistance.
The 2015 Texas HIV Case Management Standards issued new training requirements for Medical Case Managers (MCMs) and Non-Medical Case Managements (NMCMs). All training requirements and compliance are monitored by the Quality/Data Management Coordinator through desktop reviews and annual audits.

In February 2010, DSHS asked AAs to combine the QM Plan with the area comprehensive plan. Beginning April 1, 2010, the QM Plan/QI Plan is incorporated into the PanWest HIV/AIDS Service Area Comprehensive Plan for HIV Services.

VIII. Expenditures

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

IX. Evaluation and Program Adherence

Needs Assessment: The Administrative Agency conducts or commissions a Regional Needs Assessment every three years in order to identify any gaps of services provided by both the AA and the subcontractors. The QMC will use the findings in the Needs Assessment to identify any gaps in the QM/QI infrastructure.
Program Adherence: DSHS has contracted with Germane Solutions to perform monitoring for clinical and case management services in accordance with HIV Clinical and Case Management Services Standards that include monitoring of the care and treatment of persons with HIV according to the US Public Health Standards. Germane Solutions also makes annual site visits to the clinics of the Subcontractors in El Paso, Lubbock and Odessa to assure the medical needs of the clients are met. Any issues or program adherence that require correction will be reported to the AA and it is the responsibility of the Program Supervisor to

inform the QMC of the issues, if appropriate, as they may pertain to evaluation of the six core performance measures.

Data Quality Check: After the data entry process is performed at the subcontractor level, the AA Quality/Data Management Coordinator performs quarterly data quality checks. The process includes checking for missing information or unknown data. After the Administrative Agency completes the process, the Subcontractors' data manager receives statistical reports containing a list of clients with missing or unknown data on a monthly basis. The missing data must be collected as soon as possible; preferably before the next data transmission begins in the following month. The Subcontractors' data managers are encouraged to share information with the case managers in order to complete this process.

As of April 1, 2010, TX DSHS implemented a new policy, Documenting Case Management Actions in ARIES, "to assist in the improvement of the quality of documentation as well make data input more uniform." The policy requires Subcontractors to use ARIES to the maximum extent possible to include entering case notes, adherence assessments, mental health/substance abuse screenings, and risk reduction notes.

Satisfaction Surveys: The Administrative Agency (AA) implements an annual Client Satisfaction Survey and annual Provider (Subcontractor) Satisfaction Survey as a means of obtaining input and measuring satisfaction and progress.

a. Client Satisfaction Surveys, English and Spanish, are mailed directly to each client, who allows mail, along with a letter, English and Spanish, explaining the survey and a self-addressed stamped envelope to return the survey. Clients are asked to remain anonymous and not list identifying information on the survey or envelope but may list provide contact information if they want to be contacted by the AA. Clients are given the option of completing the survey by phone, in English or Spanish. An aggregate of the survey results are sent to the Subcontractors and reviewed by the QMC. Subcontractors are asked to review their individual results and respond with an action plan to the AA to address adverse outcomes if any.

b. The Provider (Subcontractor) Satisfaction Surveys are done through Survey Monkey. A survey link is e-mailed directly to each Subcontractor staff that has regular contact with the AA and primarily includes the program director, agency director, case managers, data manager, and accountant. Subcontractors are asked to remain anonymous

APPENDIX B
CLINICAL AND CASE MANAGEMENT MONITORING

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

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

Monitoring for clinical and case management services, conducted by a third-party Consultant contracted by DSHS, is performed in accordance with Texas Department of State Health Services HIV Clinical and Case Management Services Standards. It includes:

- Monitoring of the care and treatment of persons with HIV in accordance with US Public Health Standards, Health Resources Services Agency-HIV/AIDS Bureau Measures, and Texas Department of State Health Services.
- Site visits to the clinics of the Subcontractors in Amarillo, Lubbock, Odessa and El Paso to assure the medical needs of the clients are being met.
- Regular desktop monitoring of the documentation in ARIES for:
  - Timeliness and content of case notes
  - Subcontractors' adherence to payer of last resort and emergency medication policies
  - Completion of needs assessments
  - Implementation and updating of care plans
  - Updating of medication and lab results, specifically CD-4 counts and viral loads
  - Assessing the need for specialty referrals and ensuring follow-up on referrals
  - Compliance with client graduation, discharge, and termination policies and procedures
  - Compliance with other programmatic policies and procedures related to medical and non-medical case management

Other related activities of the DSHS contracted Consultant include:

- Communication with Subcontractors via telephone, e-mail and on-site for clarification of any identified issues.
- Provision of TA as requested or as determined necessary to ensure clients are receiving quality services.
- Participation in site reviews for each Subcontractor where strategic samples of client charts are assessed for continuity of care as well as the completion and content of documentation.
- Providing feedback to the Subcontractors related to TA and site visits.

APPENDIX C
UTILIZATION AND FISCAL MONITORING

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

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

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

- There is at least one site visit per year at each Subcontractor location. This site visits may or may not be announced.
- Subcontractors are notified at least two weeks in advance for scheduling of the announced visits.
- An audit tool is used to conduct the review. During the check, clients are randomly selected and the AA's data manager crosswalks the data in ARIES with the information as presented in the client's profile.
- Physical reviews of client and service data are evaluated. The reports are shared with the Subcontractors.
- As of August 8, 2010, TX DSHS implemented a new policy (231.004), Documenting Case Management Actions in ARIES, "to assist in the improvement of the quality of documentation as well make data input more uniform." The new policy requires Subcontractors to use ARIES to the maximum extent possible, to include entering case notes, adherence assessments, mental health/substance abuse screenings, and risk reduction notes.

Expenditure Monitoring

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

- The AA monitors expenditures at least monthly through ARIES data and Subcontractor billing data.
- The Planning Coordinator discusses reallocations as needed to assure adequate funding for medical core services, especially to avoid denial of services, waiting lists and delay of services for AIDS Pharmaceuticals, Health Insurance Premium and Cost Sharing, and Outpatient/Ambulatory Medical Care, and to prevent lapse of funds.
- The Program Administrator and Grant Accountant monitor the contract expenses monthly to ensure that there is no lapse or overspending of funds. This is accomplished through analyzing the expenses reported monthly by the subcontractors.

- If expenditures do not appear to be on target, Subcontractors are contacted and required to submit a plan to ensure funds are expended appropriately. If it is determined that the Subcontractor is unable to expend funds within the contract term, the AA initiates necessary steps following the DSHS reallocation policy. Monthly fiscal update calls suing Zoom have been established with providers.

APPENDIX D
MEDICAL CORE AND SOCIAL SUPPORT SERVICES

Funds for the medical core categories needed in the PanWest and West Texas areas are generally allocated through Ryan White Service Delivery funds to maintain compliance with the requirement that 75% of Ryan White Part B funding be allocated to the medical core categories. These include:

1. Ambulatory Outpatient Medical Care
2. HIV/AIDS Drug Reimbursement (AIDS Pharmaceutical Assistance - local)
3. Oral Health Care
4. Early intervention Services
5. Health Insurance Premium and Cost Sharing Assistance
6. Home Health Care
7. Medical Nutrition Therapy
8. Hospice Services
9. Home & Community-Based Health Services
10. Mental Health Services
11. Substance Abuse Outpatient Care
12. Medical Case Management.

Although the AIDS Drug Assistance Program (ADAP) is a medical core category, funding is not allocated locally since the Texas HIV Medication Program administers the ADAP.

Social support services are as those services needed by people living with HIV/AIDS to "enhance access to and retention in care."[9] HRSA has identified social support services as:

1. Non-Medical Case Management,
2. Treatment adherence counseling,
3. Medical transportation,
4. Non-medical transportation,
5. Food bank,
6. Emergency financial assistance,
7. Housing,
8. Respite care,
9. Child care,
10. Health education/risk reduction, legal,
11. Outreach,
12. Psychosocial support,
13. Referral for health care/supportive services,
14. Rehabilitation,
15. Linguistic Services.

[9] The Treatment Extension Act of 2009.

APPENDIX E
2020-2021 ALLOCATIONS

Priorities and Allocations charts are provided below by HSDA.

The first set of charts encompass the Allocation justifications.

The second set of charts encompass Ryan White Part B, State-Rebate, and State Services allocations.

The third set of charts encompass HOPWA allocations.

The allocation charts are available on the www.panwest.org website.

The 2020-2021 Priorities and Allocations were presented in May 2020 during the Virtual Community Forums held on a Zoom conference call.

LUBBOCK

Core Medical Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 1	Outpatient Ambulatory Health Services	21.0%; additional funding via State-R and State Services
Priority 2	Health Insurance Assistance	1.29%; additional funding via State-R and State Services
Priority 4	Medical Case Management	62.24%; additional funding via State-R and State Services
Priority 8	Mental Health Services	1.99%; additional funding via State-R and State Services
Not Ranked	AIDS Drug Assistance Program Treatments	0.00%; Patient Assistance Programs/340B cover med costs
Not Ranked	AIDS Pharmaceutical Assistance (LPAP)	0.00%; Patient Assistance Programs/340B cover med costs
Not Ranked	Early Intervention Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home and Community-Based Heath Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home Health Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Hospice Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Medical Nutrition Therapy	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Outpatient	0%; No data from Needs Assessment that showed a need

Support Services		Justification/Comments
Service Priority	Mental Health Services B26	**For Funding Decisions**
Priority 3	Referral for Health Care/Support Services	0.00%; funded entirely via State-R
Priority 5	Non-Medical Case Management	11.50%; additional funding via State Services
Priority 6	Medical Transportation	0.00%; questioning this
Priority 7	Housing Services	0.00%; needs met via HOPWA grant
Priority 9	Food Bank/Home Delivered Meals	0%; funded via State-R
Priority 10	Emergency Financial Assistance (EFA)	0.03%; additional funding via State Services
Priority 11	Psychosocial Support Services	0.00%; actual cost--if any--yet to be determined
Priority 12	Outreach Services	0%; activities carried out under other categories
Priority 13	Health Education/Risk Reduction	0.00%; activities carried out under MCM, clinic visits
Not Ranked	Child Care Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Legal Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Linguistic Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Other Professional Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Permanency Planning	0%; No data from Needs Assessment that showed a need
Not Ranked	Respite Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Residential	0%; No data from Needs Assessment that showed a need

A priority does not determine the allocation.

Four main services:

- Outpatient/Ambulatory Health Services
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Health Insurance & Premium Cost Sharing
- Case Management: Medical and Non-Medical

Allocations include direct and indirect costs.

ADAP: AIDS Drug Assistance Program-State of TX, administered by TX HIV Medication Program

Part B: Ryan White Federal funds, 75% must go to core medical services, in TX, DSHS gets Part B.

State Services: State of Texas funds to match portion of Part B, does not require 75% into medical.

HOPWA: Housing Opportunities for People with AIDS (DSHS): grant is not allocated by AA. City of El Paso receives HUD HOPWA directly.

EL PASO (LA FE)

Core Medical Services

Service Priority	Service Category	Justification/Comments For Funding Decisions
Priority 1	Outpatient/Ambulatory Health Services	37.94%; additional funding via State-R and State Services
Priority 2	Health Insurance Premium Assistance	6.33%; additional funding via State Services
Priority 3	Oral Health Care	2.9%; additional funding via State-R
Priority 4	Mental Health Services	1.97%; based on current utilization data
Priority 7	Medical Case Management	40.83%; based on current budget and utilization data
Priority 10	AIDS Pharmaceutical Assistance (LPAP)	4.53%; based on current utilization data
Not Ranked	AIDS Drug Assistance Program Treatments	0%; No data from Needs Assessment that showed a need
Not Ranked	Early Intervention Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home and Community-Based Health Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home Health Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Hospice Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Medical Nutrition Therapy	0%; Funded via RW
Not Ranked	Substance Abuse Outpatient	

Support Services

Service Priority	Service Category	Justification/Comments For Funding Decisions
Priority 5	Non-Medical Case Management	5.5%; additional funding via State Services
Priority 6	Medical Transportation	0.00%; additional funding via State-R and State Services
Priority 8	Referral for Health Care/Support Services	0.00%; funded under State-R
Priority 9	Housing Services	0.00%; need met via City of El Paso and SPCAA HOPWA programs
Priority 11	Outreach Services	0%; Separately funded department within La Fe provides this
Priority 12	Emergency Financial Assistance (EFA)	0.00%; other community/internal resources available
Priority 13	Food Bank/Home-Delivered Meals	0.00%; other community/internal resources available
Priority 14	Linguistic Services	0%; No definitive need has presented itself as of yet
Priority 15	Psychosocial Support Services	0.00%; cost--if any--yet to be determined
Not Ranked	Child Care Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Health Education/Risk Reduction	0%; No data from Needs Assessment that showed a need
Not Ranked	Legal Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Other Professional Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Permancy Planning	0%; No data from Needs Assessment that showed a need
Not Ranked	Rehabilitation Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Respite Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Residential	

A priority does not determine the allocation.

Four main services:

- Outpatient/Ambulatory Health Services
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Health Insurance & Premium Cost Sharing
- Case Management: Medical and Non-Medical

Allocations include direct and indirect costs.

ADAP: AIDS Drug Assistance Program-State of TX, administered by TX HIV Medication Program

Part B: Ryan White Federal funds, 75% must go to core medical services, in TX, DSHS gets Part B.

State Services: State of Texas funds to match portion of Part B, does not require 75% into medical.

HOPWA: Housing Opportunities for People with AIDS (DSHS): grant is not allocated by AA. City of El Paso receives HUD HOPWA directly.

AMARILLO

Core Medical Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 1	Outpatient Ambulatory Health Services	6.72%; additional funding via State-R and State Services
Priority 2	Health Insurance Assistance	5.90%; additional funding via State-R and State Services
Priority 3	Oral Health Care	9.86%; additional funding via State-R
Priority 5	Medical Case Management	52.36%; based on current budget and utilization data
Priority 11	Mental Health Services	0.45%; based on current utilization data
Not Ranked	AIDS Drug Assistance Program Treatments	0.00%; Patient Assistance Programs/340B funding cover med costs
Not Ranked	AIDS Pharmaceutical Assistance (LPAP)	0.00%; Patient Assistance Programs/340B funding cover med costs
Not Ranked	Early Intervention Services (EIS)	0%; No data from Needs Assessment that showed a need
Not Ranked	Home and Community-Based Health Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home Health Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Hospice Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Medical Nutrition Therapy	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Outpatient Care	0%; No data from Needs Assessment that showed a need

Support Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 4	Referral for Health Care/Support Services	0%; Funded via State-R
Priority 6	Non-Medical Case Management	24.51%; additional funding via State-R and State Services
Priority 7	Medical Transportation	0.00%; funded under State-R and State Services
Priority 8	Food Bank/Home-Delivered Meals	0.00%; funded under State-R and State Services
Priority 9	Housing Services	0.00%; need met via HOPWA grant
Priority 10	Emergency Financial Assistance	0.20%; additional funding via State-R and State Services
Priority 12	Linguistic Services	0.00%; funded via State Services
Priority 13	Health Education/Risk Reduction	0.00%; activities captured under MCM, clinic visits
Priority 14	Psychosocial Support Services	0.00%; funded via State-R
Not Ranked	Child Care Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Legal Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Other Professional Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Permanency Planning	0%; No data from Needs Assessment that showed a need
Not Ranked	Rehabilitation Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Respite Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Residential	0%; No data from Needs Assessment that showed a need

A priority does not determine the allocation.

Four main services:

- Outpatient/Ambulatory Health Services
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Health Insurance & Premium Cost Sharing
- Case Management: Medical and Non-Medical

Allocations include direct and indirect costs.

ADAP: AIDS Drug Assistance Program-State of TX, administered by TX HIV Medication Program

Part B: Ryan White Federal funds, 75% must go to core medical services, in TX, DSHS gets Part B.

State Services: State of Texas funds to match portion of Part B, does not require 75% into medical.

HOPWA: Housing Opportunities for People with AIDS (DSHS): grant is not allocated by AA. City of El Paso receives HUD HOPWA directly.

El PASO CHAMPS

Core Medical Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 1	Outpatient/Ambulatory Health Services	60.89%; additional funding via State-R
Priority 2	Health Insurance Premium Assistance	0.37%; additional funding through State Services and State-R
Priority 3	Oral Health Care	0%; funded via State-R
Priority 4	Mental Health Services	0.29%; additional funding via State Services and State-R
Priority 7	Medical Case Management	28.31%; additional funding via State Servcies
Priority 10	AIDS Pharmaceutical Assistance (LPAP)	0%; Patient Assistance Programs/340B funding cover med cost
Not Ranked	AIDS Drug Assistance Program Treatments	0%; No data from Needs Assessment that showed a need
Not Ranked	Early Intervention Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home and Community-Based Health Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home Health Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Hospice Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Medical Nutrition Therapy	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Outpatient	0%; No data from Needs Assessment that showed a need

Support Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 5	Non-Medical Case Management	10.14%; additional funding via State Services
Priority 6	Medical Transportation	0%; funded via State-R
Priority 8	Referral for Health Care/Support Services	0%; funded via State-R
Priority 9	Housing Services	0%; service currently funded via HOPWA
Priority 11	Outreach Services	0%; integrated within Rapid Start program
Priority 12	Emergency Financial Assistance (EFA)	0%; funded via State-R
Priority 13	Food Bank/Home-Delivered Meals	0%; other community resources being utilized
Priority 14	Linguistic Services	0%; no actual need presented as of yet
Priority 15	Psychosocial Support Services	0%; actual cost--if any--yet to be determined
Not Ranked	Child Care Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Health Education/Risk Reduction	0%; No data from Needs Assessment that showed a need
Not Ranked	Legal Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Other Professional Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Permancy Planning	0%; No data from Needs Assessment that showed a need
Not Ranked	Rehabilitation Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Respite Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse Residential	0%; No data from Needs Assessment that showed a need

A priority does not determine the allocation.

Four main services:

- Outpatient/Ambulatory Health Services
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Health Insurance & Premium Cost Sharing
- Case Management: Medical and Non-Medical

Allocations include direct and indirect costs.

ADAP: AIDS Drug Assistance Program-State of TX, administered by TX HIV Medication Program

Part B: Ryan White Federal funds, 75% must go to core medical services, in TX, DSHS gets Part B.

State Services: State of Texas funds to match portion of Part B, does not require 75% into medical.

HOPWA: Housing Opportunities for People with AIDS (DSHS): grant is not allocated by AA. City of El Paso receives HUD HOPWA directly.

PERMIAN BASIN

Core Medical Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 1	Outpatient/Ambulatory Health Services	28.26%; Additional funding via S-R and SS
Priority 2	Health Insurance Premium Assistance	13.09%; Also funded via State-R and State Services
Priority 3	Medical Case Management	22.69%; based on current utilization data/budget
Priority 5	Oral Health Care	10.99%%; Service also funded via State Services and State-R
Priority 7	Mental Health Services	0.00%; PermiaCare local MH provider
Not Ranked	AIDS Drug Assistance Program Treatments	0.00%; Patient Assistance Programs; 340B cover med cost
Not Ranked	Local Pharmaceutical AIDS Program (LPAP	0%; Patient Assistance Programs; 340B cover med cost
Not Ranked	Early Intervention Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home and Community Based Health Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Home Health Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Hospice Care	0%; No data from Needs Assessment that showed a need
Not Ranked	Medical Nutrion Therapy	0%; No data from Needs Assessment that showed a need
Not Ranked	Substance Abuse (Outpatient	0%; No data from Needs Assessment that showed a need

Support Services		Justification/Comments
Service Priority	**Service Category**	**For Funding Decisions**
Priority 4	Referral for Health Care Services	0.00%; provided via State-R
Priority 6	Medical Transportation	0.05%; Additional funding via State-R
Priority 8	Linguistic Services	0.43%; Additional funding via State-R
Priority 9	Housing Services	0%; Currently covered via HOPWA
Priority 10	Food Bank	0.00%: funded via State Services and State-R
Priority 11	Emergency Financial Assistance (EFA)	0.00%; funded via State Services
Priority 12	Psychosocial Support Services	0.00%; Actual activity cost undetermined;
Priority 13	Non-Medical Case Management	24.50%; additional funding via State Services
Priority 14	Health Education/Risk Reduction	0%; Activity covered via MCM
Not Ranked	Child Care Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Legal Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Other Professional Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Outreach Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Permancy Planning	0%; No data from Needs Assessment that showed a need
Not Ranked	Rehabilitation Services	0%; No data from Needs Assessment that showed a need
Not Ranked	Respite Care	
Not Ranked	Substance Abuse (Residential)	

A priority does not determine the allocation.

Four main services:

- Outpatient/Ambulatory Health Services
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Health Insurance & Premium Cost Sharing
- Case Management: Medical and Non-Medical

Allocations include direct and indirect costs.

ADAP: AIDS Drug Assistance Program-State of TX, administered by TX HIV Medication Program

Part B: Ryan White Federal funds, 75% must go to core medical services, in TX, DSHS gets Part B.

State Services: State of Texas funds to match portion of Part B, does not require 75% into medical.

HOPWA: Housing Opportunities for People with AIDS (DSHS): grant is not allocated by AA. City of El Paso receives HUD HOPWA directly.

RYAN WHITE AND STATE-R ALLOCATIONS 4/1/2020-3/31/2021		
AMARILLO		
CORE SERVICES		
Health Insurance Premium Assistance	$27,388.00	12.96%
Medical Case Management	$209,846.00	69.15%
Mental Health Services	$2,044.00	0.67%
Oral Health	$21,302.00	9.63%
Outpatient Ambulatory Health Services	$16,562.00	7.19%
SUPPORT SERVICES		
Emergency Financial Assistance	$1,099.00	0.44%
Food Bank/Home Delivered Meals	$10,104.00	4.92%
Linguistic Services	$1,086.00	0.53%
Medical Transportation Services	$1,630.00	0.79%
Non-Medical Case Management	$122,151.00	47.19%
Psychosocial Support Services	$1,195.00	0.58%
Referak For Health Care Support svc's	$94,240.00	45.93%
TOTAL	$508,647.00	
RYAN WHITE PART B TOTAL	$303,473.00	100.00%
STATE-R TOTAL	$205,174.00	100.00%

AMARILLO HSDA

STATE SERVICES 9/1/2019-8/31/2020		
AMARILLO		
CORE SERVICES		
Health Insurance Premiums/Cost Sharing Assistance	$9,473.00	10.18%
Oral Health Care	$624.00	0.67%
Outpatient Ambulatory Health Services	$13,079.00	14.05%
SUPPORT SERVICES		
Emergency Financial Assistance (EFA)	$1,669.00	1.79%
Food Bank/Home Delivered Meals	$14,000.00	15.04%
Linguistic Services	$800.00	0.86%
Medical Transportation Services	$500.00	0.54%
Non-Medical Case Management	$43,033.00	46.24%
Psychosocial Support Services	$1,000.00	1.07%
TOTAL	$84,178.00	90.45%

RYAN WHITE AND STATE-R ALLOCATIONS 4/1/2020-3/31/2021

EL PASO HSDA		
CORE SERVICES		
Health Insurance Premium Assistance	$26,160.00	1.74%
Medical Case Management	$372,419.00	24.80%
Mental Health Services	$17,637.00	1.17%
LPAP(Local AIDS Pharmaceutical Asst)	$18,813.00	1.25%
Oral Health	$15,385.00	1.02%
Outpatient Ambulatory Health Services	$836,052.00	55.68%
SUPPORT SERVICES		
Emergency Financial Assistance	$878.00	0.06%
Medical Transportation Services	$7,693.00	0.51%
Non-Medical Case Management	$73,289.00	4.88%
Referral For Health Care Support svc's	$133,334.00	8.88%
TOTAL	$1,501,660.00	100.00%
RYAN WHITE TOTAL	$903,138.00	100.00%
STATE-R TOTAL	$598,522.00	100.00%

EL PASO HSDA

STATE SERVICES 9/1/2019-8/31/2020		
EL PASO HSDA		
CORE SERVICES		
Health Insurance Premiums/Cost Sharing Assistance	$18,652.00	8.23%
Medical Case Management	$94,495.00	41.71%
Mental Health Services	$1,667.00	0.74%
Outpatient Ambulatory Health Services	$62,181.00	27.45%
SUPPORT SERVICES		
Medical Transportation Services	$6,439.00	2.84%
Non-Medical Case Management	$43,126.00	19.04%
TOTAL	$226,560.00	100.00%

RYAN WHITE AND STATE-R ALLOCATIONS 4/1/2020-3/31/2021

LUBBOCK		
CORE SERVICES		
Health Insurance Premium Assistance	$8,884.00	1.58%
Medical Case Management	$282,017.00	50.20%
Mental Health Services	$9,996.00	1.78%
Oral Health	$4,444.00	0.79%
Outpatient Ambulatory Health Services	$141,110.00	25.12%
SUPPORT SERVICES		
Emergency Financial Assistance	$2,222.00	0.40%
Food Bank/Home Delivered Meals	$6,466.00	1.15%
Rehabilitation Services	$22,222.00	3.96%
Non-Medical Case Management	$34,964.00	6.22%
Referral For Health Care Support svc's	$49,468.00	8.81%
TOTAL	$561,793.00	100.00%
RYAN WHITE PART B TOTAL	$348,279.00	100.00%
STATE-R TOTAL	$213,514.00	100.00%

LUBBOCK HSDA

STATE SERVICES 9/1/2019-8/31/2020		
LUBBOCK		
CORE SERVICES		
Health Insurance Premiums/Cost Sharing Assistance	$1,111.00	1.09%
Medical Case Management	$59,422.00	58.21%
Mental Health Services	$6,667.00	6.53%
Outpatient Ambulatory Health Services	$8,888.00	8.71%
SUPPORT SERVICES		
Emergency Financial Assistance (EFA)	$1,111.00	1.09%
Rehabilitation Services	$11,111.00	10.88%
Non-Medical Case Management	$13,777.00	13.50%
TOTAL	$102,087.00	100.00%

PERMIAN BASIN HSDA

RYAN WHITE AND STATE-R ALLOCATIONS 4/1/2020-3/31/2021		
Permian Basin		
CORE SERVICES		
Health Insurance Premium Assistance	$84,593.00	15.46%
Medical Case Management	$136,020.00	24.86%
Oral Health	$48,892.00	8.94%
Outpatient Ambulatory Health Services	$172,665.00	31.56%
SUPPORT SERVICES		
Food Bank/Home Delivered Meals	$482.00	0.09%
Linguistic Services	$3,666.00	0.67%
Medical Transportation Services	$3,555.00	0.65%
Emergency Financial Assistance	$1,112.00	0.20%
Non-Medical Case Management	$48,710.00	8.90%
Referral for Health Care/Support Sv	$47,345.00	8.65%
TOTAL	$547,040.00	100.00%
RYAN WHITE TOTAL	$331,056.00	100.00%
STATE-R TOTAL	$215,984.00	100.00%

STATE SERVICES 9/1/2019-8/31/2020		
PERMIAN BASIN		
CORE SERVICES		
Health Insurance Premiums/Cost Sharing Assistance	$26,905.00	27.78%
Oral Health Care	$13,889.00	14.34%
Outpatient Ambulatory Health Services	$18,333.00	18.93%
SUPPORT SERVICES		
Emergency Financial Assistance (EFA)	$200.00	0.21%
Food Bank/Home Delivered Meals	$356.00	0.37%
Non-Medical Case Management	$37,160.00	38.37%
TOTAL	$96,843.00	100.00%

HOPWA

HOPWA 2019-2020		
AMARILLO		
ACTIVITY	**ALLOCATION**	**HOUSEHOLDS TO BE SERVED**
TBRA	$102,068.00	23
STRMU	$48,437.00	26
PHP	$10,080.00	7
Supportive Services	$37,796.00	56
Project Sponsor Administration	$14,907.00	N/A
Total Contract Amount for Project	**$213,288.00**	

HOPWA 2019-2020		
EL PASO HSDA		
ACTIVITY	**ALLOCATION**	**HOUSEHOLDS TO BE SERVED**
TBRA	$220,582.00	29
PHP	$5,000.00	5
Supportive Services	$126,407.00	35
Project Sponsor Administration	$24,274.00	N/A
Total Contract Amount for Project	**$376,263.00**	

HOPWA 2019-2020		
LUBBOCK		
ACTIVITY	**ALLOCATION**	**HOUSEHOLDS TO BE SERVED**
TBRA	$95,712.00	13
PHP	$2,000.00	2
Supportive Services	$104,609.00	16
Project Sponsor Administration	$14,295.00	N/A
Total Contract Amount for Project	**$216,616.00**	

HOPWA 2019-2020		
Permian Basin		
ACTIVITY	**ALLOCATION**	**HOUSEHOLDS TO BE SERVED**
TBRA	$76,889.00	20
STRMU	$6,942.00	6
PHP	$2,892.00	3
Supportive Services	$25,062.00	18
Project Sponsor Administration	$8,414.00	N/A
Total Contract Amount for Project	**$120,196.00**	

APPENDIX F
NATIONAL HIV/AIDS STRATEGY ADDRESSED BY THE
2017-2021 COMPREHENSIVE HIV HEALTH SERVICES PLAN

NHAS STRATEGIES	PanWest-West Texas
GOAL 1: Reducing New HIV Infections	
• Intensify HYIV prevention efforts in communities where HIV is most heavily concentrated.	ALL
➢ Allocate public funding consistent with the geographic distribution of the epidemic.	N/A
➢ Focus on high-risk populations.	All Goals
➢ Maintain HIV prevention efforts in populations at risk but that have a low national burden of HIV.	Goals 1& 3
• Expand efforts to prevent HIV infection using a combination of effective, evidence-based approaches.	Goal 3
➢ Design and evaluate innovative prevention strategies and combination approaches for preventing HIV infection in high-risk populations and communities and prioritize and promote research to fill gaps in HIV prevention science among the highest risk populations and communities.	Goals 1 & 3
➢ Support and strengthen integrated and patient-centered HIV and related screening (sexually transmitted infections (STI), substance use, mental health, intimate partner violence (IPV), viral hepatitis infections) and linkage to basic services (housing, education, employment).	Goals 1 & 2
➢ Expand access to effective prevention services, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).	Goal 3
➢ Expand prevention with persons living with HIV.	Goals 1 & 3
• Educate all Americans with easily accessible, scientifically accurate information about HIV risks, prevention, and transmission.	All Goals
➢ Provide clear, specific, consistent and scientifically up-to-date messages about HIV risks and prevention strategies.	All Goals
➢ Utilize evidence-based social marketing and education campaigns, and leverage digital tools and new technologies.	All Goals
➢ Promote age-appropriate HIV and STI prevention education for all Americans.	Goal 1
➢ Expand public outreach, education, and prevention efforts on HIV and intersecting issues, such as IPV.	All Goals
➢ Tackle misperceptions, stigma, and discrimination to break down barriers to HIV prevention, testing, and care.	All Goals

NHAS STRATEGIES	PanWest-West Texas
GOALS 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV	
• Establish seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.	Goal 1
➢ Ensure continuity of high-quality comprehensive health care coverage to support access to HIV care.	All Goals
➢ Ensure linkage to HIV medical care and improve retention in care for people living with HIV.	Goals 1 & 2
➢ Support and strengthen capacity to implement innovative and culturally appropriate models to more effectively deliver care along the care continuum.	Goal 1
➢ Prioritize and promote research to fill gaps in knowledge along the care continuum.	Goal 1
➢ Provide information, resources, and technical assistance to strengthen the delivery of services along the care continuum, particularly at the State, Tribal, and local levels.	All Goals
• Take deliberate steps to increase the capacity of systems as well as the number of diversity of available providers of clinical care and related services for people living with HIV.	Goal 2
➢ Increase the number of available providers of HIV care.	Goal 2
➢ Strengthen the current provider workforce to ensure access to and quality of care.	Goals 1 & 2
➢ Support screening for and referral to substance use and mental health services for people living with HIV>	Goal 2
• Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-occurring conditions and challenges in meeting basic needs, such as housing.	All Goals
➢ Address policies to promote access to housing and other basic needs and other supportive services for people living with HIV.	Goal 2
➢ Improve outcomes for women in HIV care by addressing violence and trauma, and factors that increase risk of violence for women and girls living with HIV.	Goal 1

NHAS STRATEGIES	PanWest-West Texas
GOAL 3: Reducing HIV-Related Disparities and Health Inequities	
• Reduce HIV-related disparities to communities at high risk for HIV infection.	Goal 3
➢ Expand services to reduce HIV-related disparities experienced by gay and bisexual men (especially young Black gay and bisexual men), Black women, and persons living in the Southern United States.	Goal 2
➢ Support engagement in care for groups with low levels of viral suppression, including youth and persons who inject drugs.	Goals 2 & 3
• Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.	All Goals
➢ Scale up effective, evidence-based programs that address social determinants of health.	Goals 2 & 3
➢ Support research to better understand the scope of the intersection of HIV and violence against women and girls and develop effective interventions.	Goal 1
• Reduce stigma and eliminate discrimination associated with HIV status.	All Goals
➢ Promote evidence-based public health approaches to HIV prevention and care.	All Goals
➢ Strengthen enforcement of civil rights laws and assist States in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status.	Goal 1
➢ Mobilize communities to reduce HIV-related stigma.	Goal 1
➢ Promote public leadership of people living with HIV.	Goal 1

NHAS STRATEGIES	PanWest-West Texas
GOAL 4: Achieving a More Coordinated National Response to the HIV Epidemic	
• Increase the coordination of HIV programs across the Federal government and between Federal agencies and State, territorial, Tribal, and local governments.	N/A
➢ Streamline reporting requirements for Federal grantees.	N/A
➢ Strengthen coordination across data systems and the use of data to improve health outcomes and monitor use of Federal funds.	Goal 1
➢ Ensure coordinated program planning and administration.	Goal 1
➢ Promote resource allocation that has the greatest impact on achieving the Strategy goals.	N/A
• Develop improved mechanisms to monitor and report on progress toward achieving national goals.	All Goals
➢ Strengthen the timely availability and use of data.	All Goals
➢ Provide regular public reporting on Strategy goals.	All Goals
➢ Enhance program accountability.	All Goals

APPENDIX G
***HEALTHY PEOPLE 2020* OBJECTIVES ADDRESSED BY THE PANWEST-WEST TEXAS 2020-2025 COMPREHENSIVE PLAN**

Number	Objectives	Plan Addressed
HIV-1	Reduce the number of new HIV diagnoses.	Goals 1 & 3
HIV-2	Reduce the number of new HIV infections among adolescents and adults	Goals 1 & 3
HIV-3	Reduce the rate of HIV transmission among adolescents and adults	Goals 1 & 3
HIV-8.1	Reduce newly diagnosed perinatally acquired HIV cases.	All Goals
HIV-9	Reduce the proportion of persons with a diagnosis of Stage 3 HIV (AIDS) within 3 months of diagnosis of HIV infection.	All Goals
HIV-12	Reduce deaths from HIV infection.	All Goals
HIV-13	Increase the proportion of persons living with HIV who know their serostatus LHI.	Goal 2
HIV-14.1	Increase the proportion of adolescents and adults who have ever been tested for HIV.	Goals 1 & 3
HIV-14.2	Increase the proportion of men who have sex with men (MSM) who report having been tested for HIV in the past 12 months.	Goal 3
HIV-14.3	Increase the proportion of pregnant women who have been tested for HIV in the past 12 months.	Goal 3
HIV-16	Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling and support.	N/A
HIV-18	Reduce the proportion of men who have sex with men (MSM) who reported unprotected anal intercourse with a partner of discordant or unknown status during their last sexual encounter.	Goal 1 & 3
HIV-19	(Measurable) Increase the proportion of persons who are linked to HIV medical care (had a routine HIV medical visit) within 3 months of HIV diagnosis. Revised 2017.	Goal 1
HIV-20	(Measurable) Increase the proportion of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6-month period of the 24-month measurement period, with a minimum of 90 days between medical visits. Revised 2017.	Goal 1 & 2
HIV-22	Increase the proportion of person with an HIV diagnosis in medical care with a viral load <200 copies/ml. at the last test during the 12-month measurement period.	Goal 2 & 3
HIV-23	(Developmental) Reduce the proportion of persons with an HIV diagnosis receiving HIV services who were homeless or unstably housed in the 12-month measurement period.	Goal 2
HIV-24	Reduce the percentage of young gay and bisexual males in grades 9 through 12 who engage in HIV-risk behaviors.	Goal 1 & 3