

Central Texas
HIV/AIDS Planning Area

Comprehensive Services Plan
2007 – 2009



Christopher Hamilton, M.P.H.
Planner
Brazos Valley Council of Governments
HIV Administrative Services
Phone: 979.595.2830 or 866.841.7288
Fax: 979.595.2815
Email: chamilton@bvcog.org
Web: <http://hiv.bvcog.org>

Revision 1 – March 29, 2007

Thank You

Without the contributions of many people and groups, this plan would not be possible. Thank you to the Austin Area Comprehensive HIV Planning Council for its use of data and tools for the needs assessment, as well as its community input from the Planning Council. Also, thank you to the staff at the Brazos valley Council of Governments HIV Administrative Services, whose insights and analysis helped to shape the goals and objectives of the plan. Thanks are also extended to the subcontracted agencies of BVCOG and their directors and staff, who provided valuable information on care system characteristics, needs, and resources in their respective areas. Lastly, thank you to John Waara, Planner, at the Texas Department of State Health Services. His review and editorial guidance were invaluable.

TABLE OF CONTENTS

Executive Summary	1
Section 1: Where Are We Now?	6
Population Description	6
Summary of CTHPA Population and Health	6
Summary of PLWHA in the CTHPA	8
Current Population Served	14
Summary of PLWHA Population Out of Care	15
Most Recent Needs Assessment	17
Participant Profile	17
Findings	19
Service Category Rankings and Explanation	21
Unmet Need Estimates and Out-of-Care Respondents	22
Gaps in Care Services	24
Barriers to Care Services	29
Prevention Needs	32
Summary of Current Care Resources	34
Austin HSDA	35
Bryan – College Station HSDA	37
Concho Plateau HSDA	38
Temple – Killeen HSDA	39
Waco HSDA	41
The Current Care System	42
Service Category Rank Setting Methodology	42
Access Points and Process	44
Monitoring and Evaluation Procedures	50
Section 2: Where Do We Need To Go?	53
Section 3: How Will We Get There?	55
Section 4: How Will We Monitor Our Progress?	63
Appendix A: Counties in the Planning Area	65
Appendix B: Service Category Rankings	66
Appendix C: FY2007 Allocations for RW-B and SS	69

Executive Summary

Content and Focus of the Plan

As part of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (formerly Ryan White CARE Act), grantees must complete a comprehensive services plan. For the State of Texas under Part B (formerly Title II), each planning area must submit a comprehensive services plan to the Texas Department of State Health Services (DSHS). This plan was viewed not as a condition of participation, or requirement, but was written as a form of strategic plan for the Brazos Valley Council of Governments HIV Administrative Services (BVCOG). This plan details the system of care and support, problems present in the system, and strategies to address the problems for the 43 county Central Texas HIV/AIDS Planning Area (CTHPA). This plan covers a three year project period, April 1, 2007 to March 31, 2010.

In the planning area there are 1,899 living HIV cases and 2,912 living AIDS cases as of December 31, 2005. Of those that are infected, DSHS estimates 1,509 people are considered out of care. The largest number of infected individuals is in the city of Austin, which is part of a five county Transitional Grant Area (TGA), formerly Eligible Metropolitan Area (EMA).

The Central Texas HIV Planning Area is comprised of five health service delivery areas (HSDAs). The 10 county Austin HSDA also contains the Austin TGA, a Ryan White Part A grantee. Approximately 75% of all people living with HIV/AIDS in the CTHPA reside in the Austin TGA. The four other HSDAs are often referred to as the rural HSDAs, each with one or two hub cities. Austin, nevertheless, is a major metropolitan area.

Within the CTHPA, there are 1,899 living reported HIV infection cases (as of 12/31/2005) and 2,912 living reported AIDS cases (as of 12/31/2005). For both HIV and AIDS cases, males are predominately white (over 50%) and females are predominately African-American (over 50%). For males, the largest mode of exposure is male-to-male sex, for both HIV and AIDS. For females, the largest mode of exposure is heterosexual contact (over 50%) for both HIV and AIDS.

To determine the needs of people living with HIV/AIDS, a comprehensive needs assessment was conducted in the Austin TGA in 2005 and in the rest of the planning area in 2006. Overall, 548 people were surveyed. Of those surveyed, 27.4% said they needed health insurance and did not have the need met, 26.5% said they needed emergency financial assistance and the need was not met, and 25.5% said they needed oral health care and the need was not met. Many other services were noted as needed but the need not being met; this is explored more in depth in the assessment findings portion of this plan.

Gaps and barriers to care are also discussed in the assessment findings section. The need for housing assistance was met, but difficult, for 20% of those that used the service. Of those that used health insurance assistance, 15% reported the need being met, but it was difficult. At the other end of the spectrum, of those that used ambulatory outpatient medical care, 90% said the need was met easily, and almost 3% reported the need being difficult. Food bank had the most reported barriers, 118 people reported an access barrier. One hundred-three people reported an

access barrier to housing assistance, and 97 people reported an access barrier to oral health care. Access barriers were the most prevalent reported types of barriers, among information, service delivery, and personal / cultural barriers.

A brief summary of resources in the planning area are in the latter half of section one. The method of setting service category priorities and the allocations for 2007-2008 follow. The processes for accessing the care system, its components, and entry points are detailed in the last part of section one.

Continuous improvement is the principle that establishes section two. This section asks, “Where do we need to go?” Section one described the current state of the planning area, while section two projects a future state, a care system that is different in some form. Findings from the needs assessment indicate areas for improvement to move towards a better system of care. Our mission, vision, and values help shape the future state and are described in section two.

Mission:

The Brazos Valley Council of Governments HIV Administrative Services plans for the use of and administers funds to provide access to good quality medical and social services for anyone living with HIV/AIDS in the Central Texas HIV Planning Area.

Vision:

The Brazos Valley Council of Governments HIV Administrative Services will be the premier administrative agency that is forward looking and innovative, and constantly improving the system of care in our responsibility.

Values:

The values that guide our practices and decisions include data and science based decision making; use of evidence based best practices; a willingness to innovate; to not shy away from difficult changes or challenges; a desire to provide high quality services as defined by professional and clinical organizations such as the Institute for Healthcare Improvement; a belief in continuous quality improvement; planning for the future and agilely responding to change; ethics; compassion; and the voice of the client/patient.

Based upon the findings from the needs assessment, the resources available, our current care system, and the epidemiology, three broad goals were identified:

- ⇒ Increase access to services through expansion of services and reduction of barriers
- ⇒ Improve the quality of services provided
- ⇒ Improve the care system through better planning and administration

“How will we get there?” is the basis of section three, the goals and objectives of this plan. Findings from the needs assessment and other information in section one have shaped the goals and objectives; what we are going to do over the next three years that will move us toward the system of care envisioned in section two.

The goals in section three include offering medical case management throughout the CTHPA; conducting further studies related to several services; linking formerly incarcerated to medical care; increasing local area provider collaboration; supporting client self advocacy; clients engaging in routine, preventative oral health care; reducing the number of people out of care; implementing prevention with positives; improving medication adherence; supporting preventative vaccines; and increasing access to health insurance, housing assistance, emergency financial assistance, transportation, and food banks.

The last section describes, in brief, how we will monitor our progress toward the envisioned system of care. Through clinical and programmatic monitoring of contracted providers, we will assess progress towards some of the goals outlined in the plan. Client satisfaction surveys may also serve in monitoring progress of some goals; monthly monitoring of expenditures and utilization of services also assists in determining progress towards some goals. The detailed objectives included in the plan incorporate a process to monitor and evaluate progress. Overall, this plan asks where we are now, where we want to go, how we will get there, and how we will know we are getting there. Once the three year planning cycle is complete, the process begins again; the belief in continuous improvement.

Development of the Plan

The previous comprehensive services plan for the CTHPA was developed by the Central Texas HIV Planning Council in 2003. Since the rescission of the DSHS policy related to community planning and establishment of planning councils for Part B, community input and planning have taken a different form. A method for obtaining community input was developed by BVCOG and implemented in April 2006. Community members are to be involved in the development of planning activities, including setting service category priorities, allocations, and the comprehensive services plan.

Developing this comprehensive services plan utilized various methods of input, primarily town hall meetings with PLWHA and others interested in HIV/AIDS community planning. In October of 2006, the BVCOG Planner conducted town hall meetings in the Bryan – College Station, Concho Plateau, Temple – Killeen, and Waco health service delivery areas (HSDA). A fifth HSDA, Austin, is included in the planning area, but input from this HSDA is obtained through recommendations from the Austin Area Comprehensive HIV Planning Council, a Part A grantee.

Participants at the town hall meetings were presented major findings from the needs assessment, the methodology for setting service category priorities and allocations, and the proposed goals and objectives in this plan. Participants were then invited to discuss the proposals and offer suggestions for alternative methods of setting priorities and allocations, suggesting different contingency plans for increased or decreased allocations, and other goals and objectives. Each town hall meeting began a 30-day comment period, during which anyone could contact the BVCOG Planner by mail, email (including anonymous web form), phone (toll-free), or fax.

Clients that have indicated they are willing to receive mail from their service provider were mailed a letter two weeks prior to the town hall meeting, informing them of the meeting and what was to be discussed, and how it effects the services available. Case managers at BVCOG subcontracted agencies were asked to inform clients of the meetings as well.

Overall, seven clients and five advocates were present at the town hall meetings. Each offered input related to allocations, contingency plans, and the goals and objectives. Suggestions were evaluated according to the criteria set in the community input plan, "...BVCOG staff will evaluate the comments and suggestions, and to the extent logistically and fiscally possible, and to the extent to which the suggestion improves services, the delivery system, or more closely meets client needs..." Modifications were made to the proposed contingency plans and goals and objectives based upon input provided and are reflected in this plan.

Ryan White Reauthorization

During the development of this plan, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was reauthorized by Congress and signed by the President on December 19, 2006, now known as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA). The BVCOG Planner kept abreast of reauthorization issues and incorporated, to the extent possible, potential changes into the priority setting model, allocations, and the goals and objectives. At the time of this writing, many issues resulting from changes in the RWTMA are being resolved and guidance issued, however, not all issues are completely resolved.

Since the RWTMA was signed after a significant portion of this plan was written, a revision was made to reflect the new language and requirements. All references to Title I have been changed to Part A, Title II is now Part B, Title III is now Part C, and Title IV is now Part D. Additionally, the RWTMA set forth a new set of 12 core medical services that require 75% of funds be spent, applicable to Parts A, B, and C. Previously, there were six core services. Tables with service categories have been updated to reflect a category's status as a core medical service.

Limitations

The community planning process is not an exact science, and limitations surface, particularly in regards to data collection and the extent to which it may be generalized to the entire PLWHA population. The HIV/AIDS services planning process is a lower form of actuarial work, estimating the needs and the costs of providing services.

Limitations in data gathering for the needs assessment are discussed in section one in the summary of the most recent needs assessment. The vast majority of those that participated in the needs assessment were already in care. A few survey participants were considered out of care, and only one person that was out of care was outside of the Austin TGA. Because of a lack of

out-of-care participants in other areas, particularly, the findings for out-of-care populations are not entirely generalizable to all those in the planning area that are out-of-care.

A further limitation in the needs assessment process relates to the survey instrument. Some questions were not specific or did not have answers that allowed participants to accurately and completely describe their response. The most striking is the answer set for questions related to service barriers. Only four types of barriers were listed, and they did not allow for any level of specificity. For example, a person might indicate an access barrier, but the survey lists an access barrier as, “The services available were too far from your home or work. Services were not open at the hours you could get there. There was no child care. Waiting times for appointments or to see the person you needed were too long.” Each of the description examples are unique barriers to accessing the service. Since a respondent could not specify the nature of the barrier, only that it was an access barrier, problems are more difficult to identify, isolate, and ultimately to correct.

Another limitation of note pertains to the community input for this plan. Few clients / consumers participated in the development of the plan. Most of the goals and objectives are based on data from the needs assessment, and should therefore be more representative of clients than input from only seven consumers / clients present at the town hall meetings. However, information provided by the needs assessment and that provided during community input opportunities corroborated one another.

Implementation

Prior to implementation of this plan, a final 30-day comment period was opened from March 29, 2007 to April 29, 2007 to allow a last chance for input. Suggestions offered were evaluated according to the criteria in the community input plan and adjustments made accordingly. A public hearing in all five HSDAs of the CTHPA will be conducted to inform the communities served by this plan.

Section 1: Where Are We Now?

Population Description

POPULATION DESCRIPTION: Summary of the Central Texas HIV Planning Area Population and Health

The Central Texas HIV Planning Area (CTHPA) covers 43 counties of central Texas. The estimated 2002 population for the area is 2,574,350¹ people spread across 41,891 square miles. The region covers both urban and rural areas. Fourteen counties are considered urban, when using the rural – urban continuum code, and 13 counties are considered urban when using the urban influence code². Travis County, home of Austin, the State capital, is the largest county in the service area, with a population of 839,946 people, and is the densest, with 989 people per square mile¹. Sterling County, on the western edge of the planning area is the least populated, with 1,329 people, and the least dense, with 1.4 people per square mile¹.

Throughout the area, females comprise 49.72% of residents, males 50.28%. Concho County, however, demonstrates the variability in the area, where females are 34.9% of residents and males 65.1%.¹ Race and ethnicity also span a wide range. Llano County is 93% White, while Sutton County is 52.2% non-White Hispanic. Overall, the CTHPA is 10.65% African American, 24.32% non-White Hispanic, and 60.99% White. All counties of the planning area, with one exception, have an age distribution that follows the normal distribution (bell curve) with the median age range as 15-44. Llano County is the exception where the largest age bracket is 65 +, which is 31.5% of the population. Llano ranks first in Texas counties with the largest percentage of residents over the age of 65.

Brazos and Concho Counties have the lowest unemployment rates in the area, at 1.9%. The average for the area is 4.24%. Grimes County has the highest of the area, at 8.1%. Grimes County neighbors Brazos County. The state unemployment average is 6.3%. Average per capita income in the CTHPA is \$22,593. Travis County is at the top of the range, \$35,492, and Concho County is at the lowest, \$16,505. Concho County is also home to the highest poverty level of the CTHPA, 28.3% of residents are living below the poverty level. Twenty-one counties in the CTHPA have a poverty level greater than the state average, 15.3%. Williamson County, adjacent to Travis County, is the lowest of the planning area with 6.4% poverty.¹

Texas ranks first in the nation for the highest percentage of uninsured residents, and second with the largest number of uninsured. Approximately one in four Texans does not have health insurance of any type³. Approximately half of the counties in the CTHPA are designated as whole county Primary Care Health Provider Shortage Areas (HPSA), in addition, two additional counties are designated whole county HPSAs but are proposed for withdrawal⁴. Twenty-five

¹ DSHS 2002 Health Facts for Texas, by county.

² USDA Economic Research Service: <http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes/>

³ Kaiser Family Foundation, State Health Facts

⁴ DSHS 2006 Primary Care HPSA Whole County Designations
<http://www.dshs.state.tx.us/chs/hprc/PChpsaWC.shtm>

counties are whole county Mental Health HPSAs⁵. Thirty-five counties are designated as whole county Medically Underserved Areas⁶.

Other indicators of health status demonstrate the challenges posed in this area. Hamilton County has one of the highest average annual age adjusted death rates in the State, ranking number six of 249, with a rate of 1141.3 per 100,000⁷. Irion County, also in the planning area has one of the lowest, with a rate of 598.9; ranking 247 of 249⁷. Twenty-five counties have a rate higher than the state average. Hamilton County has the second highest average annual age adjusted heart disease death rate, 412.1⁷. Concho County, however, has the lowest rate, 157.8⁷. Robertson County ranks number 13 for the average annual age-adjusted cancer death rate and seventh for the average annual age-adjusted diabetes death rate⁷.

Texas has a disability prevalence of 16.8%, ranking 42 of 51 states and D.C.⁷. Obesity is highly prevalent in Texas, where 24% of the population is considered obese, tied for third place with three other states⁷. Texas ranks 20th in respect to the prevalence of poor mental health; where 34.3% of the population reported poor mental health between one and 30 days within the past 30 days⁷. Data of disability prevalence and mental health status specific to the CTHPA were not readily available at the time of this writing.

Texas ranks third in the number of syphilis cases, and sixth for the syphilis rate, 18.3%⁸. Bell County has the largest rate for Gonorrhea in the state, 381.7 per 100,000 population⁸. Falls County ranks first among Texas counties in the Chlamydia rate, 1085.4 per 100,000 population. McLennan and Travis Counties both recorded 37 cases of primary and secondary Syphilis in 2005, but the case rate for McLennan County is 16.7 per 100,000, whereas the Travis County case rate is 4.3 per 100,000⁸.

The average annual AIDS morbidity rate for the State of Texas is 16.2 per 100,000 people⁷. Travis County ranked first in the state for the average annual morbidity rate at 30.6 per 100,000, nearly twice that of the state average⁷. Thirty-six of the 254 counties in Texas are ranked for morbidity; six of which are in the CTHPA⁷. Five counties rank higher than the state average, Travis (Austin), Harris (Houston), Dallas (Dallas), Potter (Amarillo), and Gregg (Longview)⁷.

⁵ DSHS 2006 Mental Health HPSA Whole County Designations
<http://www.dshs.state.tx.us/chs/hprc/MentalWC.shtm>

⁶ DSHS 2006 MUA and MUP Designations <http://www.dshs.state.tx.us/chs/hprc/MUAList.shtm>

⁷ DSHS Selected Demographic and Public Health Measures: Rankings for Texas Counties 1998-2000
http://www.dshs.state.tx.us/chs/pubs/rank/rank1_00.pdf

⁸ DSHS Texas HIV/STD Surveillance Report 2005 Annual Report

POPULATION DESCRIPTION: Summary of PLWHA in the CTHPA

The following tables are provided by the Texas Department of State Health Services (DSHS) HIV/AIDS Reporting System (HARS) as of December 31, 2005.

Note from DSHS:

Adjustment for reporting delay: An inherent delay occurs between the diagnosis by the health care provider and the reporting of the case to the registry for all disease surveillance systems. Consequently, when cases are examined by the date of diagnosis, proportionately fewer of more recently diagnosed cases will be in the case registry, making trend analysis difficult. To correct for this, the data have to be adjusted for reporting delay to compensate for the unreported cases. The method we used was based on software programs provided by CDC that calculate the case reporting delay and estimate the proportion of cases that are unreported by quarter-year. From these estimates, cases are weighted so that more recently reported cases are more accurately represented among all cases.

Redistribution of cases with no indicated risk (NIR): A problem similar to the delay in reporting of cases also occurs with the ascertainment of risk (mode of exposure) for cases. More recently reported cases are less likely to have been fully investigated for risk factors related to contracting HIV. These NIR cases were redistributed into risk groups according to the historical pattern of how cases initially reported as NIR were subsequently found to have a specific risk.

The adjustments result in partial cases; category totals may not match exactly due to rounding.

Living Reported HIV Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Current age (from 1/30/06 HARS data set)

Age in 2005	Male % within sex	Female % within sex
Under 2	1 0.07%	0 0.00%
2 to 12	7 0.46%	7 1.72%
13 to 24	94 6.16%	42 10.32%
25 to 34	392 25.67%	135 33.17%
35 to 44	622 40.73%	118 28.99%
45 to 54	314 20.56%	72 17.60%
55 & up	97 6.35%	33 8.11%
Total	1527	407

Males tend to cluster around the 35 to 44 age range. Females however, tend to cluster around the 25 – 34 age range. Characteristics of the younger female mode are not known, nor why the females tend to be older.

Living Reported HIV Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Race – Ethnicity (from 1/30/06 HARS data set)

Race / Ethnicity	Male % within sex	Female % within sex
White	823 53.90%	127 31.28%
Black	379 24.82%	219 53.94%
Hispanic	306 20.04%	57 14.04%
Other	19 1.24%	3 0.74%
Total	1527	406

It has been observed that in many areas of the country, the rate of infection for African American women is rising and that they are a disproportionately affected population. The above table indicates that the prevalence among African American women is twice as high as African American men, and over 20 percent greater than White non-Hispanic women, following national trends. White males continue to be those with the largest numbers of positives and largest percentage of all males.

Living Reported HIV Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Mode of Exposure (from 1/30/06 HARS data set)

Mode of Exposure	Male % within sex	Female % within sex
MSM	1110 72.69%	NA
IDU	131 8.58%	97 23.83%
MSM / IDU	147 9.63%	NA
Heterosexual	112 7.33%	290 71.25%
Perinatal	14 0.92%	10 2.46%
Other	13 0.85%	10 2.46%
Total	1527	407

Male-to-male sex accounts for the vast majority of HIV infection among males, as has been the trend since the start of epidemic. Among females however, heterosexual contact accounts for the largest number of infections. Of further note is the rate of infection among injection drug users (IDU). Female IDUs are infected at almost three times the rate as their male counterparts.

Living Reported AIDS Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Current age (from 1/30/06 HARS data set)

Age in 2005	Male % within sex	Female % within sex
Under 2	0 0.00%	0 0.00%
2 to 12	5 0.21%	4 0.72%
13 to 24	30 1.24%	13 2.33%
25 to 34	289 11.99%	108 19.39%
35 to 44	1024 42.49%	230 41.29%
45 to 54	789 32.74%	149 26.75%
55 & up	273 11.38%	53 9.52%
Total	2410	557

Among living AIDS cases, the majority of cases center around the 35 to 44 age group and follow a fairly normal distribution for men.

Living Reported AIDS Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Race – ethnicity (from 1/30/06 HARS data set)

Race / Ethnicity	Male % within sex	Female % within sex
White	1231 51.06%	163 29.26%
Black	586 24.31%	300 53.86%
Hispanic	575 23.85%	90 16.16%
Other	19 0.79%	4 0.72%
Total	2411	557

Similar to living cases of HIV, the majority of males are White and the majority of females are African American. Of note are the almost equal rates among Hispanic and African American men. Since African Americans comprise approximately 11 percent of the general population in the CTHPA and Hispanics nearly 24 percent, this represents a higher case rate among African American men and women.

Living Reported AIDS Infection Cases through 12/31/05
 Central Texas HIV Planning Area
 Mode of Exposure (from 1/30/06 HARS data set)

Mode of Exposure	Male % within sex	Female % within sex
MSM	1540 63.87%	NA
IDU	346 14.35%	198 35.61%
MSM / IDU	301 12.48%	NA
Heterosexual	199 8.25%	337 60.61%
Perinatal	7 0.29%	8 1.44%
Other	18 0.75%	13 2.34%
Total	2411	556

The mode of exposure for females with AIDS is similar to females with HIV in that Heterosexual Contact is the primary mode (61% female AIDS cases, 71% female HIV cases). The second highest mode of exposure for female AIDS cases is injection drug use at 36%. Female HIV cases have an IDU rate of 24%.

POPULATION DESCRIPTION: Current population served

During Ryan White year 2005 (April 1, 2005 – March 31, 2006), 3137 clients were served, approximately 65.2% of all PLWHA in the CTHPA. The median client age is 42. Fifty-six percent of clients are in the age group 25-44, while 36.73% are in the 45-64 age group. Males make up 75% of clients. Non-Hispanic Whites are 40% of clients, African Americans 33%, Hispanics (non-white) are 24%, and other (American Indian, Alaskan Native, Hawaiian native, or Pacific Islander, Multi-racial, and Other) are 2% of clients. The majority of clients in the Temple HSDA are living with AIDS (67.72%) while the majority in the Waco HSDA are living with HIV (90.5%). Across the planning area, 26% of clients have a CD4 below 250 (n=1217). The mean CD4 level for clients is 439. The mean viral load for clients is 34,455 (n=1188). Ninety percent of clients have a viral load below 100,000⁹.

During the year, clients received 112,678 units of case management, totaling 469.5 hours. Over 13,900 units of ambulatory outpatient medical care were provided and 6,985 prescriptions were filled. Clients had 4,352 dental visits, 1,384 mental health visits, and 940 substance abuse (outpatient) visits⁹.

⁹ Based on data from the AIDS Regional Information and Evaluation System for date range 4/1/05 to 3/31/06

POPULATION DESCRIPTION: Summary of PLWHA Population Out of Care

The Health Resources and Services Administration has defined people who are HIV positive, know their status, and have not received a CD4 test, viral load test, nor are on anti-retroviral medication as out of care. In the tables below prepared by DSHS, an additional qualifier was added, no evidence of an ambulatory outpatient visit.

Number and proportion of male and female living HIV cases in the Central Planning area with Unmet Need by mode of exposure and race/ethnicity, 2004

	Males with Unmet Need		Females with Unmet Need		
	#	%	#	%	Total
MSM					
White	445	34.3	-	-	445
African American	124	39.6	-	-	124
Hispanic, all races	136	28.3	-	-	136
<i>Total</i>	<i>710</i>	<i>33.7</i>	-	-	<i>710</i>
IDU					
White	51	41.1	24	27.9	75
African American	68	36.0	25	20.2	93
Hispanic, all races	24	35.3	5	19.2	29
<i>Total</i>	<i>146</i>	<i>37.8</i>	<i>54</i>	<i>22.9</i>	<i>200</i>
MSM / IDU					
White	64	30.6	-	-	64
African American	26	24.3	-	-	26
Hispanic, all races	20	27.4	-	-	20
<i>Total</i>	<i>111</i>	<i>28.4</i>	-	-	<i>111</i>
Heterosexual Contact					
White	19	46.3	38	35.2	57
African American	34	37.8	43	20.9	77
Hispanic, all races	15	34.9	14	17.9	29
<i>Total</i>	<i>69</i>	<i>39.2</i>	<i>95</i>	<i>24.1</i>	<i>164</i>
Not Classified					
White	85	55.6	32	48.5	117
African American	87	50.6	56	41.8	143
Hispanic, all races	48	52.7	10	33.3	58
<i>Total</i>	<i>224</i>	<i>53.1</i>	<i>100</i>	<i>42.9</i>	<i>324</i>

Overall, Whites tend to have the highest rates of being out-of-care, among both sexes, and all exposure routes, with the exception of the male-to-male sex, where African Americans have the highest percentage. The reason for higher rates among Whites is not known.

Out-of-Care 2003 v 2004 CTHPA

	2003		2004	
	#	%	#	%
Austin	1039	33.3	1092	32.0
Bryan – College Station	111	46.3	112	40.6
Concho Plateau	31	36.0	31	34.1
Temple – Killeen	156	54.2	166	51.1
Waco	129	41.7	134	40.7

In the planning area, Austin is the largest city, HSDA, and has the largest number of people out-of-care. While the percentage is the lowest of the five HSDAs, it does have a large number of people out-of-care. Austin is also a Transitional Grant Area (TGA) for Part A funds, one of five Part A recipients in the State. Of the five EMA/TGA/HSDAs, Austin has the lowest number and percentage of people out-of-care.

On an HSDA by HSDA basis, the Temple – Killeen HSDA has the highest percentage of people out-of-care across all 26 HSDAs in the State. It is not known why there is such a high rate of out-of-care residents in the Temple – Killeen HSDA.

2004 Out-of-Care Demographics Temple – Killeen HSDA

	#	%
White	67	40.36
African American	76	45.78
Hispanic	19	11.45
Asian – Pacific Islander	2	1.20
American Indian - Alaskan	1	0.60

2004 Out-of-Care Mode of Exposure Temple – Killeen HSDA

	#	%
Male-to-Male	51	30.72
IDU	14	8.43
M-M IDU	10	6.02
Heterosexual Contact	29	17.47
Not Classified	58	34.94

Over 70 percent of those out-of-care in the Temple-Killeen HSDA are male. Based on previous trends of living HIV and AIDS cases, males tend to be exposed through male-to-male sex, females tend to be exposed via ‘Heterosexual Contact,’ and to a lesser extent ‘Injection Drug Use’ or are ‘Not Classified.’ The higher rate of ‘Not Classified’ is not in line with other trends of overall living cases.

Most Recent Needs Assessment

In the spring of 2006, the Central Texas HIV Planning Council contracted with the Center for Community Health Development (CCHD) at the Texas A&M Health Science Center School of Rural Public Health to conduct a client level needs assessment in the Central Texas HIV Planning Area (CTHPA). The Austin Area Comprehensive HIV Planning Council (Part A) conducted a needs assessment of the Austin health service delivery area (HSDA) in 2005. To reduce expenses and not duplicate planning efforts, the CCHD used the same survey instrument as the Austin Planning Council. The Austin Planning Council and administrative agent provided the data from their survey of the HSDA so it could be included in the CTHPA assessment analysis. A total of 548 respondents were analyzed, 371 from the Austin HSDA that was collected and analyzed for the Austin Planning Council, and 177 from the other four HSDAs (Bryan – College Station, Concho Plateau, Temple – Killeen, Waco) that was conducted by the CCHD.

Participants were recruited from a query of clients who had received a service in the preceding 18 months and who were willing to receive mail as identified in the AIDS Regional Information and Evaluation System (ARIES). The initial mailing contained a letter from the client’s case management agency, a letter from the CCHD and a consent form. To participate, clients mailed the consent form in a self addressed stamped envelope to the CCHD and were either contacted by phone, called the CCHD themselves, or met in person to complete the survey. The overwhelming majority of surveys were completed by phone. Those who participated received a \$20 gift card to Wal-Mart.

MOST RECENT NEEDS ASSESSMENT: Participant Profile

The needs assessment that was conducted is limited in how generalizable the findings are because of limitations in the conduct of the study. Participants were not selected from a truly random sample; data was self reported; and there is a possibility of self selection bias because of the incentive involved. With any type of survey, the participants should represent the overall population as closely as possible. The following tables present some comparisons of survey participants to the overall population of people living with HIV/AIDS (PLWHA) in the CTHPA. Survey participant demographics are compared against demographic data of all PLWHA in the central Texas area reported in the HIV/AIDS Reporting System (HARS) as a measure of representation. The HARS data is provided by the Texas Department of State Health Services (DSHS) in preformatted cross tabulation tables and includes data as of December 31, 2004, the most recent data set at the time of the assessment report.

Gender Distribution

	Survey (n=548)	HARS Living HIV/AIDS
Male	66 %	80 %
Female	32 %	20 %
Transgender	2 %	N/A

Age Distribution

	Survey (n=548)	HARS Current Age HIV/AIDS
Age 13 - 24	2.4 %	3.6 %
Age 25 - 34	16.4 %	19.2 %
Age 35 - 44	41.2 %	42.8 %
Age 45 - 64	38.5 %	32.3 %
Age 65 +	0.7 %	1.5 %

Racial Distribution

	Survey (n=548)	HARS Living HIV/AIDS
White (non-Hispanic)	40 %	48 %
African American	37 %	31 %
Hispanic	18 %	20%
Other	5%	1 %

Method of Exposure for Survey Participants (n=548)

	Male	Female	Transgender
Sex with a man	207	142	*
Sex with a woman	103	*	*
Sharing needles	75	27	*
Trading sex for money/drugs	16	15	*
Blood products / transfusion	14	16	0
Don't know	18	*	*

* less than 10 participants reporting

Participation by HSDA

	Survey (n=548)	HARS Living HIV/AIDS
Austin	67 %	76.46 %
Bryan – College Station	8 %	6.48 %
Concho Plateau	3 %	2.10 %
Temple – Killeen	10 %	7.47 %
Waco	12 %	7.49 %

Participant Disease Stage (n=548)

HIV positive with no symptoms	54 %
HIV positive with symptoms	17.8 %
AIDS no symptoms	10.4 %
AIDS with symptoms	14.7 %
Don't Know	2.6 %

There is a variance in the gender and racial/ethnic distribution between survey participants and the HARS demographic data. Within the survey participants, there is an over representation of females and of racial/ethnic minority groups. This is due, in part, to purposeful over-sampling when the Austin assessment was conducted. The over-sampling was done to ensure adequate representation of certain populations of interest to the Austin Area Comprehensive HIV Planning Council.

MOST RECENT NEEDS ASSESSMENT: Findings

The needs assessment report and data provided valuable information about services, barriers, and other socio-cultural factors that affect a person’s ability to receive and stay in care. The report is viewed as one component of an evaluative process of the complete care system. Findings from the assessment are used, in part, to identify areas for improvement within the system. Several issues stood out as the results were reviewed. Across all Health Service Delivery Areas (HSDAs), Oral Health is a core service that has a large amount of unfulfilled need. One quarter of survey respondents identified the service as needed but their need was not met.

Unfulfilled needs

Service	Percent of respondents (n=548)
Health Insurance	27.4 %
Emergency Financial Assistance	26.5 %
Oral Health	25.5 %
Housing Related	21.9 %
Housing Assistance	19.3 %
Legal	17.7 %
Nutritional Counseling	15.9 %
Food Bank	15.0 %
Drug Reimbursement	14.8 %
Transportation	13.3 %

In Texas where one in four adults does not have health insurance of any form, the amount of unfulfilled need is not unexpected¹⁰. However, the question of the need for health insurance is whether a client has insurance but needs assistance with premiums, or if the client needs insurance in the first place. Similarly perplexing is the service Emergency Financial Assistance. The specific nature of the need is not specified in the data, a limitation of the survey instrument. The lack of specificity in the level of unfulfilled need for these two services warrants their further study.

Substance abuse treatment did not rank highly among survey participants in terms of need and unfulfilled need, 20th and 18th respectively of 30 categories. Substance abuse, however, continues to be an issue as evidenced by the number of active substance abusers that responded to the survey. Four percent of all survey participants responded that they currently use intravenous drugs. Seventeen percent said they are currently using street drugs, other than intravenous. Twelve percent of all participants stated that alcohol affected their ability to manage their HIV infection.

¹⁰ Kaiser Family Foundation, 2006. www.statehealthfacts.org

Of those actively using intravenous drugs, almost half stated they do not need treatment, and of those currently using street drugs, 43 percent stated they do not need treatment. For those currently using street drugs, the most often cited need for treatment is free treatment, 27 percent. Fifty three percent of all survey respondents stated they have a history of using intravenous drugs, street drugs, or both. Of those with a history of substance abuse, alcohol, intravenous, or street drugs, 60 percent responded that they do not need treatment.

The Mental Health Services category is ranked 10th in terms of need and 15th among unfulfilled need (of 30 categories) across all HSDAs. Almost 60 percent of respondents stated they are currently experiencing depression and 47 percent stated that are experiencing anxiety. Only 29 percent of respondents are taking antidepressant medication. Of those currently using street drugs, 66 percent are experiencing depression, whereas 47 percent of participants not currently using any drugs, intravenous or street, are experiencing depression. These findings further highlight the link between mental health and substance abuse.

Treatment adherence is vitally important in preventing drug resistance. Forty-three percent of survey respondents are taking an ART/HAART treatment regimen. Of those taking HIV medication, 39 percent report having missed a dose rarely, defined as no more than once a week. Six and a half percent of participants report missing a dose some of the time (one to four times a week), and 4.1 percent report missing a dose often (five or more times a week). Overall, 48 percent of those taking antiretroviral and/or protease inhibitors missed a dose of some frequency. Sixty-nine percent of those that missed a dose did so because they “forgot to take them.” While there are varying degrees of adherence across HSDAs, from 41 percent missing at least one dose in Waco to 57 percent missing at least one dose in Bryan, the most often reason cited in each HSDA is “forgot to take them.”

Incarceration also poses a challenge, particularly in regards to entering care at release. Out of the 548 survey participants, 71 people (almost 13%) stated they had been incarcerated at some point during the preceding 12 months. Seventeen people said the jail or prison medical and nursing staff did not know they are HIV positive, 54 stated the jail/prison medical/nursing staff did know of their HIV positive status. Only 31 people received care for HIV while they were incarcerated. Twenty-one people said that even though the staff did know of their HIV positive status, they did not receive care. The survey instrument does not question a participant as to the length of their incarceration, which may be an explanatory factor for those who did not receive care but staff were aware of their HIV status. Sixteen of those incarcerated had been tested for HIV at least once in a prison or jail setting, although it does not specify if it was during their incarceration in the preceding 12 months. Approximately 32 percent of those that were incarcerated also have Hepatitis C, a prevalence that is almost twice as high of those who had not been incarcerated; approximately 17 percent who had not been incarcerated have Hepatitis C. The prevalence of Hepatitis A and B, syphilis, gonorrhea, or other STD, and Tuberculosis, among the previously incarcerated is comparable to that of survey participants that had not been incarcerated. Of the 71 participants who were incarcerated, 12 are currently using both intravenous drugs and street drugs, 13 are currently using street drugs only.

MOST RECENT NEEDS ASSESSMENT: Service Category Rankings and Explanation

The following table presents the results of the service category importance ranking from the analysis conducted by the CCHD. The survey instrument utilized asked participants to list, in order of importance, the 30 HRSA defined service categories. The service that was ranked first the most often is listed as number one in the table and so on. Services in bold are part of the core 12 services as defined by HRSA.

Service Category	Ranking Based on Consumer Report	Percent of Total Sample with Service Need	Percent of Total Sample with Unfulfilled Need
Ambulatory Outpatient Medical Care	1	65.9 %	7.3 %
Food Bank	2	66.3 %	15.0 %
Drug Reimbursement	3	53.0 %	14.8 %
Housing Assistance	4	51.9 %	19.3 %
Transportation	5	54.8 %	13.3 %
Case Management	6	73.8 %	7.3 %
Emergency Financial Assistance	7	65.7 %	26.5 %
Oral Health	8	74.3 %	25.5 %
Health Insurance	9	65.0 %	27.4 %
Mental Health	10	35.5 %	10.0 %
Referral	11	55.5 %	11.7 %
Housing Related Services	12	43.2 %	21.9 %
Nutritional Counseling	13	45.1 %	15.9 %
Legal	14	31.6 %	17.7 %
Psychosocial Support	15	31.3 %	11.9 %
Client Advocacy	16	38.7 %	11.7 %
Home Health	17	17.2 %	8.4 %
Outreach	18	31.2 %	12.4 %
Treatment Adherence	19	29.4 %	6.6 %
Substance Abuse Services	20	16.6 %	7.5 %
Health Education / Risk Reduction	21	24.8 %	7.3 %
Buddy Companion	22	17.6 %	12.0 %
Rehabilitation Services	23	15.2 %	9.3 %
Early Intervention	24	15.7 %	4.0 %
Hospice	25	4.8 %	3.1 %
Child Care	26	5.0 %	4.0 %
Day or Respite Care	27	8.5 %	5.5 %
Permanency Planning	28	4.3 %	2.6 %
Child Welfare	29	4.2 %	1.8 %
Other Support	30	6.6 %	2.6 %

Of the top 10 services, Emergency Financial Assistance is no longer funded in central Texas HSDAs as there is greater need for funds in core categories. The high level of need for Emergency Financial Assistance, and the high level of unmet need for the service, raises questions as to the exact nature of emergencies that people need assistance with.

MOST RECENT NEEDS ASSESSMENT: Unmet Need Estimates and Out-of-Care Respondents

Unmet need, also referred to as out-of-care, refers to people who have no evidence of medical care for HIV according to the (HRSA) definition of not having had a CD4, viral load test, or ART/HAART medication in the preceding 12 months. Throughout the central Texas planning area, as of December 31, 2004, there are 1,535 people that meet the out-of-care definition. This represents approximately 34 percent of all PLWHA in the CTHPA. The Austin HSDA is the third lowest level of unmet need in the state. At the other end of the spectrum is the Temple – Killeen HSDA that has the highest percentage of unmet need in the state, 51.1% of all PLWHA in the HSDA are considered out-of-care, as of December 31, 2004.

HSDA	Number Out-of-Care	Overall percent unmet need
Austin	1,092	32.0%
Bryan – College Station	112	40.6%
Concho Plateau	31	34.1%
Temple – Killeen	166	51.1%
Waco	134	40.7%

The assessment conducted by the CCHD included only one person that was considered out-of-care. The assessment conducted for the Austin Area Comprehensive HIV Planning Council included 97 out-of-care participants, all located within the five county TGA. Only 18 percent of needs assessment survey participants throughout the CTHPA were considered out-of-care. The results and analysis of the assessment that pertain to out-out-care are not representative of the entire out-of-care population in the CTHPA, a limitation in survey participant recruitment. The following analysis of in-care versus out-of-care is adapted from the Austin Area HIV Planning Council 2006-2008 Comprehensive HIV Health Services Plan and the 2005 Austin Area Comprehensive HIV Needs Assessment.

African Americans comprise a higher proportion of the out-of-care group, 41 percent, than the in-care group, 30 percent. There is also a higher proportion of the out-of-care versus in-care population of women, 36 percent versus 25 percent respectively. Out-of-care respondents are typically younger than in-care (43 percent of out-of-care under age 35 versus 12 percent in-care), and there is a lower level of educational attainment among the out-of-care (42 percent of out-of-care not graduating high school versus 18 percent of in-care). Out-of-care participants were twice as likely to be exposed through heterosexual contact as their in-care counterparts.

According to the findings in the Austin assessment, approximately the same percent of those who are in-care and those who are out-of-care received a referral for medical care at diagnosis. Of those who are in-care, more than half began their care immediately, compared to only 18 percent of those who are out-of-care. Sixty percent of the out-of-care participants have not received HIV medical care. Among out-of-care respondents that waited a year or more before accessing HIV medical care, 40 percent cited “not sick” as the reason for waiting, 39 percent responded with concern of disclosing HIV status, and 28 percent cited active substance use.

In the overall analysis conducted by the CCHD, 154 of 548 stated they waited one year or more after diagnosis before seeking medical care. The most often cited reason, 40.26 percent of the

154 respondents, stated they did not believe they needed medical care then because they were not sick. Thirty four percent responded that they delayed care because of concerns that someone would find out their status if they went for care. Twenty nine percent said they did not want to receive medical care. Twenty four percent stated that active substance abuse prevented them from obtaining medical care. The fifth most cited reason is “financial reasons.” (Participants could select multiple reasons for delaying entry to care, thus the percentages do not add to 100).

The top two reasons for delaying entry to medical care are the same for in-care and out-of-care, they did not feel sick and they were worried of someone finding out their status. Two very different approaches are needed to reduce or overcome these barriers to entry into care.

It is not known if those who are out of care have been educated on the importance of routine medical treatment for HIV. While education alone does not solve public health problems, it is a necessary first step in the linkage to care. Barriers to entry may be the primary factor in remaining out of care. A more detailed and in-depth study of out-of-care populations is needed in the CTHPA.

The needs and unfulfilled needs of those who are out-of-care differ from those who are in care. The following table ranks need and unfulfilled need for both in-care and out-of-care survey participants in the Austin TGA.

	In Care (n=248)		Out-of-care (n=97)	
	Total Need Rank	Unfulfilled Need Rank	Total Need Rank	Unfulfilled Need Rank
Ambulatory Outpatient Medical Care	1	-	-	-
Oral Health	2	6	6	5
Case Management	3	-	10	8
Food Bank	4	10	1	6
Referral	5	-	8	10
Emergency Financial Assistance	6	3	2	2
Drug Reimbursement	7	6	-	-
Transportation	8	-	5	9
Health Insurance	9	1	3	1
Nutritional Counseling	10	6	-	-
Housing Assistance	-	4	4	3
Housing Related	-	1	7	3
Legal	-	5	-	-
Buddy / Companion	-	9	-	-
Substance Abuse Treatment	-	-	9	7

An often cited reason for people remaining out of care is that individuals have more immediate basic needs that are given a higher priority than their medical care. Research shows correlations between receipt of ancillary services, like food and housing, and an increase in the likelihood of receiving care.¹¹⁻¹² There is also evidence that unfulfilled needs for these services are found to be

¹¹ Ashman J.J., Conviser R., Pounds M.B. Associations Between HIV-positive Individuals’ Receipt of Ancillary Services and Medical Care Receipt and Retention. AIDS Care. 2002;14. p. 109 – 118.

primary factors in delaying care¹³. This follows suit with Maslow's hierarchy of needs, which says biological/physiological needs come before safety needs¹⁴. Biological/physiological needs include breathing, regulating body temperature, need for water, sleep, food, and disposal of bodily waste. Safety needs include security of employment, revenue, physical security from violence, familial security, and security of health. Generally speaking, the total needs of the out-of-care population surveyed follow this pattern, food and housing needs come before those of medical services.

Out-of-care populations, as indicated in the 2005 Austin Area Comprehensive HIV Needs Assessment, generally do not express a need for medical services. Of the 93 participants that responded to the question of need for Ambulatory / Outpatient Medical Care, only 18 percent of out-of-care respondents stated this as a need, contrasted to approximately 94 percent of in-care respondents. Drug Reimbursement saw a similar response; of 94 out-of-care respondents, 16 percent expressed need, compared to 65 percent of in-care participants stated a need. Mental Health had less expressed need among out-of-care, 22 percent expressed a need, while in-care had a higher expression of need, 43 percent. Among respondents to the question of need for Oral Health care, 49 percent of the out-of-care population stated a need, and 83 percent of in-care stated a need. Substance abuse treatment does not follow the same pattern however; a higher percentage of out-of-care participants stated a need, 32 percent, than did their in-care counterparts, 16 percent. The antithetical findings for Substance Abuse Treatment may correspond to a higher level of active substance abuse among out-of-care populations.

Substance abuse can substantially hinder a person's ability to remain in care. In the survey, participants were asked if they have dropped out of care for more than six months. Ninety-six people responded that they had. Thirty-three percent said they dropped out of care because they were actively using drugs, alcohol, or had relapsed (n=32), the most often cited reason. Of those 32 people, 14 responded that it was hard to keep appointments.

MOST RECENT NEEDS ASSESSMENT: Gaps in Care Services

Gaps in care services can result from a multitude of factors. A high level of unfulfilled need may produce a gap in care. An unfunded and unavailable service may produce a gap in care. Services with barriers may produce a gap in care. Care, however, must be defined. The Health Resources and Services Administration has designated 12 services as "Core Medical Services" among which are Ambulatory / Outpatient Medical Care, AIDS Drug Assistance Program/Drug Reimbursement, Oral Health Care, Early Intervention Services, Health Insurance Continuation, Home Health, Medical Nutrition Therapy, Hospice, Home and Community Based Health Services, Mental Health, Substance Abuse Outpatient, Medical Case Management including treatment adherence. It is important to note that for case management, only medical case

¹² Lo W., MacGovern T., Bradford J. Association of Ancillary Services with Primary Care Utilization and Retention for Patients with HIV/AIDS. AIDS Care. 2002;14. p. 45 – 57.

¹³ Cunningham W.E., Andersen R.M., Katz M.H., et al. The Impact of Competing Subsistence Needs and Barriers on Access to Medical Care for Persons with Human Immunodeficiency Virus Receiving Care in the United States. Medical Care. December 1999, 37(12). P. 1270 – 1281.

¹⁴ Wikipedia. http://en.wikipedia.org/wiki/Maslow%27s_hierarchy_of_needs. Accessed October 1, 2006.

management is a core medical service. Many tables in this plan list only “case management” which includes both types, medical and non-medical. As such, it is bolded as a core medical service, but only for medical case management. In a similar fashion, substance abuse treatment in this plan does not distinguish between inpatient and outpatient. Only outpatient based substance abuse treatment is considered a core medical service. Since tables list only “substance abuse treatment,” it is bolded as core medical, but only for outpatient based treatment. Of further note, some tables contain “Treatment Adherence” as a specific service category. As defined in the law and interpreted by HRSA, treatment adherence when provided as a part of medical case management is a core medical service, but as a stand alone service, is not considered a core medical service, and therefore is not bolded as a core medical service in the tables in this plan.

There are several access services as denoted in the taxonomy, however two services are in the top of priorities for Central Texas HSDAs, Medical Transportation and Health Insurance Continuation. Other services are needed to maintain health and as Maslow suggests, are primary to other needs: Housing Assistance and Food Bank. As seen in the level of need among those considered out of care, a place to sleep and something to eat are top priorities. A set of the core medical services (Ambulatory / Outpatient Medical Care, Oral Health, AIDS Pharmaceutical Assistance – Local, Mental Health Care, Substance Abuse – Outpatient, Health Insurance Continuation, and Medical Case Management) and support services (Food Bank, Housing Assistance, and Medical Transportation) comprise a set of services, referred to throughout this document as the “10 Care Services.”

Based on data from the needs assessment, Oral Health ranks third highest in terms of unfulfilled need among all services and first in the level of unfulfilled need among the core services. As discussed earlier in the overall findings section, Health Insurance, Oral Health, Emergency Financial Assistance, Housing Assistance, and Housing Related Services are the top five services with unfulfilled need. When examined on an HSDA by HSDA basis, the three services with the highest level of unfulfilled need are Oral Health, Emergency Financial Assistance, and Health Insurance. The survey instrument does ask about barriers for these services, however, the information provided in the analysis does not provide a clear explanation as to the reason for unfulfilled need. Compounding the problem is a low response rate to the needs assessment, particularly in the Concho Plateau HSDA. Data collection will be addressed in the goals and objectives section of this document.

One question for further exploration is the high level of need and unfulfilled need for Emergency Financial Assistance. The needs assessment survey does not ask participants what kinds of emergencies they are having that they need financial help with. Emergencies relating to a person’s housing situation may be a source of the need for Emergency Financial Assistance. According to provider interviews, the requirements for short-term assistance under the Housing Opportunities for Persons with AIDS (HOPWA) grant have become stricter, perhaps fueling unfulfilled need. Again, further exploration of these issues is needed.

As discussed before, a gap in care can result from the need for a service that is not funded. The following tables present the Ryan White and State funded services that are offered in each HSDA. As these are directly funded services, there should theoretically not be a gap in care due to funding. Many other services are offered through referrals to other agencies, organizations, and services in each community.

Austin HSDA		
Priority	Service Category	Ryan White / State Funding Status
1	Ambulatory / Outpatient Medical Care	Funded by Ryan White Parts A, B, C, State Services, and Travis County Healthcare District
2	Medical Case Management	Funded by Ryan White Part A
3	Mental Health Services	Funded by Ryan White Part A
4	Substance Abuse – Outpatient	Funded by Ryan White Part A
5	Hospice	Funded by Ryan White Part A
7	Oral Health Care	Funded by Ryan White Parts A, B, and C
8	Health Insurance Continuation	Funded by Ryan White Parts A and B
9	AIDS Pharmaceutical Assistance – Local	Funded by Ryan White Parts A, B, C, State Services, and Travis County Healthcare District
14	Case Management – Non-Medical	Funded by Ryan White Parts A, B, as well as State Services
17	Food Bank	Funded by Ryan White Part A and State Services
18	Outreach Services	Previously funded by Ryan White Title I MAI
19	Medical Transportation	Funded by Ryan White Part A, C, and State Services

Bryan HSDA		
Priority	Service Category	Ryan White / State Funding Status
1	Case Management – Non-Medical	Funded by Ryan White Part B and State Services
2	Ambulatory / Outpatient Medical Care	Funded by Ryan White Part B
3	AIDS Pharmaceutical Assistance – Local	Funded by Ryan White Part B
3	Oral Health Care	Funded by Ryan White Part B
3	Medical Transportation	Funded by State Services
4	Health Insurance Continuation	Funded by Ryan White Part B
5	Food Bank	Funded by State Services
6	Housing Assistance	Provided by HOPWA
9	Substance Abuse Outpatient	Funded by Ryan White Part B
9	Mental Health Services	Funded by Ryan White Part B
9	Related Housing Services	Provided by HOPWA

Concho Plateau HSDA		
Priority	Service Category	Ryan White / State Funding Status
1	Medical Case Management	Funded by Ryan White Part B
1	Case Management – Non-Medical	Funded by Ryan White Part B and State Services
1	AIDS Pharmaceutical Assistance – Local	Funded by Ryan White Part B
2	Oral Health Care	Funded by Ryan White Part B
3	Ambulatory / Outpatient Medical Care	Funded by Ryan White Part B
4	Housing Services	Provided by HOPWA
5	Food Bank	Funded by State Services
6	Medical Transportation	Funded by State Services
6	Related Housing Services	Provided by HOPWA
7	Mental Health Services	Funded by Ryan White Part B
8	Health Insurance Continuation	Funded by Ryan White Part B

Temple – Killeen HSDA		
Priority	Service Category	Ryan White / State Funding Status
1	Case Management – Non-Medical	Funded by Ryan White Part B and State Services
2	Ambulatory / Outpatient Medical Care	Funded by Ryan White Part B
2	AIDS Pharmaceutical Assistance – Local	Funded by Ryan White Part B
3	Oral Health Care	Funded by Ryan White Part B
4	Medical Transportation	Funded by State Services
5	Health Insurance Continuation	Funded by Ryan White Part B
8	Related Housing Services	Provided by HOPWA
8	Housing Services	Provided by HOPWA
9	Food Bank	Funded by State Services

Waco HSDA		
Priority	Service Category	Ryan White / State Funding Status
1	Ambulatory / Outpatient Medical Care	Funded by Ryan White Part B
1	Medical Case Management	Funded by Ryan White Part B
1	Case Management – Non-Medical	Funded by Ryan White Part B and State Services
2	AIDS Pharmaceutical Assistance – Local	Funded by Ryan White Part B
3	Oral Health Care	Funded by Ryan White Part B
3	Medical Transportation	Funded by State Services
4	Health Insurance Continuation	Funded by Ryan White Part B
5	Mental Health Services	Funded by Ryan White Part B
6	Food Bank	Funded by State Services
8	Housing Services	Provided by HOPWA
8	Related Housing Services	Provided by HOPWA

Providers are required to form linkages with other agencies in their area to meet client needs for services and prevent gaps in care. For example, in the Waco HSDA, Substance Abuse Treatment has a low level of need, low level of unfulfilled need, is not funded, but there is not a gap in care. The contracted provider has developed a link with a substance abuse treatment facility in the area that can provide those services for clients as the need arises. The resources section of this plan contains more information about resources for services that are not directly funded through Ryan White, State Services, or HOPWA funds.

For each HSDA, the 10 care services are provided either through the use of Ryan White, State, or HOPWA funds, or through a linkage to another agency in the area. This does not mean there are not gaps in those 10 care services. Barriers to services can create gaps in care. Access and barriers are closely related, however are separate. The needs assessment asked participants a range of questions for each of the 30 HRSA defined services. Part of the questioning related to access, asking if it is easy, somewhat hard, or hard to access a particular service. The following table presents the percentage of respondents that answered with one of the three options.

	Easy	Somewhat hard	Hard	Responses
Ambulatory / Outpatient Medical Care	90.73 %	5.06 %	2.81 %	356
Case Management	88.78 %	4.24 %	4.49 %	401
Drug Reimbursement	82.64 %	9.92 %	5.37 %	242
Oral Health	81.93 %	9.03 %	5.61 %	321
Substance Abuse Treatment	79.84 %	8.87 %	5.65 %	124
Food Bank	79.46 %	8.33 %	9.52 %	336
Mental Health	75.25 %	11.39 %	6.44 %	202
Transportation	72.51 %	13.06 %	9.28 %	291
Health Insurance	72.08 %	10.42 %	15.42 %	240
Housing Assistance	52.34 %	21.28 %	20.85 %	235

Close to half of respondents stated that accessing Housing Assistance services is difficult (hard or somewhat hard). Nearly 25 percent of respondents stated that accessing Mental Health services, Transportation, and Health Insurance is difficult (hard or somewhat hard). With the exception of mental health, these services correspond with some of the highest levels of unfulfilled need. Oral health, the third most unfulfilled need, has much less difficulty in access according to respondents. These results indicate that gaps in care may result from barriers that prevent access to a service or make accessing a service difficult.

MOST RECENT NEEDS ASSESSMENT: Barriers to Care Services

The assessment survey asked participants about barriers that impede their access to services. Four barrier types were presented in the survey, access / availability, service delivery, information, and personal / cultural. For each type of barrier, participants were read a list of examples that pertain to the barrier; however, participants could only indicate the type of barrier and not the exact reason of the barrier.

The survey described access / availability barriers as “The services available were too far from your home or work. Services were not open at the hours you could get there. There was no child care. Waiting times for appointments or to see the person you needed to see were too long.” Because there are so many various examples of access/availability barriers, and that participants could not select the exact reason, it is difficult to understand the exact nature of the barrier.

Access barriers were the most commonly reported type of barrier reported. The following table reports the 10 care services and its corresponding most frequently cited barrier.

Most frequently cited barrier

Service	Barrier Type	Number reported the barrier type
Food	Access	118
Housing Assistance	Access	103
Oral Health	Access	97
Transportation	Access	77
Health Insurance	Information	66
Ambulatory/Outpatient Medical Care	Access	60
Case Management	Access	47
Drug Reimbursement	Information	46
Mental Health	Access	39
Substance Abuse Treatment	Information, Personal/Cultural, Access	19 each

In the interest of finding the total number of barriers reported, a query was performed to determine unduplicated participant responses. The following table lists the previously mentioned “10 Care Services” and the total number of unique respondents across all barrier types. Food Bank had the most reported barriers of all types.

Most barriers

Service	Number
Food Bank	180
Housing Assistance	178
Health Insurance	176
Oral Health	163
Transportation	131
Ambulatory/Outpatient Medical Care	106
Drug Reimbursement	97
Case Management	89
Mental Health	89
Substance Abuse Treatment	57

The order of services in the two tables of most frequently cited barriers and most responses of barriers follows the same general trend. Separate queries to determine the top five services with the most reported barriers found the same services for each barrier type. Health Insurance, for example, was in the top five most barriers for Information, Personal/Cultural, and Service Delivery Barriers. Oral Health appeared in the top five most barriers for Personal/Cultural, Service Delivery, and Access. Emergency Financial Assistance appeared in the top five most barriers for Information, Service Delivery, and Access. Housing Related Services appeared in the top five most barriers for Information, Service Delivery, and Access. The following tables show the top five services for each barrier type in the survey.

Information Barriers	
Service	Number Reported
Emergency Financial Assistance	72
Health Insurance Continuation	66
Legal Services	62
Housing Related	59
Referral	56

Personal / Cultural Barriers	
Service	Number Reported
Health Insurance Continuation	18
Substance Abuse Treatment	18
Mental Health Services	14
Referral	12
Oral Health Care	11

Service Delivery Barriers	
Service	Number Reported
Emergency Financial Assistance	51
Oral Health Care	44
Health Insurance Continuation	42
Housing Assistance	39
Housing Related	36

Access / Availability Barriers	
Service	Number Reported
Emergency Financial Assistance	119
Food Bank	118
Housing Assistance	103
Oral Health Care	102
Housing Related	85

Access and availability barriers were reported most frequently, while personal / cultural barriers were reported the least frequently.

When asked about barriers to Oral Health care, more than half the time people responded that the barriers listed were not applicable, meaning a different barrier that the four listed prevented access. When a barrier option was cited, the most common reason was an access issue. More in depth study of the barriers to Oral Health care will need to be performed throughout the planning area. The Oral Health service has traditionally not been funded as highly as other services in the HSDAs, excluding the Austin HSDA. This is perhaps one reason clients had difficulty in obtaining oral health care.

Food Bank services had the highest number of reported barriers by the most people. The most frequently cited barrier for Food Bank is access / availability. Interviews with social case managers at agencies in the CTHPA revealed that food banks can be difficult to access for clients, requiring transportation; the need to arrive at a food bank early because of long lines; or possibly because it is open only once a week, or even less frequently.

The Health Insurance service category appeared in the tables listing the most barriers, the most being information barriers. The description provided to survey participants for information barrier is “You didn’t have the information you needed about the service – that it existed, where to get it, how to qualify, etc.” As stated before, it is not known if someone had insurance and needed assistance with the associated costs, or needed to find insurance coverage in the first place. The need for, unfulfilled need of, and barriers to Health Insurance will be studied more in depth in later assessments.

Housing has surfaced as a problem for clients in terms of need, unfulfilled need, and barriers. Access and availability were the most frequently cited barrier to Housing Assistance. The resource inventory in a later part of this document notes that Section 8 housing assistance from the Housing and Urban Development department of the Federal government has waiting lists that are many months, even years long. Some waiting lists are so long they are closed, meaning they are no longer adding people to the waiting list. In some cases charitable housing resources have waiting lists. There are also program requirements for HOPWHA and Ryan White Housing Assistance that limit the amount and type of assistance provided. Because the needs assessment survey did not allow for inquiry of the type of assistance needed, more in depth study of the issue is needed.

An individual's behavior or lifestyle may create a barrier to other services or care in general. As discussed previously, substance abuse and mental health issues can create barriers to care. For those clients that waited a year or more before seeking care after diagnosis, nearly 25 percent stated the reason for delayed entry was due to active substance abuse.

When survey participants were asked about current barriers to seeking care, the most frequently cited, 87 people, is "No way to pay for it." Seventy-three were worried about an inadvertent disclosure of their status, responding to the reason "worried someone you know will see you." Forty-four stated a similar reason, "worried about family/friends finding out you are positive." Money and perceived stigma are the top barriers for seeking care in general. Stigma, or perceived stigma, is a recurring theme. It is also a barrier to entry for out-of-care populations.

MOST RECENT NEEDS ASSESSMENT: Prevention Needs

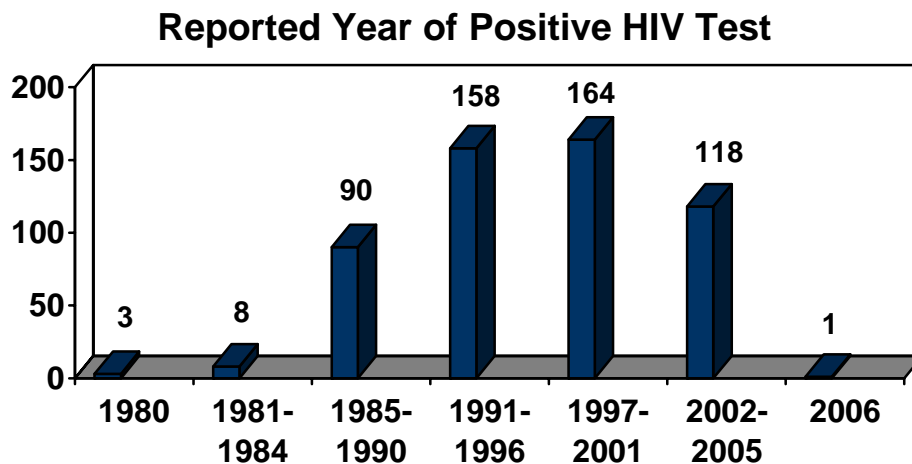
Over the course of time, prevention has been divided into two camps, prevention to keep people from becoming infected, and "prevention with positives," to prevent those who are infected from transmitting the virus to others. This bifurcation has stemmed from the different funding streams available for prevention activities. The Ryan White CARE Act/RWTMA was designed to provide medical care, not the usual testing, counseling, prevention that one thinks of in regards to HIV/AIDS. Prevention with positives however, addresses the issue from the other end of the continuum. The Health Education / Risk Reduction category has traditionally been funded in the CTHPA to teach PLWHA about transmission risk reduction strategies. As the cost of medical care increases and more emphasis is placed on core services, funds are taken from lower priority services, Health Education / Risk Reduction among them.

The needs assessment survey instrument does not ask participants any questions about sexual practices, partners, serostatus disclosure, or injection drug equipment sharing. The survey does not ask participants about potential transmission to others, or about practices that may exacerbate their own infection. Therefore there are no findings to report from the needs assessment. Future surveys should include such questions.

Participants are asked where they have tested for HIV, how many times, and when they were diagnosed. This information helps in describing the care system as testing and counseling are entry points into the care system.

Testing Site	Number (n=260)
Community Site	77
Hospital Clinic	52
City or County Health Department	43
Private Physician's Office	27
Hospital Emergency Room	20
Jail or Prison	20
Other	21

The majority of those testing at a community site tested only once, however a few have tested multiple times. The majority of people testing at other locations also reported testing only once at that location. Close to 60 percent of respondents tested positive between 1991 and 2001.



Curiously, three people reported testing positive prior to 1985, before testing was available. At the time of testing and initial diagnosis, 25 percent of respondents said they were not referred to any services. Of those that were referred for service, 63 percent were referred for medical care related to their HIV, 17 percent for medical care unrelated to HIV, 20 percent to educational classes, 18 percent for mental health services, and 13 percent referred to substance abuse counseling (respondents could answer yes to more than one, thus exceed 100%).

The Central Texas Community Planning Group (CPG) developed a prevention area action plan for 2006. The prevention planning area is the same geographic area as the HIV planning area. The prevention planning area was divided into three zones, two high morbidity analysis zones (HMAZ), and one low morbidity analysis zone (LMAZ). One HMAZ covers the city of Austin and surrounding areas; the second covers the Northern portion of the I-35 corridor of Temple/Killeen/Waco. The LMAZ applies to the Bryan – College Station and San Angelo areas.

For each HMAZ and the LMAZ, the CPG identified specific interventions for priority populations, one of which is PLWHA. For PLWHA in the Austin HMAZ, the CPG recommended CRCS/PCM, Healthy Relationships, and WILLOW interventions. The same three were recommended for the Temple/Killen/Waco HMAZ. For the Bryan – College Station area, the CRCS/PCM and Partnership for Health interventions were recommended. Representatives from the area however felt that the CRCS/PCM intervention would work better in the area. Representatives from the San Angelo area felt that the Partnership for Health intervention would be better suited for their area.

Case Management is one point of service (POS) that is available for prevention messages to be communicated to clients. Ambulatory care settings are another POS. Since funding for the Health Education / Risk Reduction category is not available, reliance on other points of service for prevention will be increasingly important. Implementation of the interventions will need to take place at some POS, most likely in the case management setting. Prior research has demonstrated the effectiveness of brief safer-sex counseling by medical providers.¹⁵

Summary of Current Care Resources

The needs of clients go beyond the services that are directly funded. To help meet those needs and to maximize limited funding, referral and resource guides are utilized. Subcontractors of BVCOG are required to have referral guides at their agency. The following resource inventory is a compilation of information taken from the referral guides at subcontracted agencies as well as interviews with case managers, agency directors, and clients. The resources below are for the 10 care services as those are generally the most used and needed services as stated by clients in the most recent needs assessment. Emergency Financial Assistance, however, is not included in the 10 care services, but is among the top 10 needs stated by clients.

In all the referral guides from BVCOG subcontractors, there is at least one mention of a church that is able to assist with an emergency, be it a rent payment, utility bill, medication, food, or other special need. Churches and other religious organizations have been a safety net, offering a form of emergency financial assistance. For assistance with acquiring medications, case managers at contracted agencies assist clients in applying directly to pharmaceutical companies' patient assistance programs. However, those who are enrolled in Medicare Prescription Assistance (Part D) are generally not eligible for the pharmaceutical company patient assistance programs. The assistance offered by churches and the pharmaceutical companies are not specifically for PLWHA, therefore they are competing with other people in need.

Housing assistance was cited by clients as the fourth highest need and as having many barriers, particularly access and availability barriers. Clients must apply for Section 8 housing assistance from the department of Housing and Urban Development prior to receiving assistance from Ryan White funds or the Housing Opportunities for Persons With AIDS (HOPWA) grant as part of the payer of last resort requirements. Case managers and agency directors in every HSDA of the

¹⁵ Richardson J. L., Milam J., McCutchan A., et al. Effect of a Brief Safer-Sex Counseling by Medical Providers to Hiv-1 Seropositive Patients: A Multi-clinic Assessment. AIDS. 2004;18. p. 1179-1186.

CTHPA stated, at the time of this writing, that there are waiting lists for Section 8 housing assistance, some up to a year long and some so long they are no longer accepting new clients to the list.

Another resource that is being heavily relied upon is the 211 directory hosted by the United Way. The United Way provides funds to not-for-profit and charitable entities in a community. They serve a coordinating role by knowing the charitable resources in a community. In every part of the state, someone may call “211” from a telephone and speak with someone who knows the resources in a community. This service is not specific to PLWHA and therefore may not be aware of any special arrangements agencies may have to assist PLWHA. The 211 directories have become in their own right a resource inventory.

At agencies throughout the CTHPA, case managers use the 211 directory and refer clients to it as well. In interviews with case managers, they have stated that it has been a great help and clients do use it. Before its dissolution, The Needs Assessment Committee of the Central Texas HIV Planning Council discussed the need for an updated resource inventory and provider profile. The overwhelming majority of committee members stated that the 211 directories are just such a guide and duplicating it would be an inefficient use of time. Providers do however maintain a referral guide at their agency.

SUMMARY OF CURRENT CARE RESOURCES: Austin HSDA:

- **Ambulatory / Outpatient Medical Care:** The David Powell Community Health Center in Austin is the main source of primary medical care for PLWHA in the Austin HSDA. The clinic is a part of the Austin / Travis County Community Health Centers, a group of federally qualified health centers, 17 sites in all. The David Powell Community Health Center is designed just for PLWHA. The David Powell Community Health Center is accessible by public or private transportation. For residents of Hays and Caldwell Counties that are uninsured and not eligible for any other insurance program, a clinic at Community Action Inc. of Hays, Caldwell, and Blanco Counties is available for PLWHA. The Community Action clinic is accessible by public and private transportation. Specialty care, such as infectious disease physicians, is available in Austin at many of the hospitals.
- **Drug Reimbursement:** The David Powell Community Health Center has a pharmacy on site and is able to fill many prescriptions for clients, serving the bulk of the clients. Community Action also has a pharmacy but is limited in the prescriptions it can fill and is geared towards clients of a family planning program. Clients may also choose their own pharmacy if the BVCOG contracted provider makes payment arrangements in advance. Such arrangements exist in Austin and San Marcos at various pharmacies.
- **Oral Health:** The Jack Sansing Dental Clinic at AIDS Services Austin (ASA) is the dental provider for PLWHA in the Austin HSDA. ASA coordinates care with the David Powell Community Health Center and with Community Action Inc. to serve all clients in the HSDA.
- **Case Management:** Medical Case Management is performed at the David Powell Community Health Center. Social Case Management is provided by two contracted agencies in the Austin HSDA. AIDS Services Austin provides case management services

primarily to residents of the five county Austin TGA, and Community Action provides case management to clients in nine counties of the Austin HSDA (excluding Travis County). They serve clients at offices in Elgin, Georgetown, and San Marcos. Anyone that receives Section 8 housing assistance from the department of Housing and Urban Development (HUD) must have a housing case manager. The housing case manager is provided by HUD.

- Substance Abuse Treatment and Mental Health: The Austin / Travis County Mental Health / Mental Retardation (MHMR) agency Community AIDS Resources and Education service provides mental health and substance abuse treatment at multiple sites. They target out-of-care / difficult to reach populations. They have a location on the east side of the city in a high prevalence area and they have a program to target people recently released from incarceration.
- Food Bank: The Austin resource guidebook published by the Austin Area Comprehensive HIV Planning Council lists over 50 food banks in the 10 county Austin HSDA. Some require a referral from another agency, while others allow clients to access the food bank on their own. Community Action, through its Food Bank funding category, provides vouchers from grocery stores so clients may purchase food. ASA provides a food bank specifically for PLWHA residing in the Austin HSDA but the client must have a case manager at one of the AIDS service organizations in the HSDA, be HIV positive and symptomatic, and provide medical information from their provider to be eligible for assistance.
- Housing: The Housing Opportunities for Persons With AIDS (HOPWA) grant program from HUD provides short term, emergency housing assistance, and long term rental assistance. A person seeking assistance from HOPWA must first apply for Section 8 Housing Assistance through HUD. HOPWA funds may be used if the applicant is ineligible, wait listed, or unable to begin Section 8 assistance for any other reason. At the time of this writing, waiting lists for Section 8 housing have been closed, meaning clients cannot be on the waiting list due to overwhelming demand, according to provider interviews. The wait list for Section 8 assistance can be as long as four years. The Austin HSDA has a variety of other housing arrangements including homeless shelters and community centers / community housing. Habitat for Humanity may also be another source of housing assistance.
- Transportation: bus passes are available to PLWHA in the City of Austin. For those residents outside of the city, gas vouchers, taxi vouchers, and rides from case managers are available for medical related appointments. For those clients that are covered by Medicaid and are able to do so, they must use the Medicaid bus before receiving transportation assistance with Ryan White funds, as part of the payer of last resort provision.
- Health Insurance: There is not an insurance pool available specifically for PLWHA. There are some government programs that PLWHA may qualify for, including Medicaid, Medicare, and the County Indigent Health Care program. Case managers assist clients in determining eligibility and applying for these programs at entry into services or as needed. Privately purchased individual policies for PLWHA are not common as insurers are reluctant to assume the associated cost of care; however, some PLWHA do have individually purchased or employer sponsored private insurance or COBRA for a period

of time. Assistance with premiums, co-payments, and co-insurance are available through the contracted provider.

SUMMARY OF CURRENT CARE RESOURCES: Bryan – College Station HSDA:

- **Ambulatory / Outpatient Medical Care:** The Brazos Valley Community Action Agency (BVCAA) is a federally qualified health center (FQHC) with six sites, available to PLWHA. Most PLWHA in the HSDA see an infectious disease specialist in private practice. Clients are able to choose their own physician as long as payment arrangements can be made between the physician and contracted provider, Project Unity. The Family Practice Clinic is a residency program in the Bryan area that sees patients on a sliding fee scale. The Health for All clinic also sees patients on a sliding fee scale.
- **Drug Reimbursement:** The BVCAA clinic has a pharmacy available to fill prescriptions for patients of the clinic. Clients of the contracted provider who are not patients at the BVCAA clinic may also choose a pharmacy to have prescriptions filled at as long as payment arrangements between the pharmacy and contracted provider are made in advance. The contracted agency has many such arrangements in place on a continuing basis.
- **Oral Health:** Dental services are available at the BVCAA FQHC dental clinic, but are limited in capacity. A local dentist is contracted to provide basic dental services such as screening, cleaning, and prophylaxis. More advanced and costly procedures are performed at the Bering Dental Clinic in Houston, which provides care at a reduced or free rate. Transportation to the Bering Dental Clinic can be provided by the contracted provider or through gas vouchers for private transportation.
- **Case Management:** Medical Case Management is not offered in the HSDA. Social Case Management is provided by one agency, which also does case management for others who are not HIV positive. Housing case management is offered by HUD for those receiving Section 8 housing assistance.
- **Substance Abuse Treatment:** The Brazos Valley Council on Alcohol and Substance Abuse (BVCASA) is the primary source of substance abuse treatment, on an outpatient basis. Inpatient substance abuse treatment for residents of the Bryan – College Station HSDA is available at the Freeman Center in Waco. Scott & White hospital also has an outpatient substance abuse treatment program in the HSDA that is available to those with third party/private insurance.
- **Mental Health:** The Brazos Valley MHMR is able to see people with severe psychosis or other extreme cases only, due to a lack of capacity. For less serious cases, counselors from Texas A&M University are available on an as needed basis.
- **Food Bank:** The Brazos Food Bank sells food only to agencies in the Brazos Valley; PLWHA are not able to access it directly. The contracted provider receives food from the Brazos Food Bank and makes it available specifically for clients.
- **Housing:** The Housing Opportunities for Persons With AIDS (HOPWA) grant program from HUD provides short term, emergency housing assistance, and long term rental assistance. A person seeking assistance from HOPWA must first apply for Section 8 Housing Assistance through HUD. HOPWA funds may be used if the applicant is ineligible, wait listed, or unable to begin Section 8 assistance for any other reason.

According to Section 8 case manager interviews, there is a waiting list for Section 8 assistance of approximately nine to 12 months at the time of this writing. The waiting list is open however. BVCAA also provides emergency housing. Phoebe's Home is another source of emergency housing / temporary shelter for women and their children that are victims of domestic violence. Twin City Mission has programs to assist residents in obtaining stable housing. The Brazos Valley Affordable Housing Corporation can assist people with purchasing their own home, geared towards those with low incomes and poor or no credit history.

- **Transportation:** The Brazos Transit System operates a bus system within the Bryan – College Station area as well as the Medicaid bus. The Retired Senior Volunteer Program and the BVCAA Elder Aid Program provide transportation assistance to older residents. The contracted provider can also provide assistance to clients for medical appointments when other resources are unavailable. Assistance from the provider include bus passes, taxi vouchers, and gas vouchers, as well as rides to appointments through the use of an agency vehicle.
- **Health Insurance:** There is not an insurance pool available specifically for PLWHA. There are some government programs that PLWHA may qualify for, including Medicaid, Medicare, and the County Indigent Health Care program. Case managers assist clients in determining eligibility and applying for these programs at entry into services or as needed. Privately purchased individual policies for PLWHA are not common as insurers are reluctant to assume the associated cost of care; however, some PLWHA do have individually purchased or employer sponsored private insurance or COBRA for a period of time. Assistance with premiums, co-payments, and co-insurance are available through the contracted provider.

SUMMARY OF CURRENT CARE RESOURCES: Concho Plateau HSDA:

- **Ambulatory / Outpatient Medical Care:** The contracted provider, San Angelo AIDS Foundation, operates a clinic specifically for PLWHA. Most clients / PLWHA see the physician at the clinic. San Angelo does have a FQHC in the city that provides primary medical care. Bluebonnet Clinic serves primarily an indigent client base.
- **Drug Reimbursement:** Pharmacies may be used if payment arrangements are made in advance between the pharmacy and the contracted provider. The provider does have existing relationships with some pharmacies that clients use regularly.
- **Oral Health:** The FQHC operates a dental clinic in addition to its primary care. The contracted agency has contracted a dentist to provide care to most of the clients in the area.
- **Case Management:** The contracted provider is the primary source of Social Case Management for PLWHA in the HSDA. They also offer Medical Case Management in the clinic. Healthcare Continuum is an agency that offers case management to people with disabilities. Those receiving Section 8 housing assistance receive housing case management from HUD.
- **Substance Abuse Treatment:** The Alcohol and Drug Abuse Council of Concho Valley has a variety of resources available for substance abuse treatment. Rivercrest Hospital offers in- and out-patient substance abuse treatment. Sara's House and the West Texas

Recovery Center both offer treatment services. William's House is a sober living facility to help those in recovery.

- **Mental Health:** The MHMR authority in the San Angelo area is able to see severe cases only, due to a lack of capacity. Samaritan Pastoral Counseling offers some counseling services. Shannon Behavioral Health Services, part of the local hospital, offers a range of mental health services as well.
- **Food Bank:** The contracted provider assists clients with food by offering grocery store vouchers as well as a food bank at the agency. The Concho Valley regional food bank is accessible by anyone in the area, as is Project Dignidad, another local food bank. Meals for the Elderly is a food assistance program geared towards those over 65.
- **Housing:** The Housing Opportunities for Persons With AIDS (HOPWA) grant program from HUD provides short term, emergency housing assistance, and long term rental assistance. A person seeking assistance from HOPWA must first apply for Section 8 Housing Assistance through HUD. HOPWA funds may be used if the applicant is ineligible, wait listed, or unable to begin Section 8 assistance for any other reason. According to case manager interviews at the time of this writing, there is a waiting list for Section 8 assistance of approximately one year. William's House is a sober living facility that combines housing assistance and substance abuse recovery. Christmas in April offers emergency housing assistance and home rebuilding services.
- **Transportation:** The Concho Valley Council of Governments operates the regional transportation system and offers reduced rate bus passes to local agencies. The Medicaid bus is available to those with Medicaid. The contracted provider also offers gas vouchers and taxi vouchers for medical appointments when other sources are unavailable.
- **Health Insurance:** There is not an insurance pool available specifically for PLWHA. There are some government programs that PLWHA may qualify for, including Medicaid, Medicare, and the County Indigent Health Care program. Case managers assist clients in determining eligibility and applying for these programs at entry into services or as needed. Privately purchased individual policies for PLWHA are not common as insurers are reluctant to assume the associated cost of care; however, some PLWHA do have individually purchased or employer sponsored private insurance or COBRA for a period of time. Assistance with premiums, co-payments, and co-insurance are available through the contracted provider.

SUMMARY OF CURRENT CARE RESOURCES: Temple – Killeen HSDA:

Temple, Texas is home to Scott & White Memorial Hospital (S&W). The hospital provides a large amount of medical care free of charge to PLWHA in the Temple – Killeen HSDA. Many of the following services are provided by Scott & White. To qualify for free or reduced cost care, the patient must meet with the hospital's social worker to determine eligibility.

- **Ambulatory / Outpatient Medical Care:** Scott & White Infectious Disease department provides primary and specialty medical care to PLWHA. Patients are screened with the Scott & White social worker to determine a fee scale. A Veterans Affairs hospital is also located in Temple and treats veterans. The Free Community Clinic also provides primary medical care. Metroplex hospital is another source of ambulatory care.

- Drug Reimbursement: The S&W Pharmacy can assist patients with low to no cost drugs, depending on income. The contracted provider, Central Texas Support Services, also makes payment arrangements with pharmacies around the HSDA for clients to fill prescriptions.
- Oral Health: Dental care is provided by Scott & White, almost exclusively.
- Case Management: Social Case Management is provided by the contracted agency, Central Texas Support Services. Medical Case Management is provided by the Scott & White Infectious Disease department. Those receiving Section 8 housing assistance receive housing case management from HUD.
- Substance Abuse: The Central Texas Alcoholic Rehabilitation Center is available for alcohol abuse. The Central Texas Council on Alcoholism and Drug Abuse provides information to residents regarding services available. Christian Farms is a drug abuse treatment facility, along with Meadows House, and Word of Life. The contracted agency has arrangements with these treatment facilities.
- Mental Health: The Central Counties Center provides some counseling, however Scott & White is the major provider of mental health services.
- Food Bank: All social service agencies in the Temple – Killeen area coordinate with the Bell County HELP Center. Anyone that would like to access any of the food banks must receive a referral from the HELP Center. The contracted provider also dispenses food vouchers for local grocery stores.
- Housing: The Housing Opportunities for Persons With AIDS (HOPWA) grant program from HUD provides short term, emergency housing assistance, and long term rental assistance. A person seeking assistance from HOPWA must first apply for Section 8 Housing Assistance through HUD. HOPWA funds may be used if the applicant is ineligible, wait listed, or unable to begin Section 8 assistance for any other reason. According to case manager interviews at the time of this writing, there is a wait list for Section 8 assistance from 16 to 24 months. The case manager also states that local community housing projects have various waiting lists for income based programs. Families in Crisis provides emergency housing assistance. Martha's Kitchen and Shelter is a shelter.
- Transportation: The contracted provider assists clients' transportation needs through gas vouchers, taxi vouchers, and bus tokens. If other means of transportation are not available or the client is not able to use public transportation due to medical reasons, the case manager may drive a client.
- Health Insurance: There is not an insurance pool available specifically for PLWHA. There are some government programs that PLWHA may qualify for, including Medicaid, Medicare, and the County Indigent Health Care program. Case managers assist clients in determining eligibility and applying for these programs at entry into services or as needed. Privately purchased individual policies for PLWHA are not common as insurers are reluctant to assume the associated cost of care; however, some PLWHA do have individually purchased or employer sponsored private insurance or COBRA for a period of time. Assistance with premiums, co-payments, and co-insurance are available through the contracted provider.

SUMMARY OF CURRENT CARE RESOURCES: Waco HSDA:

In addition to the contracted provider in Waco there is a charitable organization, the McLennan County AIDS/HIV Resources and Education Services (McCARES), which can assist anyone with HIV/AIDS with emergency needs. If the contracted provider is unable to fulfill a need due to funding issues or other programmatic reasons, McCARES is able to assist.

- **Ambulatory / Outpatient Medical Care:** The Family Practice Center in Waco is a federally qualified health center that sees patients on a sliding fee scale. Due to capacity issues, they limit eligibility to residents of McLennan County. Those with HIV/AIDS outside of McLennan County are able to use Scott & White in Temple. There are some physicians also available in counties outside McLennan County. The Falls County Hospital and Clinic is also available for those outside McLennan County. The Waco / McLennan County Public Health District (WMCPHD) is the contracted provider. They are able to perform some lab tests and blood draws as well.
- **Drug Reimbursement:** FQHC pharmacies are able to fill prescriptions as well as any pharmacies that will make payment arrangements with the contracted provider. The provider does have existing payment relationships with several pharmacies used regularly by clients.
- **Oral Health:** The WMCPHD dental unit is consulted first for clients. For residents that live farther away, payment arrangements can be made between the contracted provider and a dentist; the same is true for clients already established with a dentist.
- **Case Management:** The contracted provider is the source of Social Case Management and in 2007 will add Medical Case Management. Those receiving Section 8 housing assistance receive housing case management from HUD.
- **Substance Abuse:** The Freeman Center is the primary source of in- and out-patient substance abuse treatment. The Heart of Texas Council on Alcoholism and Drug Abuse also provides information to residents on other resources.
- **Mental Health:** The MHMR agency in Waco is able to see clients with extreme need, such as debilitating psychosis or other similar problems due to a lack of capacity. The DePaul center provides mental health services for a broad range of mental health issues.
- **Food Bank:** CARITAS is a large community food bank that sees residents from all over Waco. Food selection is limited due to capacity. The Red Door is a new food pantry specifically for PLWHA. The contracted provider also distributes vouchers for food redeemable at local grocery stores.
- **Housing:** The Housing Opportunities for Persons With AIDS (HOPWA) grant program from HUD provides short term, emergency housing assistance, and long term rental assistance. A person seeking assistance from HOPWA must first apply for Section 8 Housing Assistance through HUD. HOPWA funds may be used if the applicant is ineligible, wait listed, or unable to begin Section 8 assistance for any other reason. According to case manager interviews at the time of this writing, the waiting list for Section 8 assistance is closed. Falls County Samaritan Aid provides emergency housing assistance. The provider has also established relationships with several apartment complexes that use a sliding fee scale based on income.
- **Transportation:** County transportation systems, primarily busses, are available. Falls County Samaritan Aid will assist residents with a medical appointment. The provider can

also assist clients by distributing bus passes, gas or taxi vouchers to use for medical appointments when other resources are not available.

- Health Insurance: There is not an insurance pool available specifically for PLWHA. There are some government programs that PLWHA may qualify for, including Medicaid, Medicare, and the County Indigent Health Care program. Case managers assist clients in determining eligibility and applying for these programs at entry into services or as needed. Privately purchased individual policies for PLWHA are not common as insurers are reluctant to assume the associated cost of care; however, some PLWHA do have individually purchased or employer sponsored private insurance or COBRA for a period of time. Assistance with premiums, co-payments, and co-insurance are available through the contracted provider.

The Current Care System

THE CURRENT CARE SYSTEM: Service Category Rankings and Ranking Methodology

The priority setting model is based on four sources of data, each with a specific weight assigned. The 2006 Comprehensive HIV Client Needs Assessment accounts for 40% of an overall category score. The service taxonomy from the Texas Department of State Health Services counts for 30% of an overall score; utilization (unduplicated client count) is weighted 20%, and the 2006 Ryan White CARE Act reauthorization proposals definitions of core medical services count for 10%.

The 2006 Central Texas HIV/AIDS Client Needs Assessment ranks 30 services by importance to clients for each HSDA. The last portion of the assessment survey asks clients to rank the service categories by importance. The ranking is based upon aggregate importance from all surveys. For services ranked 1 – 6, the category received 5 points, for those ranked 7 – 12, 4 points were assigned, rank 13 – 18 received 3 points, rank 19 – 24 received 2 points, and ranks 25 – 30 received 1 point.

The Glossary of HIV-Related Service Categories and Administrative Services, part of the DSHS FY07 Request for Applications for Ryan White II and State Services, divides service categories into groups of importance (see http://hiv.bvcog.org/upload/2006/10/RFP_2007_taxonomy.pdf). Tier 1 health care services: core services (Ambulatory Outpatient Medical Care, Drug Reimbursement, Mental Health Services, Oral Health Services, Substance Abuse Inpatient/Outpatient, Case Management) received 5 points, tier 1 health care services: non-core medical services (Treatment Adherence, Health Insurance, Rehabilitation Services, Home Health Care, Hospice Care) received 4 points, tier 2 access services (Housing and Housing Related Services, Outreach Services, Referral for Health Care/Supportive Services, Referral to Clinical Research, Transportation Services, Early Intervention Services) received 3 points, and tier 3 support services (Nutritional Counseling, Childcare Services, Child Welfare Services, Buddy/Companion Service, Client Advocacy, Psychosocial Support Services, Developmental Assessment/early intervention, Day or Respite Care, Emergency Financial Assistance, Food

Bank/Home Delivered Meal, Health Education / Risk Reduction, Legal Services, Permanency Planning, Other Support Services) received 2 points.

Utilization is based on quintile calculations of unduplicated client count utilization of each service between April 1, 2005 and March 31, 2006. The number of unduplicated clients served for each service category was placed in ascending order. Using a formula to calculate the quintile division point, the services were then divided into five segments of utilization. The quintile with the most utilization received 5 points, down to the lowest utilization, which received 1 point.

Reauthorization proposals of the Ryan White CARE Act in 2006 have defined a set of core medical services in which 75% of Ryan White funds must be allocated and spent. To account for this, services that are defined in the bills as core medical received 5 points, while all other services received 3 points. The list of core medical services within the proposals include: Outpatient and Ambulatory Health Services, ADAP Treatments and Pharmaceutical Assistance, Oral Health Care, Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance, Home Health, Hospice, Home and Community-based Health Services (excluding homemaker services), Mental Health and Substance Abuse Outpatient Services, and Medical Case Management. It is important to note that the reauthorization proposals list medical case management as core medical, yet the category Case Management, is assigned only 3 points. Historically, social case management is the only funded form of case management in the Central Texas HIV Planning Area, and is not defined as a core medical service, thus receiving only 3 points.

Each score is then multiplied by its corresponding weight. See the examples below.

Example: Ambulatory Outpatient Medical Care (AOMC)

AOMC may be ranked as the most important service to clients, receiving 5 points multiplied by 40% (the weight given to the needs assessment) which equals 2. The DSHS taxonomy lists AOMC as a tier 1 core medical service, thus receiving 5 points multiplied by 30% which equals 1.5. Client utilization placed the service as one of the most used services, scoring 5 points multiplied by 20% equals 1. The Ryan White CARE Act reauthorization proposals list AOMC as a core medical service, thus scoring 5 points multiplied by 10% equals 0.5. After all point scores are multiplied by their weight, the products are added to get the service category overall score: $2 + 1.5 + 1 + 0.5 = 5$. See this example shown in the table below:

Service	Needs Asst.	DSHS Taxonomy	Utilization	RWCA Reauthorization	Total based on 40/30/20/10 weights
AOMC	$5 \times 40\% = 2$	$5 \times 30\% = 1.5$	$5 \times 20\% = 1$	$5 \times 10\% = 0.5$	5

The overall service category scores are then ordered and then assigned a priority. The highest overall category score ranks as the first priority. Some overall category scores were the same, and thus assigned the same priority ranking.

Example: Home Health Care

Home Health Care ranked in the middle of client importance, scoring 3 points; the DSHS taxonomy lists the service as tier 1 non-core medical, scoring 4 points; client utilization shows

this was one of the least used services, scoring 1 point; and the Ryan White CARE Act reauthorization proposal lists Home Health Care as a core medical service, scoring 5 points.
 $(3 \times 40\%) + (4 \times 30\%) + (1 \times 20\%) + (5 \times 10\%) = 3.1$

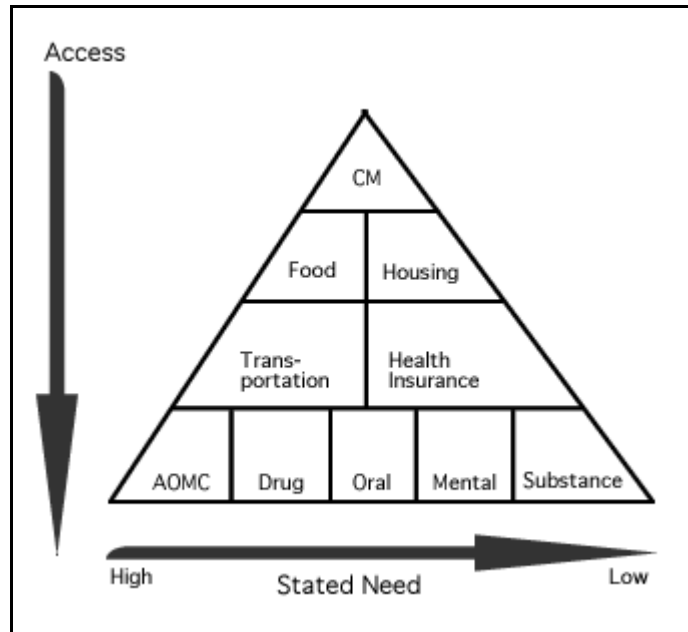
Service	Needs Asst.	DSHS Taxonomy	Utilization	RWCA Reauthorization	Total based on 40/30/20/10 weights
Home Health	3 x 40% = 1.2	4 x 30% = 1.2	1 x 20% = .2	5 x 10% = .5	3.1

The overall service category scores are then ordered and assigned a priority. The highest overall category score ranks as the first priority. Some overall category scores were the same, and thus were assigned the same priority ranking.

It is important to note that the above process was applied only to priorities for the Bryan – College Station, Concho Plateau, Temple – Killeen, and Waco HSDAs. The Austin HSDA uses the same priorities set by the Austin Area Comprehensive HIV Planning Council.

THE CURRENT CARE SYSTEM: Access Points and Process

The care system in the CTHPA, with the exception of the Austin HSDA, is built on a model with case management as a primary entry point. At entry, a client’s needs are assessed and a care plan is developed. The following model says that access to services moves downward, with the highest stated need for a medical service at the bottom left and the least stated need at the bottom right. A client must start accessing the Ryan White system of care through case management. Once food and housing needs are secure, access services (transportation and health insurance) are used to obtain medical care. If those access services are not needed by a client, then they proceed to access medical services. As seen in the out-of-care data from the needs assessment, food and housing were more important than other services, suggesting that once those needs are met, a person can begin to focus on maintaining and staying in regular medical care.

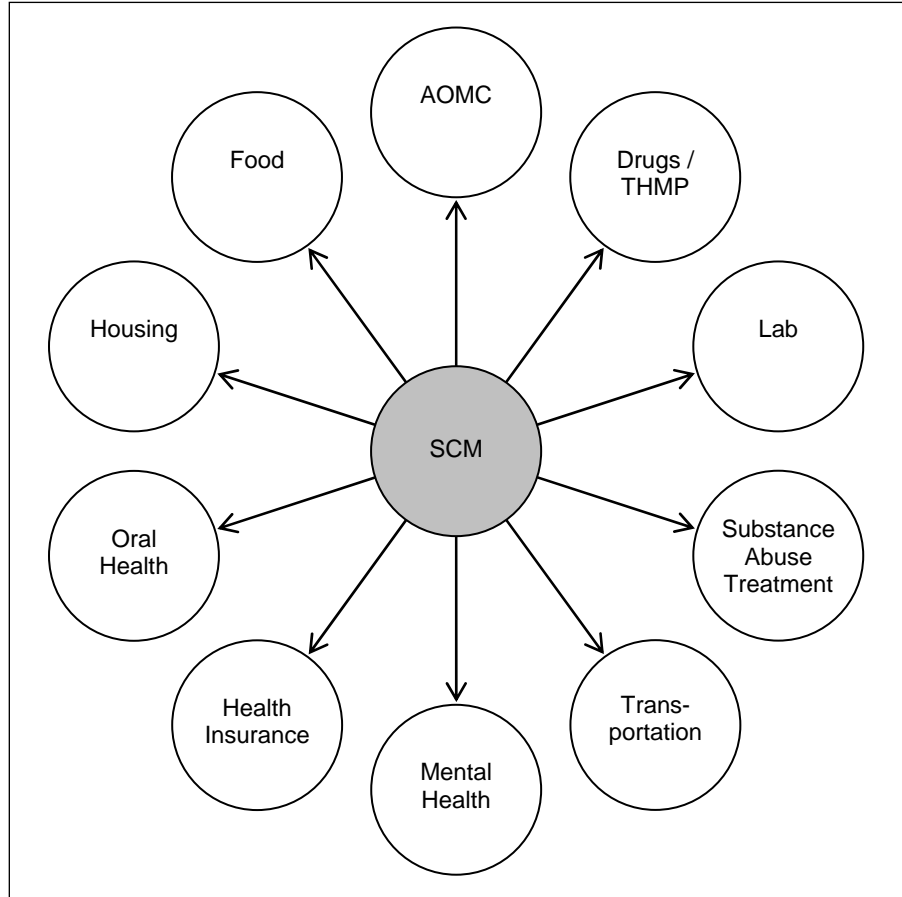


The central Texas HIV planning area contains five health service delivery areas, all of which contain only one contracted provider, with the exception of the Austin HSDA, which contains three contracted with BVCOG, and nine contracted with the City of Austin under Part A. In the four rural HSDAs (non-Austin) the contracted agency is the primary access point into the Ryan White funded system, resulting in only one access point. In the Austin HSDA, there are multiple entry points into the system.

Access to the Ryan White system in the four rural HSDAs is a hub and spoke model, with case management at the center. The four agencies, one per HSDA, are primarily case management agencies. The Concho Plateau contractor, San Angelo AIDS Foundation, is a combined clinic and case management agency. The Bryan – College Station and Temple – Killeen HSDA providers are case management agencies only. In the Waco HSDA, the provider is a part of the health department and includes some medical services.

For a client to access any of the Ryan White funded services in an HSDA, they must be enrolled in case management. Sometimes access to resources not funded by Ryan White requires a referral from an agency, in this instance the case management agency.

Bryan – College Station,
 Concho Plateau,
 Temple – Killeen, Waco
 HSDA Access Points
 (grey)

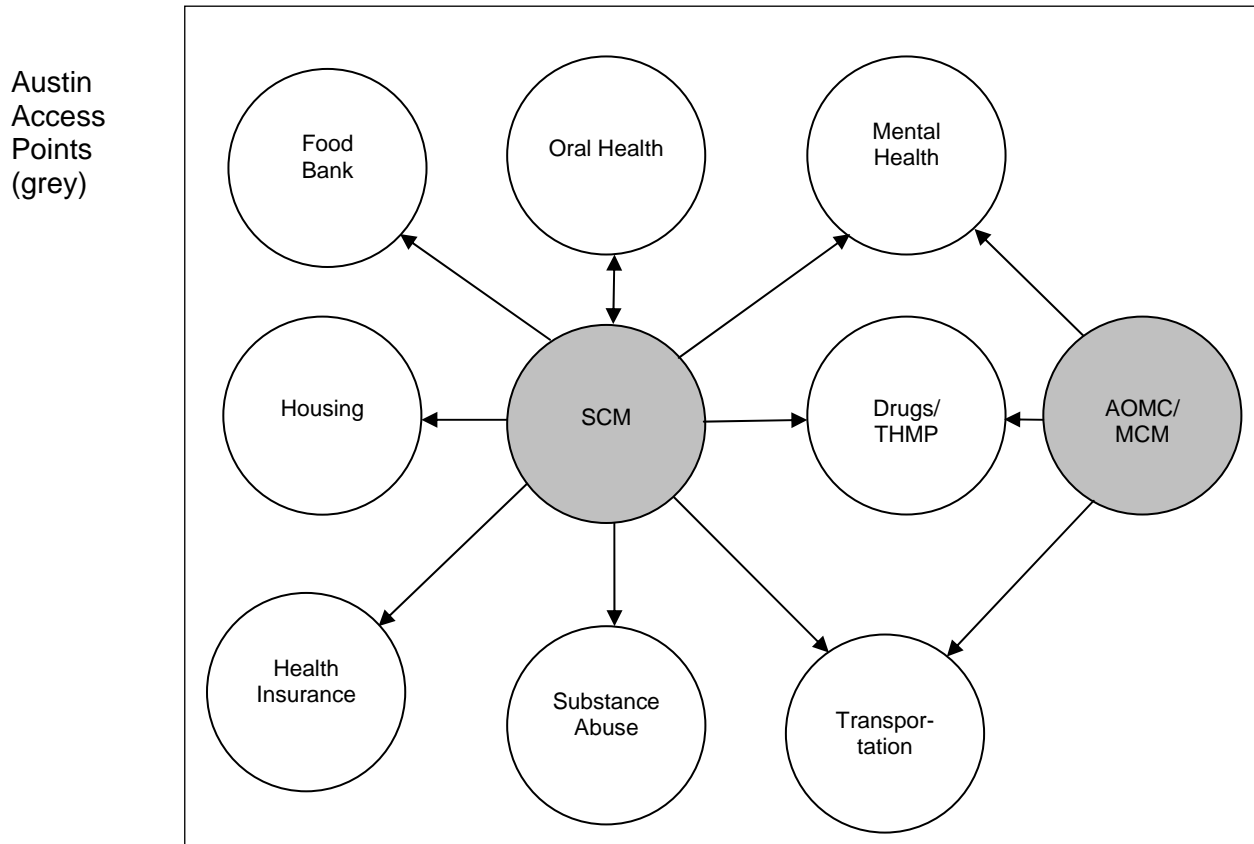


Each of the outlying service points is accessible through a case manager. People are able to access these resources on their own; however, they would not receive financial assistance through Ryan White or State Services funds. If a person would like assistance from Ryan White Part B, the person would be referred to the case management agency, enrolled in case management, and then referred to the appropriate service. The outlying service points are not access points, rather they can serve as referral points.

Other referral points exist throughout the CTHPA. Emergency rooms, testing sites, STD clinics, jail/prison release planning, and homeless shelters are some of the other referral points that will direct a person to the entry point. The needs assessment asked clients about the referral points and the frequency of referral from those sources. The majority of people tested at a community site. At the time of diagnosis, most people were referred into care. The primary source of those is at a community testing site.

The Austin HSDA is different in its system of access points. Social services and medical services are separated, but there are linkages between the two. A person may go to the David Powell Community Health Center and receive medical care funded by Ryan White Parts A, B, and C, but may not need other social services. During intake at David Powell, a client’s needs are assessed and if warranted, the client is referred to a social case management agency for social services such as food bank, housing assistance, etc. The division results in two access points,

medical care and social case management, both of which are able to provide Ryan White services.



For most clients, at the time of diagnosis, they are referred to a case management agency. During the intake, the client’s needs are assessed and a care plan is developed. As needs arise, the case management agency provides services to the client or refers the client to another agency that is able to help them. Within each HSDA, the locations and providers of the 10 care services varies.

- Austin HSDA: Access to the Ryan White system can take place at David Powell, AIDS Services Austin, or Community Action. Someone may access medical care at David Powell, along with medical case management, drug reimbursement, transportation to the appointment(s), and mental health services, all covered by Ryan White funds. Others may enter through a social case management agency, such as ASA or Community Action. Once in social case management, the client may be referred to David Powell for medical care, or any of the other services listed. The client may seek medical care at another location such as the clinic at Community Action. Prescriptions may be filled through other pharmacies, provided that payment has been arranged between the pharmacy and case management agency. For clients in rural areas that do not have transportation or are unable to travel for medical reasons, a case manager may be able to deliver the medication. AIDS Services of Austin Jack Sansing Dental Clinic is the primary provider

of oral health care services in the HSDA. If a client were to seek dental care at ASA without being enrolled in any case management, the client must enter case management at ASA so that the client's care is coordinated among services. Substance abuse and mental health issues are provided by the MHMR CARE unit via referral from the case management agency. Food may be provided to clients at ASA or clients may be given grocery store vouchers at Community Action. Housing assistance is provided by the social case management agency. Assistance with transportation and health insurance costs are also provided by social case management agencies. Clients that have Medicaid and are able to use the Medicaid bus must do so before using transportation assistance from the agency. Agencies can assist with transportation needs by providing bus passes, taxi vouchers, or gas vouchers.

- Bryan – College Station HSDA: To access services, someone must enter social case management at Project Unity / AIDS Services of Brazos Valley. To access medical care, the client sees the physician of their choice. Reimbursement of that care encounter is made from the agency to the physician. Payment arrangements must be made in advance and may be on a continuing basis. Most clients see an infectious disease specialist with whom the agency has established a relationship. For oral health care, the agency will send clients to a dentist that is contracted to provide basic dental services (cleaning, screening, x-rays). For more complex or costly procedures, the agency can take a client to the Bering Dental Clinic in Houston or provide a gas voucher for those with private transportation. Clients in need of mental health services are referred to MHMR (for severe cases) or counselors at Texas A&M University (less severe). For those needing substance abuse services on an outpatient basis, the agency has established a relationship with the Brazos Valley Council on Alcohol and Substance Abuse. Inpatient substance abuse is handled by the Freeman Center in Waco; again the agency may transport the client there or provide a gas voucher. The case management agency has established payment arrangements with many pharmacies located throughout the HSDA so that clients may pick up medications at a convenient pharmacy. If the client does not have transportation or is not able to travel for medical reasons, the case manager may be able to deliver the medication to the client. Food is provided at a food bank located at the social case management agency and purchased from a local food bank. Housing assistance is provided by the case management agency as well. For access to transportation, the agency may give the client a ride in the agency vehicle or be given a gas/taxi/bus voucher. Transportation assistance of any form is only for medical related appointments. Clients that have Medicaid and are able to use the Medicaid bus must do so before receiving transportation assistance from the agency. Assistance with health insurance costs is also provided by the case management agency.
- Concho Plateau HSDA: The case management agency also contains a clinic specifically for PLWHA. The majority of clients access ambulatory care at the agency's clinic and receive medical case management there. Some clients may choose to see a private physician that is covered by their insurance. Oral health care is provided by a dentist contracted by the case management agency. Clients may fill prescriptions at a pharmacy that have an established payment arrangement with the case management agency. New pharmacy locations can be added. Mental health and substance abuse services are

provided by others that contract with the case management agency. Food bank services are provided by having a food bank on site at the agency. They may distribute a food voucher to a local grocery store, or refer to a local food bank. Housing assistance is provided by the agency. Clients may access transportation services for medical related appointments through gas/taxi/bus vouchers distributed by the agency. Clients that have Medicaid and are able to use the Medicaid bus must do so before receiving transportation assistance from the agency. Assistance with health insurance costs is also provided by the case management agency.

- Temple – Killeen HSDA: Ambulatory services, dental care, mental health, medical case management, and medications are all provided at Scott & White Memorial Hospital. To receive care services at Scott & White, the client must meet with their social worker to determine eligibility for low or no cost services. The hospital may charge for some services. To have a cost covered by Ryan White funds, the client must enroll with the social case management agency, Central Texas Support Services (CTSS), which is part of the United Way of the Greater Fort Hood Area. The agency also provides housing assistance, help with costs for health insurance, referral to substance abuse treatment, vouchers for food at grocery stores, and vouchers for gas/taxi/bus to assist with transportation for medical related appointments. For those clients covered by Medicaid and able to do so, the Medicaid bus must be used before receiving transportation assistance with Ryan White funds. Some prescriptions are not covered by the Scott & White patient assistance program, and therefore may be purchased at another pharmacy, provided payment arrangements are made between CTSS and the pharmacy. If a client is unable to travel to a pharmacy, a case manager may be able to deliver the medication. CTSS has continuing payment arrangements with several pharmacies in the HSDA.
- Waco HSDA: The Waco / McLennan County Public Health District is the contracted case management agency for the Waco HSDA. Since they are a part of the health department, they are able to refer clients to the clinic for some lab work and dental care. Beginning April 1, 2007, the agency will provide medical case management in addition to social case management. Most clients in McLennan County seek ambulatory care at the Family Medicine Center (FMC), an FQHC with a sliding fee scale based on income. Due to a lack of capacity, the FMC limits its clientele to only residents of McLennan County. The case management agency can pay the FMC for costs incurred through an established payment relationship. Clients outside of McLennan County are able to see a private physician in Falls County or seek care at Scott & White in Temple. The case management agency does not drive clients to Scott & White, but gas/bus/taxi vouchers are available for assistance with travel to Temple. Medications are provided through payment arrangements with local pharmacies. If a client is unable to travel to a pharmacy, a case manager may be able to deliver the medication. Mental health services are provided through a referral to the DePaul center, for less serious cases, and MHMR for very serious cases. Substance abuse services are provided by referral from the agency to the Freeman Center. The Freeman Center provides both in- and outpatient substance abuse treatment services. Clients are referred to Caritas or the Red Door Project for food bank. Clients may also be able to receive a voucher for food at a local grocery store. Assistance with housing costs as well as costs associated with health insurance are

provided by the case management agency. For assistance with transportation to medical related appointments, the agency can provide the client with a voucher for gas/taxi/bus. Those clients that are covered by Medicaid and are able to do so, must use the Medicaid bus before receiving transportation assistance with Ryan White funds.

Ryan White Part B Contracted Providers and Service Locations

HSDA	Name	Address	Phone / Fax	Hours
Austin	AIDS Services Austin	7215 Cameron Rd Austin, TX 78752	p: 512-458-2437 f: 512-452-3299	8 am – 5pm
		3000-A Medical Arts Austin, TX 78705	p: 512-479-6633 f: 512-479-6617	9 am – 5pm
	Community Action Inc.	204 S. Main St Elgin, TX 78621	p: 512-285-3667 f: 512-285-4030	8 am – 5pm
		1106 College, STE C Elgin, TX 78621	p: 512-303-1403 f: 512-914-0782	
		605 E University #213 Georgetown, TX 78627	p: 512-930-3281 f: 512-948-4031	
	700 N LBJ Dr, STE 111 San Marcos, TX 78666	p: 512-754-6628 f: 512-392-1191		
	David Powell	4614 N IH-35 Austin, TX 78751	p: 512-972-4900 f: 512-972-4940	8 am – 5 pm
Bryan – College Station	Project Unity / AIDS Services Brazos Valley	3705 South College Ave Bryan, TX 77801	p: 979-764-8100 f: 979-764-8155	8 am – 5pm
Concho Plateau	San Angelo AIDS Foundation	334 W Concho San Angelo, TX 76903	p: 325-658-3634 f: 325-658-3703	9 am – 5pm
Temple – Killeen	United Way of the Greater Fort Hood Area/ Central Texas Support Services	2027 S 61 st St STE 100-B Temple, TX 76504	p: 254-778-2495 f: 254-778-4302	8:30 am – 4:30 pm
Waco	Waco / McLennan County Public Health District	225 W. Waco Dr Waco, TX 76707	p: 254-750-5499 f: 254-750-5480	8 am – 5pm

THE CURRENT CARE SYSTEM: Monitoring and Evaluation Procedures

Each agency contracted with the Brazos Valley Council of Governments to provide HIV services must distribute an anonymous client satisfaction survey each year. The surveys are evaluated by the agency as part of their quality management plan. The agencies are required to incorporate client feedback into program improvement efforts and may make changes to how it delivers services based on the responses of the survey. The results of the survey are also sent to BVCOG and reviewed at quality management meetings.

BVCOG monitors its contractors on an annual basis, or more often as needed, through desktop audits and site visits. The desktop audit is performed by examining entries in the client care database, ARIES, to ensure they conform to standards and expectations as set forth in BVCOG policies. The desktop audit also consists of a thorough review of the agency's policies and procedures, quarterly reports, expenditures, performance measures, and timeliness of monthly and quarterly reports. Site visits are performed to ensure that agencies are performing and operating according to the terms of the contract and that services provided meet or exceed professional and clinical standards as set forth by DSHS and BVCOG. Prior to the site visit, clients are mailed a letter asking them to call BVCOG at a toll free number to participate in a short survey about the services they receive. The results of the client surveys assist BVCOG in identifying specific areas of the program that need to be reviewed. Any deficiencies identified through the monitoring process must be addressed by a corrective action plan with specific time tables and action steps. The agency must submit the plan to BVCOG within the time frames requested. Technical assistance in correcting problems is available from BVCOG at the request of the agency. At the end of the time table specified in the corrective action plan, the agency must submit evidence of implementation or, in some circumstances, a follow up visit is performed to ensure all problem areas are corrected. The timeline for the next monitoring visit is decided through the use of a Priority Assessment Tool that determines whether the next visit will occur in one year or within six months based on the number of findings and critical nature of the deficiencies. The tools used to monitor subcontractors combine contractual requirements with professional and clinical standards.

The BVCOG-HIV department meets at least monthly for its quality management committee meeting, during which expenditure and utilization data from each of the agencies is reviewed. The data are compared against the performance measures and objectives specified in the agencies' contracts and applications. Performance measures and objectives, as currently written, are a target number of clients and units of service to provide during the contract period. In future requests for applications / proposals, objectives and performance measures will be outcome based and not solely how many clients / units can be provided in a time period.

Utilization and expenditure review also informs BVCOG of any systemic problems in providing services. For example, under utilization of a particular service may indicate a barrier. Overuse of a service may represent a developing need among clients or another aspect of the system. Trend monitoring of utilization and expenditures shows changes in the care system and health status, such as an increase in units of ambulatory care for the same number of clients.

Evaluation overall is not based on health status or other biological marker, but on client satisfaction and programmatic requirements. The capacity to evaluate services based on health outcomes has not been available until recently. As medical case management is implemented throughout the planning area and further use of the ARIES client level data system grows, monitoring and evaluation based on biological markers or health status will be possible. As more data is entered into ARIES, particularly medical data, it will be possible to take a more in depth look at the relationship between support services use and health status based on markers such as CD4, viral load, hospital visits, and prescription monitoring including those for opportunistic infections.

Because monitoring and evaluation are based in large part on contractual requirements, goals and objectives of this comprehensive services plan will be incorporated in the request for applications / proposals process. Applicants will have to address in their application how they intend to provide services and a care system that supports and works toward the stated goals and objectives of the comprehensive plan.

Section 2: Where Do We Need to Go?

Who we are, who we want to be, and the values that we share, shape the services we provide. In writing this plan, we sought input from clients as well as service providers. Town hall meetings were conducted throughout the planning area during the first week of October, 2006. Clients were mailed an invitational letter, asking for their participation and input. A total of eight meetings were held in the Waco, Temple – Killeen, Concho Plateau, and Bryan – College Station HSDAs, two in each HSDA.

Across all eight meetings, a total of seven clients attended. Service providers were generally double the number of clients present at a meeting. A 30 day comment period opened on the day of a town hall meeting. During the comment period, BVCOG-HIV staff received one phone call to offer input. The lack of participation or interest is perplexing to the BVCOG-HIV staff; however, the communities' input will continue to be sought. The mission, vision, values, and content of this plan was therefore developed solely by BVCOG-HIV staff.

Mission:

The Brazos Valley Council of Governments HIV Administrative Services plans for the use of and administers funds to provide access to good quality medical and social services for anyone living with HIV/AIDS in the Central Texas HIV Planning Area.

Vision:

The Brazos Valley Council of Governments HIV Administrative Services will be the premier administrative agency that is forward looking and innovative, and constantly improving the system of care in our responsibility.

Values:

The values that guide our practices and decisions include data and science based decision making; use of evidence based best practices; a willingness to innovate; to not shy away from difficult changes or challenges; a desire to provide high quality services as defined by professional and clinical organizations such as the Institute for Healthcare Improvement; a belief in continuous quality improvement; planning for the future and agilely responding to change; ethics; compassion; and the voice of the client/patient.

This plan was written with the intent that it would serve as a three year strategic plan for the BVCOG-HIV Administrative Services; that it would guide the contracting and delivery of services for the next three years; and provide a map for others to understand the Ryan White funded system of care in the CTHPA.

Data from the needs assessments conducted by the CCHD and by the Austin Area Comprehensive HIV Planning Council were analyzed to find issues of access and barriers to services, social and medical problems encountered by clients, and to have a better understanding of the clients served and their needs.

Clients reported unfulfilled needs for a variety of services; however 20 to 25 percent reported unfulfilled needs for health insurance, emergency financial assistance, oral health care, and

housing assistance. These four services had the highest levels of unfulfilled need. It was found that overall, personal and cultural barriers were the least reported barrier and that access was the most frequently cited barrier. Needs at the top of the list for those considered out-of-care are different from the top needs of those in-care. After all the data were collected and the surveying time period closed, we found a poorer than hoped for response rate among clients and an especially poor response rate among people that are out of care.

At any level, HRSA, RWTMA grantee (Texas), administrative agency (BVCOG), AIDS service organization (contractor), or client, the overarching goal is to get people into care and keep them in care. Subordinate to that are three broad goals that guide this plan and the goals and objectives for the next three years.

- ⇒ Increase access to services through expansion of services and reduction of barriers
- ⇒ Improve the quality of services provided
- ⇒ Improve the care system through better planning and administration

Improve access to / reduce barriers to services

All services have issues of access and barriers to them, unique to the place in which they are provided and to sub-populations for which they are provided. One role of the BVCOG is to reduce, to the extent possible, any barriers to services. The goals and objectives that pertain to this broad goal are primary to getting people into care.

Improve the quality of services provided

Part of the mission, vision and values of BVCOG are a belief in continuous quality improvement. While quality of services was not measured in the needs assessments, there is a strong desire within BVCOG to measure the quality of care that is being provided and find ways to improve. Goals and objectives that are related to quality are primary to keeping people in care.

Improve the system of care including planning and administration

Other goals and objectives in this plan are not directly related to access and barriers or directly impact the quality of care, but are improvements to the care system overall. The successful completion of systemic goals and objectives results in better planning and administration in the CTHPA. We believe that better planning and administration can lead to better access and better quality of care, and therefore an indirect improvement in accessing services.

Section 3: How Will We Get There?

The three overarching goals of improve access to / reduce barriers to services, improve the quality of services provided, and improve the system of care including planning and administration, are divided into corresponding topic areas, system goals, quality goals, and service access goals. Some objectives will span multiple years, some will continue throughout the three year planning cycle.

Type	Goal: Objective	Year
System and Service Access	GOAL 1: Medical Case Management: transition the CTHPA to a blended medical (MCM) and social case management (SCM) system, rather than social case management only. The end result will be medical case management offered in all HSDAs	
	⇒ OBJECTIVE 1.A: Allocate to the Medical Case Management service category in HSDAs where MCM personnel are currently employed or can be hired within one month of contract initiation.	1, 2
	⇒ OBJECTIVE 1.B: Assess social case management activities that incorporate aspects of medical case management so that activities may be reclassified when appropriate.	1
	⇒ OBJECTIVE 1.C: BVCOG Quality Management Committee (QMC) to review findings of case management activities assessment and develop strategies to address findings.	1
	⇒ OBJECTIVE 1.D: Survey medical case management personnel on data or other tools needed to perform medical case management activities. Results provided to QMC and strategies developed to address findings.	1
	⇒ OBJECTIVE 1.E: Obtain and provide training to subcontracted agencies on combined medical and social case management models.	1, 2
	⇒ OBJECTIVE 1.F: Improve entry of client medical data such as last CD4 test and result, last viral load test and result, in to ARIES so that 90 percent of clients have information present and up to date.	1
	⇒ OBJECTIVE 1.G: Survey medical case management personnel on perceived effectiveness of program and additional tools / resources needed. QMC to review findings and develop further strategies.	2

System	GOAL 2: Issues of further study: conduct small scale, focused studies of need, unfulfilled need, and barriers to Drug Reimbursement, Emergency Financial Assistance, Food Bank, Health Insurance, Housing Assistance, Nutritional Counseling, and Transportation in the CTHPA	
	⇒ OBJECTIVE 2.A Research at least two methods for better survey participation of out-of-care and hard to reach sub-populations, and overall population participation.	1
	⇒ OBJECTIVE 2.B Develop short assessments / surveys for services noted above.	1
	⇒ OBJECTIVE 2.C Recruit clients and people out-of-care for surveying, administer surveys (see Service Access goals.)	2
	⇒ OBJECTIVE 2.D Report findings to QMC and determine actionable items for incorporation into the comprehensive plan.	2

System and Service Access	GOAL 3: Link from incarceration: ensure access to services and medication at release through improved link to service providers	
	⇒ OBJECTIVE 3.A Compile a list of all Federal, State, and County incarceration facilities in the CTHPA and provide to subcontracted agencies.	1
	⇒ OBJECTIVE 3.B Send a request to case management subcontracted agencies that referral source be tracked for all incoming clients and noted in ARIES. Referral source to be monitored quarterly by QMC.	1
	⇒ OBJECTIVE 3.C Assess links from incarceration facilities to subcontracted agencies, survey incarceration medical and release planning staff for knowledge of HIV population in facility, available services upon release, release planning, and information provided at release. Results reported to QMC and subcontracted agencies to determine links that need to be established.	2
⇒ OBJECTIVE 3.D Facilitate linkage between incarceration release planning staff and subcontracted agency in the form of an MOU or other agreement, or through an informal relationship.	2	

System	GOAL 4: Provider network and local collaboration: increase referrals to non Ryan White funded services	
	⇒ OBJECTIVE 4.A Perform a gap analysis in all HSDAs; findings will be compared against resource inventory and results of comparison will be reported to subcontracted agency directors and the BVCOG Contract Monitor.	2
	⇒ OBJECTIVE 4.B Subcontracted agencies to develop MOUs with other organizations / agencies to cover the gaps identified.	2
	⇒ OBJECTIVE 4.C Monitor subcontracted agencies for any increases in the number of MOUs with other social service agencies. Monitor referrals and follow up through ARIES referral tracking and case notes.	2, 3
	⇒ OBJECTIVE 4.D Update resource inventory and perform gap analysis, report gaps to Contract Monitor and subcontract agencies for an updated gap list to cover through MOU development.	3

System	GOAL 5: Support client self advocacy: improve the information given to clients of what services are available from the contracted agency and through referral	
	⇒ OBJECTIVE 5.A Develop standardized client information packet to be given to clients at intake, packets to be distributed to agencies.	1
	⇒ OBJECTIVE 5.B Develop orientation guides specific to an agency to be given to clients detailing services, process, and other resources.	1
	⇒ OBJECTIVE 5.C Follow up survey clients for informational barrier reductions.	2

Quality and Service Access	GOAL 6: Oral health care: shift from reactive, emergency procedure based care model to routine preventative care	
	⇒ OBJECTIVE 6.A Research training materials for case managers to use to teach clients importance of oral health care. QMC to review and select materials. Selected materials provided to subcontracted agencies.	1
	⇒ OBJECTIVE 6.B Send request to case management subcontracted agencies that all case managers educate clients on importance of preventative oral health care based on training materials identified previously and refer clients to oral health care services at care plan / client needs assessment update.	1
	⇒ OBJECTIVE 6.C QMC to monitor utilization and expenditures of oral health prophylaxis and emergency procedures, note any changes in increased prophylaxis and decreased emergency use.	1, 2, 3

Quality and Service Access	GOAL 7: Out-of-care reduction: reduce the number of people out of care / unmet need in each HSDA, particularly in Temple – Killeen HSDA	
	⇒ OBJECTIVE 7.A Survey out-of-care populations (dropped out of care and never made it to care) in non-TGA areas and report results to QMC.	1, 2
	⇒ OBJECTIVE 7.B Assess referral link from testing sites (hospitals, clinics, etc.) to care services and report findings to QMC.	1, 2
	⇒ OBJECTIVE 7.C Research at least two methods / strategies to link people to care who are considered out-of-care.	1, 2
	⇒ OBJECTIVE 7.D Research feasibility of using social networking interventions to bring out-of-care people in to care, report findings to QMC.	1,2
	⇒ OBJECTIVE 7.D.1 Research alternate funding sources for social networking theory project.	2
	⇒ OBJECTIVE 7.E QMC to evaluate findings from surveys and compare to interventions and select appropriate interventions for implementation.	1, 2
	⇒ OBJECTIVE 7.F Develop a plan to implement an intervention for reducing the number of people out-of-care.	1, 2
	⇒ OBJECTIVE 7.G Implement intervention(s) through subcontracted agencies, inclusion in contracts in scope of work.	2, 3
	⇒ OBJECTIVE 7.H QMC will review monthly ARIES report of number of clients considered to be out-of-care.	2, 3

Quality and System	GOAL 8: HERR / Prevention: implement standardized and routine risk assessments at client intake to case management and appropriate referral to an intervention	
	⇒ OBJECTIVE 8.A Research risk assessment tools. QMC to review and select for implementation.	1
	⇒ OBJECTIVE 8.B Provide training to case managers on rapid risk assessment tools and require implementation for screening at client intake and care plan / client needs assessment update.	1
	⇒ OBJECTIVE 8.C Assess link from care services to CDC funded prevention programs and prevention services available. QMC to review findings and develop strategies based on findings.	1, 2
	⇒ OBJECTIVE 8.D Facilitate establishment of regular meetings between CDC funded prevention programs and BVCOG subcontracted agencies (if separate) or regular meetings among staff of prevention and care programs for better collaboration between prevention and services. Agencies report back to BVCOG in quarterly report results of meetings.	1, 2
⇒ OBJECTIVE 8.E Explore possibility of prevention messages for PLWHA being provided at ambulatory and dental care sites, report findings to QMC.	3	

Quality	GOAL 9: Medication adherence: increase medication adherence among clients and integrate into medical case management	
	⇒ OBJECTIVE 9.A Research at least two interventions for medical and social case managers to use with clients on improving medication adherence and report methods to QMC.	1, 2
	⇒ OBJECTIVE 9.B Survey case managers to gauge their perceptions of clients' medication adherence and issues as to why doses may be missed. Findings reported to QMC and used in selecting appropriate interventions.	1, 2
	⇒ OBJECTIVE 9.C QCM review interventions and select those appropriate for implementation.	1, 2
	⇒ OBJECTIVE 9.D Train case managers on importance of medication adherence and train on interventions selected by QMC.	2
	⇒ OBJECTIVE 9.E Monitor case notes for documentation of treatment adherence counseling provided to clients when appropriate.	2, 3
	⇒ OBJECTIVE 9.F Track medication adherence through client self report during case management sessions and monitor case notes for changes in medication regimen due to resistance. Findings to be reported to QMC for possible changes to interventions.	2, 3

Quality	GOAL 10: Preventative vaccinations: increase preventative vaccinations delivered to clients, including hepatitis series and HPV	
	⇒ OBJECTIVE 10.A Quality Management Committee to review screening guidelines and recommended populations for vaccinations.	2
	⇒ OBJECTIVE 10.B Implement screening and risk assessment at intake to medical case management for referral to vaccines when appropriate.	2
	⇒ OBJECTIVE 10.C Monitor client files and ARIES for increases of referrals for clinically indicated vaccines.	3

Service Access	GOAL 11: Health Insurance: increase access to health insurance services	
	⇒ OBJECTIVE 11.A Send request to case management subcontracted agencies that case managers assess clients at least twice a year for eligibility for public insurance programs.	1
	⇒ OBJECTIVE 11.B Send request to case management subcontracted agencies that case managers assess clients' need for assistance with health insurance costs if client is already enrolled in any insurance program (premiums, co-pays, and co-insurance) at least twice a year.	1
	⇒ OBJECTIVE 11.C Survey clients enrolled in Medicare Part D to assess coverage, access, availability, barriers, and costs (including doughnut hole if applicable.)	2
	⇒ OBJECTIVE 11.D Survey clients on needs and barriers to health insurance and report results to QMC.	2
	⇒ OBJECTIVE 11.E QMC to develop strategies to address findings from surveys / assessments.	2
	⇒ OBJECTIVE 11.F Follow up survey clients on barriers and access to health insurance.	3

Service Access	GOAL 12: Housing Assistance: expand access to stable housing	
	⇒ OBJECTIVE 12.A Monitor case notes and client file documentation for evidence of HOPWA screening and HUD Section 8 housing application.	1
	⇒ OBJECTIVE 12.B Survey case managers on client assessment process of housing needs.	1
	⇒ OBJECTIVE 12.C Research other housing assistance services available in each HSDA, including emergency assistance from churches and report findings to social case management subcontracted agency directors.	1
	⇒ OBJECTIVE 12.D Survey clients on needs and barriers to housing assistance and report results to QMC.	2
	⇒ OBJECTIVE 12.E QMC to develop strategies to address findings from surveys / assessments.	2
	⇒ OBJECTIVE 12.F Follow up survey clients on access and barriers to housing assistance.	3

	GOAL 13: Emergency Financial Assistance: increase access to non-Ryan White funded sources of emergency financial assistance	
Service Access	⇒ OBJECTIVE 13.A Survey clients on the needs and barriers pertaining to emergency financial assistance, including the nature of the emergencies and recurrence and report results to QMC.	1
	⇒ OBJECTIVE 13.B Survey case managers on what they see as the top needs of emergency financial assistance, barriers in obtaining assistance for clients, and where assistance is received. Results provided to QMC.	1
	⇒ OBJECTIVE 13.C QMC to develop strategies to address findings from surveys.	1
	⇒ OBJECTIVE 13.D Send request to social case management contracted agencies that social case managers develop plans for clients to reduce the number of financial emergencies clients experience such as documenting referral to debt management, job training, or employment services.	1
	⇒ OBJECTIVE 13.E Develop and implement a tracking system for social case managers to use to monitor the financial emergencies for which clients need assistance and where assistance was received. Results from tracking to be reported to QMC quarterly.	1
	⇒ OBJECTIVE 13.F Follow up survey clients on access and barriers to obtaining emergency financial assistance and number of emergencies experienced.	3

	GOAL 14: Transportation and Food Bank: expand access to transportation and food bank services	
Service Access	⇒ OBJECTIVE 14.A Facilitate establishment of link between subcontracted agency and transit planning authority for inclusion in medical aspects of transportation system. Linkage will result in an MOU or other agreement between the agency and transit planning authority.	1
	⇒ OBJECTIVE 14.B Send request to subcontracted agencies requiring clients use directly funded transportation only for medical and care related appointments and evidence of completed appointment.	1
	⇒ OBJECTIVE 14.C Survey clients on needs and barriers to transportation and food bank services and report results to QMC.	2
	⇒ OBJECTIVE 14.D QMC to develop strategies based on findings from assessments / surveys.	2

	GOAL 15: Mental Health and Substance Abuse Treatment: increase access and ease of access to mental health services and substance abuse treatment	
Service Access	⇒ OBJECTIVE 15.A Complete an assessment of capacity at directly-funded and non-funded mental health counseling and substance abuse treatment agencies and report findings to QMC.	1
	⇒ OBJECTIVE 15.B QMC review findings and develop strategies to address findings.	1
	⇒ OBJECTIVE 15.C Research at least two risk assessment and other screening tools for medical and social case managers to use at intake and periodically assess clients; report findings to QMC who will select appropriate tools and distribute to case management subcontracted agencies for implementation.	1
	⇒ OBJECTIVE 15.D Provide training to case managers on risk assessment tools selected by QMC.	1
	⇒ OBJECTIVE 15.E QMC to monitor utilization and expenditures of mental health and substance abuse services at monthly meeting. Contract monitor to review case notes and client files for evidence of referrals to services when indicated.	2

Section 4: How Will We Monitor Our Progress?

Through some of the goals and objectives, we will start to move in the direction of health status monitoring and examining medical outcomes. The addition of a registered nurse for clinical monitoring will help facilitate this process. For monitoring progress towards the objectives of this plan, and for monitoring agencies contracted with BVCOG, we will continue to use our current monitoring practices and methods. Many of the goals and objectives will be included in the request for proposals / applications and subsequently incorporated into contracts between BVCOG and its contracted service providers. Current monitoring practices will be able to detect progress towards goals and objectives with minimal modification of subcontractor monitoring tools.

BVCOG monitors its contractors on an annual basis, or more often as needed, through desktop audits and site visits. The tools used to monitor subcontractors combine contractual requirements with professional and clinical standards. The desktop audit is performed by examining entries in the client care database, ARIES, to ensure they conform to standards and expectations as set forth in BVCOG policies. The desktop audit also consists of a thorough review of the agency's policies and procedures, quarterly reports, expenditures, performance measures, and timeliness of monthly and quarterly reports.

Prior to a site visit, clients are mailed a letter asking them to call BVCOG at a toll free number to participate in a short survey about the services they receive. The results of the client surveys assist BVCOG in identifying specific areas of the program that need to be reviewed. Site visits are performed to ensure that agencies are performing and operating according to the terms of the contract and that services provided meet or exceed professional and clinical standards as set forth by DSHS and BVCOG.

Any deficiencies identified through the monitoring process must be addressed by a corrective action plan with specific time tables and action steps. The agency must submit the plan to BVCOG within the time frames requested. Technical assistance in correcting problems is available from BVCOG at the request of the agency. At the end of the time table specified in the corrective action plan, the agency must submit evidence of implementation or, in some circumstances, a follow up visit is performed to ensure all problem areas are corrected.

The BVCOG-HIV department meets at least monthly for its quality management committee meeting, during which expenditure and utilization data from each of the agencies is reviewed. The data are compared against the performance measures and objectives specified in the agencies' contracts and applications. Performance measures and objectives, as currently written, are a target number of clients and units of service to provide during the contract period. Performance measures will be outcome based and guided by the goals and objectives of this plan, not solely how many clients / units can be provided in a time period. The quality management committee reviews quarterly reports from subcontractors to further monitor performance and service delivery. Information provided in the quarterly reports provides another avenue for tracking progress of comprehensive plan goals and objectives.

A master log of comprehensive plan progress will be created, tracking progress for each objective and overall goals. On a quarterly basis, the BVCOG-HIV quality management committee will review the goals and objectives of this plan, examine the data acquired from subcontractors and other sources, and update the tracking log accordingly. At the end of a planning year, a progress report will be generated detailing the progress made towards the goals and objectives as well as update parts of the plan, such as allocations. Goals and objectives and their associated tasks and timelines may be updated based on progress made in the preceding year. The progress report will be distributed to subcontractors and published on the BVCOG-HIV departmental web site.

Appendix A – Counties In The Planning Area

Austin HSDA: Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis, Williamson

Austin TGA: Bastrop, Caldwell, Hays, Travis, Williamson

Bryan – College Station HSDA: Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington

Concho Plateau HSDA: Coke, Concho, Crockett, Irion, Kimble, McCulloch, Mason, Menard, Reagan, Schleicher, Sterling, Sutton, Tom Green

Temple – Killeen HSDA: Bell, Coryell, Hamilton, Lampasas, Milam, Mills, San Saba

Waco HSDA: Bosque, Falls, Freestone, Hill, Limestone, McLennan

Appendix B – Service Category Rankings

It is important to note that the above process was applied only to priorities for the Bryan – College Station, Concho Plateau, Temple – Killeen, and Waco HSDAs. The Austin HSDA uses the same priorities set by the Austin Area Comprehensive HIV Planning Council. Services in the following tables that are red or grey (depending on print) are core medical services.

Austin HSDA Service Priorities 2007			
1	Outpatient & Ambulatory Health Services	15	Health Education / Risk Reduction
2	Medical Case Management including Treatment Adherence	16	Housing Services
3	Mental Health Services	17	Food Bank / Home Delivered Meals
4	Substance Abuse Services – Outpatient	18	Outreach Services
5	Hospice Services	19	Medical Transportation Services
6	Early Intervention Services	20	Psychosocial Support Services
7	Oral Health Care	21	Treatment Adherence Counseling
8	Health Insurance Premium Assistance & Cost Sharing Assistance	22	Child Care Services
9	AIDS Pharmaceutical Assistance – Local	23	Respite Care
10	AIDS Drug Assistance Program (ADAP) Treatments	24	Emergency Financial Assistance
11	Medical Nutrition Therapy	25	Legal Services
12	Home and Community Based Health Services	26	Linguistic Services
13	Home Health Care	27	Referral for Health Care / Supportive Services
14	Case Management – Non-Medical	28	Rehabilitation Services

Bryan – College Station HSDA Service Priorities 2007			
1	Case Management – Non-Medical	10	Legal Services
1	Medical Case Management	11	Outreach Services
2	Ambulatory / Outpatient Medical Care	11	Referral for Healthcare / Supportive Services
3	AIDS Pharmaceutical Assistance – Local	12	Hospice Services
3	Oral Health Care	12	Health Education / Risk Reduction
3	Medical Transportation	12	Rehabilitation Services
4	Health Insurance Continuation	13	Early Intervention Services
5	Food Bank / Home Delivered Meals	14	Child Care Services
6	Housing Services	14	Respite Care
7	Emergency Financial Assistance	14	Treatment Adherence Counseling
8	Home Health Care	15	Medical Nutrition Therapy
9	Substance Abuse Services – Outpatient	NR	Home and Community Based Health Services
9	Mental Health Services	NR	Linguistic Services
10	Psychosocial Support Services		

Concho Plateau HSDA Service Priorities 2007			
1	Case Management – Non-Medical	9	Referral for Healthcare / Supportive Services
1	Medical Case Management	11	Home Health Care
1	AIDS Pharmaceutical Assistance – Local	11	Hospice Services
2	Oral Health Care	11	Medical Nutrition Therapy
3	Ambulatory / Outpatient Medical Care	12	Rehabilitation Services
4	Housing Services	13	Early Intervention Services
5	Food Bank / Home Delivered Meals	14	Treatment Adherence Counseling
6	Medical Transportation	15	Outreach Services
7	Mental Health Services	16	Psychosocial Support Services
8	Health Insurance Continuation	16	Child Care Services
8	Health Education / Risk Reduction	16	Respite Care
8	Emergency Financial Assistance	NR	Linguistic Services
8	Legal Services	NR	Home and Community Based Health Services
9	Substance Abuse Services - Outpatient		

Temple – Killeen HSDA Service Priorities 2007			
1	Case Management – Non-Medical	9	Legal Services
1	Medical Case Management	10	Substance Abuse Services – Outpatient
2	Ambulatory / Outpatient Medical Care	10	Outreach Services
2	AIDS Pharmaceutical Assistance – Local	11	Rehabilitation Services
3	Oral Health Care	12	Early Intervention Services
4	Medical Transportation	13	Medical Nutrition Therapy
5	Health Insurance Continuation	13	Psychosocial Services
6	Mental Health Services	14	Health Education / Risk Reduction
7	Home Health Care	14	Treatment Adherence Counseling
7	Emergency Financial Assistance	15	Child Care Services
8	Housing Services	15	Respite Care
8	Referral for Healthcare/Supportive Services	NR	Linguistic Services
9	Hospice	NR	Home and Community Based Health Services
9	Food Bank / Home Delivered Meals		

Waco HSDA Service Priorities 2007			
1	Ambulatory / Outpatient Medical Care	10	Outreach Services
1	Case Management – Non-Medical	11	Early Intervention Services
1	Medical Case Management	12	Hospice Services
2	AIDS Pharmaceutical Assistance – Local	12	Medical Nutrition Therapy
3	Oral Health Services	12	Psychosocial Supportive Services
3	Medical Transportation	12	Legal Services
4	Health Insurance Continuation	12	Treatment Adherence Counseling
5	Mental Health Services	13	Rehabilitation Services
6	Food Bank / Home Delivered Meals	14	Health Education / Risk Reduction
7	Emergency Financial Assistance	15	Child Care Services
8	Substance Abuse Services – Outpatient	15	Respite Care
8	Housing Services	NR	Home and Community Based Health Services
8	Referral for Healthcare / Supportive Services	NR	Linguistic Services
9	Home Health Care		

Appendix C – FY2007 Allocations for RW-B and SS

Following are the allocations and justifications for the 2007 grant year. This provides a detailed accounting of the services that will be available directly through the use of Ryan White Part B and HIV Health and Social Services (State Services) funds.

Austin HSDA Part B Allocations 2007-2008:

Service	Priority	Ryan White	State Services	Description
Ambulatory / Outpatient Medical Care	1	\$722,663	\$124,509	Increased above 06-07 to address shortfall in lab services.
Mental Health Services	3	\$0	\$20,000	New psychiatric program being offered through donations, this will bridge the gap at the end of donation funding. May be reallocated out if Part C expansion grant picks up this service.
Oral Health Services	7	\$77,876	\$0	Increased based on needs assessment results indicating high levels of unmet need for Oral Health as well as insufficient funding to maintain the standard of care for prophylaxis.
Health Insurance Continuation	8	\$18,000	\$57,000	Significant increase to cover Part D premiums and co-pays as well as to eliminate a service cap on premium assistance, offering more complete coverage for clients.
AIDS Pharmaceutical Assistance – Local	9	\$80,000	\$21,837	Reduced on expectation of Medicare Part D savings.
Case Management – Non-Medical	14	\$21,780	\$216,919	Increase over 06-07 to account for cost of living and a reduction in a five month gap for a split SS contract.
Food Bank / Home Delivered Meals	17	\$0	\$10,000	Slight increase from 06-07.
Medical Transportation	19	\$0	\$26,644	Increase from 06-07 to help in covering increased fuel cost and for rural clients to access new services such as Medical Case Management and Mental Health.
	Total	\$920,319	\$476,909	

Bryan – College Station HSDA Allocations 2007-2008:

Service	Priority	Ryan White	State Services	Description
Case Management – Non-Medical	1	\$160,252	\$46,968	Threshold \$210,954. Based on changes at agency and CM is not unit cost based, allocation adjusted down from threshold. Reduction of \$2,111 from 06-07 moved to other categories.
Medical Case Management	1	\$30,070	\$0	No threshold calculation. Allocation based on estimate of part time medical case manager providing service.
Ambulatory / Outpatient Medical Care	2	\$29,500	\$0	Threshold \$40,315. Based on previous expenditures, allocation was adjusted down from threshold. \$864 increase from 06-07
AIDS Pharmaceutical Assistance - Local	3	\$20,000	\$0	Threshold \$14,874. Based on past expenditures, threshold calculation underestimated need.
Oral Health Services	3	\$15,000	\$0	Threshold \$6,819. Calculation severely under-represents need. Assessment indicates high level of unmet need. More use of local dentist than clinic in Houston.
Medical Transportation	3	\$3,000	\$17,795	Threshold \$29,538. Changes to transportation use for Oral Health reduce the need for previous levels of transportation.
Health Insurance Continuation	4	\$10,000	\$0	Threshold \$4,715. Part D increases cost were not part of threshold calculation.
Food Bank / Home Delivered Meals	5	\$0	\$5,000	Remained level and at threshold.
Mental Health Services	9	\$2,000	\$0	Threshold \$3,460. Threshold best guess calculation, no previous usage to base on.
Substance Abuse - Outpatient	9	\$1,000	\$0	Threshold \$2,907. No previous use to base calculation on. Best guess threshold calculation.
Medical Nutrition Therapy	15	\$10,000	\$0	No threshold calculation. Allocation based on estimate of part time counseling and supplements provided.
	Total	\$280,822	\$69,763	

Concho Plateau HSDA Allocations 2007-2008:

Service	Priority	Ryan White	State Services	Description
AIDS Pharmaceutical Assistance - Local	1	\$36,500	\$0	Threshold \$36,224
Case Management – Non-Medical	1	\$8,870	\$44,467	Threshold \$83,571. Portion of threshold calculation would have included Medical Case Management.
Medical Case Management	1	\$50,000	\$0	No Threshold calculation, this is the first year of funding.
Oral Health Services	2	\$4,800	\$0	Threshold \$4,758
Ambulatory / Outpatient Medical Care	3	\$63,899	\$0	Threshold \$26,052. Based on previous expenditures, as well as other funding source changes, allocation increased.
Food Bank / Home Delivered Meals	5	\$0	\$5,000	Threshold \$10,703. Under threshold to adjust for decreased Ryan White funds, more SS placed in SCM.
Medical Transportation	6	\$0	\$9,553	Threshold \$5,687, increased to help with fuel costs.
Mental Health Services	7	\$3,631	\$0	Threshold \$4,592. Under threshold to account for increases in higher priority core medical services.
Health Insurance Continuation	8	\$11,631	\$0	Threshold \$18,423. Based on previous expenditures and number of clients with insurance, adjusted down from threshold.
	Total	\$179,331	\$59,020	

Temple – Killeen HSDA Allocations 2007-2008:

Service	Priority	Ryan White	State Services	Description
Case Management – Non-Medical	1	\$141,521	\$60,502	Threshold \$205,643. Calculation is based on a unit cost and CM does not use. Reduced \$5,647 from 06-07 level to hold harmless core medical services from RW reductions.
Ambulatory / Outpatient Medical Care	2	\$25,873	\$0	Threshold \$8,520. Scott & White provides majority of AOMC care at no cost. Additional may be reallocated to other HSDA.
AIDS Pharmaceutical Assistance - Local	2	\$77,679	\$0	Threshold \$87,725. Calculation based on previous allocations. Part D savings as well as changes to the medications purchased will result in savings, adjusted down from threshold.
Oral Health Services	3	\$15,000	\$0	Threshold \$18,675. Based on previous expenditures and S&W care, adjusted down from threshold.
Medical Transportation	4	\$0	\$10,818	Threshold \$11,521. Funded less than threshold to place funds in other core services
Health Insurance Continuation	5	\$45,304	\$0	Threshold \$9,156. Calculation did not have Part D costs included, adjusted up from threshold.
Food Bank / Home Delivered Meals	9	\$0	\$3,081	Threshold \$8,606. Less than threshold to place funds in other core services.
	Total	\$305,377	\$74,401	

Waco HSDA Allocations 2007-2008:

Service	Priority	Ryan White	State Services	Description
Ambulatory / Outpatient Medical Care	1	\$51,607	\$0	Threshold \$30,731. Based on previous expenditures and need for AOMC care closer to Waco, increased above threshold.
Case Management – Non-Medical	1	\$85,000	\$37,793	Threshold \$191,086. Calculation did not split between Social and Medical.
Medical Case Management	1	\$81,000	\$0	First year of funding Medical Case Management, no threshold calculated.
AIDS Pharmaceutical Assistance - Local	2	\$63,606	\$0	Threshold \$61,295.
Oral Health Services	3	\$35,606	\$0	Threshold \$23,358.
Medical Transportation	3	\$0	\$18,249	Threshold \$7,592. Calculation based on costs from 2005. Increased over threshold to help cover fuel costs.
Health Insurance	4	\$25,000	\$0	Threshold \$18,083. Based on previous expenditures, adjusted down from threshold.
Mental Health	5	\$1,500	\$0	Threshold \$222. Added to accommodate more clients in counseling services.
Food Bank / Home Delivered Meals	6	\$0	\$29,960	Threshold \$61, 176. Adjusted down to move funds to core services, more unfulfilled need in core services like Oral Health.
Total		\$343,319	\$86,002	