

Application for Federal Assistance SF-424		
* 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"/>
* 3. Date Received: <input type="text" value="09/18/2014"/>	4. Applicant Identifier: <input type="text"/>	
5a. Federal Entity Identifier: <input type="text"/>	5b. Federal Award Identifier: <input type="text" value="H89HA00036"/>	
State Use Only:		
6. Date Received by State: <input type="text"/>	7. State Application Identifier: <input type="text"/>	
8. APPLICANT INFORMATION:		
* a. Legal Name: <input type="text" value="City of Austin Health and Human Services Department (HHSD)"/>		
* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="74-6000085"/>	* c. Organizational DUNS: <input type="text" value="9456072650000"/>	
d. Address:		
* Street1: <input type="text" value="7201 Levander Loop, Building H"/>	Street2: <input type="text"/>	
* City: <input type="text" value="Austin"/>	County/Parish: <input type="text"/>	
* State: <input type="text" value="TX: Texas"/>	Province: <input type="text"/>	
* Country: <input type="text" value="USA: UNITED STATES"/>	* Zip / Postal Code: <input type="text" value="78702-5168"/>	
e. Organizational Unit:		
Department Name: <input type="text" value="Austin/Travis County HHSD"/>	Division Name: <input type="text" value="Community Services Division"/>	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: <input type="text" value="Mr."/>	* First Name: <input type="text" value="Gregory"/>	
Middle Name: <input type="text" value="L."/>	* Last Name: <input type="text" value="Bolds"/>	
Suffix: <input type="text"/>	Title: <input type="text" value="Manager, HIV Resources Administration Unit"/>	
Organizational Affiliation: <input type="text" value="Austin/Travis County HHSD"/>		
* Telephone Number: <input type="text" value="512-972-5081"/>	Fax Number: <input type="text" value="512-972-5082"/>	
* Email: <input type="text" value="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-15-003

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-15-003

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 Part A HIV Emergency Relief Grant Program
City of Austin, Austin/Travis County Health and Human Services Department
7201 Levander Loop, Bldg. H, Austin, Texas 78702-5168
Project Director: Gregory L. Bolds
(512) 972-5081 Voice; (512) 972-5082 Fax
gregory.bolds@austintexas.gov
Funds requested in the application: \$4,486,881

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. As one of the fastest growing areas in the United States, it has a third more residents than 10 years ago and almost double the population of 20 years ago. The racial/ethnic distribution is as follows: 53.2% White; 32.7% Hispanic; 6.9% African American; and 7.2% reported as Other.

The number of persons living with HIV in the Austin TGA continues to increase every year. As of December 31, 2013, there were 2,994 persons living with HIV (not AIDS) and 2,260 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 20.3% of new HIV cases reported for the period 2010-2013. 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 at each stage of HIV care. Although this HIV Care Continuum 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 2015 to HIV service categories that address the growing number of clients with more complex disease, inadequate knowledge of HIV, and multiple socio-economic issues. The priority core medical services for FY 2015 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 HIV care. As of the current year, FY 2014, the Austin TGA has received Ryan White Program Title I/Part A funding for twenty (20) years and MAI funding for sixteen (16) 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="4,486,881.00"/>
* 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="4,486,881.00"/>

*** 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

10th
17th
21st
25th
31st

Additional Congressional Districts of Program/Project

27th

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: 150px;" type="text"/>
* Last Name: <input style="width: 350px;" type="text" value="Leffingwell"/>	Suffix: <input style="width: 80px;" type="text"/>
* Title: <input style="width: 250px;" type="text" value="Mayor"/>	
* SIGNATURE: <input style="width: 300px;" type="text" value="Gregory Boldt"/>	* DATE: <input style="width: 150px;" type="text" value="09/18/2014"/>

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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL <input type="text" value="Gregory Bolds"/>	TITLE <input type="text" value="Mayor"/>
APPLICANT ORGANIZATION <input type="text" value="City of Austin Health and Human Services Department (HHSD)"/>	DATE SUBMITTED <input type="text" value="09/18/2014"/>

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		Total (g)
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	
1. Administration	93.914	\$ 419,851.00	\$	\$	\$	\$ 419,851.00
2. Quality Management	93.914	210,329.00				210,329.00
3. Direct Services	93.914	3,571,015.00				3,571,015.00
4. MAI	93.914	285,686.00				285,686.00
5. Totals		\$ 4,486,861.00	\$	\$	\$	\$ 4,486,861.00

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	\$ 275,400.00	\$ 123,859.00	\$	\$ 29,958.00	\$ 429,217.00
b. Fringe Benefits	112,931.00	55,694.00		12,894.00	181,519.00
c. Travel	12,537.00	7,904.00		0.00	20,441.00
d. Equipment	900.00	1,800.00		0.00	2,700.00
e. Supplies	10,188.00	3,377.00		0.00	13,565.00
f. Contractual	3,200.00	14,000.00	3,543,054.00	242,834.00	3,803,088.00
g. Construction	0.00	0.00			
h. Other	4,695.00	3,695.00	27,961.00		36,351.00
i. Total Direct Charges (sum of 6a-6h)	419,851.00	210,329.00	3,571,015.00	285,686.00	\$ 4,486,881.00
j. Indirect Charges	0.00	0.00			
k. TOTALS (sum of 6i and 6j)	\$ 419,851.00	\$ 210,329.00	\$ 3,571,015.00	\$ 285,686.00	\$ 4,486,881.00
7. Program Income	\$	\$	\$	\$	\$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program		(b) Applicant		(c) State		(d) Other Sources		(e) TOTALS	
8.	Quality Management	\$		\$		\$		\$	
9.	Direct Services								
10.	MAI								
11.									
12.	TOTAL (sum of lines 8-11)	\$		\$		\$		\$	

SECTION D - FORECASTED CASH NEEDS

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

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	\$			
17.	Quality Management				
18.	Direct Services				
19.	MAI				
20.	TOTAL (sum of lines 16 - 19)	\$			

SECTION F - OTHER BUDGET INFORMATION

21.	Direct Charges:	\$4,486,881
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.

BUDGET JUSTIFICATION NARRATIVE - AUSTIN TGA

Ryan White Part A FY 2015 Grant Application

Object Class Categories	Administration	Quality Management	HIV Services	Minority AIDS Initiative (MAI)			Total	Justification
				Administration	Quality Management	HIV Services		
a. Personnel (Name)/(Position Title)/(FTE)								
Greg Bolts, Ryan White Program Manager 0.30 FTE	\$8,025	\$16,051				\$24,076	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.	
Brenda Mendiola, Ryan White Grant Coordinator 0.60 FTE	\$27,062	\$9,021				\$36,083	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. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction and other quality indicators.	
Hugh Beck, Ryan White Grant Coordinator 0.47 FTE	\$15,425	\$9,255		\$4,319		\$28,999	Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction and other quality indicators.	
David Garza, Ryan White Grant Coordinator 0.58 FTE	\$15,821	\$12,656		\$8,227		\$36,704	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. Monitor provider improvements in quality of care including accessibility, availability, continuity, effectiveness, efficiency, client satisfaction and other quality indicators.	
Carmen Chronis, Ryan White Financial Specialist 0.38 FTE	\$14,702			\$7,645		\$22,347	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 and grantor fiscal conditions are met.	

Ryan White Part A FY 2015 Grant Application

Object Class Categories	Administration	Quality Management	HIV Services	Minority AIDS Initiative (MAI)			Total	Justification
				Administration	Quality Management	HIV Services		
a. Personnel (Name)(Position Title)(FTE)								
Richard Waite, Ryan White Planner II 0.70 FTE	\$33,748						\$33,748	Performs annual onsite monitoring of subcontracted services. Ensures compliance with National Monitoring Standards. Reports finding results to contractor, and Administration Manager. Develops Corrective Action Plan based on on-site monitoring findings and concerns.
Vacant Position, Ryan White Data Manager 0.63 FTE	\$2,938	\$29,383			\$4,701		\$37,022	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.
Vacant Position, Ryan White Quality Management Coordinator 0.83 FTE		\$47,493			\$5,066		\$52,559	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.
Kimberly Williams, Planning Council Community Services Program Manager 1.0 FTE	\$66,047						\$66,047	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.
John Waller, Planning Council Planner II 1.0 FTE	\$58,976						\$58,976	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.
Ashton Gray, Planning Council Administrative Senior 1.0 FTE	\$32,656						\$32,656	Assists the HIV Planning Council Coordinator to prepare Planning Council meeting agendas and supporting documents for approximately 48 meetings annually.
a-Total Personnel	\$275,400	\$123,859	\$0	\$20,191	\$9,767	\$0	\$429,217	

Ryan White Part A FY 2015 Grant Application

Object Class Categories	Administration	Quality Management	HIV Services	Minority AIDS Initiative (MAI)			Total	Justification
				Administration	Quality Management	HIV Services		
a. Personnel (Name)(Position Title)(FTE)								
FICA calculated at 6.2%	\$17,075	\$7,679		\$1,252	\$606		\$26,611	Fringe Benefits are calculated at various rates. This includes FICA at 6.2%.
Medicare Tax calculated at 1.45%	\$3,993	\$1,796		\$293	\$142		\$6,224	Fringe Benefits are calculated at various rates. Medicare at 1.45%
Retirement-Salaries x 18% x 7.49 FTEs	\$43,694	\$22,295		\$3,634	\$1,758		\$71,381	Fringe Benefits are calculated at various rates. This includes Retirement at 18%.
Medical Benefits at \$10,862 annually per FTE x 7.49 FTEs	\$43,991	\$21,181		\$3,470	\$1,740		\$70,382	Health Care Benefits are calculated on an annual basis, this year's costs estimate is \$10,862 per employee.
Annual Stability Incentive Pay for 5.00 FTEs	\$4,178	\$2,743					\$6,921	Incentive pay for employees with five or more years of continuous service.
b-Total Fringes Benefits	\$112,931	\$55,694	\$0	\$8,649	\$4,245	\$0	\$181,519	
c-Travel								
Local Travel	\$357	\$1,500					\$1,857	Grantee: Administration and Planning Council staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 638 miles x 0.560 = \$357. QM staff travel in local TGA to perform QM activities, attend meetings and coordinate QM training and program activities approximately 2,679 miles x 0.560 = \$1,500.
Out of Town Travel	\$10,800						\$10,800	Grantee: Attend four quarterly EMA/TGA meetings. Includes, lodging, meals, and travel related expenses for one (1) person from the Administrative Agency \$800. Grantee personnel attends HRSA's sponsored All Grantee's meeting in Washington D.C. Includes airfare, lodging, meals and travel related expenses for three (3) persons from the Administration Agency and two (2) from Planning Council at \$2,000 per person = \$10,000.
Out of Town Travel		\$6,404					\$6,404	One (1) QM person attending two Texas EMA/TGA & Part B meetings \$400. Data Manager, attends Ryan White Services Report (RSR) data report training. Includes, lodging, meals, and travel related expenses \$2,004. QM Manager attends QM conferences and interactive meetings with other QM regions \$2,000 One person from QM will attend HRSA's sponsored All Grantee's meeting in Washington D.C. Includes airfare, lodging, meals, and travel related expenses for one (1) QM person at \$2,000 per person.

Ryan White Part A FY 2015 Grant Application

Object Class Categories	Administration	Quality Management	HIV Services	Minority AIDS Initiative (MAI)			Total	Justification
				Administration	Quality Management	HIV Services		
a. Personnel (Name)(Position Title)(FTE)								
Part B Planner Travel Expenses	\$1,380					\$1,380	Ryan White Part B Planner Travel Expenses to participate in Planning Council's meetings to coordinate Ryan White Part A and B funding allocations.	
c- Total Travel	\$12,537	\$7,904	\$0	\$0	\$0	\$20,441		
d. Equipment	\$900	\$1,800				\$2,700	Grantee \$900; and Quality Management \$1,800; Computer purchase to replace obsolete ones.	
d-Total Equipment	\$900	\$1,800	\$0	\$0	\$0	\$2,700		
e. Supplies							Office supplies, usual and customary, each costing less than \$100.	
Food and Beverages	\$5,900					\$5,900	Food and beverages for Planning Council members when HIV Planning Council and committee meetings extend through meal time.	
Postage	\$162					\$162	Postage for subcontractor's contracts and correspondence. Planning Council for meeting minutes and announcements.	
Office Furniture	\$200	\$600				\$800	Office furniture, to purchase or replace office chairs.	
Telephone Base Cost	\$788					\$788	Planning Council telephone basic system including equipment and calling charges of an HIV hot line.	
Purchase Micro Projector	\$324					\$324	Micro Projector for meetings and presentations for staff and providers.	
Office Supplies	\$2,814	\$2,777				\$5,591	Office supplies, usual and customary, each costing less than \$100.	
e- Total Supplies	\$10,188	\$3,377	\$0	\$0	\$0	\$13,565		
f. Contractual								
Sub-Contracted Direct Part A and MAI Services			\$3,543,054			\$3,785,888	Service contracted with local non-profit organizations for an array of core and support services.	
Sub-Contracted Other Services	\$3,200					\$3,200	Planning Council will contract a Professional to provide one-one-one RW mandates and changes in new law \$3,200.	
Sub-Contracted Other Services		\$9,300				\$9,300	Quality Management will contract with license professional consultants versed in improving agency training in skills and knowledge needed to improve health outcomes. e.g. Health Literacy, Culture and Communication Skills to meet Federal Requirements approximately \$4,200; Training to evaluate previous year Quality Management goals and development of upcoming year Quality Management plan and its functions approximately \$5,100.	

Ryan White Part A FY 2015 Grant Application

Object Class Categories	Administration	Quality Management	HIV Services	Minority AIDS Initiative (MAI)			Total	Justification
				Administration	Quality Management	HIV Services		
a. Personnel (Name)/(Position Title)/(FTE)								
Sub-Contracted Other Services		\$4,700					\$4,700	Specialized Quality Review of medical care, substance abuse, mental health, Specialized Quality Review of medical care, substance abuse, mental health and case management of providers within the TGA approximately \$4,700.
f - Total Contractual	\$3,200	\$14,000	\$3,543,054	\$0	\$0	\$ 242,834.00	\$3,803,088	
g. Construction	\$0	\$0	\$0	\$0	\$0	-	\$0	
h. Other	\$4,695						\$4,695	Administration: Advertising of Public Notices \$350; Subscriptions to HIV-related publications \$479 Printing and Reproduction expenses of client surveys \$974; Training/Seminar Fees, Staff Development, attendance to Annual State HIV-AIDS conference \$900; Purchase of project management software \$1,592; HIV PC: Advertising in community media to increase PC membership and promote awareness/encourage involvement \$150; Translation of annual client survey from English to Spanish \$250.
h. Other		\$3,695					\$3,695	QM: Subscriptions to HIV-related publications \$475 Printing and Reproduction expenses of client surveys \$1,248; Training/Seminar Fees, Staff Development, attendance to Annual State HIV-AIDS conference \$1,522; Translation of annual client survey from English to Spanish \$450.
h. Other			\$27,961				\$27,961	Medical Transportation services provided in house through HHSD covers cost of bus passes, taxi vouchers, gas debit cards and special transit system passes \$27,961.
h - Total Other	\$4,695	\$3,695	\$27,961	\$0	\$0	\$0	\$36,351	
I. Total Direct Charges	\$419,851	\$210,329	\$3,571,015	\$28,840	\$14,012	\$242,834	\$4,486,881	
j. Indirect Charges								
k. TOTALS	\$419,851	\$210,329	\$3,571,015	\$28,840	\$14,012	\$ 242,834.00	\$4,486,881	
Program Income								

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 enable eligible jurisdictions to provide services for persons living with HIV/AIDS (PLWH) at each stage on the HIV Care Continuum: new diagnosis; linkage to care; retention in care; prescription of antiretroviral therapy (ART); and viral suppression. The Austin Transitional Grant Area (TGA) system of care also focuses on increasing access to stage-based services and decreasing HIV/AIDS health disparities among affected subpopulations and historically underserved communities. In collaboration with the Austin Area Comprehensive HIV Planning Council, the Austin TGA strives to offer a comprehensive HIV Care Continuum with prioritized core medical services and health-related support services for optimal medical treatment of 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 2015, 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 2015 to HIV service categories that provide core medical and support services designed to facilitate access to and retention in HIV primary medical care at all stages on the HIV Care Continuum. 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, with the ultimate goal of improving health outcomes for PLWH.

NEEDS ASSESSMENT

1. Jurisdictional Profile

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 of residence. The City of Austin is located in Travis County. A majority of the population (59%) resides in Travis County followed by Williamson County (25%). Most of the TGA population is White (53%) followed by Hispanic (33%). Over two-thirds (67%) of all African Americans in the Austin TGA reside in Travis County. Similarly, 67% of persons who are considered Other races and ethnicities reside in Travis County. Since 2009, the population of the Austin TGA has increased by 293,055 people, a 19% increase.

Table A. Distribution of Austin TGA population by race/ethnicity and county, 2014

Race/Ethnicity	County					Total
	Bastrop	Caldwell	Hays	Travis	Williamson	
White	43,661	17,303	103,093	538,035	289,042	991,134
African American	5,901	2,561	5,563	85,992	27,991	128,008
Hispanic	27,971	19,798	65,201	380,741	115,353	609,064
Other	2,192	875	5,473	90,944	35,259	134,743
Total	79,725	40,537	179,330	1,095,712	467,645	1,862,949

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

(1) HIV and AIDS incidence and prevalence, 2011-2013

The Austin TGA's HIV and AIDS prevalence and incidence data through December 31, 2013 is shown in Table B. During 2011-2013, 873 new HIV cases were reported in the Austin TGA. During this same time period, 428 new AIDS cases were reported in the Austin TGA. Most (88%) of the new HIV cases were males and most (77%) of these new cases reported an exposure category of men who have sex with men (MSM). More than half (55%) of the new HIV cases were 13 through 34 years of age. Five new HIV cases were 12 years of age or less. As of December 31, 2013, the number of persons living with HIV in the Austin TGA was 2,260. The number of persons living with AIDS was 2,994.

Table B. Incidence and Prevalence Numbers of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Cases, Austin TGA, 2011-2013

	Year					
	2011		2012		2013	
	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence
HIV	296	1,912	293	2,131	284	2,260
AIDS	158	2,764	136	2,953	134	2,994

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

(2) Demographic characteristics and exposure categories

Attachment 3 provides Austin TGA HIV/AIDS cases data by demographic characteristics and exposure categories for the past three calendar years. Table C shows the number of persons living with HIV by race/ethnicity for the years 2006 through 2013. In 2006, Whites comprised 50% of the persons living with HIV. Hispanics comprised 24.9% of the persons living with HIV in 2006. In 2013, the percent of persons living with HIV who were White decreased to 45.6% while the percent who were Hispanic increased to 31.0%. The percentage of PLWH who were African American decreased slightly from 24.2% in 2006 to 22.3% in 2013.

Table C. Number of Persons Living with HIV by Race/Ethnicity, Austin TGA, 2006-2013

Race/Ethnicity	Year							
	2006	2007	2008	2009	2010	2011	2012	2013
White	1,799	1,879	1,965	2,036	2,121	2,245	2,302	2,334
African American	875	910	943	980	1,010	1,082	1,117	1,142
Hispanic	894	980	1,049	1,104	1,161	1,256	1,502	1,587
Other	29	31	34	37	40	50	47	53
Unknown	20	21	23	20	20	43	116	138
Total	3,617	3,821	4,014	4,177	4,352	4,676	5,084	5,254

Source: Texas Department of State Health Services, eHARS

Table D shows the number of PLWH in the Austin TGA in 2013 by gender and age group. A majority (85.1%) of PLWH are males. Twelve persons are 12 years of age or younger. Overall, a majority (76.2%) of PLWH are between 35 through 54 years of age.

Table D. Number of persons living with HIV by age groups and gender, Austin TGA, 2013

Age Group (Years)	Gender		Total
	Female	Male	
< 2		0	0
2 – 12		6	12
13 – 24		36	195
25 – 34		105	896
35 – 44		239	1,362
45 – 54		256	1,745
≥ 55		140	1,044
Total	782	4,472	5,254

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. Overall a majority (85.1%) of PLWH are males; less than half (45.6%) are White. Among Whites, 92.2% of cases are male. Among males, African Americans comprise 17.7% of all males while, among females, African Americans comprise 48.8% of all females.

Table E. Number of Persons Living with HIV by Race/Ethnicity and Gender, Austin TGA, 2013

Race/Ethnicity	Gender		Total
	Female	Male	
White	181	2,153	2,334
African American	369	773	1,142
Hispanic	197	1,390	1,587
Other	9	44	53
Unknown	26	112	138
Total	782	4,472	5,254

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

Table F 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 alone accounted for the largest proportion of male PLWH at 79%. For African American males, this exposure category accounted for only 57% compared with 86% for White males. Intravenous drug use alone accounted for 26% of females living with HIV compared with 6% for males living with HIV.

Overall, heterosexual sex accounted for 16% of the PLWH ranging from 72% for females to 6.0% for males. Only 2% of White males reported heterosexual sex as an exposure category compared with 15% of African American males. Heterosexual sex was the reported exposure category for 80% of Hispanic females compared with 7% for Hispanic males.

Table F. Number of Persons Living with HIV by Gender, Race/Ethnicity and Exposure Category, Austin TGA, 2013

Gender	Race/Ethnicity	Exposure Category						Total
		MSM	IDU	MSM/IDU	Heterosexual	Pediatric	Adult Other	
Male	White	1,854	66	179	44	8	2	2,153
	African American	440	132	84	113	4	1	773
	Hispanic	1,120	80	87	93	9	1	1,390
	Other	35	3	3	3	1	0	44
	Unknown	89	5	12	4	2	0	112
	Subtotal	3,537	286	365	257	24	4	4,472
Female	White	0	61	0	119	1	0	181
	African American	0	98	0	261	10	0	369
	Hispanic	0	34	0	158	4	1	197
	Other	0	1	0	7	1	0	9
	Unknown	0	7	0	19	0	0	26

Subtotal	0	201	0	564	16	1	782
Total	3,537	487	365	820	40	5	5,254

Source: Texas Department of State Health Services, eHARS

(3) Disproportionate impact of HIV/AIDS on specific populations, representation in Ryan White HIV/AIDS Program primary medical care, and new/emerging populations

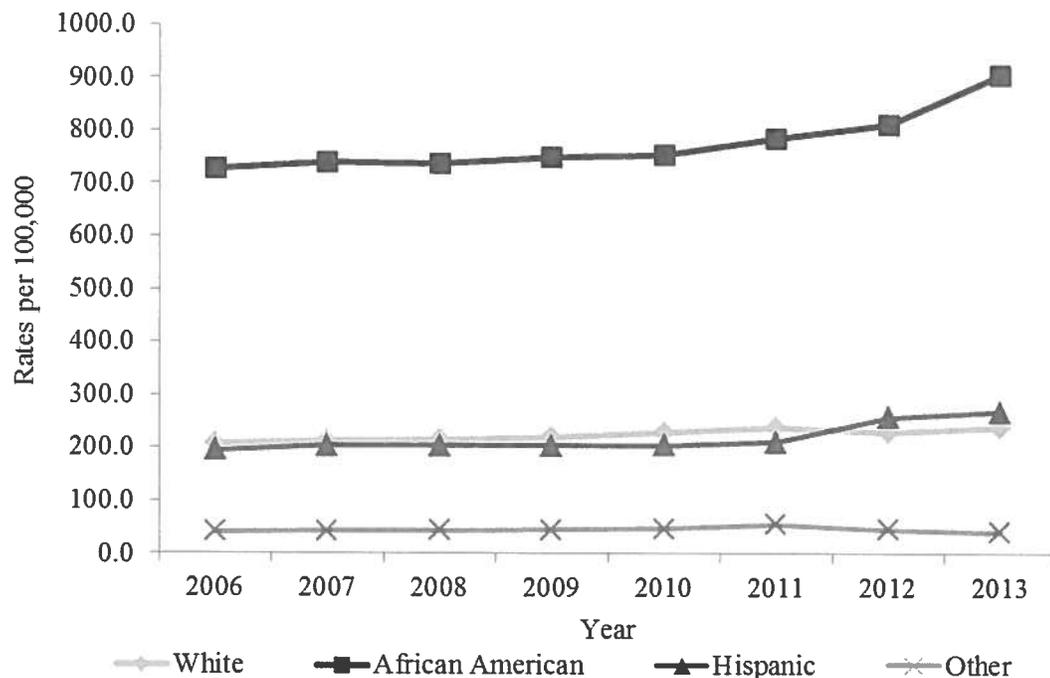
a. Disproportionate impact of HIV/AIDS on specific populations

Most of the Austin TGA population is White (53.2%) followed by Hispanic (32.7%). 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 20.3% of the new HIV cases reported during 2010-2013 were African American. While 3.4% of the Austin TGA population is African American males, 14.73% 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 7.0% of the persons living with HIV are African American females.

The percentages of Hispanic males and females in the Austin TGA population are 16.7% and 16.0%, respectively. However, the percentages of persons living with HIV in the TGA who are Hispanic males and females are 26.4 and 3.8%, respectively.

Figure A. Persons Living with HIV Prevalence Rates by Race/Ethnicity, Austin TGA, 2006 – 2013



Source: Texas Department of State Health Services, eHARS

Figure A shows the prevalence rate for persons living with HIV by race/ethnicity for 2006 through 2013. In 2013, the rate (risk) of HIV in African Americans was 3.8 times higher compared with Whites. From 2010 to 2013, the rate (risk) of disease increased 31% for Hispanics and 20% for African Americans compared with a slight increase (4%) for Whites. Rates for Other decreased 13% over the same time period.

Table G show the PLWH prevalence rates by gender and race/ethnicity for 2013. HIV infection disproportionately impacts African American males. The prevalence rate for African American males is three times higher compared with White males. A greater disproportionate impact is seen when comparing prevalence rates among females. The prevalence rate for Hispanic females is 18 times higher compared with the rate for White females. The prevalence rate for African American females is 15 times higher compared with the rate for White females.

Table G. Persons Living with HIV Prevalence Rates* by Race/Ethnicity Austin TGA, 2013

Race/ethnicity	Gender		Overall
	Male	Female	
White	441.2	3.7	238.6
Black	1,248.5	57.5	905.4
Hispanic	461.3	68.0	268.6
Other	68.7	13.5	40.5
Overall	488.6	85.9	287.7

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

*Rates per 100,000 population

Compared with the general population, homelessness contributes to difficulties in diagnosing and adequately treating HIV infections. Limited access to comprehensive health care due to homelessness delays the identification of HIV and accelerates the onset of AIDS. Limited access also contributes to the increased prevalence of opportunistic infections and other medical conditions, including tuberculosis, that are more common among homeless people than among other groups. In addition, many homeless people lack health insurance and cannot pay for medications and health services.

There is no local population-based study on HIV infection among the homeless population in Austin. The estimated prevalence of HIV in homeless persons in San Francisco, California was 3.4%. (Source: National Alliance to End Homelessness, August 2006). This prevalence was over eight times greater than the prevalence (0.4%) in the general population. In San Francisco, the percentage of PLWH who were homeless during 2006-2012 ranged annually from 9% to 14% (Source: HIV/AIDS Epidemiology Annual Report, 2012, San Francisco Department of Public Health). Compared to all HIV cases, persons who were homeless at their HIV diagnosis were more likely to be women, African Americans, and intravenous drug users. Similarly, homeless PLWH in King County, WA, were more likely to be African American and intravenous drug users (Source: Public Health-Seattle & King County, June 2009).

In the Austin TGA, an estimated 205 PLWH are homeless. Based on prior studies, a high percentage of these persons may be African American and intravenous drug users. The high percentage of homeless persons who are African American may contribute to the higher risk of HIV in the African American population in the Austin TGA. The prevalence rate for African American males in the Austin TGA is three times higher compared with White males. The prevalence rate for African American females is 15 times higher compared with the rate for White females.

Providing medical services to formerly-incarcerated individuals living with HIV is an emerging need in the Austin TGA. Table H shows the total number of inmates with HIV released by the Texas Department of Criminal Justice (TDCJ) for 2007 through 2013. The county of residence for the newly released inmates is not provided by TDCJ. However, to estimate the number of inmates with HIV infection released to Travis County, the percentage of current inmates with HIV that came from Travis County is applied to the total number of inmates with HIV released during that year. During 2013, an estimated 49 inmates with HIV infection were released from TDCJ and moved to Travis County. For the period 2007 through 2013, the estimated average annual number of TDCJ inmates with HIV released to Travis County is 51.

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

	Year						
	2007	2008	2009	2010	2011	2012	2013
Number of inmates with HIV released – Texas	1,413	1,382	1,376	1,339	1,228	1,388	1,240
Estimated number of inmates with HIV released – Travis County residents	60	61	52	40	43	55	49

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

b. Representation in Ryan White HIV/AIDS Program primary medical care

A comparison of persons living with HIV in the Austin TGA to the patients seen by the Ryan White-funded medical care provider, the David Powell Community Health Center, shows that patients receiving Ryan White-funded medical care are fully representative of populations in the TGA by gender, race/ethnicity, and risk category. Slight differences exist for female gender and the heterosexual risk category. The proportions of females and those with the heterosexual sex as a risk category are higher in the Ryan White care system compared with the Austin TGA.

c. New/emerging populations not reported on in last year’s application

Hispanics

Hispanics in the Austin TGA are an emerging population increasing impacted by HIV/AIDS. In 2006, Hispanics comprised 25% of the PLWH in the Austin TGA. By 2013, Hispanics comprised 31% of the PLWH. Prevalence rates from 2006 to 2013 for Hispanics have increased 35% compared with increases of 9% for Whites and 12% for African Americans. Hispanic PLWH have a greater prevalence (4.2%) of early or secondary syphilis compared with White

PLWH (2.8%) which complicates medical care. Hispanic PLWH have a greater chance of late diagnosis. Over a third (35.8%) of Hispanic PLWH have a diagnosis of AIDS within one year of HIV diagnosis compared with 31.4% for Whites.

Unique challenges related to prevention and medical care of the Hispanic population include lack of understanding English and less education. Some Hispanic PLWH are undocumented migrants which complicates gaining access to health care services.

Persons 55 years of age or older

Persons age 55 years or older comprise an increasing number of PLWH in the Austin TGA. In 2006, 9.5% of the 3,617 PLWH in the TGA were 55 years of age or older. By 2013, 20% of the PLWH were 55 years of age or older. The prevalence rate for the 55 years of age or older group has increased 98% since 2006, the greatest increase compared with other age groups. Co-morbidities associated with increasing age such as diabetes and cardiovascular disease increase the cost and complicate the delivery of medical care services.

Persons in this age group have a greater misunderstanding about how HIV is transmitted compared with other age groups (Source: 2009 Survey of Americans on HIV/AIDS: Summary of Findings on the Domestic Epidemic. Kaiser Family Foundation, April 2009. <http://www.kff.org/kaiserpolls/upload/7889.pdf>). Misunderstandings of how HIV is transmitted may increase the transmission of HIV in this age group.

2. Demonstrated Need

A. Unmet Need

(1) The Unmet Need Framework is Attachment 4

(2) Unmet Need for medical care in CY 2011, 2012, and 2013

Table I. Number and Percent of Persons Living with HIV with Unmet Need for Medical Care, Austin TGA, 2011-2013

Characteristic	Year					
	2011		2012		2013	
	N	%	N	%	N	%
Disease Status						
HIV	435	22.8	483	22.7	487	21.6
AIDS	392	14.2	391	13.2	408	13.6
Gender						
Female	132	18.5	114	15.2	124	15.9
Male	695	17.5	760	17.5	771	17.2
Race/Ethnicity						
White	343	15.3	344	14.9	358	15.3
African American	210	19.4	210	18.8	208	18.2
Hispanic	259	20.6	300	20.0	299	18.8
Other	12	24.0	12	25.5	15	28.3

Unknown	3	7.0	8	6.9	15	10.9
Age Group (years)						
< 2	0	0	0	0	0	0
2 – 12	3	30.0	2	18.2	2	16.7
13 – 24	37	20.7	39	18.8	36	18.5
25 – 34	182	23.1	191	22.4	209	23.3
35 – 44	239	18.6	239	17.7	249	18.3
45 – 54	245	15.1	268	15.4	250	14.3
≥ 55	121	15.4	135	14.6	149	14.3
Risk Category						
MSM	507	16.6	568	16.8	587	16.6
IDU	108	21.9	97	19.9	97	19.9
MSM/IDU	54	15.0	58	15.6	54	14.8
Heterosexual	153	20.8	144	18.3	150	18.3
Pediatric	5	15.2	6	15.0	7	17.5
Adult Other	1	20.0	1	20.0	0	0
Overall	827	17.7	874	17.2	895	17.0

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

(3) Unmet Need trends, planning, and decision making

Table I above shows the number and percentage of persons living with HIV with unmet need for medical care by disease status and various demographic characteristics. In 2013, an estimated 17% 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 in the other four EMAs/TGAs range from 22% to 27%. 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 2011 to 2013. Exceptions are those in the White race/ethnicity category and those in the MSM risk category where the percent unmet need remained the same. Other exceptions included 1) those in the Other race/ethnicity category, 2) those in the Pediatric risk category, and 3) those in the 25-34 years age group. The small numbers of persons in these Other and Pediatric groups may be responsible for the apparent increase seen in those two groups.

The most recent Austin Area HIV Planning Council's Comprehensive Needs Assessment was completed in June 2014. It was conducted by Austin/Travis County Health and Human Services Department (ATCHHSD) staff that provide administrative support to the Planning Council. Staff administered the needs assessment in accordance with an approved project plan, following the ongoing direction and input of Planning Council's Comprehensive Planning/Needs Assessment Committee. The Needs Assessment Plan included the following components: a

written survey administered to PLWH within the TGA; focus groups consisting of PLWH representing specific populations; and demographic and statistical data from the AIDS Regional Information and Evaluation System (ARIES) and The Texas Department of State Health Services (DSHS) Epidemiological Profile. The list of priority populations included the newly diagnosed, young MSMs, and the out-of-care. Efforts to recruit participants from these three groups were not successful. While not surprising based upon past outreach experience, the difficulty in recruiting underscores the fact that these populations are hard to reach and generally underserved. However, under direction from the Comprehensive Needs Assessment Committee, Planning Council staff currently are working with the ATCHHSD’s Communicable Disease Unit on a plan to survey out-of-care PLWH who present at the HIV/STD Clinic.

The Unmet Need Framework (Attachment 4) was used to project the number of PLWH who are out-of-care in FY 2015, and to produce a demographic breakdown of the out-of-care minority populations. Documenting 895 PLWH with Unmet Need in 2013, Table I shows the exposure groups of IDU along with MSM/IDU representing a significant percentage of those with Unmet Need. These data further supported Planning Council’s allocations efforts directed towards the IDU and MSM/IDU populations. As reflected in the Planning Council’s final allocations decision, funding for Substance Abuse Services outpatient and residential was increased to a level that not only accommodates current utilization trends but also creates capacity for access as a result of outreach strategies that will be used to bring these populations into care. Refer to the Work Plan on p. 41 for additional information on how the Unmet Need Framework was used in planning and decision making, as well as the EIIHA Plan on p. 16.

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

(1) EIIHA Data

The target populations included in the 2014 EIIHA Plan were Young Men Who Have Sex With Men, African American Women and Minority Injection Drug Users. The requested data for these target populations for the period 01/01/2014 through 06/30/2014 is presented in the tables below.

Table J. Early Identification of Individuals with HIV/AIDS, Men Who Have Sex with Men (MSM) 13 to 24 Years of Age, January 1 through June 30, 2014.

13 to 24 Year Old Men who Have Sex with Men	Targeted Testing		Non-Targeted Testing		Total	
	N	%	N	%	N	%
Newly Diagnosed Positive HIV Texas Events						
Number of test events	253	100.0	0	0.0	253	100.0
Number of newly diagnosed positive test events	5	2.0	0	0.0	5	2.0
Number of newly diagnosed positive test events with client linked to HIV medical care	3	1.2	0	0.0	3	1.2
Number of newly diagnosed confirmed positive test events	5	2.0	0	0.0	5	2.0
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 Texas Events						
Number of test events	253	100.0	0	0.0	253	100.0
Number of newly diagnosed positive test events	1	0.4	0	0.0	1	0.4
Number of newly diagnosed positive test events with client linked to HIV medical care	1	0.4	0	0.0	1	0.4
Number of newly diagnosed confirmed positive test events	1	0.4	0	0.0	1	0.4
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

Source: *Texas Department of State Health Services STD*MIS and eHARS*

*All persons 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; therefore a match cannot be made at this time.

†To determine if CD4 and viral load testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data; therefore a match cannot be made at this time.

Table K. Early Identification of Individuals with HIV/AIDS, African American and Hispanic Intravenous Drug Users, January 1 through June 30, 2014

African American and Hispanic Intravenous Drug Users	Targeted Testing		Non-Targeted Testing		Total	
	N	%	N	%	N	%
Newly Diagnosed Positive HIV Texas Events						
Number of test events	14	100.0	20	100.0	34	100.0
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 Texas Events						
Number of test events	14	100.0	20	100.0	34	100.0
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

Source: *Texas Department of State Health Services STD*MIS and eHARS*

*All persons 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; therefore a match cannot be made at this time.

†To determine if CD4 and viral load testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data; therefore a match cannot be made at this time.

Table L. Early Identification of Individuals with HIV/AIDS, African American Females, January 1 through June 30, 2014

African American females	Targeted Testing		Non-Targeted Testing		Total	
	N	%	N	%	N	%
Newly Diagnosed Positive HIV Texas Events						
Number of test events	113	100.0	480	100.0	593	100.0
Number of newly diagnosed positive test events	0	0.0	3	0.6	3	0.5
Number of newly diagnosed positive test events with client linked to HIV medical care	0	0.0	2	0.4	2	0.3
Number of newly diagnosed confirmed positive test events	0	0.0	2	0.4	2	0.3
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 Texas Events						
Number of test events	113	100.0	480	100.0	593	100.0
Number of newly diagnosed positive test events	0	0.0	1	0.2	0	0.2

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	1	0.2	0	0.2
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

Source: *Texas Department of State Health Services STD*MIS and eHARS*

*All persons 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; therefore a match cannot be made at this time.

†To determine if CD4 and viral load testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data; therefore a match cannot be made at this time.

(2) FY 2015 EIIHA Plan

The overarching goal of the FY 2015 EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and ensure that once tested they are accessing HIV care and treatment.

a. Describe the planned activities of the EMA/TGA EIIHA Plan for FY 2015

Updated estimate of individuals who are HIV positive and who are unaware of their status:

According to the most recent data provided by the Texas Department of State Health Services (DSHS), a total of 986 PLWH are unaware of their status. This is 15.8% of the estimated number of PLWH residing in the Austin TGA. The estimate for the percentage of PLWH who are unaware of their infection is provided by DSHS based upon calculations extrapolated from estimates provided by the Center for Disease Control. (Note that the 2014 estimate was based upon 18.1%, reflecting previous CDC methodology. There is no indication of an actual drop in the number of PLWH who are unaware.)

Populations included in the EIIHA Plan:

- Young men who have sex with men (YMSM ages 13-24). Data trends clearly show a steady increase in the number of MSM in this age group. Additionally, data which quantifies risk clearly show YMSM are at greater risk than the overall risk rate for the TGA.
- African American Women. African American women continue to experience a disproportionately high rate of HIV infection.
- Minority (African American and Hispanic) Injection Drug Users (IDUs). While the number of PLWH who utilize injection drugs remains relatively low as a percentage of the overall PLWH population, minority IDUs remain the most challenging group in terms of outreach and achieving successful outcomes.

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

- Continue outreach initiatives, including outreach services funded by Ryan White Part A.
- Continue HIV testing, including the Austin/Travis County Health and Human Services Department (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 continues to have 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:

The Austin TGA has enthusiastically embraced efforts by the Texas Department of State Health Services to create the HIV Syndicate, which began in the fall of 2013. The objective of the HIV Syndicate is to bring together the various AIDS service organizations, Community Based Organizations serving HIV populations, and state and local agencies administering HIV programs in order to create a unified strategy for addressing HIV/AIDS, specifically including prioritized plans for care and prevention. The impetus for the HIV Syndicate comes from the fact that HIV planning in Texas has historically been separated into jurisdictional "siloes" lacking unified direction. The HIV Syndicate now provides a foundation for a more coordinated and effective strategy, use of resources, and the opportunity to share best practices. Following a statewide kick-off meeting, participants established six "domains" for action via workgroups. The Austin TGA has joined the Public Awareness Domain, which has set a goal of *increasing public awareness via information dissemination about social determinants in the spread of HIV*. The Domain group meets periodically via conference call and is actively developing marketing strategies in keeping with this goal.

In addition to the HIV Syndicate, a major focus of the EIIHA Plan will be to continue the highly successful collaboration with the Austin Area HIV Collaborative. The HIV Collaborative is a community-based coalition which brings together a broad base of HIV service providers, City/County 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 other organizations with both direct and 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 HIV Collaborative has been meeting since early 2013 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, recent meetings have moved forward with a determination to accomplish meaningful goals. The individual chairing and organizing meetings recently changed careers resulting in temporary loss of momentum for the HIV Collaborative. A new chair will be in place soon and the work of the Collaborative will continue. Accomplishments of the HIV Collaborative include:

- Completion of a survey directed at target populations to determine how to best reach at-risk populations using media most meaningful to the specific population, e.g., social media web sites for youth. The Collaborative will now use the results to develop marketing material focused on correcting misinformation and misconceptions among target populations. Specifically, the Collaborative intends to address the widely held perception among young MSM that “HIV is no big deal anymore – you just take a pill.” The HIV Collaborative project is directly aligned with the first of the three EIIHA target populations.
- The HIV Collaborative worked with Austin Area predominately African American churches to bring attention to HIV/AIDS in the African American community. This included presentations to ministers and church leaders regarding HIV/AIDS, HIV services and resources, and material to enable ministers to address stigma and inclusiveness as part of their sermons. The Collaborative also organized testing at local churches with ministers setting the example to encourage testing.

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

Planned outcomes from 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 a City of Austin HHSD program to reach out to individuals who tested positive but who were never successfully linked to care. The outcome will also be accomplished through the efforts of Ryan White service providers to enroll/re-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 outreach efforts to reach those PLWH who know their status but are out of care to be brought back into care, and also through continued efforts to enroll/re-enroll PLWH in insurance under ACA.

Reduce New HIV Infections. This outcome will be achieved through outreach and education, specifically including the HIV Coalition's prevention marketing campaign.

b. Describe how the overall FY 2015 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy and the White House Continuum of Care Initiative.

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 2013 Austin TGA Treatment Cascade shows Met Need at 83%; Continuity of Medical Care at 70% (at least 2 visits, labs or ARVs in 12 months) and Viral Suppression at 64%. 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. The Treatment Cascade also shows improvement over 2012 numbers for the Austin TGA. Additionally, DSHS epidemiological data over the last five years show moderate improvement in the rate of new infection for African American Women and IDUs. While it is not possible to directly attribute this success specifically to EIIHA efforts, the outcomes suggest the EIIHA Plan contributed to overall collaborative effort within the Austin TGA, and the Austin TGA has in fact realized a measure of success in trending outcomes in the right direction.

c. Describe how the Unmet Need estimate and activities related to the Unmet Need population inform and relate to the 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 there is an overall decrease in the number of PLWH with Unmet Need. However, while target groups likewise reflect overall decrease in Unmet Need, the target groups continue to reflect disproportionately higher rates. As demonstrated by the Austin TGA Treatment Cascade, the overall trend over the last five years shows a notable reduction in Unmet Need. However Unmet Need data during this five year period shows target populations remain consistently higher than the general data trends. For example, from 2009 to 2013 white PLWH in the Austin TGA showed a reduction in Unmet Need of 29% (2009) to 15% (2013), while African Americans went from 28% to 18% and Hispanics from 28% to 19%. It is also noteworthy that IDUs and IDU-MSMs show negligible improvement during this period.

During this same five year period, while White PLWH continue to represent the majority population, the percentage of White PLWH dropped from 48% to 44.4% while the percentage of African American and Hispanic PLWH increased. In fact, Hispanic prevalence increased from 26% to 30.2%. This demonstrates that the EIIHA plan is targeting populations with the greatest Unmet Need.

d. Describe how the EIIHA Plan for FY2014 (e.g., process, activities and outcomes) influenced the development of the EIIHA Plan for FY2015.

The success realized in bringing more PLWH into care and the increase in the number of people who achieved viral suppression confirms that the Austin TGA is doing something right. The

extent to which this success can be attributed to the EIIHA Plan is a matter of speculation. Thus it is essential that the Austin TGA evaluate the specific activities and the resultant outcomes of EIIHA activities. Consequently, the experiences and outcomes resulting from the current EIIHA Plan have been considered in developing the 2015 EIIHA Plan. One conclusion from evaluation of 2014 Plan activities is that it is important to separate out the relative merits of an objective from what was actually accomplished. For example, 2014 activities included “*active support for opt-out testing.*” The fact that no local hospitals agreed to incorporate opt-out testing does not negate the value of that goal. Each of the activities proposed in the 2014 EIIHA Plan were likewise evaluated both from the standpoint of the merits of the stated objective as well as what, if anything, was accomplished. Another conclusion reached from review of 2014 activities is that the activities were stated in broad terms such as “*continue to support*” and thus lack specific activity definition and measurability of outcomes. Consequently, 2015 activities will be stated in more specific terms. Rather than simply saying that the Austin TGA will support Test Texas, the Plan will commit to active participation in Test Texas events and offer active participation in discussions Test Texas has with hospital administrators to address barriers to testing.

e. Describe any 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 routine HIV testing within the Austin TGA. Therefore, 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. There is clearly an opportunity presented by this second barrier, albeit not a “legal” barrier in the strict sense. Medical practices do indeed dictate that a medical provider not deliver a positive test result to a patient without providing counseling, follow up and linkage information. But Ryan White funded services are available to provide that service in conjunction with the legal responsibility of the ATCHHSD Communicable Disease Unit to follow up with a communicable disease report. Therefore, one specific EIIHA activity will be to ensure that hospitals are aware of the services available and thus reduce this perceived barrier to routine opt out testing.

f. Select three (3) distinct populations for the FY 2015 EIIHA Plan.

The three populations selected for the 2014 EIIHA Plan are:

- Young men who have sex with men (YMSM) ages 13-24
- African American women
- Minority (African American and Hispanic) Injection Drug Users (IDU)

For each selected target population describe:

Why the target population was chosen for the FY 2015 EIIHA Plan and how 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 continue to show these populations to be experiencing a disproportionately high rate of

growth, high levels of risk of exposure, and behaviors that place these groups at higher risk. The most recent Epidemiologic Profile published by the Texas Department of State Health Services (DSHS) shows that the Austin TGA has four subpopulations that exceed prevalence in excess of one percent, in contrast to the general population rate of 254.1 per 100,000. The data present a compelling argument for all three target populations' inclusion as target groups. Specific data findings include:

- African American males and females constitute two percent of the Austin TGA population but over 15% of PLWH in the Austin TGA. DSHS surveillance data also notes that HIV positive young African American males are predominately MSM while older African American males are largely IDU or MSM/IDU.
- The prevalence rate for African American females is 10 to 14 times higher than the rate for White and Hispanic females.
- The percentage of PLWH who are Hispanic has grown steadily over the last seven years within the Austin TGA, while the rate of late diagnosis for Hispanics is nearly 10% higher than the rate for Whites and African Americans.
- DSHS also reports that 38% of HIV positive African American women are IDU.
- Over the last seven years there was a 57% increase in the rate of diagnosis among young MSM ages 13-24.

These high rate subpopulations reflect overlap in risk factors. This overlap is the basis for focusing on minority IDU rather than all IDU. 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 the Austin TGA. This is especially true for the IDU population. The fact that no positives were identified out of 14 IDU targeted tests belies the point that a concerted effort to test this population could only find 14 candidates. This emphasizes the fact that no population is more in the shadows and challenging to reach than the IDU.

Additionally, data which quantify risk clearly show that the selected target groups are at greater risk than the overall population. 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 YMSMs. 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.

Specific challenges with or opportunities for working with the target 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: AAW are not comfortable openly discussing the topic of sexuality from a personal perspective; some AAW possess low self-worth and self-esteem issues which prohibit them from engaging in and requiring condom use; and 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 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; lack of 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 lack of treatment and care for sexually transmitted infections.

The specific activities that will be utilized for target populations

The following activities are planned for all three target groups:

- Continue street outreach activities
- Complete the educational campaign for YMSM (HIV Coalition)
- Continue social marketing campaign (ATCHHSD)
- Continue HIV testing schedule (mobile and fixed locations)
- Continue support and involvement 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 and support groups
- Conduct follow up Needs Assessment for PLWH who are out of care

Specific activity for African American Women:

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

Specific activity for IDUs:

- Advocate for a needle exchange program within the City of Austin (currently illegal under City ordinance)

Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T. objectives – Specific, Measurable, Achievable, Realistic, and Time phased)

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. A specific area of emphasis will be the efforts of the ATCHHSD Communicable Disease Unit to reach individuals previously tested positive but never successfully linked to care.

Informing individuals of their HIV status

The Austin TGA's plan to inform unaware individuals is to use existing methods and service providers to reach individuals previously tested who were never informed and/or linked to care because they could not be located. Emphasis will be placed on improving the coordination among these providers in order to increase the number of clients informed of their status and minimize the number of positives who "fall through the cracks." 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. The strategy for 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 and based upon strategies proven most effective. In the TGA, the majority of referrals into medical care or other HIV support services are done through the case management system. Counseling and testing staff, client advocates and non-medical case managers also provide assistance in referring to medical and support services. Strengthening the Memorandums of Understanding (MOU) between collaborating agencies and ensuring that follow ups are routinely completed will be a key to improving the referral process.

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 ATCHHSD HIV Prevention Unit, the responsible party is generally the case manager or designee.

Activities involving collaboration with the HIV Coalition and HIV Syndicate will be the responsibility of the Planning Council with support of Planning Council staff. This includes the educational campaigns described above that are projects of the Coalition and the HIV Syndicate Public Information Domain.

Planned outcomes that will be achieved for the target population as a result of implementing the 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 and successfully engage 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.

g. Describe plans to present, discuss, and/or disseminate the EIIHA Plan and outcomes of your EIIHA Plan activities to stakeholders (e.g., poster presentations, journal articles, presentations to planning bodies).

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 Austin Area HIV 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 HIV Aging Symposium and various community health fairs and forums. Planning Council is a sponsor for many of these events and staffs a table to disseminate 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 provides press releases via the Public Information Officer to share public health information including HIV-related information, as appropriate, with the local media.

C. Unique Service Delivery Challenges

Co-morbidities increase the challenge of providing care to PLWH in the Austin TGA in three main ways. First, these factors tend to complicate the prevention and management of HIV infection. Second, they are associated with inadequate information about the disease, its prevention and treatment, availability of services, and reduced ability to navigate the care system. Third, historically underserved and hard-to-reach populations are disenfranchised from health and other social service systems in general. Additionally, they may not access care regularly or adhere to treatments because of impaired judgment from substance abuse or mental illness.

The high prevalence of injection drug and other substance abuse in the TGA not only complicates the management of HIV but also puts the user at risk for other infections. The high rate of homelessness in a rapidly growing population reduces the ability of the care system to reach patients and often results in poor adherence to treatment regimens. These factors are associated with diagnosis at a later stage of the disease, and multiple social challenges. Service delivery in the TGA is further complicated by challenges resulting from implementation of the Affordable Care Act (see p. 24-28).

Additional service delivery challenges in the Austin TGA:

- Many PLWHA move to Austin to seek care, with nearly 1 in 4 newly reported cases of HIV and AIDS in the TGA already documented as cases in other jurisdictions.
- Continuity of care is a critical problem, with clients experiencing barriers in accessing specialty care within the local indigent health care system. More and more subspecialty care providers are reluctant to accept Medicaid or Medicare clients.
- The David Powell Community Health Center reports that more than 40% of its HIV patients have injection drug use and/or mental illness co-morbidity.

- The high rates of STIs, particularly Chlamydia and syphilis, are evidence of high levels of risky sexual behavior in the TGA's large youth population ages 13-24.

D. Minority AIDS Initiative

(1) Minority Populations in Austin Targeted with MAI Funds for FY 2015

The Austin TGA continues its funding commitment for improving health outcomes in the two local minority communities most heavily impacted by HIV and AIDS: African American/Black and Hispanic/Latino. As evident from the epidemiological data presented on p. 5-7 above, due to multiple reasons these two groups continue to be affected disproportionately by the disease in our area. The real effects of poverty, educational disparities, stigma, lack of health care access, higher incarceration rates, and other socioeconomic challenges have combined to impact Black and Hispanic individuals living with HIV to a greater degree than other groups in Austin. For these reasons the Latino and African American communities have been targeted for receiving MAI program services locally.

(2) MAI Allocation Planning and Service Categories Selected

The Austin Area Comprehensive HIV Planning Council incorporated specific attention to MAI funding in its allocation and priority setting processes. Besides reviewing the epidemiological data noted above, the Council considered the current MAI activities and recent performance impacts of those programs. After determining that current Part A primary medical care and other support services were being funded sufficiently to serve our minority populations along with other HIV-affected groups, the Council again focused on which services would further improve access and enhance outcomes for the targeted MAI groups. Based upon demonstrated need and past performance, the Council decided to continue funding for MAI Medical Case Management, MAI Non-medical Case Management, and MAI Outreach. With their specific focus on African American and Hispanic clients, the Austin TGA's MAI services continue achieving good results on key performance measures. For example, MAI case management successfully links more than 90% of clients with primary medical care and HIV support services. MAI Outreach also links more than 80% of individuals into medical case management or other services.

(3) MAI Activities Impacting the HIV Care Continuum

Two main MAI-funded service categories locally, Medical Case Management and Non-medical Case Management, together incorporate comprehensive client-centered activities which reduce barriers and improve service effectiveness for our targeted communities. To address the challenge of minority individuals newly diagnosed or at-risk for falling out of care, MAI program staff have targeted MAI Outreach activities and increased referrals of clients to needed medical and support services. Case managers work closely with clients after enrollment to identify their specific barriers to care and develop goals to address those barriers. MAI staff assist clients to address their individual barriers to attendance, providing transportation as needed, and attend appointments when warranted. Additionally, MAI Medical and Non-medical case managers work with their clients to keep initial primary care appointments and maintain ongoing medical visits.

Some of the most difficult challenges for minority clients are securing basic needs such as food, housing, and reliable transportation, which can affect key health factors such as linkage to and retention in care and viral load suppression. Through a comprehensive inter-disciplinary approach, MAI staff have been successful in linking clients to needed support services such as transitional and permanent housing, social security benefits, food stamps, bus passes and other programs. Securing such benefits enables the MAI client to focus more effectively on their medical care goals. While MAI patient navigators and Non-medical case managers work on the clients' basic needs and programmatic requirements, Medical case managers and other staff can focus on behavioral changes and medication/treatment adherence. This tandem approach results in more effective overall care for the minority clients, and is reflected in the improved viral suppression rates that the Austin TGA has demonstrated.

3. Impact of Funding

A. Impact of the Affordable Care Act (ACA)

(1) Uninsured and Poverty

The table below provides required data on PLWH who are uninsured and living in poverty.

Table M. Estimated Number of Persons Living with HIV by Income Range and Type of Insurance Coverage, Austin TGA, 2013.

Poverty and Insurance Coverage Characteristics	Percentage	Estimated Number of Persons Living with HIV
Income Range*		
100% FPL and below	23.0	1,208
101% - 138% FPL	9.0	473
139% - 250% FPL	21.0	1,103
≥ 400% FPL	4.0	210
Type of Insurance Coverage†		
Medicaid/Medicare	41.1	2,159
Private	30.1	1,581
Uninsured	17.1	898

*Data provided by Texas Department of State Health Services

†Percentage of insurance coverage obtained from The Henry J. Kaiser Family Foundation, Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV, January 2014

A total of 5,254 persons living with HIV reside in the Austin TGA. Approximately one quarter (23%) live at or below the federal poverty level (FPL). An additional 473 PLWH are estimated to have incomes between 101% FPL and 138% FPL. An estimated 210 PLWH had incomes at or greater than 400% FPL. The estimated percentage of PLWH who are uninsured is 17.1%. Using this percentage, the estimated number of PLWH who lack health insurance is 898. An estimated 71.2% of PLWH in the Austin TGA are covered by Medicaid, Medicare, or private insurance.

In contrast to the data presented above, evaluating data from ARIES (the client-level data system that tracks consumers receiving HIV services) presents a different picture regarding poverty. Out of the 3,103 consumers who received service from one or more Ryan White Program Parts in 2013, 61.4% have incomes below 100% FPL, 72.6% are below 138% FPL, and 97% have incomes below 400% FPL. This difference is to be expected since Ryan White tends to serve a significant share of the low income population living with HIV. However, the ARIES data are relevant because it is the existing Ryan White consumers who must be evaluated for eligibility under the payer of last resort policy.

Additional data relevant to quantifying ACA impact

Tobacco use – One of few health related questions asked on the ACA application is whether or not the applicant smokes. Answering “yes” to the smoking question has a dramatic effect on the premiums. Depending on age and level of insurance selected smoking can add as much as 50% to the cost of a premium. More importantly, federal subsidies will not assist with the increased cost of the premium. This can make the cost of marketplace insurance prohibitively expensive for low income PLWH who must bear the full additional cost of the premium. Over the last three decades, smoking rates have dropped dramatically in the United States. However, this does not translate to the HIV positive population. The Austin Area HIV Needs Assessment conducted in the spring of 2014 found that 39% of respondents surveyed reported tobacco use. This is consistent with a 2009 CDC report estimating that 42% of PLWH are smokers on a nationwide level. Clearly no single data element has a more significant impact in analyzing the number of PLWH who may be eligible for marketplace insurance.

Citizenship – Citizenship or lawfully admitted status is also a requirement in determining ACA eligibility. Since the question is not relevant for Ryan White eligibility, the citizenship status of consumers has not historically been tracked. Thus citizenship data are limited and only addressed indirectly in relation to at-risk HIV populations (e.g., language barriers, fear of legal issues, etc.). Eleven (11) percent of respondents to the Needs Assessment survey indicated they were not U.S. Citizens, and of that group, four (4) percent indicated they had legal status. Only two (2) percent indicated they do not have legal status, with the remainder selecting “*prefer not to answer*” on the survey. This question was included on the survey in part to quantify the number of consumers who may not qualify to ACA insurance. No other data source is available to help quantify this question. A report published by the Travis County Human Services Department in 2007 estimated there are approximately 110,000 undocumented immigrants in Travis County. Whatever the actual number of undocumented PLWH residing in the Austin TGA, it is clear that the citizenship issue is also a significant qualifier when evaluating the number of PLWH who may be eligible for marketplace insurance.

(2) Impact of insurance expansion

Despite the fact that a great deal of effort and planning went into preparation for the Affordable Care Act (ACA), the impact of ACA has been limited to date. While there is no available data to definitively quantify the number of PLWH who have purchased insurance via the marketplace to date, all indications are that the number is very low. The Planning Council anticipated the need

to reallocate funds to support the Health Insurance Continuation service category. However, increased reallocation has not proven necessary to this point. There are several reasons for the minimal impact of ACA to date:

Texas opted not to expand Medicaid – Obviously, no single issue had more impact on Ryan White Part A. Given the large number of PLWH with incomes at or below 138% FPL, Medicaid expansion would have had a dramatic impact on Ryan White eligibility. There is no indication that the position of the State will change in the near future.

Consumer education – ACA is unquestionably a complicated subject. In order for low income citizens who have never had insurance to acquire sufficient understanding of the opportunity presented to them, citizens need an appropriate level of education. The educational need for PLWH is even more significant given the complexity of their medical issues. Simply put, PLWH were not properly informed and motivated to act on the ACA opportunity. This is despite the diligent efforts of CBO's and navigators to spread the word and to encourage people to apply. One of the questions put to consumers participating in focus groups during the recent Austin TGA Needs Assessment was designed to measure their understanding of ACA. Since there were only 39 focus group participants the findings should be considered antidotal, but the fact is not a single respondent reported having anything more than cursory awareness of ACA. What focus group participants were most aware of was the negative media reports related to political infighting and the legal challenges to "Obamacare." Many were aware of the "threat" of an IRS penalty and several indicated they had discussions with provider staff or navigators about applying for an exemption to the mandate. Not a single participant understood the fact that for the first time since their diagnosis they could obtain affordable insurance that was previously unavailable due to their diagnosis. More concerning was the fact that not a single participant understood the opportunity available from the context of acquiring inpatient coverage and preventative care. Several participants made statements such as "*I don't need that, I have Ryan White.*"

Selecting a policy - For those consumers who did contact a navigator, selecting a policy from the available levels is an even more complex educational issue. Policy details regarding specific services covered under each plan were not available unless/until and applicant selected that plan. Thus it was difficult to provide guidance to PLWH. Texas DSHS put out a plan recommendation based upon policy analysis but that information was available only later during the enrollment period because DSHS was unable to obtain policy and formulary details. The temptation to select the policy with the lowest premium must be balanced with an understanding of the scope and level of coverage a given policy provides. Understanding which policy and coverage level affords the best coverage for complex HIV needs requires extensive research. Thus the ACA educational need for PLWH is arguably more extensive than for the general public.

Issues being monitored (*Issues of concern, not validated impacts of expansion*)

Maintaining a policy once purchased - Even with significant subsidy assistance, the cost of insurance can be daunting to low income consumers, especially when the cost includes co-payments and deductibles. It may prove challenging for PLWH to avoid a lapse in coverage.

Impact of insurance on continuity of care – A concern that will be monitored going forward is that PLWH who do not have the funds to pay for a co-payment or who have not yet met a deductible will avoid keeping appointments for scheduled care. This would have a potential negative impact on continuity of medical care.

(3) Outreach and enrollment

As stated above, a concerted effort was made by community based organizations to enroll low income citizens in ACA insurance. This effort included not only those organizations which received federal funding for navigators, but also the Ryan White service agencies and other support agencies that provide service to PLWH. As stated above, the bottom line is that the level of education that PLWH needed to motivate them to follow through with an application was simply not realized. Negative news always gets more attention than good news. ACA was a very visible topic on television, radio and newspaper headlines. But that news was largely dominated by stories about system failures, political resistance to the law, litigation and the penalties that citizens may be subject to. This information overwhelmed PLWH and there is no evidence they received the essential details they needed to prompt them to follow through. It is also clear that poster slogans and advisements were ineffective in encouraging PLWH to take the next step to investigate and ultimately apply.

Based upon comments received from participants during the Needs Assessment, there is also some indication that adding an ACA discussion to an already comprehensive eligibility and case management review may have presented too much information at one time.

Looking forward to the upcoming open enrollment period beginning November 2014, the Austin TGA has taken steps to address the inadequacy of educational information. A vendor has been contracted to provide direct assistance to Ryan White service providers including staff training and direct outreach to PLWH. This contractor is well aware of the issues experienced to date both locally and across the nation. This outreach contract should better position the service providers to take full advantage of the upcoming enrollment period with a plan of action that incorporates the lessons learned from the initial enrollment period.

(4) Marketplace options

The range of insurance plans and options available in Central Texas were extensive, with options exceeding 100 plans. The Austin TGA did not experience many of the issues reported in other states with plans that denied HIV medications, set unreasonable co-pay requirements, or otherwise excluded critical HIV services. The difficulty that was experienced was in determining which plans provided a level of coverage consistent with the standards of care for HIV and AIDS patients. Texas DSHS made a diligent effort to evaluate all the plans available across the state to determine the appropriateness of each plan in terms of adequacy of HIV related care. No one had envisioned that it would be difficult to obtain sufficient plan details in order to make an assessment. The level of information available on the marketplace website was inadequate and the insurers were slow to cooperate. This led DSHS to issue a recommendation in late October to all Part A and B grantees to wait to select a plan until adequate information could be obtained. Ultimately the necessary policy detail was obtained and it was determined that a single Silver plan met all the coverage and formulary criteria for recommendation.

(5) Successes/Outcomes

According to data provided by David Powell Community Health Center, the single Ryan White-funded medical care provider for the Austin TGA, the clinic has a total of twenty (20) patients who have enrolled in an ACA Marketplace plan and who are currently receiving medical care paid for by their insurance policy. Given the potential number of individuals who could qualify for ACA coverage as evidenced by the data as presented above, obviously the Austin TGA has a long way to go to realize the opportunity presented by ACA. At this point there is no measure of the number of PLWH in private care that may have purchased insurance. Physicians who are known to serve the majority of PLWH in private care were contacted during the recent Needs Assessment to ascertain ACA impacts. The responses from those physicians do not suggest significant numbers of marketplace enrollees, although the majority of private practice patients already have some form of coverage.

Perhaps the most important outcome from the initial enrollment period experience is the lessons learned. These lessons will enable the Austin TGA to better understand the challenges associated with ACA enrollment in order to do a more effective job during the upcoming enrollment period.

B. Impact Reduction in Ryan White HIV/AIDS Program Formula Funding

For FY 2014, the Austin TGA did not have a decline in Ryan White Part A Formula funding.

C. Impact of Co-Morbidities on the Cost and Complexity of Providing Care

The incidence of specific infectious diseases and socioeconomic and health status characteristics of the Austin TGA and persons living with HIV may complicate the delivery of medical care to PLWH.

Sexually Transmitted Infections

In 2013, a total of 9,647 persons with *Chlamydia* infections were reported in the Austin TGA. The number of persons with gonorrhea and early syphilis total 2,543 and 364, respectively.

Table N. Selected Sexually Transmitted Infections Incidence Rates¹, Austin TGA, 2011-2013

Race/ Ethnicity	<i>Chlamydia</i>			Gonorrhea			Syphilis ²		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
White	224.5	208.1	183.9	43.0	52.9	54.6	10.8	13.2	13.6
African American	1,181.6	1,072.5	939.4	447.6	445.4	466.5	38.4	33.4	29.2
Hispanic	547.3	451.0	459.2	103.8	86.3	109.8	15.3	22.9	28.3
Other ³	226.6	229.7	158.4	35.5	9.7	29.3	4.4	2.9	11.0

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

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.

Table N presents 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 2013, the incidence rate for gonorrhea for African Americans is over eight times higher compared with Whites. The incidence rates for early syphilis in African Americans and in Hispanics are over twice as high compared with Whites. Syphilis incidence rates have increased from 2011 to 2013 for Whites, Hispanics, and Others while rates have decreased for African Americans.

The occurrence of *Chlamydia*, gonorrhea, or syphilis among persons living with HIV in the Austin TGA continues to be a concern. Between 1.5% to 3.0% of PLWH have been diagnosed with one of these diseases. Almost 10% of African American PLWH have a history of syphilis compared with 2.8% of White PLWH. The high rate of co-morbidity contributes to higher costs for providing medical care to PLWH.

Tuberculosis

In 2013, 56 tuberculosis cases were reported in the Austin TGA. A similar number, 58 cases, were reported in 2012. The incidence rate in 2012 and 2013 was 3.0 cases per 100,000 population. In 2013, the incidence rate for African Americans in the Austin TGA was nine (9) times higher compared with Whites. Similar to the general population, the risk of tuberculosis infection is greater in African Americans with HIV compared with White persons living with HIV.

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 2014, National Alliance to End Homelessness, Washington, DC*).

The estimated prevalence of homelessness in Texas is 11.2 persons per 10,000 populations or 0.112% of the population. Based on this prevalence, an estimated 2,087 persons are homeless in the Austin TGA. For PLWH in the Austin TGA, approximately 4% are considered homeless, a rate over 30 times higher compared with the general Austin TGA population.

Formerly incarcerated

Providing services to formerly-incarcerated individuals living with HIV is a continuing issue for medical providers in the Austin TGA. It is estimated that over 48,000 persons with a history of

incarceration reside in the Austin TGA. (*Prevalence of Imprisonment in the United States Population, 1974-2001, Bureau of Justice Statistics, U.S. Department of Justice, Washington, DC*). Data on former inmates of the Texas Department of Criminal Justice (TDCJ) provide some estimates on the number of formerly incarcerated persons with HIV infections released to Travis County. The county of residence for the newly released inmates is not provided by TDCJ. However, to estimate the number of inmates with HIV infection released to Travis County, the percentage of current inmates with HIV that came from Travis County is applied to the total number of inmates with HIV released during that year. During 2013, an estimated 49 inmates with HIV infection were released from TDCJ and moved to Travis County. For the period 2007 through 2013, the estimated average annual number of TDCJ inmates with HIV released to Travis County is 51.

Number and Percent of Persons Without Insurance Coverage

In the Austin TGA, an estimated 399,000 persons or 21.5% of the population lack health insurance (*US Census Bureau, Small Area Health Insurance Estimates, 2011*). Over half (61%) of the uninsured population resides in Travis County. A similar percentage (24.6%) of PLWH in the TGA also lacks health insurance. 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*).

D. Coordination of Services and Funding Streams

(1) Attachment 6 is a presentation of other public funding in the Austin TGA.

(2) How Part A funds are used to address gaps in services within the Austin TGA

For information on how Part A funds are being used to address gaps in services within the Austin TGA, refer to the HIV Continuum of Care narrative on p. 37 and the FY 2015 Implementation Plan narrative on p. 39.

METHODOLOGY

1. Planning and Resource Allocation

A. Letter of Assurance from Planning Council Chair

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

B. Description of the Community Input Process

(1) Overall structure of community input process

The Austin HIV Planning Council planning structure is comprised of a leadership committee (Executive) and two standing committees (Comprehensive Planning/Needs Assessment and Allocations) in accordance with tenets outlined in the bylaws. The Executive Committee (EC) exercises a wide range of planning authority and decision-making from membership activities to quality initiatives. Working in synergy with the other two committees, the EC also delegates planning tasks to the committees. The Planning Council Chair assigns members to committees based on interests, skillset, and overall needs of the Planning Council, ensuring diversity and representation of persons living with HIV/AIDS in the community.

With the goal of effectively addressing needs and priorities of persons living with HIV/AIDS, the community input process was carried out in a collaborative and productive manner among the committees. The Comprehensive Planning/Needs Assessment Committee (CPNA) set service category priorities using a proven methodology that considered the needs of those in and out of care. Findings from the recently conducted Comprehensive HIV Needs Assessment served as the basis in linking future planning to health outcomes along the HIV Care Continuum. Once established, service category priorities were provided to the Allocations Committee to inform the resource allocations process. Recommendations from the Allocations Committee were subsequently approved by the full Planning Council.

(2) Specific prioritization and allocation process

a. How needs of persons not in care (Unmet Need), persons unaware of their HIV status (EIIHA), and historically underserved populations were considered

Needs of persons not in care (Unmet Need)

The Planning Council employed a systematic methodology to quantify and address the needs of persons not in care. Using an established quantification process to determine the number of persons not in care, demographic data was gathered from the Texas HIV/AIDS Reporting System (eHARS) and the AIDS Regional Information and Evaluation System (ARIES). Demographic data from the two reporting systems were 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. Historical ARIES data reports were produced to take full advantage of the available data. 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. ARIES reports also produced further detail on 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 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 sessions to gather information in preparation for a comprehensive 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 Austin Area Comprehensive HIV Needs Assessment was conducted to determine the capacity and need across the full spectrum of core and support service categories, regardless of funding source. Finally, membership of the Planning Council includes individuals representing organizations that deliver outreach, case management, and other services directly focused on engaging PLWH not in care. The Planning Council capitalized on this valuable expertise when evaluating the needs of those out of care. Specifically, information was gained regarding outreach strategies that were proven successful in returning those individuals out-of-care back into a quality care program.

Needs of those persons unaware of their HIV status (EIIHA)

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. The demographic makeup of the unaware population based on these numbers proved to mirror that of the local community being served. Surveillance data was used to determine the characteristics of those known to be in care. This information enabled the Planning Council to determine a profile for those persons unaware of their HIV status, and eventually determine their needs. Information regarding local testing is readily available to the CPNA Committee and was used to make important decisions about the needs of those unaware of their HIV status. 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 in identifying individuals unaware of their status. The ultimate goal is to link these individuals to care. To this end, 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.

Needs of historically underserved populations

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 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 showed 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 through its routine meetings, community events, and research 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 (NWOPHA), 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 planning processes for Ryan White Part A and MAI funding.

b. How PLWH were involved in the planning and allocation processes and how their priorities were considered in the process

Current Planning Council membership consists of consumers who are represented on each of the subcommittees, 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 frequently attending Planning Council meetings include PLWH who contribute their insight to the decision-making process. Of the nearly thirty (30) Planning Council meetings held since the FY 2014 grant cycle began in March, nearly 100% of those meetings were attended by PLWH who were involved in the priority setting and allocation process in some manner.

c. How data were used in the priority setting and allocation processes to increase access to core medical services and to 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 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 also were used showing the demographic profile of consumers accessing core services by service type. The summation of all these 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 have 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.

d. How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process

The expanded ARIES data reports and the Epidemiologic Profile produced by the Texas Department of State Health Services (DSHS) were reviewed to evaluate disease or social trends. Expanded ARIES data included additional demographic and geographic analysis within the Austin TGA. The data have been consistent with the number of new cases indicating relative and moderate increase. Overall growth was apparent in the number of PLWH 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 Needs Assessment 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 years. Data and information shared through the coalition are pivotal in the planning process.

Epidemiological and ARIES utilization data steadily demonstrate that minority populations are underserved and have more barriers to care. The African American population experiences a disproportionate burden of the disease in terms of the number of cases relative to the overall population. The data also support 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. This year's funding trend continues with a focus on Psychosocial Support Services groups in the most needed suburban and rural areas.

e. How cost data were used in making funding allocation decisions

The Administrative Agent provided the Allocations Committee expenditure reports sorted by services each month. Service categories that were underspent or overspent received special analysis through use of a Monthly Variance Report. The Planning Council's process and focus on expenditure trends resulted in allocations and/or planning changes. 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 were expended in order to anticipate and plan for future spending patterns. This was a heavy determinant in the allocations decisions.

f. How the community input process considered and addressed any funding increases or decreases in the Part A award

The Planning Council adopted the FY 2015 Allocations Model on the basis of level funding, yet constructed an Increase/Decrease Contingency Plan for the allocations of Part A and MAI services funds. The strategy for the increase and decrease plan focuses on ensuring adequate support is directed to primary medical services and that specified support service categories receive no less than a minimum level amount. This strategy ensures that core medical services remain the central focus of allocations and that support services deemed most essential to linking and retaining PLWH in care are part of the HIV Continuum.

g. How MAI funding was considered during the planning process to enhance services to minority populations

Data indicate African American and Hispanic populations share a disproportionate burden of HIV/AIDS. Data also indicate 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 have needs met and gaps filled in order to prevent attrition in treatment adherence. Planning Council also strives to work with Ryan White Part B planners to effectively leverage MAI funding. With this coordination, services administered with MAI funds may enhance access for these minority populations.

h. How data from other federally funded HIV/AIDS programs were used in developing priorities (Attachment 6)

Planning Council considered other funding sources when setting priorities, including various parts of Ryan White (Parts B and C), and HOPWHA. For example, a significant number of PLWH in the Austin TGA depend on housing funded through the HOPWHA (Housing Opportunities for Persons with HIV/AIDS). Although housing is listed high on the priority list, it was not a service category that was funded with Part A funds, primarily due to the funding from other federal sources.

i. How anticipated changes, due to the Affordable Care Act, were considered in developing priorities

Changes due to the Affordable Care Act (ACA) were considered by the Planning Council during its priority setting process. Because the Austin TGA has unique circumstances which impeded full compliance with ACA, many factors may or may not impact service delivery. Due to the State of Texas not expanding Medicaid, this factor may force the Planning Council to consider other options for clients not eligible for insurance in the near future. Because some 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. However, the savings may have to cover the costs of premiums and deductibles under the health insurance premium and cost sharing assistance service category. Prior to ACA, there was a lack of funds to dedicate solely to this highly prioritized service area. Another factor that was considered is the unknown numbers of PLWH who are undocumented migrants currently receive services under Part A funding. ACA prohibits this population from accessing services through the newly created system. This factor will impact how the priority setting process will change in future funding cycles. Essentially, this year's priorities reflect a careful consideration of 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 significantly affect the allocation of funds because of all the intangible factors.

j. What efforts have or will be taken to integrate prevention and care planning at the Part A level

Efforts have been made and continue to be advanced in the area of integrating prevention and care planning. Members of the HIV Planning Council and their staff are actively involved in a local HIV Prevention Coalition where area prevention and care planners collaborate on

initiatives and programs that meet the needs of PLWH, both aware and unaware. The information discussed during these planning sessions is shared with the Planning Council through its CPNA Committee to consider in needs analysis and decision-making. Another initiative on the regional level involves a partnership with the Region 7 Epidemiological Workgroup, which includes practitioners, prevention workers, and university representatives. HIV Planning Council staff is very engaged in this workgroup tasked with focusing on the various issues related to HIV/AIDS and prevention efforts in the local community. As the Epidemiological Workgroup continues to meet and develop its research, data will be shared with the Planning Council.

C. Funding for Core Medical Services

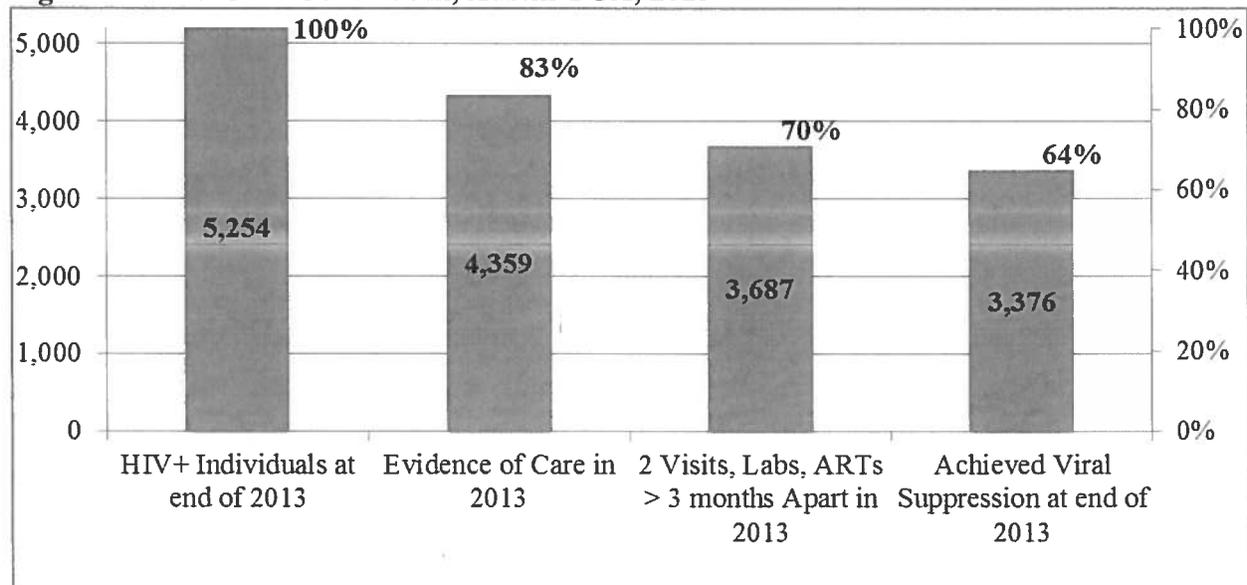
Attachment 8 lists planned services for FY 2015 that address the 75 percent core medical services allocation requirement.

WORK PLAN

A. HIV Care Continuum for FY 2015

(1) Figure B is a graph depicting the Ryan White HIV/AIDS Program Part A HIV Care Continuum in the Austin TGA.

Figure B. HIV Care Continuum, Austin TGA, 2013



Source: Texas Department of State Health Services

Figure B shows the proportion of PLWH who are engaged at each stage of HIV care. Data depicted in the figure were obtained from eHARS, AIDS Regional Information and Evaluation System (ARIES), AIDS Drug Assistance Program, electronic laboratory reports, Medicaid, and private insurance payers. As of December 31, 2013, a total of 5,254 persons living with HIV resided in the Austin TGA (Diagnosed). A high percentage (83%) of PLWH had evidence of care defined as at least one medical visit, antiretroviral therapy prescription, viral load test, or CD4 count (Linked to Care). Most (70%) of the PLWH in the Austin TGA were retained in care by evidence of at least two (2) medical visits, laboratory tests, or antiretroviral therapy prescriptions at least three (3) months apart during a 12 month period (Retained in Care). Over half (64%) of PLWH achieved viral suppression, i.e., their last viral load value in 2013 was ≤ 200 copies/ml (Virally Suppressed).

(2) HIV Care Continuum Narrative

a. How the HIV Care Continuum is currently or may be utilized in planning, in prioritizing, in targeting and in monitoring available resources in response to needs of PLWH in the jurisdiction and in improving engagement at each stage in the continuum

The current treatment cascade in the Austin TGA shows remarkable progress made in the effort to link individuals into care, retain them in care, and address Unmet Need. While the HIV Care

Continuum shows great strides have been made in the TGA, it is also being used to incorporate quality initiatives that will not only maintain a system of care, but improve it as well.

Administered in a coordinated fashion by a historically tight-knit community of local providers and ASOs, the Austin TGA HIV Care Continuum is characterized by quality services structured 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. As depicted in Figure B, the Continuum accommodates over 5,000 PLWH, with over 60% being virally suppressed. That number is coupled with a growing percentage of clients who are new to the care system, demonstrating that measures to ensure access to care have been effective.

b. Current successes or possible improvement in supporting PLWH as they move from one stage in the continuum to the next

The integration of HIV prevention and care planning in the area will be used to engage individuals in care. The premise is that these potential clients will take advantage of testing opportunities and, if warranted, will be linked to care, thus increasing the bottom-line of the current 83% in 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 action in the 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 PLWH. 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 one and others, 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.

c. Any gaps, barriers, or unique challenges that exist in developing and utilizing the HIV Care Continuum model in the Part A Program. Describe how the Part A program addresses these gaps, barriers, or unique challenges

Currently no gaps, barriers, or unique challenges exist in developing and utilizing the HIV Care Continuum model. Figure B is an accurate and positive depiction of the work taking place from the planning to the grassroots levels. For additional information, refer to the Resolution of Challenges section on p. 42-43.

d. How the FY 2015 award will be used to address gaps/barriers and improve the HIV Care Continuum

Because there is currently 64% of virally suppressed PLWH in the system, efforts will be made to increase this number by supporting findings outlined in the Austin Area Comprehensive HIV Needs Assessment. Recent data indicate that one of the support categories, psychosocial support services, is key to addressing PLWH social needs, thereby improving retention in care. The

Planning Council's most recent allocations decision to divert funds to this service indicates one strategy being employed that addresses potential gaps/barriers to care.

e. Any significant health disparities brought to light related to reach, gender, sexual orientation and age among populations within your jurisdiction's HIV Care Continuum and activities targeted current or planned to address these disparities

The HIV Care Continuum for FY 2015 responds to the high HIV prevalence rates in minority populations. The high rates create a profound and disproportionate effect on those living with HIV/AIDS in minority communities. More specific details about these challenges are discussed in the Needs Assessment section. The FY 2015 Implementation Plan is designed to increase access to the HIV Care Continuum for minority communities through the TGA's Minority AIDS Initiative (MAI) programs and through the activities outlined in the Comprehensive HIV Services Plan. Findings from the Austin Area Comprehensive HIV Needs Assessment helped inform the FY 2015 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 PLWH.

B. FY 2015 Implementation Plan

The FY 2015 Implementation Plan is Attachment 9. It includes both the Service Category Table and the HIV Care Continuum Table.

C. FY 2015 Implementation Plan Narrative

(1) Identify any prioritized core medical services that will not be funded with FY 2015 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 sole service in the top 10 priorities not funded for FY 2015 was Housing. From a historical perspective, the Planning Council's rationale for not funding Housing with Part A funds was due to the availability of other adequate funding sources, including Housing Opportunities for Persons with HIV/AIDS (HOPHA).

(2) 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 serving PLWH who reside in areas heavily impacted by HIV. Factors contributing to this decision include households receiving public assistance and those with high rates of poverty and unemployment concentrated heavily in tracts east of Interstate-35 and south of the Colorado River. The majority of residents in these neighborhoods are African American and Hispanic. Nearly all of the Ryan White Part A service providers in Travis County are located within the

geographic areas noted. 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. Finally, the comprehensiveness of services is addressed in the HIV Care Continuum, which accounts for all services in a manner that links and retains PLWH to primary care. Services are categorized in the HIV Care Continuum and Implementation Plan based upon how these services meet the specific needs of clients, including those who are identified as out of care.

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

The Planning Council makes strategic planning decisions that meet the challenges faced by populations with special cultural or linguistic needs. These decisions are effective in addressing and diminishing barriers to care. For example, a decision was made to increase funding in psychosocial support services based on research that indicated minority populations (African Americans) were more apt to stay in care when accessing this service. The cultural appropriateness of this service is realized when trained peers, rather than professionally licensed personnel, lead group support sessions held under the auspices of psychosocial services. 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). This level is ascertained and measured through surveys administered by the Planning Council throughout the year, such as Consumer Satisfaction Surveys and the Administrative Mechanism Survey which inquires about provider training/technical assistance. The Administrative Agency has also required compliance with the fifteen (15) CLAS Standards in its contracts with Part A service providers.

(4) How the objectives, action items, and performance measures relate to the goals of Comprehensive Plan

The FY 2015 Implementation Plan is designed to support the goals outlined in the current Comprehensive HIV Services Plan (CHSP). Parallel to goals outlined in the National HIV/AIDS Strategy (NHAS), the CHSP contain goals that serve as the foundation for the HIV Care Continuum: (1) Increase the number of individuals aware of their HIV status; (2) Reduce HIV-related health disparities; (3) Increase the number of HIV positive individuals who are in care; (4) Increase access to care and improve health outcomes for people living with HIV; and (5) Reduce new HIV infections. As described in the FY 2015 Implementation Plan Table (Attachment 9), four (4) core services and two (2) support services strongly facilitate meeting these goals through the objectives and action items noted. Outpatient/Ambulatory Medical Care, Oral Health Care, AIDS Pharmaceutical Assistance—local, and Medical Case Management are the core services; Non-Medical Case Management and Residential Substance Abuse are listed as the support services, which altogether foster access to and retention in care. This paradigm ensures a well-balanced and optimal quality of life for the PLWH supported by Ryan White Part A funding.

(5) How 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 units of service delivered to each WICY population is compared to the total units of service for all clients receiving services. The percentage of units of service for each WICY population is applied as a percentage of total actual cost. The 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.

(6) How any recent TGA needs assessments or updates are linked or may be related to the HIV Care Continuum, including results of the TGA's Unmet Need Framework and any new or different initiatives funded.

Findings from the Austin Area Comprehensive HIV Needs Assessment indicate a well-established fact that adherence to care is negatively impacted by PLWH who are economically disadvantaged and struggling with basic needs. Considering this, the HIV Care Continuum is designed in a manner that not only provides opportunities for access and consideration of barriers to care, but strong linkage to and retention in care. Support services such as non-medical case management are pivotal in addressing the social and economic needs of PLWH. Case managers providing this service have successfully educated and informed consumers about community resources that help them in many areas. For example, non-medical case managers direct consumers to emergency cash facilities for assistance with household utility bills, food banks, and even transportation-related resources, all of which are basic needs in the lives of PLWH trying to adhere to their treatment plans while struggling with everyday life issues.

The Unmet Need Framework (Attachment 4) was used to determine the care patterns of PLWH who received specified care, and to further calculate the values of those with Unmet Need patterns. Illustrating over 1,700 PLWH (17%) with Unmet Need, the Unmet Need Framework clearly indicates the Austin TGA's success in addressing PLWH needs and providing a viable Plan that is responsive to the epidemic.

RESOLUTION OF CHALLENGES

The National HIV/AIDS Strategy has set the goal of linking 85% of newly diagnosed HIV patients to clinical care within 3 months of diagnosis. After individuals are diagnosed with HIV, positive health outcomes are achievable when individuals are both immediately linked into medical care and remain adherent to medical treatment. As discussed under HIV Care Continuum for FY 2015 in the Work Plan section above, the Austin TGA has achieved a relatively high percentage of PLWH (83%) who have evidence of being in care defined as at least one medical visit, antiretroviral therapy prescription, viral load test, or CD4 count.

The concept of an HIV care continuum of quality services has been utilized in the Austin TGA for many years. The newly configured HIV Care Continuum or HIV Treatment Cascade model consists of the collection and reporting of data on the proportion of PLWH who are engaged at five specific stages of HIV care: Diagnosed; Linked to Care; Retained in Care; Prescribed ART, and Virally Suppressed. As active partners with the Texas Department of State Health Services (DSHS) Ryan White Part B Program, the Austin TGA has access to a greater pool of data than can be collected and analyzed at the local level. Initially, in the first year of implementation, the primary challenge in fully integrating the HIV CARE Continuum into planning and program implementation will be not having immediate access to the data elements required for all stages of the Continuum.

Matching methods used by DSHS varied depending on the type of information that was available for matching. For data sets where names and other personal identifiers (e.g., date of birth) were available, Link King or other linking algorithms were used for matching. When only unique record numbers or limited data elements were available (e.g., first and third initial of first and last name combined with date of birth) were available, SAS 9.2 was used for exact matching. The following data sets were matched against HIV/AIDS cases in eHARS to determine if a client had a met medical need: Electronic HIV/AIDS Reporting System (eHARS); Texas AIDS Drug Assistance Program (ADAP) or State Pharmacy Assistance Program (SPAP); Electronic Lab Reporting (ELR); AIDS Regional Information and Evaluation System (ARIES); Medicaid/Children's Health Insurance Program (CHIP); and private insurers.

The midyear 2013 eHARS dataset (6/30/2013) was used for the 2013 unmet need estimates, retention in care estimates, linkage to care estimates, and the continuity of care measures (OAMC visit, CD4 labs, and viral load labs). Diagnosed HIV/AIDS cases that had been entered and were living on 12/31/2013 were included for the total population for unmet need in 2013. Using the datasets and matching methods described above, a newly diagnosed individual in 2013 is said to be linked into care within three months if they have a CD4 count, a viral load test, antiretroviral therapy, or an outpatient/ambulatory medical care visit 90 days or less starting from the first date of diagnosis in Texas as identified in eHARS.

However, for 2013, DSHS was not able to isolate and provide data for the fourth stage on the HIV Care Continuum, the number and percentage of PLWH in the TGA prescribed a combination of three or more antiretroviral drugs from at least two different HIV drug classes every day to control the virus. This challenge will be resolved with continued information-sharing and other communication about data collection methods that have been developed and

used successfully by other jurisdictions, and collaborating in developing a methodology that can provide data required for the Prescribed Antiretroviral Therapy (ART) stage on the HIV Care Continuum.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

1. Clinical Quality Management (CQM)

A. CQM Program Infrastructure

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 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 QM 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 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 2014, a combined total of 1.95 FTEs are funded for QM activities by Austin's Part A grant. The positions listed above work closely together in providing the core quality management tasks.

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 subgrantee staff as appropriate: HIV case management, screening for mental health and substance abuse issues, culturally and linguistically appropriate services (CLAS) and QM plan development. Trainings for subgrantee staff on new monthly reporting forms for performance and contract expenditures are also being provided in September 2014.

Effective coordination of QM activities with other Ryan White grantees in the area continues as a high priority for the Austin TGA. The Part B Administrative Agency, Brazos Valley Council of Governments, is represented in our bimonthly CQI/QM Committee meetings. Quality-related items of mutual interest and benefit are reviewed regularly. The Austin/Travis County Health and Human Services Department is the Ryan White Part C grantee for this area; therefore, its HIV Resources Administration Unit provides coordinated planning, fiscal, administrative, and quality management resources for both Parts A and C in a comprehensive and unified structure.

B. Performance Measurement for CQM

The Clinical Quality Management program for the Austin TGA monitors certain key performance measures in assessing effectiveness. All funded Part A service categories (See Attachment 8) have performance measures. The indicators and 2013 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 service

providers, the Clinical Quality Improvement Committee, and the Austin Area Comprehensive HIV Planning Council.

Table A: Outpatient/Ambulatory Medical Care

Outpatient/Ambulatory Medical Care Indicators (with standard exclusions applied)	Results – Part A Clinic (DPCHC) (with standard exclusions applied)
1. 90% of clients with CDC-Defined AIDS will be prescribed an antiretroviral therapy (ART) regimen during the measurement year.	98% 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.	86% 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.	83% 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.	85% 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.	100% of pregnant women with an HIV infection were prescribed antiretroviral therapy during the measurement year.
Medical Case Management Indicator (with standard exclusions applied)	Results – Aggregate (with standard exclusions applied)
75% of clients receiving medical case management services will keep at least two subsequent medical provider visits over the course of the measurement year.	83% of medical case management clients received at least two medical provider visits over the course of the measurement year.

Source: ARIES Client-level data system

C. Continuous Quality Improvement

In order to achieve sustainable improvements, the Quality Improvement Model utilized by the Austin TGA is the PDSA Cycle (Plan, Do, Study, Act).

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 forms ad hoc workgroups to address targeted quality issues as needed to facilitate completion of the PDSA cycle. Some recent projects are described below:

- Austin is actively participating in the new statewide HIV Standards of Care and subgrantee monitoring initiative. Weekly working teleconference sessions are ongoing since July 2014, with the Texas Department of State Health Services and other Ryan White grantees/Administrative agencies. Each session focuses on a different service

category, and the project will result in common minimum standards and monitoring practices for all the participants.

- Through a collaborative effort between the providers, HIV Planning Council, and grantee staff, 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. Over 815 clients completed the survey, a significant increase in response rate over the 631 responses received in 2012. Significantly, only 11 clients (2%) indicated dissatisfaction with Ryan White services, while 92% were satisfied or very satisfied. A summary of the final 2013 survey results is provided in the table below.

Table B: FY 2013 Client Satisfaction Survey Aggregate Results

Rating of All Ryan White Services	# of Respondents	Percentage
1 - Very Satisfied	539	66%
2 - Satisfied	215	26%
3 - Not Satisfied nor Dissatisfied	12	1%
4 - Dissatisfied	5	1%
5 - Very Dissatisfied	6	1%
6 - Not Applicable	8	1%
7 - No Response	30	4%
TOTAL	815	100%

Source: Austin TGA Client Satisfaction Survey Database – August/Sept. 2013

- The Return to/Retention in Care (RTC) Workgroup continues 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 increased communication with the Ryan White-funded HIV medical care provider, the David Powell Community Health Center (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 continues 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. In December 2013, Sherry Martin, Health Care Quality Management Consultant, provided an Organizational Assessment to identify and begin strengthening Austin's structures, processes, and functions that support measurement and quality improvement activities. Organizational infrastructure factors reviewed include sustained leadership, staff training and

support, team meetings, and use of data systems for tracking outcomes. This assessment identified the important elements associated with successful quality management. Scores were assigned to identify gaps in the program and to help set priorities for improvement. Although Austin's scores were comparatively high for most elements, this assessment is helping Austin's program to further evaluate its progress and guide the future development of quality goals and objectives.

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 internal staff group, including the Quality Coordinator, Data Manager, and Grants Coordinators, also reviews quality issues periodically. These individuals have direct involvement with the subgrantees 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 2006, and consists primarily of sub-grantee providers who are responsible for reporting their CQI related activities to the grantee. Additionally, the CQI Committee provides 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. 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.

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 DPCHC that provides 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 which are aimed at improving HIV viral suppression within the area. For example, when examining outcomes data for all providers, an opportunity to improve was identified 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 and surveys on why clients have missed appointments. 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 incomplete. In response, the Data Manager

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.

D. 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 2013, the Data Manager performed ARIES desktop monitoring 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 RSRs are carefully reviewed prior to grantee approval.

All (100%) of the Austin TGA's eight subgrantee service provider agencies were able to successfully report their CY 2013 client level data for the RSR. No agencies had more than 10% missing data elements for the CY 2013 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 2014 reporting period. The Data Manager has and will continue to provide the agencies with 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 Quality 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 most recent Needs Assessment, and findings from fiscal and program monitoring reports. Assessment and evaluation of the data are performed to determine if the data warrant any action on the part of the Committee/Council.

ORGANIZATIONAL INFORMATION

1. Grantee Administration

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 sources administered by the HRAU include: Ryan White Part A including 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 of Services

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.

B. Grantee Accountability

(1) Program Oversight

a. Update on implementation of National Monitoring Standards

Both Fiscal and Program Monitoring Standards compliance has been incorporated in Ryan White Part A Contracts as follows:

“Contractor agrees to meet specific program and fiscal requirements as detailed in the *National Monitoring Standards for Ryan White Grantees*. Contractor has reviewed the *National Monitoring Standards for Ryan White Grantees*, agrees to comply with them, and they are incorporated by reference.”

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.

Prior to and during FY 2014, Administrative Agency staff participated in all HRSA-sponsored technical assistance on National Monitoring Standards for Part A Ryan White Grantees. When the A/TCHHSD created a new Contract Compliance Unit (CCU) in the Administrative Services Division, an HIV contract monitoring position, primarily funded by Part A, was included to lead on-site HIV comprehensive contract monitoring activities. The HIV contract monitor’s active participation in updating the Department’s Contract Management and Compliance Manual has ensured that Ryan White Part A National Monitoring Standards are being addressed in relevant policies and procedures. In FY 2014, HIV Services Providers Quarterly Meetings included regular technical assistance on the National Monitoring Standards, primarily as a result of feedback from CCU monitoring of the Standards during annual site visits.

b. The process used to conduct program monitoring

One monitor in the Austin/Travis County Health and Human Services’ (A/TCHHSD) Contract Compliance Unit (CCU) is dedicated to conducting comprehensive yearly on-site fiscal and programmatic monitoring for all service providers receiving Ryan White Part A funding. The monitoring plan is developed annually based on a Risk Assessment, available resources, contractor availability, and anticipated time to complete such monitoring. Additionally, contract managers within the HIV Resources Administration Unit (HRAU) are required to conduct one on-site visit annually for each contract and must report their results to the contractor. Contract managers also complete monthly fiscal and programmatic desk reviews as part of processing service providers’ monthly reimbursement requests.

The CCU uses a comprehensive monitoring tool to document on-site monitoring results. This tool is then used to develop an Executive Summary to brief A/TCHHSD management and program staff on initial monitoring results and to vet results. The CCU schedules a formal Exit Conference with the contractor and reviews initial results. The contractor is given five (5) business days to provide any additional documentation that addresses preliminary results that may have been missed during on-site review. After additional documentation is reviewed, a formal Monitoring Report is written and signed by the A/TCHHSD Director. A Management Response may be requested from contractors, and they are given 10 business days to complete it. After reviewing the Management Response, a Corrective Action Plan may be developed, reviewed with program staff and management, and sent to the contractor. Contractors are given up to 90 days to complete the Corrective Action Plan, or less time if the full 90 days is not needed. Contractors report monthly on their Corrective Action Plan progress to their contract manager who, in turn, reports progress to the CCU. At the end of the 90 days, if both CCU and

the contract manager agree the Corrective Action Plan has been successfully completed, the monitoring action is closed out by the CCU.

c. Total number of contractors funded in FY 2014, frequency of monitoring site visits (both programmatic and fiscal), generation of reports during program year, number and percentage of contractors that have received fiscal and/or programmatic monitoring site visit to date, and total number planned for FY 2015

Contracts with eight service providers are funded in FY 2014, plus one contract with the Texas ADAP program. Fiscal and programmatic monitoring is conducted at least annually, and every service provider receives a report even if there are no findings or concerns. Five of eight contractors (approximately 63%) have received both a fiscal and programmatic monitoring site visit as of August 31, 2014. It is anticipated that 100% of contractors will receive fiscal and programmatic monitoring by the end of FY 2014. A/TCHHSD plans on monitoring 100% of service providers in FY 2015.

d. Process and timeline for corrective actions when fiscal or programmatic-related concern is identified, any improper charges or other findings in FY 2014 to date, and summary of corrective actions planned or taken to address these findings

Refer to b. above for the process and timeline for corrective actions. During this process, HRAU 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.

As of August 31, 2014, the CCU has issued Monitoring Reports containing the following findings:

- Some eligibility recertification was not completed every six months (1 contractor).
Corrective Action: The agency updated their eligibility policy so that every client is screened for eligibility at intake and in January and July of each year.
- Some client files did not contain a client-signed acknowledgement of receiving the agency's grievance policy (1 contractor).
Corrective Action: The agency had their grievance policy and acknowledgement form translated into Spanish and is now giving all clients a copy of their grievance policy to take with them and sign acknowledgement that they received it.
- One client file did not contain an updated service plan (1 contractor).
Corrective Action: The agency has an appointment scheduled with the client to update their service plan.

e. Technical assistance provided FY 2014 to date

The types and time frames of technical assistance (TA) provided by the Administrative Agency in FY 2014 and the number of contractors receiving the TA as indicated in parentheses are as follows:

Attestation of Ineligibility Policy and Client Charges Policy, one one-hour session (8); Provider Report portion of the Ryan White Services Report (RSR), one one-hour session (8); Positive Living Through Understanding and Support (PLUS) Medical Case Management Program, one

one-hour session (7); Client Eligibility Documentation, one half-hour session (8); Incorporating the SMART Model in Treatment Plans, one half-hour session (8); Review of FY 2014 Quality Management Plan for the Austin TGA and service provider Quality Management Plan update requirements, one half-hour session (7); Texas Department of State Health Services Ryan White Standards of Care and Monitoring Initiative, one half-hour session (8); and Cost Reimbursement Transition including new Monthly Reporting Forms, two one-hour sessions (8).

(2) Fiscal Oversight

a. Process used by program and fiscal staff to coordinate activities

As noted under b. above, HRAU 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. 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.

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.

In the HRAU, a Financial Specialist 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.

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 HRAU Financial Specialist. This position also reviews and approves grant budget amendments. The Accounting Unit's Accounting Technician 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 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 ensures timely submission of the annual Part A Federal Financial Report (FFR).

b. Process Used to Separately Track Formula, Supplemental, MAI, and Carry-over Funds

The Administrative Agency has a comprehensive contractor reimbursement process to ensure that 100% of Supplemental and Carry-over funds are expended by the end of the grant year. This same process further ensures that no more than 5% of Formula funds will be unexpended by the end of the grant year. Each contractor's monthly invoice is accounted for under Formula, Supplemental or MAI funding as applicable, as are Carry-over funds. This tracking capability is embedded in the MS Excel master spreadsheet that maintains all contract expenditure data. Each individual contract is set up as a separate tab in the master spreadsheet maintained by the HRAU's Financial Specialist. This methodology for accounting of expenditures has been successful in ensuring that the TGA does not incur Unobligated Balance (UOB) penalties. Additionally, to ensure that the 10% aggregate cap is maintained, an Administrative Expenditures Report is submitted by contractors monthly with the HIV Services Monthly Performance and Budget Status Report for City of Austin HIV-related Grants and Contracts. Relying on the processes described above, the TGA will again ensure there is less than 5% of the TGA's Formula award unexpended at the end of the FY 2014 grant year.

c. Timely monitoring and redistribution of unexpended funds

HRAU 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. 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 needed. 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 processes facilitate the timely amendment and redistribution of funds.

d. OMB Circular A-133 Audit Requirement

Contractors 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 contractor's fiscal year. In FY 2013 and FY 2014 to date, all contractors (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 contractors to forward a copy of their corrective action plan and tracks plan progress during the following year.

e. Findings in contractors' A-133 Audit Reports

There were no findings in any contractor's A-133 Audit Report.

f. Process for reimbursing contractors

Contractors submit monthly payment requests to their assigned HRAU 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 2014, Part A contractors continued submitting payment requests with back-up in the Community Impact Online Data Manager (CIODM) system, resulting in greater efficiency and accountability. Following approval by the Administrative Agency contract manager, financial specialist, and manager, invoices are submitted to the Department's Accounting Unit for processing. The Accounting Unit's Accounting Technician reviews and prepares payment transaction documents for contractors' approved invoices, and forwards them to the City Controller's Office for payment either by check or direct deposit.

C. Third Party Reimbursement

a. Process used by grantees

All clients seeking services eligible for third party reimbursement are required to be 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 under the Affordable Care Act (ACA). For additional information on ACA implementation related to third party reimbursement, see p. 25-28. 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.”

b. Process to conduct screening and eligibility

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.

c. Tracking and use of program income

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 on the HIV Monthly Performance and Budget Status Report, and then is reinvested in the Part A-funded HIV services program so that program income is expended before grant funds are utilized.

D. Administrative Assessment

(1) Results of the Planning Council's assessment of the administrative mechanism

a. Assessment of grantee activities to ensure timely allocation/contracting of funds and payments to contractors

The Planning Council assessed the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the Austin TGA by distributing electronic surveys to funded providers and soliciting feedback in areas integral to the administrative mechanism process. Many of the same survey questions have been posed to providers in the past three (3) years to determine any trends that may require further exploration or action. This year, the Allocations Committee decided to add a question which would serve as a filter in collecting more valuable information. Survey-takers were asked about their longevity with the organization for which they were responding. Individuals taking the survey were required to have worked with the organization's Ryan White Part A Program for at least two (2) years in order to add validity to the responses. Eight (8) survey links were sent via email to all Part A funded service providers. Seven (7) surveys were anonymously returned, equating to an 88% return rate.

The survey period was for Part A FY 2013, March 1, 2013 through February 28, 2014. Surveys contained a total of twenty-seven (27) questions, all of which had open-ended options. The open comment section was a new addition in order to capture more specific information from providers that could be readily followed up on. The four survey categories related to: 1) RFPs; 2)

Reimbursement; 3) Technical Assistance; and 4) Contract Management. The questions were designed to measure providers' level of satisfaction pertaining to the administrative mechanism cycle and operations.

The Planning Council's process in assessing the administrative mechanism is based on the degree or level of response rates. Questions with response rates or open comments that indicate potential negative issues may exist are presented to the Allocations Committee for further direction. This information, along with the committee's guidance, will be shared with the Administrative Agency (AA) for follow-up.

Based on a summary of survey data for the FY 2013 period, the following was deemed to be adequate (satisfactory) in assessing the administrative mechanism:

1. Adequate time allotted to prepare budget after initial contract award.
2. Process to request reallocation of funds is simple.
3. Process for reallocation of funds ensures expediency and efficiency.
4. Agency received a fiscal audit with written report of visit outlining findings and recommendations.
5. Agency received a programmatic/QM audit visit.
6. Agency received a written report of the monitoring visit.
7. Agency received training/technical assistance on the AA's billing process.
8. Agency received training/technical assistance on other relevant topics.
9. Agency reimbursed for accurate billings in a timely manner.

b. Deficiencies identified by the Planning Council, grantee's response to those deficiencies, and current status of grantee's corrective actions

Based on a summary of survey data for the FY 2013 period, the following was deemed to be deficient (requiring change/attention) in assessing the administrative mechanism:

1. Length of time to finalize agency contract.
2. Technical assistance did not meet needs in helping agency effectively carry out Ryan White A mandates.

Grantee's response and current status:

1. In response, contract negotiation and submission of information by contractors is now being initiated in advance of the start of the contract year, regardless of whether a Notice of Grant Award (NGA) has been received. Aspects of service delivery outside of specific service units and budget amounts were clarified in advance, such as changes in financial models or service delivery expectations. Additionally, when partial Part A funding was received at the beginning of the current fiscal year, the AA developed an abbreviated contract amendment with one-page performance measures and budget summaries, so that contracts could be executed rapidly and funding encumbered in a timely manner, thereby ensuring that contracts were set up and ready for payment in the City's purchasing and accounting systems.

2. Technical assistance provided by the Administrative Agency (AA) during FY 2013 included:

Implementation of National Monitoring Standards Training

Dr. Julia Hidalgo provided technical assistance sessions for provider staff on Eligibility Certification and Recertification, Program Income, Client Charges/Sliding Fee Scales, Caps on Client Charges, and preparation for the ACA. Additionally, the AA 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 EMAs/TGAs and information on how to access HRSA webcasts related to Part A requirements.

HIV Positivity Documentation Training

A Nurse Practitioner from the David Powell Community Health Center, the TGA's Ryan White-funded provider of HIV primary medical care, provided technical assistance training for staff from other agencies on how to best obtain proof of HIV Positivity documentation and laboratory reports, and how to correctly interpret the laboratory reports.

Cultural and Linguistically Appropriate Services (CLAS) Training

A consultant provided training on the CLAS Standards and Ethics in two different sessions for which participants could receive 3 CE Credits.

HIV Quality Performance Measurement Training

Sherry Martin, HIVQUAL Consultant, conducted a QM site visit to assist with identifying any gaps in our QM processes. Because her assistance is at no cost through HRSA, agencies were informed and encouraged to utilize her services as a quality management expert.

Quality Management Plan Development Training

The AA Quality Management Coordinator provided training on development of annual Quality Management Plans including standards of care, goals and objectives, and data elements that can be used to measure outcomes. HIVQUAL Consultant Sherry Martin presented "Quality Management Plans, Manuals for Success."

RSR/ARIES Technical Assistance Training

The AA'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 or requested basis.

Administrative Agency contract managers provide routing technical assistance to service providers via monthly telephone calls and quarterly meetings. Areas covered include interpretation of contract issues, financial reporting, performance measures, and quality management. The AA will continue to work with service providers in the future to address their technical assistance needs.

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 2012 and FY 2013 is Attachment 11.

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, Job Descriptio	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	IGA signature, Agreements As	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	HIV AIDS Table.doc	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	Unmet Need Framework.doc	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Co-morbidities Table.doc	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Coordination Services Fundin	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Chair Letter of Assurance.rt	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	Planned Services Table.doc	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	Implementation Plan Service	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	Organizational Chart.doc	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	Maintenance of Effort.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
Administrative Agency			
1.	G. Bolds Manager 10% AA	Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure adherence to established policies. 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.	B.A., Political Science; M.S., Urban Studies Over 31 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.
2.	B. Mendiola Grants Coordinator 45% AA	Responsible for coordination and preparation of the Part A grant application and preparation of grant post-award reports. Coordinates procurement process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with terms of grant by monitoring subcontracts. Processes payment requests, and monitors and analyzes contract expenses.	Master of Social Work, M.S.W. Over 32 years of health and human services experience in administration, research, planning, and clinical services including 16 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.

	Name Job Title FTE %	Job Description and Rationale for Amount of Time Requested	Education and Licensure Experience and Qualifications
3.	C. Chronis Financial Specialist 25% 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.	VACANT Data Manager .05% 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.	
5.	H. Beck Grants Coordinator 25% 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 21 years of HIV grants and contracts administration experience, with emphasis on contract monitoring including provision of technical assistance.
6.	D. Garza Grants Coordinator 25% AA	See description in row 5 above. Also serves as lead on MAI program including preparation and submission of grant post-award reports.	M.P.A. (Public Admin.); B.S., RTF Communication Over 21 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 7 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.); B.S. in Psychology. 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 32 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. J.A. Gray 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.	Over 5 years of experience in Public Health including nonprofit hospitals, health departments, and indigent care facilities. Significant experience working in substance abuse treatment center in administrative capacity. Attended Chattanooga State Community College studying Early Childhood Education. Also attended Academy of Allied Health completing Medical Administrative Assistant training.

Quality Management

11.	VACANT QM Coordinator 75% 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.	
12.	VACANT Data Manager 50% 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. Bolds Manager 20% QM	See description in row 1 above.	See row 1 above.
14.	B. Mendiola Grants Coordinator 15% 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 15% 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 20% 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 Date: 9/18/98
Kirk Watson, Mayor

TRAVIS COUNTY

By: Bill Aleshire Date: 9/15/97
Bill Aleshire, County Judge

Appendix A
FY 2015 AGREEMENTS AND COMPLIANCE
ASSURANCES
Ryan White HIV/AIDS Program
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.

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

² The six new TGAs (Baton Rouge, Columbus, 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).

Section 2604(c)

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, expend 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 9/15/2014

Attachment 3

AIDS Prevalence and HIV (non-AIDS) Prevalence Data by Demographic Group and Exposure Category

Demographic Group/ Exposure Category	2011- PREVALENCE AS OF 12/31/11		2012- PREVALENCE AS OF 12/31/12		2013- PREVALENCE AS OF 12/31/13	
	HIV	AIDS	HIV	AIDS	HIV	AIDS
<i>Race/Ethnicity</i> ¹						
White, not Hispanic	995	1,250	1,032	1,270	1,070	1,264
Black, not Hispanic	406	676	421	696	442	700
Hispanic	469	787	605	897	663	924
Other / Unknown	42	51	73	90	85	106
Total	1,912	2,764	2,131	2,953	2,260	2,994
<i>Gender</i>						
Male	1,624	2,338	1,823	2,512	1,924	2,548
Female	288	426	308	441	336	446
Total	1,912	2,764	2,131	2,953	2,260	2,994
<i>Current Age as of 12/31/2012</i>						
<13 years	9	2	11	1	11	1
13 - 24 years	135	44	158	49	150	45
25 - 34 years	487	302	545	309	600	296
35 - 44 years	556	727	592	755	617	745
45-54 years	518	1,109	566	1,172	576	1,169
≥55 years	207	580	259	667	306	738
Total	1,912	2,764	2,131	2,953	2,260	2,994
<i>Exposure Category</i> ²						
Men who have sex with men	1,340	1,713	1,541	1,849	1,640	1,898
Injection drug users	136	356	132	358	132	355
Men who have sex with men and inject drugs	124	234	121	254	123	242
Heterosexuals	292	442	313	473	340	480
Other/Unknown	20	18	25	20	26	19
Total	1,912	2,764	2,131	2,953	2,260	2,994

Source: Texas Department of State Health Services (eHARS as of July 2014), unadjusted for reporting delay.

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

² Cases 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

Unmet Need Framework

Population Sizes		Value		Data Source(s)
A.	Number of persons living with AIDS (PLWA), December 31, 2013.	2,994		Cases from eHARS diagnosed and living as of 12/31/13; 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, 2013.	2,260		Cases from eHARS diagnosed and living as of 12/31/13; Cases diagnosed in TDCJ removed and cases with unknown mode of exposure have been proportionately redistributed.
C.	Total number of HIV+/aware, December 31, 2013.	5,254		
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).	2,586		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)	1,773		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).	4,359		
Calculated Results		Value	%	Calculation
G.	Number of PLWA who did not receive the specified HIV primary medical care	408	14%	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	487	22%	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)	895	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.*

Attachment 5

Profile of Co-morbidities

Infectious Disease ¹	General Population		Persons Living with HIV/AIDS	
	Number	Rate per 100,000	Number	% PLWH/A Cases
Early Syphilis	364	19.3	150	2.8
White	140	13.6	66	2.8
African American	41	29.2	11	9.6
Hispanic	170	28.3	67	4.2
Other	12	11.0	1	1.9
<i>Chlamydia</i>	9,647	512.3	90	1.7
White	1,899	183.9	38	1.6
African American	1,317	939.4	20	1.7
Hispanic	2,760	459.2	28	1.8
Other	173	158.4	0	0.0
Gonorrhea	2,543	135.0	128	2.4
White	564	54.6	68	2.9
African American	654	466.5	17	1.5
Hispanic	660	109.8	39	2.4
Other	32	29.3	2	3.8
Tuberculosis	56	3.0	109	2.1
White	11	1.1	16	0.7
African American	14	10.0	49	4.3
Hispanic	18	3.0	43	2.7
Other	13	11.0	0	0.0
Homeless Persons²	Number	Percent	Number	% PLWH/A Cases
General population				
Bastrop	89	--	--	--
Caldwell	45	--	--	--
Hays	201	--	--	--
Travis	1,227	--	--	--
Williamson	524	--	--	--
Total	2,087	0.112	--	--
PLWHA	--	--	205	3.9
Formerly incarcerated^{3,4}	Number	Percent	Number	% PLWH/A Cases
General population	48,300	2.7		
2013 – Travis County	–	–	49	1.1
2012 – Travis County	–	–	55	1.3

Persons without health insurance (<65 years of age)⁵	Number	Percent	Number	% PLWH/A Cases
General population				
Bastrop	20,569	25.8	--	--
Caldwell	11,513	28.4	--	--
Hays	40,349	22.5	--	--
Travis	245,439	22.4	--	--
Williamson	81,716	17.4	--	--
Total	399,241	21.5	--	--
PLWHA	--	--	1,292	24.6
Type of substance abuse⁶	Number	Percent	Number	% PLWH/A Cases
General population				
Any illicit drug use, past year	298,071	16.0	--	--
Heavy Alcohol, past month	121,091	6.5	--	--
Cocaine, past year	33,533	1.8	--	--
Crack, past year	7,452	0.4	--	--
Marijuana, past year	225,417	12.1	--	--
Inhalants, past year	13,041	0.7	--	--
Injection drug use	--	--	852	16.2
Mental Illness Prevalence⁷	Number	Percent		
General population				
Any mental illness	--	25.0	--	--
Depression	--	15.4	--	--
Any anxiety disorder	--	10.3	--	--
Psychological distress	--	5.2	--	--
PLWHA	--	--	1,187	22.6⁹

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, 2013. 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 2014, National Alliance to End Homelessness, Washington, DC, Appendices, page 19.

³ Prevalence of Imprisonment in the United States Population, 1974-2001, Bureau of Justice Statistics, U.S. Department of Justice, Washington, DC, August 2003

⁴ Texas Department of State Health Services

⁵ US Census Bureau, 2011 Small Area Health Insurance Estimates (SHAIE) using American Community Survey (ACS) Data

⁶ *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, Center for Behavioral Health Statistics and Quality, U.S. Department of Health and Human Services, Rockville MD, September 2013*

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.*

⁹ *AIDS Regional Information and Evaluation System (ARIES), 2012*



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
Lily Smullen

OFFICERS
Dr. Victor Martinez, Chair
Shanika Cornelius, Vice Chair
Justin Smith, Secretary

MEMBERS
Justin Irving
Jerry Juarez
Jessica Pierce
Christopher Shaw
Charlotte Simms-Sattiewhite
Seth Shulman
L.J. Smith
Aubrey Staples
Curtis Weidner

OFFICE OF COORDINATION & PLANNING
Kimberly Williams, Program Manager
John Waller, Health Planner
Jessica Ashton Gray, Administrative Senior

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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WEBSITE
www.cityofaustin.org/hivcouncil
austintexas.gov/aachpc

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September 10, 2014

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 2014 Planning Council Letter of Assurance

Dear Mr. Young:

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

- FY 2014 Formula, Supplemental, and MAI funds awarded to the Austin TGA have been expended according to the priorities established by the Planning Council.
- All FY 2014 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. Also, new planning council members participated in an orientation session designed to equip members with a foundation for healthcare planning and board service.
- Planning Council membership is representative and reflective of the epidemic in the Austin TGA. Four (4) representative membership slots are currently vacant. Targeted recruitment is underway based on a local organizational list representing key membership positions. The goal is to have these vacant slots filled by year end. There are no noted variations between the demographics of non-aligned consumers and the HIV disease prevalence in the TGA.

Respectfully,

Dr. Victor Martinez



Attachment 8

Planned Services Table

Priority	Core Medical Services	Amount
1	Medical Case Management	\$290,267
3	Outpatient / Ambulatory Medical Care	\$1,161,892
4	Health Insurance Premium & Cost Sharing Assistance	\$195,620
5	Substance Abuse Services – outpatient	\$131,485
9	AIDS Pharmaceutical Assistance – local	\$377,607
13	AIDS Drug Assistance Program (ADAP)	\$1
14	Oral Health Care	\$476,945
16	Mental Health Services	\$208,149
17	Medical Nutrition Therapy	\$70,208
28	Hospice Services	\$112,273
Total Core = 79.3%		\$3,024,447
Priority	Support Services	Amount
6	Case Management Services Non-Medical	\$437,645
8	Substance Abuse Services – residential	\$115,344
10	Outreach Services	\$103,176
12	Food Bank / Home-Delivered Meals	\$68,778
15	Medical Transportation Services	\$27,961
21	Psychosocial Support Services	\$36,498
Total Support = 20.7%		\$789,402
TOTAL SERVICES		\$3,813,849

Attachment 9

Ryan White Part A Implementation Plan: Service Category Table

Grantee Name: Austin TGA Fiscal Year: 2015
Budget Period: 03/01/2015 through 02/28/2016

Service Category Name: Outpatient/Ambulatory Medical Care		Total Service Category Allocation: \$ 1,161,892		
Service Category Priority Number: 3	Part A Core Medical X	Part A Support <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity:		
		3a) Number of people to be served	3b) Total number of service units to be provided	4. Time Frame:
5. Funds:				
a. Provide outpatient primary medical care consistent with PHS/NIH/ISDA guidelines to existing HIV positive clients in the TGA.	Per visit	1,079	2,511	03/01/2015 - 02/28/2016 \$ 778,467
b. Provide outpatient primary medical care consistent with PHS/NIH/ISDA guidelines to new HIV positive clients in the TGA.	Per visit	177	413	03/01/2015 - 02/28/2016 \$ 127,808
c. Provide laboratory tests consistent with PHS/NIH/ISDA guidelines to existing HIV positive clients in the TGA.	Per test	1,155	3,950	03/01/2015 - 02/28/2016 \$ 197,521
d. Provide laboratory tests consistent with PHS/NIH/ISDA guidelines to new HIV positive clients in the TGA.	Per test	339	1,161	03/01/2015 - 02/28/2016 \$ 58,096

6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy X V. Virally Suppressed X

7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:

HIV Positivity Late HIV Diagnosis Linkage Frequency /Retention Prescribing ART X Viral Load Suppression X

Service Category Name: Oral Health Care		Total Service Category Allocation: \$476,945				
Service Category Priority Number: 14		Part A Core Medical X	Part A Support <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>	
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity:			4. Time Frame:	5. Funds:
		3a) Number of people to be served	3b) Total number of service units to be provided			
a. Provide diagnostic, preventive, and therapeutic dental service consistent with Standards of Care to existing eligible clients in the TGA.	Per visit	1,041	2,583	03/01/2015 - 02/28/2016	\$ 434,019	
b. Provide diagnostic, preventive, and therapeutic dental service consistent with Standards of Care to new eligible clients in the TGA.	Per visit	103	255	03/01/2015 - 02/28/2016	\$ 42,926	
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.						
I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>						
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:						
HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage <input type="checkbox"/> Frequency /Retention X Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>						

Service Category Name: AIDS Pharmaceutical Assistance-local		Total Service Category Allocation: \$ 377,607		
Service Category Priority Number: 9	Part A Core Medical X	Part A Support <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity:		5. Funds:
		3a) Number of people served to be served	3b) Total number of service units to be provided	
			4. Time Frame:	
a. Provide FDA-approved pharmaceuticals/medications to existing eligible clients including those awaiting approval of ADAP or Compassionate Use Programs.	Per prescription	769	03/01/2015 - 02/28/2016	\$ 336,070
b. Provide FDA-approved pharmaceuticals/medications to new eligible clients including those awaiting approval of ADAP or Compassionate Use Programs.	Per prescription	95	03/01/2015 - 02/28/2016	\$ 41,537
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.				
I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care <input type="checkbox"/> IV. Prescribed Antiretroviral Therapy X V. Virally Suppressed X				
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:				
HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage <input type="checkbox"/> Frequency /Retention X Prescribing ART <input type="checkbox"/> Viral Load Suppression X				

Service Category Name: Medical Case Management		Total Service Category Allocation: \$224,046				
Service Category Priority Number: 1		Part A Core Medical X	Part A Support <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>	
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity:			4. Time Frame:	5. Funds:
		3a) Number of people to be served	3b) Total number of service units to be provided			
a. Provide Medical Case Management services consistent with Standards of Care to existing eligible clients in TGA.	Per 15 minutes	66	4,747	03/01/2015 - 02/28/2016	\$ 129,946	
b. Provide Medical Case Management services consistent with Standards of Care to new eligible clients in TGA.	Per 15 minutes	48	3,438	03/01/2015 - 02/28/2016	\$ 94,100	
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.						
I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>						
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:						
HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage X Frequency /Retention X Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>						

Service Category Name: Non-Medical Case Management		Total Priority Allocation: \$ 296,680		
Service Category Priority Number: 6	Part A Core Medical <input type="checkbox"/>	Part A Support X <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above a. Provide Non-Medical Case Management services consistent with Standards of Care to existing eligible clients in the TGA. b. Provide Non-Medical Case Management services consistent with Standards of Care to new eligible clients in the TGA.	2. Service Unit Definition: Define the service unit to be provided Per 15 minutes Per 15 minutes	3. Quantity: 3a) Number of people to be served		5. Funds: \$ 269,978 \$ 26,702
		3b) Total number of service units to be provided	4. Time Frame: 03/01/2015 - 02/28/2016 03/01/2015 - 02/28/2016	
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X <input checked="" type="checkbox"/> IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>				
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category: HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage X <input checked="" type="checkbox"/> Frequency/Retention X <input checked="" type="checkbox"/> Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>				

Service Category Name: Substance Abuse Services – residential		Total Service Category Allocation: \$ 115,344			
Service Category Priority Number: 8	Part A Core Medical <input type="checkbox"/>	Part A Support X <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support <input type="checkbox"/>	
Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided	3. Quantity:		4. Time Frame:	5. Funds:
		3a) Number of people served to be served	3b) Total number of service units to be provided		
a. Provide access to substance abuse treatment and/or counseling services in a residential setting to existing eligible clients in the TGA.	Per 24-hour day	24	447	03/01/2015 - 02/28/2016	\$ 76,127
b. Provide access to substance abuse treatment and/or counseling services in a residential setting to new eligible clients in the TGA.	Per 24-hour day	12	230	03/01/2015 - 02/28/2016	\$ 39,217
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.					
I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X <input type="checkbox"/> IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>					
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:					
HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage <input type="checkbox"/> Frequency /Retention X <input type="checkbox"/> Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>					

Service Category Name: Medical Case Management – MAI		Total Service Category Allocation: \$ 66,221				
Service Category Priority Number: 1	Part A Core Medical <input type="checkbox"/>	Part A Support <input type="checkbox"/>	MAI Core Medical X	MAI Support <input type="checkbox"/>		
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit to be provided		3. Quantity:		4. Time Frame:	5. Funds:
	3a) Number of people to be served	3b) Total number of service units to be provided				
a. Provide Medical Case Management services consistent with Standards of Care to existing eligible clients in TGA.	Per 15 minutes	27	1,950	03/01/2015 - 02/28/2016	\$ 58,936	
b. Provide Medical Case Management services consistent with Standards of Care to new eligible clients in TGA.	Per 15 minutes	3	217	03/01/2015 - 02/28/2016	\$ 7,285	
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.						
I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>						
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category:						
HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage X Frequency /Retention X Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>						

Service Category Name: Non-Medical Case Management – MAI		Total Service Category Allocation: \$ 140,965		
Service Category Priority Number: 6	Part A Core Medical <input type="checkbox"/>	Part A Support <input type="checkbox"/>	MAI Core Medical <input type="checkbox"/>	MAI Support X
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above a. Provide Non-Medical Case Management services consistent with Standards of Care to existing eligible clients in the TGA. b. Provide Non-Medical Case Management services consistent with Standards of Care to new eligible clients in the TGA.	2. Service Unit Definition: Define the service unit to be provided Per 15 minutes Per 15 minutes	3. Quantity: 3a) Number of people to be served		5. Funds: \$ 133,916 \$ 7,049
		185	5,784	
6. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed <input type="checkbox"/> II. Linked to Care <input type="checkbox"/> III. Retained in Care X IV. Prescribed Antiretroviral Therapy <input type="checkbox"/> V. Virally Suppressed <input type="checkbox"/>				
7. HHS/HAB Performance Measure related to the above Stage of the HIV Care Continuum related to this service category: HIV Positivity <input type="checkbox"/> Late HIV Diagnosis <input type="checkbox"/> Linkage X Frequency /Retention X Prescribing ART <input type="checkbox"/> Viral Load Suppression <input type="checkbox"/>				

Ryan White Part A Implementation Plan: HIV Care Continuum Table

Grantee Name: Austin TGA **Fiscal Year:** 2015
Budget Period: 03/01/2015 through 02/28/2016

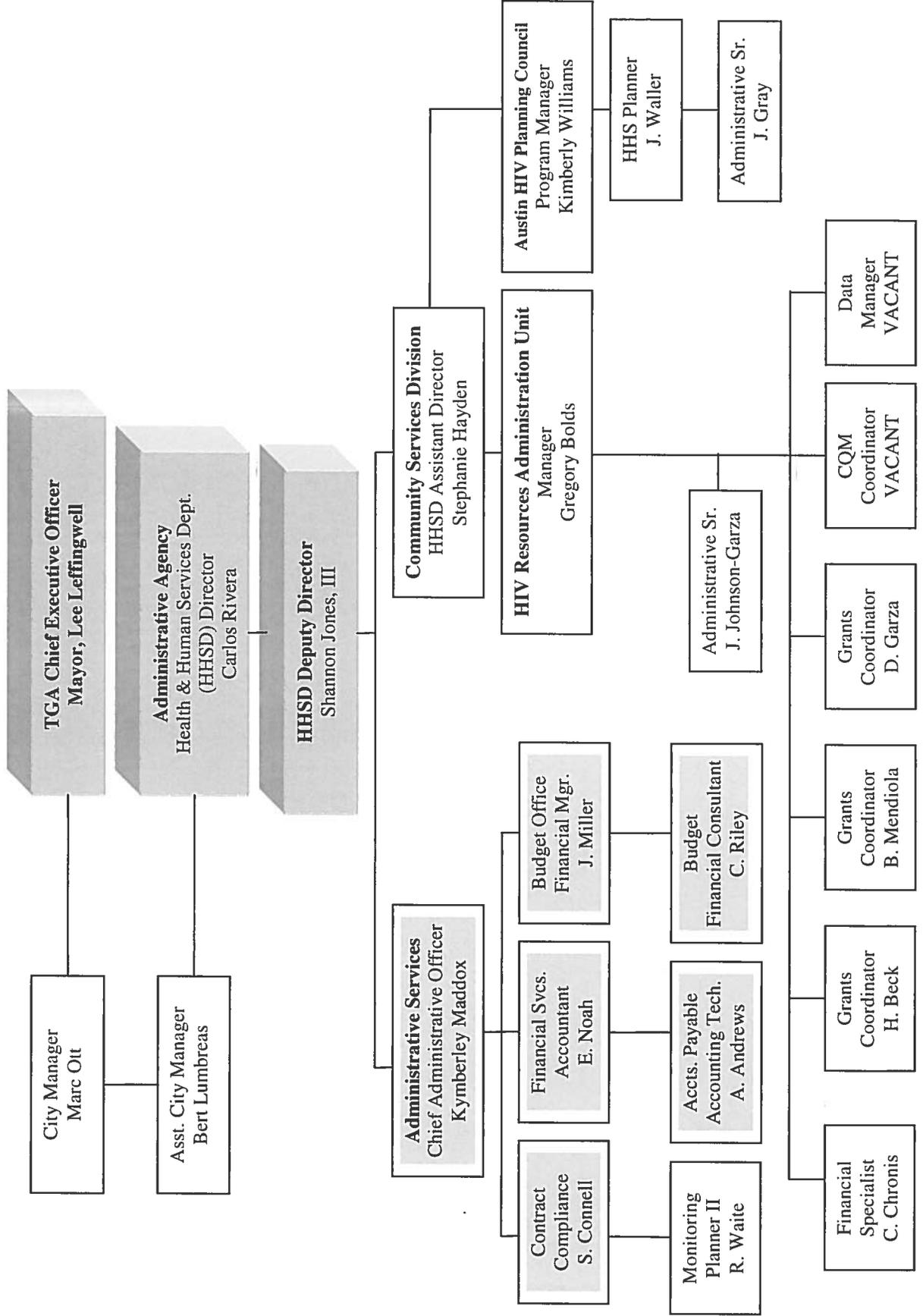
Stages of the HIV Care Continuum	Goal	Outcome	Service Category (one or more may apply)
I. Diagnosed	Decrease the percentage of clients with a late DX(1 yr. or 3 months between HIV and AIDS)	HIV Positivity* Late HIV Diagnosis* Baseline: Numerator/Dominator, % 85/313---27.1% Source: TDSHS Target: Numerator/Dominator, % 75/350---21.4%	Outreach MAI Outreach
II. Linked to Care	Increase the percentage of clients linked to HIV medical care	Linkage to HIV Medical Care* Baseline: Numerator/Dominator, % 233/289----81% Source: TDSHS Target: Numerator/Dominator, % 245/289---85%	Non-medical & medical case management, MAI Non-medical case management
III. Retained in Care	Increase the percentage of clients retained in care	Retention in HIV Medical Care* HIV Medical Visit Frequency** Baseline: Numerator/Dominator, % 2,033/1,706---83.9% Source: ARIES Target: Numerator/Dominator, % 2,100/1,785---85%	APA(local) Oral Health Care Substance Abuse Services Outpatient and Residential Medical and Non-medical case management
IV. Prescribed ART	Increase the percentage of clients with access to prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care* Prescription of HIV Antiretroviral Therapy ** Baseline: Numerator/Dominator, % 1,135/1,097---96.65% Source: ARIES Target: Numerator/Dominator, % 1,200/1,164---97%	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance(local)
V. Virally Suppressed	Increase the percentage of clients with a viral load<200	Viral Load Suppression Among Persons in HIV Medical Care* HIV Viral Load Suppression** Baseline: Numerator/Dominator, % 2,123/1,617---76.17% Source: ARIES Target: Numerator/Dominator, % 2,200/1,694---77%	Outpatient/Ambulatory Medical Care, AIDS Pharmaceutical Assistance(local)

*HHS Measures can be found at: <http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf>

**HAB Core Performance Measures can be found at: <http://hab.hrsa.gov/deliverhivaidscare/coremeasures.pdf>

Attachment 10

Austin Transitional Grant Area (TGA) Organizational Chart



Attachment 11

Maintenance of Effort

TGA: Austin, Texas		Report for FY 2012 and FY 2013	
Prepared by: Carmen Chronis, Financial Specialist		Telephone: (512) 972-5078	
Item No.	Agency/Department/Other Unit of Government	FY 2012 Amount	FY 2013 Amount
1	Austin Health and Human Services Department Communicable Disease HIV Education and Outreach Program Fund 1000-9100-3030	\$476,506.88	\$427,316.20
2	Austin Health and Human Services Department (HHSD) HIV Social Services Contracts with CBOs Fund 1000-4700-6161, 6162 and 6163	\$501,909.74	\$559,149.00
3	Travis County HIV Social Services Contracts CBOs Dept. 58 – Div. 91	\$574,002.86	\$568,726.00
4	Travis County Health Care District (TCHD) David Powell Community Health Center (DPCHC) Fund - Community Care	\$1,058,377.00	\$1,441,404.00
TOTALS		\$2,610,796.48	\$2,996,595.20

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.