

Application for Federal Assistance SF-424

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|---|---|--|
| * 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application | * 2. Type of Application: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision | * If Revision, select appropriate letter(s): <input type="text"/> * Other (Specify): <input type="text"/> |
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| * 3. Date Received: 10/09/2013 | 4. Applicant Identifier: <input type="text"/> |
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|---|--|
| 5a. Federal Entity Identifier: <input type="text"/> | 5b. Federal Award Identifier: H89HA00036 |
|---|--|

State Use Only:

| | |
|--|--|
| 6. Date Received by State: <input type="text"/> | 7. State Application Identifier: <input type="text"/> |
|--|--|

8. APPLICANT INFORMATION:

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| * a. Legal Name: City of Austin Health and Human Services Department (HHSD) |
|--|

| | |
|--|---|
| * b. Employer/Taxpayer Identification Number (EIN/TIN): 74-6000085 | * c. Organizational DUNS: 9456072650000 |
|--|---|

d. Address:

| |
|--|
| * Street1: 7201 Levander Loop, Building H |
| Street2: <input type="text"/> |
| * City: Austin |
| County/Parish: <input type="text"/> |
| * State: TX: Texas |
| Province: <input type="text"/> |
| * Country: USA: UNITED STATES |
| * Zip / Postal Code: 78702-5168 |

e. Organizational Unit:

| | |
|--|--|
| Department Name: Austin/Travis County HHSD | Division Name: Community Services Division |
|--|--|

f. Name and contact information of person to be contacted on matters involving this application:

| | |
|-------------------------------------|------------------------------|
| Prefix: Mr. | * First Name: Gregory |
| Middle Name: L. | |
| * Last Name: Bolds | |
| Suffix: <input type="text"/> | |

| |
|--|
| Title: Manager, HIV Resources Administration Unit |
|--|

| |
|---|
| Organizational Affiliation: Austin/Travis County HHSD |
|---|

| | |
|---|---------------------------------|
| * Telephone Number: 512-972-5081 | Fax Number: 512-972-5082 |
|---|---------------------------------|

| |
|---|
| * Email: gregory.bolds@austintexas.gov |
|---|

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

C: City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-14-034

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

5840

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

AreasAffectedbyProject.doc

Add Attachment

Delete Attachment

View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI, HIV Emergency Relief Grant Program for the Austin Transitional Grant Area. Project Abstract is attached.

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Areas Affected by Project

City of Austin, Counties of Bastrop, Caldwell, Hays, Travis, and Williamson, located in the State of Texas

Project Abstract

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI HIV Emergency Relief Grant Program; HRSA Grant Number H89HA00036
City of Austin, Austin/Travis County Health and Human Services Department
7201 Levander Loop, Bldg. H, Austin, Texas 78702-5168
(512) 972-5081 Voice; (512) 972-5082 Fax
gregory.bolds@austintexas.gov

Located in central Texas, the Austin Transitional Grant Area (TGA) covers 4,281 square miles and encompasses the five counties of Bastrop, Caldwell, Hays, Travis, and Williamson. The Austin TGA, which is about 40 percent larger than Rhode Island and Delaware combined, has a population of over 1.8 million in 2013. As one of the fastest growing areas in the United States, it has a third more residents than 10 years ago and double the population of 20 years ago. The racial/ethnic distribution is as follows: 53.6% White; 32.4% Hispanic; 6.9% African American; and 7.1% reported as Other.

The number of persons living with HIV in the Austin TGA continues to increase every year. As of December 31, 2012, there were 2,131 persons living with HIV (not AIDS) and 2,953 persons living with AIDS in the TGA. The demographic characteristics of persons with HIV/AIDS in the TGA continue to change, indicating a shift in the populations most affected by HIV/AIDS. Although comprising only 6.9% of overall population, African Americans accounted for 19% of new HIV cases and 24% of new AIDS cases for the period 2010-2012. HIV services providers, primarily located along the Interstate Highway 35 corridor in the TGA, offer service facilities that are accessible to the TGA's underserved populations. African American and Hispanic are the two populations served with Minority AIDS Initiative (MAI) funds.

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A HIV Emergency Relief Grant Program, the Austin TGA has developed a coordinated service delivery system with a comprehensive range of services for persons living with HIV infection, in order to meet their primary medical care and related needs throughout all stages of disease. Although this continuum of care is largely supported with Ryan White Program funds, it also relies on additional support from multiple funding sources including local city and county funding.

The Austin Area Comprehensive HIV Planning Council has set priorities and allocated funds for FY 2014 to HIV service categories that address the growing number of clients with more complex disease, inadequate knowledge of HIV, and multiple socio-economic problems. The priority core medical services for FY 2014 include medical case management, outpatient/ambulatory medical care, health insurance premium and cost sharing assistance, outpatient substance abuse services, mental health services, oral health care, local pharmaceutical assistance, hospice services and medical nutrition therapy, as well as non-medical case management, medical transportation services, and other health-related support services designed to facilitate access to and retention in care. As of FY 2013, the Austin TGA has received Ryan White Program Title I/Part A funding for nineteen (19) years and MAI funding for fifteen (15) years.

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

* b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

| | |
|---------------------|---|
| * a. Federal | <input type="text" value="4,024,795.00"/> |
| * b. Applicant | <input type="text" value="0.00"/> |
| * c. State | <input type="text" value="0.00"/> |
| * d. Local | <input type="text" value="0.00"/> |
| * e. Other | <input type="text" value="0.00"/> |
| * f. Program Income | <input type="text" value="0.00"/> |
| * g. TOTAL | <input type="text" value="4,024,795.00"/> |

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

a. This application was made available to the State under the Executive Order 12372 Process for review on

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

Yes No

If "Yes", provide explanation and attach

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number:

Fax Number:

* Email:

* Signature of Authorized Representative:

* Date Signed:

Additional List of Program/Project Congressional Districts

Additional Congressional Districts of Applicant

21st
25th

Additional Congressional Districts of Program/Project

15th
21st
25th
28th
31st

Project/Performance Site Location(s)

Project/Performance Site Primary Location I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Project/Performance Site Location 1 I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country:

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s)

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

| | |
|--|--|
| * APPLICANT'S ORGANIZATION | |
| <input style="width: 100%;" type="text" value="City of Austin Health and Human Services Department (HHSD)"/> | |
| * PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE | |
| Prefix: <input style="width: 100px;" type="text" value="Honorable"/> | * First Name: <input style="width: 200px;" type="text" value="Lee"/> Middle Name: <input style="width: 100px;" type="text"/> |
| * Last Name: <input style="width: 300px;" type="text" value="Leffingwell"/> | Suffix: <input style="width: 100px;" type="text"/> |
| * Title: <input style="width: 200px;" type="text" value="Mayor"/> | |
| * SIGNATURE: <input style="width: 300px;" type="text" value="Gregory Boldt"/> | * DATE: <input style="width: 150px;" type="text" value="10/09/2013"/> |

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

| | |
|---|---|
| <p>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p> <p>Gregory Bolts</p> | <p>TITLE</p> <p>Mayor</p> |
| <p>APPLICANT ORGANIZATION</p> <p>City of Austin Health and Human Services Department (HHSD)</p> | <p>DATE SUBMITTED</p> <p>10/09/2013</p> |

Project Narrative File(s)

* Mandatory Project Narrative File Filename:

To add more Project Narrative File attachments, please use the attachment buttons below.

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INTRODUCTION

The Ryan White Part A HIV/AIDS Program is authorized by Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009. Part A funds provide direct financial assistance to metropolitan areas that have been severely affected by the HIV epidemic. These critical funds allow eligible program areas to develop and enhance access to a comprehensive continuum of high quality, community-based care for low-income persons living with HIV/AIDS (PLWH). The Austin Transitional Grant Area (TGA) strives to maintain a comprehensive continuum of care with prioritized core medical services and health-related support services that allow PLWH to obtain optimal medical treatment for HIV infection.

Since 1999, the U.S. Congress has earmarked funds appropriated under Title I/Part A of the Ryan White HIV/AIDS Program to support efforts to improve quality of care and health outcomes in minority communities disproportionately affected by HIV disease. The goals of the Austin TGA's Minority AIDS Initiative (MAI) program are to improve client-level health outcomes, increase life expectancy, and decrease transmission of HIV infection in minority populations. The Austin Area Comprehensive HIV Planning Council evaluates data and determines the MAI populations to be served with set-aside MAI funds. Again for FY 2014, African American and Hispanic PLWH comprise the two Austin TGA MAI populations.

Located in central Texas, the Austin TGA encompasses the five counties of Bastrop, Caldwell, Hays, Travis, and Williamson. Approximately 85% of all HIV/AIDS cases diagnosed in the TGA are reported within Travis County. As described in the Project Narrative below, the Austin Area Comprehensive HIV Planning Council has set priorities and allocated funds for FY 2014 to HIV service categories that provide a continuum of core medical and support services designed to facilitate access to and retention in HIV primary medical care. The overarching purpose of the Austin TGA's Ryan White HIV/AIDS Program Part A is to be responsive to current epidemiological trends and factors in the external environment, in order to optimize health outcomes for PLWH.

NEEDS ASSESSMENT

1. Demonstrated Need

Demographic Characteristics of Austin Transitional Grant Area Population

Approximately 1.8 million people reside in the Austin Transitional Grant Area (TGA). Table A shows the TGA population by race/ethnicity and county. A majority of the population (59%) resides in Travis County followed by Williamson County (25%). Most of the TGA population is White (53.6%) followed by Hispanic (32.4%). Over two-thirds (67.5%) of all African Americans in the Austin TGA reside in Travis County. Similarly, 67.6% of persons of other races and ethnicities reside in Travis County.

Table A. Distribution of Austin TGA population by race/ethnicity and county, 2013

| Race/Ethnicity | County | | | | | Total |
|------------------|---------|----------|---------|-----------|------------|-----------|
| | Bastrop | Caldwell | Hays | Travis | Williamson | |
| White | 43,357 | 17,183 | 100,343 | 533,056 | 284,219 | 978,158 |
| African American | 5,810 | 2,535 | 5,429 | 85,206 | 27,154 | 126,134 |
| Hispanic | 26,961 | 19,316 | 62,639 | 371,188 | 110,791 | 590,895 |
| Other | 2,133 | 868 | 5,267 | 88,442 | 34,047 | 130,757 |
| Total | 78,261 | 39,902 | 173,678 | 1,077,892 | 456,211 | 1,825,944 |

Source: *Texas State Data Center, The University of Texas at San Antonio*

1) A. HIV/AIDS Epidemiology

(1) Attachment 3

The Austin TGA's HIV and AIDS prevalence and incidence data through December 31, 2012 is show in Attachment 3. During 2010-2012, 815 new HIV cases were reported in the Austin TGA. Most (88%) of the new HIV cases were males and most (75%) of these new cases reported an exposure category of men who have sex with men (MSM). During 2010-2012, 457 new AIDS cases were reported in the Austin TGA. As of December 31, 2012, the number of persons living with HIV in the Austin TGA was 2,131. The number of persons living with AIDS was 2,953.

(2) (a) Demographic characteristics and exposure categories

Table B shows the number of persons living with HIV by race/ethnicity for the years 2006 through 2012. In 2006, Whites comprised 50% of the persons living with HIV. Hispanics comprised 24.9% of the persons living with HIV in 2006. In 2012, the percent of persons living with HIV who were White decreased to 46.3% while the percent who were Hispanic increased to

30.2%. The percentage of PLWH who were African American decreased slightly from 24.2% in 2006 to 22.1% in 2012.

Table B. Number of persons living with HIV by race/ethnicity, Austin TGA, 2006-2012

| Race/Ethnicity | Year | | | | | | |
|------------------|-------|-------|-------|-------|-------|-------|-------|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| White | 1,799 | 1,879 | 1,965 | 2,036 | 2,121 | 2,245 | 2,302 |
| African American | 875 | 910 | 943 | 980 | 1,010 | 1,082 | 1,117 |
| Hispanic | 894 | 980 | 1,049 | 1,104 | 1,161 | 1,256 | 1,502 |
| Other | 29 | 31 | 34 | 37 | 40 | 50 | 47 |
| Unknown | 20 | 21 | 23 | 2 | 2 | 43 | 116 |
| Total | 3,617 | 3,821 | 4,014 | 4,177 | 4,352 | 4,676 | 5,084 |

Source: *Texas Department of State Health Services, eHARS*

Table C shows the number of PLWH in the Austin TGA in 2012 by gender and age group. A majority (85.3%) of PLWH are males. Twelve persons are 12 years of age or younger. Overall, a majority (60.7%) are between the ages of 35 to 54 years. Similarly, a majority of males (60.4%) and females (62.3%) are between the ages of 35 to 54 years.

Table C. Number of persons living with HIV by age groups and gender, Austin TGA, 2012

| Age Group (Years) | Gender | | Total |
|-------------------|--------|-------|-------|
| | Female | Male | |
| < 2 | 0 | 1 | 1 |
| 2 – 12 | 6 | 5 | 11 |
| 13 – 24 | 35 | 172 | 207 |
| 25 – 34 | 110 | 744 | 854 |
| 35 – 44 | 213 | 1,134 | 1,347 |
| 45 – 54 | 254 | 1,484 | 1,738 |
| ≥ 55 | 131 | 795 | 926 |
| Total | 749 | 4,335 | 5,084 |

Source: *Texas Department of State Health Services, eHARS*

Table D shows the number of persons living with HIV in the Austin TGA by gender and race/ethnicity. A majority (85.3%) of PLWH are males and a minority race/ethnicity (54.7%). African American females comprise 46.1% of all females while African American males comprise only 17.7% of all males.

Table D. Number of persons living with HIV by race/ethnicity and gender, Austin TGA, 2012

| Race/Ethnicity | Gender | | Total |
|------------------|--------|-------|-------|
| | Female | Male | |
| White | 180 | 2,122 | 2,302 |
| African American | 345 | 772 | 1,117 |
| Hispanic | 190 | 1,312 | 1,502 |
| Other | 9 | 38 | 47 |

| | | | |
|---------|-----|-------|-------|
| Unknown | 25 | 91 | 116 |
| Total | 749 | 4,335 | 5,084 |

Source: *Texas Department of State Health Services, eHARS*

Table E shows the number of persons living with HIV in the Austin TGA by gender and race/ethnicity for six exposure categories. Overall, the exposure category for 40 persons was pediatric. For males, the exposure category of male-to-male sex accounted for the largest proportion of male PLWH at 78.2%. For African American males, this exposure category accounted for only 54.8% compared with 85.4% for White males. Intravenous drug use only accounted for 27.4% of females living with HIV compared with 6.6% for males living with HIV.

Overall, heterosexual sex accounted for 15.5% of the PLWH ranging from 70.3% for females to 6.0% for males. Only 2.1% of White males reported heterosexual sex as an exposure category compared with 15.5% of African American males. Heterosexual sex was the reported exposure category for 79.9% of Hispanic females compared with 6.8% for Hispanic males.

Table E. Number of persons living with HIV by gender, race/ethnicity and exposure category, Austin TGA, 2012

| Gender | Race/Ethnicity | Exposure Category | | | | | | Total |
|--------|---------------------|-------------------|-------|---------|--------------|-----------|-------------|-------|
| | | MSM | IDU | MSM/IDU | Heterosexual | Pediatric | Adult Other | |
| Male | White, not Hispanic | 1,812.2 | 67 | 189.2 | 43.6 | 8 | 2 | 2,122 |
| | African American | 423.1 | 133.4 | 89.8 | 119.7 | 5 | 1 | 772 |
| | Hispanic | 1,051.1 | 78.8 | 84.5 | 88.6 | 8 | 1 | 1,312 |
| | Other | 28.5 | 2.4 | 2.5 | 3.6 | 1 | 0 | 38 |
| | Unknown | 74.1 | 2.7 | 8.9 | 3.3 | 2 | 0 | 91 |
| | Subtotal | 3,389 | 284.3 | 374.9 | 258.8 | 24 | 4 | 4,335 |
| Female | White, not Hispanic | 0 | 66 | 0 | 113 | 1 | 0 | 180 |
| | African American | 0 | 95.3 | 0 | 238.7 | 11 | 0 | 345 |
| | Hispanic | 0 | 34.2 | 0 | 151.8 | 3 | 1 | 190 |
| | Other | 0 | 2.4 | 0 | 5.6 | 1 | 0 | 9 |
| | Unknown | 0 | 7.3 | 0 | 17.7 | 0 | 0 | 25 |
| | Subtotal | 0 | 205.2 | 0 | 526.8 | 16 | 1 | 749 |
| | Total | 3,389 | 489.5 | 374.9 | 785.6 | 40 | 5 | 5,084 |

Source: *Texas Department of State Health Services, eHARS*

Number of people living with HIV

As of December 31, 2012, the total number of people living with HIV (not AIDS) in the Austin TGA was 2,131. Most (86%) of these persons were males and almost half (48%) were Whites. The predominate risk category for persons living with HIV (not AIDS) is MSM, as MSM alone

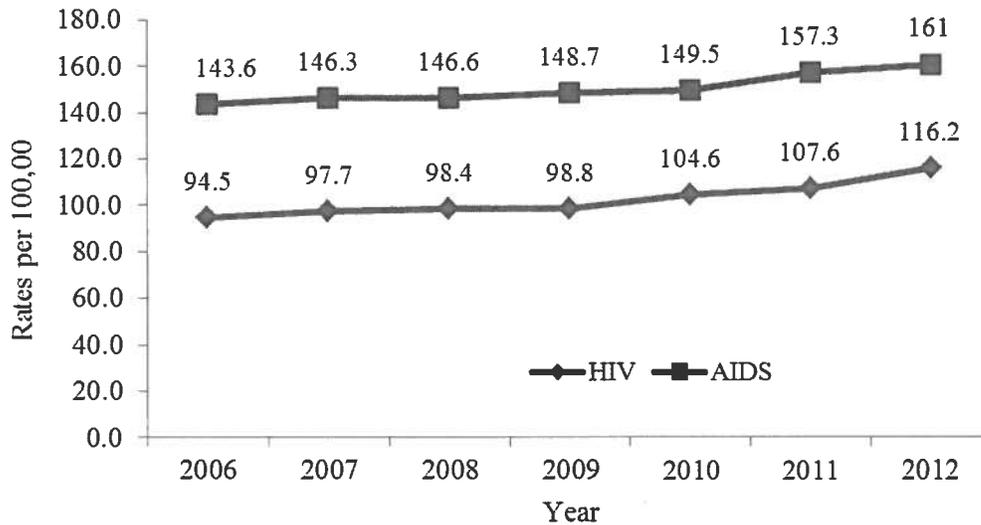
(72%) or MSM/IDU (6%). Approximately a quarter (23%) of people living with HIV were 24 years of age or younger.

Number of people living with AIDS

As of December 31, 2012, the total number of people living with AIDS in the Austin TGA was 2,953. Most (85%) of these persons were males. Whites comprised 43% of the persons living with AIDS cases followed by Hispanics (30%). Three-fourths (75%) of these persons were 25 to 44 years of age.

Figure 1 shows the prevalence rates per 100,000 population for HIV (not AIDS) and AIDS. From 2006 to 2012, the HIV (not AIDS) prevalence rate increased 12%. During the same time period, the AIDS prevalence rate increased 23%.

Figure 1. HIV and AIDS prevalence rates, Austin TGA, 2006 – 2012



Source: *Texas Department of State Health Services, eHARS*

Number of new AIDS cases reported during 2010-2012

The total number of new AIDS cases reported during 2010-2012 was 457. A majority of the new AIDS cases were males. Whites comprised 38% of the new AIDS cases followed by Hispanics (35%). Most (93%) of these new cases were 25 years of age or older. Men who have sex with men was the primary risk category for 66% of the new AIDS cases.

(2) (b) Disproportionate impact of HIV/AIDS

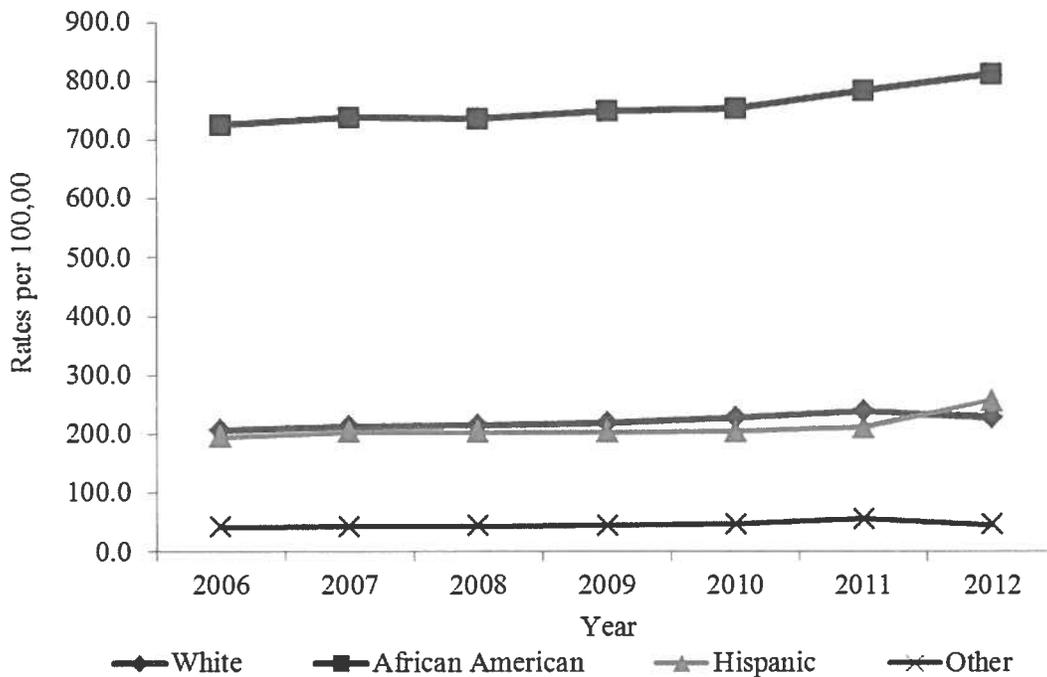
The disproportionate impact of HIV /AIDS on certain populations is discussed below. Within the Austin TGA, HIV/AIDS disproportionately impacts several populations including African Americans, Hispanic males and those 35-54 years of age.

Impacted minority communities

Most of the Austin TGA population is White (53.6%) followed by Hispanic (32.4%). Only 6.9% of the population is African American. Half (50.1%) of the population is male. The highest risk of HIV infection is among African Americans. Overall, 6.9% of the Austin TGA is African American however 19% of the new HIV cases reported during 2010-2012 were African American. While 3.4% of the Austin TGA population is African American males, 15.3% of the persons living with HIV are African American males. A similar percentage (3.5%) of the Austin TGA population is African American females while 6.8% of the persons living with HIV are African American females. The percentages of Hispanic males and females in the Austin TGA population are 16.5% and 15.8%, respectively. However, the percentages of persons living with HIV in the TGA who are Hispanic males and females are 26% and 3.8%, respectively. In the Austin TGA, 38.4% of the population is 35-54 years of age. Over 60% (60.7%) of the PLWH are in this age group.

Figure 2 shows the HIV prevalence rates by race/ethnicity for the Austin TGA. Rates for African Americans were consistently higher for each year compared with Whites, Hispanics, and Other. Rates for African Americans were over three (3) times higher for each year compared with the rates for Whites. Rates for each year for Whites and Hispanics were similar.

Figure 2. HIV prevalence rates by race/ethnicity, Austin TGA, 2006 - 2012



Source: Texas Department of State Health Services, eHARS

Prevalence of homelessness

For discussion of prevalence of homelessness, please refer to description of Attachment 4 information on page 10.

HIV/AIDS Individuals Released from the Texas Department of Criminal Justice

Table F shows the total number of inmates with HIV released by the Texas Department of Criminal Justice (TDCJ) for 2008 through 2012. The county of residence for the newly released inmates is not provided by TDCJ. To estimate the number of inmates with HIV infection released to Travis County, the current prevalence of incarcerated inmates from Travis County (ranges from 3%-4%) is applied to the total number of inmates released with HIV. For the period 2008 through 2012, the estimated average annual number of TDCJ inmates with HIV released to Travis County is 50.

Table F. Number of Texas Department of Criminal Justice Inmates with HIV infection released and estimated number released to Travis County, Texas, 2008-2012

| | Year | | | | | Average |
|---|-------|-------|-------|-------|-------|---------|
| | 2008 | 2009 | 2010 | 2011 | 2012 | |
| Number of inmates with HIV released – Texas | 1,382 | 1,376 | 1,339 | 1,228 | 1,388 | 1,343 |
| Number of inmates with HIV released – Travis County residents | 61 | 52 | 40 | 43 | 55 | 50 |

Source: *Texas Department of State Health Services, eHARS*

(2) (c) Populations of PLWH in the TGA that are underrepresented

A comparison of persons living with HIV in the Austin TGA to the patients seen by Ryan White-funded medical care providers is shown in Table G. Generally patients receiving care from Ryan White-funded medical providers are representative by gender, race/ethnicity, and risk category. Slight differences exist for female gender and heterosexual risk category. The proportions of females and those with heterosexual sex as a risk category are higher in the Ryan White System compared with the Austin TGA.

Table G. Characteristics of persons living with HIV in the Austin TGA and Ryan White Program medical care patients

| Demographic Group | TGA % | Ryan White % |
|-----------------------|-------|--------------|
| Gender | | |
| Male | 85.3 | 80.0 |
| Female | 14.7 | 19.0 |
| Transgender | - | 1.0 |
| Race/Ethnicity | | |
| White | 45.3 | 41.0 |
| African American | 22.0 | 27.0 |

| | | |
|----------------------|------|------|
| Hispanic | 29.5 | 30.0 |
| Other | 0.9 | 2.0 |
| Unknown | 2.3 | 0.0 |
| Risk Category | | |
| MSM | 66.7 | 58.5 |
| IDU | 9.6 | 8.4 |
| MSM/IDU | 7.4 | 6.1 |
| Heterosexual | 15.5 | 23.5 |
| Pediatric | 0.8 | 0.5 |

Source: *Texas Department of State Health Services, eHARS and AIDS Regional Information and Evaluation System (ARIES), 2012*

(2) (d) Estimated level of service gaps among PLWH

For a discussion of service gaps, refer to Assessment of Emerging Populations with Special Needs on pages 14-18.

1) B. Impact of Co-morbidities on the Cost and Complexity of Providing Care

(1) Attachment 4

Incidence rates for selected infectious diseases and socioeconomic and health status characteristics of the Austin TGA population and the persons living with HIV in the Austin TGA are shown in Attachment 4.

(2) Explanation of information in Attachment 4

Sexually Transmitted Infections Rates

In 2012, a total of 9,450 persons with *Chlamydia* infections were reported in the Austin TGA. The number of persons with gonorrhea and early syphilis total 2,152 and 321, respectively. The syphilis rate in 2012 for the Austin TGA (17.5 cases per 100,000 population) is the second highest among Texas EMAs/TGAs in 2012 (*Source: Texas DSHS, 2012*). The *Chlamydia* infection rate in 2012 for the Austin TGA (515.2 cases per 100,000 population) was also the second highest among Texas EMAs/TGAs in 2012 (*Source: Texas DSHS, 2012*).

Table H shows the annual incidence rates of *Chlamydia* infections, gonorrhea and early syphilis by race/ethnicity for the Austin TGA. For each year, for each infection, African Americans have the highest rates compared with Whites, Hispanics, and Other. In 2012, the incidence rate for gonorrhea for African Americans is over eight times higher compared with Whites. The incidence rate for early syphilis for African Americans is over twice as high compared with Whites.

Table H. Selected sexually transmitted infections incidence rates¹, Austin TGA, 2009-2012

| Race/ Ethnicity | Chlamydia | | | | Gonorrhea | | | | Early Syphilis ² | | | |
|--------------------|-----------|---------|---------|---------|-----------|-------|-------|-------|-----------------------------|------|------|------|
| | 2009 | 2010 | 2011 | 2012 | 2009 | 2010 | 2011 | 2012 | 2009 | 2010 | 2011 | 2012 |
| White | 190.0 | 203.3 | 224.5 | 208.1 | 42.2 | 50.2 | 43.0 | 52.9 | 9.8 | 10.6 | 10.8 | 13.2 |
| African American | 1,287.0 | 1,144.7 | 1,181.6 | 1,072.5 | 553.7 | 411.9 | 447.6 | 445.4 | 42.8 | 51.5 | 38.4 | 33.4 |
| Hispanic | 580.5 | 571.9 | 547.3 | 451.0 | 102.5 | 109.9 | 103.8 | 86.3 | 14.0 | 12.2 | 15.3 | 22.9 |
| Other ³ | 288.7 | 157.2 | 226.6 | 229.7 | 33.8 | 26.8 | 35.5 | 9.7 | 7.2 | 5.8 | 4.4 | 2.9 |

¹Rates per 100,000 population

²Includes Primary, Secondary, and Early Latent Syphilis

³Rate is combined for Asian/Pacific Islander, Native American, Multi-Racial and Other cases.

Source: *Texas Department of State Health Services, STD*MIS*

Diagnoses of syphilis and gonorrhea contribute to higher costs for providing medical care to PLWH. The average cost to deliver care to PLWH who also have syphilis is 6.8% higher compared to a PLWH without syphilis. Similarly, the average cost to deliver care to PLWH who also have gonorrhea is 15.7% higher compared to a PLWH without gonorrhea (Source: *Austin ARIES, 2012*).

Acute Hepatitis B and Hepatitis C Infections

During 2008-2012, eight (8) persons with acute hepatitis C virus infections were reported from the five (5) counties comprising the Austin TGA. Three (3) of these infections were reported in 2012. The incidence rate for acute hepatitis C virus is 0.16 cases per 100,000 population. During the same time period, a total of 123 persons with acute hepatitis B virus infections were reported from the Austin TGA. In 2008 and 2009, 32 and 39 infections respectively were reported. In 2012, only 15 infections were reported. The incidence rate for acute hepatitis B virus is 0.8 cases per 100,000 population.

For the Austin TGA, 12% of PLWH have evidence of hepatitis C virus (HCV) infection. The average cost to deliver medical care to those PLWH with evidence of HCV (\$3,595) is 30% higher compared to the average cost to deliver care to those PLWH without evidence of HCV (\$2,764) (Source: *Austin ARIES, 2012*).

Tuberculosis

During 2009-2011, the annual number of reported tuberculosis cases in the Austin TGA ranged from 70 to 83 cases. The annual incidence rate ranged from 4.0 to 4.8 cases per 100,000 population. During this period, incidence rates for African Americans in the Austin TGA were five (5) to nine (9) times higher compared with Whites. During 2012, a total of 58 tuberculosis cases were reported in residents of the Austin TGA. The incidence rate in 2012 was 3.1 cases per 100,000 population. The annual incidence rate per 100,000 was 1.1 for Whites and 15.4 for Others. Rates per 100,000 population for African Americans and Hispanics were similar, 4.4 and 4.3 respectively. Rates for African Americans (4.4) and Hispanics (4.3) were four times higher compared with Whites.

Prevalence of homelessness

The United States Department of Housing and Urban Development (HUD) defines homelessness as an individual who lives in an emergency shelter, transitional housing program, safe have, or a place not meant for human habitation. Each January, point-in-time counts in various communities of families and individuals experiencing homelessness, are conducted by Continuums of Care (CoCs). Continuums of Care are local or regional entities that coordinate providing services for homeless populations. The most recent point-in-time count was conducted in January 2012 (*The State of Homelessness in American 2013, National Alliance to End Homelessness, Washington, DC*). A total of 34,052 persons were identified as homeless in Texas. The estimated prevalence of homelessness in Texas is 13.3 persons per 10,000 populations or 0.133% of the population. Based on this prevalence, an estimated 2,429 persons are homeless in the Austin TGA. The estimated number of homeless persons in the Austin TGA is approximately 0.13% of the population. For PLWH in the Austin TGA, approximately 3% are considered homeless; a rate 23 times higher compared to the general Austin TGA population (Source: *Austin ARIES, 2012*). The average cost to provide medical care to homeless persons living with HIV in the Austin TGA is 42% higher compared to persons living with HIV who are not homeless (Source: *Austin ARIES, 2012*).

Number and Percent of Persons Without Insurance Coverage

In the Austin TGA, an estimated 342,084 persons or 21.4% of the population lack health insurance (*US Census Bureau, Small Area Health Insurance Estimates, 2011*). Over half (59%) of the TGA population resides in Travis County. For African Americans aged 25-34 years in Travis County, 24.7% lack health insurance. For Hispanics aged 25-34 years in Travis County, 48.9% lack health insurance (*US Census Bureau, American Community Survey, 2012*). The lack of health insurance increases the costs of providing medical care to PLWH in the Austin TGA. Without health insurance, the average cost of providing care is 28% higher compared to PLWH with health insurance (Source: *Austin ARIES, 2012*).

Number and Percent of Persons Living at or Below 300 Percent of the 2013 Federal Poverty Level

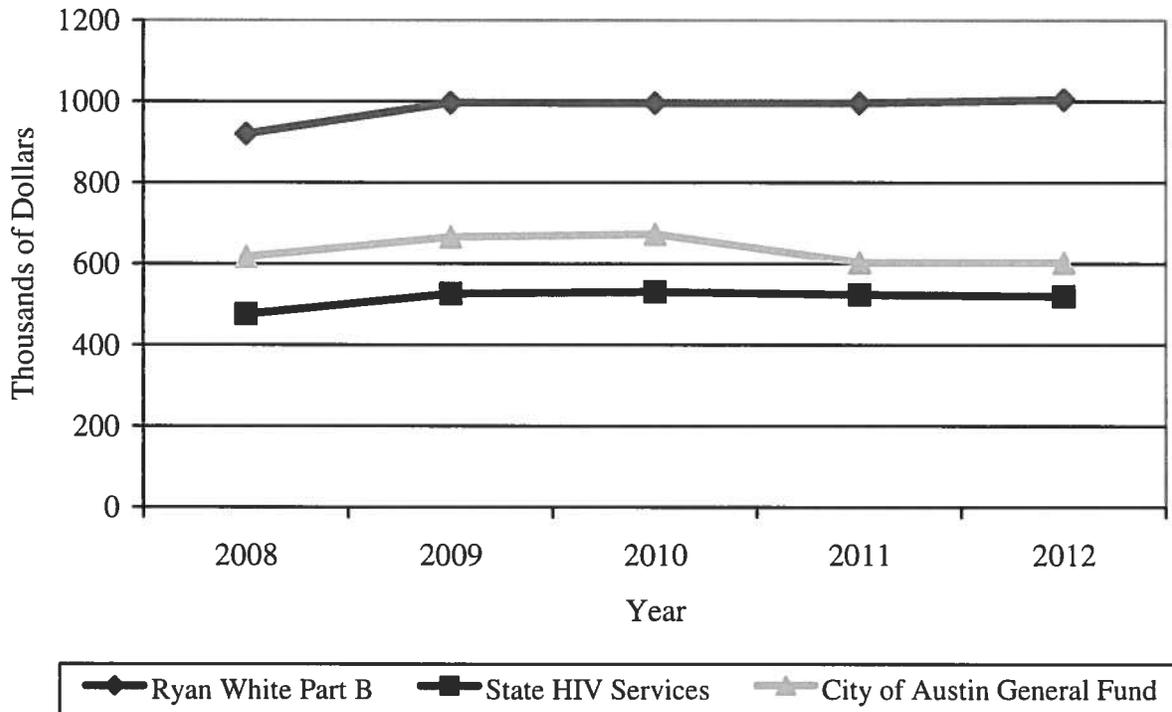
In the Austin TGA, over half (56.4%) of the population lives at or below 300% of the 2013 Federal Poverty Level (FPL). A larger proportion of African Americans (65.2%) and Hispanics (75.4%) live at below 300 FPL compared with Whites (39.5%). Almost all (94%) of the clients seen by Ryan White-funded medical care providers were at or below 300% FPL; 61% were at or below 100% FPL. The average cost for medical care for clients at or below 100% FPL is over 2.5 times higher compared with clients over 300% FPL (Source: *Austin ARIES, 2012*).

Identify needs in services and fiscal resources as a result of municipal and state budget cuts in HIV related services

Municipal and state funding for HIV services has relatively level in recent years; however, these budgeted amounts do not meet the need for services due to continuing increase in HIV case

counts in the Austin TGA population. Trends in fiscal resources through Ryan White Part B, Texas Department of State Health Services HIV/STD Prevention and Care Branch, and the City of Austin are presented in Figure 3. From 2008 through 2012, the number of PLWH in the Austin TGA has increased 26.7%. During this same time period, overall funding increased \$113,822 or 5.7%. In 2008, the funds available for clinical and non-clinical services for each PLWH were \$501.88 per person. In 2012, the funds available was \$418.64 per person; a 16.6% decrease from 2008.

Figure 3. Trends in Federal, State and Local Fiscal Resources, Austin TGA, 2008-2012



(3) Impact on service delivery of individuals released from custody during the preceding three years

As of December 31, 2011, 2,320 persons living with HIV were incarcerated in a Texas Department of Criminal Justice (TDCJ) facility. Most (90%) inmates living with HIV were males and most (62%) were African American. The average offender population is just over 150,000. The estimated prevalence of HIV infection in the Texas Department of Criminal Justice incarcerated population is 2.6% (Source: *Texas Department of Criminal Justice*).

A large proportion of HIV-infected inmates released from TDCJ fail to establish outpatient care. Only 28% of inmates released between January 2004 and December 2007 enrolled in an HIV clinic within 90 days of release (Source: *Public Health Reports, volume 125, pp 64-71*). Eighteen percent of HIV-infected Texas prison inmates have a psychiatric disorder such as depression and schizophrenia.

During 2010-2012, the estimated number of inmates released from the Texas Department of Criminal Justice with HIV infection that resided in Travis County totaled 138. For those former inmates incarcerated during the past three (3) years and receiving care by Ryan White-funded medical care providers in 2012, most (80%) were males, 47% had a history of hepatitis C virus infections, and 86% lived below 100% FPL.

1) C. Impact of Part A Funding: Funding Mechanisms

(1) Report on Availability of Other Public Funding

Attachment 5 shows the amounts and percentages of total available public funding for HIV-related services in the specified eight categories for FY 2013, and anticipated public funding in the FY 2014 budget period.

(2) Coordination of Services and Funding Streams

Coordination with other Ryan White Programs

Ryan White programs in the Austin TGA are mainly coordinated through the Austin/Travis County Health and Human Services Department (A/TCHHSD) which serves as the Administrative Agency for Ryan White Part A, including the Minority AIDS Initiative (MAI) Program, and Part C. There is no Ryan White Part D or Part F funding in the Austin TGA. Although the A/TCHHSD does not serve as Administrative Agency for Ryan White Part B, a Part B representative fills a designated slot on the Part A HIV Planning Council to assure optimal coordination with Part B and Texas HIV State Services funding. Moreover, Part A Administrative Agency staff meet quarterly with Part B Administrative Agency staff to coordinate efforts such as policy development and monitoring. Planning Council members also have participated in the development of the Texas Statewide Coordinated Statement of Need (SCSN).

Centralized coordination enables the HIV Planning Council to ensure that services provided by Part A, including MAI, do not duplicate those provided by other Ryan White funded grant programs. The Administrative Agency provided detailed information on funding from other Ryan White programs for consideration during the FY 2014 Part A and MAI priority setting and allocation processes. Prior to setting service priorities and allocating Part A funds, the Planning Council was able to identify gaps in services and allocate dollars strategically by examining all sources of funding for all eligible services.

Coordination with Other State and Federal Resources

In addition to serving as Administrative Agency for Ryan White Program funds, the A/TCHHSD receives Housing Opportunities for Persons with AIDS (HOPWA) and City of Austin funding for HIV services. To maximize coordination, the Austin HIV Planning Council provides input into development of the City of Austin Consolidated Plan for Housing Services, which includes funding for the HOPWA Program. The A/TCHHSD has oversight of major CDC Prevention Programs in the TGA, thereby facilitating close coordination of both HIV prevention and HIV care activities. Moreover, Part A grant subrecipients receive funding under a Centers for Disease

Control (CDC) Initiative to provide counseling, testing and referral, prevention case management, and evidence-based interventions with high-risk and HIV positive persons. The HIV Planning Council carefully considered services duplication during its planning process.

The David Powell Community Health Center (DPCHC) for HIV primary medical care is an active Medicaid provider that has signed contracts with multiple Medicaid managed care companies. Texas Medicaid covers all clinical visits and provides some coverage for laboratory testing and prescription drugs for eligible clients. At this time, Texas will not be expanding Medicaid coverage under the Affordable Care Act. Since DPCHC does not allow patients to forgo needed drugs or procedures because of inability to pay, Ryan White Part B and Part C funds, as well as Part A funds, will be combined for the purchase of pharmaceuticals as indicated. DPCHC bills for all covered services and receives an enhanced reimbursement rate due to its status as a Federally Qualified Health Center. For additional information on third party reimbursement mechanisms, see page 61.

Texas has a State Children's Health Insurance Program (CHIP), which generally covers children up to age 19 with family income less than 200 percent of poverty. In addition, the Texas Healthy Kids program covers children above 200 percent of poverty, ages 2 through 17, who have been uninsured for 90 days or more. HIV-infected children are referred to CHIP when eligible; with fewer than 30 pediatric cases of HIV/AIDS in the TGA, the impact of CHIP is not significant.

Insurance industry surveys show rates are the most important factor in drawing consumers to the Affordable Care Act's health insurance exchanges. The Texas overall monthly rates are below the nation-wide state average, and Austin rates may be below the Texas average. With 76 plans to choose from in Austin, a 27-year-old would pay \$169 per month for the lowest-cost mid-tier one plan. In comparison, the Dallas-Fort Worth premium would be \$217, from 43 plans available (Source: *Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2013*). The impact on utilization of Ryan White funding is not known at this time; however, local efforts are underway to inform eligible persons and coordinate access to the health insurance exchanges as described on page 28.

DPCHC screens individuals for Veterans Administration (VA) benefits as part of its intake process. However, since eligible veterans cannot be compelled to receive their medical treatment through the VA, medical case management staff can only educate patients about care available through the VA. If a veteran living with HIV prefers to receive care at DPCHC and has no other potential third-party payer, he/she is placed on the same sliding fee scale as any other uninsured patient. The regional VA estimates that approximately 50 veterans with HIV in the TGA are seen at its outpatient clinic in Austin or, for specialty or inpatient care, at VA hospitals in nearby Temple or San Antonio, Texas.

A Part A contractor coordinates its Substance Abuse and Mental Health Services Administration (SAMHSA) funds with Ryan White Part A funds in order to deliver a comprehensive range of substance abuse services to persons with HIV in the TGA. SAMHSA-funded services include: HIV counseling and testing; early intervention; lab testing; street outreach; case management; prevention for HIV positive persons; and health education and risk reduction education. Part A complements these programs by funding other components of the substance abuse treatment spectrum.

1) D. Assessment of Emerging Populations with Special Needs

Intravenous drug users (IDUs)

An estimated 1.5% of the Austin TGA population report a history of intravenous drug use. Of the 5,084 PLWH in the Austin TGA, 9.6% reported an IDU exposure category. An additional 7.4% reported an exposure category of MSN/IDU. A third (33.4%) of females PLWH reported an IDU exposure category.

Unique Challenges

For HIV-positive IDUs, the greatest challenges for providers are risky behavior, the dual stigma of HIV and drug addiction, mental health problems, and adherence to treatment plans. The majority of all IDUs in the TGA share needles. More than 9 in 10 women, 7 in 10 Hispanics, and 8 in 10 African Americans who had ever used injection drugs had shared needles. Of people who shared needles, 43.5% shared with people they did not know, 14.1% with people they knew to be HIV positive, and 44.7% with people they knew to be men who have sex with men (Source: *Travis County SHAS*). Drug abuse is also associated with disruption in daily living, making it difficult for PLWH to keep appointments or follow treatment regimens. Evidence of high unmet need can be seen when examining unmet need by exposure category (Table J, page 22). In 2012, IDU had the highest percent of unmet need (19.9%). Within PLWH reporting exposure as IDU, males of all race/ethnicity groups had a higher percent of unmet need than females.

The most recent comprehensive Austin HIV Needs Assessment identified barriers to care as: not wanting medical care; fear HIV status being discovered by others; cannot afford medical care; and actively using drugs/alcohol. Although not self-identified as a barrier, 75% of IDU respondents were experiencing a mental health problem. Depression and anxiety were the most common diagnoses.

Service Gaps

Significant service gaps reported in the 2010 Austin HIV Needs Assessment include psychosocial (non-medical) case management; AIDS drug assistance; transportation; and oral health services. With three-quarters identified as having a mental health problem, the IDU population has high need for mental health services. Gaps in oral health care, substance abuse services, mental health services, and medical transportation are common for several emerging populations including IDUs.

Estimated costs associated with delivering services

The estimated cost associated with delivering services to PLWH who report intravenous drug use as the primary risk category is \$3,706. The estimated cost ranges from \$3,016 for males to \$4,922 for females.

Substance Users Other Than IDUs

Unique challenges

Overall, 7.4% of the PLWH in the Austin TGA report non-IDU substance abuse. Use of marijuana and cocaine/crack are the most prevalent substances abused. Almost all (99%) of the PLWH reporting non-IDU substance abuse live below 300% of federal poverty level; most (73%) live below 100% of federal poverty level. A high proportion of PLWH who report non-IDU substance abuse also report mental health issues (73%) and lack health insurance (59%).

Cocaine use negatively affects access to HIV care (Source: *The AIDS Reader: Substance Abuse and HIV in Treatment Challenges*, August 13, 2010). Cocaine use or cocaine plus opioid use is associated with missed outpatient visits, increased use of emergency departments, and lack of antiretroviral therapy. Cocaine use has also been shown to adversely affect medication adherence.

Service gaps

The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. Housing Service providers in the 2005 HIV Needs Assessment stressed the inadequate capacity of all services, especially mental health and substance abuse treatment. Additionally, treatment adherence counseling is important in helping PLWH who are experiencing chaotic lifestyles.

Estimated costs associated with delivering services

Persons living with HIV who report substance use other than IDU have estimated costs associated with service delivery of \$4,847. The cost associated with service delivery of a PLWH without substance abuse is \$2,683.

White MSM

Over 2,100 (2,122) of the persons living with HIV that reside in the Austin TGA are White males. Most (86%), report a MSM exposure category. For comparison, only 55% of the 772 African American males living with HIV report this exposure category. Over half (53%) of the 81 syphilis cases in PLWH are in Whites. A vast majority (90.1%) of these Whites males are MSM.

Unique Challenges

White MSMs continue to constitute the largest number of PLWH in the TGA. Risky sexual behavior and substance abuse present significant challenges for providers of care to HIV-positive White MSMs. Figure 9 demonstrates the increased risky sexual behavior among White MSMs in the area. In 2000, there was only one case of early syphilis among men for each female. In 2011, for every one white female case of early syphilis, there were 16 male cases. From 2004 to 2007, the ratio of white male to white female early syphilis cases was much wider, an indication of transmission primarily in males (source: Texas STD*MIS, 2012). The present decrease in the ratio may indicate that whites of both sexes are engaging in riskier sexual behavior, exposing more women to syphilis. The larger number of early syphilis cases reported in women may also

be due to efforts to increase active surveillance. The most recent comprehensive HIV Needs Assessment found that 22% of White MSM had a history of IDU and 59% reported substance abuse, thereby presenting another challenge.

Service Gaps

Significant service gaps found in the 2010 HIV Needs Assessment include: oral health services, medical case management, outpatient/ambulatory medical care, and AIDS drug assistance. In addition to these self-reported needs, providers and surveys indicate that significant numbers of White MSM need mental health, substance abuse, and health education/risk reduction services.

Estimated costs associated with delivering services

The estimated cost associated with delivering services for White MSM is \$2,424. For White males reporting MSM and IDU, the estimated cost is \$3,503.

Men of Color (Hispanic and African American)

Hispanic and African American men comprise 20% of the Austin TGA. However, these men comprise 41% of the PLWH.

Unique challenges

Challenges for providers of services to PLWH men of color MSMs include stigma, lack of HIV education, and risky behavior. Men of color MSMs face the multiple stigmas of being MSM, HIV-positive, and racial/ethnic minority. This translates into a higher number of men of color MSMs with unmet need in the TGA; in 2012, 510 (58.4% of total) MSMs had unmet need (source: *Texas DSHS, 2013*). Stigma extends beyond health care providers and the larger society to their own communities, where many men of color MSMs do not self-identify, making them a hidden population. TGA provider data reported that minorities had a lower level of knowledge about HIV/AIDS, found out about their HIV status at a later stage of disease, or knew their status but chose not to use services until a late stage of disease. These factors increase the cost and complexity of providing services to clients. The most recent comprehensive HIV Needs Assessment identified barriers to care as: cannot afford medical care, fear HIV status being discovered by others, and fear of their children discovering HIV status.

Service gaps

The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. According to ARIES data, African American and Hispanic men had more service visits than White men. African American men averaged 65 visits and Hispanic men 58 visits, compared to White men who averaged 46 visits.

Estimated costs associated with delivering services

The estimated cost associated with delivering services for Hispanic males and African American males is \$2,924 and \$2,933, respectively. The estimated cost is lower for White males (\$2,495). For African American males reporting MSM and IDU as the primary risk category, the estimated cost is \$4,552.

African American Women

African American females are 3.5% of the Austin TGA population, however they represent 6.8% of all PLWH in the TGA. In 2012, 345 African American women living with HIV resided in the Austin TGA. The HIV prevalence rate for African American women (553.1 per 100,000 population) is eight (8) times higher compared with Hispanic women and 15 times higher compared with White women. The exposure category for a majority (69%) of the African American women was heterosexual sex followed by injection drug abuse (28.6%).

Unique challenges

Concurrent infections with sexually-transmitted diseases or tuberculosis may complicate access to care for African American women. For 2009 – 2012, for gonorrhea, syphilis and *Chlamydia* infections, African Americans have the highest rates compared with Whites, Hispanics, and Other. In 2012, the incidence rate for gonorrhea for African Americans is over eight times higher compared with Whites. The incidence rate for early syphilis for African Americans is over twice as high compared with Whites. In 2012, 58 tuberculosis cases were reported in the Austin TGA. Incidence rates per 100,000 population for African Americans (4.4) were four (4) times higher compared with Whites (1.1).

Almost one quarter (24.7%) of the African American females in Travis County lack health insurance. During 2012, an estimated 28% of African American females in Travis County earned income in the past 12 months below the poverty level (*US Census Bureau, American Community Survey, 2012*). In the United States, a higher percentage of African American females aged 18 years or older, reported a high rate of past month illicit drug use (6.2%) compared with the national average (5.7%). (*National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, 2010*).

Service gaps

According to the most recent comprehensive Austin HIV Needs Assessment, a higher percent (36%) of African American women were out-of-care than among women overall. Service gaps reported in the 2010 HIV Needs Assessment included: oral health services, mental health services, transportation, utility assistance, and AIDS drug assistance. Comments from focus group participants also suggested that support groups facilitated by a mental health professional would be beneficial.

Estimated costs associated with delivering services

The estimated mean cost to care for an African American female is \$3,529 compared with \$3,021 for White females. The estimated mean cost to care for an African American female reporting IDU as the primary risk category is \$4,567.

Persons Recently Released from Jail/Prison

During 2010-2012, the estimated number of inmates released from the Texas Department of Criminal Justice with HIV infection that resided in Travis County totaled 138. For those former inmates incarcerated during the past three (3) years and receiving care by Ryan White-funded medical care providers in 2012, most (80%) were males and 86% lived below 100% FPL.

Intravenous drug use was the primary risk category for 47% of the former inmates under care by Ryan White-funded providers.

Unique Challenges

Numerous challenges exist in managing and preventing HIV/AIDS among the recently released. Substance abuse presents a challenge in getting these individuals into care, with 52% of out-of-care recently released reporting alcohol and drug use as their most frequently identified reason for being out of care. The recently released have lower levels of educational attainment when compared to the population as a whole. Among recently released, 38% have not graduated from high school (Source: *2005 Austin Area Comprehensive HIV Needs Assessment*).

Service Gaps

According to the 2010 HIV Needs Assessment, the recently released population ranked transportation first among their most frequently identified service gaps. There is a significant gap for basic needs services as well. Other service gaps included: utility assistance, housing, food bank, and oral health services. Focus group participants indicated that services are needed to help the recently released navigate housing barriers and criminal justice obstacles. Furthermore, 89% of recently released participants were not provided with transitional services to assist them in accessing HIV medical and social services, obtaining prescriptions, and entering into case management (Source: *2010 Austin TGA Comprehensive HIV Needs Assessment*).

Estimated costs associated with delivering services

The estimated cost associated with delivering services is \$2,304. Almost half (47%) of the PLWH recently released from prison or jail have hepatitis C virus infections. The estimated cost associated with delivering services for those former inmates who are co-infected with hepatitis C is \$3,014 compared with a cost of \$1,683 for those former inmates without hepatitis C.

1) E. Unique Service Delivery Challenges

Efforts to acknowledge and understand the beliefs of patients from a variety of cultural backgrounds are necessary for effective service delivery. In the Austin TGA, racial and ethnic groups are overrepresented among people with HIV. Overall, 6.9% of the Austin TGA is African American; however, 19% of the new HIV cases reported during 2010-2012 were African American. Hispanic males comprise 16.5% of the Austin TGA population; however, the percentage of persons living with HIV in the TGA who are Hispanic males is 26%. Spanish is the primary language for 11% of the clients seen by Ryan White-funded medical care providers in the Austin TGA during 2012. This has increased slightly from 9% in 2009. Providing linguistically appropriate services is necessary to ensure medical care delivery to minority PLWH (Source: *Austin ARIES*, 2012). Ensuring bilingual staff are available and all documents and forms translated correctly increases the complexity of providing care and increases service costs.

In 2011-2012, 34.4% of all new HIV diagnoses in the Austin TGA received a late diagnosis and were diagnosed with AIDS within 12 months of HIV diagnosis. Hispanics had a higher percentage (42.0%) of late HIV diagnoses while the percentage for Whites (30.8%) was lower

(Source: *Texas Department of State Health Services, 2012*). In 2011-2012, the percentage of all new HIV diagnoses for the five (5) EMAs/TGAs in Texas who received a late diagnosis and were diagnosed with AIDS within 12 months ranged from 28.7% to 34.4%. The Austin TGA had the highest proportion. The percentage of Hispanics and African Americans in the Austin TGA who received a late diagnosis was higher compared with the other four (4) EMAs/TGAs (Source: *Texas Department of State Health Services, 2012*).

Persons living with HIV have a multitude of needs that were not as prevalent in years past, including sexually transmitted diseases (STDs), poverty, substance abuse issues, homelessness, and chronic mental health problems. The syphilis rate in 2012 for the Austin TGA (17.5 cases per 100,000 population) is the second highest among Texas EMAs/TGAs in 2012. The *Chlamydia* infection rate in 2012 for the Austin TGA (515.2 cases per 100,000 population) was also the second highest among Texas EMAs/TGAs in 2012 (Source: *Texas Department of State Health Services, 2012*). In 2012, almost all (94%) of the clients seen by Ryan White-funded medical care providers in 2012 were at or below 300% FPL; 61% were at or below 100% FPL. The average cost for medical care for clients at or below 100% FPL is over 2.5 times higher compared with clients over 300% FPL (Source: *Austin ARIES, 2012*). The Austin TGA has a high prevalence of illicit drug use (43.6%) (Source: *Texas Commission on Alcohol & Drug Abuse*). The percentage of injection drug use among PLWH in the Austin TGA is 14.0% (Source: *Austin ARIES, 2012*). The rate of homeless in persons living with HIV in the Austin TGA is approximately 3%; a rate 23 times higher compared to the Austin TGA population (Source: *Austin ARIES, 2012*).

During 2010-2012, the estimated 138 inmates released from the Texas Department of Criminal Justice with HIV infection resided in Travis County (Source: *Texas Department of State Health Services, 2012*). Intravenous drug use was the primary risk category for 47% of the former prison and jail inmates under care by Ryan White-funded providers in the Austin TGA (Source: *Austin ARIES, 2012*).

The total number of people who need care for HIV in the Austin TGA is increasing. Since 2008, the number of persons living with HIV has increased 26.6%. The number of persons living with HIV who are Hispanic has increased 43.2% from 2008 through 2012 (Source: *Texas Department of State Health Services, 2012*).

The proportion of persons living with HIV in older age groups is increasing. From 2008 to 2012, the number of PLWH who are 55 years of age or older has increased 97%. The number of PLWH who are 45-54 years of age has increased 31%. In 2012, PLWH who are 45 years of age or older represented over half (52.4%) of the persons living with HIV in the Austin TGA (Source: *Texas Department of State Health Services, 2012*). Adverse conditions commonly seen older population groups, e.g. coronary heart disease, hypertension, cancers, etc., will change and increase the complexity of medical care and the delivery cost of medical services to persons living with HIV.

Retention in care is associated with improved individual health outcomes for PLWH. Retention in care, defined as having a met need for medical care every year during 2008-2012, for persons living with HIV in the Austin TGA is 57.2%. The other four (4) EMAs/TGAs in Texas have

lower levels of retention in care ranging from 48.2% to 53.4%. Increasing the retention in care level for PLWH in the Austin TGA is a recurring challenge (*Source: Texas Department of State Health Services, 2012*).

1) F. Impact of Decline in Ryan White HIV/AIDS Program Formula Funding

For FY 2013, the Austin TGA experienced a \$246,550 or 8.4% decline in Ryan White Part A formula funding. This decline was effectively mitigated by submission of a successful Ryan White Part C supplemental grant application, and also by Ryan White Part B and HIV State Services funding in the TGA.

1) G. Unmet Need

Attachment 6

The data source for Attachment 6 unmet need estimates is the Texas Department of State Health Services database eHARS. Cases diagnosed and living as of December 31, 2012 was used in calculating the estimates. Cases diagnosed in Texas Department of Criminal Justice were removed and cases with unknown mode of exposure have been proportionately redistributed. The Electronic HIV/AIDS Reporting System (eHARS) was the source database for HIV/AIDS cases for estimating unmet need, retention in care for PLWH, linkage to care for newly diagnosed individuals and continuity of care for outpatient/ambulatory medical care visits, CD4 labs and viral load labs. The following data sets were matched against HIV/AIDS cases in eHARS to determine if a client had a met medical need:

- Texas AIDS Drug Assistance Program (ADAP) or State Pharmacy Assistance Program (SPAP) - If ADAP/SPAP provided antiretroviral (ARV) medications for a client, then that person was considered to have met medical need for the year in which the medication was provided. Name based matching was performed to determine persons with a met medical need during 2012.
- Electronic Lab Reporting (ELR) – The largest providers of laboratory services throughout the state report CD4 and viral load labs to DSHS. Name based matching of these reports was used to determine if individuals received a CD4 count or viral load test during 2012. Please note that most paper-based labs were not available at the time these measures were developed and are not reflected in the estimates.
- AIDS Regional Information and Evaluation System (ARIES) – Services provided to Ryan White eligible clients by funded service providers are reported in ARIES. If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory visit medical care during 2012, the client was reported as having a met medical need during that year. When available, name based matching was used to determine persons with a met medical need during 2012. When client names were not available, matching was based on a unique record number generated in ARIES and eHARS.
- Medicaid/Children's Health Insurance Program (CHIP) – If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory medical visit through Medicaid/CHIP during 2012, the client was reported as having a met medical need during that year. Name based matching was performed to determine persons with a met medical need during 2012. Please note that the fourth quarter of the 2012 Medicaid/CHIP data was not

available for release at the time these estimates were developed and are not reflected in the estimates.

- Private Insurers – For this analysis, a few of the largest private providers in Texas extracted relevant procedures (CD4 counts, viral load measurements, ARV, or an outpatient/ambulatory medical visit) from their claims systems. Matching was based on available data elements such as first and third initial of first and last name, date of birth and sex.

The Texas Department of State Health Service estimates that 874 persons or 17.2% of the PLWH in the Austin TGA have unmet need. Unmet need measures for PLWA and PLWH (non-AIDS) for 2010 through 2012 are provided in Table I. Generally, the percentage of persons living with AIDS and persons living with HIV/non-AIDS who did not receive specified HIV primary medical care decreased approximately over 20% since 2010. The percentage of PLWA who did not receive the specified HIV primary medical care decreased 41% from 2010 to 2012. The percentage of HIV+/aware not receiving the specified HIV primary medical care decreased 32% from 2010 to 2012.

Table I. Need for HIV-Related Health Services by Individuals with HIV Who Are Aware of Their HIV Status, Austin TGA, 2009-2012

| Unmet Need Measure | Time Period | | |
|--|----------------------|----------------------|----------------------|
| | 1/1/10 – 12/31/10 | 1/1/11 – 12/31/11 | 1/1/12 – 12/31/12 |
| Percentage of PLWA who did not received the specified HIV primary medical care | 22 | 14 | 13 |
| Percentage of PLWH/non-AIDS aware who did not received the specified HIV primary medical care | 30 | 23 | 23 |
| Percentage of HIV+/aware not receiving the specified HIV primary medical care (quantified estimated of unmet need) | 25 | 18 | 17 |

Source: *Texas Department of State Health Services, 2010-2012 using HRSA/HAB Unmet Need Framework Excel Worksheets.*

Table J shows the number and percentage of persons living with HIV with unmet need for medical care by disease status and various demographic characteristics. An estimated 17.2% of the PLWH in the Austin TGA have unmet needs. This percent is lower than the estimated unmet need for each of the other four EMAs/TGAs in Texas. The percent unmet need for persons with HIV has decreased almost 24% from 29.8% in 2010 to 22.7% in 2012. A greater decrease (39.7%) from 2010 to 2012 in unmet need was seen in those persons with AIDS. For each year, the percentage of persons with HIV not receiving medical care is greater than the percentage of persons with AIDS not receiving medical care. This difference may be attributed in part to care provided for an AIDS-defining condition which could necessitate an outpatient medical care visit which is an indicator of need.

With a few exceptions, regardless of gender, race/ethnicity, age group and risk category, the percent unmet need has decreased from 2010 to 2012. The exceptions are 1) those in the Other

race/ethnicity category, 2) those in the Pediatric risk category, and 3) those in the Adult other risk category. The small numbers of persons in these three groups may be responsible for the apparent increase. A determination of care for one additional person in each group during 2012 may result in a decrease in unmet need from 2010 to 2012.

Table J. Number and percent of persons living with HIV with unmet need for medical care, Austin TGA, 2010-2012

| Characteristic | Year | | | | | |
|-----------------------|--------------|-------------|------------|-------------|------------|-------------|
| | 2010 | | 2011 | | 2012 | |
| | N | % | N | % | N | % |
| Disease Status | | | | | | |
| HIV | 533 | 29.8 | 435 | 23.4 | 483 | 22.7 |
| AIDS | 562 | 21.9 | 392 | 14.4 | 391 | 13.2 |
| Gender | | | | | | |
| Female | 154 | 22.6 | 132 | 18.8 | 114 | 15.2 |
| Male | 941 | 25.6 | 695 | 18.0 | 760 | 17.5 |
| Race/Ethnicity | | | | | | |
| White | 528 | 24.9 | 343 | 15.3 | 344 | 14.9 |
| African American | 270 | 26.7 | 210 | 19.4 | 210 | 18.8 |
| Hispanic | 283 | 24.4 | 259 | 20.6 | 300 | 20.0 |
| Other | 9 | 22.5 | 12 | 24.0 | 12 | 25.5 |
| Unknown | 5 | 25.0 | 3 | 7.0 | 8 | 6.9 |
| Age Group | | | | | | |
| < 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 – 12 | 3 | 33.3 | 3 | 30.0 | 2 | 18.2 |
| 13 – 24 | 45 | 27.6 | 37 | 20.7 | 39 | 18.8 |
| 25 – 34 | 226 | 32.3 | 182 | 23.1 | 191 | 22.4 |
| 35 – 44 | 340 | 25.8 | 239 | 18.6 | 239 | 17.7 |
| 45 – 54 | 333 | 22.0 | 249 | 15.1 | 268 | 15.4 |
| ≥ 55 | 148 | 22.8 | 121 | 15.4 | 135 | 14.6 |
| Risk Category | | | | | | |
| MSM | 691 | 24.6 | 507 | 16.6 | 568 | 16.7 |
| IDU | 138 | 29.6 | 108 | 21.9 | 97 | 19.9 |
| MSM/IDU | 91 | 25.6 | 54 | 15.0 | 58 | 15.6 |
| Heterosexual | 169 | 25.0 | 153 | 20.8 | 144 | 18.3 |
| Pediatric | 4 | 11.4 | 5 | 15.2 | 6 | 15.0 |
| Adult Other | 1 | 16.7 | 1 | 20.0 | 1 | 20.0 |
| Overall | 1,095 | 25.2 | 827 | 18.1 | 874 | 17.2 |

Source: *Texas Department of State Health Services, HIV/STD Epidemiology and Surveillance Branch, eHARS*

METHODOLOGY

1. Planning and Resource Allocation

1) A. Letter of Assurance from Planning Council Chair

The Letter of Assurance from Planning Council Chair is Attachment 7.

2) B. How the priority setting and allocation process was conducted

The Austin HIV Planning Council is composed of one leadership committee and two standing committees. The Executive Committee (EC) exercises a wide range of decision-making control and delegates planning tasks to the other two committees: (1) Comprehensive Planning and Needs Assessment Committee (CPNA); and Allocation Committee. The Planning Council Chairmen assigns members to committees based on their interests and skill sets. He ensures that all committees are racially and ethnically diverse, as well as reflective of persons living with HIV/AIDS in the community. Affirmative efforts are made to ensure each committee is assigned, at a minimum, one individual who is a consumer of Ryan White Part A services. In 2013, the Planning Council worked synergistically to accomplish four primary tasks pertaining to the priority setting and resource allocation process: 1) Evaluate and document access/barrier issues; 2) Review the continuum of care; 3) Quantify need and document consumer priorities; and 4) Determine the best fiscal response, with contingencies relative to need and funding.

The FY 2014 priority setting and resource allocation process was carried out in a collaborative manner to effectively address the needs and priorities of persons living with HIV/AIDS, those in care and those out of care. The CPNA Committee set service category priorities and reviewed the existing continuum of care. CPNA's services category priorities were shared with the Allocation Committee for their use in allocating funds. Recommendations from the Allocation Committee were approved by the full Planning Council in its September 2013 Business meeting, thus enabling the Planning Council to complete its mandated duties of needs assessment, priority setting, and resource allocation.

(1) How the needs of those persons not in care were considered

A systematic methodology to quantify and address the needs of persons not in care was utilized by the Planning Council. The process began by assessing the number of persons not in care through an established quantification process which included gathering demographic data from the Texas HIV/AIDS Reporting System (eHARS) and the AIDS Regional Information and Evaluation System (ARIES). Demographic data from the two reporting systems was analyzed to develop a holistic profile of persons not in care. Zip code analysis was further used as part of the quantification process to effectively enhance response to PLWH needs. A number of new ARIES data reports were produced to take full advantage of the data available. An analysis of the 13–24 age group revealed that the overwhelming majority of new HIV cases were young men ages 21–24. Conversely, there were very few reported cases in ages 13–17. Additionally, ARIES reports were produced providing further detail regarding the utilization of Ryan White services across demographic profiles, including frequency of access to primary medical care.

These profiles provided a firm foundation for considering the needs of persons not in care during the priority setting and resource allocations process.

Information was also garnered from other sources to determine the needs of persons not in care, including Unmet Need data from the Texas Department of State Health Services (DSHS). The Planning Council participated in and hosted a number of public meetings to gather information in preparation for a targeted needs assessment study. Meetings with service providers, PLWH, and other community stakeholders provided key input which enabled the Planning Council to make sound decisions based on PLWH needs. The targeted needs assessment study was conducted to determine the capacity of need for services not historically funded by the Planning Council with Ryan White Part A funds. These services included child care, transportation, linguistics, community-based healthcare, and housing. The survey included questions designed to discover the reasons why respondents were out of care. The Planning Council utilized the survey information in considering the needs of those out of care. Lastly, the membership of the Planning Council included members who lead service organizations delivering outreach, case management, and other services directly focused on engaging PLWH who are not in care. The Planning Council drew from this valuable experience and expertise when evaluating the needs of those out of care. Specifically, information was gained regarding outreach strategies that were proven successful in returning the out-of-care population to care.

(2) How the needs of those persons unaware of their HIV status were considered

The Planning Council studied National and State epidemiological data, as well as local ARIES data in order to project the number of persons unaware of their HIV status. HIV case data trends for new cases over the last five years for the Austin TGA area provided validity for projections indicating that, in addition to the known HIV positive population, approximately 21% of these individuals are unaware of their HIV status. The demographic makeup of the unaware population based on these numbers proved to mirror that of the local community being served. An appointed chair of one of the Planning Council's sub-committees serves in a key HIV/AIDS surveillance role with the Austin/Travis County Health and Human Services Department Communicable Disease Unit. Surveillance data is used to determine the characteristics of those known to be in care. This information enables the Planning Council to determine a profile for those persons unaware of their HIV status, and eventually to determine their needs. Information regarding local testing is readily available to the sub-committee chair and is often used by the committee to make important decisions about the needs of those unaware of their HIV status. Based on this first-hand knowledge, the Planning Council has had access to HIV unaware data, as well as information on the challenges and successful strategies for reaching the unaware population. A key objective outlined in the Comprehensive HIV Services Plan is to target at-risk populations that have a higher statistical probability of being HIV positive and unaware, thus ensuring a continued and broad focus on meeting the needs of this population.

HIV testing is a key method to identify individuals unaware of their status. The ultimate goal however, is to get them into care in the Austin TGA. Members of the Planning Council and its support staff are actively engaged in local prevention and testing initiatives, including the Test Texas Coalition and the HIV/STD Health Coalition. Both are grassroots organizations dedicated to advocacy for routine HIV testing.

(3) How the needs of historically underserved populations were considered

An expanded set of ARIES data reports was utilized to determine the service utilization patterns of specific populations. The expanded data include Minority AIDS Initiative (MAI) service reports that highlight the service needs of two (2) underserved populations in the Austin TGA: African Americans and Hispanics. Demographic data on underserved populations, in conjunction with growth rates, provided a distinct profile of the underserved populations. Overall, these two populations sought care later in the progression of HIV disease, while Hispanics show the highest percentage progression from HIV to AIDS within one year of initial diagnosis.

In addition to analysis of data, the Planning Council considered input from the community gained from meetings, community events, and targeted studies. Many Planning Council members are community leaders and professionals who work directly with minority and/or underserved populations. One community initiative that the HIV Planning Council has been engaged in is the National Week of Prayer for the Healing of AIDS where collaboration was formed with predominately African American churches and their ministers. Since the ministers have been shown to possess first-hand knowledge of how best to reach the underserved, several meetings were conducted to solicit information about the needs of people in their congregations. These, along with other population-specific findings, were considered by the Planning Council during the priority setting and resource allocations processes for Ryan White Part A and MAI funding.

(4) How PLWH were involved in the priority setting and allocation process and how their priorities are considered in the process

Current Planning Council membership consists of consumers who are represented on each of the sub-committees, including the executive committee. The representation of PLWH on the Planning Council and in key leadership positions ensures the Planning Council maintains a constant focus on the needs and perspectives of PLWH. Citizens who frequently attend Planning Council meetings include PLWH who contribute their insight to the decision-making process. Of the nearly thirty (30) Planning Council meetings that have been held since the FY13 grant cycle began in March, over half (50%) of those meetings were attended by PLWH who were involved in the priority setting and allocation process.

(5) How data were used in the priority setting and allocation processes to increase access to core medical services and reduce disparities in access to the continuum of HIV/AIDS care in the TGA

The Planning Council analyzed data from two distinct sources: Texas HIV/AIDS Reporting System (eHARS) and ARIES. Consumer surveys were also used to determine satisfaction levels of persons receiving core medical services. The triangulation of these three data sources helped to develop a profile of those out of care. ARIES reports were used to show frequency of medical care and the timeframe when consumers are deemed out of care or last received care. Reports were also used that showed the demographic profile of consumers accessing core services by service type. The summation of all this data was used by the Planning Council during the priority setting and allocations processes to increase access to core medical services and reduce disparities in access to the continuum of HIV/AIDS care in the Austin TGA. Findings from last year's process has demonstrated that using data in this way increases access to core medical

services and reduces disparities in access as determined by a comparison of utilization data and client satisfaction surveys.

(6) How changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process

The expanded ARIES data reports and the Epidemiologic Profile produced by the Texas Department of State Health Services (DSHS) were carefully reviewed to evaluate the status of the epidemic and trends indicated by the data. Expanded ARIES data included additional demographic and geographic analysis within the Austin TGA, in an effort to identify populations and areas that required additional focus. The data has been consistent with the number of new cases holding relatively steady and the overall growth in the number of PLWH increasing as antiretroviral medications impact the longevity of PLWH and the aging of the population. Austin's aging PLWH is a growing population whose needs are diverse and often complex. As cited in the Demonstrated Needs section of this application, nearly half (1/2) of the area's PLWH population is considered aging (over 45 years old). This change in trend has been monitored by the Planning Council and its support staff through involvement in the HIV/AIDS Aging Coalition (HAAC) for the past three (3) years. Data shared through the coalition and at the annual HIV/AIDS Aging Symposium is incorporated in the priority setting and allocation process

Epidemiological and ARIES utilization data steadily demonstrate minority populations are underserved. African American populations experience a disproportional burden in terms of the number of cases relative to the population. The data also supports the need for outreach to the MSM population, as this group continues to constitute the largest percentage of PLWH and those at high risk. The Planning Council also carefully monitors trends at the remote county level where a small, yet growing number of PLWH live. For example, the population of PLWH in nearby Williamson County has risen to the point that additional service providers require resources in the area. As a result of the trends indicated by epidemiological data and information from neighboring counties, funding was initially increased for non-medical case management and MAI Tier 2 non-medical management. This year's funding trend continues with a focus on Psychosocial Support Services groups in the most needed suburban and rural areas.

(7) How cost data were used by the Planning Council in making funding allocation decisions

The Evaluations/Quality Management sub-committee of the Planning Council began work on historically tracking a cohort of persons in care to determine what top five (5) services were being accessed and funded. A benefit/cost analysis was also considered in making funding allocation decisions. The goal was to study a trend in spending and how to get more bang for the buck. Provider billings and cost reports were provided by the Administrative Agent each month. Service categories that were under-spent or over-spent received special analysis. The Planning Council's process unearthed factors for changes in spending habits. The process has yielded changes to funding in many service areas. In addition to the cost data analysis, the Planning Council considered information gained from provider presentations. As in previous years, this information enabled the Planning Council to fully understand how funds have been expended in order to predict how they will be spent in the future. This was a heavy determinant in the allocations decisions.

(8) How Unmet Need data were used by the Planning Council in making funding allocation decisions

Unmet need was quantified utilizing demographic data from Texas eHARS and ARIES. Demographic data from the two reporting systems were compared using established “subtraction” methodology to quantify and present a demographic profile of persons with unmet need. Data from consumer surveys and data provided by service provider presentations were used to profile those PLWH/A with unmet need and the reason(s) why a person’s needs were unmet. By identifying the barriers to care, Planning Council was able to assess which barriers could be directly reduced by redirecting service category resources, and which barriers are best addressed through psychosocial case management.

(9) How the Planning Council considered and addressed in their prioritization and allocation process any funding increases or decreases in the Part A award

The Planning Council developed the FY 2014 Allocations Model with the assumption of level funding. The Planning Council also developed an Increase/Decrease Contingency Plan for the allocation of Part A and MAI service funds. The strategy for the increase and decrease plan focuses on ensuring adequate funding is directed to primary medical services and that specified support service categories receive no less than a minimum level amount. This strategy ensures that primary medical services remain the central focus of allocations and that support services deemed most essential are funded at a level that ensures the service is viable from a service delivery perspective and thus able to meet the need.

(10) How MAI funding was considered during the planning process to enhance access to services for disproportionately impacted minority populations

Data indicate African American and Hispanic populations shoulder a disproportionate burden with respect to HIV disease. Data also indicates these two populations are underserved and tend to begin care later in the progression of the disease, thus validating the Austin TGA’s existing MAI target populations. African American and Hispanic PLWH require continued MAI funding and concentrated focus in order to adequately meet their needs. While MAI funding was shifted from case-management services to substance and mental health services, the priority levels for these services dictated the change. Planning Council also worked with Part B planners to effectively leverage MAI funding. With this coordination, services administered with MAI funds enhanced access to minority populations. Information reported to the Planning Council on a monthly basis displayed all funding sources

(11) How the data related to EIIHA were used in the priority and allocations decision making process

Surveillance and epidemiological data from Texas DSHS were used in conjunction with data and estimates from the Centers for Disease Control and Prevention (CDC) to determine HIV testing and awareness data in the local area. The goal was to develop a demographic profile of persons living in the Austin TGA who are unaware of their HIV status. It was determined that a significant number of those HIV+ but unaware of their status exist in the area, with the number growing. The data was used in the priority and allocations process by factoring the significant unaware population into the overall allocations model. Planning Council continued to support

the EIIHA Collaborative, which consists of community and service providers dedicated to working with the HIV unaware and out-of-care populations. The EIIHA group also explored variables that are most effective in helping people become aware of their HIV status and remain in care. The EIIHA Collaborative, whose goals coincide with those contained in the National HIV/AIDS survey were developed for organizations to engage in the research and information dissemination of HIV testing practices.

(12) How data from other federally funded HIV/AIDS programs were used in developing priorities

Planning Council took into account data from other federally funded HIV/AIDS programs when developing priorities. For example, a significant number of PLWH in the Austin TGA depend on housing funded through the HOPWHA (Housing Opportunity for People with HIV/AIDS). Although housing is listed as priority in the local area, it was not a service category that was funded with Part A funds, due to the contribution from HOPWHA.

(13) How anticipated changes due to the Affordable Care Act were considered in developing priorities

The anticipated changes due to the Affordable Care Act (ACA) were considered by the Planning Council during its priority setting and resource allocation process. The Austin TGA has unique circumstances which will impede full compliance with ACA. The impact on service delivery due to the State of Texas not expanding Medicaid is unknown at this time. This factor will force the Planning Council to consider other options for clients not eligible for insurance in the near future. Although many PLWH who currently receive care through Ryan White Part A funding will be eligible for insurance under ACA, the TGA should be able to reduce funding for outpatient medical care but the savings may have to cover the costs of premiums and deductibles under the health insurance continuation and cost sharing service category. Prior to ACA, there was a lack of funds to dedicate solely to this highly prioritized service area. Another unknown factor that was considered is the number of PLWH who currently receive services under Part A funding, but are undocumented aliens. ACA prohibits this population from accessing services through the newly created system. The factor will impact how the priority setting process will change in next cycle. Essentially, this year's priorities reflect a careful consideration for the known rather than the unknown, which makes it a more robust model to meet PLWH needs in an ever-changing environment. ACA, while used as a factor in the priority matrix and weighting of the variables did not affect the allocation of funds because of all the unknowns related to ACA.

1) C. N/A

1) D. **Funding for Core Medical Services (see Attachment 8)**

1) E. Early Identification of Individuals with HIV/AIDS (EIIHA)

(1) EIIHA Plan Background Summary

The Austin Transitional Grant Area's (TGA) overall strategy is to collaborate with existing organizations performing EIIHA activities to develop a coordinated and seamless system which identifies, informs, refers, and links high-risk unaware HIV positive persons to medical care. Successful development and implementation of this strategy involves collaboration between HIV prevention and care service providers. The Austin Area Comprehensive HIV Planning Council (Planning Council) will continue to serve a lead role in facilitating this coordinated strategy through the establishment and ongoing facilitation of an EIIHA collaborative.

(a) Description of overall EIIHA Plan since initial implementation

Summary of how the overall Plan was developed and implemented:

Information or activities used to inform the Plan

The EIIHA Plan utilizes information from a variety of sources, both to develop the EIIHA Plan and to monitor outcomes. This includes demographic, statistical and epidemiological data from data from a number of databases, surveillance data available from the City of Austin HIV Prevention Unit, the Austin TGA Needs Assessment Report, reports and outcomes from Ryan White service providers, and collaboration between the Planning Council and the broader HIV service community.

Main EIIHA Plan objectives

The primary objectives of the EIIHA Plan were to:

- Increase the number of individuals aware of their HIV status
- Reduce HIV Related Health Disparities
- Increase the number of HIV positive individuals who are in care
- Increase Access to Care and Improving Health Outcomes for PLWH
- Reduce New HIV Infections

Collaborative efforts required to implement the EIIHA Plan and its objectives, including other programs/agencies participating in the EIIHA Plan development and implementation

Clearly the most successful component of the EIIHA Plan during the last year has been the community collaboration efforts. As a result of hard work and leadership provided by the Austin Travis County Health and Human Services Department (ATCHHSD), a new coalition has been formed within the Austin TGA to bring together a broad base of HIV service providers, State and City agencies, medical providers, the business community and numerous community members. Participation has included a national drug store chain (dedicating time and resources), two private physicians, and several organizations with indirect links to the HIV community. A total of sixteen organizations have come together with a unified focus of making positive inroads in addressing the HIV epidemic. The new HIV Collaborative has now been meeting for nine months and continues to grow both in scope and enthusiasm. In the past, collaborations have resulted in little more than meetings to identify HIV related needs and issues together with an

expressed desire to collaborate on solutions. Meaningful follow through to address issues was limited at best. However, the new HIV Collaborative is different. While initial meetings became mired in discussion regarding the myriad of issues facing those infected with HIV, the recent meetings have moved forward with a determination to accomplish meaningful goals.

Target groups in the current EIIHA Plan and why each target group was chosen

The current EIIHA plan consisted of four target groups:

- African American Women (AAW)
- Minority Injection Drug Users (IDUs)
- Young men who have sex with men (YMSM)
- Recently released from incarceration (RR)

Each group was chosen because the group is disproportionately impacted by the HIV epidemic and because the unmet need and related barriers for each group is high.

How EIIHA related data have been collected, analyzed and used to revise implementation activities, including data sources used in the EIIHA Plan

The EIIHA Plan utilizes data from a number of sources, including data supplied by Texas Department of State Health Services (DSHS) eHARS system, the Ryan White ADAP system, and surveillance data available from the City of Austin HIV Prevention Unit.

Overall major successful outcomes of the EIIHA Plan

Major successful outcomes include creation of the HIV Collaborative and the generally positive trends in epidemiological data.

Overall major challenges encountered

The biggest challenge the HIV Collaborative has encountered is deciding which of the myriad of issues to address first. Collaborative members represent a broad range of special interests. Many Collaborative members have extensive experience and detailed knowledge of specific HIV sub-population issues (e.g., homeless, substance abuse) that they want to champion as a focus. Ultimately so many issues were identified that the Collaborative became bogged down during initial meetings with problem identification and discussion. The number and scope of participants began to dwindle because nothing was being accomplished. The challenge has been addressed by agreement to focus on one significant issue at a time.

How the EIIHA Plan has contributed to achieving the goals of the National HIV/AIDS Strategy

Both long term epidemiological data and the Treatment Cascade published by the Texas Department of State Health Services (DSHS) demonstrates that the Austin Area TGA is moving in the right direction in terms of the goals contained in the National HIV Strategy and as incorporated into the Austin TGA Comprehensive Plan. The Treatment Cascade for the Austin TGA, i.e., Continuum of Care, shows Met Need at 68%; Continuity of Medical Care at 57% and Viral Suppression at 52%. These numbers are significantly better than the Texas statewide average (60% met need, 52% in care and 41% viral suppression) and better than any other TGA or EMA in the State. Additionally, DSHS epidemiological data over the last five years show moderate improvement in the rate of new infection for African American Women and IDU. The overall EIIHA effort of the Austin TGA, service providers and the HIV community is realizing a measure of success in trending outcomes in the right direction.

(b) Data for the three (3) target populations in current EIIHA Plan

The target populations for the EIIHA Plan are:

- Young Men who have sex with men (YMSM Ages 13-24)
- African American Women (AAW)
- Minority (African American and Hispanic) Injection Drug Users (IDUs)

| | Targeted Testing | | Non-Targeted Testing | | Total | |
|---|------------------|---------|----------------------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Target 1: Young (13 - 24) MSM | | | | | | |
| Newly Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 146 | 100.0% | 0 | 100.0% | 146 | 100.0% |
| Number of newly diagnosed positive test events | 3 | 2.1% | 0 | 0.0% | 3 | 100.0% |
| number of newly diagnosed positive test events with client linked to HIV medical care | 3 | 2.1% | 0 | 0.0% | 3 | 100.0% |
| Number of newly diagnosed confirmed positive test events | 3 | 2.1% | 0 | 0.0% | 3 | 100.0% |
| Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of newly diagnosed confirmed positive test events with client referred to prevention services | 1 | 0.7% | 0 | 0.0% | 1 | 100.0% |
| Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |
| Previously Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 146 | 100.0% | 0 | 100.0% | 146 | 100.0% |
| Number of previously diagnosed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 100.0% |
| number of previously diagnosed positive test events with client linked to HIV medical care | 0 | 0.0% | 0 | 0.0% | 0 | 100.0% |
| Number of previously diagnosed confirmed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 100.0% |
| Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of previously diagnosed confirmed positive test events with client referred to prevention services | 0 | 0.0% | 0 | 0.0% | 0 | 100.0% |
| Total number of previously diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |

**All people diagnosed with HIV in Texas are 'Referred' to partner services through the HIV surveillance system. To determine whether an interview was conducted, the testing data and STD*MIS would have to be matched. Names are not currently collected in the testing data, so a match cannot be made at this time.*

[^]To determine if CD4 and VL testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data, so a match cannot be made at this time.

| Target 3: African American Women | Targeted Testing | | Non-Targeted Testing | | Total | |
|---|------------------|---------|----------------------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Newly Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 170 | 100.0% | 690 | 100.0% | 860 | 100.0% |
| Number of newly diagnosed positive test events | 0 | 0.0% | 4 | 0.6% | 4 | 0.5% |
| number of newly diagnosed positive test events with client linked to HIV medical care | 0 | 0.0% | 2 | 0.3% | 2 | 0.2% |
| Number of newly diagnosed confirmed positive test events | 0 | 0.0% | 4 | 0.6% | 4 | 0.5% |
| Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of newly diagnosed confirmed positive test events with client referred to prevention services | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |
| Previously Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 170 | 100.0% | 690 | 100.0% | 860 | 100.0% |
| Number of previously diagnosed positive test events | 0 | 0.0% | 2 | 0.3% | 2 | 0.2% |
| number of previously diagnosed positive test events with client linked to HIV medical care | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of previously diagnosed confirmed positive test events | 0 | 0.0% | 2 | 0.3% | 2 | 0.2% |
| Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of previously diagnosed confirmed positive test events with client referred to prevention services | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total number of previously diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |

**All people diagnosed with HIV in Texas are 'Referred' to partner services through the HIV surveillance system. To determine whether an interview was conducted, the testing data and STD*MIS would have to be matched. Names are not currently collected in the testing data, so a match cannot be made at this time.*

[^]To determine if CD4 and VL testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data, so a match cannot be made at this time.

| Target 2: Minority (African American & Hispanic) IDU | Targeted Testing | | Non-Targeted Testing | | Total | |
|---|------------------|---------|----------------------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Newly Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 8 | 100.0% | 23 | 100.0% | 31 | 100% |
| Number of newly diagnosed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of newly diagnosed positive test events with client linked to HIV medical care | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of newly diagnosed confirmed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of newly diagnosed confirmed positive test events with client referred to prevention services | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |
| Previously Diagnosed Positive HIV Test Events: | | | | | | |
| Number of test events | 8 | 100.0% | 23 | 100.0% | 31 | 100% |
| Number of previously diagnosed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of previously diagnosed positive test events with client linked to HIV medical care | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of previously diagnosed confirmed positive test events | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services* | NA | NA | NA | NA | NA | NA |
| Number of previously diagnosed confirmed positive test events with client referred to prevention services | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Total number of previously diagnosed confirmed positive test events who received CD4 cell count and viral load testing [^] | NA | NA | NA | NA | NA | NA |

**All people diagnosed with HIV in Texas are 'Referred' to partner services through the HIV surveillance system. To determine whether an interview was conducted, the testing data and STD*MIS would have to be matched. Names are not currently collected in the testing data, so a match cannot be made at this time.*

[^]To determine if CD4 and VL testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data, so a match cannot be made at this time.

(2) FY 2014 EIIHA Plan

The overarching goal of the FY 2014 EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and to ensure that they are accessing HIV care and treatment.

(a) Planned activities of the EMA/TGA EIIHA Plan for FY 2014

Updated estimate of individuals who are HIV positive and do not know their status, including the estimated methodology

According to the most recent data released by the Texas Department of State Health Services (DSHS), a total of 1,124 PLWH residing in the Austin Area TGA are unaware of their status. This is 18.1% of the estimated total number of PLWH residing in the Austin Area TGA. DSHS utilizes the methodology recommended by the Center for Disease Control (CDC) to calculate this estimate.

Target populations for the EIIHA Plan

The target population for the EIIHA Plan includes:

- Young Men who have sex with men (YMSM Ages 13-24)
- African American Women
- Minority (African American and Hispanic) Injection Drug Users (IDUs)

Primary activities that will be undertaken, including system level interventions

Primary activities supporting EIIHA goals that will continue to be undertaken include:

- Continue outreach initiatives, including outreach services funded by Ryan White
- Continue HIV testing, including the ATCHHSD HIV Prevention Program mobile and clinic testing as well as the various CDC funded testing services across the TGA
- Continue to support Opt-out testing initiatives for all clinics and hospital emergency rooms within the TGA. This includes a continued active support role in the Test Texas Collaborative, which has growing success in encouraging medical facilities to implement opt-out testing.
- Continue to support the efforts of Test Texas to educate medical providers regarding the importance of identifying at risk populations and recognizing the need for periodic testing and education for those at risk of HIV infection
- Continue active involvement in the HIV Collaborative in order to leverage the interaction various Collaborative members have with target groups and those at risk of HIV infection.
- Continue to take a lead role in completion of the HIV Coalition's current priority project, which is to develop a marketing campaign that targets HIV prevention messages for at risk populations.

Major collaborations with other programs and agencies, including HIV prevention and surveillance programs

As described under primary activities above, a major focus of the EIIHA Plan will be to continue the highly successful collaboration with the HIV Collaborative. Members of the Collaborative have elected to focus on a single objective in the coming months, which is to

develop a comprehensive marketing campaign that will target at risk populations specifically including young MSMs. The objective is to craft messages that will be effective in educating target populations and ultimately impact risky behavior. The first step in this effort is to determine how to best reach target populations using media most meaningful to the specific population, e.g., media web sites for youth. The need for this marketing campaign is predicated upon the conclusion that erroneous information and misconceptions can be a bigger challenge than lack of information.

A commitment made by each member of the HIV Collaborative is to recruit additional members. The specific commitment made by the Planning Council is to engage additional faith-based members. Engaging churches in HIV prevention discussions has been identified by the HIV Collaborative as a key to reaching specific minority populations.

Collaborations also will continue with Test Texas with the objective of encouraging all major hospital emergency rooms within the TGA to adopt opt-out testing.

Planned outcomes of Austin TGA's overall EIIHA strategy

The planned outcomes of the overall EIIHA strategy are:

- Increase the number of individuals aware of their HIV status
- This outcome will be achieved by continued focus on targeted outreach and testing.
- Reduce HIV Related Health Disparities
- This outcome will be achieved through the efforts of Ryan White service providers to enroll PLWH in an insurance plan via the Affordable Care Act (ACA).
- Increase the number of HIV positive individuals who are in care
-This outcome will be achieved by focus on linking to care every individual who is newly tested positive and through case management follow up with those PLWH who have fallen out of care. ACA enrollment will also have a positive impact on getting more PLWA into care.
- Increase Access to Care and Improving Health Outcomes for People Living with HIV
-This outcome will be achieved through ACA enrollment.
- Reduce New HIV Infections
-This outcome will be achieved through outreach and education.

(b) How overall FY 2014 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy

The EIIHA Plan incorporates goals from the National HIV/AIDS Strategy which will ensure that the Plan's overall strategy is achieved and is consistent with the National Strategy. The specific National HIV/AIDS Strategy goals which are included in the EIIHA Plan include:

- Increase the number of individuals aware of their HIV status
- Reduce HIV Related Health Disparities
- Increase the number of HIV positive individuals who are in care
- Increase Access to Care and Improving Health Outcomes for People Living with HIV
- Reduce New HIV Infections

(c) How Unmet Need estimate and activities related to the Unmet Need population inform and relate to EIIHA planned activities

The target groups and activities identified in the EIIHA Plan are in direct correlation to the estimates of Unmet Need within the Austin TGA. Data trends clearly show that while there is an overall slow steady increase in the number of PLWH, specific races/ethnicities and MSM are disproportionately impacted by HIV/AIDS. MSMs continue to be the most common HIV exposure group. In Texas, between 2004 and 2010 the number of HIV positive Hispanics grew by 50%, and African Americans grew by 39%. Contrasting this rate of growth with the overall population, the HIV growth rate for African Americans is a staggering four times the growth rate for Whites.

(d) Planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing

No State laws or regulations have been identified as specific barriers to HIV testing within the Austin TGA. Consequently, specific efforts to address State laws or regulations are not a part of the EIIHA Plan. Based upon the experiences of Test Texas in promoting opt-out testing, it appears cost and internal resistance are the primary barriers to expansion of opt-out testing. Two of the most commonly cited barriers are: (1) for emergency rooms, resistance by staff to adding activities not related to the medical emergency; and (2) concern that a positive HIV test will require additional effort to inform the patient and engage in referral/follow-up activity.

(e) Description related to three (3) distinct target populations for the FY 2014 EIIHA Plan.

Why the target population was chosen and how the epidemiological data, unmet need estimate data, or other data supports that decision

The three target populations were chosen for inclusion in the EIIHA Plan based upon the fact that data (see tables on pages 32-34) show these populations to be experiencing the greatest rate of proportionate growth, the highest levels of risk of exposure, and behaviors that place these groups at higher risk. It is important to note that while testing data do not always show high rates of HIV positive results for these groups, epidemiological data clearly show the rate of infection for these groups to be much higher than the overall rate for all groups. Additionally, data which quantify risk clearly show that these groups are at greater risk. The selection of these three groups also was influenced by the results of outreach reports. Most notably, outreach and social workers report an alarming lack of factual information and “relevant” educational material among young MSMs. Many young MSMs have fatalistic attitudes regarding the perceived inevitability of acquiring HIV and misconceptions such as the “benefit” of acquiring a less virulent strain of HIV.

Challenges with or opportunities for working with the targeted population

African American Women (AAW)

AAW represent a target group having unique challenges which prevent them from becoming aware of their HIV status. The three most difficult challenges associated with making AAW aware of their HIV status are: (1) AAW are not comfortable openly discussing the topic of sexuality from a personal perspective; (2) some AAW possess low self-worth and self-esteem issues which prohibit them from engaging in and requiring condom use; and (3) AAW who are

dealing with the use of drugs or who have a mental illness, often undiagnosed, are resistant to outreach activities and public messages that promote testing efforts. Other priority needs impacting this target group are low perception of risk, poverty, lack of access to quality health care, lack of HIV knowledge, high rates of sexually transmitted diseases, and relationship dynamics such as not insisting on condom use and reluctance to question the sexual history of male partners.

Minority Injection Drug Users (IDUs)

IDUs are another target group with some unique challenges which prevent them from knowing their HIV status. The priority needs associated with IDU are: fear of learning one's HIV status; stigma of being seen at HIV testing sites; culture and language barriers; socioeconomic problems such as poverty, lack of insurance, and stable housing; fear of confidentiality breaches; concerns about undocumented status; lack of basic HIV education; mental illness, continued substance abuse; and timely access to drug treatment.

Young Men who have Sex with Men (YMSM) Ages 13-34

YMSM make up the greatest proportion of persons unaware of their HIV status in the Austin TGA. The priority needs and barriers to knowing their HIV status for this target group are as follows: underestimating personal risk; belief that HIV treatment minimizes infection risk; substance use; complacency about HIV; fear of stigma and homophobia; multiple sex partners, often anonymous; lack of awareness about risk of HIV infection; indifference or fatalistic attitude toward high risk taking behaviors; insufficient access to information on HIV counseling, testing, condom use, harm-reduction strategies; and treatment and care for sexually transmitted infections.

Specific activities that will be utilized with the target population

The following activities are planned for all three target groups:

- Continue street outreach activities
- Initiate an educational campaign (HIV Coalition)
- Continue social marketing campaign (ATCHHSD)
- Continue HIV testing schedule (mobile and fixed locations)
- Continue support for opt-out testing (Test Texas)
- Continue Case Management Prevention activities
- Continue Partner Notification Program (ATCHHSD HIV Prevention Unit)
- Continue condom distribution program (service providers and ATCHHSD)
- Continue HIV counseling services

Specific activity for African American Women:

- Continue collaboration with Women's Rising (Planning Council)

Specific activity for IDUs:

- Advocate for a needle exchange program

Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population

Identifying individuals unaware of their HIV status

The strategy for identifying individuals who are unaware of their status is predicated upon a targeted approach to identification of and outreach to at risk populations utilizing the resources

and network established by providers within the EIIHA collaborative. The strategy is to increase the number of individuals who are aware of their HIV status through a collaboration of service and prevention providers utilizing proven targeted outreach, testing and case management strategies.

Informing individuals of their HIV status

The TGA's plan to inform unaware individuals is to use existing methods and service providers. Emphasis will be placed on improving the coordination among these providers in order to increase the number of clients informed of their status. The TGA's overall strategy and goals for informing are general and applicable to each of the target groups. Activities specific to achieving these goals will be based on characteristics and other high-risk behavioral factors both common and unique to each group. Informing unaware individuals will be customized based on their specific needs and challenges as shown by the planned activities for each target group.

Referring individuals to medical care

The plan to refer Target Group individuals to care takes a variety of forms depending on the needs of the newly diagnosed client. In the TGA, the majority of referrals into medical care or other HIV support services are done through its case management system. Counseling and testing staff, client advocates and non-medical case managers provide assistance in referring to medical and support services.

Linking to Medical Care

The plan for linking all of target groups to care will be accomplished utilizing existing service providers. Essential linking activities include:

- Verifying referrals with clinic/provider
- Client education regarding eligibility process and medical care
- Assisting clients with completion of applications
- Advocating on behalf of client
- Following up with referrals and monitoring client progress

The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities is implemented, and their respective roles

The responsible party for identification, informing, referring and linking to care is generally the service provider who has direct contact with the client. The procedures will vary according to the organization, but the essential requirement is to ensure that the client is linked to care, either directly or via referral. For HIV positive test results occurring at medical facilities, the responsible party is the attending medical personnel. For Ryan White service providers and the HHSD HIV Prevention Unit the responsible party is generally the case manager or designee.

Planned outcomes that will be achieved for the targeted population as a result of implementing EIIHA Plan activities

The planned outcomes for the targeted populations will be to reduce the number of HIV positives and the rate of infection for each target group. Making inroads in reducing the number and rate of HIV infection begin with recognition that the target groups face significant

challenges that dominate their lives. In turn these challenges present barriers the HIV service community must overcome in order to reach these target groups. Success often comes in small measures. Turning the infection rate in the right direction is an important initial goal. Recognizing what activities worked and adopting those successful strategies for the future will be an important outcome of the targeted approaches.

(f) Plans to present, discuss and/or disseminate the EIIHA Plan and outcomes

HIV Collaborative

One of the benefits of the active engagement with the community via the HIV Collaborative is the opportunity to share information and objectives. The Planning Council will continue to use the opportunity presented by the HIV Collaborative meetings to share EIIHA plans and objectives with this broad based group. This not only promotes visibility for the EIIHA Plan across the HIV service community, but also provides an opportunity to maximize synergy between the efforts of the HIV Collaborative and the EIIHA Plan in order to improve outcomes.

Social Marketing

The ATCHHSD will continue to utilize the social marketing website www.AustinHIV.com as a foundation for social marketing campaign efforts related to HIV and specifically early intervention. The website includes:

- HIV facts and prevention information
- A link to several educational videos including: *Living with HIV is Not Dying of AIDS*
- Testing and referral information including testing schedules
- A testing “locator” tool to assist individuals in finding available testing sites and times
- A calendar of HIV related events within the TGA (e.g., World AIDS Day)
- A link to Twitter providing social contact and support
- A link to primary HIV resources within the TGA
- A link to the Planning Council website
- Current HIV news and events
- Links to national HIV organizations
- A component for use by HIV service providers

This website provides the HIV community easy access to a wide range of information and support. The effectiveness of the website is evidenced by the fact that a steady flow of inquiries are received, including requests for referral to HIV services.

HIV Related Community Events

The Planning Council participates in a wide variety of community events, including World AIDS Day, HIV Testing Day, AIDS Walk, the Aging Symposium and various community health fairs and forums. Planning Council is a sponsor for many of these events and staffs a table to distribute educational material. The Planning Council will continue to promote EIIHA at each of these events.

Radio Interviews and Press Releases

The ATCHHSD promotes public health via radio station KAZI. The Planning Council periodically participates in presentations via KAZI to provide information on HIV/AIDS including EIIHA related topics. Additionally, ATCHHSD periodically provides press releases

via the Public Information Officer to share public health information, including HIV related information as appropriate, with the local media.

WORK PLAN

1. Access to HIV/AIDS Care and the FY 2014 Implementation Plan

1) A. Continuum of Care for FY 2014

The Austin TGA system of care is characterized by quality services administered in a coordinated fashion. This structured system is built to effectively support the varying needs of eligible PLWH. A strategically developed care system comprised of sound core and support services continues to be the hallmark of HIV/AIDS service delivery in the Austin TGA. The system accommodates over 3,000 people living with HIV/AIDS. That number is coupled with a growing percentage of clients who are new to the care system, evidencing that measures to ensure access to care have been effective.

The integration of HIV prevention and care planning in the area has contributed to the percentage of individuals who take advantage of testing opportunities, and if the situation warrants, those individuals come into care. The Planning Council has served a pivotal role on the HIV/STD Prevention Coalition, with the staff health planner attending each planning meeting and conveying information to the Planning Council for them to act upon in their decision-making process. The Coalition is a multi-county group of professional and community stakeholders who work at the forefront of HIV/AIDS. The goal of the Coalition is to build a local framework for which prevention and care efforts can thrive for the benefit of PLWHs. Beyond a local scope, the Coalition and Planning Council work to carry out goals outlined in the National HIV/AIDS Strategy and to work proactively in meeting PLWH needs, particularly in an environment of changing policies and budget cuts. Due primarily to the Planning Council's partnerships such as this, the Austin TGA is poised to be at the forefront of care with regards to the Affordable Care Act (ACA). This includes education, enrollment, and engagement. To this end, the Planning Council recently issued guidance to the Administrative Agent on working strategically with funded providers to educate and inform clients on various tenets of ACA, with the ultimate goal being enrollment of clients into an acceptable health insurance exchange in order to access quality HIV services and maintain retention in care.

Another challenge that the FY 2014 Continuum of Care responds to is the high HIV prevalence rates in minority communities. The high rates create a profound and disproportionate effect on those living with HIV/AIDS in the minority community. More specific details about these challenges are discussed in the Demonstrated Need section. The FY 2014 Plan is designed to increase access to the HIV continuum of care for minority communities through the TGA's Minority AIDS Initiative (MAI) programs and through the activities outlined in the 2012-2015 Comprehensive Plan. Findings from the Comprehensive Needs Assessment and the specialized needs assessment study help inform the FY 2014 Plan regarding issues of access. The Planning Council has created strategies and goals contained in the Comprehensive Plan to directly address the needs of newly infected, underserved, hard-to-reach individuals, emerging populations, and disproportionately impacted communities of color. Through four overarching goals adopted from the National HIV/AIDS Strategy, various objectives and action items included in the Comprehensive Plan effectively address and meet the needs of PLWHs. On the local level, a return to care group and EIIHA initiative work to gather the needs and gaps in care for these populations. The information and data is then filtered through the HIV Planning Council's

decision-making process where results are seen in the priority setting and resource allocations processes, as well as the implementation plan discussed below.

1) B. FY 2014 Implementation Plan

The FY 2014 Implementation Plan Table is Attachment 9.

1) C. Plan Narrative

(1) How the TGA links its latest needs assessment including results of the TGA's Unmet Need Framework, service priorities, the FY 2014 Implementation Plan, and the 2012 Comprehensive Plan, including how the goals and objectives relate to the strategies identified in the Comprehensive Plan

The FY 2014 Plan is designed to support the continuum of care discussed above with Part A funding for the listed service categories (see Attachment 8, Planned Services Table). The FY 2014 Implementation Plan Table (Attachment 9) lists the core medical service categories: (1) Outpatient/Ambulatory Medical Care; (2) Oral Health Care; (3) AIDS Pharmaceutical Assistance–local; and (4) Mental Health Services. Two support services are addressed in the Plan: Case Management–Non-Medical and Substance Abuse Services–Residential. These support services facilitate access and continued engagement in medical care, thus ensuring maximum health outcomes.

Altogether, the highest funded core and support services listed in the FY 2014 Implementation Plan are consistent with goals outlined in the Austin TGA's current Comprehensive Plan, as well as with findings from 2010 Comprehensive Needs Assessment and 2012 specialized needs assessment study. For example, contained within the Comprehensive Plan are specific goals and objectives developed by the Planning Council to ensure the availability of quality core and support services to eliminate disparities in access for disproportionately affected sub-populations and historically underserved communities. FY 2014 funding decisions reflect a decrease in non-medical case management from the previous year, based in part on the service needs identified by a significant number of surveyed minority respondents in the 2010 Comprehensive Needs Assessment project.

(2) Identify any prioritized core medical services that will not be funded with FY 2014 Ryan White HIV/AIDS Program funds and how these services will be delivered in the TGA

Based on the Planning Council's priority setting and resource allocations process, the only service in the top 10 priorities that was not funded for FY 2014 was Housing. The Planning Council's rationale for not funding Housing with Part A is because of other funding sources available to support this service.

(3) How the activities described in the Plan will provide increased access to the HIV continuum of care for minority communities

The Austin TGA's high HIV prevalence rate in minority communities creates a profound and disproportionate affect on those living with HIV/AIDS. The FY 2014 Plan is designed to increase access to the HIV continuum of care for minority communities through the TGA's Minority AIDS Initiative (MAI) programs and through the activities outlined in the Comprehensive Plan. Findings from the Comprehensive Needs Assessment and additional

recommendations also inform the FY 2014 Plan. For example, psychosocial support was identified in the Needs Assessment as a support service for African Americans that would enable access and retention in care. In response, the Planning Council has ensured that the function of support is delivered through psychosocial support groups. Similarly, MAI funding resources and activities target two minority populations: Hispanic and African American. These two communities have a higher burden of poverty, are reluctant to enter the system of care, and prone to fall out of medical care if not provided with extensive support services and personal intervention. Immigrant Hispanic clients face immigration issues and language barriers in accessing services. Furthermore, African Americans in the TGA have a higher proportion of substance abuse issues in comparison to other racial/ethnic groups.

(4) How the activities described in the Plan will address the needs of emerging populations, as discussed in the Demonstrated Needs section

The needs of the following priority populations were examined in the Comprehensive Needs Assessment: African American men and women, Hispanic men and women, injection drug users, non-injection drug users, the out-of-care population, White men who have sex with men, (MSM), men of color MSM, persons recently released from jail/prison, rural residents, and youth. The FY 2014 Plan focuses on unmet need and service gaps experienced by the aforementioned emerging populations. Each population represents unique challenges that must be addressed in order to improve HIV health outcomes. For example, one initiative supported by the Planning Council is a strategic planning effort among community stakeholders, particularly those working in the HIV prevention arena. A primary purpose of the strategic planning initiative is to address health disparities in the minority community. The overarching goal in the Austin TGA is to develop and implement evidence-based strategies consistent with those outlined in the National HIV/AIDS Strategy.

(5) How the activities described in the Plan will encourage PLWH to remain engaged in HIV/AIDS primary medical care and adherent to HIV treatments

According to research conducted by the Planning Council and its staff, two services were identified as key to PLWH remaining engaged in primary medical care and adherent to HIV treatments: Medical Case Management, including Treatment Adherence Services and Non-Medical Case Management. Medical Case Management, along with treatment adherence, was designated as an “essential” service category which promotes the likelihood of PLWH remaining in primary medical care. The Planning Council continues to recognize that treatment adherence services are crucial for successful antiretroviral treatment. PLWH who adhere to treatment regimens are more likely to experience an improved CD4 cell count and viral load suppression, and less likely to develop drug-resistant virus. The Planning Council also determined that treatment adherence counseling could not be addressed satisfactorily through outpatient medical care services alone due to rising demand for services and stagnant or reduced funding. The increasing complexity of primary care for PLWH means that there is less time in primary care visits to address issues such as treatment adherence.

(6) How the activities described in the Plan will promote parity of HIV services throughout the TGA

Geographic parity is addressed by continuing to give priority for funding to providers located in heavily impacted by HIV. Households receiving public assistance and with high rates of poverty and unemployment are heavily concentrated in tracts east of Interstate-35 and south of the

Colorado River. The majority of residents in these neighborhoods are African American and Hispanic. All of the Ryan White Part A service providers in Travis County are located within these geographic areas. Moreover, parity in quality of services is also addressed by establishing quality of care guidelines and examining research on quality of care issues that impact special populations. The Planning Council received research reports on physician-to-patient ethnic concordance and quality of care, the impact of treatment adherence programs on quality of care, and the impact of cultural competency training on quality of care. The Planning Council used these reports in determining service and funding priorities to establish the 2012 Comprehensive Plan goals and objectives. Finally, the comprehensiveness of services is addressed in the continuum of care model, which links all services in a manner that brings people into primary care and maintains them in care. It categorizes services based upon how they serve the specific needs of clients, particularly those out of care.

(7) How planned activities assure that services delivered by subcontractors are culturally and linguistically appropriate to the populations served within the TGA

The Planning Council strives to meet the challenges posed by populations with special cultural or linguistic needs by establishing a system which effectively addresses and eradicates existing barriers to care. To this end, the Planning Council included the service of linguistics in its specialized needs assessment study. It sought to explore the correlation between culturally and linguistically appropriate care and to what degree clients accessed care deemed to meet these standards. Services were assessed and studied through client surveys and focus groups hosted by the Planning Council. The goal was to investigate out-of-care issues, document barriers to care, document special needs such as cultural proficiency issues, and work with the Administrative Agency's Quality Management Coordinator to study standards of care and other issues. The Planning Council's goal is to attain a high level of cultural proficiency reflective of the composition of the communities served. In order to achieve this level, there is ongoing review and revision of cultural competency, sensitivity, and proficiency standards that govern the provision of services funded by Ryan White Part A, including the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Moreover, the Administrative Agency has required compliance with the fourteen (14) CLAS Standards in its contracts with Part A service providers.

(8) How the services and their goals and objectives relate to goals of the National HIV/AIDS Strategy

The three (3) goals of the National HIV/AIDS Strategy (NHAS) serve as the foundation and premise for the system of care in the Austin TGA and the Plan overall. Efforts to prevent new HIV infections, increase access, and reduce health disparities are reflective of the most highly funded and prioritized services funded in the system. A strong coordination with prevention providers strengthens the opportunity for preventing new infections, while also enabling the Plan to focus primarily on the areas of disparities and access. The sub-populations identified in the EIIHA plan demonstrate the NHAS implications to recognize a vast populations' diversity and the fact that a one-size fits all strategy is inadequate to meet PLWH needs. The Plan takes into account that service and care needs must be met in a meaningful manner which enhances quality of life. Likewise, the health outcomes noted in the Plan indicate the intentionality of using NHAS goals to strengthen and improve the service delivery system.

(9) How the services and their goals and objectives relate to the goals of the healthy People 2020 initiative

The Planning Council has identified the following two overarching goals in its current Comprehensive Plan:

- GOAL 1: a) To engage out-of-care persons living with HIV/AIDS (PLWHA) and maintain in-care PLWHA in the system of care by providing full access to medical care and other eligible core service; and b) Administration of care shall focus on cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard to reach populations.
- GOAL 2: a) To optimize the continuum of care by ensuring all Ryan White funded services, particularly mental health therapy and substance abuse treatment, are of the highest quality; and b) coordinated with non-Ryan-White organizations for linkage to other funding sources.

These two overarching goals address the service needs, gaps, and barriers to care consistently identified in previous needs assessments, as well as in the most recent Comprehensive Needs Assessment. In order to reach each goal, a comprehensive list of objectives is included in the Comprehensive Plan. Each objective has long and/or short-term activities, action steps, strategies, or initiatives designed to maintain and improve the TGA’s system of HIV care. Finally, the FY 2014 Implementation Plan goals and objectives are responsive to the Healthy People 2020 Objectives for HIV Infection as shown in the table below.

Table A: Relationship between Healthy People 2020 HIV Objectives and FY 2012 Plan

| Healthy People 2020 Objectives for HIV Infection | Related Goals FY 2012 Implementation Plan |
|---|---|
| HIV-1-3: (Developmental) Reduce the number of new HIV diagnoses among adolescents and adults. | Goal 1.a. & 2.b. |
| HIV- 4, 6: Reduce the number of new AIDS cases among adolescent and adult MSM. | Goal 1.a. & 2.b. |
| HIV-7: Reduce the number of new AIDS cases among adolescent and adult MSM and IDU. | Goal 1.a., 1.b. & 2.b. |

(10) How the TGA will ensure that resource allocations for services to provide services for WICY are in proportion to the percentage of TGA AIDS cases represented by each priority population

HIV services providers contractually are required to submit units of service delivered to WICY populations by entering data in the AIDS Regional Information and Evaluation System (ARIES). This system captures various levels of service utilization and spending data on every client served including age, gender, date of service delivery, number of units delivered, and HIV service objectives. Data show the utilization of primary medical care and health-related support services for these four specific populations. To track the amount expended, the number of actual units delivered is multiplied by the unit cost for each service objective for each WICY population. The actual amount of Part A funds expended on each WICY priority population is monitored by the Administrative Agent and reported to the HIV Planning Council and to HRSA as required in the Part A and B Ryan White HIV/AIDS Program Guidelines for Implementing

the Minimum Expenditure Requirement to Provide Services to Women, Infants, Children and Youth.

(11) How the TGA Planning Council (PC) or community planning process is using MAI funding to reduce disparities in access to care, to further enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic, and how those activities are integral to the overall Part A FY 2014 Implementation Plan

MAI-funded activities are an integral part of the overall FY 2014 Implementation Plan. The Planning Council leverages MAI funds to support programs designed to improve client care quality and health outcomes for members of targeted minority racial and ethnic communities. African Americans and Hispanics are two of the populations most disproportionately impacted by HIV/AIDS in the Austin TGA. Quality of care can be linked to client satisfaction; therefore, to gauge the relative effectiveness of MAI-funded services, the Planning Council routinely assigns a standing subcommittee to study and address results from the current year's client satisfaction survey. In the past, the two service categories that were supported with MAI funds were outreach and non-medical case management. For the FY 2014 Plan, findings indicated an additional service would be funded with MAI funds: Medical Case Management including treatment adherence. Whenever appropriate, the Planning Council issues directives about how the services are provided in order to enhance the quality of services. Quality of care standards and service category performance measures are also used to determine whether intended client health outcomes are being achieved.

Finally, MAI funding will be used to reduce disparities by considering and using as a basis, specific strategies outlined in the National HIV/AIDS Strategy. As noted in the Strategy, *"there are differences in health care access and treatment outcomes by race/ethnicity . . . access to care and supportive services are particularly difficult for HIV-positive persons in rural areas."* Through the support of MAI funding, the Austin TGA plans to respond to the unique issues faced by African American and Hispanic PLWH/A, by *"taking deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV."* This step will be taken through strategic capacity building efforts for local gatekeepers and HIV-service providers not currently or historically funded through the Ryan White Part A Program. The goal is to reach HIV positive minorities who are out-of-care or unaware, by expanding the venues that currently exist.

(12) How the results of the Unmet Need analysis was utilized by the PC or community planning body and impacted in their allocation decisions

The Unmet Need Framework (Attachment 6) was used to project the number of FY 2014 Part A clients out-of-care and to produce a demographic breakdown of the out-of-care minority populations. Illustrating over 1,100 PLWH/A with unmet need, the Unmet Need Framework details the exposure groups of IDU and MSM/IDU representing a significant percentage (over 50%) of those with unmet need. This information further supports allocations efforts directed towards the emerging populations of MSM and IDU. As reflected in the Planning Council's final allocation decisions, Substance Abuse Outpatient Services, Residential and Mental Health Services was increased by almost 5% from last year's allocation.

(13) How the PC or community planning body considered/addressed the need for HIV medications by the target population during their Part A funding allocation process

As the Planning Council's allocation amount to local AIDS Pharmaceutical Assistance demonstrates, HIV medications are an essential component to the Austin TGA system of care. Of particular note is the critical role of HIV medication issues in the lives of target populations including minorities, the recently incarcerated, IDU, and youth MSM PLWH/A. For the estimated 18.1% who are not aware of their HIV status, antiretroviral drugs can serve as a lifeline to well-being and a sustained quality of life. The Planning Council also considered the service utilization data of corresponding populations currently in care. For example, data indicated Hispanic MSM in the youth category accessed HIV medication services at a lower rate than White MSM in the same age group. Based on this information, the Planning Council increased the funding for AIDS Pharmaceutical Assistance, with a projection that the outreach to underrepresented populations would increase utilization.

(14) Describe how the PC or community planning body considered/addressed the population groups identified in EIIHA during their Part A funding allocation process

The Planning Council's work was guided by a fundamental responsibility to leverage Ryan White Part A funds in providing quality medical care to all PLWH/As and increasing access to medical care for all affected in the TGA. However, the specific populations outlined in the EIIHA Matrix, African American Women, Incarcerated Population, MSM of youth age, and Intravenous Drug Users were the primary focus of the Planning Council's decision-making. The Allocations Committee reviewed current and historical unit cost data and information on other funding sources for the Part A service categories that the Needs Assessment identified as being most needed by the EIIHA population groups. Furthermore, utilization data sorted by the frequency of use for these populations was considered during the funding allocation process. Building upon the Needs Assessment Committee's work of assessing the need for each service category prioritized, the Allocations Committee proceeded with using various documented indicators including unit cost, units per client, and ability to contribute to the requirements outlined in Early Identification of Individuals with HIV/AIDS (EIIHA).

EVALUATION AND TECHNICAL SUPPORT CAPACITY

1. Clinical Quality Management

(1) A. Description of Clinical Quality Management (CQM) Program

(1) (a) CQM plan goals and infrastructure

The mission of the Austin TGA Clinical Quality Management (CQM) Program is to ensure that all people receiving Ryan White Part A funded services living with HIV/AIDS receive the highest quality of medical care and vital health-related support services available. The goals of the Austin TGA CQM program are: to provide a coordinated approach to addressing quality assessment and process improvement in the Austin TGA; to ensure HIV medical services are provided to patients consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections; to continuously improve clinical practice standards for vital health related supportive services; and to ensure that these supportive services enhance client linkages to HIV medical care and positive health outcomes. In order to achieve sustainable improvements, the Quality Improvement Model used throughout the Austin TGA is the Model for Improvement known as the PDSA Cycle (Plan, Do, Study, Act).

The Austin TGA CQM program is led by the Quality Management Coordinator who serves under the direction of the Program Manager of the City of Austin HIV Resources Administration Unit (HRAU). HRAU's Program Manager is the key grantee leader responsible for the overall administration of the Ryan White Part A grant program for the Austin TGA. The Program Manager oversees and monitors all expenditures of allocated resources for the CQM program, along with those of the entire grant. HRAU's Data Manager collaborates regularly with the CQM Coordinator to ensure data integrity, analyze data, and develop reports on client demographics and service utilization trends. Grants Coordinators/contract managers collaborate with the QM Coordinator to ensure that performance measures are achieved and the contractors reach their quality management goals.

Five percent (5%) of the Ryan White Part A grant award supports the CQM program, including salaries or portions of salaries for the CQM Coordinator, Data Manager, Program Manager, Grants Coordinators (see Attachment 1) as well as related program support expenses. For FY 2013, 1.69 FTEs are funded by Austin's Part A grant. Currently, no entities are under contract for CQM activities, including reporting, data collection and/or training. In order to meet the mission and goals of the CQM program, the grantee has provided trainings and resources in the following areas to quality committee members and sub-grantee staff as appropriate: HIV case management, screening for mental health and substance abuse issues, culturally and linguistically appropriate services (CLAS) and QM plan development.

(1) (b) CQM program processes and activities

The Clinical Quality Management program for the Austin TGA monitors certain key performance measures in assessing effectiveness. The indicators and current results for primary

medical care and medical case management services are listed below. Each indicator is measured against a benchmark or target developed by the Administrative Agency with input from services providers, the Clinical Quality Improvement Committee and the Planning Council.

Table A: Outpatient/Ambulatory Medical Care

| Outpatient/Ambulatory Medical Care Indicators | Results – Part A Clinic (DPCHC) |
|---|---|
| 1. 90% of clients with CDC-Defined AIDS will be prescribed an antiretroviral therapy (ART) regimen during the measurement year. Excluded patients newly enrolled in care during last three months of the measurement year. | 97% of clients with CDC-Defined AIDS were prescribed an antiretroviral therapy (ART) regimen during measurement year. |
| 2. 95% of clients with an HIV infection and a CD4 T-Cell count < 200 cells/mm ³ will be prescribed PCP prophylaxis during the fiscal year. Excluded are patients with CD4 T-Cell count < 200 cells/mm ³ repeated within three months rose above 200 cells/mm ³ and patients newly enrolled in care during last three months of the measurement year. | 93% of clients with an HIV infection and a CD4 T-Cell count <200 cells/mm ³ were prescribed PCP prophylaxis during the fiscal year. |
| 3. 90% of clients with an HIV infection will have 2 or more CD4 T-Cell counts performed during the fiscal year. Excluded are patients newly enrolled in care during last six months of the measurement year. | 84% of clients with an HIV infection had 2 or more CD4 T-Cell counts performed during the fiscal year. |
| 4. 80% of clients with an HIV-infection will have two or more medical visits during the measurement year. Excluded are patients newly enrolled in care during the last six months of the measurement year. | 83% of clients with an HIV-infection will had two or more medical visits during the measurement year. |
| 5. 100% of pregnant women with an HIV infection will be prescribed antiretroviral therapy during the measurement year. Excluded are patients whose pregnancy is terminated, and pregnant patients who are in the 1st trimester and newly enrolled in care during the last three months of the measurement year. | 100% of pregnant women with an HIV infection were prescribed antiretroviral therapy during the measurement year. |

Source: ARIES

| Medical Case Management Indicator | Results - Aggregate |
|---|---|
| 75% of clients receiving medical case management services will keep at least two subsequent medical provider visits over the course of the measurement year. Excluded are patients newly enrolled in care during the last three months of the measurement year. | 74% of medical case management clients (those who were not newly enrolled during the last 3 months of the measurement year) received at least two medical provider visits over the course of the measurement year. |

Source: ARIES

CQM data collected to date and summary of results

The CQM Program has been successful in improving the quality of services to HIV positive clients in the Austin TGA by bringing all Ryan White providers together to collaborate on improving services to clients and developing quality tools to provide uniformity and consistency. The activities listed below have resulted in improvements or changes in service delivery. The

CQI Committee has ad hoc Workgroups to address targeted quality issues as needed to facilitate completion of the PDSA cycle. Some recent projects are described below:

- The Case Management Workgroup has continued efforts to transition to the Medical Case Management Model across the TGA. Currently the Model is being piloted with an RN medical case manager. The process of revising the Case Management Standards of Care is underway and, as noted above, the case management acuity scale that will be utilized consistently throughout the Case Management Model was reviewed and restructured to close the gaps identified in order to better meet client needs. Efforts are being made to ensure more consistent intake processes, and the CQI Committee is now focusing on standardizing the referral and documentation of referral process across funded providers.
- Through a collaborative effort between the providers, HIV Planning Council, and QM Coordinator, the client satisfaction survey tool was updated. The goal of this process was to revise or delete tool elements that yielded vague or no responses in order to enhance the quality of the data received. Surveys were administered during August and September of 2013. In addition, demographic information was collected, including but not limited to race/ethnicity, age, ZIP code, gender, and sexual orientation. To date 980 clients have completed the surveys for this year, a significant increase in response rate over 2012. Final 2013 results were not available in time for this application, but the 2012 survey results summary is provided in the table below.

Table B: FY 2012 Client Satisfaction Survey Aggregate Results

| Rating of All Ryan White Services | # of Respondents | Percentage |
|------------------------------------|------------------|-------------|
| 1 - Very Satisfied | 440 | 70% |
| 2 - Satisfied | 154 | 24% |
| 3 - Not Satisfied nor Dissatisfied | 26 | 4% |
| 4 - Dissatisfied | 6 | 1% |
| 5 - Very Dissatisfied | 4 | 1% |
| 6 - No Response | 1 | 0% |
| TOTAL | 631 | 100% |

Source: Austin TGA Client Satisfaction Survey Database - Fall/Winter 2012

- The Return to/Retention in Care (RTC) Workgroup was formed in September 2009 to focus on the return of clients to care who were previously in care or who were at risk of falling out of care. The RTC Workgroup reported that the increased communication with DPCHC regarding clients' linkage to medical care has improved case management planning. Needs identified include, but are not limited to, a consistent process across TGA providers for referrals to case management and the need for a centralized system for case management agencies to share capacity. The RTC Workgroup has identified that clients who are linked and followed by other agencies are more likely to remain in care and keep their scheduled medical appointments; therefore, DPCHC is allowing providers to post their information at DPCHC to further encourage the linkage to other services. Other changes to processes include case managers following up on initial no-shows to decrease the number of clients who fall out of care. DPCHC has added provider intake appointments in order to increase access.

The CQM program is assessed annually by grantee staff and periodically by an outside consultant. The Austin TGA Part A grantee has established a robust internal process for not only the development of the CQM Program but also ongoing evaluation and assessment. An informal staff group including the Quality Coordinator, Data Manager, and Grants Coordinators, also reviews quality issues periodically. These individuals have direct involvement with the sub-grantees and the day-to-day processes for grant activities. This staff group receives updates during regularly scheduled unit meetings, and opportunities for improvement related to various grant activities are discussed at that time. In addition, the group meets on an ad hoc basis to discuss development, implementation, and evaluation of process changes. It also provides feedback that flows into the annual evaluation of the Administrative Agency's CQM Program and to the HIV Resources Administration Unit Program Manager, who assesses the program via a review of annual goals and objectives. Feedback is subsequently provided to the CQM Coordinator and adjustments are incorporated into the program/CQM Plan for the upcoming year.

The CQM Coordinator is responsible for facilitating activities related to the design, implementation, monitoring, and evaluation of the CQM Program. The model for improvement noted above is utilized as a structure, from design to evaluation and ongoing monitoring. Depending on the type of Quality Improvement activity, internal and/or external, the design of process changes begins with the input of appropriate individuals involved in the subject day-to-day tasks. QI workgroups are formed to focus their efforts on specific opportunities for improvement. Specific activities that have been implemented have been related to client eligibility, focusing on the appropriate documentation needed to meet monitoring standards, and how to obtain it by taking into account the numerous barriers faced by providers. Also, during the development of Case Management Standards of Care and procedures, testing was carried out on Case Management Acuity Tools available, which resulted in significant gaps in necessary elements being identified. Ongoing work to address those gaps is currently underway.

Determining priorities is primarily the responsibility of the CQM Coordinator; however, input and feedback from the internal CQM Advisor Committee as well as the Continuous Quality Improvement (CQI) Committee, and data generated by the Data Manager are all utilized in this process. The CQI Committee has been meeting on a regular basis since April 2012, and consists primarily of sub-grantee providers who are responsible for reporting their CQI related activities to the grantee in addition to providing feedback on opportunities for improvement and other activities related to the CQM Program. Consumers are involved in the CQM program through their input on client satisfaction surveys and participation in focus groups. Unfortunately, the one consumer member who previously was active is no longer able to serve on the CQI Committee; therefore, active recruitment of consumers is underway. Additionally, the CQI Committee provides input into the development of quality improvement tools, (e.g., client satisfaction surveys, client grievance policies, case management acuity scales, client eligibility by service category, and standards of care). CQI members also assist with implementation of activities as appropriate to achieve success with goals and objectives of the CQM Plan. Members assist with refining the standards of care and recommending additional performance measures and training needs, in addition to openly discussing quality data generated and recommending system-level quality improvement activities. One example is need for the

development of specific provider-level reports that assist providers in ensuring data integrity in the AIDS Regional Information and Evaluation System (ARIES).

The process of analyzing data and developing reports on client demographics and service utilization trends is primarily done by the Data Manager in collaboration with the CQM Coordinator. QM staff also develop health outcome indicators and methods for collecting and analyzing health outcome data, conduct program monitoring, and analyze client satisfaction and chart review data for use in developing service improvement plans. The CQM staff review all RFPs and contracts to ensure CQM requirements are addressed including contractor grievance policies and procedures, standards of care, CQM plans, cultural competency, client satisfaction, and adherence to data collection requirements. As another layer of retrospective and real-time information, the CQM Coordinator conducts periodic client chart audits to ensure adherence to established PHS treatment guidelines, analyzes clinical and service utilization data, ensures target outcomes are achieved, develops quality improvement plans with health service providers, and monitors progress in implementing improvement strategies. The process for providing feedback and implementing changes is continuous among the CQM Program staff and the Ryan White Part A funded providers. The CQM staff also offer technical assistance to providers in the following areas: collecting and reporting of client-level data, standards of care implementation, CQM plan development, use of CQI tools, and data interpretation. The CQM Coordinator conducts a CQI Committee review of the CQM Program annually. As needed, program changes are implemented through performance improvement plans and contract amendments.

All Ryan White providers are required to have a CQM Plan and to evaluate their program's performance in meeting their CQM goals and standards of care by analyzing results from both Quality Improvement and Quality Assurance functions, output and outcome data, client satisfaction surveys, and client chart reviews. One specific example is the David Powell Community Health Center (DPCHC) that provides ambulatory outpatient medical care and is part of the Federally Qualified Health Center (FQHC) network. DPCHC is required to perform regular chart audits and quality control reviews as set forth in the FQHC Quality Management/Risk Management Plan. This Plan addresses quality management and improvements across all services provided within the FQHC network including medical care, behavioral health, medical case management, pharmacy, and safety and risk management.

Several quality improvement projects are currently underway within the TGA. For example, when examining outcomes data for all providers, it was identified that, even though they were meeting and/or exceeding most of their performance measures, there was an opportunity to improve all measures by assisting clients to become more engaged in their care. This led to joining the In+Care Collaborative and having a Workgroup meeting quarterly on Returning and/or Retaining Clients in Care. Both of these activities have allowed the HIV provider community in the TGA to openly share visit no-show rates, engage in assistance with linkage to care for intake appointments, and obtain necessary eligibility documents. The Workgroup tracks and trends data over time by looking at visits scheduled vs. kept, surveys on why clients have missed appointments, and interventions have been put in place to impact several barriers that were identified, i.e., reminder calls by case managers prior to the next scheduled visit assessing the need for transportation assistance, other service providers assisting with completion of intake paperwork, and accompanying to the first clinic visit if desired. Additionally, it was identified

that the data collected to identify clients receiving medical care were incomplete in that providers were only collecting and reporting data on the one Ryan White funded outpatient medical clinic within the TGA. Because some TGA clients receive their medical care at other clinics, the data were showing a false negative. The Data Manager has developed a way for all TGA Providers to record medical visits at other clinics into ARIES, in order to improve the data integrity within ARIES and also provide a more accurate representation of TGA clients actually linked to and receiving medical care. Plans also are underway for this to be done to capture dental care performed by non-Ryan White providers.

1) B. Data for Program Reporting

The Austin TGA uses the AIDS Regional Information and Evaluation System (ARIES) for HIV/AIDS client level data collection and reporting. ARIES is a web-based, Ryan White Reporting Services (RSR)-ready data system. The Austin TGA has been using this system since 2006.

For CY 2011 and 2012, the Data Manager performed ARIES desktop monitorings during and towards the end of each calendar year to ensure that providers were collecting all required data elements. The X-ERT Client Level Data Analysis Tool developed by HRSA's Data and Reporting Team (DART) was used in this process. Agencies received detailed reports regarding missing and unknown data.

Prior to the RSR submission period, the Data Manager disseminated an informational RSR newsletter. Since most agency data management staff were experienced with the RSR, they were offered RSR training on an ad-hoc basis. In addition, the Data Manager provided the agencies information on HRSA RSR webcasts. Submitted RSR's are carefully reviewed prior to grantee approval.

No agencies had more than 10% missing data elements for the CY 2012 RSR.

The X-ERT Client Level Data Analysis Tool has proven to be very helpful in monitoring RSR data quality. Therefore, its use was continued for the CY 2013 reporting period. The Data Manager has and will continue to provide the agencies information on HRSA's data quality expectations.

CQM and client level data are used to improve service delivery and planning. The Data Manager and the Health Quality/Risk Management Coordinator review and analyze data on at least a quarterly basis. The Data Manager runs several different types of validation reports that are sent to the specific provider to act on and/or report any discrepancies. Data reports are presented for review to the Internal CQI Advisory Committee periodically and shared with Project Officers during Monthly calls as requested. MAI Outcomes data is used to support allocations decisions and management of the program. The Planning Council regularly receives a wide variety of reports including service utilization data from ARIES, results from the Retention in Care Collaborative, and epidemiological data from the State of Texas and CDC. Results from the Client Satisfaction Survey also are reviewed along with the Needs Assessment

update, and findings from fiscal and program monitoring reports. Assessment and evaluation of the data are performed to determine if the data warrants any action on the part of the Committee/Council.

ORGANIZATIONAL INFORMATION

1. Grantee Administration

1) A. Program Organization

(1) Administration of Part A Funds in the TGA

The Chief Elected Official (CEO) of the five-county Austin TGA is the Mayor of the City of Austin, Texas. CEO responsibility for the Ryan White Program Part A and Minority AIDS Initiative (MAI) funds is designated to the Mayor in accordance with an Interlocal Cooperation Agreement between the City of Austin and Travis County. In the Agreement, the CEO assigns Administrative Agent responsibilities for the Ryan White Program Part A to the Austin/Travis Health and Human Services Department (A/TCHHSD) which has appointed its HIV Resources Administration Unit (HRAU) as the entity responsible for performing Ryan White Program Part A and MAI administrative functions.

The Administrative Agency's relationship to the CEO is shown on the Organizational Chart (Attachment 10), and the Staffing Plan, Job Descriptions, and Biographical Sketches Table which describes all positions funded by Ryan White Part A (Attachment 1). Staff shown under Administrative Services in shaded boxes provide some assistance but are not funded by the grant. Funding streams administered by the HRAU include: Ryan White Part A and MAI, Ryan White Part C, Housing Opportunities for Persons with AIDS (HOPWA), and City of Austin HIV Services. HIV Planning Council staff is responsible for supporting the Council in fulfilling its legislatively mandated roles and responsibilities including needs assessment, priority setting, planning, and resource allocation.

(2) Process and Mechanisms to Avoid Duplication

The Administrative Agency is able to track Ryan White Part A and MAI service utilization and expenditures separately across all service categories and service objectives using the client-level database, AIDS Regional Information and Evaluation System (ARIES). Ryan White Part B and Part C expenditure data also are entered and tracked in ARIES. The Austin TGA does not receive Part D or Part F funding. ARIES enables the Administrative Agency to capture demographic, service utilization, and expenditure data for each unduplicated client including date of service delivery, number of service units delivered, funding source, and total amount of funds expended. One unit of service for each HRSA service category is defined by the *Texas Department of State Health Services Glossary of HIV Services*. When a service provider enters a unit of service in ARIES, it can be assigned to only one funding source. Unit of service entries in ARIES are validated with each monthly HIV Monthly Performance and Budget Status Report, and also during annual site visit monitoring.

1) B. (1) Grantee Accountability

(a) Update on implementation of National Monitoring Standards

The Universal Standards, Part A Program Monitoring Standards, and Part A Fiscal Monitoring Standards were distributed to all current Part A-funded service providers in the spring of 2011, in an RFP that was released in November 2011, and again following the Standards revision in April

2012. Prior to and during FY 2013, Administrative Agency staff have participated in all HRSA-sponsored Technical Assistance Webinars on National Monitoring Standards for Part A Ryan White Grantees. Following Department reorganization, the ATCHHSD created a new Contract Compliance Unit located in the Administrative Services Division. An HIV contract monitoring position, primarily funded by Part A, was included in the Contract Compliance Unit to lead on-site HIV comprehensive contract monitoring activities. In FY 2013, the Community-based Resources Unit Manager convened a special project workgroup to update the Contract Management and Compliance Manual for the Department. The HIV contract monitor's active participation in this workgroup ensured that Ryan White Part A National Monitoring Standards were being addressed in relevant policies and procedures. In FY 2013, quarterly technical assistance training sessions on the National Monitoring Standards have been held with all Austin TGA Part A subrecipients.

Medical Case Management and Non-Medical Case Management Program Monitoring Standards, including Performance Measures/Methods, and Provider/Subgrantee Responsibilities, were used in the development of Austin TGA's Case Management Coordination Model. Both Fiscal and Program Monitoring Standards were incorporated in an RFP that was released in November 2011, and throughout new Ryan White Part A contracts that were developed and executed for FY 2012, and amended for FY 2013. The Part A Program Monitoring Standards for all services currently are being used in updating and revising Standards of Care for all Austin TGA service categories.

(b) Process Used to Separately Track Formula, Supplemental, MAI, and Carry-Over Funds

The City of Austin Health and Human Services Department (City HHSD) accounting staff separately tracks formula and supplemental funds for Part A and MAI using the City's accounting system, Austin Integrated Management System (AIMS). The City Controller's Office is responsible for assigning a unique major program and program identifier number for each grant at the time of the grant budget set-up. All expenses for a particular program are posted at the program level. The budget profile includes: Fund Number, Department, Major Program, Program Number, and Program Period. Additionally, a distinctive task order number is created and set up to track grant personnel expenses for Administration, including HIV Planning Council, and for Clinical Quality Management. This allows for the tracking of formula and supplemental salary charges for each budget category. Salary expenditures are reported on a monthly accounting report. Each month, the City of Austin performs a month-end close of all expenses posted to AIMS. Departments are provided a detailed reporting of expenses posted by transaction at the program level. The monthly reports are reviewed by grant management and accounting staff prior to completion of the grant billing.

When the City's Purchasing Officer executes contracts, contracted funds are individually encumbered and linked to the formula or supplemental fund number using the City's accounting profile. In addition, after contract execution, a document order is generated in lieu of a voucher, with a specific number that directly links the contract to the funding source. When a subcontractor's payment request is received, a unique number is assigned to the invoice in order to clearly link the payment request to the proper funding source.

(c) Timely monitoring and redistribution of unexpended funds

Administrative Agency contract management staff meet at least monthly to review expenditures-to-date and determine whether unexpended funds need to be reallocated. Detailed expenditure information is presented on a monthly basis to the HIV Planning Council's Allocations Committee. Effective in FY 2013, a new Monthly Expenditure Variance Report by HIV Service Category was added to the required back-up documentation submitted with monthly invoices. In this Report, percentages of service category outputs and expenditures are compared to the contract term lapsed percentage. An explanation is provided for variances that are either 10% more or 10% less than expected levels. During the first three quarters of the grant period, the Allocations Committee makes written reallocation recommendations to bring to the full Planning Council for a vote. Once a reallocation motion is approved, the Administrative Agency amends contracts as indicated. In accordance with Planning Council's Rapid Reallocation Policy, the Administrative Agency has authority to reallocate funds during the fourth quarter of the grant period to services that have demonstrated need for additional funding and ability to expend funds before the end of the contract term. These procedures facilitate the timely amendment and redistribution of funds.

(d-f) Fiscal and Program Monitoring Processes

Administrative Agency contract managers conduct desk reviews and provide technical assistance to ensure compliance with program objectives including target populations, services provided, number of clients served, outcomes measured, and client-level data completeness and accuracy. Contractors submit monthly payment requests to their assigned Administrative Agency contract manager who reviews required supporting documentation: the HIV Services Monthly Performance and Budget Status Report; the ARIES Data Report showing units of service delivered and numbers of unduplicated clients served by service category; a Monthly Expenditure Variance by HIV Service Category Report if indicated; and computer-generated expenditure detail from the agency's accounting system. In FY 2013, Part A contractors continued submitting payment requests with back-up in the Community Impact Online Data Manager (CIODM) system which has resulted in improved efficiency and accountability. Following approval, invoices are submitted to the Department's Accounting Unit for processing as described below. Administrative Agency staff also review each contractor's annual independent financial audit to obtain an overview of the agency's financial position, and the annual Administrative and Fiscal Review (AFR) Report required for all Department contractors.

In addition to desk monitoring, site visits take place at least annually so that Administrative Agency contract managers can assess program compliance, data management and other systems. During site visits, contract managers review client files, meet with staff, check methods for collecting and reporting service outcomes, and follow-up on any compliance issues. Additionally, program operations are assessed by review of program policies and procedures, standards of care, the quality management plan, and annual client satisfaction survey results. Program monitoring is conducted on an ongoing basis through Clinical Quality Management activities. Of particular interest during clinically-focused site visits is the demonstration of how services complement primary medical care by facilitating access, encouraging treatment adherence, and/or improving health outcomes.

The Contract Compliance Unit (CCU), located in the Administrative Services Division of the Department, conducts comprehensive in-depth site monitoring. Thirty calendar days prior to the on-site visit, the lead CCU monitor sends an official notice to the Executive Director or other designated recipient. CCU requests specific documentation from the agency to be sent to CCU prior to the site visit for review and additional preparation. Typically, the agency is allowed 10 business days to submit the requested information. CCU staff schedule and hold an entrance conference where they discuss the purpose and scope of the visit, process and timeframes. Monitoring is conducted using special monitoring tools developed to coincide with the Part A National Monitoring Standards including Universal, Fiscal and Program components. The draft monitoring report is completed and submitted to the CCU Manager for review and approval no longer than 15 business days after completing the on-site visit. The Monitoring Report identifies findings and concerns, if any, discovered during the monitoring process. After meeting with Administrative Agency staff and updating the draft monitoring report as needed, the CCU monitoring team leader contacts the agency to schedule the formal exit conference. The purpose of the exit conference is discussion of monitoring results and next steps in the process. Content of the approved draft monitoring report is shared verbally with the agency staff during the exit conference. Additional information pertinent to the monitoring report findings can be presented within five (5) business days of the exit conference. The Monitoring Reports is finalized following the five days allotted to the contractor to provide additional information. The contractor has ten (10) business days to respond to the report.

The multi-faceted monitoring activities described above help ensure that systems are in place to deliver high quality services in compliance with Part A National Monitoring Standards as well as contract terms and conditions. When a fiscal or programmatic-related concern is identified, a Corrective Action Plan has a three-month maximum timeframe for completion; however, correction deadlines may be shorter when indicated. The purpose of the Corrective action Plan is to ensure that appropriate follow-up is being conducted to correct Contractor non-compliance. Required minimum items in a Corrective Action Plan include:

- A clear statement of the specific deficiency(ies) to be corrected;
- A summary of the method used to discover the deficiency(ies);
- A summary of the findings;
- Required actions; and
- Timeframe for follow up review to determine whether the Corrective Action Plan is being followed and is effective.

Administrative Agency staff offer technical assistance as needed to assure that contractors are in compliance with HRSA and contract requirements. A contractor's failure to implement corrective action can result in contract suspension or termination as specified in the contract.

(g) The total number of contractors funded in FY 2013, the number and percentage of contractors that have received a fiscal and/or programmatic monitoring site visit to date, and the total number planned for the FY 2014 grant year;

Eight contractors were funded in FY 2013. To date, comprehensive on-site monitoring visits, using a new monitoring tool developed to coincide with the Part A National Monitoring Standards, have been conducted at two (2) contractors (50%) with an additional 2 (50%) planned for the remainder of the fiscal year. The Austin TGA was granted an annual on-site requirement exemption for FY 2013; therefore, the total number of agencies requiring on-site monitoring is

four (4) instead of eight (8). The minimum total number of comprehensive monitoring site visits currently planned for the FY 2014 grant year is eight (8).

(h) Any improper charges or other findings in FY 2013 to date and a summary of the corrective actions planned or taken to address these findings

The following findings are still preliminary and are being vetted through the monitoring process. Comprehensive on-site monitoring conducted by the CCU has resulted in the following improper charges or other findings in FY 2013, followed by the corrective actions planned or taken:

1. Documentation of “In Care” status was not found in client records.
Corrective Action Plan pending
2. Oral Healthcare records did not contain consistent documentation of oral health education or updated medical histories.
Corrective Action Plan pending
3. Dates were found missing from Intake/Update forms.
Corrective Action Plan pending

(i) Number of Subcontractors Receiving Technical Assistance (TA) FY 2013 and Types of TA

The types and time frames of technical assistance provided by the Administrative Agency in FY 2013, and the number of contractors receiving assistance are as follows:

Culturally and Linguistically Appropriate Standards (CLAS), seven three-hour sessions (7); Entering Acuity Scale Data in ARIES, one one-hour session (8); Medical Case Management Standards of Care, four two-hour sessions (5); Service Plan Documentation, one two-hour session (1); Developing a Quality Management Plan, one two-hour session (8); Eligibility Documentation, one one-hour session (8); How to Interpret Confirmatory HIV Tests, one one-hour session (8); ARIES Data Entry Policies and Procedures, one two-hour session (1); Corrective Action Plan follow-up, two one-hour sessions (2).

(j-k) OMB Circular A-133 Audit Requirement

Subcontractors are required to arrange for an annual financial and compliance audit of funds received and performance rendered under their contract with the City of Austin in accordance with OMB Circular A-133. The annual independent audit must be submitted to the Administrative Agency within 120 days after the end of the subcontractor’s fiscal year. In FY 2012 and FY 2013 to date, all subcontractors (100%) have demonstrated compliance with the audit requirement in OMB Circular A-133, and there were no findings. However, when there are findings, the Administrative Agency requires subcontractors to forward a copy of their corrective action plan and tracks plan progress during the following year.

(l) Process of receiving invoices and making payments

This process is described below under (2) Fiscal Staff Accountability.

1) B. (2) Fiscal Staff Accountability

Fiscal accountability for the Ryan White Part A grant is supported by the City Health and Human Services Department’s Administrative Services Division. Key staff are shown in the shaded boxes linked to the Administrative Agency box on the Austin TGA Organizational Chart

(Attachment 10). These positions are not funded by the Ryan White Part A grant, but they perform critical roles in ensuring fiscal oversight and control.

At the Administrative Agency level, a Financial Specialist serves as Grants and Contracts Financial Coordinator. This position prepares and monitors staff salary allocations, and ensures staff charge time to correct task orders by reviewing timesheet reports and tracking task order balances on eCombs/DXR accounting systems expenditure reports. In addition, the position reviews grant expenditures weekly on Austin Integrated Management System (AIMS), and reviews DXR reports monthly and quarterly until closeout. Contract expenditures are monitored by reviewing Document Orders (DOs) on a monthly basis. Following receipt of the Notice of Grant Award, this position prepares a request for fund amendment in order to direct budget allocations. The process used to separately track formula, supplemental, unobligated balances, and carry-over funds is described above on page 57.

In the Administrative Services Division's Budget Unit, the Financial Consultant sets up the approved grant award on AIMS, including funding codes and personnel task orders, in close collaboration with the Financial Coordinator. This position also reviews and approves grant budget amendments. The Accounting Unit's Accounting Associate reviews and prepares payment transaction documents for contractors' grant-eligible, approved invoices. The Accounting Manager's responsibilities include:

- Review grant contract for financial reporting purposes;
- Review monthly grant billing documents (financial reports from AIMS, Journal Vouchers, Accounts Receivables, spreadsheets, etc.) completed by accountant;
- Review and approve online AIMS Journal Vouchers and Accounts Receivable Transactions;
- Review and verify reconciliation of grant fund;
- Review and approve grant financial reports (Vouchers, Financial Status Reports) per contract requirements;
- Review/approve online AIMS payment transactions of grant-eligible invoices/travel claims/mileage reports received from program;
- Review/perform accounting approval online (WORKS) of grant-eligible credit card purchases approved by HRAU; and
- Maintain grant financial records for auditing purposes (Grant and Annual Single Audit).

The Accounting Manger also submits the annual Part A Federal Financial Report (FFR).

1) C. Third Party Reimbursement

All clients seeking services eligible for third party reimbursement are screened for coverage by third party payers, including Medicaid, Medicare, Veterans benefits, private insurance, or other programs such as the Medical Assistance Program (MAP), a locally funded health care benefit program. In addition, although currently Texas is not expanding Medicaid coverage, HIV services eligibility staff are being trained and incorporating screening for new private insurance options available within the health insurance marketplace established by the Affordable Care Act (ACA). For additional information on ACA implementation related to third party reimbursement, see Planning and Resource Allocation page 28.

Staff verifies Medicaid or Medicare coverage online through the Centers for Medicare and Medicaid Services (CMS) website or by using the Medicader software. Documentation of eligibility screening and coverage is maintained in individual client charts and/or electronic health records. Case managers assist clients in applying for SSI or SSDI, since they will be eligible for Medicaid if approved. When no coverage is available, the client is placed on a sliding fee scale based on current Federal Poverty Guidelines. An initial intake form is filed in the client's chart, along with a financial eligibility worksheet. During initial intake, clients are informed that they need to update their financial and medical insurance coverage information as needed at each follow-up visit or, at minimum, once every six months. Staff reviews the client's eligibility status, and the updated information is recorded on the financial worksheet. This screening process, which occurs at least every six months, ensures financial and proof of insurance status eligibility. Discussion is underway about aligning eligibility screening periods with health insurance exchange open enrollment periods.

Through its contract language, the Administrative Agency requires that all accounting information and records are available for review. Moreover, contract language states:

“Contractor agrees not to use funds provided under this Contract to pay for services covered by third party funding sources including, but not limited to, Medicaid, State Children's Health Insurance Programs, Medicare including the Part D prescription drug benefit, and private insurance.”

When contracts are amended in March 2013, language related to the health insurance exchange will be added to the above paragraph.

Program income is collected by HIV services providers in the form of co-pays, co-insurance, clinic use fees, and reimbursement from third-party payers and is deposited into designated accounts and tracked using the providers' accounting system. Program income is reported to the Administrative Agency on a monthly basis, and then reinvested in the Part A-funded HIV services program so that all program income is expended before grant funds are utilized.

1) D. Administrative Assessment

(1) (a) Planning Council assessment of the administrative mechanism

The Planning Council assessed the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the Austin TGA. The process was carried out by distributing electronic surveys to funded providers and soliciting feedback in various areas integral to the administrative mechanism process. An identical survey administered in previous years was used in order to identify response trends. Eight (8) survey links were sent via e-mail to all service providers. Eight (8) surveys were anonymously returned, equating to a 100% return rate of surveys distributed.

Surveys contained a total of twenty-seven (27) questions which could be categorized as relating to: 1) RFPs, 2) Reimbursements, 3) Technical Assistance, and 4) Contract Management. The questions measured a provider's level of satisfaction or perception to various scenarios

represented in the administrative mechanism cycle. A separate group of questions concluding the survey allowed providers to share open comments and feedback.

Relevant questions indicating a response rate of more than 50% in an area (e.g., Satisfied versus Not Satisfied, Yes versus No, and Quantity of Days), were identified as potential issues and further explored. The responses were then categorized as being either “positive,” “negative,” or “neutral” to the administrative process. For those areas cited as negative, the information was shared with the Administrative Agent (AA) for an explanation of how the issue was being or would be addressed.

Technical Assistance – 87.5% of survey respondents indicated technical assistance was required from the Administrative Agent; however, 62.5% of the same respondents indicated that they did not receive the required/requested technical assistance. Additional comments from providers further support the notion that technical assistance was a much needed and requested tool that was not made available.

(1) (b) Administrative Agency response

In the area of technical assistance, the Administrative Agency provides the following training summary as evidence to challenge comments from a few service providers that technical assistance was not provided.

Cultural and Linguistically Appropriate Services Training

Contractor staff was provided a tailored agency specific training for the 14 CLAS standards and Health Literacy by the National Center for Farmworker Health, Inc. Additionally, another consultant provided technical assistance training on the CLAS Standards and Ethics in two different sessions for which participants will receive 3 CE Credits.

Implementation of National Monitoring Standards Training

Consultant Dr. Julia Hidalgo came for two weeks in February and provided Technical Assistance for provider staff on Eligibility, Program Income, Client charges/Sliding Fee Scales, Caps on Client charges, and preparation for the ACA. Additionally, the Administrative Agency staff provided technical assistance training to providers on implementation of the National Monitoring Standards via quarterly provider meetings. HRAU staff shared best practices from other TGAs and HRSA webcasts.

HIV Positivity Documentation Training

Nurse Practitioner, Tom Hull provided technical assistance training for providers on how to best obtain proof of HIV Positivity documentation and laboratory reports and how to correctly read the lab reports.

HIV Quality Performance Measurement Training

Sherry Martin, HIVQUAL Consultant, conducted a QM site visit to assist us with identifying any gaps in our QM processes. Agencies were encouraged to consider seeking her services as a quality management expert since her assistance is free through HRSA.

Medical Case Management Certification Training

Medical case management training was provided to TGA case managers by a consultant, Diverse Management Solutions. Case managers were provided with a strong knowledge base and a clinical skill set to succeed with the diverse set of client needs inherent in their work. A combination of online and in person workshops was provided to case managers in both urban and rural settings.

SAMISS Assessment Training

The Texas Department of State Health Services provided training on the SAMISS Assessment to case management providers during the grant year.

ARIES Technical Assistance Training

The Administrative Agency's Data Manager provided technical assistance on the use of the ARIES system and HRSA's RSR requirements to provider staff on an as needed basis.

The Administrative Agency will continue to work with service providers in the future to address their technical assistance needs.

1) E. Maintenance of Effort (MOE)

The Maintenance of Effort (MOE) table that identifies MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for FY 2011 and FY 2012 is Attachment 11.

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

| Grant Program Function or Activity (a) | Catalog of Federal Domestic Assistance Number (b) | Estimated Unobligated Funds | | New or Revised Budget | | |
|--|---|-----------------------------|-----------------|-----------------------|-----------------|-----------------|
| | | Federal (c) | Non-Federal (d) | Federal (e) | Non-Federal (f) | Total (g) |
| 1. Administration | 93.914 | \$ 376,451.00 | \$ | \$ | \$ | \$ 376,451.00 |
| 2. Quality Management | 93.914 | 188,223.00 | | | | 188,223.00 |
| 3. Direct Services | 93.914 | 3,199,831.00 | | | | 3,199,831.00 |
| 4. MAI | 93.914 | 260,290.00 | | | | 260,290.00 |
| 5. Totals | | \$ 4,024,795.00 | \$ | \$ | \$ | \$ 4,024,795.00 |

SECTION B - BUDGET CATEGORIES

| 6. Object Class Categories | GRANT PROGRAM, FUNCTION OR ACTIVITY | | | | Total (5) |
|---|-------------------------------------|---------------------------|------------------------|---------------|-----------------|
| | (1) Administration | (2) Quality Management | (3) Direct Services | (4) MAI | |
| a. Personnel | \$ 237,137.00 | \$ 120,330.00 | \$ 0.00 | \$ 29,109.00 | \$ 386,576.00 |
| b. Fringe Benefits | 113,804.00 | 52,621.00 | 0.00 | 9,935.00 | 176,360.00 |
| c. Travel | 12,114.00 | 4,413.00 | 0.00 | 0.00 | 16,527.00 |
| d. Equipment | 900.00 | 1,000.00 | 0.00 | 0.00 | 1,900.00 |
| e. Supplies | 7,612.00 | 3,377.00 | 0.00 | 0.00 | 10,989.00 |
| f. Contractual | 400.00 | 4,000.00 | 3,180,160.00 | 221,246.00 | 3,405,806.00 |
| g. Construction | 0.00 | 0.00 | 0.00 | 0.00 | |
| h. Other | 4,484.00 | 2,482.00 | 19,671.00 | 0.00 | 26,637.00 |
| i. Total Direct Charges (sum of 6a-6h) | \$ 376,451.00 | 188,223.00 | \$ 3,199,831.00 | \$ 260,290.00 | \$ 4,024,795.00 |
| j. Indirect Charges | 0.00 | | | | |
| k. TOTALS (sum of 6i and 6j) | \$ 376,451.00 | \$ 188,223.00 | \$ 3,199,831.00 | \$ 260,290.00 | \$ 4,024,795.00 |
| 7. Program Income | \$ | \$ | \$ | \$ | \$ |

| SECTION C - NON-FEDERAL RESOURCES | | | | | |
|-----------------------------------|---------------|-----------|-------------------|------------|----|
| (a) Grant Program | (b) Applicant | (c) State | (d) Other Sources | (e) TOTALS | |
| 8. | \$ | \$ | \$ | \$ | \$ |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. TOTAL (sum of lines 8-11) | \$ | \$ | \$ | \$ | \$ |

| SECTION D - FORECASTED CASH NEEDS | | | | |
|------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Total for 1st Year | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
| 13. Federal | \$ 4,024,795.00 | \$ 1,006,199.00 | \$ 1,006,199.00 | \$ 1,006,199.00 |
| 14. Non-Federal | \$ | | | |
| 15. TOTAL (sum of lines 13 and 14) | \$ 4,024,795.00 | \$ 1,006,199.00 | \$ 1,006,199.00 | \$ 1,006,199.00 |

| SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT | | | | |
|---|--------------------------------|-----------------|-----------------|-----------------|
| (a) Grant Program | FUTURE FUNDING PERIODS (YEARS) | | | |
| | (b) First | (c) Second | (d) Third | (e) Fourth |
| 16. Administration | \$ 402,477.00 | \$ 402,477.00 | \$ 402,477.00 | \$ 402,477.00 |
| 17. Quality Management | 201,242.00 | 201,242.00 | 201,242.00 | 201,242.00 |
| 18. Direct Services | 3,199,830.00 | 3,199,830.00 | 3,199,830.00 | 3,199,830.00 |
| 19. MAI | 221,246.00 | 221,246.00 | 221,246.00 | 221,246.00 |
| 20. TOTAL (sum of lines 16 - 19) | \$ 4,024,795.00 | \$ 4,024,795.00 | \$ 4,024,795.00 | \$ 4,024,795.00 |

| SECTION F - OTHER BUDGET INFORMATION | |
|--------------------------------------|--|
| 21. Direct Charges: | |
| 22. Indirect Charges: | |
| 23. Remarks: | |

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:**

To add more Budget Narrative attachments, please use the attachment buttons below.

FY 2014 Ryan White Part A Budget Justification Narrative

A. Personnel

\$386,576

Administration

\$237,137

- Manager (G. Bolds, \$78,326 x 0.05 FTE = \$3,916). Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure grant requirements are met; oversees data and quality management activities to ensure adherence to established policies.
 - Grant Coordinator (B. Mendiola, \$59,366 x 0.35 FTE = \$20,778). Responsible for the coordination and preparation of the Part A grant application and coordination and preparation of grant related post-award reports. Coordinates the subcontracting process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance by monitoring subcontracts; processes payment requests, monitors contract expenses; reviews contractor compliance with program objectives.
 - Grant Coordinator (H. Beck, \$60,043 x 0.12 FTE = \$7,205). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses including administrative caps, program income, payer of last resort; reviews contractor compliance with program objectives.
- Grant Coordinator (D. Garza, \$62,515 x 0.12 FTE = \$7,502). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses; reviews contractor compliance with program objectives.
- Financial Specialist (C. Chronis, \$57,192 x 0.10 FTE = \$5,719). Responsible for administrative and fiscal aspects of the grant. Prepares grant application budget documents, develops final program budgets and monitors grant and contract expenditures. Compiles monthly financial reports to analyze grant and contract expenditures; coordinates grant close-out activities ensuring reports are submitted to HRSA, including end of year MOE reports.
 - Planner II (R. Waite \$47,454 x 0.70 FTE = \$33,218). Performs full annual onsite fiscal audits of subcontracted services. Report finding results to contractor, and Administration Manager. Develops Corrective Action Plan based on on-site monitoring findings and concerns.
 - Data Manager (C. Manor, \$57,995 x 0.03 FTE = \$1,740). Responsible for all aspects of maintaining the HIV services client-level data collection system. Collects and analyzes data, and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.
 - Planning Council Community Services Program Manager (K. Williams, \$65,279 x 1.0 FTE). Coordinates and supervise various aspects of the Planning Council's activities and mandated functions. Facilitates and ensures Planning Council processes adhere to federal, state and local laws. Supervise support staff.

- Planning Council Planner II (J. Waller, \$58,209 x 1.0 FTE). Assist the HIV Planning Council Manager in all aspects of supporting the Planning Council. Supports the Need Assessment and Comprehensive Planning committees. Provides research and data collection in support of the Council priority settings and allocation process.
- Planning Council Administrative Senior (Vacant, \$33,571 x 1.0 FTE). Assists the HIV Planning Council Coordinator to prepare Planning Council meeting agendas and supporting documents for approximately 25 meetings annually.

Administration MAI

\$18,727

- Grant Coordinator (H. Beck, \$60,043 x 0.07 FTE = \$4,203). Prepares and negotiates grant subcontracts; assures compliance with MAI conditions of grant by monitoring subcontracts; processes payment requests and monitor MAI contract expenses. Review contractor compliance with MAI quality management activities.
- Grant Coordinator (D. Garza, \$62,515 x 0.15 FTE = \$9,377). Prepares and negotiates grant subcontracts; assures compliance with MAI conditions of grant by monitoring subcontracts; processes payment requests and monitor MAI contract expenses. Review contractor compliance with MAI quality management activities.
- Financial Specialist (C. Chronis, \$57,192 x 0.09 FTE = \$5,147). Responsible for administrative and fiscal aspects of the MAI funds. Prepares grant application budget documents, develops program budgets and monitors grant and contract expenditures. Prepares financial reports as needed to analyze grant and contract expenditures; grant close-out activities ensuring reports are submitted to HRSA, including MOE.

Quality Management

\$120,330

- Program Manager (G. Bolds, \$78,326 x 0.20 FTE = \$15,665). Responsible for the overall administration of Ryan White Part A quality management program. Supervises staff to ensure grant requirements are met and quality program procedures are followed; meets with subcontractors regarding TGA quality improvement issues; ensures adherence to established QM program policies.
- Grant Coordinator (B. Mendiola, \$59,366 x 0.12 FTE = \$7,124). Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures.
- Grant Coordinator (H. Beck, \$60,043 x 0.12 FTE = \$7,205). Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures.

- Grant Coordinator (D. Garza, \$62,515 x 0.12 FTE = \$7,502). Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures.
- Data Manager (C. Manor, \$57,995 x 0.50 = \$28,998). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.
- Quality Management Coordinator (Vacant, \$71,781 x 0.75 FTE = \$53,836). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and established standards of care.

Quality Management MAI **\$10,382**

- Data Manager (C. Manor, \$57,995 x 0.08 = \$4,640). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.
- Quality Management Coordinator (Vacant, \$71,781 x 0.08 FTE = \$5,742). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and establishes/updates standards of care.

B. Fringe Benefits **\$176,360**

Fringe Benefits are calculated at various rates. This includes FICA at 6.2%, Medicare at 1.45% Retirement at 18%, Health Care Benefits at \$10,862 per FTE for 7 months and \$11,731 for 5 months due to fiscal year transition per 6.75 FTE. Incentive Pay for 2.34 FTE.

- Total Administration \$113,804
- Total Administration MAI \$7,302
- Quality Management \$52,621
- Quality Management MAI \$2,633

C. Travel **\$16,527**

Administration Local Travel: **\$1,252**

- Grantee: Staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 1,859 miles x 0.565 = \$1,050.
- Planning Council: PC member's mileage to attend Planning Council meetings/functions approximately 358 miles x 0.565 = \$202.

Quality Management Local Travel: **\$1,413**

- QM staff travel in local TGA to perform QM activities, attend meetings and coordinate QM program activities approximately 2,501 miles x 0.565 = \$1,413.

Administration Out Of Town Travel: \$10,862

- Grantee: Attend three quarterly EMA/TGA meetings. Includes, lodging, meals, and travel related expenses for three (3) persons from the Administrative Agency at \$2,362.
- Planning Council: Attend 3 quarterly EMA/TGA meeting. Includes, lodging, meals, and travel related expenses for one (1) Planning Council representative at \$400.
- Three (3) grantees will attend the annual All Parts Conference in Washington \$6,300
- One (1) planning council member will attend the annual All Parts Conference in Washington \$1,800

Quality Management Out Of Town Travel: \$3,000

- One (1) QM person attending two Texas EMA/TGA & Part B meetings. Attend the annual Institute of Health Care Improvement meeting. Attend Ryan White Services Report (RSR) data report training. Includes, lodging, meals, and travel related expenses at \$1,200.
- One (1) Quality Management will attend the annual All Parts Conference in Washington \$1,800

D. Equipment **\$1,900**

Administration: \$900

- Grantee: Computer purchase to replace obsolete ones \$900

Quality Management: \$1,000

- Quality Management: Computer purchase to replace obsolete ones \$1,000

E. Supplies **\$10,989**

Administration: \$7,612

Grantee: \$1,515

- Postage for subcontractor's contracts and correspondence \$75
- Office furniture, to purchase or replace office chairs \$200
- Micro Projector for meetings and presentations for staff and providers \$324
- Office supplies, usual and customary, each less than \$100. \$916

Planning Council: \$6,097

- Food and beverages for Planning Council members when HIV Planning Council and committee meetings extend through meal time. \$4,500
- Postage for meeting minutes and announcements. \$125
- Telephone basic system including equipment and calling charges. \$672
- Office supplies, usual and customary, each less than \$100. \$800

Quality Management: \$3,377

- Office furniture, to purchase or replace office chairs \$600
- Office supplies, usual and customary, each less than \$100. \$2,777

F. Contractual **\$3,405,806**

HIV Services \$3,180,160

Service contracts with local non-profit organizations for an array core medical and support services for \$3,180,160.

HIV Services MAI \$221,246
 Service contracts with local non-profit organizations for MAI services for \$221,246.

Administration \$400

- Planning Council: subcontract for Parliamentary services. \$400.

Quality Management: \$4,000

- Consultants to follow up on agency training in skills and knowledge needed to improve health outcomes, e.g. health literacy, culture and communication skills to meet Federal Requirements. \$2,000
- Consultants to train providers to evaluate previous year Quality Management goals and development of upcoming year Quality Management plan and its functions \$1,000.
- Specialized Quality Review of medical care, case management, substance abuse and mental health providers within the TGA. \$1,000

G. Construction **\$0**

H. Other **\$26,637**

Administration \$4,484

Grantee: \$3,355

- Advertising of Public Notices for Request for Proposal announcements. \$250
- Subscriptions to HIV-related publications. \$175
- Printing and Reproduction expenses. \$180
- Training/Seminar Fees Staff Development. \$1,000
- Purchase project management software. \$1,750

Planning Council: \$1,129

- Printing client surveys and update the HIV Resources Guide. \$179
- Training/Seminar Fees Staff Development. \$800
- HIV Planning Council advertising in community media to recruit and increase Council membership and promote awareness/encourage involvement in Council activities. \$150

Quality Management: \$2,482

- Subscriptions to HIV-related publications. \$290
- Printing and reproduction expenses of program materials such as surveys. \$900
- Quality Management Personnel training and Seminar Fees for staff development. \$817
- Translation of annual client survey from English to Spanish. \$475

HIV Services: \$19,671

Medical Transportation services provided in house through HHSD covers cost of bus passes, taxi vouchers, gas debit cards and special transit system passes. \$19,671

Total amount \$4,024,795

AUSTIN/TRAVIS COUNTY HEALTH & HUMAN SERVICES DEPARTMENT
Ryan White Part A Emergency Relief Project Grant
FY 2014 Grant Period Line Item Budget

| Budget Item | Salary | % FTE | Admin. | % FTE | Quality Management | HIV Services | % FTE | MAI Admin. | MAI QM | HIV Services | Total |
|---|----------|-------|-----------|-------|--------------------|--------------|-------|------------|----------|--------------|-------------|
| PERSONNEL | | | | | | | | | | | |
| Program Manager - Bolds | \$78,326 | 0.05 | \$3,916 | 0.20 | \$15,665 | | | | | | |
| Grant Coordinator - Mendiola | \$59,366 | 0.35 | \$20,778 | 0.12 | \$7,124 | | | | | | |
| Grant Coordinator - Beck | \$60,043 | 0.12 | \$7,205 | 0.12 | \$7,205 | | 0.07 | \$4,203 | | | |
| Contract Coordinator - Garza | \$62,515 | 0.12 | \$7,502 | 0.12 | \$7,502 | | 0.15 | \$9,377 | | | |
| Financial Specialist - Chronis | \$57,192 | 0.10 | \$5,719 | | | | 0.09 | \$5,147 | | | |
| Planner II - Waite | \$47,454 | 0.70 | \$33,218 | | | | 0.31 | | | | |
| Data Manager - Manor | \$57,995 | 0.03 | \$1,740 | 0.50 | \$28,998 | | 0.08 | | \$4,640 | | |
| Quality Management Coordinator - Vacant | \$71,781 | 1.47 | | 0.75 | \$53,836 | | 0.08 | | \$5,742 | | |
| Community Services Program Manager-Williams | \$65,279 | 1.00 | \$65,279 | | | | 0.16 | | | | |
| Planning Council Planner II - Waller | \$58,209 | 1.00 | \$58,209 | | | | | | | | |
| Planning Council Administrative Assistant-Vacant | \$33,571 | 1.00 | \$33,571 | | | | | | | | |
| | | 3.00 | | | | | | | | | |
| Personnel Subtotal | | 4.47 | \$237,137 | 1.81 | \$120,330 | | 0.47 | \$18,727 | \$10,382 | | \$386,576 |
| FRINGE | | | | | | | | | | | |
| FICA calculated at 6.2% | | | \$14,702 | | \$7,460 | | | \$1,161 | \$644 | | |
| Medicare Tax calculated at 1.45% | | | \$3,438 | | \$1,745 | | | \$272 | \$151 | | |
| Retirement-Salaries x 18% x 4.47 FTEs | | | \$42,685 | | \$21,659 | | | \$3,371 | \$1,838 | | |
| Medical Benefits 7 months x \$10,862 and 5 months x \$11,731 x 6.75 FTE | | | \$50,172 | | \$20,557 | | | \$2,498 | \$0 | | |
| Annual Stability Incentive Pay for 1.98 FTEs | | | \$2,808 | | \$1,200 | | | | | | |
| Fringe Subtotal | | | \$113,804 | | \$52,621 | | | \$7,302 | \$2,633 | | \$176,360 |
| Total Personnel | | | \$350,941 | | \$172,951 | | | \$26,029 | \$13,015 | | \$562,936 |
| TRAVEL | | | | | | | | | | | |
| Local Travel | | | \$1,252 | | \$1,413 | | | | | | |
| Out of Town Travel to Attend TGA/EMA meetings and to attend All Parts Grant Meeting | | | \$10,862 | | \$3,000 | | | | | | |
| Travel Subtotal | | | \$12,114 | | \$4,413 | | | \$0 | \$0 | | \$16,527 |
| EQUIPMENT | | | | | | | | | | | |
| Computer hardware purchased to replace obsolete equipment | | | \$900 | | \$1,000 | | | | | | |
| Equipment Subtotal | | | \$900 | | \$1,000 | | | | | | \$1,900 |
| SUPPLIES | | | | | | | | | | | |
| Food and beverages | | | \$4,500 | | | | | | | | |
| Postage | | | \$200 | | | | | | | | |
| Office furniture | | | \$200 | | \$600 | | | | | | |
| Telephone Base Cost | | | \$672 | | | | | | | | |
| Purchase Micro Projector | | | \$324 | | | | | | | | |
| Office supplies | | | \$1,716 | | \$2,777 | | | | | | |
| Supplies Subtotal | | | \$7,612 | | \$3,377 | | | \$0 | \$0 | | \$10,989 |
| CONTRACTUAL | | | | | | | | | | | |
| Subcontracted Services | | | | | | \$3,180,160 | | | | \$221,246 | |
| Planning Council Parliamentarian Services | | | \$400 | | | | | | | | |
| Individualized agency training in skills and knowledge needed to improve health outcomes, e.g. Health Literacy, Culture and Communication Skills to meet Federal Requirements | | | | | \$2,000 | | | | | | |
| Training to evaluate previous year Quality Management goals and development of upcoming year Quality Management plan and its functions. | | | | | \$1,000 | | | | | | |
| Specialized Quality Review of medical care, case management, substance abuse and mental health providers within the TGA | | | | | \$1,000 | | | | | | |
| Contractual Subtotal | | | \$400 | | \$4,000 | \$3,180,160 | | | | \$221,246 | \$3,405,806 |
| OTHER | | | | | | | | | | | |
| Advertising of Public Notices for RFP announcements | | | \$250 | | | | | | | | |
| Subscriptions to HIV-related publications | | | \$175 | | \$290 | | | | | | |
| Printing and Reproduction expenses | | | \$359 | | \$900 | | | | | | |
| Training/Seminar Fees Staff Development | | | \$1,800 | | \$817 | | | | | | |
| Purchase project management software | | | \$1,750 | | | | | | | | |
| Advertising for PC Membership | | | \$150 | | | | | | | | |
| Translation of annual client surveys from English to Medical Transportation Services | | | | | \$475 | | | | | | |
| | | | | | | \$19,671 | | | | | |
| Other Subtotal | | | \$4,484 | | \$2,482 | \$19,671 | | | | | \$26,637 |
| GRAND TOTAL | | | \$376,451 | | \$188,223 | \$3,199,831 | | \$26,029 | \$13,015 | \$221,246 | \$4,024,795 |
| Function Percentage | | | 9.35% | | 4.68% | 79.50% | | 10.00% | 5.00% | 85.00% | 100.00% |

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

| | | | | |
|---------------------------------|--------------------------------|----------------|-------------------|-----------------|
| 1) Please attach Attachment 1 | Staffing Plan FY14.doc | Add Attachment | Delete Attachment | View Attachment |
| 2) Please attach Attachment 2 | IGA signature Assurances Agr | Add Attachment | Delete Attachment | View Attachment |
| 3) Please attach Attachment 3 | HIV AIDS Prevalence Incidenc | Add Attachment | Delete Attachment | View Attachment |
| 4) Please attach Attachment 4 | Co-morbidities Co-factors Tal | Add Attachment | Delete Attachment | View Attachment |
| 5) Please attach Attachment 5 | Other Public Funding Table F | Add Attachment | Delete Attachment | View Attachment |
| 6) Please attach Attachment 6 | Unmet Need Framework FY14.doc | Add Attachment | Delete Attachment | View Attachment |
| 7) Please attach Attachment 7 | Chair Letter of Assurance FY | Add Attachment | Delete Attachment | View Attachment |
| 8) Please attach Attachment 8 | Planned Services Table FY14.c | Add Attachment | Delete Attachment | View Attachment |
| 9) Please attach Attachment 9 | Implementation Plan Table FY | Add Attachment | Delete Attachment | View Attachment |
| 10) Please attach Attachment 10 | Organizational Chart FY14.doc | Add Attachment | Delete Attachment | View Attachment |
| 11) Please attach Attachment 11 | Maintenance of Effort FY14.doc | Add Attachment | Delete Attachment | View Attachment |
| 12) Please attach Attachment 12 | | Add Attachment | Delete Attachment | View Attachment |
| 13) Please attach Attachment 13 | | Add Attachment | Delete Attachment | View Attachment |
| 14) Please attach Attachment 14 | | Add Attachment | Delete Attachment | View Attachment |
| 15) Please attach Attachment 15 | | Add Attachment | Delete Attachment | View Attachment |

Attachment 1

Staffing Plan, Job Descriptions, and Biographical Sketches

Note: All positions funded by Ryan White Program Part A, including MAI, are listed. Positions, including FTE percentages, are shown by Part A budget categories: Administrative Agency (AA); HIV Planning Council (PC); or Clinical Quality Management (QM). Refer to Organizational Chart (Attachment 10) for placement in the organization.

| | Name Job Title FTE % | Job Description and Rationale for Amount of Time Requested | Education and Licensure Experience and Qualifications |
|----|--|---|---|
| 1. | G. Bolds Manager .05% AA | <p>Administrative Agency</p> <p>Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure adherence to established policies.</p> <p>This position oversees and manages staff to ensure grant requirements are met, assesses the quality of services provided by subcontractors, and supervises data collection and quality management activities to ensure adherence to established policies.</p> | <p>B.A., Political Science; M.S., Urban Studies</p> <p>Over 30 years of experience in health and human services program planning and administration, including seven years in the Ryan White program. Extensive experience in program assessment and evaluation, data collection and analysis, research methods and performance measures development.</p> |
| 2. | B. Mendiola Grants Coordinator 35% AA | <p>Responsible for coordination and preparation of the Part A grant application and preparation of grant post-award reports.</p> <p>Coordinates procurement process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with terms of grant by monitoring subcontracts.</p> <p>Processes payment requests, and monitors and analyzes contract expenses.</p> | <p>Master of Social Work, M.S.W.</p> <p>Over 31 years of health and human services experience in administration, research, planning, and clinical services including 13 years of administering HIV grants and contracts. Former Manager, hospital-based Community Health Education Dept; Assistant Director, Stanford Urban Coalition; Research Associate and Counselor, Addiction Research Foundation.</p> |

| Name Job Title FTE % | Job Description and Rationale for Amount of Time Requested | Education and Licensure Experience and Qualifications |
|---|--|--|
| 3. C. Chronis Financial Specialist 10% AA | Responsible for conducting all fiscal activities of the grant. Establishes and monitors program budgets; ensures all fiscal reports are submitted to HRSA. Develops grant-related documents for Austin City Council action. Coordinates grant closeout activities and end-of-year reports. This position monitors Part A grant and subcontractor expenditures. | B.A., Accounting General accounting experience in varied financial settings ranging from banking to hospital auditing and governmental systems, including 13 years supporting the Ryan White Part A program. |
| 4. C. Manor Data Manager .03% AA | Responsible for all data management tasks related to the Part A grant; provide training and support of subcontracts on client level data collection and manages the HIV services data reporting system (ARIES), including data quality. Prepares service utilization data reports for use in monitoring contractor programs, and for HIV Planning Council; also prepares required HRSA/HAB grant reports (RSR/RDR) and other administrative reports for the HIV Resources Administration Unit Manager. | B.A., major in English and minor in Business Management Over 10 years of experience supporting the Ryan White program; proficient in the use of Microsoft Excel, Access, SPSS, and the ARIES client level software application. |
| 5. H. Beck Grants Coordinator 19% AA | This position provides Part A grant contract management and monitoring for contracts and assists with grant reporting activities. Performs site visits, processes requests for payment, ensures contractor compliance with contract requirements, and provides technical assistance to service providers regarding contractual, performance reporting, and capacity-building issues. | B.A., Business Administration Over 20 years of HIV grants and contracts administration experience, with emphasis on contract monitoring including provision of technical assistance. |
| 6. D. Garza Grants Coordinator 27% AA | See description in row 5 above. Also serves as lead on MAI grant program including preparation of grant application and preparation and submission of grant post-award reports. | M.P.A. (Public Admin.); B.S., RTF Communication Over 20 years of administrative experience, including management and program auditing, performance reporting, with additional expertise in public policy research and strategic planning. |
| 7. R. Waite Planner II 70% AA | Develops on-site monitoring tools and procedures, and Annual Monitoring Plan. Conducts comprehensive, annual on-site monitoring for all Ryan White Part A contracts. Performs site visits and reports contractor non-compliance with contract and HRSA requirements. Develops Corrective Action Plan based on | B.A., Social Work Over 6 years of HIV services experience, with emphasis on reporting and compliance monitoring. Additional expertise in community planning, |

| Name Job Title FTE % | Job Description and Rationale for Amount of Time Requested | Education and Licensure Experience and Qualifications |
|---|---|--|
| | findings and concerns, and follows up on contractor compliance with Plan. Maintains Master Contract List of all HIV services contracts. Conducts internal monitoring of AA compliance with HHSD and HRSA requirements. | development, and implementation of HIV/STD prevention. Over 10 years of community leadership experience with organizations that address the needs of populations most affected by HIV/AIDS. |
| HIV Planning Council | | |
| 8. K. Williams Program Manger 100% PC | Coordinates and supervises various aspects of the Planning Council's activities and mandated functions. Facilitates processes and ensures compliance with federal, state and local requirements. Supervises support staff. Oversees and manages the HIV Planning Council activities to ensure legislatively-mandated responsibilities are met. | Master of Public Administration (M.P.A.) Site Director for Urban League of Greater Chattanooga; Patient Service Representative for Hamilton County Health Department; counselor and Case Manager with Volunteer Treatment Center. |
| 9. J. Waller Planner II 100% PC | Supports Planning Council and its committees by collecting, analyzing, and interpreting epidemiological, programmatic and fiscal data and other information. Prepares reports for Planning Council. | B.A., Psychology Over 31 years of experience in health and human service program administration, including ten months as a Health Planner for Ryan White Part A. Managed a state Human Services office, serving as Project Director for Electronic Benefit Transfer (EBT) implementation and operation in two states. |
| 10. VACANT Admin. Senior 100% PC | Performs administrative support functions for HIV Planning Council staff and members, including meeting/event planning, posting of agendas, preparing meeting minutes and assisting in preparation of reports and documents. | |
| Quality Management | | |
| 11. VACANT QM Coordinator 83% QM | This position oversees the Part A QM program and tasks related to Part A QM program reporting. Facilitates activities related to design and implementation of QM Plan, selecting continuous quality improvement evaluators, initiating a comprehensive system to measure client satisfaction, and developing and implementing service-specific standards of care. | |

| | Name Job Title FTE % | Job Description and Rationale for Amount of Time Requested | Education and Licensure Experience and Qualifications |
|-----|--|---|--|
| 12. | C. Manor Data Manager 58% QM | Responsible for all aspects of maintaining a comprehensive HIV Services data collection system that supports the QM program. Collates and processes QM data. | See row 4 above. |
| 13. | G. Bolts Manager 20% QM | See description in row 1 above. | See row 1 above. |
| 14. | B. Mendiola Grants Coordinator 12% QM | Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures. | See row 2 above. |
| 15. | H. Beck Grants Coordinator 12% QM | Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures. | See row 5 above. |
| 16. | D. Garza Grants Coordinator 12% QM | Conduct programmatic and operational data analysis in order to identify issues that impact quality of services. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction, timeliness of care, and other quality indicators. Monitor contract outcomes performance measures. | See row 6 above. |

Attachment 2

and legally to all terms, performances, and provisions in this Agreement.

15.0 CONFLICT OF INTEREST

15.01 The parties shall ensure that no person who is an employee, agent, consultant, officer, or elected or appointed official of City or County who exercises or has exercised any functions or responsibilities with respect to activities performed pursuant to this Agreement or who is in a position to participate in a decision-making process or gain inside information with regard to these activities, may obtain a personal or financial interest or benefit from the activity, or have an interest in any Agreement, subcontract or agreement with respect to it, or the proceeds under it, either for him or herself or those with whom he or she has family or business ties, during his or her tenure or for one year thereafter.

16.0 INTERPRETATIONAL GUIDELINES

16.01 Computation of Time. When any period of time is stated in this Agreement, the time shall be computed to exclude the first day and include the last day of the period. If the last day of any period falls on a Saturday, Sunday or a day that County or City has declared a holiday for its employees these days shall be omitted from the computation.

16.02 Number and Gender. Words of any gender in this Agreement shall be construed to include any other gender and words in either number shall be construed to include the other unless the context in the Agreement clearly requires otherwise.

16.03 Headings. The headings at the beginning of the various provisions of this Agreement have been included only to make it easier to locate the subject matter covered by that section or subsection and are not to be used in construing this Agreement.

CITY OF AUSTIN

By: Kirk Watson
Kirk Watson, Mayor Date: 9/18/98

TRAVIS COUNTY

By: Bill Aleshire
Bill Aleshire, County Judge Date: 9/15/98

Appendix A

FY 2014 AGREEMENTS AND COMPLIANCE ASSURANCES Ryan White HIV/AIDS Treatment Extension Act of 2009 Part-A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area
Austin TGA, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)^{1,2}

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)

The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)

The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604 (a)

The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

Section 2604(c)

¹ All statutory references are to the Public Health Service Act, unless otherwise specified.

² The six new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in Section 2609(d)(1)(A).

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by The Secretary.

Pursuant to Section 2604(f)

The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by The Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)

The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)

The EMA/TGA will establish a CQM Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5 percent of program funds or \$3 million.

Pursuant to Section 2604(i)

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)

With regard to the use of funds,

- a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
- b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
- c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
- d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)

The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)

The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)

Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)

The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)

The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)

The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)

Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684

No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature 

Date 9/22/13

Attachment 3

HIV/AIDS Prevalence and Incidence Data – Austin TGA

| | AIDS INCIDENCE: 01/01/10 to 12/31/12 | | AIDS PREVALENCE as of 12/31/12 | | HIV (NOT AIDS) PREVALENCE as of 12/31/12 | |
|-----------------------------|---|--------------|--------------------------------------|--------------|--|--------------|
| | No. | % | No. | % | No. | % |
| Race/Ethnicity | | | | | | |
| White | 177 | 38 | 1,270 | 43 | 1,032 | 48 |
| African American | 111 | 24 | 696 | 24 | 421 | 20 |
| Hispanic | 158 | 35 | 897 | 30 | 605 | 28 |
| Other ¹ | 1 | 0 | 22 | 1 | 25 | 1 |
| Sex | | | | | | |
| Male | 391 | 85 | 2,512 | 85 | 1,823 | 86 |
| Female | 66 | 14 | 441 | 15 | 308 | 14 |
| Age | | | | | | |
| <2 years | 0 | 0 | 0 | 0 | 1 | 0 |
| 2 – 12 years | 0 | 0 | 1 | 0 | 10 | 0 |
| 13 – 24 years | 34 | 7 | 49 | 2 | 158 | 7 |
| 25 – 34 years | 122 | 27 | 309 | 10 | 545 | 26 |
| 35 – 44 years | 139 | 30 | 755 | 25 | 592 | 28 |
| 45 – 54 years | 117 | 26 | 1,172 | 40 | 566 | 27 |
| ≥55 years | 45 | 10 | 667 | 23 | 259 | 12 |
| Exposure² | | | | | | |
| MSM | 300 | 66 | 1,849 | 63 | 1,541 | 72 |
| IDU | 41 | 9 | 358 | 12 | 132 | 6 |
| MSM/IDU | 24 | 5 | 254 | 9 | 121 | 6 |
| Heterosexual | 91 | 20 | 473 | 16 | 313 | 15 |
| Pediatric | 1 | 0 | 15 | 1 | 25 | 1 |
| Other | 0 | 0 | 5 | 0 | 0 | 0 |
| Total | 457 | 100.0 | 2,953 | 100.0 | 2,131 | 100.0 |

Source: Texas Department of State Health Services (eHARS as of July 2013), unadjusted for reporting delay.

¹Other race/ethnicity includes Asian/Pacific Islander, Native American, Multi-Racial and other race/ethnicity cases.

²Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification. Column totals may not accurately sum due to rounding.

Attachment 4

Co-morbidities and Co-factors – Austin TGA

| Infectious Disease ¹ | General Population | | Persons Living with HIV/AIDS | |
|-------------------------------------|--------------------|---------------------|------------------------------|---------------------------|
| | N | Rate per 100,000 | N | % PLWH/A Cases |
| <u>Early Syphilis</u> | <u>321</u> | <u>17.5</u> | <u>81</u> | <u>1.6</u> |
| White | 133 | 13.2 | 43 | 1.9 |
| African American | 46 | 33.4 | 8 | 0.7 |
| Hispanic | 134 | 22.9 | 27 | 1.8 |
| Other | 1 | 2.9 | - | - |
| <u>Chlamydia</u> | <u>9,450</u> | <u>515.2</u> | <u>71</u> | <u>1.4</u> |
| White | 2,099 | 208.1 | 24 | 1.0 |
| African American | 1,476 | 1,072.5 | 23 | 2.0 |
| Hispanic | 2,635 | 451.0 | 23 | 1.5 |
| Other | 139 | 229.7 | - | - |
| <u>Gonorrhea</u> | <u>2,152</u> | <u>117.3</u> | <u>113</u> | <u>2.2</u> |
| White | 534 | 52.9 | 48 | 2.1 |
| African American | 613 | 445.4 | 24 | 2.1 |
| Hispanic | 504 | 86.3 | 38 | 2.5 |
| Other | 21 | 9.7 | 1 | 2.1 |
| <u>Tuberculosis</u> | <u>58</u> | <u>3.1</u> | <u>90</u> | <u>1.8</u> |
| White | 11 | 1.1 | 14 | 15.6 |
| African American | 6 | 4.4 | 41 | 45.6 |
| Hispanic | 25 | 4.3 | 35 | 38.9 |
| Other | 16 | 15.4 | 0 | 0 |
| <u>Acute Hepatitis C</u> | <u>3</u> | <u>0.16</u> | <u>292</u> | <u>9.4</u> |
| White | 2 | 0.20 | 104 | 8.3 |
| African American | 0 | - | 119 | 14.4 |
| Hispanic | 1 | 0.17 | 64 | 6.9 |
| Other | 0 | - | 5 | 6.4 |
| Homeless Persons² | N | % | N | % PLWH/A Cases |
| <u>General population</u> | | | -- | -- |
| Bastrop | 104 | -- | -- | -- |
| Caldwell | 53 | -- | -- | -- |
| Hays | 231 | -- | -- | -- |
| Travis | 1,434 | -- | -- | -- |
| Williamson | 607 | -- | -- | -- |
| Total | 2,429 | 0.133 | -- | -- |
| PLWHA | -- | -- | 93 | 3.0 |

| Persons without health insurance (<65 years of age)³ | N | % | N | % PLWH/A Cases |
|---|------------------|-------------|--------------|-----------------------|
| General population | | | | |
| Bastrop | 16,520 | 25.8 | -- | -- |
| Caldwell | 9,208 | 28.4 | -- | -- |
| Hays | 31,933 | 22.5 | -- | -- |
| Travis | 215,707 | 22.4 | -- | -- |
| Williamson | 68,716 | 17.4 | -- | -- |
| Total | 342,084 | 21.4 | -- | -- |
| PLWHA | -- | -- | 1,669 | 54.0 |
| Persons living at or below 300 percent of the 2012 Federal Poverty Level⁴ | N | % | N | % PLWH/A Cases |
| White, not Hispanic | 377,833 | 39.5 | -- | -- |
| African American, not Hispanic | 92,413 | 65.2 | -- | -- |
| Hispanic | 472,085 | 75.4 | -- | -- |
| Other & multiracial, not Hispanic | 43,686 | 46.3 | -- | -- |
| Total | 1,025,769 | 56.4 | 2,914 | 94.0 |
| Type of substance abuse^{5,6} | N | % | N | % PLWH/A Cases |
| General population | | | | |
| Any illicit drug use | 593,902 | 43.6 | -- | -- |
| Intravenous drug use | 20,432 | 1.5 | -- | -- |
| Heavy Alcohol | 95,351 | 7.0 | -- | -- |
| Cocaine/crack | 230,205 | 16.9 | -- | -- |
| Marijuana | 630,680 | 46.3 | -- | -- |
| Psychedelics | 209,773 | 15.4 | -- | -- |
| Inhalants | 87,172 | 6.4 | -- | -- |
| Any illicit drug use Injection drug use | -- | -- | -- | -- |
| Injection drug use | -- | -- | 432 | 14.0 |
| Mental Illness Prevalence⁷ | N | % | N | % PLWH/A Cases |
| General population | | | | |
| Any mental illness | -- | 25.0 | -- | -- |
| Depression | -- | 15.4 | -- | -- |
| Any anxiety disorder | -- | 10.3 | -- | -- |
| Psychological distress | -- | 5.2 | -- | -- |
| PLWHA | -- | -- | 697 | 22.6 |

¹ Texas Department of State Health Services, 2013; Centers for Disease Control and Prevention, estimate of persons co-infected with HIV and HCV, 2011. Austin/Travis County Health and

Human Services Department, 2012. Rates calculated with a numerator less than 20 should be interpreted with caution. Early syphilis includes primary, Secondary, Early Latent. Other race/ethnicity includes Asian / Pacific Islander, Native American, Multi-Racial and other race/ethnicity cases. Total number of STI cases includes cases with unknown race/ethnicity.

² *The State of Homelessness in America 2013, National Alliance to End Homelessness, Washington, DC, Appendices, page 33.*

³ *US Census Bureau, 2011 Small Area Health Insurance Estimates (SHAIE) using American Community Survey (ACS) Data*

⁴ *Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035; US Census Bureau 2010 American Community Survey Public Use Microdata Sample; & Texas State Data Center & Office of the State Demographer. Household size, income & race/ethnicity obtained for the state of Texas from the American Community Survey and were applied to 2012 projected TGA population.*

⁵ *Texas Commission on Alcohol & Drug Abuse, 2000 Texas survey of substance use among adults, prevalence estimates applied to 2013 projected \geq 18-year-old Austin TGA population; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

⁶ *Texas Commission on Alcohol & Drug Abuse, Adult survey of substance use and related risk behaviors in seven major Texas County, Travis County Report 2007-2008, prevalence estimates applied to 2013 projected \geq 18-year-old Austin TGA population*

⁷ *Centers for Disease Control and Prevention. Mental Illness Surveillance Among Adults in the United States MMWR 2011;60 (Suppl): [1-29].; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

Attachment 5

Other Public Funding – Austin TGA

| Categories | Ryan White Program not Part A | | Other Federal Funds | | State Funds | | Local Funds | | TOTAL FUNDS | |
|--|-------------------------------|-----------------------|-----------------------|-----------------------|---------------------|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | FY 2013 | FY 2014 | FY 2013 | FY 2014 | FY 2013 | FY 2014 | FY 2013 | FY 2014 | FY 2013 | FY 2014 |
| Outpatient/ Ambulatory Medical Care | \$1,248,578 14.81% | \$1,268,578 15.12% | \$0 0.00% | \$0 0.00% | \$136,021 10.13% | \$136,021 9.54% | \$1,048,024 44.02% | \$1,092,457 44.96% | \$2,432,623 16.40% | \$2,497,056 16.75% |
| State AIDS Drug Assistance Programs | \$6,595,236 78.25% | \$6,504,561 77.51% | \$0 0.00% | \$0 0.00% | \$431,719 32.16% | \$446,639 31.34% | \$0 0.00% | \$0 0.00% | \$7,026,955 47.36% | \$6,951,200 46.62% |
| Home and Comm. Based Support Services | \$198,922 2.36% | \$198,922 2.37% | \$1,392,775 51.88% | \$1,493,935 56.12% | \$275,699 20.54% | \$268,699 18.85% | \$693,792 29.14% | \$698,292 28.74% | \$2,561,188 17.16% | \$2,659,848 17.84% |
| Other Outpt./ Comm. Based Primary Med Care | \$65,768 0.78% | \$89,438 1.07% | \$0 0.00% | \$0 0.00% | \$70,752 5.27% | \$70,552 4.95% | \$123,437 5.18% | \$123,437 5.08% | \$259,957 1.75% | \$283,627 1.90% |
| Oral Health Care | \$250,443 2.97% | \$260,443 3.10% | \$100,000 3.73% | \$0 0.00% | \$0 0.00% | \$0 0.00% | \$0 0.00% | \$0 0.00% | \$350,443 2.36% | \$260,443 1.75% |
| Substance Abuse/ Mental Health Services | \$70,000 0.83% | \$70,000 0.83% | \$399,666 14.89% | \$399,666 15.01% | \$20,000 1.49% | \$20,000 1.40% | \$0 0.00% | \$0 0.00% | \$489,666 3.30% | \$489,666 3.28% |
| Minority AIDS Initiative (MAI) | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| HIV Counseling and Testing Services | \$0 0.00% | \$0 0.00% | \$791,936 29.50% | \$768,481 28.87% | \$408,121 30.40% | \$483,234 33.90% | \$515,683 21.66% | \$515,683 21.22% | \$1,715,740 11.56% | \$1,767,398 11.85% |
| TOTAL PUBLIC FUNDING | \$8,428,947 100% | \$8,391,942 100% | \$2,684,377 100% | \$2,662,082 100% | \$1,342,312 100% | \$1,425,145 100% | \$2,380,936 100% | \$2,429,869 100% | \$14,836,572 100% | \$14,909,238 100% |

Attachment 6

Unmet Need Framework

| Population Sizes | | Value | Data Source(s) | |
|--------------------|--|-------|--|---|
| A. | Number of persons living with AIDS (PLWA), December 31, 2012. | 2,953 | Cases from eHARS diagnosed and living as of 12/31/12; Cases diagnosed in Texas Department of Criminal Justice (TDCJ) removed and cases with unknown mode of exposure have been proportionately redistributed. | |
| B. | Number of persons living with HIV (PLWH)/non-AIDS/aware, December 31, 2012. | 2,131 | Cases from eHARS diagnosed and living as of 12/31/12; Cases diagnosed in TDCJ removed and cases with unknown mode of exposure have been proportionately redistributed. | |
| C. | Total number of HIV+/aware, December 31, 2012. | 5,084 | | |
| Care Patterns | | Value | Data Source(s) | |
| D. | Number of PLWA who received the specified HIV primary medical care during the 12-month period (January-December 2012). | 2,562 | Evidence of met need found in eHARS or through matches with AIDS Drug Assistance Program (ADAP), Ryan White program data (all Titles), data from electronic laboratory reporting of viral load and CD4 results, Medicaid or private insurance medical care data. | |
| E. | Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (January-December 2012) | 1,648 | Evidence of met need found in eHARS or through matches with ADAP, Ryan White program data (all Titles), data from electronic laboratory reporting of viral load and CD4 results, Medicaid or private insurance medical care data. | |
| F. | Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (January-December 2012). | 4,210 | | |
| Calculated Results | | Value | % | Calculation |
| G. | Number of PLWA who did not receive the specified HIV primary medical care | 391 | 13% | Value: Value A - Value D. Percent: Value G/ Value A |
| H. | Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care | 483 | 23% | Value: Value B - Value E. Percent: Value H / Value B |
| I. | Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) | 874 | 17% | Value: Value C - Value F. Percent: Value I / Value C |

Source: Texas Department of State Health Services, 2013 using HRSA/HAB Unmet Need Framework Excel Worksheets.

The mission of the Austin Area Comprehensive HIV Planning Council is to develop and coordinate an effective and comprehensive community-wide response to the HIV/AIDS epidemic.

CHIEF ELECTED OFFICIAL

Mayor Lee Leffingwell

MAYOR REPRESENTATIVE

Amy Everhart

OFFICERS

Dr. Victor Martinez, Chair
Paul Hassell, Vice Chair
Vacant, Secretary

MEMBERS

Shanika Cornelius
Leah Graham
Justin Irving
Jerry Juarez
Winifred Muhammad
Jessica Pierce
Amelia Reinwald
Christopher Shaw
Charlotte Simms-Sattiewhite
Seth Shulman
Justin Smith
Curtis Weidner

OFFICE OF COORDINATION & PLANNING

Kimberly Williams, Program Manager
John Waller, Health Planner

EXECUTIVE LIAISON

Stephanie Hayden, Assistant Director
Community Services
Health and Human Services Department

ADMINISTRATIVE AGENT

Gregory Bolds, Manager
HHS HIV Resources Administration

Austin Area Comprehensive
HIV Planning Council
~ ~ ~

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September 13, 2013

Mr. Steven R. Young, M.S.P.H.
Director, Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau, HRSA
5600 Fishers Lane Room 7A-55
Rockville, Maryland 20857

SUBJECT: FY 2013 Planning Council Letter of Assurance

Dear Mr. Young:

As Chair of the Austin HIV Planning Council, I attest to the following:

- FY 2013 Formula, Supplemental, and MAI funds awarded to the Austin TGA have been expended according to the priorities established by the Planning Council;
- All FY 2013 Conditions of Award relative to the Planning Council have been addressed;
- FY 2014 Priorities were determined by the Planning Council, and the approved process for establishing those priorities was used by the Planning Council;
- Planning Council annual membership training took place in the format of a retreat held on July 30, 2013.
- Planning Council membership is representative and reflective of the epidemic in the Austin TGA. Four (4) representative membership slots are vacant. Targeted recruitment in the form of personal contacts and planned recruitment events have been discussed by the Planning Council and are underway.

Respectfully,



Dr. Victor Martinez



Attachment 8

Planned Services Table

| Priority | Core Medical Services | Amount |
|------------------------------|--|--------------------|
| 2 | Medical Case Management | \$260,629 |
| 4 | Outpatient / Ambulatory Medical Care | \$1,038,678 |
| 5 | Health Insurance Premium & Cost Sharing Assistance | \$174,875 |
| 7 | Substance Abuse Services – outpatient | \$117,546 |
| 8 | AIDS Drug Assistance Program (ADAP) | \$1 |
| 9 | Mental Health Services | \$202,185 |
| 15 | Oral Health Care | \$426,378 |
| 17a | AIDS Pharmaceutical Assistance – local | \$337,575 |
| 24 | Hospice Services | \$100,354 |
| 26 | Medical Nutrition Therapy | \$70,208 |
| Total Core = 79.8% | | \$2,728,429 |
| Priority | Support Services | Amount |
| 1 | Case Management Services Non-Medical (Tier 1) | \$251,324 |
| 3 | Medical Transportation Services | \$25,000 |
| 8 | Case Management Services Non-Medical (Tier 2) | \$142,338 |
| 12a | Outreach Services | \$92,846 |
| 12b | Substance Abuse Services – residential | \$103,118 |
| 17c | Food Bank / Home-Delivered Meals | \$61,500 |
| 22b | Psychosocial Support Services | \$16,521 |
| Total Support = 20.2% | | \$692,647 |
| TOTAL SERVICES | | \$3,421,076 |

Attachment 9

FY 2014 Implementation Plan

| Service Priority Number: 4 | | Service Priority Name: Outpatient/Ambulatory Medical Care | | | |
|--|---------------------------------|---|-----------------|-------------------|----------------------|
| Service Goal: Increase access to care and optimize health outcomes for people living with HIV | | | | | |
| Objective: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 Funds |
| | | Projected Clients | Projected Units | | |
| | | a. Provide outpatient primary medical care consistent with PHS/NIH/IDSA guidelines to existing and new HIV positive clients in the TGA. | Per visit | | |
| | Per laboratory test | 893 | 4,146 | | 207,014 |

| Service Priority Number: 15 | | Service Priority Name: Oral Health Care | | | |
|--|---------------------------------|---|-----------------|-------------------|----------------------|
| Service Goal: Increase access to care and optimize health outcomes for people living with HIV | | | | | |
| Objective: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 Funds |
| | | Projected Clients | Projected Units | | |
| | | a. Provide diagnostic, preventive, and therapeutic dental services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per visit | | |

| Service Priority Number: 17a | | | | | Service Priority Name: AIDS Pharmaceutical Assistance (Local) | | |
|---|---------------------------------|-------------------|-----------------|-------------------|--|--|--|
| Service Goal: Increase access to care and optimize health outcomes for people living with HIV | | | | | | | |
| Objective: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 Funds | | |
| | | Projected Clients | Projected Units | | | | |
| a. Provide FDA-approved medications to existing and new eligible clients including those awaiting approval of ADAP or Compassionate Use Programs. | Per prescription | 1,280 | 6,438 | 3/1/14 to 2/28/15 | \$337,575 | | |

| Service Priority Number: 9 | | | | | Service Priority Name: Mental Health Services | | |
|--|---------------------------------|-------------------|-----------------|-------------------|--|--|--|
| Service Goal: Increase access to care and optimize health outcomes for people living with HIV | | | | | | | |
| Objective: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 Funds | | |
| | | Projected Clients | Projected Units | | | | |
| a. Provide mental health treatment and/or counseling services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per visit | 267 | 2,003 | 3/1/14 to 2/28/15 | \$202,185 | | |

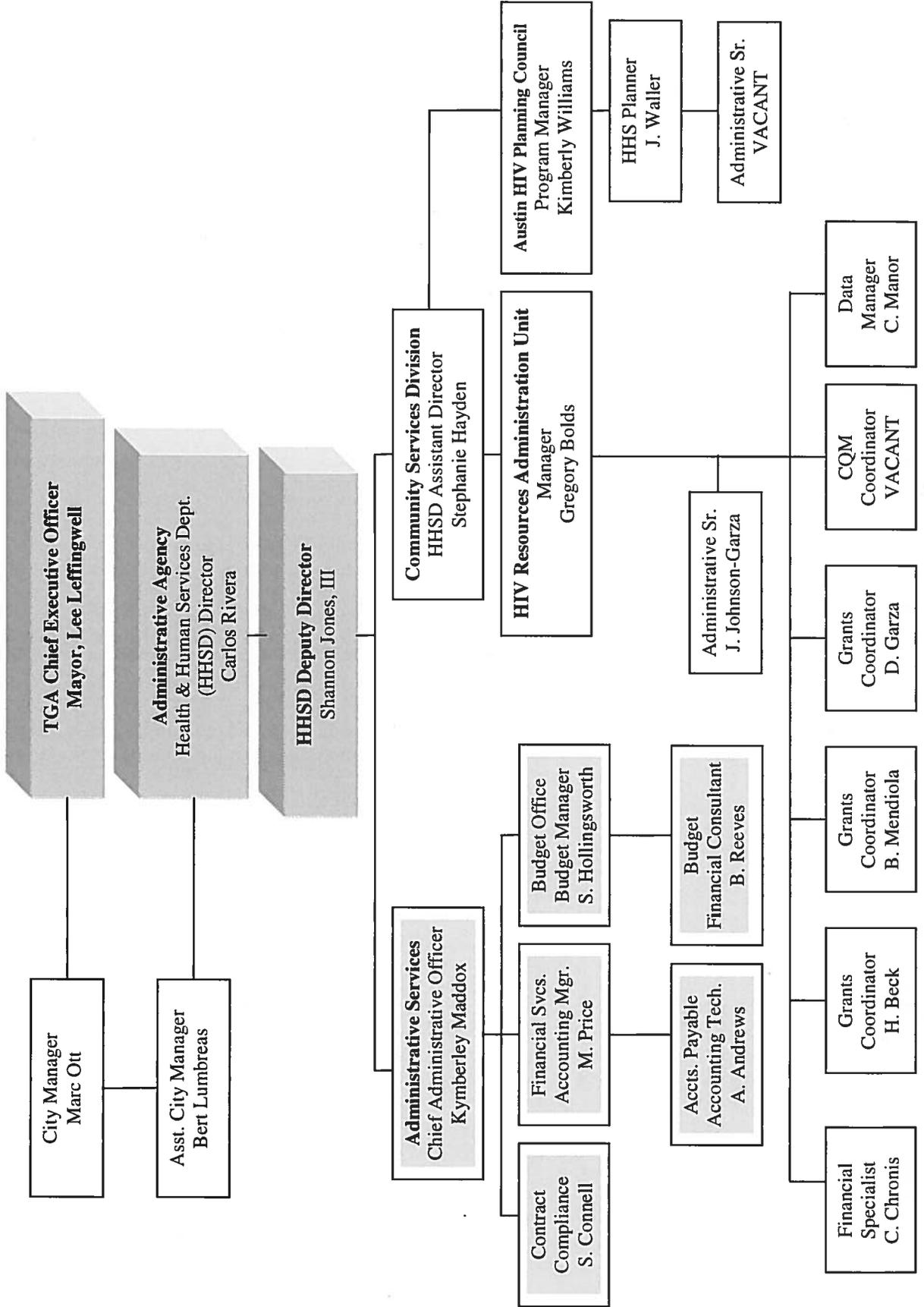
| Service Priority Number: 1 (Tier 1); 8 (Tier 2) | | Service Priority Name: Non-Medical Case Management Services (Part A and MAI) | | | |
|---|---------------------------------|--|-----------------|-------------------------|--|
| <p>Service Goal 1: Increase access to care and optimize health outcomes for people living with HIV</p> <p>Service Goal 2: Reduce HIV-related health disparities</p> | | | | | |
| Objective Tier 1: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 Part A & MAI Funds Tier 1 |
| | | Projected Clients | Projected Units | | |
| Part A and MAI a. Provide non-medical case management services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per 15 minutes | Part A 187 | Part A 6,754 | 3/1/14 to 2/28/15 | Part A \$188,985 MAI \$62,339 |
| | | MAI 75 | MAI 2,646 | | |
| Objective Tier 2: | Service Unit Definition: | Quantity: | | Time Frame | FY 2014 MAI Funds Tier 2 |
| | | Projected Clients | Projected Units | | |
| MAI only a. Provide patient navigation services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per 15 minutes | MAI 78 | MAI 3,163 | 3/1/14 to 2/28/15 | MAI \$66,107 |

| Service Priority Number: 2 | | Service Priority Name: Medical Case Management (MAJ) | | |
|--|--|---|-------------------|--------------------------|
| Service Goal 1: Increase access to care and optimize health outcomes for people living with HIV | | | | |
| Service Goal 2: Reduce HIV-related health disparities | | | | |
| Objective: | | Service Unit Definition: | Quantity: | Time Frame |
| | | | Projected Clients | |
| | | | Projected Units | |
| a. Provide medical case management services consistent with Standards of Care to existing and new eligible clients in the TGA. | | Per 15 minutes | 14 | 3/1/14 to 2/28/15 |
| | | | 2,041 | |
| | | | | FY 2014 Funds MAI |
| | | | | \$62,339 |

| Service Priority Number: 12b | | Service Priority Name: Substance Abuse Services – Residential | | |
|---|--|--|-------------------|----------------------|
| Service Goal 1: Increase access to care and optimize health outcomes for people living with HIV | | | | |
| Service Goal 2: Reduce the number of people who become infected with HIV | | | | |
| Objective: | | Service Unit Definition: | Quantity: | Time Frame |
| | | | Projected Persons | |
| | | | Projected Units | |
| a. Provide access to substance abuse treatment and/or counseling services in a residential setting to existing and new eligible clients in the TGA. | | Per 24-hour day | 131 | 3/1/14 to 2/28/15 |
| | | | 2,393 | |
| | | | | FY 2014 Funds |
| | | | | \$103,118 |

Attachment 10

Austin Transitional Grant Area (TGA) Organizational Chart



Attachment 11

Maintenance of Effort

| TGA: Austin, Texas | | Report for FY 2011 and FY 2012 | |
|---|---|--------------------------------|-----------------------|
| Prepared by: Carmen Chronis, Financial Specialist | | Telephone: (512) 972-5078 | |
| Item No. | Agency/Department/Other Unit of Government | FY 2011 Amount | FY 2012 Amount |
| 1 | Austin Health and Human Services Department Communicable Disease HIV Education and Outreach Program Fund 1000-9100-3030 | \$467,939.83 | \$476,506.88 |
| 2 | Austin Health and Human Services Department (HHSD) HIV Social Services Contracts with CBOs Fund 1000-4700-6161, 6162 and 6163 | \$629,831.44 | \$501,909.74 |
| 3 | Travis County HIV Social Services Contracts CBOs Dept. 58 – Div. 91 | \$524,028.89 | \$574,002.86 |
| 4 | Travis County Health Care District (TCHD) David Powell Community Health Center (DPCHC) Fund - Community Care | \$827,762.00 | \$1,058,377.00 |
| TOTALS | | \$2,449,562.16 | \$2,610,796.48 |

Austin HHSD uses the City of Austin accounting system Austin Integrated Management System (AIMS), and a segmented chart of accounts to capture and monitor grant specific budget and expenditures. The main components of the chart of accounts are the fund, department and unit codes (FDU). Digital Express Report (DXR) is used to view financial reports, which are produced using AIMS system. Expenditures related to HIV/AIDS core medical and support services, as well as prevention services, have unique identifier code (FDU) and are tracked on a monthly basis. The TCHD CommUnityCare's accounting system, Sage MIP, uses a segmented chart of accounts to capture expenditures. One segment in the chart of accounts discerns the location within the network to which each transaction pertains. The only services provided at DPCHC are those related to the primary medical care of persons living with HIV/AIDS. Travis County uses the Sungard accounting system, a segmented chart of accounts that captures and monitors budget and expenditures. The components of the chart of accounts are the fund number, department/division numbers, activity/subactivity codes, and element and object numbers. Financial reports can be obtained from the system using the fourteen digit line item numbers. Expenditures for the HIV social services contracts are separated by using commodity subcommodity codes for HIV programs specified in the contract.