Austin Area Comprehensive HIV Planning Council

2012

COMPREHENSIVE PLAN

3-Year HIV/AIDS Services Plan

Austin Area Comprehensive HIV PLANNING COUNCIL

TABLE OF CONTENTS

SECTION 1.

WHERE ARE WE NOW?

Summary:

The Austin Transitional Grant Area (TGA) is strategically located in central Texas and covers 4,281 square miles. Comprised of Bastrop, Caldwell, Hays, Travis and Williamson counties, as of 2011, the Austin TGA population was 1.8 million. Austin Texas has been marked as one of the fastest growing areas in the United States, having a third more residents than 10 years ago and double the population of 20 years ago. The racial/ethnic distribution is as follows: 53.3% White, 33.7% Hispanic, 7.8% African American, and 5.1% classified as "Other." In reference to age, approximately 67.6% of the population is less than 45 years old. Over 1.5 million people currently reside in the TGA, with the majority (57.3%) of residents living within Travis County boundaries.

Relative to growth in the general population, the number of persons living with HIV/AIDS (PLWHA) in the Austin TGA continues to increase each year as well. As of December 31, 2010, there were 1,791 individuals living with HIV and 2,561 living with AIDS in the Austin TGA. Half of PLWHA are White non-Hispanic (49.1%), and 84.4% are males. The highest burden of disease is among African Americans. Of particular note is the HIV infection among African American males, which is 2.5 times higher than White males. Likewise, the rate among African American females is eleven times higher than among white females (Table 1).

Table 1: Prevalence rate per 100,000 of HIV infection in the Austin TGA by race/ethnicity, 2010

	Males			Females			Total		
Race/ethnicity	N	%	Rate	N	%	Rate	N	%	Rate
White	1921	52.3	410.4	200	28.8	43.6	2121	49.1	228.9
African American	683	18.6	1023.0	327	48.8	486.3	1010	23.7	753.7
Hispanic	1018	27.7	333.9	143	20.6	54.7	1161	25.8	205.1
Other	49	1.3	113.0	11	1.5	25.9	60	1.4	69.9
Total	3671	100.0	415.7	681	100.0	82.1	4352	100.0	254.1

Source: Texas eHARS (unadjusted for reporting delays), 2011.

A. Description of the local HIV/AIDS epidemic

Calendar Year (CY) 2010 Epi Profile

A total of 4,352 persons in the TGA were living with HIV infection as of 12/31/2010 (Table 2). Of those, a total of 1,791 persons were living with HIV (not AIDS). Based on Texas Department of State Health Services (DSHS) estimates, AIDS prevalence has increased 67.5% since 2000. Although half of PLWHA are White, non-Hispanic (49.1%) and 84.4% male, the rate for African Americans living with HIV infection is 3 times higher than that of other groups (Table 1).

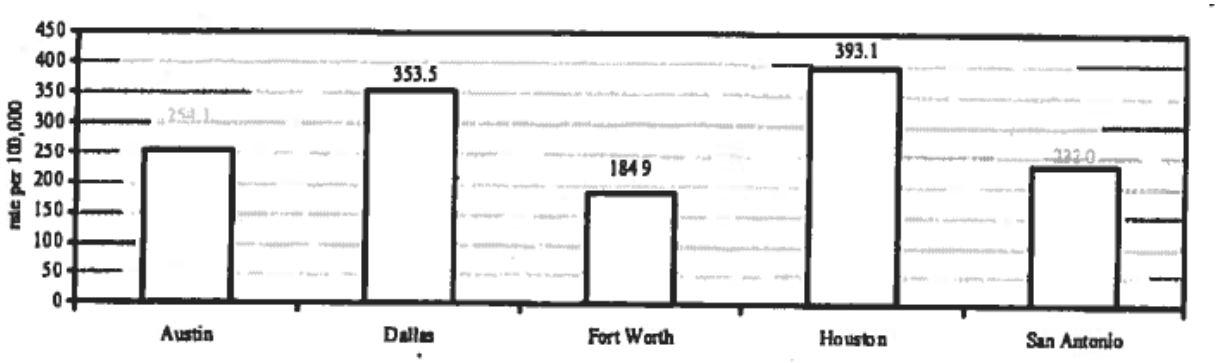
Table 2: HIV/AIDS Prevalence and Incidence Data – Austin TGA

CATEGORY	AIDS INCIDENCE: 01/01/08 to 12/31/10		AIDS PREVALENCE as of 12/31/10		HIV (NOT AIDS) PREVALENCE as of 12/31/10	
	No.	%	No.	%	No.	%
Race/Ethnicity						
White	190	41.4	1185	46.3	936	52.3
African American	98	21.4	629	24.6	381	21.3
Hispanic	157	34.2	713	27.8	448	25.0
Other	6	1.3	23	0.9	17	0.9
Sex						
Male	377	82.1	2151	84.0	1520	84.9
Female	82	17.9	410	16.0	271	15.1
Age						
<2 years	0	0.0	0	0.0	0	0.0
2-12 years	0	0.0	1	0.0	8	0.4
13 - 24 years	39	8.5	36	1.4	127	7.1
25 - 34 years	132	28.8	277	10.8	422	23.6
35 - 44 years	154	33.6	7.6	28.7	580	32.4
45+ years	90	19.6	1040	40.6	475	26.5
55+	44	9.6	471	18.4	179	10.0
Risk Category						
MSM	293	63.8	1552	60.6	1258	70.2
IDU	41	8.9	346	13.5	122	6.8
MSM/IDU	34	7.4	237	9.3	118	6.6
Heterosexual	86	18.7	405	15.8	273	15.2
Pediatric	4	0.9	16	0.6	19	1.1
Other	2	0.4	5	0.2	1	0.1
Total	459	100	2561	100	1791	100

Source: Texas Department of State Health Services (eHARS data as of July 2011, adjusted for reporting delays. Risk statistically redistributed. Other race/ethnicity includes Asian / Pacific Islander, Native American and Multi-races cases. Column totals may not accurately sum due to rounding.)

Compared to other Texas EMAs/TGAs, the Austin TGA is not the most populous area; however, regarding HIV infection, the burden is much higher than in other Texas jurisdictions. The prevalence of PLWHA in the Austin TGA is ranked as the third highest in the state. Austin, Houston, and Dallas have HIV (not AIDS) prevalence rates in the triple digits (Table 3).

Table 3: Prevalence of Persons Living with HIV/AIDS, Texas EMAs/TGAs, 2010



Source: Texas eHARS (adjusted for reporting delays), 2011.

Table 4 displays the statistical difference in distribution according to risk factors by race/ethnicity in the TGA. The most common risk was male-to-male sexual contact (68.9%) for all races/ethnicities. Among African Americans (47.8%), Hispanics (75.0%), and Whites (78.7%), most new HIV cases were in the male-to-male sexual contact exposure category.

Table 4: HIV cases in the Austin TGA, by exposure category and race/ethnicity, 2009-2010.

	White		African American		Hispanic		Asian-PI & Multi Racial		Total	
Exposure Category	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Male-to-male sex	157	78.7	49	47.8	104	72.3	9	75.0	319	69.8
Injection drug use	10	5.1	15	15.1	9	5.9	1	8.3	35	7.7
MSM & IDU	12	6.1	2	1.7	5	3.5	1	8.3	82	18.0
Heterosexual	20	10.2	34	33.5	26	18.3	1	8.3	82	18.0
Adult Other	0	0	0	0.0	0	0.0	0	0	0	0.4
Total	199	100.0	102	100.0	144	100.0	12	100	457	100.0

Source: Texas HARS (risk not redistributed), 2011.

Unmet Need Estimate for 2010

The Texas Department of State Health Services (DSHS) estimates the number of people living with HIV/AIDS (PLWHA) with unmet need at 1,095 persons or 25.2% of the entire PLWHA population. The Austin TGA uses the HRSA definition of unmet need with regards to medical care: *"During a 12 month period, there is no evidence of a CD4 count, viral load test, or antiretroviral therapy."* In the absence of any of these three events, an individual is considered

to have an unmet need. The actual estimate for unmet need is calculated by DSHS and provided to local health departments for analysis (Table 5).

Table 5: PLWHA with Unmet Need for Medical Care

	Living with HIV with unmet need		Living with AIDS with unmet need		PLWH with unmet need	
	No.	%	No.	%	No.	%
Sex						
Male	941	25.6	562	21.9	533	29.8
Female	154	22.6				
Race/Ethnicity						
White	528	24.9				
African American	270	26.7				
Hispanic	283	24.4				
Other/Unknown	14	47.5				
Age						
<2	-	-				
2-12	3	33.3				
13-24	45	27.6				
25-34	226	32.3				
35-44	340	25.8				
45-54	333	22.0				
55+	148	22.8				
Risk Category						
MSM	691	24.6				
IDU	138	29.6				
MSM / IDU	91	25.6				
Heterosexual	169	25.0				
Pediatric	4	11.4				
Adult Other	1	16.7				
Total	1,095	25.2				

Source: Texas DSHS, as of 12/31/2010. Note: Numbers may not sum to totals due to rounding error and risk statistically redistributed.

Early Identification of Individuals with HIV/AIDS (EIIHA) Unaware Estimate for 2009

The EIIHA strategy for the Austin TGA entails collaborating with local organizations that are currently engaged in the administration of EIIHA-related services and activities. The overall strategy involves the coordination of a seamless system which identifies, informs, refers, and links high-risk unaware HIV positive persons to medical care. A key component of this system is the inclusion of HIV prevention providers, with the HIV Planning Council serving as the lead organization in developing this coordinated system. The Austin TGA has selected four target

groups, or subpopulations considered to be high risk and historically underserved in the community: *African American Women*, *Young Men who have Sex with Men*, *Injection Drug Users*, and *Persons Recently Released from Incarceration*. Of particular note is that racial and ethnic minority populations make up a disproportionate share of all the targeted groups, thus an emphasis on addressing disparities in access is incorporated into the strategy. According to the Texas Department of State Health Services, the unaware estimate of individuals who were HIV positive for calendar year ending 2009 is 1,110. The following Back Calculation (EBC) methodology was used to derive at this number:

Summary:

National Proportion Undiagnosed = 21%
.21 x 4,177 (diagnosed living) = 1,110 (undiagnosed)
(.79)

Estimation Methods

The unmet need estimated matched individuals from the following six datasets representing different funding streams:

- **Electronic HIV/AIDS Reporting System *(eHARS)* -** This is the data source that is used as the universe of HIV/AIDS cases for estimating unmet need, retention in care for PLWHA, linkage to care for newly diagnosed individuals, and continuity of care for outpatient/ambulatory medical care visits, CD4 labs, and viral load labs.

- **Texas AIDS Drug Assistance Program *(ADAP)* -** Also known as the State Pharmacy Assistance Program (SPAP), in the event ADAP/SPAP is provided, antiretroviral (ARV) medications for a client, a person is considered to have met medical need for the year in which the medication was provided. Name-based matching was performed to determine persons with a met medical need during 2010.

- **Electronic Lab Reporting *(ELR)* -** The largest providers of laboratory services throughout the state report CD4 and viral load measurements to the DSHS. Name-based matching of these reports was used to determine if individuals received a CD4 count or viral load test during 2010.

- **AIDS Regional Information and Evaluation System *(ARIES)* -** Services provided to Ryan White eligible clients by funded service providers are reported in ARIES. If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory visit medical care during 2010, the client was reported as having a met medical need during that year. When available, name based matching was used to determine persons with a met medical need during 2010. When client names were not available, matching was based on a unique record number generated in ARIES and eHARS.

- **Medicaid/Children's Health Insurance Program *(CHIP)* -** For clients who received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory

medical visit through Medicaid/CHIP during 2010, the client was reported as having a met medical need during the year.

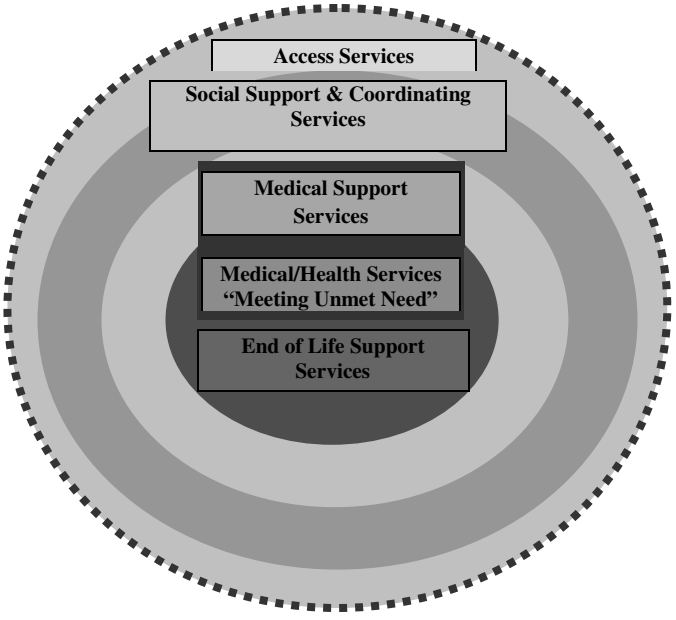
- **Private Insurers** – For this analysis, a few of the largest private providers in Texas extracted relevant procedures (CD4 counts, viral load measurements, and ARV) from their claims systems.

B. Description of Current Continuum of Care

The current system of care in the Austin TGA is supported by what the HIV Planning Council terms the pillars of "Access" and "Address." The pillar of Access establishes mechanisms that promote the availability of affordable and equitable healthcare for newly affected and underserved populations, thereby leveling the healthcare playing field in the five county area. The second pillar of Address provides a systematic approach that takes into account the service needs of special populations, including communities of color who are disproportionately impacted. Emerging populations and those out-of-care who know their HIV status are also considered in this constructed care system. A framework that facilitates maximum health outcomes is the end result for all clients to access for their varying disease levels. As indicated in Table 6, the essence of this framework is characterized by Ryan White funded core and support services.

The TGA's continuum of care pictured in Figure 1 illustrates two primary goals for the TGA: 1) identifying unmet need and thereby linking out-of-care individuals to primary medical care services; and 2) optimizing the healthcare needs of PLWHA by focusing on quality care. The model also emphasizes the Planning Council's intent to utilize access services in order to bring people into medical care. Support and coordinating services are used to maintain clients in care. Finally, to address the needs of PLWHA who do not respond to medical interventions, end-of-life services, such as hospice, are placed at the center of the continuum model along with primary medical care.

Figure 1: Continuum of Care
Unmet Need HIV+ aware, not in care



The continuum of care served more than 2,800 clients in 2011, with this number being relatively constant for the previous two years during the last comprehensive planning phase. Although the continuum is heavily supported with Ryan White Part A funds, it relies on significant support from other federal, state, and local funding sources. Integration and coordination of Part A funded services with other services and programs in the TGA contributes to the viability of the continuum of care. By filling in funding and service gaps, these complementary services attempt to meet the needs of those currently in care as well as those of newly infected, underserved, hard-to-reach, and emerging populations.

Table 6: Ryan White Funded HIV Care and Service Inventory

Core Medical Services
Medical Case Management
Health Insurance Premium & Cost Sharing Assistance
Early Intervention Services
Outpatient / Ambulatory Medical Care
AIDS Drug Assistance Program (ADAP)
AIDS Pharmaceutical Assistance – local
Mental Health Services
Oral Health Care
Substance Abuse Services – outpatient
Hospice Services
Medical Nutrition Therapy
Support Services
Medical Transportation Services
Case Management Services Non-Medical (Tier 1)
Substance Abuse Services – residential
Case Management Services Non-Medical (Tier 2)
Outreach Services
Psychosocial Support Services
Food Bank / Home-Delivered Meals

Table 7: Non-Ryan White Funded HIV Care and Service Inventory

(Service Legend: A-Advocacy; B-Basic Needs; C-Counseling/Mental Health; D-Disability/Aging; E-Education/Information; F-Financial/Emergency Utility Assistance; H-Housing/Homeless/Hospice; I-Insurance; J-Job Training/Employment/Workforce Development; L-Legal; M-Medical/Dental Care; T-HIV/STD Testing; Y-Youth)

COMMUNITY RESOURCE	SERVICES
Abiding Love Food Pantry	B
ADAPT of Texas, Institute for Disability Access, Inc.	A,B,C,D,E
Addiction and Psychotherapy Services	C, M
Advanced Testing Center	T
Advocacy Outreach	E, T
Advocacy Outreach, Bastrop	A,B,C,E,T
Aging Services Council of Central Texas (South Austin Caregivers)	B,C,D,E,H
AK Black Health Center (CommUnityCare)	C,M,T
Alcoholics Anonymous Hill Country Intergroup	A,C
American Cancer Society	A,E
American Diabetes Association	A,E
American Red Cross of Central Texas	A,B,C,E,H,M
American YouthWorks	C,E,J,Y
Any Baby Can Child and Family Resource Center	A,B,C,E,Y
ARC of the Capital Area	A,B,C,D,E,H,I,J,L,M,T

COMMUNITY RESOURCE	SERVICES
ARCH – Healthcare for the Homeless (CommUnityCare)	A,B,C,D,E,H,I,M,Y,T
Aseracare Hospice	H
Ashera Project	A,E,J,Y
Assistive and Rehabilitative Services	D,M
Austin Academy, The	E
Austin Area Urban League	A,E,F,H,J,Y
Austin Diagnostic Clinic	M
Austin Family Institute	C,E
Austin General Medical	M
Austin Infectious Disease Consultants	M,T
Austin Latina/Latino LGBT Organization (ALLGO)	A,C,EM,Y
Austin Outreach and Community Service Center, Inc.	A,B,C,T
Austin Project, The	A,B,C
Austin Recovery Center (1)	C,M
Austin Recovery Center (2)	C,M
Austin Recovery Center (3)	C,M

COMMUNITY RESOURCE	SERVICES
Austin Regional Clinic	C,E,M
Austin Resource Center for the Homeless (ARCH)	A,B,C,D,E,H,I,T
Austin State Hospital	C,E,M
Austin Veteran Outpatient Clinic, Central Texas Veterans Health Care System	B,C,D,E,J
Austin/Travis Country Re-Entry Roundtable	A,B,C,D,H
Austin/Travis County Community Health Initiative	A,C,E
Austin/Travis County Integral Care	C,E,M
Austin/Travis County Integral Care (by referral by ATCIC only)	C,E,M
Austin/Travis County RBJ STD Clinic	C,E,M,T
Avicenna Medical Center	M
Basic Needs Coalition of Central Texas	A,B,H
Bastrop County Emergency Food Pantry & Support Center	B,C,
Beat AIDS, Coalition Trust, Inc.	A,E
Ben White Dental (CommUnityCare)	M
Bisexual Network of Austin	A,E
Black Faith-based Health Initiative (B-FHI)	A,E

COMMUNITY RESOURCE	SERVICES
Blackland Neighborhood Center/Clinic	B,I,J,M,Y
Blackstock Health Center	M,T
Bluebonnet Trails Community MHMR Center	C,E
Brackenridge Hospital	C,E,M
Burning Tree Lodge	C,J
Camelot Community Care	B,E
Capital IDEA	E,J
Care Communities, The	A,C
Caring Place, The	A,B,C
Caritas of Austin	B,C,H,E,J
Casa Marianella	B,C,H,E
CASA of Travis County	B,E,H
Catholic Charities Of Central Texas	B,E,F,H
Cedar Park Regional Medical Center	M,T
Central Texas Medical Center	H,T
Community Action, Inc. Rural AIDS Services Program	B,C,E,H,M,T
Community AIDS Resource & Education (C.A.R.E.) Program	B,C,E,H,M,T

COMMUNITY RESOURCE	SERVICES
Cornerstone Counseling, Inc.	C,E
Cornerstone Hospital of Austin	C,E,M
Creative Initiatives, Inc.	A,B,E
CTMC Hospice Care	H,M
Del Valle Health Center (CommUnityCare)	E,M,T
Dell Children's Medical Center of Central Texas	M,Y
East Austin Neighborhood Center	B,E,J,M,Y
East Rural Community Center (Manor Clinic)	B,E,J,M,T,Y
Easter Seals Central Texas	A,B,E,J,M,Y
Eastside Community Connection	A,B,E,J
El Buen Samaritano Episcopal Mission	A,B,C,E,J
Ending Community Homelessness Coalition (ECHO)	A,B,C,E,H
Equality Texas	A

COMMUNITY RESOURCE	SERVICES
Faith in Action Caregivers	B,E
Family Crisis Center, Bastrop	B,C,E,F,H,Y
Family Eldercare	A,B,C,D,E
Family Life Center	A,B,C,E
Family Wellness Center UT School of Nursing (CommUnityCare)	E,M
Far South Clinic	E,M,T,Y
Foundation Communities	A,E,H
Foundation for the Homeless	B,C,D,E,H,J
Front Steps (Austin Resource Center for the Homeless (ARCH)	B,C,D,E,H,I,J,M
Georgetown Hospital	M,T
Gilead Healthcare, Inc.	M
Goodwill Industries of Central Texas	B,E,J
H.A.N.D. Inc. (Helping the Aging, Needy, & Disabled)	A,B,C,D,H
Hancock Walk-In Care (CommUnityCare)	E,I,M,Y
Harvest Foundation, The	A,E,Y
Hays County Food Bank	B

COMMUNITY RESOURCE	SERVICES
Hays County Personal Health Department	B,E,M,T,Y
Hays County Personal Health Department	B,E,M,T,Y
Hays/Caldwell Women's Center	E,M
Hays-Caldwell Council On Alcohol & Drug Abuse	C,E
Hays-Caldwell Women's Center (Roxanne's House)	A,B,C,E,H,Y
Highland Lakes Family Crisis Center, Inc.	M
Hill Country Community Ministries (HCCM), Williamson County	A,B,C,E
Hill Country Intergroup	A,E
Home Health of Central Texas Medical Center	H,M
Hospice Austin Christopher's House	H,M
Hospital at Westlake Medical Center, The	M
Housing Authority of the City of Austin	H
Huston-Tillotson Health Connect	A,E
Huston-Tillotson University Health Clinic	E,M,Y
Indigent Health Care, Bastrop County	A,B,C,D,E,F,H,I,J,M,Y

COMMUNITY RESOURCE	SERVICES
Indigent Health Care, Caldwell County	A,B,C,D,E,F,H,I,J,M,T,Y
Interfaith Care Alliance	A,B,C,E
John's Community Hospital	E,M,Y
Jonestown Northwest Rural Community Center	E,M,Y
Life Steps Williamson Council on Alcohol and Drugs	C,E
Life Works	A,E,J
Literacy Coalition of Central Texas	A,E
Lockhart Family Medicine	M,T,Y
Lone Star Circle Of Care www.lscctx.org	A,B,C,D,E,M,T
Lone Star Circle of Care (1) www.lscctx.org	A,B,C,D,E,M,T
Lone Star Circle of Care (2) www.lscctx.org	A,B,C,D,E,M,T
Lone Star Circle of Care (3) www.lscctx.org	A,B,C,D,E,M,T
Lone Star Hospice	M
Manor Health Center (CommUnityCare)	M
Manos de Cristo	D,M

COMMUNITY RESOURCE	SERVICES
Meals on Wheels and More	A,B,E
Medical Assistance Program (MAP)	E,I
Medical Institute for Sexual Health	E,M
Methadone Maintenance Treatment Program	C,M
Montopolis Clinic	E,M,T
Montopolis Health Center (CommUnityCare)	M,Y
Montopolis Neighborhood Center	B,E,M,T,Y
MyPlace Transitional Housing (Caritas of Austin)	B,H,M
North Austin Medical Center, St. David's	M,T
North Central Health Center (CommUnityCare)	D,M,T
North Rural Community Center	B,E,M,T
Northeast Austin Health Center (CommUnityCare)	E,M,T
Nubian Queen	A,B
Oak Hill Health Center (CommUnityCare)	M,T
Oak Hill West Rural Community Health	E,M,T

COMMUNITY RESOURCE	SERVICES
Oak Springs Treatment Center	E,M
Oakwood Women's Centre	M
Olivet Helping Hands Center (Olivet Baptist Church)	A,B,C
Out Youth Austin	A,C,E,Y
Peoples Community Clinic	E,M,T
Personal Connection Healthcare HIV Services	A,B,E
Pflugerville Health Center (CommUnityCare)	E,M,T,Y
Planned Parenthood of the Texas Capital Region	A,E,M,T,Y
Project Access	E,I
Public Utility Commission of Texas: Lifeline Program	E,I
Push-Up Foundation Men's Treatment Program	A,B,C,D,E
Push-Up Foundation Women's Treatment Program	A,B,C,D,E
RBJ Dental (CommUnityCare)	M,T,Y
Reliant Central Texas	E,M
Right Step Alcohol & Drug Treatment	C,E

COMMUNITY RESOURCE	SERVICES
Rosewood-Zaragosa Health Center	E,M,T,Y
Rosewood-Zaragosa Neighborhood Center	B,C,E,M,Y
Round Rock Area Serving Center	A,B,E
Round Rock Medical Center, St. David's	M,T,Y
Rundberg Health Center (CommUnityCare)	E,M,T
Sacred Heart Community Clinic	E,M
SafePlace: Domestic Violence & Sexual Assault Survival Center	A,B,C,E,Y
Salvation Army Adult Rehabilitation Center	A,B,C,E,F,H,J,Y
Salvation Army Hays County Service Unit/Health Clinic	A,B,C,D,E,F,H,J,M,Y
Salvation Army, Austin Baptist Chapel	A,B,C,E,F,Y
Samaritan Counseling Center Services: First United Methodist Church	B,C,E
Samaritan Health Ministries	B,C,E,M
Scott & White Clinic	M,T
Seton Healthcare Family	M,T
Sexual Assault and Abuse Services	A,B,C,E,L

COMMUNITY RESOURCE	SERVICES
Sickle Cell Association of Austin (Marc Thomas Foundation)	A,E
Skillpoint Alliance	E, J
Smithville Regional Hospital	M,T
South Austin Health Center (CommUnityCare)	E,M,T
South Austin Neighborhood Center	B,E,M,T
South Rural Community Center (Del Valle Clinic)	B,E,M,T
St. David's Healthcare	M,T
St. John's Community Center/Community Health Center	B,C,E,M,T
Sustainable Food Center	B,E,Y
TACT (Transgender Advocates of Central Texas)	A,E
Texas Department of Aging and Disability Services	A,C,D,E,H,I
Texas Department of State Health Services	A,E
Texas Health and Human Services Commission	B,E,F,I,J,Y
Texas HIV Connection	A,E
Texas HIV SPAP (State Pharmaceutical Assistance Program): HIV Medication Program	E,I

COMMUNITY RESOURCE	SERVICES
Texas Legal Aid, TX Rio Grande Legal Aid, Inc.	E,L
Texas Medical Foundation	E,I
Texas State University Health Education Resource Center	E,M,T
Thurmond Heights Wellness Center	B,C,D,E,J,M,Y
Top Drawer Thrift Shop (Project Transitions, Inc.)	B
Travis County Family Support Services	A,B,E,J,Y
Travis County Health and Human Services	A,E,M
TX Low Income Housing Information Services	A,E.H
University Medical Center at Brackenridge	M,T
University of Texas Student Health Center	E,M,T
Volunteer Healthcare Clinic	E,M,T
West Rural Community Center (Oak Hill Clinic)	B,E,M,T,Y
William Cannon Health Center (CommUnityCare)	M,T
Williamson County Council on Alcohol and Drug Abuse	C

COMMUNITY RESOURCE	SERVICES
Williamson County Health District	E,M,T,Y
Women Rising Project	A,E
Women's Advocacy Project, Inc.	A,E,L
Women's Health Center (CommUnityCare)	M,T
Wonders and Worries, Inc.	A,C,E,Y
Workforce Solutions, Capital Area	E,J,Y
YMCA of Greater Austin YWCA	B,E,J,Y

How Ryan White funded Care/Services Interact with Non-RW funded Services to ensure Continuity of Care

The existing continuum of care is comprised of services which are supported by Ryan White and non-Ryan White resources. Major services provided by the TGA's HIV/AIDS continuum of care are discussed below with emphasis on HRSA-identified core services, linkages and coordination of services.

HIV Testing: To ensure access to care, the TGA aggressively promotes knowledge of HIV status and provides free HIV counseling and testing at a number of public facilities such as STD clinics and community-based organizations. Rapid testing has been expanded to STD clinics, HIV voluntary counseling and testing sites, homeless shelters, public clinics, and community-based organizations serving communities of color. The TGA also invests heavily in initiatives promoting identification, counseling and testing of the partners of individuals who have tested HIV-positive. The TGA also uses MAI funds to support early intervention services, including HIV testing and counseling in select high-prevalence settings; however, the vast majority of early intervention services activities are funded outside of Ryan White, yet serve to enrich the current funded services.

Outpatient/Ambulatory Health Services: For several years, the TGA has delivered high-quality primary medical care to nearly 2,000 PLWHA annually through Part A, B, C, and other funding sources such as Medicaid, Medicare, and the local Healthcare District. As the primary provider

of medical care is a Federally Qualified Health Center (FQHC), the clinic adheres to HIV/AIDS clinical standards that meet or exceed those of the U.S. Public Health Service. The goals of this service are to provide state-of-the-art HIV/AIDS care; improve overall health; educate clients on the HIV disease process; improve CD4 counts within the medical boundary presented by each patient; decrease viral load per appropriate medical guidelines; prevent opportunistic infections (OIs) through antiretroviral treatment and OI prophylaxis per protocols; maintain patient retention and treatment adherence; and contribute to the overall quality of life of PLWHA.

AIDS Pharmaceutical Assistance (local): The TGA's local drug assistance program is also provided by the FQHC. Its on-site Class A pharmacy makes possible a highly integrated approach to medication regimens, with constant interaction between medical providers and pharmacy staff. This integrated model provides immediate care plan assistance and revision when any of the members of the care team identify barriers to successful treatment while a patient is still in the clinic. With the co-location of medical care and the pharmacy, many patients can receive their medication at the completion of their provider appointment. On-site pharmacists are also readily available for consultation with providers regarding drug reactions and potential interactions. The on-site pharmacy is also a link to new medication treatment options for the patients.

Oral Health Services: The connection between access to oral health and improved physical health for persons with HIV/AIDS is well documented. Oral manifestations of HIV are common, and oral health maintenance can often identify infections at early stages before they become systemic and alter physical health. Sound oral health is a prerequisite to healthy eating, which is essential for maintaining overall health for HIV-positive persons. Oral Health services seek to improve both dental and overall health for persons with HIV. The TGA is experiencing an increase in new patients with little or no dental care history and in patients needing specialty dental care. In both cases, patients require repeat visits to the dental clinic to stabilize their oral health. The TGA offer oral health care to people with HIV/AIDS who could not afford care or were refused service by private providers. The TGA provides routine and emergency dental care for HIV-positive individuals. Services include oral examination; treatment planning; oral surgery; treatment of lesions; ulcers and gum disease; simple root canal treatment; periodontal therapy (non-surgical); restorative dentistry such as fillings, crowns, and removable prosthodontics (both partial and full dentures); patient education; oral hygiene; and alleviation of dental pain. Ryan White Part A funding covers over 40% of costs associated with HIV-related dental care for low-income PLWHA, while the remaining costs are covered by other funding sources.

Health Insurance Premium & Cost Sharing Assistance: The goals of the TGA's health insurance premium and cost sharing services are to assist clients in maintaining private health insurance coverage so that they can access HIV primary medical care and to assist clients in utilizing private health insurance benefits to decrease use of public funding for HIV primary medical care. Health insurance services help "enhance health and well being". With these services, clients are able to maintain insurance coverage and often have access to a wider range of health care services than are available through local, state and federal assistance. The program is designed to provide both short and long–term assistance to clients. Because this service is highly intensive

with regards to costs and care, the $200,000+ Ryan White funds allocated to this service is further supported by other funding sources.

Hospice Services: The TGA's hospice services are designed to provide residential care to individuals who need 24-hour support, whether temporary or near end of life. Services are provided in a home-like atmosphere with support designed to meet the emotional, physical, spiritual and social needs of people in all stages of HIV/AIDS. Services include room, board, medical care, hospice/palliative care, nursing services, personal care, emotional and spiritual support, and opportunities for social interactions. This service continuum is designed to enhance quality of life and to provide access to other needed services while enabling individuals to live in an environment of care, respect, and concern. In light of continual diminishing allocations to this particular service, other funding sources are sought, including Medicaid/Medicare eligibility for the organization to ensure proper reimbursement.

Mental Health Services: For PLWHA, mental illness is strongly correlated with reduced health care access, lower treatment adherence, poor medical outcomes, and higher rates of substance abuse and housing instability. Part A funding is essential to address the mental health needs of multiply diagnosed PLWHA, as existing services for the mentally ill and chemically addicted population, such as those provided through Medicaid or other sources which have long waiting lists and are often ill equipped to provide the breadth and intensity of services required by this population. To promote health care access, continuity of care, and treatment adherence, the TGA allocated over $300,000 in FY 2012 to mental health services. A diverse array of mental health service providers target PLWHA in acute need of mental health support. In recognition of the many impediments to effective utilization of mental health services, the TGA has increasingly invested in mental health services that are available, either through co-location or linkage, with other services, such as medical care, substance abuse treatment, and case management. Other funding sources contribute to this service in excess of $20,000.

Medical Nutrition Therapy: The TGA's medical nutrition therapy service is designed to help PLWHA use food products in the best way possible. The goals of the program are to educate PLWHA about ways to maximize their health through food selection and preparation; educate PLWHA on appropriate diets for chronic diseases related to lifestyle (e.g., diabetes, insulin resistance, hypertension, hyperlipidemia, osteoporosis, hepatitis, and obesity); and to enhance the effectiveness of food pantry services for improving and maintaining health.

Medical Case Management (Including Treatment Adherence): Medical case management services promote health care access, maintenance in care, and continuity of care. To support successful treatment adherence, the TGA makes Part A investments in medical case management services to address key medical and social barriers to adherence. The Part A-funded treatment adherence is provided with medical case management services. The Planning Council allocated $279,294 in Part A funding in FY2012 for these services. Other funding sources were used to fill gaps in care.

Substance Abuse Services (Outpatient): HIV-infected individuals who abuse substances are significantly less likely to adhere to treatment or to access essential medical services. HIV-infected IDUs are also significantly more likely to die than their non-injecting counterparts. To

address the related epidemics of substance addiction and HIV/AIDS, the TGA in FY 2012 allocated $214,948 in Part A funds for client-centered, low-threshold substance abuse programs that were not covered by other payment sources. Because PLWHA with substance abuse problems often experience other health problems and barriers to care, the TGA's substance abuse services are co-located with mental health services. In addition to Part A-funded services, the TGA uses a combination of federal and State funds to support additional drug treatment services, with the aim of increasing drug treatment capacity and utilization.

Supportive Services: The core services described above comprise the bulk of the TGA's service continuum. The TGA's service portfolio, however, also recognizes that multiple disadvantaged clients require support services to stabilize their living situations and make health care access and treatment adherence feasible. Legal services not funded with Part A dollars ensure rapid access to entitlements and other benefits; food bank and nutrition services provide life-sustaining support for PLWHA living in poverty and encourage continuity of care and housing placement; and transportation services (especially important for the physically impaired and for low-income individuals in rural parts of the five county region) help patients keep medical appointments and access essential services.

Case Management-Non medical (Tier 1 and 2): Case management services are the foundation of the TGA's efforts to promote health care access and continuity of care. Part A supports HIV/AIDS case management at four (4) locations throughout the TGA. Using case management standards of care, Part A-funded case managers perform a comprehensive intake assessment for PLWHA, develop and implement a service plan tailored to the client's needs, and monitor and evaluate the plans on an ongoing basis. The Planning Council allocated $384,876 in Part A funding in FY 2012 for non medical case management services. Other funding sources provided a substantial amount for non medical case management services targeting special populations.

Food Bank/Home Delivered Meals: Food Bank/Home Delivered Meals service is designed to offer quality food, personal and household care products, and nutritional supplements to people with HIV/AIDS who are at risk of declining health due to their inability to take in adequate food and nutrients. The primary goals of the Food Bank/Nutritional Supplements Program are to offer nutritional products that enable low-income HIV+ persons to improve or maintain their health and to provide quality nutrition that meets the dietary health needs of people with HIV through products that supplement other food sources. Food bank staff plans menus and order food items in accordance with industry standards and guidelines. Dietician ensures nutritional quality of menu items by advising staff of appropriate selections periodically and through standardized menu analysis.

Clients access the food bank twice per month. Case managers or volunteers deliver food and/or nutritional supplements to homebound clients during the weeks that the food bank is open. Case managers can also provide food outside of food bank distribution hours on a case by case basis and in an emergency. Clients can receive nutritional supplements through the Nutritional Counseling Program during weekly drop-in hours and by appointment, as well as during food bank distribution hours. There are numerous Non-Ryan White funded providers of food bank services which help meet the capacity in the community.

Medical Transportation: The TGA's medical transportation services program is administered by the HIV Resources Administration Unit of the Austin/Travis County Health & Human Services Department. The program provides transportation services, as a payor of last resort, for medical and support services to low-income clients living with HIV and AIDS and their immediate families.

The goal of the program is to reduce barriers in accessing, maintaining, and adhering to primary health care and related social and support services for PLWHA. The Planning Council's decreased allocation of $25,000 in Part A funding in FY 2012 for these services allowed other funding sources to expand their capacity and help meet the needs of PLWHA.

Housing: The Federal Housing Opportunities for People with AIDS (HOPWA) program provides the majority of funding for housing services such as scatter site housing, and short term rent, mortgage, & utility assistance. Part A supplemented the program by providing case management assistance to HOPWA clients.

How the Service System/Continuum of Care has been affected by State and Local Budget Cuts; How the Ryan White Program has adapted

State and local budget cuts have enabled the system of care to operate in a more coordinated fashion. Rather than limit the accessibility or availability of services, the HIV Planning Council ensures an optimal coordination with Part B and Texas HIV State Services funding to maximize resources. For example, joint efforts have been undertaken in the areas of policy development and program/fiscal monitoring. This centralized coordination ensures services that are provided by Part A, including MAI, do not duplicate those provided by other Ryan White funded grant programs. It also ensures the gaps in services are being met by appropriate entities in the TGA.

Additionally, the HIV Planning Council provides input for Housing Opportunities for Persons with AIDS (HOPWA) and City of Austin funding for HIV services. The planning insight provided by the Planning Council facilitates coordination of both HIV prevention and HIV care activities. During planning activities, service duplication is often considered.

C. Description of Need

Care Needs

The most recent Comprehensive HIV Needs Assessment evaluated the unmet need, service gaps, and barriers to care for HIV-positive persons not in care. The need, gaps and barriers for the entire out of care population are summarized in Table 8. Service needs include basic assistance and assistance with health insurance. Not surprisingly, the most important gap in services for the out of care population was health insurance. Barriers to getting into care took several different broad forms. First, there was fear in having HIV status revealed. Second, there were perceptions care was not necessary. Lastly, there were other factors like substance abuse and financial concerns. Mental health issues were also identified as significant barriers to care, with an estimated 47% of PLWHA suffering from a mental illness.

Capacity Development Needs

Significant service gaps reported in the 2010 Austin HIV Needs Assessment include psychosocial (non-medical) case management; AIDS drug assistance; transportation; and oral health services. With three-quarters identified as having a mental health problem, the IDU population has high need for mental health services. Gaps in oral health care, substance abuse services, mental health services, and medical transportation are common for several emerging populations, including IDUs. Six populations in the TGA have been selected for their special needs: *injection drug users*, *substance users other than injection drug users*, *men of color who have sex with men*, *White men who have sex with men*, *African American women*, and the *recently released from jail/prison*.

Injection Drug Users – There were 21,696 injection drug users in the Austin TGA in 2011, representing a significantly larger percentage in comparison to other areas *(source: Texas Commission on Drugs & Alcohol)*. The percentage of PLWHA is estimated to be between 6% and 27% *(source: 2010 Austin TGA Comprehensive Needs Assessment)*. Significant service gaps reported in the 2010 Austin HIV Needs Assessment update include psychosocial (non-medical) case management; AIDS drug assistance, transportation, and oral health services.

Substance Users other than IDU – The Austin TGA has the highest rates of drug use in the state of Texas. The overall rate of illicit drug use in the Austin TGA was twice that of any other Texas TGA/EMA. Substance users represented 29.7% of respondents in the 2010 needs assessment. Overall, 79% respondents of Travis County SHAS (Supplement to HIV/AIDS) Surveillance reported using non-injection drugs. Because substance abuse can lead to risky behavior, this population faces unique challenges.

Men of Color who have sex with men **–** Among men of color living with HIV, MSM (including MSM and IDU) was the most common risk factor (78.7%). Service gaps for this population, as identified in the needs assessment, include psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. According to ARIES data, African American and Hispanic men had more service visits than white men. African American men averaged 65 visits and Hispanic men 58 visits, compared to White men who averaged 46 visits. Identifying and bringing into care men of color (MSM) requires additional focus on unmet need as well as outreach and adherence services.

White men who have sex with men **–** White men who have sex with men comprised 36.7% of all PLWHA in the TGA. When White MSMs who are injection drug users are included, the percentage increases to 41.1%. In 2009-2010, 34.4% of all newly diagnosed AIDS cases were White MSM (source: Texas eHARS, 2011). Service gaps for this population include oral health services, medical case management, outpatient/ambulatory medical care, and AIDS drug assistance. In addition to these self-reported needs, providers and surveys indicate that significant numbers of White MSM need mental health, substance abuse, and health education/risk reduction services.

African American women – In 2011, 54.6% of all women in the TGA were White, 32.1% were Hispanic, 8.1% African American, and 5.2% other races/ethnicities (source: Texas State Data Center and Office of the State Demographer, 2011). Although among the smallest race/ethnic groups in the TGA, just under half (48.8%) of all females living with HIV/AIDS is African American (source: Texas eHARS, 2011). According to the 2005 HIV Needs Assessment, a higher percent (36%) of African American women were out of care than among women overall. Service gaps reported in the 2010 needs assessment include: oral health services, mental health services, transportation, utility assistance, and AIDS drug assistance. Focus group data also suggested that support groups facilitated by a mental health professional would be a beneficial component to care.

Rural communities

Four of the five counties comprising the Austin TGA are considered to be in rural communities. Transportation continues to be an identified care need in the rural communities. To address this issue, the Planning Council allocated resources for mental health services to take place in the outlying four rural counties. The services would be administered through group counseling sessions, which have proven to be effective in getting and keeping PLWHA into medical care.

D. Description of priorities for allocation of funds

Size and demographics of PLWHA/Needs of individuals with HIV/AIDS

The Planning Council used a systematic method to quantify and address the needs of PLWHA in three different categories: 1) those in care, 2) those unaware of their HIV status, and 3) those historically underserved. First, the number of persons not in care was quantified utilizing demographic data from the Texas HIV/AIDS Reporting System (eHARS) and the AIDS Regional Information and Evaluation System (ARIES). Demographic data from the two reporting systems were compared using established "subtraction" methodology to present a demographic profile of persons not in care. To present a comprehensive picture, quantification included analysis of zip code and county specific data for the five-county TGA. The construct of age was also used to further breakdown the specifics of each sub-populations.

Secondly, the Planning Council studied National, State, and local ARIES data in projecting the number of persons unaware of their HIV status. HIV case data trends for new cases over the last five years provided validity for projections, indicating that in addition to the known HIV positive population, an additional 21% to 25% are unaware of their HIV status. Based on this information, the Planning Council was afforded access to HIV unaware data, as well as information on the challenges and successful strategies for reaching the unaware population. The aforementioned methods were all used during the priority setting and allocations process to understand and address the needs of persons unaware of their HIV status.

Finally, to obtain a good demographic profile of the underserved populations, an expanded set of ARIES reports was utilized, which included Minority AIDS Initiative service reports. In addition to data analysis, the Planning Council considered input from the community gathered from

meetings and community forums. The findings from these venues was then used to inform the priority setting process.

E. Description of gaps in care

Prior to setting service priorities and allocating Part A funds, the Planning Council was able to identify gaps in services and allocate dollars strategically by examining all sources of funding for all eligible services. Particular service gaps proved to vary among different populations. Overall, significant service gaps reported in the 2010 Needs Assessment include psychosocial (non-medical) case management, AIDS drug assistance; transportation, and oral health services. Gaps in oral health, substance abuse services, mental health services, and medical transportation are common for several emerging populations including IDUs. The most important gap in services for the out of care population was health insurance.

Substance Abuse Treatment

The 2005 Needs Assessment identified significant service gaps in the areas of housing-related services, emergency financial assistance, food bank, oral health, nutritional counseling, transportation, and substance abuse treatment. With three-quarters identified as having a mental health problem, the IDU population has high need for both substance treatment and mental health services. Gaps in oral health care, substance abuse services, mental health services, and medical transportation are common for several populations including Intravenous Drug Users (IDUs).

The consumer survey samples of IDU and other substance users emphasize the critical relationship between substance use and HIV in the Austin TGA. Combined, these populations comprise 59% of the total survey sample, with current IDU and current substance users making up 43% of the out-of-care sample. This includes 53% of current substance users who are out-of-care and 91% of current IDUs who are out-of-care.

Mental Health Therapy and Counseling

Over two-thirds of the consumer survey participants reported currently experiencing a mental health condition. Most frequently identified were depression (59%) and anxiety (47%). Only 40% of consumer survey respondents, however, identified a need for mental health therapy and counseling. During the provider focus groups, the most frequently identified gap in the service continuum was mental health therapy and counseling. Providers stated that mental health therapy and counseling is a service that is widely needed and unavailable to their clients with waits for an initial assessment of between one and two months.

Housing

Homelessness or unstable housing is a significant risk factor for being out-of-care. The housing difference between in-care and out-of-care consumers reveals the importance of housing in maintaining access to medical care. Over three-quarters of in-care consumers reported living in their own house or apartment compared to 23% of out-of-care. Out-of-care consumers most frequently lived in someone else's house or apartment, with 32% reporting this situation, compared to 4% of in-care. Over 20% of out-of-care lived with their parents, compared to 6% of in-care.

Nearly 15% of out-of-care were homeless, compared to less than 2% of in-care. In addition, over 40% of out-of-care reported being homeless at some point during the past year, compared to 3% of in-care. Housing assistance and housing-related service were frequently identified as unfulfilled needs for the survey sample, in-care, out-of-care and most priority populations.

Early Intervention Services--Linkage at Diagnosis

Moving newly diagnosed PLWHA into medical care immediately after diagnosis is the critical first step to maintaining PLWHA in the care system. Effective post-test counseling, referral to HIV medical care and referral to other needed services are essential. Approximately 40% of both in-care and out-of-care consumer survey respondents reported not receiving a referral to medical care at the time of diagnosis.

Mental health support at the time of diagnosis may support newly diagnosed PLWHA in moving into care. It is worthwhile to consider expanding follow-up frequency with the newly diagnosed to assess need for support and information.

F. Description of Prevention and Service Needs

With over 4,000 HIV positive individuals living in the TGA, prevention needs in the area are paramount. In order for the Comprehensive Plan to be successfully implemented and to serve its intended purpose, the HIV Planning Council has determined that care and treatment services must be coordinated and integrated with prevention services.

The Council is beginning to make inroads into this area by collaborating with and building upon the work of a city-wide HIV comprehensive planning initiative. The purpose of the initiative is twofold. First, there is a need to develop a strategic plan for the investment of City of Austin and Travis County general revenue funds for HIV care and prevention services. Second, there is a need to develop an ongoing, comprehensive community planning process to coordinate federal, state, and local planning efforts, and funding streams. This effort will improve the HIV continuity of care and the delivery of prevention services for individuals with HIV or those at risk of HIV infection.

The development of an HIV social marketing campaign was one outcome of this initiative. Culturally-appropriate social marketing messages that educated the public about HIV/AIDS facts were developed by a consultant. HIV testing and referral services information, along with the prevention messages targeted at underserved populations further enhanced the prevention and care continuum in the TGA.

According to the last Comprehensive Needs Assessment Provider Survey, five of the nine (5/9) Ryan White funded agencies offered HIV prevention services. Other findings were:

- All provide prevention interventions for persons living with HIV, and four provide HIV partner counseling and referral services. All conduct street outreach.
- Three provide rapid testing in non-clinical settings.
- A wide range of populations were targeted with prevention services in the region including MSM, African-Americans, Hispanics, women, IDUs.

- Prevention funding came from a variety of sources including CDC, SAMHSA, Texas DSHS, Travis County and the City of Austin.

Previously, there were two major types of prevention programs being operated in the TGA. The first type of program targets **individuals** and directly influences their knowledge, attitude, and behavior. Information is delivered in one-on-one setting by professionals, peers, and/or media targeted to individuals. This program reaches a limited number of persons, but often provides the most flexibility to meet client needs. The second type of program targets newly formed or existing **groups.** Activities are conducted with couples, small groups, or families that also use professionals, peers, and/or other media. Moderate numbers of people are reached and the programs offer some flexibility to meet the needs of individuals.

Based upon the two types of prevention programs described above, the need for **community** and **structural** prevention efforts in the TGA was warranted. Hence, the Planning Council formulated an EIIHA Plan in order to converge and maximize the efforts of prevention and care providers. It is believed that these types of programs can have a greater impact on the area.

G. Description of barriers to care

Routine testing – In FY 2010, the local network of FQHCs (CommUnityCare) began implementing CDC-recommended opt-out (routine) HIV testing. Using demographic and surveillance data and information from HIV testing programs, three clinics were identified as pilot sites. In FY 2011, the Austin/Travis County Health and Human Services Department Sexually Transmitted Infections (STI) Clinic continued its successful HIV opt-out testing program where 5,171 persons were tested for STIs at the clinic. Of those, 5,091 consented to an HIV test. However, barriers persist in further developing these efforts due to lack of coordination and willingness with local hospitals and ERs, as well as doctor's offices.

Program related barriers **–** Co-morbidities, high poverty, and low rates of health insurance coverage increase the challenge of providing care to PLWHA in the TGA in three main ways. First, these factors tend to complicate the prevention and management of HIV infection and AIDS. 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 clients are disenfranchised from health and other social service systems in general. Moreover, they may not access care regularly or adhere to treatments because of impaired judgment form substance abuse or mental illness. These factors, when considered together, often pose barriers to care when it comes to programmatic planning and services.

Provider related barriers **–** The growing number of PLWHA and the cost of antiretroviral therapies also affects the TGA's ability to provide services. The need for expensive genotypic and phenotypic assay and other laboratory testing imposes an additional cost burden on the primary medical care system. Early intervention is now more critical because of effective treatment options; however, those most in need of care often are least willing or able to access and remain in primary medical care. Other factors that complicate service needs and impair

effective service delivery in the TGA include changes in managed care, effects of the economic downtown, and cutbacks in basic social services previously funded by the Ryan White Program.

Client related barriers - The following barriers to care were identified during the 2005 Austin Area Comprehensive Needs Assessment and further supported in the most recent 2010 Needs Assessment update:

Feeling Well

PLWHA who feel well are often reluctant or unwilling to access HIV medical care. This was confirmed by responses to the consumer survey. Both out-of-care respondents and consumers who did not access care for a year or more after diagnosis were asked their reasons. In both cases, "I was not sick" was the most frequently identified reason. Among those who did not receive care within a year of diagnosis, 40% identified this reason. Among out-of-care, 28% provided this as their "top of mind" response to an open-ended question about why they were not receiving medical care. This was followed by a multiple choice question, "you don't believe you need medical care currently because you are not sick," which was identified by 32%.

Stigma/Fear of Disclosure of HIV Status

On the consumer survey, out-of-care consumers were asked an open-ended question about their reasons for not receiving medical care. Fear of disclosure of HIV status was the third most frequently discussed reason, identified by 12%. This question was followed by a list of potential barriers to accessing medical care. From that list, "someone might find out your HIV status if you go there" was the most frequent barrier identified, with 40% of out-of-care consumers citing it. During consumer and provider focus groups and interviews with those who delayed accessing medical care, HIV stigma was discussed as a psychological barrier to care for PLWHA.

Comments included:

- There's that stigma that people don't want to come forward. I think it is a huge issue that we overlook in this community. (Case Managers)
- Some people want to keep it a secret. My friend would not come to this focus group because he is afraid he will see someone from this group when he's out at a club. (Young Men)
- Gay men are alienated by everybody and now HIV makes it worse. (Latino Men)
- Negative attitudes toward HIV are widespread. (Substance Users)
- I was diagnosed in jail and was put in a cell by myself. I didn't know too much about it, I just knew I was going to die. I didn't want to tell anyone, didn't want to tell my family. I told my daughter who was 16. I wanted someone to know what happened if I died. (African-American Women)
- People are still not very educated about the epidemic. Some people think that I am contagious if I breathe near them, shake their hands or even use the same restroom. (Delayed Care)

Disclosure was also a reason cited for not accessing HIV medical care after diagnosis. Consumer survey respondents who waited a year or more to begin HIV medical care were asked their reasons. Nearly 40% identified disclosure concerns, including 54% of out-of-care consumers.

Substance Use

Substance use and injecting drug use are significant barriers to care. This is particularly true of current substance and injecting drug users. A total of 212 consumer survey respondents, 59% of the survey sample, report either a history of or current injecting drug use or other substance use.

- Current substance users and IDUs tend to be out-of-care, with 91% of current IDUs and 53% of current substance users not receiving HIV medical care.

- On the consumer survey, 28% of PLWHA identified substance use and/or relapse as reasons for not accessing HIV medical care for a year or more after diagnosis. This includes 37% of out-of-care respondents.

- Drug use was identified as the "top of mind" reason for being out-of-care by 14% of survey participants. In addition, more than 25% identified it when presented with a list of possible reasons for being out-of-care.

Financial Concerns

- Among in-care consumers, "no way to pay for it (HIV medical care)" was the most identified barrier to care, cited by 17% of survey respondents. In addition, 38% of out-of-care cited this barrier.

- Consumers who did not receive HIV medical care for a year or more after diagnosis were asked their reasons. Financial reasons were a concern for nearly a quarter of respondents, including 29% of out-of-care.
- Although not frequently mentioned as a "top of mind" reason for being outside the HIV medical care system, financial reasons were cited by 25% of out-of-care consumers when presented with a list of possible barriers to care.

Informational Barriers

When reviewing needs for all Ryan White funded services and accompanying barriers to care for needed services, informational barriers to care were the most frequently identified for 14 (47%) services. The consumer survey defined informational barriers as "you didn't have the information you needed about the service—that it existed, where to get it, how to qualify, etc." In addition, 21% of consumers who did not receive HIV medical care for a year or more after reported "not knowing where to go for medical care." This included 38% of those currently in-care.

In addition to the aforementioned client-related barriers, the following issues were also noted:

- Number and rate (per 100,000) of selected infectious diseases – The Austin TGA's 2010 rate of chlamydia (496.0 per 100,000) is the second highest among Texas EMAs/TGAs (source: Texas DSHS, 2011).
- The estimated number of homeless in the TGA is 8,518. Housing in the Austin TGA is expensive. The average homeless client costs 14.7% more than clients who were not homeless (source: City of Austin ARIES, 2011).

- Texas has the highest uninsured rate in the nation (source: Income, Poverty, and Health Insurance Coverage in the United States: 2009, US Census Bureau). Nearly 1 in 4 persons ages 19 to 64 do not have health insurance in the TGA. Among PLWHA, estimates place the percent of uninsured between 24.7% (source: 2010 Austin TGA Comprehensive Needs Assessment) and 54.8% (source: Travis County SHAS). The percent of PLWHA without documented public or private medical insurance seen by the Ryan White-funded HIV primary medical care provider was 65.9% in 2010 (source: City of Austin ARIES, 2011).

H. Evaluation of 2009 Comprehensive Plan

Successes

- 100% of funded providers participated in approved cultural competency training within six months of contract execution. (Goal 1; Objective 1:1)

- 100% of providers participated in annual client satisfaction survey process. (Goal 1; Objective 1.2b)

- 90% of client satisfaction surveys reflect average satisfaction or above. (Goal 1; Objective 1.2c)

- At least one evidence-based strategy was implemented by service category to address issues identified in the most current State-administered Unmet Need Framework. (Goal 1; Objective 1.3)

- Annual update of service delivery goals and objectives (Goal 2; Objective 2.6)

- Annual assessment of service demand based on funded and unfunded core/support services. (Goal 2; Objective 9)

Challenges

- Distribution of client satisfaction surveys yielded less than 80% of service category's total client number (Goal 1; Objective 1.2a)

- Clients with no activity in ARIES in a 90-day timeframe contacted within two weeks, followed by a quarterly report being submitted to Planning Council (Goal 1; Objective 1.4)

- Organization of one bi-monthly conference call among funded providers, administrative agent, and other stakeholders (Goal 1; Objective 1.5).
- Establishment of an informational hotline and online FAQ forum to respond to service-related inquiries (Goal 1; Objective 1.6).

SECTION 2.

WHERE DO WE NEED TO GO?

Summary:

The Austin TGA Ryan White Program is committed to improving the quality of life for PLWHA through the most effective and efficient methods possible. One step in fulfilling this commitment is to provide adequate treatment, care, and support services to PLWHA in accordance with identifiable needs and priorities, particularly those services that have a track record in getting individuals into medical care and retaining them there.

The Austin HIV/AIDS service delivery system has a rich, stable, and experienced provider base who works together in a coordinated fashion to serve PLWHA in the five-county area. However, as the goals contained in the Comprehensive Plan are met, the capacity to serve a greater number of PLWHA will increase, thus warranting an expansion of the provider base as well as services offered.

As the 2012 Comprehensive Plan is implemented, the HIV Planning Council will work collaboratively with the Administrative Agent to explore areas of service resources in the community, outside of the traditional and direct network.

A. Plan to meet challenges identified in the evaluation of 2009 Comprehensive Plan

The Planning Council has already embarked on initiative and community activities that will help address and meet the challenges found in the 2009 Comprehensive Plan. These include the following:

- Strategic Community Forum – In 2011, the Planning Council worked collaboratively with the Administration Agent and several stakeholders to conduct a series of community forums relating to HIV/AIDS services in the Austin TGA. The findings from these forums are currently being analyzed to formulate policies that will enable the Planning Council to meet and exceed goals outlined in the Comprehensive Plan.

- "State of the Epidemic" Symposium – In early 2011, the Planning Council hosted its first annual symposium on HIV. The purpose of the event was to bring together a vast number of stakeholders to share new information with (e.g., National HIV/AIDS Strategy), as well as to garner information about various issues in the service care community. More of these type of information-sharing/interactive forums will be scheduled in the upcoming months.

- Communication continues to be barrier among the Planning Council, Administrative Agent, and Provider-base. In order to strengthen communication among these entities, a more deliberate effort will be made to schedule collaborative planning meetings.

B. 2012 Proposed Care Goals

In sync with the National HIV/AIDS Strategy, the proposed care goals for 2012 are:

- Reducing the number of people who become infected with HIV.
- Increasing access to care and optimizing health outcomes for people living with HIV.
- Reducing HIV-related health disparities.

C. Goals regarding individuals Aware of their HIV status, but are not in care (Unmet Need)

- Decreasing 2010 number of PLWHA with unmet need (1,095) by 5% in Grant Year 2013.
- Decreasing number of male PLWHA with unmet need by 4.7% from 2012-2014 to continue trend from timeframe 2007-2010 (decrease was 987 to 941).
- Continue trend of decreasing disparity of unmet need by race/ethnicity over the next three years. For 2008-2010 White (24.9%), African Americans (26.7%) and Hispanics (24.4%) PLWHA had unmet need.

D. Goals regarding individuals Unaware of their HIV status (EIIHA)

- Increase the number of individuals aware of their HIV status.
- Reduce HIV related health disparities.
- Increase the number of HIV positive individuals who are in care.
- Increase access to care and improve health outcomes for PLWHA.
- Reduce new HIV infections.

E. Proposed solutions for closing gaps in care

- Coordination of ADAP Resources.
- Coordination with Ryan White Part C programs.
- Coordination with prevention and disease control/intervention programs.

F. Proposed solutions for addressing overlaps in care

- Strengthening coordination efforts with Part B planners/providers.
- Regularly convening the EIIHA Planning Collaborative.
- Conducting an extensive resource and service inventory.
- Developing a forum whereby pertinent data can be shared among stakeholders.

G. Provide a description detailing the proposed coordinating efforts with the following programs to ensure optimal access to care

- Part B Services, including the AIDS Drug Assistance Program (ADAP) – The Part B Grantee, the Texas Department of State Health Services (DSHS), and Part A Grantees

will continue to meet on a quarterly basis to collaborate in addressing common service delivery issues. DSHS's EIIHA plan will be coordinated with the Part A plan as well.

- Part C Services – Planning information yielded from the HIV Planning Council, and the decision-making process of the Planning Council will continue to be pivotal in informing and defining the administration of Ryan White Part C services.
- Part D Services – The Austin TGA does not receive Part D funding.
- Part F Services – The Austin TGA does not receive Part F funding.
- Private Providers (Non-Ryan White Funded) – Strategies to engage non-Ryan White funded providers include extending invitations to community forums and other events, as well as increasing communication through the quarterly Planning Council newsletter, Beyond the Plan. These providers include the Veterans Administration, local housing authority, and private physicians.
- Prevention Programs including, Partner Notification Initiatives and Prevention with Positive Initiatives – The local Communicable Disease Unit (CDU) is a funded provider involved in partner notification initiatives and prevention with positive initiatives. Increasing the number of FTEs to meet the capacity of partner notification, as well as increasing the number of group therapies focused on prevention with positives can be supported through the Planning Council planning and resource allocations process.
- Substance Abuse Treatment Programs/Facilities – According to the 2010 HIV Needs Assessment, service gaps identified were: psycho-social (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. Building capacity in each of these areas, particularly mental health and substance abuse treatment, will be at the forefront of HIV planning and further supported by resource allocations decisions.
- STD Programs – Collaboration with the Austin Travis County Health and Human Services Department Communicable Disease Unit (CDU) to enhance the Test Austin initiative. The initiative's goal is to test as many individuals as possible in a focused period of time. For the pilot event (one day), 152 individuals tested for HIV and STIs. Another period of time yielded 91 additional people tested.
- Medicare – Medicare continues to be a contentious issue in the state of Texas, particularly as it relates to the eligibility of PLWHA. The Planning Council's staff is carefully watching and routinely reporting on the state of Medicare in the Texas legislature. Strategies will be implemented to ensure eligible PLWHA are accessing services and using their Medicare benefits, with Ryan White funding being a payor of last resort.
- Medicaid – As aforementioned in the Medicare discussion, the Planning Council will continue to work with the Administrative Agent as they work with Providers to ensure eligibility for Medicaid services.
- Children's Health Insurance Program – The number of children eligible for this program and represented in the current HIV system of care is numerically insignificant to address.

SECTION 3.

HOW WILL WE GET THERE?

Summary:

The 2012 Comprehensive Plan was developed in the spirit of the National HIV/AIDS Strategy (NHAS). Therefore, the goals supported by this current plan are parallel to those listed in the NHAS. Below are the three overarching goals, along with the Planning Council's "Business Areas" that will facilitate meeting each goal.

Goals

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.

5.) Reduce new HIV infections.

Business Area

1.) Resource Allocation

2.) Quality Care (CLAS – Cultural and Linguistic Appropriate Standards)/Care Strategy

3.) Comprehensive Planning and Monitoring/Evaluation

4.) Community Stakeholder Collaboration

5.) Needs Assessment/Data Analysis

A. - D. (The strategy, plan, activities (including responsible parties), and timeline for the following objectives is included in the tables below:

- To close gaps in care.
- To address the needs of individuals aware of their HIV status, but are not in care.
- To address the needs of special populations, including but not limited to adolescents, injection drug users, homeless, and transgender.

1. Resource Allocation

Objective: The Planning Council will allocate Ryan White and other sources of funding in the most effective ways possible.

Responsibility: Planning Council

Number	Strategy/Plan/Activities		Start Date	Completion Date	Reporting Interval
1.1	The Planning Council will research and implement the best allocation strategy possible to ensure the success of its stated mission within the Target Grant Area.		January 2012	December 2014	Annually
1.2	The Planning Council will work to research, investigate, and apply for all sources of funding to allocate to the needs of high risk, out-of-care, and PLWHA in the Target Grant Area.		January 2012	December 2014	Annually
1.3	The Planning Council will consider its existing priorities, service gaps, and HRSA mandates when making decisions in its resource allocation process.		January 2012	December 2014	Annually
1.4	The Planning Council will make monthly reviews of expenditures and utilization of HIV/AIDS funding and investigate deviations from projections.		January 2012	December 2014	Annually
1.5	The Planning Council will provide guidance to the Administrative Agent concerning the allocation of funds, including carryover requests among service categories.		January 2012	December 2014	Annually
1.6	The Planning Council will provide guidance and directives to the Administrative Agent to be used for developing requests for proposals/applications for the purchase of services.		January 2012	December 2014	Annually

2. Quality Care/CLAS/Care Strategies

Objective: The Administrative Agent will ensure that each funded provider adheres to CLAS standards regarding cultural competency training.

Responsibility: Administrative Agent

Number	Strategy/Plan/Activities		Start Date	Completion Date	Reporting Interval
2.1	The Administrative Agent will require each funded service provider's staff to annually participate in cultural competency training.		January 2012	December 2014	Annually
2.2	The Administrative Agent will conduct annual monitoring to determine if each funded provider is in compliance.		January 2012	December 2014	Annually
2.3	The Administrative Agent will provide feedback to the Planning Council on the results of annual monitoring.		January 2012	December 2014	Annually

Objective: The Administrative Agent will ensure that each funded provider adheres to CLAS standards regarding the cultural composition of their staff.

Responsibility: Administrative Agent

Number	Strategy/Plan/Activity		Start Date	Completion Date	Reporting Interval
2.4	The Administrative Agent will require the staff of each funded service provider's to reflect the cultural composition of the community being served.		January 2012	December 2014	Annually
2.5	The Administrative Agent conduct annual monitoring to determine if each funded provider is in compliance.		January 2012	December 2014	Annually
2.6	The Administrative Agent will provide feedback to the Planning Council on the results of annual monitoring.		January 2012	December 2014	Annually

3. Comprehensive Planning/Monitoring/Evaluations

Objective: The Planning Council will conduct a comprehensive planning process for the three-year planning cycle.

Responsibility: Planning Council

Number	Strategy/Plan/Activities		Start Date	Completion Date	Reporting Interval
3.1	The Planning Council will develop a Comprehensive Plan for the 2012-2014 planning cycle.		January 2012	December 2014	Annually
3.2	The Planning Council will develop the Comprehensive Plan according to HRSA guidelines.		January 2012	December 2014	Annually
3.3	The Planning Council will incorporate into the 2012-2014 Comprehensive Plan the three primary goals outlined in the National HIV/AIDS Strategy for the United States dated July 2010.		January 2012	December 2014	Annually
3.4	The Planning Council will ensure the activities and objectives of each committee support the Comprehensive Plan goals and objectives.		January 2012	December 2014	Annually
3.5	The Planning Council will ensure participation of stakeholders for updates to the plan.		January 2012	December 2014	Annually
3.6	The Planning Council will conduct an annual review and update to the Comprehensive Plan.		January 2012	December 2014	Annually
3.7	The Planning Council will conduct Planning Council business according to the Goals and Objectives contained in the 2012-2014 Comprehensive Plan.		January 2012	December 2014	Annually

Objective: The Planning Council will adopt the HRSA plan for the Early Identification of Individuals with HIV/AIDS (EIIHA).

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
3.8	The Planning Council will receive guidance from HRSA concerning the EIIHA plan.		January 2012	December 2014	Annually
3.9	The Planning Council will follow all HRSA guidelines relating to the EIIHA plan.		January 2012	December 2014	Annually
3.10	The Planning Council will provide guidance to the Administrative Agent regarding the adoption of the EIIHA components.		January 2012	December 2014	Annually
3.11	The Planning Council will provide guidance to the Administrative Agent regarding the adoption of community-level approaches to reduce HIV infection in high risk communities in accordance with the National HIV/ AIDS Strategy for the United States (Dated July 2010). (National Strategy – Goal 3, Step 2)		January 2012	December 2014	Annually
3.12	The Planning Council will take steps to develop a coordinated effort which identifies, informs, refers, and links high risk, unaware, and HIV-positive individuals to the appropriate testing, treatment, and care services.		January 2012	December 2014	Annually
3.13	The Planning Council will consider input from organizations and individuals serving in minority and underserved communities on the best methods to reach underserved persons in the Target Grant Area.		January 2012	December 2014	Annually
3.14	The Planning Council will take steps to "normalize" HIV testing by encouraging all HIV/AIDS community stakeholders to adopt "Opt Out" HIV testing within the Target Grant Area.		January 2012	December 2014	Annually
3.15	The Planning Council will make recommendations to the Administrative Agent regarding all five components of HRSA's EIIHA strategy: Testing, Counseling, Information/Education, Referral Services, and Feedback.		January 2012	December 2014	Annually
3.16	The Planning Council will identify HRSA-defined "Key Points of Entry" and determine if linkages to HIV services exist within the Target Grant Area.		January 2012	December 2014	Annually
3.17	The Planning Council will research methods to increase the number of local points of entry that could serve as settings in which infected or out-of-care individuals can be identified and brought into care.		January 2012	December 2014	Annually
3.18	The Planning Council will take steps to ensure adequate coordination between Ryan White Part A and Part B efforts and service providers.		January 2012	December 2014	Annually
3.19	The Planning Council will seek to achieve 90% disclosure and linkage to care among PLWHA and individuals identified as out-of-care.		January 2012	December 2014	Annually

Objective: The Administrative Agent will successfully implement the HRSA plan for the Early Identification of Individuals with HIV/AIDS (EIIHA).

Responsibility: Administrative Agent

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
3.20	The Administrative Agent will adhere to EIIHA-related guidance provided by the Planning Council. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.21	The Administrative Agent will implement a process to identify individuals who need to be linked to services according to the EIIHA plan. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.22	The Administrative Agent will implement a process to provide counseling to individuals according to the EIIHA plan. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.23	The Administrative Agent will implement a process to provide testing to individuals according to the EIIHA plan. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.24	The Administrative Agent will implement a process to provide appropriate information & education to individuals according to the EIIHA plan. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.25	The Administrative Agent will implement a process to provide referrals to individuals according to the EIIHA plan. (National Strategy – Goal 1, Steps 1 & 2)		January 2012	December 2014	Annually
3.26	The Administrative Agent will implement a process to link to care newly diagnosed HIV-positive individuals. (National Strategy – Goal 1, Steps 1 & 2, Goal 2, Step 1)		January 2012	December 2014	Annually
3.27	The Administrative Agent will implement a process of feedback between the agencies which provide testing / counseling and those providing medical care / support services to ensure individuals were able to obtain needed care.		January 2012	December 2014	Annually

4. Community Stakeholder Collaboration

Objective: The Planning Council will take steps to effectively engage community stakeholders throughout the Target Grant Area.

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
4.1	The Planning Council will take steps to increase its engagement with African American stakeholders in the community.		January 2012	December 2014	Annually
4.2	The Planning Council will take steps to increase its engagement with Hispanic/Latino American stakeholders in the community.		January 2012	December 2014	Annually
4.3	The Planning Council will take steps to increase its engagement with women stakeholders in the community.		January 2012	December 2014	Annually
4.4	The Planning Council will take steps to increase its engagement with		January 2012	December 2014	Annually

	MSM stakeholders in the community.				
4.5	The Planning Council will take steps to increase its engagement with Faith-based stakeholders in the community.		January 2012	December 2014	Annually
4.6	The Planning Council will take steps to increase its engagement with non-contracted AIDS Service Organizations stakeholders in the community.		January 2012	December 2014	Annually
4.7	The Planning Council will take steps to increase its engagement with medical /dental stakeholders in the community.		January 2012	December 2014	Annually
4.8	The Planning Council will take steps to increase its engagement with corporate pharmaceutical stakeholders in the community.		January 2012	December 2014	Annually
4.9	The Planning Council will take steps to increase its engagement with university-based research stakeholders in the community.		January 2012	December 2014	Annually
4.10	The Planning Council will take steps to increase its engagement with criminal justice stakeholders in the community.		January 2012	December 2014	Annually
4.11	The Planning Council will develop a social marketing campaign with input from local HIV/AIDS stakeholders to increase the community's awareness and knowledge about HIV, AIDS, treatment services and other related information.		January 2012	December 2014	Annually
4.12	The Planning Council will make 100% of HIV Planning Council decision-making processes, including reports, meeting minutes, and agendas accessible to the public via the HIV Planning Council website.		January 2012	December 2014	Annually

5. Continuum of Care or Care Strategy

Objective: The Planning Council will take steps to improve the effectiveness of the Care Strategy.

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
5.1	The Planning Council will ensure the availability of all funded core and support services in the Target Grant Area.		January 2012	December 2014	Annually
5.2	The Planning Council will conduct an annual review and update of the continuum of care.		January 2012	December 2014	Annually
5.3	The Planning Council will conduct a biennial review and update of the standards of care.		January 2012	December 2014	Annually
5.4	The Planning Council will develop plans for the delivery of services, including plans for addressing the Minority AIDS Initiative, Early Intervention Services, Outreach and the Early Identification of Individuals with HIV/AIDS.		January 2012	December 2014	Annually
5.5	The Planning Council will take steps to identify all unmet needs of PLWHA in the Target Grant Area.		January 2012	December 2014	Annually
5.6	The Planning Council will take steps to link out-of-care PLWHA to primary medical care services in the Target Grant Area.		January 2012	December 2014	Annually
5.7	The Planning Council will take steps to sustain engagement of PLWHA in primary medical care in the Target Grant Area.		January 2012	December 2014	Annually
5.8	The Planning Council will take steps to provide necessary support for end-of-life services such as hospice care for PLWHA		January 2012	December 2014	Annually

	in the Target Grant Area.				
5.9	The Planning Council will take steps to identify gaps in service within the Target Grant Area.		January 2012	December 2014	Annually
5.10	The Planning Council will take steps to identify unfunded providers within the Target Grant Area which currently provide services that could fill identified gaps in the TGA's care strategy.		January 2012	December 2014	Annually
5.11	The Planning Council will make recommendations to the Administrative Agent regarding gaps in service within the Target Grant Area.		January 2012	December 2014	Annually
5.12	The Planning Council will take steps to address homelessness as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
5.13	The Planning Council will take steps to address homelessness as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
5.14	The Planning Council will take steps to address substance abuse as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
5.15	The Planning Council will take steps to address mental illness as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
5.16	The Planning Council will take steps to address stigma and fear of exposure as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
5.17	The Planning Council will take steps to increase the number of people with comorbidities in care.		January 2012	December 2014	Annually
5.18	The Planning Council will take steps to ensure increased access to the HIV continuum of care for PLWHA in minority and underserved communities through its Minority AIDS Initiative (MAI) programs.		January 2012	December 2014	Annually
5.19	The Planning Council will take make recommendations to the Administrative Agent to eliminate unnecessary duplication of services within the Target Grant Area.		January 2012	December 2014	Annually

6. Quality Care or Care Strategy

Objective: The Administrative Agent will take steps to implement an improved Care Strategy.

Responsibility: Administrative Agent

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
6.1	The Administrative Agent will take steps to identify gaps in service within the Target Grant Area.		January 2012	December 2014	Annually
6.2	The Administrative Agent will take steps to identify unfunded providers within the Target Grant Area which currently provide those services that could fill identified gaps.		January 2012	December 2014	Annually
6.3	The Administrative Agent will take steps to link funded and unfunded providers within the Target Grant Area.		January 2012	December 2014	Annually
6.4	The Administrative Agent will take steps to address homelessness as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
6.5	The Administrative Agent will take steps to address		January	December	Annually

	homelessness as a key barrier to maintaining treatment and drug therapy in its care strategy.		2012	2014	
6.6	The Administrative Agent will take steps to address substance abuse as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
6.7	The Administrative Agent will take steps to address mental illness as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
6.8	The Administrative Agent will take steps to address stigma and fear of exposure as a key barrier to maintaining treatment and drug therapy in its care strategy.		January 2012	December 2014	Annually
6.9	The Administrative Agent will take steps to eliminate unnecessary duplication of services within the Target Grant Area.		January 2012	December 2014	Annually
6.10	The Administrative Agent will establish an informational hotline and online FAQ forum to respond to service-related inquiries and complaints.		January 2012	December 2014	Annually

Quality Care or Care Strategy

Objective: The Planning Council will take steps to document and measure the capacity and effectiveness of the continuum of care services.

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
6.11	The Planning Council will develop criteria for conducting an annual cost benefit analysis of the continuum of care by service category.		January 2012	December 2014	Annually
6.12	The Planning Council will conduct an annual cost benefit analysis of the continuum of care by service category.		January 2012	December 2014	Annually
6.13	The Planning Council will take steps to expand the information on the Planning Council website to include summary information on the cost/benefit analysis of services provided within the Target Grant Area.		January 2012	December 2014	Annually
6.14	The Planning Council will take steps to expand the information on the Planning Council website to include data on the Target Grant Area's Continuum of Care / Care Strategy and availability of services.		January 2012	December 2014	Annually

Quality Care or Care Strategy

Objective: The Administrative Agent will take steps to improve the medical and non-medical case management systems of care.

Responsibility: Planning Council / Administrative Agent

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
6.15	The Administrative Agent will work with the existing service providers to develop standard intake, assessment, service planning, and referral tracking forms.		January 2012	December 2014	Annually
6.16	The Administrative Agent will mandate and implement the use of standardized forms among all funded service providers in the Target Grant Area.		January 2012	December 2014	Annually
6.17	The Administrative Agent will recommend the use of standardized forms among all unfunded service providers in the Target Grant Area.		January 2012	December 2014	Annually
6.18	The Planning Council and Administrative Agent will develop and improve standards of care for medical case management.		January 2012	December 2014	Annually
6.19	The Planning Council and Administrative Agent will develop and improve standards of care for non-medical case management.		January 2012	December 2014	Annually
6.20	The Planning Council and Administrative Agent will monitor changes in the medical case management system to determine if improvements have positively or negatively impacted client entrance to care and maintenance in care.		January 2012	December 2014	Annually
6.21	The Planning Council and Administrative Agent will monitor changes in the non-medical case management system to determine if improvements have positively or negatively impacted client entrance to care and maintenance in care.		January 2012	December 2014	Annually
6.22	The Planning Council and Administrative Agent will monitor case management service delivery to determine if improvements have enhanced tracking and referral efforts to non-funded service providers.		January 2012	December 2014	Annually

7. Needs Assessment/Data Analysis

Objective: The Planning Council will take steps to make an accurate determination of the medical and support needs of PLWHA in the Target Grant Area.

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
7.1	The Planning Council will conduct a comprehensive Needs Analysis of the medical and support needs of PLWHA according to their demographic profiles.		January 2012	December 2014	Annually
7.2	The Planning Council will ensure all demographic sectors are adequately represented in the gathering of Needs Analysis information.		January 2012	December 2014	Annually
7.3	The Planning Council will consider recent Needs Analysis		January	December	Annually

	information when making resource allocation decisions.		2012	2014	
7.4	The Planning Council will review the needs assessment and other data sources to identify service gaps, barriers and disparities in access.		January 2012	December 2014	Annually
7.5	The Planning Council will assist in designing needs assessment tools, surveys and methods as necessary.		January 2012	December 2014	Annually
7.6	The Planning Council will compare utilization to demographics to determine service access disparities.		January 2012	December 2014	Annually
7.7	The Planning Council will update the unmet need framework to estimate the number of PLWHA that are not in service.		January 2012	December 2014	Annually
7.8	The Planning Council will update the formula to determine the number of people who are positive and unaware of their status as part of the Early Identification of Individuals with HIV/AIDS initiative.		January 2012	December 2014	Annually

8. Comprehensive Planning/Monitoring/Evaluation; Quality Care/Care Strategy

Objective 4: The Planning Council will take steps to implement an effective Evaluation and Quality Management Program.

Responsibility: Planning Council

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
8.1	The Planning Council will take steps to ensure program monitoring by implementing a system to assess whether allowable services are provided to eligible clients according to service limits.		January 2012	December 2014	Annually
8.2	The Planning Council will develop evaluation instruments and methods for the efficiency of the administrative mechanism and services including the Minority AIDS Initiative, Early Intervention Services, Outreach and the Early Identification of Individuals with HIV/AIDS.		January 2012	December 2014	Annually
8.3	The Planning Council will use their evaluation instruments and methods to evaluate the efficiency of the administrative mechanism.		January 2012	December 2014	Annually
8.4	The Planning Council will use their evaluation instruments and methods to evaluate the efficiency of services in terms of cost and outcomes.		January 2012	December 2014	Annually
8.5	The Planning Council will implement grantee and service provider responsibilities according to the National Monitoring Standards.		January 2012	December 2014	Annually
8.6	The Planning Council will ensure that all alternative approaches to grantee and service provider responsibilities meet standards according to the National Monitoring Standards.		January 2012	December 2014	Annually

Comprehensive Planning/Monitoring/Evaluation

Objective 2: The Administrative Agent will take steps to implement an effective Evaluation and Quality Management Program.

Responsibility: Administrative Agent

Number	Strategies/Plan/Activities		Start Date	Completion Date	Reporting Interval
8.7	The Administrative Agent will take steps to ensure fiscal monitoring by implementing a system to assess the appropriate use of funds including the control, disbursement, use and reporting of allowable costs.		January 2012	December 2014	Annually
8.8	The Administrative Agent will take steps to ensure program monitoring by implementing a system to assess whether allowable services are provided to eligible clients according to service limits.		January 2012	December 2014	Annually
8.9	The Administrative Agent will take steps to ensure quality management by implementing a system to assess the degree to which a service meets or exceeds established professional standards and user expectations.		January 2012	December 2014	Annually
8.10	The Administrative Agent will implement grantee and service provider responsibilities according to the National Monitoring Standards.		January 2012	December 2014	Annually
8.11	The Administrative Agent will ensure that all alternative approaches to grantee and service provider responsibilities meet standards according to the National Monitoring Standards.		January 2012	December 2014	Annually
8.12	The Administrative Agent will integrate the National Monitoring Standards into contracting and monitoring efforts (monitoring tools, site visit schedules and scopes as needed).		January 2012	December 2014	Annually
8.13	The Administrative Agent will hold meetings with providers and sub-grantees to introduce the standards and clarify compliance issues.		January 2012	December 2014	Annually
8.14	The Administrative Agent will make the standards easily accessible to providers and sub-grantees.		January 2012	December 2014	Annually
8.15	The Administrative Agent will fully implement any needed changes in the sub-grantee monitoring such as policies, procedures, tools, management and reporting.		January 2012	December 2014	Annually

E. Description detailing activities to implement proposed coordinating efforts with the following programs to ensure optimal access to care:

- Part B Services, including the AIDS Drug Assistance Program (ADAP) – Coordinating of needs assessments and annual resource allocations processes. Additionally, routine planning meetings with Part A and B Planners to discuss service and client needs.
- Part C Services **–** Planning Council will assist in informing the Part C funding process through its own planning decisions. Part C services will be compared to Part A services and appropriate modifications will be made in the area of funding, guidance, or service administration.
- Part D Services – There are currently no Part D services in the Austin TGA.
- Part F Services – There are currently no Part F services in the Austin TGA.

- Providers – (non-Ryan White funded, including private providers) Plans are underway to invite non-funded, non-traditional providers to the HIV Planning table as EIIHA Collaborative members.

- Prevention Programs – Using social marketing, activities such as testing, community forums, and other opportunities will be shared and broadcast.

- Substance Abuse Treatment Programs/Facilities – Model programs may be highlighted in the HIV Planning Council quarterly newsletter. Inclusion of these providers in provider surveys and other research will be key to effectively enhance this relationship.

- STD Programs – Information sharing through surveillance reporting is an activity that will be focused on. Regularly scheduled "roundtable" meetings with STD providers to gauge the quality of services and identify any barriers to care.

- Medicare – Currently, the HIV Planning Council staff health planner is monitoring legislative activities pertaining to Medicare. Information is currently being shared on a regular basis to increase access to care among Medicare-eligible clients.

- Medicaid – As mentioned above, information gathering is paramount in this area in order to translate and effectively convey information to eligible clients.

- Children's Health Insurance Program – Due to the negligent number of youth in the current system eligible for CHIPS, this area has not been explored for ensuring optimal access to care.

- Community Health Centers – The Austin TGA currently contains several FQHCs, of which one is strictly dedicated to HIV/AIDS care. Activities to ensure optimal access to health include continuing and supporting the new case management model (non-medical), and the return to care collaborative, to reach PLWHA not in care.

F. How the plan addresses Healthy People 2020 objectives

The Planning Council has adopted as part of the current Comprehensive Plan, the same goals outlined in the National HIV/AIDS Strategy. These goals address the service needs, gaps, and barriers to care consistently identified in previous needs assessments, as well as in the most recent needs assessment update. In order to reach each goal, a comprehensive list of objectives is included in the Comprehensive Plan. Each objective has long and/or short-term activities, action steps, strategies, or initiatives designed to maintain and improved the TGA's system of HIV care. The Comprehensive Plan goals, as well as the objectives are responsive to the following Healthy People 2020 Objectives for HIV infection:

- HIV 1-3: (Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.

- HIV 4,6: Reduce the number of new AIDS cases among adolescent and adult MSMs.
- HIV 7: Reduce the number of new AIDS cases among adolescent and adult MSM and IDU.

G. How this plan reflects the Statewide Coordinated Statement of Need (SCSN)

Based on the following facts purported in current SCSN, the 2012 Comprehensive Plan has been developed to carefully reflect the needs of PLWHA out of care.

- Approximately one out of every three Texans living with HIV did not receive HIV related treatment in 2010.
- Estimated Percentage of people living with HIV has declined slightly from 38% in 2007 to 33% in 2010.
- Males are more likely to have unmet need.
- Black, Hispanic and other racial/ethnic minority males are more likely to have unmet need.

Based on the following facts included in the current SCSN, the 2012 Comprehensive Plan contains strategies that address unique challenges faced by those late diagnosed or undiagnosed.

- CDC estimates that as many as 21% of people infected are not aware of their infection.
- Roughly 1/3 of new HIV diagnoses in Texas are late diagnoses.
- Earlier diagnosis increases health outcomes, reduces cost associated with treatment and prevents new infections.

Other issues based on the SCSN were considered in the development of the Comprehensive Plan:

- Limited resources for support services.
- Mental health and substance abuse impact.
- Capacity to treat based on current provider base and need.

H. How this plan is coordinated with and adapts to changes that will occur with implementation of the Affordable Care Act

Anticipating Change

The ongoing changes of health care reform, in particular the Affordable Care Act (ACA), promise great opportunity for persons living with HIV/AIDS (PLWHA). However, the ACA also presents formidable challenges both to PLWHA and to the HIV system of care. It is critical that HIV advocates have a seat at the table as decisions are being made. Otherwise, the needs of PLWHA can easily be overlooked and the HIV system of care can become fragmented.

The Comprehensive Plan addresses the four distinct outcomes key to the Affordable Care Act (ACA):

- The Supreme Court finds the ACA constitutional in it's entirety and full ACA implantation occurs in January 2014;
- The "individual mandate" potion of the ACA is found unconstitutional but the remainder of ACA (including Medicaid expansion) is determined to be separable and allowed to continue;
- The individual mandate and Medicaid expansion are found unconstitutional, but other components of the law are implemented;
- The entire ACA is found unconstitutional by the Supreme Court.

I. Describe how the comprehensive plan address the goals of the NHAS

Since the Comprehensive Plan has been modeled after the National HIV/AIDS Strategy (NHAS) and incorporates the same goals, each key component of the plan supports the NHAS, particularly issues relating to need and care.

J. Discuss the strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts

The Planning Council has developed the FY 2012 Allocations Plan with the assumption of level funding, however in the case of unanticipated budgetary changes/cuts, a contingency plan has been developed. This plan takes into account increases as well as decreases in Part A and MAI awards, but its principles may be used to respond to other funding cuts as well. At the essence of a sound strategy is the preservation of specific core services. This ensures core services remain the primary focus of the system of care and that a viable service delivery system can exist.

SECTION 4.

HOW WILL WE MONITOR PROGRESS?

Summary:

Monitoring and evaluation of the new Comprehensive Plan will be the joint responsibility of the Austin Area HIV Planning Council and the Part A Grantee, the Travis County Health and Human Services Department. Joint Plan monitoring and evaluation is essential because the plan's action steps involve many different entities within the local HIV service delivery system, often working in conjunction with one another to enhance and improve the continuum of care.

The 2012 Comprehensive Plan is considered a tool for directing Ryan White activities in the Austin TGA. As such, it is a living document subject to review and revision, as appropriate. The monitoring and evaluation processes serve to keep the Plan alive and relevant to the changing environment. The Planning Council is entrusted with overall responsibility for monitoring the Plan, and specific parties are delegated responsibilities for implementation of objectives and action steps in accordance with their stated timeframe.

A. Describe the plan to monitor and evaluate progress

The Plan includes a rigorous timeline outlining start and completion dates for each action step, appropriate reporting intervals to track progress and status summaries. Some objectives and actions require frequent review while other long term objectives will be reviewed less often, but no less than annually.

Success of the Plan will be measured by the following outcomes:

- Ability to implement stated action steps within the projected timeframe;
- Achievement of the objectives;
- Documented system improvements that support the two goals.

Progress in achieving a high quality, comprehensive continuum will be measured by the following outcomes:

- Clients reporting an increased ability to navigate the service system;
- Clients reporting greater access to care and services;
- Increased number of clients who engage and remain in medical care;
- Positive client outcomes;
- Positive system outcomes through continuous quality improvement;
- Increased collaborative agreements;
- Coordination of EIIHA plans and activities with the Comprehensive Plan activies.

An evaluation of the Plan and its effectiveness as defined by the above-stated outcomes will be undertaken annually by the Planning Council and Grantee staff. Data will be collected to measure the outcomes. Analysis and results will be reported to the Planning Council for

consideration. This information will be used to determine the effectiveness of the Plan, the extent to which system change has been accomplished and future directions for policy decisions.

Improved use of Ryan White client level data

- The TGA uses a number of ways to collect client level outcome data and related information on program progress. This information is used to meet the goals and objectives outlined in the Comprehensive Plan, as well as the Clinical Quality Management Plan. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report on client level data.

Use of data in monitoring service utilization

- In a healthy literacy project, the ARIES client consent form allowed providers to share client data that was reviewed to assess a client's ability to understand the consent form and to make appropriate decisions. As a result, a brochure in both English and Spanish was created, enabling more clients to enter the care system.
- In cases where utilization is low or high in particular service categories, the Planning Council reviews status reports from the Administrative Agent each month. Decisions are made based on what service utilization displays.
- A Planning Council sub-committee (Needs Assessment) is responsible for the gathering and analysis of service utilization data used in the decision-making process.

Measurement of clinical outcomes

- Clinical outcomes are routinely measured and reported to the Planning Council in a report issued by the Administrative Agent. A sub-committee (Care Strategy) is assigned the task of reviewing standards of care while another sub-committee (Quality Management/Evaluations) is focused on the quality of care. Both committees work together on a monthly basis to monitor clients' clinical outcomes.

Conclusion

The 2012 Comprehensive Plan is considered a tool for directing Ryan White activities in the Austin TGA. As such, it is a living document subject to review and revision, as appropriate. The monitoring and evaluation processes serve to keep the Plan alive and relevant to the changing environment.

The HIV Planning Council is entrusted with overall responsibility for adopting the Plan, and specific parties are delegated responsibilities for implementation of objectives and action steps in accordance with the timeframe to be determined. A monitoring tool will be incorporated into the format of the Action Plan to facilitate ongoing review.

HIV PC staff will provide semi-annual progress reports on the status of the Plan. Action steps will be noted as completed, as was done with the former; however, an additional step to measure

the impact of the action step will be incorporated. For example, in some instances, rather than checking off when an item was completed, a triangulation of data and resources will be employed to measure the effectiveness of the item on the service delivery system. This report will be used to assess overall progress as well as to recommend modifications that may be needed.