San Antonio Area HIV Health Service Planning Council

2012-2016

Comprehensive HIV/AIDS Services Plan

Ryan White Parts A & B

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ACRONYMS

AA: Administrative Agency

AACOG: Alamo Area Council of Governments

AARC: Alamo Area Resource Center

ACA: Affordable Care Act

ADAP: AIDS Drug Assistance Program through the TX HIV Medication Program

AETC: AIDS Education and Training Center

AIDS: Acquired Immunodeficiency Syndrome diagnosed (caused by HIV)

ARIES: AIDS Regional Information and Evaluation System

ASO: AIDS Service Organization

BCDCR: Bexar County Department of Community Resources

CBI: Community Based Initiative

CDC: Centers for Disease Control and Prevention

CHIP: Children's Health Insurance Program

CNA: Comprehensive Needs Assessment

DSHS or TX DSHS: Texas Department of State Health Services

EFA: Emergency Financial Assistance

EIIHA: Early Identification of Individuals with HIV/AIDS

EIS: Early Intervention Service

FPL: Federal Poverty Level

FQHC: Federally Qualified Health Center

HASA: HIV/AIDS Administrative Service Area

HERR: Health Education/Risk Reduction

HIV: Human Immunodeficiency Virus

HOPWA: Housing Opportunities for Persons with AIDS

HRSA: Health Resources and Services Administration (under the USDHHS)

HSDA: HIV Service Delivery Area (San Antonio, Victoria, Uvalde)

IDU: Injection Drug Use(r)

MOU: Memorandum of Understanding

MSM or **MMS**: Men who have Sex with Men

NHAS: National HIV/AIDS Strategy

OAMC: Outpatient/Ambulatory Medical Care

OB/GYN: Obstetrical/Gynecological services for women

OOC: Out of Care

PLWHA: People/Person(s) Living with HIV or AIDS

QM and **QMC**: Quality Management and Quality Management Committee

SAMHSA: Substance Abuse Mental Health Services Administration

SNG: Severe Need Group(s)

SOC: Standards of Care

SPOC: Single Point of Contact

STD or **STI**: Sexually Transmitted Disease or Sexually Transmitted Infection

STFAN: South Texas Family AIDS Network

STRMU: Short Term Utility, Rent and Mortgage Assistance

TA: Technical Assistance

TANF: Temporary Assistance for Needy Families (formerly AFDC)

TB: Tuberculosis

TBRA: Tenant Based Rental Assistance

TDCJ: Texas Department of Criminal Justice

TGA: Transitional Grant Area

TXSCSN or **SCSN**: Texas Statewide Coordinated Statement of Need

UHS: University Health System

USDHHS: U.S. Department of Health and Human Services

VA: Veterans Administration

WOC: Women of Color

EXECUTIVE SUMMARY

Development of this San Antonio HIV Administrative Services Area (HASA) Ryan White Parts A and B 2012 – 2015 Comprehensive HIV/AIDS Services Plan resulted from a cooperative process between the Bexar County Department of Community Resources (BCDCR) and the San Antonio Ryan White Planning Council (herein referred to as "Planning Council"). These two organizations jointly provide a strong foundation for achieving the goals of this Plan.

- The Planning Council has stable leadership, and hard-working, dedicated members.
- The BCDCR, since assuming administrative agency (AA) responsibility in 2008, draws on its many community partnerships to:
  - Enhance collaborations between Ryan White funded agencies and other community organizations.
  - Transfer knowledge and expertise throughout the community to improve care for PLWHA and other severe needs populations.
  - Establish new community collaborations, such as the 92-member San Antonio HIV/Syphilis Testing Taskforce, of which the BCDCR was a founding member.
  - Improve the quality of Ryan White care and services for people living with HIV/AIDS (PLWHA) through an enhanced quality management program.

Although this Plan is ambitious, it is achievable with the AA and the BCDCR continuing to work together to achieve their mission.

Mission

To create a broad-based community response to the HIV epidemic affecting people within the Transitional Grant Area and to ensure the availability and coordination of high quality, comprehensive health and social services to individuals infected or affected by HIV.

Vision

To have the SAHASA become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have immediate access to a high quality continuum of HIV care and services, free from stigma and discrimination.

Shared Values

- Strive for a seamless system of coordinated care meeting consumer needs.
- Provide the highest quality care and services in the most cost-effective manner.
- Ensure equal and easy access to services.
- Ensure that all services are culturally competent and sensitive.
- Treat all consumers with compassion and respect.

I. WHERE WE ARE NOW: WHAT IS IN OUR CURRENT SYSTEM OF CARE?

The SAHASA Region

The SAHASA is divided into four areas as follows:

- San Antonio Transitional Grant Area (TGA) is comprised of four (4) counties, Bexar, Comal, Guadalupe, and Wilson. The Planning Council is responsible for determining the needs of the HIV affected community within the San Antonio TGA. San Antonio HIV Services Delivery Area (HSDA) is comprised of 12 counties including those in the TGA and Atascosa, Bandera, Frio, Gillespie, Karnes, Kendall, Kerr, and Medina.
- Uvalde HSDA includes nine counties: Dimmit, Edwards, Kinney, La Salle, Maverick, Real, Uvalde, Val Verde, and Zavala.
- Victoria HSDA includes seven counties: Calhoun, Dewitt, Goliad, Gonzales, Jackson, Lavaca, and Victoria.

This region is diverse, with the following characteristics:

- With 1.7 million residents, Bexar County, home to San Antonio, is the population center of the region.
- The region combines urban and rural areas. Bexar County has a population density of 1,383 people per square mile while the Uvalde HSDA has only 6.5 people per square mile and the Victoria HSDA averages 31.4 people per square mile.

  - The San Antonio TGA, San Antonio HSDA, and Uvalde HSDA are minority-majority areas, with 55%, 53%, and 83% Hispanic residents, respectively.
  - In Bexar County, 43% of residents speak a language other than English at home. Similar percentages are found in the SATGA and SAHSDA. In the Uvalde HSDA, nearly three quarters of residents do not speak English at home, while a quarter of Victoria HSDA residents do not speak English at home.
  - The Uvalde HSDA has the highest poverty rate in the region, 29.8%. All other areas have poverty rates between 15.8% and 16.9%.
  - The two most rural areas have the lowest levels of educational attainment. In the Uvalde HSDA, 62% of residents have completed high school, and in the Victoria HSDA 77% are high school graduates. This compares to 82% in the San Antonio TGA and HSDA.

2010 Epidemiological Profile[1]

Between 2006 and 2010, **the epidemic increased in all of the HSDAs**. The number of PLWHA increased by:

- 24% in the San Antonio HSDA to 4,628 people. Bexar County accounted for 93% of PLWHA in the San Antonio HSDA.
- 19% in the Victoria HSDA to 145 people with 61% residing in Victoria County.
- 49% in Uvalde HSDA to 97 people. Forty-four percent reside in Maverick County, home of Eagle Pass.

Considering the regional HIV **epidemic by race/ethnicity**:

- Hispanics comprise 56% of the San Antonio HSDA epidemic followed by Whites (30%) and Blacks/African Americans (15%).
  - Blacks/African Americans have the highest infection rate in the region at 455/100,000.
  - Between 2006 and 2010, the San Antonio HSDA experienced a 24% increase in Hispanic PLWHA and a 32% increase in African American PLWHA.
- In the Victoria HSDA Whites comprise the largest percentage of PLWHA, 40%. This is followed by Hispanics (38%) and Blacks/African Americans (22%).
- In the Uvalde HSDA, Hispanics comprise 80% of the HIV/AIDS epidemic. This population experienced a 57% increase between 2006 and 2010.

Consumers who are **"late to care"** are those that convert from HIV to AIDS within one year of initial diagnosis. These individuals not only experience personal health concerns but also present public health issues since they may have been carriers of HIV disease for a long period of time.[2]

- In the San Antonio HSDA, 37% of newly diagnosed PLWHA were late to care. This includes 39% of Whites and Hispanics and more than 40% of all women diagnosed.
- Among newly diagnosed consumers in Victoria HSDA, 36% were late to care, including 83% of Whites (please note total cases of 5 people).
- More than half of consumers in the Uvalde HSDA were late to care, including 60% of Whites and 51% of Hispanics.

In 2010, a total of 1,375 PLWHA in the SAHASA were **not receiving HIV medical care and had an "unmet need."**[3] This included:

- 28% of PLWHA in the San Antonio HSDA, 33% of PLWHA in the Uvalde HSDA and 21% in the Victoria HSDA.

[1] The SATGA and the SAHSDA have very similar epidemiology profiles. Therefore, throughout this section the SAHSDA data will be used unless differences between the two areas are apparent or data are unavailable.
[2] Available data combine late to care consumers diagnosed between 2005 and 2009.
[3] Unmet need is defined by HRSA as no viral load test, no CD4 count and no antiretroviral medication for 12 months. The estimate provided by the Texas DSHS also include not medical care visit when available.

- In the San Antonio HSDA, Blacks/African Americans and Whites were more likely to have an unmet need than Hispanics. In both the Victoria and Uvalde HSDAs, Hispanics had the highest percentage with unmet need.
- Throughout the SAHASA, PLWHA age 25 to 34 were the most likely to be out of care, including 33% in the San Antonio HSDA, 40% in the Uvalde HSDA and 29% in the Victoria HSDA.

It has been estimated that a total of 1,141 PLWHA are living in the San Antonio TGA and are **unaware** of their HIV status. The profile of these unaware consumers is similar to the overall regional epidemic: predominantly male (84%), a majority of Hispanic residents (55%) and two-thirds resulting from MSM transmission and 17% from heterosexual contact.

Continuum of Care

The Administrative Agency and the Planning Council are committed to increasing access to care and decreasing health disparities, with particular emphasis on the needs of newly infected and disproportionately impacted populations. The SAHASA Ryan White Program funds 11 core medical and six support services.

- Five providers are located in San Antonio and together they provide 16 of the 17 services in the continuum. Transitional housing is the exception, and that is funded in San Antonio through Housing Opportunities for People with AIDS (HOPWA).
- For the rural HSDAs, one provider is located in Victoria serving the Victoria HSDA and the other is located in Eagle Pass serving the Uvalde HSDA.
    - United Medical Center in Eagle Pass provides 13 services of which eight are core medical and five are support services.
    - Victoria City/County Health Department provides 10 services including six core medical and four support services.

Innovative early intervention services (EIS) are funded at two San Antonio HSDA providers and one Uvalde HSDA provider. These programs effectively provide out of care and newly diagnosed PLWHA with counseling, testing, referral and linkage to care, and necessary support to remain in the care system.

The SAHASA **Early Identification of Individuals with HIV/AIDS (EIIHA) strategy** provides a complete continuum of prevention, routine and targeted counseling, testing, and early intervention services (EIS) through the integration of three components:

1. The San Antonio HIV/Syphilis Testing Taskforce—a collaboration with more than 90 members.
2. Routine testing efforts at the county hospital system and at a Federally Qualified Health Center (FQHC).
3. San Antonio TGA/HSDA Ryan White funded EIS programs.

Interaction Between Ryan White Funded and Other Care/Services to Ensure Continuity

All of the Ryan White funded care and service providers are well established and have strong community connections. Providers work together to optimize available services for PLWHA, always maintaining Ryan White as the payer of last resort.

Changing the administrative agency in 2008 to the Bexar County Division of Community Resources has allowed significant expansion in coordination and collaboration between the Ryan White Program and other community organizations. Management has a strong understanding of community issues and is expert at bringing key partners/collaborators to the table. They have been instrumental in organizing community collaborations to expand services for PLWHA including:

- The San Antonio HIV/Syphilis Testing Taskforce which has resulted in strong collaborations between area outreach, counseling/testing, early intervention and care providers.
- The San Antonio Health Collaborative, which includes representatives from leading hospitals, the San Antonio Metropolitan Health District, key community organizations and BCDCR.
- The Mental Health Consortium which has received grant funding to expand and improve mental health services and the mental health continuum of care in the region.
- The Ryan White Quality Management Committee which includes not only providers from all Ryan White parts but also private providers.

Assessment of the Needs of People Living with HIV/AIDS

The Planning Council conducted Comprehensive Needs Assessments (CNA) in 2009 and 2011 and a Mini-Needs Assessment in 2010. Using data from these needs assessment has allowed the Planning Council and the AA to respond to consumer needs, reduce gaps in the continuum and enhance the quality of care and services available to PLWHA in the region.

II. WHERE DO WE NEED TO GO?

The Comprehensive Planning Process

The planning process that produced this 2012 – 2015 Comprehensive HIV/AIDS Services Plan included:

- Evaluation of the 2008 – 2011 Comprehensive Plan and review of 2009, 2010 and 2011 needs assessment findings.
- Consideration of national issues including: National HIV/AIDS Strategy, *Healthy People 2020* HIV objectives, expected changes resulting from the Affordable Care Act (ACA).
- Review of information from the Texas Department of State Health Services (TDSHS) related to upcoming requirements, possible funding changes and other statewide issues.
- Review and evaluation of the 2008 - 2011 San Antonio Area Comprehensive HIV/AIDS Services Plan.
- Review and revision of the mission, vision and shared values.

- Development of goals and strategies by the CPCC Committee and the AA.
- Development of actions by the parties that will be responsible for implementation, with Planning Council committees and the AA providing detailed input.

2012 – 2015 Goals

The first goal of the plan focuses on the continuum of care – increasing access, engagement and retention in services. It specifically states:

- ***Goal I: Increase access, engagement and retention in quality care and services for PLWHA.***

Two goals address identifying PLWHA who are either unaware of their HIV status or aware but not receiving HIV medical care, linking and retaining them in care. One outlines the specific activities required to accomplish these tasks, and the other focuses on the stigma of HIV in the region that causes people to hide their HIV status or avoid testing. Specific goals include:

- ***Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.***
- ***Goal III: Reduce health disparities resulting from the stigma of HIV in the region***.

Goal IV provides detail to continue and expand the SAHASA's successful quality management program as follows:

- ***Goal IV: Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.***

The final goal of the plan supports coordination with other providers and available funding sources to ensure that Ryan White is the payer of last resort and changes in funding are anticipated so that PLWHA care and services will be supported and maintained.

- ***Goal V: Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget cuts and implementation of the Affordable Care Act.***

III. HOW WILL WE GET THERE?

This Plan outlines specific strategies and actions that the Planning Council committees and the AA will take to achieve all goals. An overview is provided below.

The strategies and actions associated with **Goal I** will expand and enhance the continuum of care for PLWHA. Specifically:

- Strategy I.A focuses on maintaining the current service system, enhancing it and ensuring it is seamless to achieve the National HIV/AIDS Strategy goal of 85% of Ryan White clients accessing and maintaining HIV medical care. It will be accomplished by:

- Increasing the percentage of Ryan White clients receiving HIV medical care from 74% to 85%. This uses FY2011 ARIES data as the baseline.
- Providing training to local primary care physicians annually.
- Building capacity in rural locations to increase the number of PLWHA treated in their local communities by 5% annually. Telemedicine will be considered for capacity building. In addition it increases utilization of rural case managers by 5% annually.
- Engaging co-located primary care and medical specialists in the Ryan White care system to effectively treat PLWHA with co-morbid conditions.
- Expanding PLWHA treatment options by enhancing linkages to Ryan White and non-Ryan White funded providers.

- Strategy I.B increases collaboration to expand services available to PLWHA. It will be accomplished by:
  - Increasing collaborations with Medicaid service providers, and community partners that promote client self-sufficiency.
  - Identifying collaborative partners' training needs and providing at least one training program annually.

- Strategies I.C through 1.G focus on expanding specific services within the care continuum including: oral health care (I.C), mental health services (I.D), residential substance abuse treatment (I.E), housing (I.F), and transportation (I.G).

Goal II strategies address the needs of individuals aware of their HIV status but not in care:

- Strategy II.A targets populations or geographic areas for early intervention, outreach, and testing services. It will be accomplished by:
  - Conducting annual needs assessments to identify target/focus populations; developing and implementing plans to reach them; and evaluating results prior to beginning the process with another target population.

- Strategy II.B ensures immediate linkage for all newly diagnosed PLWHA with a seamless service system resulting in a 2% annual increase in the percentage of newly diagnosed linked to HIV medical care. This will be accomplished by:
  - Educating and supporting all counseling and testing providers to ensure HIV positive clients are linked to appropriate services.
  - Monitoring newly diagnosed and returned-to-care clients to ensure they are retained in HIV medical care for at least six months from referral.
  - Expanding the patient navigator program to support newly diagnosed and returned-to-care for at least six months after beginning HIV medical care.

- Strategy II.C focuses on people with negative HIV test results to ensure linkage with appropriate community resources to provide risk reduction and education.

Goal III focuses on reducing health disparities resulting from the stigma of HIV in the region. HIV stigma was found to be a critical barrier to care in the 2011 Comprehensive Needs Assessment. Strategies include:

- Developing and implementing three-year education and training plans for both non-Ryan White funded providers and the general community to reduce stigma. (III.A and III.B))
- Updating and distributing the HIV Resource Guide and Mini-Resource Guide, as well as identifying mechanisms to incorporate regular updates of provider information to all guides. (III.C)
- Increasing use of the HIV210.org website by consumers, providers and the general public by at least 10% annually. (III.D)
- Revitalizing the People's Caucus to expand participation. (III.E)

The Quality Management Program that has been developed by the AA with the support of the Quality Management Committee will be maintained and improved with **Goal IV**. Strategies include:

- Continuing to use data to determine progress toward the quality measurement benchmarks incorporated into the standards of care for each service category offering provider training/technical assistance, as needed. (IV.A)
- Improving overall patient/client satisfaction annually. (IV.B)
- Expanding partnerships with all Ryan White Program Parts to coordinate quality management activities. (IV.C)

Goals V focuses on coordination of available funding sources, preparing for possible funding changes that may result from state and municipal budget cuts as well as implementation of the ACA. Strategies include:

- Reviewing and evaluating the actual and expected funding changes by the Planning Council's Fiscal Monitoring and Reallocations Committee and AA. (V.1)
- Establishing a third-party verification system for implementation by all Ryan White funded providers. (V.2)
- Requiring Medicaid and Medicare certification by all Ryan White funded providers of core services. (V.3)
- Recruiting a Medicaid representative to serve on the Planning Council. (V.4)

IV. HOW WILL WE MONITOR OUR PROGRESS?

Monitoring and evaluation of the 2012 - 2015 Comprehensive HIV/AIDS Services Plan will be the joint responsibility of the Planning Council and the BCDCR.

Monitoring

Monitoring is the process of routinely gathering information to measure progress toward accomplishing the goals and strategies of the Plan. An Implementation Matrix has been developed with all of the actions, responsible parties, start dates, completion dates and

monitoring intervals. This Matrix will facilitate the monitoring process by both the Planning Council and the BCDCR.

Planning Council Monitoring Role

- Each Planning Council committee is responsible for fulfilling its responsibilities as outlined in the Plan.
- The Plan will result in regular agenda items for each committee based on the time frames in the Plan.
- Each month the Planning Council Liaison will work with the committee chairs to include Comprehensive Plan action items on each committee's agenda.
- Progress in accomplishing each action item will be monitored by the responsible committee.
- The committees will submit a quarterly Progress Report to the Comprehensive Planning and Continuum of Care (CPCC) Committee. This oversight group will review progress, make recommendations back to the committee(s) and forward the Progress Report to Executive Committee with their comments, if any.

BCDCR Monitoring Role

- Many of the Plan's actions are the responsibility of the AA or the Quality Management Committee.
- These groups will monitor their progress in accomplishing requirements of the Plan at least quarterly.
- They will submit their quarterly Progress Report to the CPCC Committee to allow a snapshot of progress in accomplishing the actions, strategies and goals of the Plan. As appropriate, the CPCC Committee may make recommendations, suggestions and/or assign appropriate tasks to Planning Council Committees.

Quarterly Oversight by Planning Council and BCDCR

- Each quarter the BCDCR leadership and the Planning Council's Executive Committee will jointly review the Progress Report and the recommendations of the CPCC Committee. Any adjustments/changes to the Plan's actions, timetable, or responsible parties can be made at these joint sessions.

Evaluation

This 2012 – 2015 Comprehensive HIV/AIDS Services Plan will be evaluated on an annual basis using two approaches: process evaluation and goal-based evaluation. The evaluations will be the joint responsibility of the Planning Council's CPCC Committee, Executive Committee and AA.

Process Evaluation

Process Evaluation reviews how well the defined actions allow achievement of the strategy. The Plan's Implementation Matrix makes the process evaluation easy.

- Each strategy has a series of tasks to achieve the objective.
- Each task has a timeline, a responsible party and a measure, or evidence of completion.

- Once all tasks for any strategy have been completed and a measure or evidence of completion has been achieved, the CPCC Committee, Executive Committee and AA can evaluate whether the strategy supports the accomplishment of the goal.

Goal-Based Evaluation

Goal-based evaluation determines whether the goals with their defined strategies and actions achieve the goal and produce the desired result. Goal-based evaluation will be conducted annually to ensure that the strategies will ultimately lead to goal accomplishment. Each year the CPCC Committee, Executive Committee and AA will jointly ask the following questions:

- Have these strategies resulted in increasing access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA)? (Goal I)
- Have the targeted early intervention and outreach resulted in reduced new HIV infections, ensuring all people who were newly diagnosed or were not receiving HIV medical care were effectively linked to appropriate services? (Goal II)
- Have these strategies and actions resulted in reduced health disparities and HIV stigma in the region? (Goal III)
- Do all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction? (Goal IV)
- Were all available funding sources coordinated as a result of these strategies, preparing for possible funding changes resulting from state and municipal budget cuts and implementation of the ACA? (Goal V)

San Antonio Planning Area Ryan White Parts A & B
2012-2015 Comprehensive HIV/AIDS Services Plan

PART ONE: NARRATIVE

I. WHERE ARE WE NOW?

A. Description of the Local HIV/AIDS Epidemic

Definition of Service Area

The San Antonio Ryan White Planning Council (Planning Council) in conjunction with the Bexar County Department of Community Resources (BCDCR) is responsible for planning services that identify, link and maintain people living with HIV/AIDS (PLWHA) with HIV medical care in the San Antonio HIV Administration Services Area (SAHASA), a 28-county region. The SAHASA is divided into four areas as follows:

- San Antonio Transitional Grant Area (TGA) is comprised of four (4) counties, Bexar, Comal, Guadalupe, and Wilson. The Planning Council is responsible for determining the needs of the HIV affected community within the San Antonio TGA. San Antonio HIV Services Delivery Area (HSDA) is comprised of 12 counties including those in the TGA and Atascosa, Bandera, Frio, Gillespie, Karnes, Kendall, Kerr, and Medina.
- Uvalde HSDA, with nine counties, includes Dimmit, Edwards, Kinney, La Salle, Maverick, Real, Uvalde, Val Verde, and Zavala.
- Victoria HSDA, with seven counties, includes Calhoun, Dewitt, Goliad, Gonzales, Jackson, Lavaca, and Victoria.

Characteristics of this diverse region include:

- With 1.7 million residents, Bexar County, home to San Antonio, is the population center of the region. It is also the epicenter of the HIV epidemic.
- The region combines urban and rural areas. Bexar County has a population density of 1,383 people per square mile while the Uvalde HSDA has only 6.5 people per square mile. (Table I.2)
- The SATGA, SAHSDA, and Uvalde HSDA are minority-majority areas, with 55%, 53%, and 83% Hispanic residents, respectively.
- In Bexar County, 43% of residents speak a language other than English at home. Similar percentages are found in the SATGA and SAHSDA. The Uvalde HSDA, however, has nearly three quarters of residents that speak a language other than English at home, and a quarter of Victoria HSDA residents speak a language other than English at home.
- All areas, except the Uvalde HSDA have poverty rates between 15.8% and 16.9%. Uvalde's is much higher at 29.8%.
- The two most rural areas have the lowest levels of educational attainment. In the Uvalde HSDA, 62% of residents have completed high school, and in the Victoria HSDA 77% are high school graduates. This compares to 82% in the San Antonio TGA and HSDA.

Table I.1
Population Including Race/Ethnicity
Bexar County, San Antonio TGA and San Antonio, Victoria, Uvalde HSDAs
2010

	Population	% White	% Black/ African American	% Hispanic
San Antonio TGA	1,997,696	34.8%	7.0%	54.9%
San Antonio HSDA	2,249,011	37.3%	6.4%	53.2%
Victoria HSDA	188,626	48.8%	6.4%	38.7%
Uvalde HSDA	167,010	15.2%	0.80%	83.1%
Texas	25,145,561	45.3%	11.8%	37.6%
Source: http://quickfacts.census.gov. Retrieved March 2, 2012.				

Table I.2
Population Including Poverty, Education and Populations Density
Bexar County, San Antonio TGA and San Antonio, Victoria, Uvalde HSDAs
2010

	2010 Population	% Below Poverty 2010	High School Graduates	Persons per sq. mile 2010	Language Other Than English Spoken at Home
Bexar County	1,714,773	16.9%	81.4%	1,383.1	43.2%
Total SA TGA	1,997,696	15.9%	82.1%	602.7	40.3%
San Antonio HSDA	2,249,011	15.8%	81.9%	198.1	39.1%
Victoria HSDA	188,626	15.7%	77.6%	31.4	25.5%
Uvalde HSDA	167,010	29.8%	61.8%	6.5	74.3%
Texas	25,145,561	16.8%	80.0%	96.3	34.2%
* Source: http://quickfacts.census.gov retrieved March 2, 2012.					

2010 Epidemiological Profile[4]

Between 2006 and 2010, the epidemic has increased in all the HSDAs. The number of PLWHA increased by:

- 24% in the San Antonio HSDA
- 19% in the Victoria HSDA
- 49% in Uvalde HSDA

[4] The SATGA and the SAHSDA have very similar epidemiology profiles. Therefore, throughout this section the SAHSDA data will be used unless differences between the two areas are apparent.

Table I.3 demonstrates the steady increase in both cases and rates seen in all areas during this time.

Table I.3
People Living with HIV/AIDS
San Antonio, Victoria, Uvalde HSDAs
2006 – 2010

	2006		2007		2008		2009		2010	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
San Antonio HSDA	3,732	188.1	3,920	188.0	4,154	194.8	4,421	203.3	4,628	211.5
Victoria HSDA	122	65.2	127	67.4	131	69.6	137	72.1	145	74.0
Uvalde HSDA	65	40.2	72	44.4	82	50.4	90	54.6	97	56.8

Table I.4 presents HIV prevalence and rate in each of the 28 counties comprising the SAHASA. It also provides the percentage change in the prevalence between 2006 and 2010.

- Bexar County is home to the largest number of PLWHA in the SAHASA, with 4,316 PLWHA, and the prevalence increased by 23% between 2006 and 2010.
- Comal and Guadalupe follow Bexar County in the San Antonio HSDA, with 81 cases and 67 cases, respectively.
- Frio County, with a case rate of 128 PLWHA/100,000, experienced an increase of 187.5% between 2006 and 2010.
- In the Uvalde HSDA, Maverick County with 43 cases, accounts for 44% of the 2010 PLWHA. This county experienced a 34% increase in cases between 2006 and 2010.
- Victoria County with 89 cases is home to 61% of PLWHA in the Victoria HSDA.

Table I.4
2006 and 2010 Prevalence and Rate by County
San Antonio, Uvalde, Victoria HSDAs

	2006		2010		Change in Number 2006 - 2010
County	**Number**	**Rate†**	**Number**	**Rate†**	**%**
San Antonio HSDA					
Atascosa	25	59.7	35	76.3	40.0%
Bandera	9	46.1	13	61.1	44.4%
Bexar	3507	232.2	4316	263.7	23.1%
Comal	63	65.9	81	66.9	28.6%
Frio	8	48.9	23	128.1	187.5%
Gillespie	4	17	7	27.1	75.0%
Guadalupe	53	50.9	67	51.9	26.4%
Karnes	3	19.6	8	47.5	166.7%
Kendall	12	41.4	19	53.7	58.3%
Kerr	19	40.6	24	51.3	26.3%
Medina	16	37.4	17	37.2	6.3%
Wilson	13	34.1	18	39.5	38.5%

	2006		2010		Change in Number 2006 - 2010
Total San Antonio HSDA	3732		4628		24.0%
Uvalde HSDA					
Dimmit	4	39.7	6	61.5	50.0%
Edwards	0	0	3	135.6	na
Kinney	1	30	4	116	300.0%
La Salle	3	50.2	7	116.1	133.3%
Maverick	32	62.4	43	77.9	34.4%
Real	1	30.7	1	29.8	0.0%
Uvalde	7	26.2	10	35.9	42.9%
Val Verde	13	27.5	14	28	7.7%
Zavala	4	34.3	9	70.1	125.0%
Total Uvalde HSDA	65		97		49.2%
Victoria HSDA					
Calhoun	10	48.5	14	60.2	40.0%
De Witt	4	19.4	9	43.8	125.0%
Goliad	2	28.2	2	25.9	0.0%
Gonzales	15	77	13	63.8	-13.3%
Jackson	5	34.5	5	32.6	0.0%
Lavaca	12	61.9	13	66.4	8.3%
Victoria	74	86.6	89	99.8	20.3%
Total Victoria HSDA	122		145		18.9%

Among PLWHA in the region, 60% have an AIDS diagnosis. This compares to 55% in the state of Texas.

- In the San Antonio HSDA, 60% have an AIDS diagnosis.
- In the Uvalde HSDA 66% have an AIDS diagnosis.
- In the Victoria HSDA, 52% have an AIDS diagnosis.

Table I.5
PLWHA Disease Status
San Antonio, Victoria, Uvalde HSDAs
2010

	San Antonio HSDA			Uvalde HSDA			Victoria HSDA		
Disease Status	**#**	**Rate**	**%**	**#**	**Rate**	**%**	**#**	**Rate**	**%**
HIV	1,856	84.8	40.1%	33	19.3	34.0%	70	35.7	48.3%
AIDS	2,772	126.7	59.9%	64	37.5	66.0%	75	38.3	51.7%
Total	4,628	211.5	100.0%	97	56.8	100.0%	145	74.0	100.0%

A total of 311 new cases were diagnosed in the region in 2010. This is a decrease from 2008 and 2009, returning to the level of 2007.

Considering the SAHASA HIV epidemic by race/ethnicity finds:

- Hispanics comprise 56% of the San Antonio HSDA epidemic followed by Whites (30%) and Blacks/African Americans (15%).
  - Blacks/African Americans have the highest infection rate in the region at 455/100,000.
  - Between 2006 and 2010, the San Antonio HSDA experienced a 24% increase in Hispanic PLWHA and a 32% increase in Blacks/African American PLWHA.
- Whites are the predominant population infected with HIV, comprising 40% of that area's epidemic. This is followed by Hispanics (38%) and Blacks/African Americans (22%).
  - Blacks/African Americans and Whites experienced the highest percentage increase, 23% and 21% respectively.
- In the Uvalde HSDA, Hispanics comprise 80% of the HIV/AIDS epidemic. This population experienced a 57% increase between 2006 and 2010.

Table I.6
People Living with HIV/AIDS by Race/Ethnicity
San Antonio, Victoria, Uvalde HSDAs
2006 and 2010 Change

	2006			2010			2006 - 2010
San Antonio HSDA	**#**	**Percent**	**Rate**	**#**	**Percent**	**Rate**	**% Change in Cases**
White	1,129	31%	142.1	1,346	30%	165.2	19.2%
Black/African American	504	14%	418.6	663	15%	454.9	31.5%
Hispanic	2,050	56%	200.4	2,546	56%	219.2	24.2%
Total	3,683	100%	188.1	4,555	100%	211.5	23.7%
Victoria HSDA							
White	47	39%	45.8	57	40%	57.3	21.3%
Black/African American	26	21%	204.0	32	22%	165.0	23.1%
Hispanic	48	40%	69.2	54	38%	67.3	12.5%
Total	121	100%	65	143	100%	74	18.2%
Uvalde HSDA							
White	13	20%	46.4	17	18%	57.3	30.8%
Black/African-American	2	3%	172.4	2	2%	232.7	0.0%
Hispanic	49	77%	37.4	77	80%	55.0	57.1%
Total	64	100%	38.3	96	100%	58.0	50.0%

New cases increased throughout the SAHASA in 2010.

- In the San Antonio HSDA, new cases declined in 2010 to the rate experienced in 2006 and 2007. The 286 new cases yielded a rate of 13.1/100,000.
- In the Victoria HSDA, the new case rate has been steadily increasing to 6.1/100,000 in 2010.
- In the Uvalde HSDA, both new cases and the new case rate increased in 2010 to 13 cases and 7.6/100,000 respectively.

Table I.7
New Cases
San Antonio, Victoria, Uvalde HSDAs
2006 – 2010

	2006		2007		2008		2009		2010	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
San Antonio HSDA	251	12.7	288	13.8	307	14.4	352	16.2	286	13.1
Victoria HSDA	4	2.1	7	3.7	5	2.7	8	4.2	12	6.1
Uvalde HSDA	7	4.3	9	5.6	11	6.8	9	5.5	13	7.6

Consumers who are "late to care" are those that convert from HIV to AIDS within one year of initial diagnosis. These individuals not only experience personal health concerns, but also present public health issues since they may have been carriers of HIV disease for a long period of time.

- In the San Antonio HSDA, 37% of newly diagnosed PLWHA between 2005 and 2009 were late to care. This includes 39% of Whites and Hispanics and more than 40% of all women diagnosed during this time.
- Among diagnosed consumers in Victoria HSDA, 36% were late to care, including 83% of Whites (please note small number).
- More than half of consumers in the Uvalde HSDA were late to care, including 60% of Whites and 51% of Hispanics.

Table I.8
Late to Care—New Diagnoses Converting to AIDS in One Year
San Antonio, Victoria, Uvalde HSDAs
2005 - 2009

	Male		Female		Total	
	#	%	#	%	#	%
Total San Antonio HSDA	453	36%	119	42%	572	37%
White	121	38%	26	46%	147	39%
Black/African American	46	29%	34	40%	80	33%
Hispanic	282	38%	57	43%	339	39%
Total Victoria HSDA	10	45%	0	0%	10	36%
White	5	83%	0	0%	5	83%
Hispanic	5	45%	0	0%	5	36%
Total Uvalde HSDA	19	53%	2	40%	21	51%
White	2	50%	1	100%	3	60%
Hispanic	17	55%	1	25%	18	51%

2010 Unmet Need Estimate

In 2010, a total of 1,375 PLWHA in the SAHASA were not receiving HIV medical care and had an "unmet need."[5] This included:

- 28% of PLWHA in the San Antonio HSDA, 33% of PLWHA in the Uvalde HSDA and 21% in the Victoria HSDA.
- In the San Antonio HSDA, Blacks/African Americans and Whites were more likely to have an unmet need than Hispanics. In both the Victoria and Uvalde HSDAs, Hispanics had the highest percentage with unmet need.
- People with an AIDS diagnosis were more likely to be receiving HIV medical care than those with an HIV diagnosis, particularly in the San Antonio HSDA and Uvalde HSDA.
- Women were more likely to be in care than men, but the numbers of women in the Victoria and Uvalde HSDAs are small.
- Throughout the SAHASA, PLWHA age 25 to 34 were the most likely to be out of care, including 33% in the San Antonio HSDA, 40% in the Uvalde HSDA and 29% in the Victoria HSDA.
- In all HSDAs, IDU and MSM/IDU is the most frequent transmission modes to have an unmet need.

Table I.9
Number and proportion of PLWHA with Unmet Need 2010

	San Antonio HSDA		Uvalde HSDA		Victoria HSDA	
	Unmet Need		Unmet Need		Unmet Need	
	Number	Percent	Number	Percent	Number	Percent
Total	1,312	28	32	33	31	21
Disease Status						
HIV	663	36	13	39	16	23
AIDS	649	23	19	30	15	20
Sex						
Male	1,130	29	29	35	25	23
Female	182	24	3	21	6	16
Race/Ethnicity						
White	423	31	2	12	11	19
Black/African American	213	32	0	0	6	19
Hispanic	646	25	29	38	13	24
Other	25	52	1	100	1	100
Age Group						
02-12	5	31				
13-24	69	28	1	25	1	13

[5] Unmet need is defined by HRSA as no viral load test, no CD4 count and no antiretroviral medication for 12 months. The estimate provided by the Texas DSHS also include not medical care visit when available.

	San Antonio HSDA		Uvalde HSDA		Victoria HSDA	
	Unmet Need		Unmet Need		Unmet Need	
25-34	277	33	8	40	6	29
35-44	349	27	13	52	7	18
45-54	397	26	6	20	13	22
55+	215	30	4	22	4	22
Mode of Exposure						
MSM	865	28	16	30	14.9	20
IDU	154	32	6	49	4.4	28
MSM/IDU	77	36	1.7	37	2.1	20
Heterosexual	200	26	8.3	32	9.6	24
Pediatric	10	32	0	0	0	0

Early Identification of Individuals with HIV/AIDS/Unaware Estimate for CY 2009

The SAHASA Early Identification of Individuals with HIV/AIDS (EIIHA) strategy provides a complete continuum of prevention, routine and targeted counseling, testing, and early intervention services through the integration of three components:

1. The San Antonio HIV/Syphilis Testing Taskforce—a collaboration of 90 members (comparison with Texas presented in Table I.10).
2. Routine testing efforts at the county hospital system and at a Federally Qualified Health Center (FQHC).
3. The San Antonio TGA Ryan White funded Early Intervention Services (EIS) program.

The profile of the San Antonio TGA unaware is similar to the overall regional epidemic:

- Predominantly male (84%).
- A majority of Hispanic residents (55%).
- Two-thirds resulting from a MSM transmission and 17% from heterosexual contact.

Differences from the state include:

- A smaller percentage of women in the San Antonio TGA.
- Variations in race/ethnicity with smaller percentages of both White and Blacks/African Americans.
- More MSM transmission and fewer heterosexual and IDU transmission in the San Antonio TGA.

Table I.10
2009 Unaware Estimate
San Antonio TGA and Texas

	San Antonio TGA Unaware		Texas Unaware	
	Number	**Percent**		**Percent**
Total	1,141	100%	61,948	100%
Gender				
Male	958	84.0%	48,231	77.9%
Female	183	16.0%	13,717	22.1%
Race/Ethnicity				
White	326	28.6%	21,158	34.3%
Black/African American	166	14.5%	23,627	38.3%
Hispanic	632	55.4%	16,230	26.3%
Other	11	0.9%	621	1.0%
Age				
2 - 12	4	0.4%	227	0.4%
13 - 24	55	4.8%	2,983	4.8%
25 - 34	207	18.1%	11,158	18.0%
35 - 44	347	30.4%	19,402	31.3%
45 - 54	374	32.8%	19,822	32.0%
55+	154	13.5%	8,340	13.5%
Exposure Category[2]				
MSM	767	67.2%	33,672	54.4%
IDU	119	10.4%	8,696	14.0%
MSM/IDU	53	4.7%	4,144	6.7%
Hetero	191	16.8%	14,653	23.7%
Perinatal	8	0.7%	636	1.0%
Other	3	0.3%	147	0.2%

[1] Data Source: Texas HARS data as of July, 2011

[2] Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

B. Description of the Current Continuum of Care

Ryan White Funded—HIV Care and Service Inventory

Over the years, the SAHASA has developed its Continuum of Care supporting the following goals:

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

The SAHASA Ryan White Program funds 11 core medical and six support services.

- Five providers are located in San Antonio and together they provide 16 of the 17 services in the continuum. Short term housing is the exception, and that is funded in San Antonio through Housing Opportunities for People with AIDS (HOPWA).
- For the rural HSDAs, one provider is located in Victoria serving the Victoria HSDA and the other is located in Eagle Pass serving the Uvalde HSDA.
  - United Medical Center in Eagle Pass serves the Uvalde HSDA providing 13 services of which eight are core medical and five are support services.
  - Victoria City/County Health Department provides 10 services including six core medical and four support services.

Detail of Ryan White Parts A and B funded services, providers and locations is presented below.

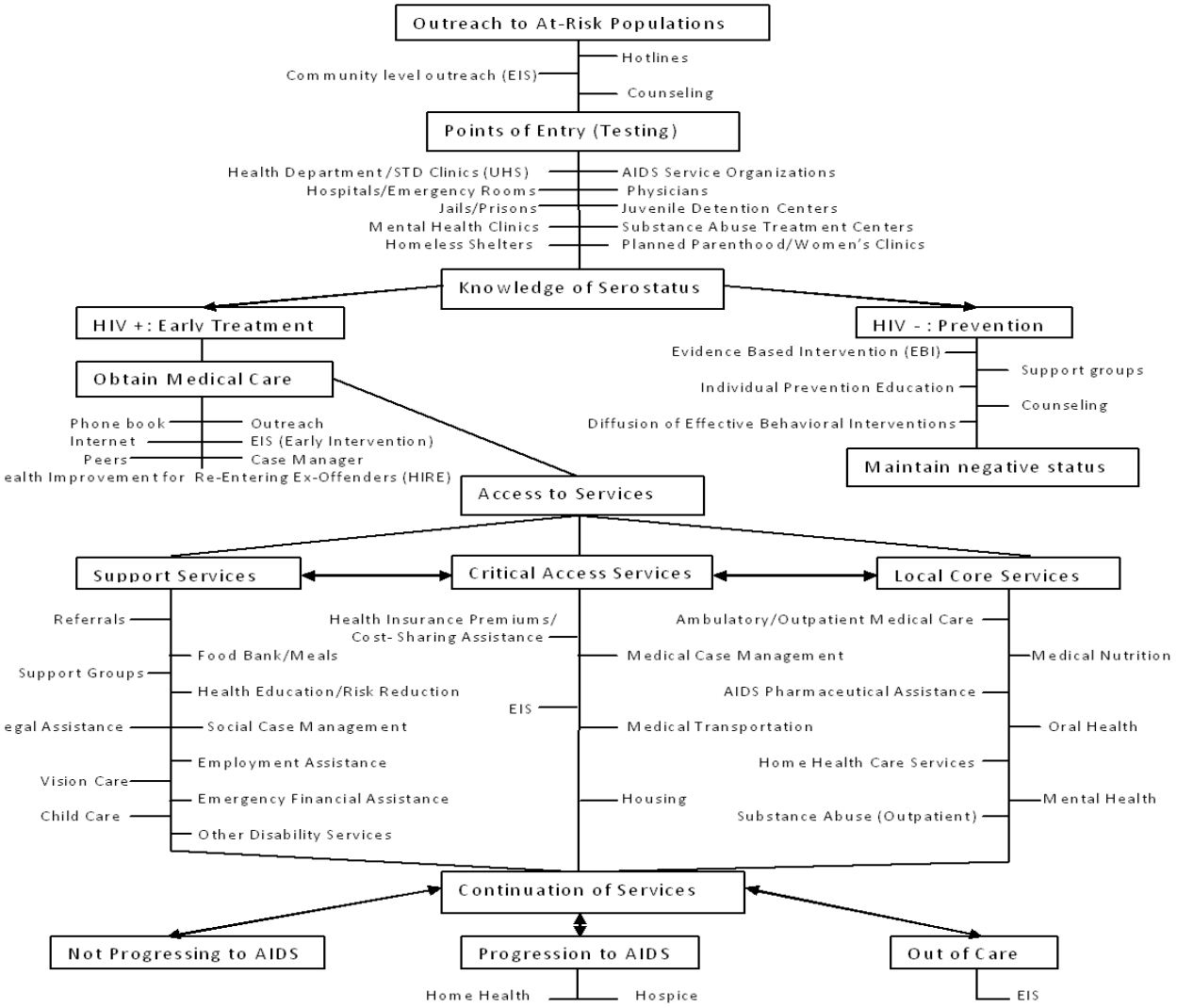
Table I.11
Core Medical and Support Service Providers and Categories
FY2012 – 2013

Core Medical Services		
Service Category	**Provider**	**HSDA Location**
1. AIDS Pharmaceutical Assistance (local)	1. El Centro del Barrio (CentroMed) 2. University Health System FFACTS Clinic 3. United Medical Center—Eagle Pass 4. Victoria City/County Health Department	San Antonio San Antonio Uvalde Victoria
2. Early Intervention Services	1. Alamo Area Resource Center 2. United Medical Center—Eagle Pass	San Antonio Uvalde
3. Health Insurance Premium and Cost Sharing Assistance	1. Alamo Area Resource Center 2. United Medical Center—Eagle Pass 3. Victoria City/County Health Department	San Antonio Uvalde Victoria
4. Home Health Care	1. University Health System FFACTS Clinic	San Antonio
5. Hospice Services	1. San Antonio AIDS Foundation 2. United Medical Center—Eagle Pass	San Antonio Uvalde
6. Medical Case Management	1. Alamo Area Resource Center 2. El Centro del Barrio (CentroMed) 3. San Antonio AIDS Foundation 4. University Health System FFACTS Clinic 5. United Medical Center—Eagle Pass 6. Victoria City/County Health Department	San Antonio San Antonio San Antonio San Antonio Uvalde Victoria
7. Medical Nutritional Therapy	1. University Health System FFACTS Clinic	San Antonio
8. Mental Health Services	1. Alamo Area Resource Center 2. Center for Health Care Services	San Antonio San Antonio

	3. El Centro del Barrio (CentroMed) 4. University Health System FFACTS Clinic 5. United Medical Center—Eagle Pass 6. Victoria City/County Health Department	San Antonio San Antonio Uvalde Victoria
9. Oral Health Services	1. San Antonio AIDS Foundation 2. United Medical Center—Eagle Pass 3. Victoria City/County Health Department	San Antonio Uvalde Victoria
10. Outpatient/Ambulatory Medical Care	1. El Centro del Barrio (CentroMed) 2. University Health System FFACTS Clinic 3. United Medical Center—Eagle Pass 4. Victoria City/County Health Department	San Antonio San Antonio Uvalde Victoria
11. Substance Abuse Services—Outpatient	1. Alamo Area Resource Center 2. Center for Health Care Services 3. University Health System FFACTS Clinic	San Antonio
Support Services		
Service Category	**Provider**	**Location**
1. Emergency Financial Assistance	1. Alamo Area Resource Center 2. San Antonio AIDS Foundation 3. United Medical Center—Eagle Pass 4. Victoria City/County Health Department	San Antonio Uvalde Victoria
2. Food Bank/Home Delivered Meals	1. Alamo Area Resource Center 2. San Antonio AIDS Foundation 3. United Medical Center—Eagle Pass 4. Victoria City/County Health Department	San Antonio Uvalde Victoria
3. Housing	1. United Medical Center—Eagle Pass	Uvalde
4. Linguistic Services	1. San Antonio AIDS Foundation	San Antonio
5. Medical Transportation Services	1. Alamo Area Resource Center 2. San Antonio AIDS Foundation 3. United Medical Center—Eagle Pass 4. Victoria City/County Health Department	San Antonio Uvalde Victoria
6. Non-Medical Case Management	1. Alamo Area Resource Center 2. San Antonio AIDS Foundation 3. University Health System FFACTS Clinic 4. United Medical Center—Eagle Pass 5. Victoria City/County Health Department	San Antonio Uvalde Victoria

The Planning Council developed the Multi-Track Continuum of Care depicted in Figure I.1. This demonstrates the interaction and integration of Ryan White funded services and non-Ryan White funded services to meet the needs of all PLWHA in the region, including the in care, out of care and unaware.

Figure I.1
Multi-Track Continuum of Care



It should be noted that the SAHASA receives funding for Parts A, B, C, D and F.

- The AA is responsible for service delivery under Parts A and B.
- Part A funds coordinate with ADAP funding through a yearly contract, in which unspent Part A supplemental funds are transferred to ADAP. These funds are allocated for clients living in Bexar, Comal, Guadalupe, and Wilson Counties.
    - Part A and B funds are used to supplement the limited ADAP formulary. This ensures clients are able to receive all needed pharmaceuticals.
- The AA is also responsible for ensuring data entry in the ARIES data system for Parts A, B and D.
- Part C funds in the SAHASA are administered by an FQHC, which utilizes the funds primarily for outpatient/ambulatory medical services. This Part C provider (CentroMed) also receives Part A funding for outpatient/ambulatory medical care, medical case management, and mental health services. Thus, they are integrally involved with the continuum of HIV/AIDS services.
- Part D funds are administered by The University of Texas Health Science Center at San Antonio, The South Texas Family AIDS Network (STFAN), which utilizes funding to provide family-centered HIV primary care, specialty medical care, and support services to HIV-positive women, infants, children, and youth (WICY) and HIV-affected family members and caregivers in the South Texas region.
- The University of Texas Health Science Center participates in the Part F reimbursement program. They are also a Part A and Part B sub-contractor for a wide range of services.

Non-Ryan White Funded—HIV Care and Service Inventory

In 2009, the BCDCR and the Planning Council developed a detailed resource guide for use by both consumers and providers. In 2011 they developed a "mini" resource guide which is a pocket guide for use by consumers. Both of these guides have been translated into Spanish and are available on the HIV210.org website.

Since service access varies by payer, this section focuses on key funding sources and services used by PLWHA in the SAHASA.

Medicaid is an important funding source for HIV medical care and treatment.

- Most people with HIV who currently qualify for Medicaid meet the program income and disability standards caused by a progressing illness.
- Others participate in the Medicaid Buy-in Program which allows persons with a disability and with incomes less than 250% of federal poverty level (FPL) to receive Medicaid by paying a monthly premium.

Texas Medicaid Managed Care program, STAR+PLUS, allows enrollees to choose a health plan and a primary care provider. In 2012 it expanded to cover routine dental exams and dental treatment for children.

Limitations experienced by some PLWHA relate to:

- Access to providers and specialists who are experienced in the treatment of HIV/AIDS.
- Coordination between medical and social services.

This Comprehensive HIV/AIDS Services Plan outlines actions the BCDCR staff will take to expand the verification system to ensure that all Medicaid-eligible clients receive their medical and dental care through Medicaid. This will maintain Ryan White as the payer of last resort and allow the Ryan White funds to be used to expand services for the uninsured.

Children's Health Insurance Program (CHIP) is administered by the Texas Department of Health and Human Services and is designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy private insurance for their children.

- CHIP coverage provides eligible children with coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits and more.
- This medical care program includes eligible children through 18 years of age and covers full HIV/AIDS primary care services, including prescription drug coverage.

Medicare, including Medicare Part D*:* SAHASA consumers accessing Medicare may be 65 years of age or older, or disabled, and have an AIDS diagnosis and a CD4 count under 200. Medicare is organized into four parts: Part A covers hospital insurance; Part B covers medical insurance; Part C covers private plans contracts; and Part D provides outpatient prescriptions. All Ryan White funded programs screen for eligibility to Medicare and assist Medicare-eligible persons to apply for the program as a part of the payer of last resort compliance.

Veterans Affairs: The SAHASA is home to one of the largest populations of veterans in the country. San Antonio's Audie Murphy Veterans Hospital has an Infectious Disease Clinic which provides medical care to approximately 350 HIV positive veterans.

- Many of these patients are referred to community-based agencies to provide support services that the Veterans Administration (VA) cannot accommodate.
- Veterans who are diagnosed as HIV positive do not receive VA benefits unless they have served enough time to be vested in their respective military branch of service.

Housing Opportunities for Persons with AIDS Programs (HOPWA) funds are administered through the BCDCR and the City of San Antonio through their Department of Human Services. Stable housing is a critical need in the SAHASA. Programs offered include:

- Short Term Utility, Rent and Mortgage Assistance (STRMU)
- Tenant Based Rental Assistance (TBRA)
- Transportation
- Housing placement assistance through the Housing Works program which offers a resource locator for affordable housing and intensive housing case management.
- Supportive services program provides assistance for case management, basic telephone services and the provision of smoke detectors.

- The Carson House, which provides transitional housing services in collaboration with HUD to stabilize PLWHA. This program can accommodate up to 20 persons, males, females and transgender residents with the maximum length of stay of 90 days.

CDC Prevention: Via the San Antonio HIV/Syphilis Testing Taskforce, the AA and Planning Council are informed of new prevention and testing services, as well as the number of people who are testing positive. Two individuals from the Planning Council serve on the Testing Taskforce. This allows for better planning of activities to target newly diagnosed.

Local and State Programs that PLWHA can access have increased as a result of the placement of the Ryan White Program in the BCDCR. This has created a shortcut to county and state-funded programs that support the stabilization of PWLHA in the SAHASA. Programs of note include:

- CareLink is a financial assistance program of the University Health System (UHS), the County's Hospital that is available to eligible Bexar County residents who do not have health insurance and do not qualify for other programs such as Medicare, CHIP or VA benefits.
  - CareLink offers participants a monthly payment plan that is based on their income and family size. Payments may be as little as $5.00. Residents up to 300% of the FPL qualify.
  - All Part A Providers have undergone extensive training in the CareLink eligibility process and it has been placed as a resource on the payer of last resort checklist form.
- Bexar County's Utility Assistance program works with AIDS Service Organizations (ASO) so that program funds that assist with the payment of utilities can be set aside for the benefit of income-eligible clients.
- Housing funds available through the Bexar County's HUD funded TBRA are also available for income-eligible PWLHAs.
- Bexar County Housing Finance Corporation has allocated funding for housing that can also be accessed. It has also provided funding for the local HIV/AIDS transitional housing program and a new transitional housing program for women with HIV/AIDS who have been recently released from incarceration.
- Bexar County Health Facilities Corporation has allocated $25,000 to a local ASO this fiscal year for expansion of a testing initiative in the southern quadrant of Bexar County where the numbers of newly diagnosed and out of care statistics are high.

Texas AIDS Drug Assistance Program (ADAP) has been in existence since 1997. There are 43 drugs on the formulary and it is operated through a network of participating pharmacies.

- While Texas has not experienced a waiting list for these services, the program has strict eligibility restrictions.
- Texas is one of six states that limit income eligibility to 200% of FPL.
- Additional support for eligible clients is also available from Part A through the service category AIDS Pharmaceutical Assistance Local which was ranked second during the FY2012 Priority Setting.

Local and Federal funds for substance abuse/mental health treatment services: Substance Abuse and Mental Health Services Administration (SAMHSA) funding has been awarded to:

- Bexar County's Adult Drug Court
- Veterans Treatment Court
- University of Texas Health Science Center
- Three other local non-profit organizations

Reduction in funding from the State of Texas for substance abuse and mental health treatment has placed an increased demand on all other providers of these services, including the Ryan White Program. In order to meet the need for substance abuse and mental health services, a contract with the local mental health authority, the Center for Health Care Services, has been executed.

How Ryan White and Non-Ryan White Funded Care/Services Interact to Ensure Continuity

All of the Ryan White funded care and service providers are well established and have strong community connections. Providers work together to optimize available services for PLWHA, always maintaining Ryan White as the payer of last resort. In addition, the Resource Guide provides additional information for medical and non-medical case managers in making client referrals.

The AA for the SAHASA has an excellent relationship with other community providers and publicly funded entities. Many non-Ryan White funded agencies serve on the Planning Council such as the Veterans Administration (VA), San Antonio Metropolitan Health District, and the TDSHS to ensure coordination and collaboration of services. The BCDCR leadership collaborates with organizations throughout Bexar County and the region, and they have been instrumental in organizing community collaborations to expand services for PLWHA. These include:

- The San Antonio HIV/Syphilis Testing Taskforce which now has over 90 members.
- The Health Collaborative, which includes representatives from leading hospitals, the San Antonio Metropolitan Health District, key community organizations and BCDCR.
- The Mental Health Consortium
- The AA's Quality Management Committee which includes providers from all Ryan White parts, as well as private providers

State and Local Budget Cuts Affecting the Service System and Ryan White's Adaptation

Between 2011 and 2012, local funding for HIV care and treatment will be maintained. State funding for AIDS Drug Assistance Programs (ADAP) is expected to decline slightly, but the federal funds will be expanded and will cover this shortfall.

The collaborations taking place throughout the region, have allowed organizations to work together and "do more with less."

The BCDCR and the Planning Council monitor state and local funding changes and are exploring the effects of the Affordable Care Act on service provision in the region. Goal V. of this plan outlines actions and responsibilities associated with this.

C. Description of Need

Comprehensive Needs Assessments (CNA) were conducted in 2009 and 2011 and a Mini-Needs Assessment was conducted in 2010. Comparing results of these three needs assessments demonstrates the BCDCR and Planning Council's responsiveness to fulfilling consumer needs and reducing identified barriers to care.

Table I.12 identifies the care and capacity development needs, and accompanying actions taken to fulfill these needs.

Table I.12
Care and Capacity Development Needs

Identified Consumer Need	Response and Resolution of Need
Medical Care	
• The 2009 CNA recommended improving medical clinic efficiency—reducing waiting time, paperwork, staff cultural competency.	• The 2011 CNA found this was resolving with wait times at the clinics and for appointments within acceptable limits.
Medical and Non-Medical Case Management	
• This is consistently the highest rated consumer need in all needs assessments. In 2009, it was recommended to provide case manager training and technical assistance to enhance this function.	• Training and technical assistance has improved case managers' function. • The 2009 Resource Guide and 2011 Mini-Resource Guide have provided additional information and education for both case managers and consumers.
Oral Health Care	
• Consumers identified a high level of need for oral health care in the 2009 and 2010 needs assessments. It was recommended to expand capacity as appropriate.	• In January 2012, the AA provided technical assistance training for dental residents, community dentists and dental hygienists through the Southwest AIDS Education and Training Center (AETC). • Medicaid oral health care has also become available in 2012, expanding funding sources for this service. • This need continues and is addressed in this Plan.
Substance Abuse Treatment	
• The 2009 CNA recommended evaluating the substance abuse continuum of care to ensure access to all treatment modalities for PLWHA. • A local provider closed in 2011.	• Gaps in the continuum were identified for both outpatient and residential treatment. An additional outpatient treatment provider was funded, and an RFP for residential treatment was determined not to be feasible. • Residential treatment will be evaluated in this plan.
Support Groups	
• Support groups were identified as a consumer need in the 2010 Mini-Needs Assessment.	• Support groups for women, older MSM, and transgendered individuals exist. • The University Health System FFACTS Clinic is developing additional support groups in response to this identified need.

Transportation	
• Consumers identify transportation needs on every needs assessment, and it is a reason cited for dropping out of care. • Bexar County has public transportation available in the City of San Antonio, but not in the outlying areas. • Rural counties have limited public transportation services, and agencies often struggle to provide adequate van service.	• The 2011 CNA found public transportation meeting many consumers' needs, but those who do not live near the bus line or in rural areas find transportation a barrier. • The AA strives to expand transportation services with available funds and through collaborations. This will continue in this Plan.
Emergency Financial Assistance	
• Emergency financial assistance (EFA) is a chronic need for low-income consumers.	• The AA has arranged for Bexar County Utility Assistance to be provided to PLWHA through some of the Ryan White funded ASOs.

The 2009 Comprehensive Needs Assessment included evaluations of both urban and rural consumer needs. In March of 2012, the BCDCR staff conducted another needs assessment of Uvalde and Victoria HSDA PLWHA. The consumer survey included 22 Uvalde HSDA and 19 Victoria HSDA residents. Figure I.2 presents medical core service needs identified.

- Outpatient medical care and medications were the most needed services. Everyone identifying these needs received the services.
- Dental/oral health care was the service most frequently identified as needed but "could not get it." Two consumers reported needing it but didn't know about the service.
- Fifteen percent of respondents needed health insurance assistance but were unable to get it.
- Nutritional counseling was needed by nine (22%) respondents. Of these, three could not get the service and two were not aware of the service.
- One consumer in Uvalde HSDA and one in Victoria HSDA reported needing substance abuse treatment. The former was able to access the service while the latter was not.
- Home health and hospice was needed by one respondent.

Figure I.3 presents social/non-medical service needs identified in the Uvalde/Victoria consumer needs assessment.

- Food bank is the service most often needed and received. However, three respondents needed the service and could not get it, and one Victoria respondent did not know about the service.
- Seventeen (41%) respondents needed and received non-medical case management. Twenty three (56%) reported not needing this service.
    - Over 75% of those accessing the service were Victoria HSDA residents.
    - Over 75% of those not needing the service were Uvalde HSDA residents.

- Eighteen respondents needed emergency financial assistance while 17 did not. Four, however, needed it and could not get it, and two were not aware this service was available.
- Fourteen (34%) respondents needed and received medical transportation. Twenty five (60%) do not need this service. One Victoria HSDA respondent needed but couldn't access transportation and one other Victoria respondent did not know about this service.

Figure I.2
Medical Core Services
Need and Use in Past 12 Months
Victoria, Uvalde HSDAs

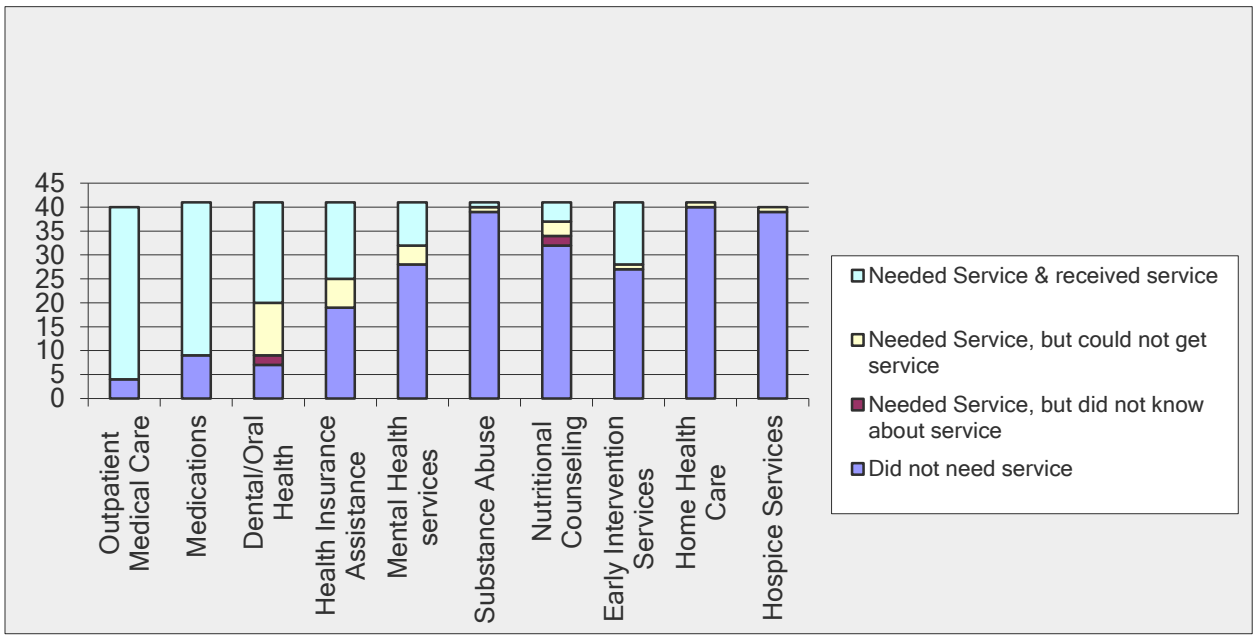
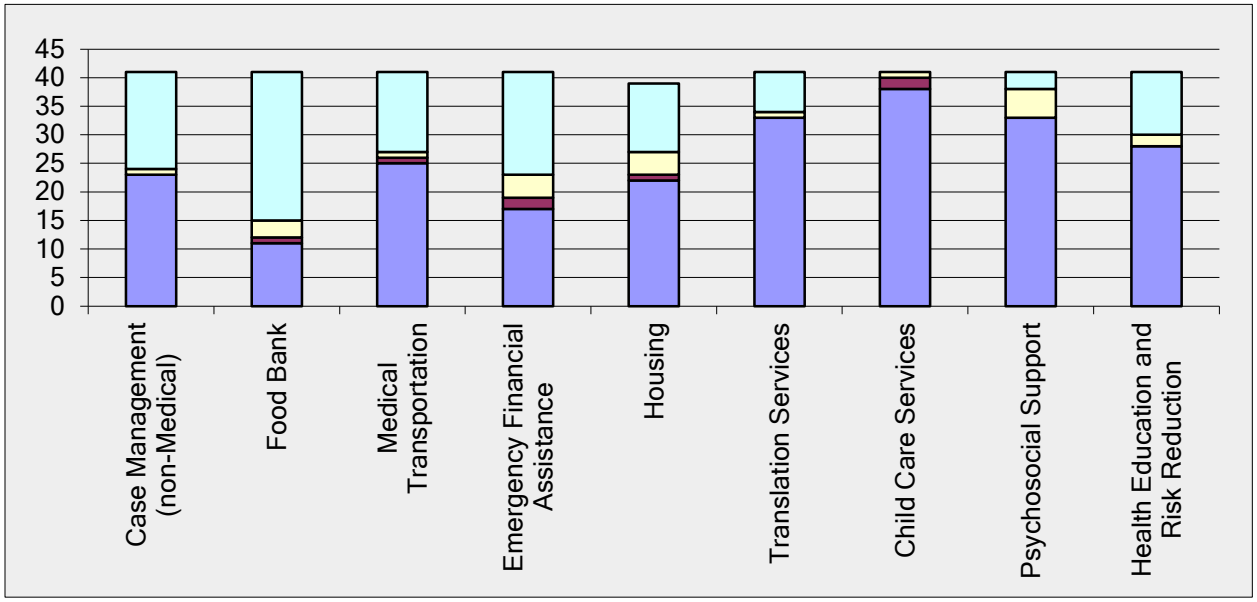


Figure I.3
Social/Non-Medical Services
Need and Use in Past 12 Months
Victoria, Uvalde HSDAs



D. Priorities for the Allocation of Funds

Priority Setting and the Use of Epidemiological Data

The Planning Council is responsible for determining the needs of the HIV affected community within the San Antonio TGA. They also establish priorities and set funding percentages for service categories.

- The Planning Council ensures the availability of quality comprehensive health and social services to individuals affected by the HIV epidemic.
- The Planning Council uses information contained in the Needs Assessments and Comprehensive Plan in addition to utilization data, expenditure information and trending statistics received from the AA staff in order to set the initial priorities and service categories for Ryan White funding.
  - Planning Council members receive training on using and understanding available data prior to the priority setting process.
  - The epidemiological data used include the number, profile and trends of both newly diagnosed and those living with HIV/AIDS in the region.
- Funding decisions are data driven and include qualitative information on need and with consideration of public input.

Needs of Individual with HIV/AIDS

The Planning Council members reviewed a wide range of data about consumer needs during the priority setting process. Table I.13 presents service needs that if not met can be barriers to care as well as cultural challenges faced by each population. Table I.13 identifies service needs/gaps and available services to address these.

Table I.13
Needs and Cultural Challenges of Significant Need Populations

Prohibitive Service Needs	Cultural Challenges
African American Youth MSM	
• Transportation • Housing • Jobs • Poverty • Substance abuse treatment	• Stigma • Lack of awareness of risk • Low literacy • Complacency • Fear • Religious rejection • Lack of leadership in the African American community to discuss HIV/AIDS and homosexuality • Perception that HIV/AIDS is "no big deal"
Latino MSM	
• Transportation • Housing • Lack of health insurance coverage • Poverty • Citizenship status	• Fear of isolation and rejection • Homophobia within the Latino culture and religious groups • Low literacy in English and/or Spanish • Not a priority concern • Sense of fatalism
Formerly Incarcerated	
• Inability to access entitlement benefits • Poverty • Limited employment potential • Lack of health insurance • Housing • Transportation	• Stigma • Discrimination • Low literacy
Women of Color--Child-Bearing Age (13 – 44 Years)	
• Child care • Transportation • Lack of health insurance • Emergency financial assistance • Food bank • Struggling to support the family	• Stigma • Fear • Isolation • Shame • Low literacy • Gender roles • Putting others' needs before her own, particularly her children

***How data was used in priority setting/resource allocation to increase access and reduce disparities*:** The Council's decision to allocate 91.96% of funding to core medical services

reflects their commitment to planning and managing core medical services. A mandatory data workshop was held prior to the priority setting and resource allocations meeting. Information on the number and demographics of people living with HIV, levels of unmet need, utilization and expenditures from the previous three years, outcome measures of service categories and other available resources were presented by the HIV Planner and considered by the Planning Council to increase access to care and reduce disparities.

Table I.14 provides an overview of the populations considered, the data analyzed and examples of resulting decisions.

Table I.14
Data-Driven Priority Setting

Data Sources Identifying Need	Planning Council's Priority Setting Response
Historically Underserved Populations	
• Specific populations considered include: male Latinos, men who have sex with men (MSM), African Americans, women of color, late to care and monolingual Spanish speakers. • Using the CNA reports, the Planning Council reviewed specific population characteristics, as well as service use, needs, availability, gaps and barriers to care.	• The Planning Council used this data to make appropriate prioritization of resources to the service categories that would best support care services for these populations.
Out of Care Consumers (Those with Unmet Need)	
• In care and out of care service utilization. • Project THRIVE and other EIS programs to determine the number of out of care entering the care system. • HIV/Syphilis Testing Taskforce	• Increase funding for EIS and services most used by newly diagnosed clients • Ensure adequate funding for ambulatory outpatient medical care and medical/non-medical case management.
Unaware Consumers (EIIHA)	
• Information from the HIV/Syphilis Testing Task Force • Project THRIVE	• The Planning Council based their decision to increase funding in the highly utilized services for those out of care on the anticipation that those unaware of their HIV status coming into care would have similar needs as those currently newly diagnosed.
Increase Access and Reduce Disparities	
• Data identifying the need for core medical services was brought forward and supported by members of the People's Caucus. • Following HRSA guidance and the technical assistance, the Planning Council focused on the core medical services revealed in data to be critical and necessary. • Planning Council members agree that the availability of core medical services is essential, particularly in light of the fact that 33% of newly diagnosed PLWHA are late to care, requiring a significant amount of care and treatment once diagnosed, and that the EIIHA initiative will also expand core medical service demand.	• 91% of funding will be for core medical services in 2012. • The funds designated for support services will be supplemented through collaborations and other funding sources.

E. Description of Gaps in Care

Needs assessments identified services gaps in the care continuum by severe need population. Table I.15 outlines the gaps and available services to fill them.

Table I.15
Service Gaps and Service Needs
Selected Severe Need Populations

Monolingual Hispanics	
Identified Service Gaps	**Services to Fill Gaps**
• Medical Case Management • Dental Care • Emergency Funds for Utilities • Food Bank • HIV Support Groups • Emergency Funds for Rent • Free Supplements/Vitamins	• Interpreters/Linguistic Services • Primary medical care services • Expanded and/or innovative HIV outreach • Intensive Case Management to ensure the ongoing acquisition of basic supportive service needs (food, housing, transportation) • Increased engagement and retention strategies, inclusive of family/social and group support service • Intensive Early Intervention Services and Patient Navigation services
African Americans	
• Free Supplements/Vitamins • Emergency Funds for Utilities • Social Case and Medical Case Management • Dental Care • HIV Support Groups	• Non-medical and Medical Case Management, Outpatient/Ambulatory Medical Care • AIDS Pharmaceutical Assistance • Food Bank • Mental Health Services • Early Intervention Services
Men Who Have Sex With Men	
• Medical Case Management • Dental Care • Emergency Utility Assistance • Food Bank • HIV Support Groups • Emergency Funds for Rent • Free Supplements/Vitamins	• Ambulatory/Outpatient Medical Care • AIDS Pharmaceutical Assistance • Early Intervention Services
Women of Color	
• Social Case Management • Medical Case Management • Dental Care • Food Bank • Permanent Housing	• Medical and Non-Medical Case Management • Ambulatory Outpatient Medical Care • Oral Health Care • AIDS Pharmaceutical Assistance • Early Intervention Services—Women's HEART • Housing—HOPWA
Recently Incarcerated	
• Housing • Access to medication • Substance abuse treatment • Mental health services • Employment and vocational rehabilitation • Lack of eligibility for entitlements such as SSDI (only SSI)	• A full continuum of services is needed for this population to address medical needs, co-morbidities and support services • HIRE (Health Improvement for Re-Entry Ex-Offenders) brings together multiple stakeholders to connect the re-entry populations with community-based, minority-serving organizations that provide

• Food stamps • Section 8 housing	HIV/AIDS related services and transition assistance.

F. Description of Prevention and Service Needs

The San Antonio HIV/Syphilis Testing Taskforce

The San Antonio HIV/Syphilis Testing Taskforce is an important prevention collaborative in San Antonio. The BCDCR leadership was instrumental in its organization in order to coordinate both targeted and routine testing in all available agencies and clinics. The Testing Taskforce:

- Strives to reach those who are not usually tested and those unaware of their status such as MSM of color, women and minorities.
- Works with different agencies outside of the medical field, such as jails and prisons, to educate them on the importance of testing.
- Includes 92 members representing a broad range of providers from across the San Antonio community who are committed to informing, educating and reducing the spread of HIV and Syphilis.
- Piloted a survey of its members to identify aspects of testing they conduct.
- Holds training and informational sessions for members, primary care physicians and community organizations.
- Participates in numerous coordinated community testing events.
- Provides testing in underserved rural areas to discover emerging populations.
- Develops baseline data on severe need populations and geographic areas in the region.

Prevention Services

In addition to the HIV/Syphilis Testing Task Force, other prevention activities include:

- TDSHS pilot grant to the UHS for routine testing in its emergency room and in two acute Express Med clinics.
- CentroMed, a federally funded qualified community health center and a Ryan White Part A and C provider, began conducting routine testing in all of its 15 medical clinics within the SATGA in October 2011.
- Expanded linkages with Disease Intervention Specialists of the San Antonio Metropolitan Health District and local ASOs and the Testing Taskforce.

Table I.16
Prevention Programs

Project	Purpose	Target Population	Funding Period	Key Collaborators
Project FATE	To provide HIV/AIDS/STI prevention education to high-risk heterosexual Hispanic and African American women in Bexar County using the Partners in Prevention Women's Edition Curriculum	High-risk heterosexual Hispanic and African American women	9/1/07– Present	17 different agencies
Salud y Vida	1) To provide intensive family therapy, substance abuse counseling/treatment, case management, and comprehensive risk counseling services; 2) To reduce the prevalence of substance abuse among project participants; 3) To reduce HIV risk among participants; and 4) To increase HIV-seropositive knowledge.	Youth	10/1/07 – 9/30/12	Family Service Association of San Antonio
Women's HEART	1) To enhance access, retention, and re-linkage to quality HIV care for Women of Color (WOC); 2) To assess the effectiveness of HEART in improving outcomes for WOC living with HIV/AIDS; and 3) To disseminate and sustain HEART findings and services.	295 HIV/AIDS-infected females – primarily women of color	9/1/09 – 8/31/14	UHS FFACTS Clinic AARC
TEEN REACH	1) To provide rapid, on-site HIV testing and counseling to enrolled participants; 2) To enhance HIV/substance abuse prevention among participants; 3) To link participants to needed ancillary services; 4) To ensure sustainability over five years; and 5) To reduce prevalence of substance use and risk of HIV among participants.	450 minority adolescents ages 14 to 17 years attending one of three alternative high schools in San Antonio	10/1/08 – 9/30/13	Por Vida Academy George Gervin Center Healy Murphy Alternative High School
Project HOPE (CBI)	To utilize Strategic Prevention Framework to reduce substance abuse and HIV risk behaviors among 18 to 24 year olds in our community through community awareness and direct prevention services.	18 to 24 year old Black/African American and Hispanic youth living in the East and West sides of San Antonio	9/30/10– 9/29/15	San Antonio Fighting Back BEAT AIDS

Early Intervention Services

Project THRIVE is the early intervention service (EIS) program funded by Ryan White. It is a collaboration between Alamo Area Resources Center (AARC) and HIV testing and counseling sites. AARC provides referral services to PLWHAs who know their status but are not in primary medical care, or who are recently diagnosed and not in primary medical care, for the purpose of facilitating access to HIV-related health services with the goal of retention in medical care. The primary goal of Project THRIVE is to facilitate early access to medical care and remove barriers to remaining in treatment.

Through Project THRIVE, AARC is able to conduct client intake and assessment, and make referrals to HIV medical care, medical case management, ADAP and all other continuum services that the client needs. They also assist clients with applying for entitlement program benefits such as Medicare, Medicaid, and Veterans Administration (VA). Project THRIVE has established the following milestones for each participant:

1. Access to medical care;
2. Assessment of mental health and substance abuse service needs;
3. Receipt of health education and risk reduction (HERR) services; and
4. Assessment by a medical nutritionist.

When the milestones have been met, clients are referred to a primary case management agency of the client's choice. A six-month follow up continues to track adherence to medical care. As of September 30, 2011, the EIS program has served 631 clients, of which 248 were newly diagnosed (39.3%). Of the 456 clients who have transitioned from the program, 355 (78%) remain in medical care.

Women's HEART (HIV Entry, Access, and Retention in Treatment) project is an evidence-based intervention program targeting women of color, designed to provide innovative strategies to overcome barriers across the spectrum of engagement and retention in care.

- It is a collaboration of the University of Texas Health Science Center at San Antonio, Department of Pediatrics, Division of Community Pediatrics (UTHSCSA-DCP), UHS FFACTS Clinic, and AARC, a community-based HIV service provider.
- The program uses a team of patient navigators, peer educators, and outreach workers to support participants identified at the UHS FFACTS medical case management program.
- Participants are engaged in patient navigation services and educational sessions facilitated by staff at AARC.

In the **Uvalde HSDA**, Ryan White EIS funding provides HIV counseling and testing, referrals, and outreach. Since the beginning of the program in 2011, UMC has tested 107 clients resulting in two HIV positive diagnoses. Testing is conducted at UMC, health fairs, the Quad County Substance Abuse facility, and community centers.

G. Description of Barriers to Care

In the 2009, 2010, and 2011 Needs Assessments, the stigma of HIV was identified as a barrier to care. Stigma was a significant focus in the 2011 Comprehensive Needs Assessment. It is particularly acute in the Latino and African American communities which comprise 70% of the SAHASA epidemic.

Other stigma-related barriers identified in the 2011 Comprehensive Needs Assessment include fear, shame, and cultural taboos.

Other barriers include: language, literacy, poverty, lack of health insurance, citizenship, complacency, transportation, a lack of awareness of risk, a sense of invulnerability in youth and the lack of a needle exchange program.

Routine Testing

Stigma causes delays in counseling and testing. The result can be seen in those diagnosed with HIV and converting to AIDS within one year (defined as "late to care"). Between 2006 and 2009, 37% of newly diagnosed San Antonio HSDA consumers were late to care. In addition, 36% of Victoria HSDA and 51% of Uvalde HSDA consumers diagnosed during this time period converted to an AIDS diagnosis within one year, and thus were late to care.

Several initiatives are working to reduce barriers to routine testing in the region:

- The HIV/Syphilis Testing Taskforce, a collaboration with more than 90 members, is raising awareness and developing interventions to reduce barriers to routine HIV counseling and testing.
- Supporting the Testing Taskforce, Project FATE is conducting research to identify high risk communities with limited counseling and testing services. Project FATE's recommendations will guide strategies for expanding prevention services in disproportionate need areas.

Program Related Barriers

Stigma impacts HIV-specific programs, since consumers often prefer to access general programs that don't have the "HIV label."

- The 2011 Comprehensive Needs Assessment found out of care Latina women receive social services at "non-HIV" providers.

Provider Related Barriers

The findings of the 2011 Comprehensive Needs Assessment state, "There are not significant barriers to care as related to the service delivery system." It was stated that wait times at the clinic or to get a routine medical appointment are similar to the wait times faced by the general population for appointments. Further, it stated, "the financial challenges mirror those represented in the general population for an individual in similar socio-economic situations, regardless of their medical need."

BCDCR is vigilant in working with Ryan White funded providers to ensure cultural competency and services are provided without disparities. In addition, BCDCR management, through their many collaborative relationships, work with non-Ryan White funded providers to reduce stigma and discrimination associated with the HIV disease.

Client Related Barriers

Table I.17 presents client related barriers associated with significant need populations found in the SAHASA.

Table I.17
Client Related Barriers

Monolingual Hispanics

- Although most Hispanics in the SAHASA are bilingual, many speak Spanish at home and consider Spanish their first language. Many persons with this profile have better comprehension of sensitive information when it is communicated in their primary language and prefer to communicate in Spanish on health-related matters.
- This preference can often make clients feel uncomfortable with health care professionals.
- Providers need culturally appropriate health education and patient education strategies and bilingual patient navigators.
- The most significant barriers to medical care encompass:
  - Immigrant/legal status;
  - Limited knowledge and fear of unfamiliar health care systems;
  - HIV stigma levels are perceived to be higher among Hispanics than other populations.

All of these factors lead to late diagnosis and ultimately an increase in the cost of HIV care.

Blacks/African Americans

- Blacks/African Americans face stigma and often the unwillingness of the African American community and church leadership to discuss openly the issues of homosexuality and HIV/AIDS.
- Blacks/African Americans experience high levels of poverty, unemployment, higher rates of incarceration, and low educational attainment.
- Blacks/Africans Americans are most likely to be out of care, and those in care have the challenge of transportation because there is no HIV medical clinic on the Eastside of San Antonio where the majority of this target population resides.

MSM

- MSM continue to be disproportionately affected by HIV/AIDS in the SAHASA. Sex between men continues to be stigmatized in the U.S., specifically in the Latino and African American cultures. Stigma often prevents MSM from accessing needed services or seeking knowledge of their HIV status.

Women of Color

- Three-quarters of the HIV positive women in the SAHASA are women of color.
- In a women's focus group conducted for the needs assessment, 30% of the participants were not receiving medical care. This is often due to the fact that women tend to put others' needs before their own; especially those of their children. Women work multiple jobs to support children. Many of these women lack recognition of their partners' risk factors.
- Many find their social service needs are better addressed in other systems and don't access HIV-specific medical care or services.

Recently Released from Incarceration

- Texas has one of the highest rates of incarceration in the U.S., largely related to drug possession or distribution. Complicating factors in serving the needs of formerly incarcerated PLWHA are linked to the tendency for inmates not to disclose their HIV status, thus not receiving treatment while incarcerated.
- Although SAHASA providers have established formal linkages with jails and prison, challenges exist in the provision of services. These include:
  - Limited or no discharge planning;
  - Release with only a 10-day supply of meds;
  - Reluctance to seek treatment immediately following release; or
  - Release after normal business hours making it difficult to link them to care in the traditional manner.

H. Evaluation of the 2009 Comprehensive Plan

Accomplishments

The 2009 - 2011 Comprehensive HIV/AIDS Services Plan (2009 Plan) was developed shortly after the BCDCR became the administrative agency. The 2009 Plan included seven goals, and a wide range of supporting strategies and actions which served as a guide to this new AA and the Planning Council. All of the actions outlined in the plan were completed and the objectives achieved, allowing significant progress toward the Plan's goals. The following presents the 2009 Plan's goals and a sample of accomplishments for each.

1. Ensured the availability and quality of all core medical services.

- The Planning Council in conjunction with the AA revised the Standards of Care (SOC) to include QM measures. The AA/QM developed appropriate benchmarks to measure clinical and service outcomes.
- The AA has developed and maintained a quality management committee and a committee of the Quality Management Single Point of Contacts from each agency. Each group reviews outcome measures, QM plans, patient satisfaction surveys, and other information to ensure the highest quality services are being offered.

2. Eliminated disparities in access to core medical services and support services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities.

- Conducted comprehensive needs assessments in 2009 and 2011 and a mini-needs assessment in 2010. All assessments identified needs and barriers experienced by disproportionately affected sub-populations and historically underserved communities.
- Used the results of all needs assessment to enhance access, reduce disparities, prioritize services, and develop training and technical assistance for Ryan White funded providers.
- Developed a multi-track continuum of care with an evaluation methodology to address the access needs of severe need groups, with special emphasis on points of entry and outreach. Provided technical assistance training about the multi-track continuum of care to all providers, front-line staff and People's Caucus members.
- Developed an Ad Hoc Transportation Committee following the 2010 Mini-Needs Assessment that identified transportation as a barrier to care for many groups. This committee worked with providers to develop solutions to fill these gaps.
- The Ad Hoc Transportation Committee developed uniform enrollment applications to ensure those with the highest level of need were prioritized when accessing medical transportation services.
- The AA and Planning Council increased resources available to the Spanish-speaking PLWHA including:
    - Making the Planning Council's website, HIV210.org, available in Spanish,

  - Adding two Spanish language videos to the website including one focusing on Spanish-speaking women,
  - Translating several forms used by service providers into Spanish.
- Contracted with a bilingual physician in the Victoria HSDA to address health disparities among monolingual Spanish-speakers.
- Conducted a Rural Access Community Health Forum in New Braunfels Texas in 2010 and 2011 in order to expand outreach and education to rural clients.

3. Developed strategies for identifying individuals who know their HIV status but are not in care, informing them about available medical care and support services, and assisting them in accessing medical care and the use of those services.

- The Planning Council and the AA used Early Intervention Services (EIS) to increase access to care and eliminate disparities in care for historically underserved communities. The EIS program in the San Antonio HSDA began in December of 2008. Since that time it has served 807 clients, 74% of which have evidence of medical care.
- An EIS program was started in the Uvalde HSDA in March of 2011. It has served 14 HIV+ clients and has tested 107 individuals.
- The Planning Council developed many tools for consumers to more easily access services. These include a Spanish/English resource guide which lists both HIV and non-HIV services; a mini version of the bilingual resource guide; the Health Diary in both English and Spanish, which helps consumers maintain their health by keeping track of appointments and lab results; and the website, www.HIV210.org. The website includes an electronic version of the resource guide.
- The AA presented the Planning Council with GIS maps which depict points of entry, current providers, and PLWHA by residential ZIP code.

4. Established a Quality Management Program and Plan that conforms to HRSA standards.

- The AA has successfully established a clinical Quality Management Program. The goal of the Program is to improve the health outcomes of all PLWHA in the SAHASA by incorporating the HAB performance measures, other clinical outcomes and supportive services into the plan of service for each consumer.
- The QM Committee is composed of 14 members including representatives from: Parts A, B, C, D and F funded programs, private practitioners, consumers, Planning Council members, the Chair of the Comprehensive Planning/Continuum of Care (CPCC) Committee and other community stakeholders (mental health, service providers, substance abuse providers).
- The QM Committee oversees the implementation of QM strategies through the annual review of the local Standards of Care (SOC). The CPCC Committee develops the SOC for all service categories and provides perspective to the QM staff. The SOC include outcomes and performance measures for each.

5. Developed strategies to address primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in HIV/AIDS care systems.

- The San Antonio TGA made significant progress in reducing the percentage of consumers not receiving HIV medical care. The unmet need decreased nearly 35% in 2008 to 28% in 2010.
- In the Victoria HSDA 21% of PLWHA have unmet need, and efforts are continuing in the Uvalde HSDA to reduce the percentage from 33%.

6. Coordinated programs for HIV prevention, including outreach and early intervention services.

- The AA was a founding member of the San Antonio HIV/Syphilis Testing Taskforce, a collaboration of 92 members from a wide range of provider agencies including HIV Prevention, Outreach and Early Intervention.
- The Testing Taskforce provides the SAHASA with enhanced service coordination and targeted programs.

7. Ensured the availability of services for the prevention and treatment of substance abuse.

- In the San Antonio HSDA and TGA substance abuse services continued to be funded.
- A new outpatient substance abuse treatment provider was funded in 2011.
- Needs assessments identified a need for additional substance abuse treatment, and attempts were made to contract for Residential Substance Abuse Treatment. Limited funding for this service resulted in funding reallocation.

Challenges

The 2009-2011 San Antonio Area Comprehensive HIV/AIDS Services Plan was transitional in nature. The AA was transferred from AACOG to Bexar in April of 2008 and the Plan was submitted to HRSA in January of 2009. The Comprehensive Plan from 2009 was a first effort for the new AA and the Planning Council. The AA and Planning Council were able to complete all the actions outlined in the Plan and make progress in achieving the goals. However, many of the goals of the 2009 Plan were ongoing in nature, and fully completing them is very challenging.

Many of the accomplishments of that plan laid the foundation for the 2012 – 2015 Plan's goals. Table I.18 compares the 2008 goals with those of the current plan.

Table I.18
Comparison of 2008 and 2012
Comprehensive HIV/AIDS Services Plan Goals

2008 – 2011 Goals	2012 – 2015 Goals
1. Ensure the availability and quality of all core medical services.	Goal I: Increase access, engagement and retention in quality care and services for PLWHA. Goal IV: Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.
2. Eliminate disparities in access to core medical services and support services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities.	Goal I: Increase access, engagement and retention in quality care and services for PLWHA. Goal III: Reduce health disparities resulting from the stigma of HIV in the region.
3. Specify strategies for identifying individuals who know their HIV status but are not in care, informing them about available medical care and support services, and assisting them in accessing medical care and the use of those services.	Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.
4. Include a discussion of clinical quality measures.	Goal IV: Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.
5. Include strategies that address primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in HIV/AIDS care systems.	Goal I: Increase access, engagement and retention in quality care and services for PLWHA. Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.
6. Provide goals, objectives, timelines, and appropriate allocation of funds, as determined by the needs assessment.	Goal I: Increase access, engagement and retention in quality care and services for PLWHA.
7. Include strategies to coordinate the provision of service programs for HIV prevention, including outreach and early intervention services.	Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

Changes to Ryan White Health Care

- Since the implementation of the Ryan White HIV/AIDS Treatment Extension Act of 2009, the Planning Council is required to develop a strategy to identify the status of unaware individuals (i.e., testing), make them aware of their status, and refer them to appropriate care if they are positive. The challenge has been defining the Planning Council's role in this process.
    - The Planning Council continues to work closely with the San Antonio HIV/Syphilis Testing Taskforce to develop a coordinated testing strategy within the TGA. The Testing Taskforce is comprised of AIDS Service Organizations, Criminal Justice System representatives, Mental Health and Substance Abuse service organizations, the Planning Council, Bexar County, the City of San Antonio's Metropolitan Health District, the Texas Department of State Health Services routine testing initiative and other interested parties.
    - The 2012 – 2015 Comprehensive HIV/AIDS Services Plan increases Planning Council participation in the Testing Taskforce by assigning to Planning Council members to that coalition.
    - The Testing Taskforce has developed a survey to identify the gaps and barriers to getting people tested, and have examined best practices to address community need. These results will be used for targeting high-risk populations in the 2012 – 2015 Plan.

- When Congress passed the ACA in March of 2010, very few people understood what changes were coming as a result of its implementation. This was a challenge for the Planning Council and the AA. As we get closer to the time where the major changes in health care will occur, the AA will continue to update the Planning Council on anticipated changes so that they can prepare for the effects on the local program.
    - Strategies to accomplish Goal V of the 2012 – 2015 focus on both monitoring and appropriate Planning Council and AA response to the ACA.

Changes in service providers

- During FY2009-2010, one large Ryan White agency was defunded by Bexar County because of fiscal problems. This lead to challenges in providing continuity of services for high acuity substance abusers. The AA diligently assisted in the transition of clients from one agency to another so that clients would not be lost to care.

Changing the Case Management System

- Weaknesses in the San Antonio TGA Ryan White case management function were identified in FY2009 – 2010. These included:
    - Treatment plan documentation was pervasively weak.
    - Case managers needed to learn how to empower their clients to independently navigate the health care system on their own.
    - Little preparation was being made to assist clients to be informed and prepared for the upcoming changes in the health care system.

- With the increase in the number of newly diagnosed clients found through our EIIHA initiative and the clients who were returning to care, it was imperative that the AA develop a strategy to work with case managers to improve the quality of their treatment plans, to learn to empower clients and to explore restructuring the duties among case managers. The AA implemented process improvement and technical assistance with the case management agencies and their staffs to address these concerns. Specifically:
  - Strategies were implemented to segregate some of the functions that case managers were performing.
  - In early 2011 the AA began to meet with case management supervisors, conducted a survey of case managers, and provided agencies with needed training.
  - Technical assistance is ongoing on an agency-specific basis.

II. WHERE DO WE NEED TO GO?

A. Plan to Meet Challenges Identified in the Evaluation of the 2009 Comprehensive Plan

The 2012 – 2015 San Antonio HASA Comprehensive HIV/AIDS Services Plan builds on the achievements of the 2009 – 2012 Plan. The BCDCR and the Planning Council reviewed the mission, vision and shared values of the 2009 Comprehensive Plan to ensure their continued relevance in 2012. While the mission and most of the shared values have continued, the vision has changed to encompass the EIIHA strategy and the National HIV/AIDS Strategy.

Mission

The mission of the San Antonio Ryan White Planning Council has remained the same between the 2009 and 2012 Comprehensive HIV/AIDS Services Plans. The mission is:

> To create a broad-based community response to the HIV epidemic affecting people within the Transitional Grant Area and to ensure the availability and coordination of high quality, comprehensive health and social services to individuals infected or affected by HIV.

Vision

The vision was changed to reflect the Planning Council's focus on reducing infections, immediate access to a comprehensive service continuum without stigma. The 2012 – 2015 vision is:

> To have the SAHASA become a place where new HIV infections are rare, and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have immediate access to a high quality continuum of HIV care and services, free from stigma and discrimination.

Shared Values

The shared values were maintained, with one change—the issue of "cost-effective" services was added to focus both on quality and cost. The shared values are:

- Strive for a seamless system of coordinated care to meet consumer needs.
- Provide the highest quality care and services in the most cost-effective manner.
- Ensure equal and easy access to services.
- Ensure that all services are culturally competent and sensitive.
- Treat all consumers with compassion and respect.

Goals, Strategies and Actions

The seven 2009 – 2012 goals were realistic and attainable, and the AA and the Planning Council completed or exceeded the strategies and actions outlined. The challenges identified during the evaluation of the 2009 Comprehensive HIV/AIDS Services Plan related to:

- Continuing and building on previous, successful strategies.
- Continuing and expanding collaborations and partnerships.
- Expanding services to underserved urban and rural communities in a cost-effective manner.
- Identifying and accommodating environmental changes and challenges.
- Reducing stigma and discrimination PLWHA face in the region, particularly among significant need populations.

B. 2012 Proposed Care Goals

The first goal of the plan focuses on the continuum of care with increasing access, engagement and retention in services. Specifically:

- Goal I: Increase access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA).

One goal also provides detail to continue and expand the SAHASA's successful quality management program as follows:

- Goal IV: Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

The final goal of the plan supports coordination with other providers and available funding sources to ensure that Ryan White is the payer of last resort, and changes in funding are anticipated so that PLWHA care and services will be supported and maintained.

- Goal V: Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget cuts and implementation of the Affordable Care Act (ACA).

C. Goals Regarding Individuals Aware of Their HIV Status but not In Care (Unmet Need)

Two goals address identifying PLWHA who are not receiving HIV medical care, and linking and retaining them in care. One outlines the specific activities required to accomplish these tasks, and the other focuses on the stigma of HIV in the region that causes people to hide their HIV status. Specific goals include:

- Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.
- Goal III: Reduce health disparities resulting from the stigma of HIV in the region.

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

Goals II and III have strategies that focus on identifying, providing early intervention services and ongoing care connections for people who are currently unaware of their HIV status (EIIHA). The issues of stigma and discrimination are a significant barrier to accessing HIV counseling and testing, and this goal will support the EIIHA goal and associated strategies.

E. Proposed Solutions for Closing Gaps in Care

The following strategies outlined in Goal I and Goal II support enhancing the continuum of care and closing gaps.

- Enhance the continuum, ensuring it is seamless. (I.A)
- Increase collaborations to expand services. (I.B)
- Expand demand and capacity for oral health. (I.C)
- Expand the mental health continuum of care through collaborations and telemedicine. (I.D)
- Evaluate options for residential substance abuse treatment. (I.E)
- Increase the number of stably housed PLWHA. (I.F)
- Expand transportation services, both urban and rural, through collaboration and alternative funding. (I.G)
- Expand early intervention, outreach and counseling and testing to targeted populations or geographic areas, particularly those with gaps. (II.A)

F. Proposed Solutions for Addressing Overlaps in Care

Overlaps in care will be addressed through collaboration and education of community partners as well as through developing a payment verification system to assure Ryan White is the payer of last resort:

Strategy I.B.

Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES.
Responsible Party: AA

Strategy V.B.

Establish a third-party payer verification system to easily share consumers' insurance statuses between funded providers and ensure Ryan White is the payer of last resort by September 2013.
Responsible Party: AA

Strategy V.C.

Require Medicare and Medicaid certification of all Ryan White funded providers of outpatient/ambulatory medical care (OAMC), medical case management, mental health services, and substance abuse services by March 2014.
Responsible Party: AA

G. Description Detailing the Proposed Coordinating Efforts with the following programs (at a minimum) to ensure optimal access to care:

Changing the administrative agency in 2008 to the BCDRC has allowed significant expansion in coordination and collaboration between the Ryan White Program and other community organizations. Management has a strong understanding of community issues and is expert at bringing key partners/collaborators to the table. The following is a brief overview of the community organizations that have come together and will continue to collaborate to ensure optimal access to care for PLWHA.

All Ryan White Funded Parts

BCDCR coordinates with all Ryan White funded parts to ensure optimal access to care as follows:

- The AA is responsible for service delivery under Parts A and B.
- Part A funds coordinate with ADAP funding through a yearly contract, in which unspent Part A supplemental funds are transferred to ADAP. These funds are allocated for clients living in Bexar, Comal, Guadalupe, and Wilson Counties.
  - Part A and B funds are used to supplement the limited ADAP formulary. This ensures clients are able to receive all needed pharmaceuticals.
- The AA is also responsible for ensuring data entry in the ARIES data system for Parts A, B and D.
- Part C funds in the SAHASA are administered by an FQHC, which utilizes the funds primarily for outpatient/ambulatory medical services. This Part C provider (CentroMed) also receives Part A funding for outpatient/ambulatory medical care, medical case management, and mental health services. Thus, they are integrally involved with the continuum of HIV/AIDS services.
- Part D funds are administered by The University of Texas Health Science Center at San Antonio, The South Texas Family AIDS Network (STFAN), which utilizes funding to provide family-centered HIV primary care, specialty medical care, and support services to HIV-positive women, infants, children, and youth (WICY) and HIV-affected family members and caregivers in the South Texas region.
- The University of Texas Health Science Center participates in the Part F reimbursement program. They are also a Part A and Part B sub-contractor for a wide range of services.
- Parts A, B, C, D and F participate in the Ryan White Quality Management Committee.

Private Providers

BCDCR regularly reaches out to private providers in order to enhance access to their services and support the delivery of the highest quality care.

- Select private providers currently participate in the Ryan White Quality Management Committee which provides oversight to QM activities and the QM Plan.
- Private providers are included in the 92-member HIV/Syphilis Testing Taskforce
- BCDCR management serves on the Board of Directors for the San Antonio Health Collaborative that includes hospitals, health care systems, the San Antonio Health Department and leading community organizations.
- Private providers have been and will continue to be included in Ryan White educational training programs.

Prevention Programs

Through the HIV/Syphilis Testing Taskforce and other initiatives, BCDCR and the Planning Council collaborate and coordinate with the following:

- UHS pilot project for routine HIV testing in its emergency room and two acute Express Med clinics.
- CentroMed, a FQHC and a Ryan White Part A and C provider, began conducting routine testing in all of its 15 medical clinics within the SAHASA in October 2011.
- Expanded linkages with Disease Intervention Specialists of the San Antonio Metropolitan Health District and local ASOs and the Testing Taskforce.
- Women's Heart
- Project FATE
- South Texas Family AIDS Network (STFAN)
- Teen REACH
- Salud y Vida
- Project HOPE

Substance Abuse Treatment Programs/Facilities

Substance abuse treatment programs and facilities collaborate with BCDCR through the HIV/Syphilis Testing Taskforce and the Mental Health Consortium.

Ryan White Part A funds three outpatient substance abuse treatment providers, and this Comprehensive Plan will evaluate the substance abuse treatment continuum available to PLWHA, specifically considering the need for residential treatment.

STD Programs

Via the HIV/Syphilis Testing Taskforce, the AA and Planning Council are informed of new prevention initiatives and the number of people who are testing positive for both HIV and STDs. Two individuals from the Planning Council serve on the Testing Taskforce. This allows for better planning of activities to target newly diagnosed.

Medicare

Private providers are often willing to accept Medicare reimbursement. Therefore, Medicare verification expands capacity throughout the HIV medical care system. This will not only continue but also be expanded in this Plan.

Medicaid

Medicaid eligibility will significantly expand under the Affordable Care Act (ACA). Expansion of Medicaid verification capabilities and training Medicaid providers will allow the SAHASA to be prepared for this transition.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program is an important safety net, and the BCDCR and contracted providers verify CHIP coverage so that Ryan White is the payer of last resort.

Community Health Centers

Two types of Community Health Centers are found in the SAHASA:

1. The San Antonio FQHC (CentroMed) and Eagle Pass FQHC (United Medical Centers) that incorporates an HIV clinic. CentroMed receives Part A and C while UMC receives Parts B and D funding.
2. General community health centers that provide general primary medical care.

FQHC representatives are integrally involved with the Ryan White continuum of care, the Ryan White Quality Management Committee and the Planning Council.

BCDCR reaches out to general community health centers through collaborative efforts including the HIV/Syphilis Testing Taskforce, the Health Collaborative and the Mental Health Consortium.

Veterans Administration

The SAHASA is home to one of the largest populations of veterans in the country. San Antonio's Audie Murphy Veterans Hospital has an Infectious Disease Clinic which provides excellent medical care to approximately 350 HIV positive veterans. Many of these patients are referred to community-based agencies to provide support services that the Veterans Administration (VA) cannot accommodate.

The Planning Council includes a VA representative which supports reciprocal communication and collaboration.

III. HOW WILL WE GET THERE?

Please refer to Part Two which presents the complete Comprehensive HIV/AIDS Services Plan. It provides the detailed plans for accomplishing each goal. These include strategies, activities, responsible parties, timeframes and monitoring intervals. Narrative overviews will be provided in this section.

A. Strategy, plan, activities (including responsible parties), and timeline to close gaps in care.

The first goal addresses the continuum of care, and each strategy addresses enhancing an essential service or closing an identified gap.

Goal I. Increase access, engagement and retention in quality care and services for PLWHA.

- Strategy I.A focuses on maintaining the current service system, enhancing it and ensuring it is seamless to achieve the National HIV/AIDS Strategy goal of 85% of Ryan White clients accessing and maintaining HIV medical care.
  - The Comprehensive Planning Continuum of Care Committee will be responsible for this strategy.
  - Actions will begin immediately and will continue through March 2016 and ongoing.
  - Strategy I.A will be accomplished by:
    - Increasing the percentage of Ryan White clients receiving HIV medical care from 74% to 85%. This uses FY2011 ARIES data as the baseline.
    - Providing training to local primary care physicians annually.
    - Building capacity in rural locations to increase the number of PLWHA treated in their local communities by 5% annually. Telemedicine will be considered for capacity building.
    - Increasing utilization of rural case managers by 5% annually.
    - Engaging co-located primary care and medical specialists in the Ryan White care system to effectively treat PLWHA with co-morbid conditions.
    - Expanding PLWHA treatment options by enhancing linkages to Ryan White and non-Ryan White funded providers.

- Strategy I.B increases collaboration to expand services available to PLWHA.
  - The Administrative Agency will be responsible for completing this strategy.
  - Actions will begin immediately and will continue through March 2016 and ongoing.
  - Strategy I.B will be accomplished by:
    - Increasing collaboration with five entities that provide Medicaid services in 2013.
    - Maintaining or expanding these collaborations, with two additional partners to be added annually.
    - Increasing collaboration with community partners that assist with self-sufficiency, including such services as financial literacy, job training, etc.

- Identifying collaborative partners' training needs and providing at least one training program annually.

- Strategy I.C strives to expand both the demand for and capacity of oral health care annually.
  - The Administrative Agency will be responsible for this strategy.
  - It will begin in March 2012 and continue throughout this plan.
  - Strategy I.C will be accomplished by:
    - Increasing capacity by partnering with FQHCs throughout the region
    - Providing training for oral health care providers, including both dentists and dental hygienists.
    - Educating HIV physicians, nursing and case managers in order to increase appropriate referrals for oral health care.
    - Providing consumer-focused educational information about the importance of oral care on the HIV210.org website.
    - Tracking referrals and utilization of oral health care services.

- Strategy I.D focuses on expanding the mental health continuum of care through collaborations and telemedicine.
  - The Needs Assessment Committee has overall responsibility for this strategy.
  - It begins immediately and continues throughout this plan, but much of the work of this strategy takes place during October 2012 through October 2013.
  - Strategy I.D will be accomplished by:
    - Appointing two members to serve on the Mental Health Consortium in order to expand collaboration and communication.
    - Defining the mental health services continuum of care available for PLWHA.
    - Conducting a mental health services assessment during the fall and winter of FY2012.
    - Implementing recommendations of the mental health services assessment to expand access and reduce barriers to mental health treatment.
    - Conducting a Mental Health Forum targeting consumers, providers and the general community in order to inform them about available mental health services.

- Strategy I.E evaluates residential substance abuse treatment options in order to identify the most cost-effective service strategy.
    - The Needs Assessment Committee will have responsibility for this strategy which will be undertaken and completed in the fall/winter of FY2013.
    - Strategy I.E will be accomplished by:
        - Compiling and organizing available data to support the evaluation of residential substance abuse services.
        - Reviewing consumer need for residential substance abuse services.
        - Identifying alternatives to effectively meet that need and the costs of each.
        - Formulating an RFP to support Ryan White funding of this service, if appropriate.

- Strategy I.F increases PLWHA with stable housing from 51% to 55% of Ryan White program clients.
    - This will be the responsibility of the Administrative Agency in conjunction with service providers and the Needs Assessment Committee.
    - This strategy will begin in October 2014 and will continue through March 2016.
    - Strategy I.F will be accomplished by:
        - Conducting an assessment of housing resources, identifying gaps in the housing continuum and developing recommendations to reduce housing barriers and gaps while increasing access.
        - Implementing recommended housing strategies.
        - Providing training for both case managers/service providers and consumers through Housing Forums to improve understanding of available housing options.

- Strategy I.G expands transportation services, both urban and rural, through collaboration and alternative funding.
    - The Administrative Agency and an Ad Hoc Transportation Committee will be responsible for implementing this strategy.
    - This strategy will begin in September 2012 with actions continuing through March 2016 and ongoing.
    - Strategy I.G will be accomplished by:
        - Establishing a “collaborative pool” to negotiate with VIA, the San Antonio public transportation system, for reduced fares for PLWHA and other low income consumers with medical/behavioral health conditions.
        - Collaborating with the Alamo Area Council of Governments (AACOG) and rural transportation providers to allow PLWHA to access reduced fares in rural areas.

- Identifying Medicaid and Medicare transportation benefits for medical care and other services.
- Using the third-party verification system to require eligible consumers to use those payer sources.
- Educating both providers and consumers about HRSA transportation mandates and the process to access transportation services from other payers.
- Expanding medical transportation in rural areas as funds become available.

B. Strategy, plan, activities (including responsible parties), and timeline to address the needs of individuals aware of their HIV status, but are not in care (with an emphasis on retention in care).

Closing gaps in care, as described above Goal I will maintain PLWHA in the care system. Specifically, Strategy I.A, outlined above, establishes a specific target of 85% of Ryan White clients accessing and maintaining medical care.

Goal II addresses targeted early intervention and outreach to ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services. Goal II strategies to address the needs of individuals aware of their HIV status but not in care include:

- Strategy II.B ensures immediate linkage for all newly diagnosed PLWHA with a seamless service system resulting in a 2% annual increase in the percentage of newly diagnosed linked to HIV medical care in three months.
  - The Administrative Agency will lead this strategy, involving quality management staff and the People's Caucus.
  - This strategy will begin immediately, continuing through March 2016 and ongoing.
  - Strategy II.B will be accomplished by:
    - Educating and supporting all counseling and testing providers to ensure HIV positive clients are linked to appropriate services by providing two training programs annually in conjunction with collaborative partners.
    - Monitoring newly diagnosed and returned-to-care clients to ensure HIV medical care for at least six months from referral.
    - Expanding the patient navigator program to support newly diagnosed and returned-to-care for at least six months after beginning HIV medical care.

C. Strategy, plan, activities (including responsible parties), and timeline to address the needs of individuals unaware of their HIV status (with an emphasis on identifying, informing, referring, and linkage to care needs).

Addressing the needs of individuals unaware of their HIV status will be accomplished with Strategy II.A.

- Strategy II.A targets populations or geographic areas for early intervention, outreach, and testing services.
  - The Administrative Agency and Quality Management has overall responsibility for this strategy. The Needs Assessment Committee has responsibility for needs assessments and defining targeted populations for interventions.
  - It begins immediately and continues through March 2016 and ongoing, with different populations targeted annually.
  - Strategy II. A will be accomplished by:
    - Conducting annual needs assessments to identify target/focus populations.
    - Developing annual plans to reach the targeted population(s), setting implementation priorities in conjunction with collaborative partners.
    - Implementing these plans and evaluating the results prior to beginning the process the next fiscal year.

D. Strategy, plan, activities (including responsible parties) for addressing the needs of special populations, including but not limited to; adolescents, injection drug users, homeless, and transgender.

This Comprehensive Plan allows for annual determination of targeted special populations using data from needs assessments, viral load mapping and information from the San Antonio HIV/Syphilis Testing Taskforce.

- It is anticipated that among the first populations targeted will be young MSM of color and transgendered individuals.
- To reach substance users and injection drug users, Strategy I.E enhances the substance abuse continuum of care by evaluating options to enhance access for residential substance abuse treatment.
- To support the homeless, Strategy I.F expands the housing continuum and educates consumers and providers about housing options.
- Rural consumers are targeted for service expansion in their local communities, specifically:
  - Strategy I.A which expands medical care and medical case management in the rural community.
  - Strategy I.D which expands mental health, including a rural expansion.
  - Strategy I.G which expands transportation in the rural areas.

E. Description Detailing the Proposed Activities to Implement the Coordinating Efforts to Ensure Optimal Access to Care.

All Ryan White Funded Parts

The following strategies and actions pertain to coordinating with all Ryan White funded parts:

Strategy I.A

Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care.

Strategy III.D

Increase use of the HIV210.org website by consumers, providers and the general public by at least 10% annually.

Strategy IV.C

Participate in partnership with all Ryan White Program Parts to coordinate quality management activities.

Actions include:

- Build capacity in rural locations, possibly with the support of telemedicine, in order to increase the number of rural clients receiving medical services in their local communities by 5% annually. (I.A.3)
- Work with all Ryan White funded providers and community partners to include a link to HIV210.org on their websites. (III.D.8)
- Link with Part C and Part D providers for South Texas HIVQual Regional Group. (IV.C.1)
- Maintain Quality Management Committee with Parts A, B, C, D, F and non-Ryan White funded providers, including privately funded providers. (IV.C.2)

Non-Ryan White Funded Providers, including Private Providers

The following strategies and actions relate to non-Ryan White funded providers. Private providers will also be included:

Strategy I.A

Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care.

Strategy I.B

Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES.

Strategy III.A

Develop and implement a three-year education and training plan for non-Ryan White funded providers.

Strategy III.D

Increase use of the HIV210.org website by consumers, providers and the general public by at least 10% annually.

Actions include:

- Provide training to local internists and family practitioners about current HIV treatment, offering at least one program annually. (I.A.2)
- Build capacity in rural locations, possibly with the support of telemedicine, in order to increase the number of rural clients receiving medical services in their local communities by 5% annually. (I.A.3)
- Identify and engage co-located primary care and medical specialists to efficiently and effectively treat PLWHA with co-morbid conditions and complications as evidenced by additional proposals during the 2015 – 2016 RFP process. (I.A.5)
- Expand PLWHA treatment options by enhancing linkages between Ryan White funded and non-funded providers as evidenced by PLWHA reporting HIV medical care outside the Ryan White provider network. (I.A.6)
- Increase collaboration with five key community organizations that provide Medicaid services in 2013. Maintain or expand these collaborations while adding at least two additional partners annually through FY2015. (I.B.1)
- Identify collaborative partners' training needs related to HIV care and treatment, conducting at least one training annually through FY2015. (I.B.3)
- Evaluate education and training needs for non-Ryan White funded providers targeting at least two groups annually. Consider medical, oral health, social service, housing, prevention, and long term care (nursing homes) providers. (III.A.1)
- Identify appropriate training resources and implement at least one training per targeted provider group annually. (III.A.2)
- Evaluate each training program and modify future plans based on feedback. (III.A.3)
- Work with all Ryan White funded providers and community partners to include a link to HIV210.org on their websites. (III.D.8)

Prevention and STD Programs

The following strategies and actions pertain to collaborating with prevention and STD programs:

Strategy II.A

Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, resulting in reduction in the number of consumers with unmet need and reduced HIV transmission rates.

Strategy II.B

Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a 2% annual increase in the percentage of newly diagnosed linked to care within three months.

Strategy II.C

Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education as evidenced by documentation of referrals annually.

Strategy III.A

Develop and implement a three-year education and training plan for non-Ryan White funded providers.

Strategy III.B

Develop and implement a three-year community education plan to reduce HIV stigma.

Actions include:

- Identify annual targeted/focus populations through data review, including viral load mapping, unmet need analysis, and the needs assessment results. (II.A.1)
- Develop an annual plan to reach the targeted population(s), setting implementation priorities in conjunction with collaborative partners, such as the San Antonio HIV/Syphilis Testing Taskforce. (II.A.2)
- Implement the annual plan in conjunction with collaborative partners. (II.A.3)
- Evaluate the plan prior to beginning the process for the next fiscal year. (II.A.4)
- Educate and support all counseling and testing providers to ensure HIV positive clients are linked to appropriate services, providing at least two training programs annually in conjunction with collaborative partners such as the HIV/Syphilis Testing Taskforce. (II.B.1)
- Maintain and expand collaborations with HIV prevention providers (such as HIV/Syphilis Testing Taskforce and others) to provide appropriate referrals to all clients with HIV negative test results. (II.C.1)
- Evaluate education and training needs for non-Ryan White funded providers targeting at least two groups annually. Consider medical, oral health, social service, substance abuse treatment, housing, prevention, and long term care (nursing homes) providers. (III.A.1)
- Identify appropriate training resources and implement at least one training per targeted provider group annually. (III.A.2)
- Evaluate each training program and modify future plans based on feedback. (III.A.3)
- In conjunction with community partners, such as the HIV/Syphilis Testing Taskforce, implement annual community education programs that support stigma reduction in targeted communities. Involve key neighborhood community organizations such as faith based organizations, community centers, etc. (III.B.3)

Substance Abuse Treatment Facilities

Strategy I.E.

Evaluate residential substance abuse treatment options, identifying and implementing the most cost-effective service strategy.

Strategy III.A

Develop and implement a three-year education and training plan for non-Ryan White funded providers.

Actions include:

- Compile and organize available data to support the evaluation of residential substance abuse services. (I.E.1)
- Review consumer need for residential substance abuse services. (I.E.2)

- Identify alternatives to effectively meet that need and the costs of each. (I.E.3)
- If appropriate, formulate an RFP to support Ryan White funding of this service. (I.E.4)
- Evaluate education and training needs for non-Ryan White funded providers targeting at least two groups annually. Consider medical, oral health, social service, substance abuse treatment, housing, prevention, and long term care (nursing homes) providers. (III.A.1)

Medicare, Medicaid and Children's Health Insurance Program (CHIP)

Strategies pertaining to Medicare, Medicaid and CHIP tend to overlap and are outlined below.

Strategy V.B

Establish a third-party payer verification system to easily share consumers' insurance statuses between funded providers and ensure Ryan White is the payer of last resort by September 2013.

Strategy V.C

Require Medicare and Medicaid certification of all Ryan White funded providers of ambulatory outpatient medical care, oral health care, medical case management, mental health services, and substance abuse services by March 2014.

Strategy V.D

Recruit a Medicaid representative as a Planning Council member by March 2013

Actions supporting these strategies include:

- Evaluate HRSA's recommended third-party payer verification systems, outlining strengths and weaknesses of each. (V.B.1)
- Inventory and evaluate providers' third-party payer verification systems for core medical services, determining if it is feasible and cost-effective to implement an existing provider system by the fourth quarter of 2012. (V.B.2)
- Implement the selected verification system throughout the San Antonio HIV/AIDS Administrative Services Area by September 2013. (V.B.3)
- All providers who are not certified must develop and implement plans and timelines for becoming Medicare/Medicaid certified by March 2013. (V.C.2)
- All Ryan White funded providers will be Medicare and Medicaid certified. (V.C.3)
- Identify options for a Medicaid representative to serve on the Planning Council who will provide information and updates on Medicaid funding changes. (V.D.1)
- Orient the Medicaid representative to allow full Planning Council membership. (V.D.2)
- Encourage the Medicaid representative's active Planning Council participation on an ongoing basis. (V.D.3)

Community Health Centers

Two types of Community Health Centers are found in the SAHASA:

1. The San Antonio FQHC (CentroMed) and Eagle Pass FQHC (United Medical Centers) that incorporates an HIV clinic. CentroMed receives Part A and C while UMC receives Parts B and D funding.
2. General community health centers that provide general primary medical care.

There is some overlap in the strategies that apply to these two types of community health centers.

Strategy I.A

Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care.

Strategy I.B

Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES.

Strategy I.C

Increase demand for and capacity to provide oral health care as evidenced by at least 50% of consumers accessing at least one visit annually by 2015.

Strategy III.A

Develop and implement a three-year education and training plan for non-Ryan White funded providers.

Actions that pertain to the FQHC:

- Increase the percentage of Ryan White clients receiving HIV medical care from 74% to 85% as documented in ARIES. (I.A.1)

Actions that pertain to other community health centers:

- Expand PLWHA treatment options by enhancing linkages between Ryan White funded and non-funded providers as evidenced by PLWHA reporting HIV medical care outside the Ryan White provider network. (I.A.6)
- Increase collaboration with five key community organizations that provide Medicaid services in 2013. Maintain or expand these collaborations while adding at least two additional partners annually through FY2015. (I.B.1)
- Evaluate education and training needs for non-Ryan White funded providers targeting at least two groups annually. Consider medical, oral health, social service, substance abuse treatment, housing, prevention, and long term care (nursing homes) providers. (II.A.1)
- Identify appropriate training resources and implement at least one training per targeted provider group annually. (III.A.2)
- Evaluate each training program and modify future plans based on feedback. (III.A.3)

Actions that pertain to both the FQHC and other community health centers:

- Provide training to local internists and family practitioners about current HIV treatment, offering at least one program annually. (I.A.2)
- Increase capacity for oral health care throughout the region by partnering with FQHC(s) in underserved areas with a high concentration of PLWHA. (I.C.1)

F. How the Plan Addresses *Healthy People 2020* Objectives

Healthy People 2020 was launched in December 2010 with the ten-year agenda for monitoring and improving the nation's health. It includes objectives with monitoring benchmarks in order to:

- Encourage collaborations across communities
- Empower individuals toward making informed health decisions
- Measure the impact of prevention activities

It is the result of a multi-year process that included input from diverse groups of individuals and organizations.[6]

Eighteen objectives related to HIV prevention and care. Seventeen of these are addressed in the SAHASA Comprehensive HIV/AIDS Services Plan.

Table III.1 outlines the goals and strategies of the SAHASA Comprehensive HIV/AIDS Services Plan that address *Health People 2020* Objectives.

Table III.1
Comparison of Healthy People 2020 and
SAHASA Comprehensive Plan Goals and Strategies

Number	Objectives	SAHASA Plan
HIV–1	(Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.	Goal II: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services. Strategy II.C Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education as evidenced by documentation of referrals annually.
HIV–2	(Developmental) Reduce new (incident) HIV infections among adolescents and adults.	Strategy II.C
HIV–3	Reduce the rate of HIV transmission among adolescents and adults.	Strategy III.B Develop and implement a three-year community education plan to reduce HIV stigma.
HIV–4	Reduce the number of new AIDS cases among adolescents and adults.	Goal I: Increase access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA). Strategy I.A Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care. Goal II and Strategy II.A Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, resulting in reduction in the number of consumers with unmet need and reduced HIV transmission rates. Strategy II.B: Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a 2% annual increase from the 2011
HIV–5	Reduce the number of new AIDS cases among adolescent and adult heterosexuals.	
HIV–6	Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.	
HIV–7	Reduce the number of new AIDS cases among adolescents and adults who inject drugs.	

[6] http://www.healthypeople.gov/2020/about/default.aspx. Retrieved 4-5-2012.

Number	Objectives	SAHASA Plan
		baseline in the percentage of newly diagnosed PLWHA linked to care within three months.
HIV–9	(Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS.	Goal II
HIV–10	(Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.	Goal IV: Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction. Strategy IV.A Use data to determine progress toward the quality measurement benchmarks incorporated into the standards of care for each service category.
HIV–11	Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.	Goal I and Strategy I.A and Strategy I.B Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES.
HIV–12	Reduce deaths from HIV infection.	
HIV–13	Increase the proportion of persons living with HIV who know their serostatus.	Goal II; Strategy IIA and Strategy II.B
HIV–14	Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.	Goal II
HIV–15	Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.	Goal II
HIV–16	Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.	III.A Develop and implement a three-year education and training plan for non-Ryan White funded providers.
HIV–17	Increase the proportion of sexually active persons who use condoms.	Goal II; Strategy II.C
HIV–18	(Developmental) Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.	

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

The most recent Texas' Statewide Coordinated Statement of Need (SCSN) is for 2008 through 2010. Another SCSN will be developed and published in 2012. The BCDCR and Planning Council have always supported the Statewide Coordinated Statement of Need and the actions of Texas Department of State Health Services (DSHS).

This plan supports the previous SCSN, and when the updated document is available, BCDCR staff and Planning Council members will review and confirm support of the that document with this plan.

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

The BCDCR and Planning Council have been monitoring changes that will occur with the Affordable Care Act (ACA) and preparing for them. Goal V of this plan specifically addresses these changes and will allow continued focus on them. It states:

Goal V:
Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget cuts and implementation of the Affordable Care Act (ACA).

Specific strategies associated with this goal include:

Strategy V.A.

Evaluate and report on changes resulting from the Affordable Care Act that will affect funding for HIV/AIDS services. The responsible parties are the AA and the Fiscal Monitoring and Reallocations Committee. It has an ongoing timeframe during the course of this plan.

Strategy V.B.

Establish a third-party payer verification system to easily share consumers' insurance status between funded providers and ensure Ryan White is the payer of last resort. The AA will be responsible for this strategy, and it will be completed by September 2013.

Strategy V.C.

Require Medicare and Medicaid certification of all Ryan White funded providers of outpatient ambulatory medical care (OAMC), oral health, hospice, medical case management, mental health services, and substance abuse services. The AA is the responsible party, and all Ryan White funded providers will be Medicare and Medicaid certified by March 2014.

Strategy V.D.

Recruit a Medicaid representative as a Planning Council member by March 2013.
The Membership, Nominations and Elections (MNE) Committee will be responsible for this strategy.

I. Describe how the comprehensive plan addresses the goals of the National HIV/AIDS Strategy (NHAS), as well as which specific NHAS goals are addressed.

The Planning Council is fully supportive of the National HIV/AIDS Strategy (NHAS). The NHAS vision, goals and strategies have been translated to the regional priorities that will be enacted in this SAHASA Comprehensive HIV/AIDS Services Plan.

The NHAS vision was adopted by the Planning Council and helped guide this Comprehensive Plan. It states:

> "The SAHASA (will) become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have immediate

access to a high quality continuum of HIV care and services, free from stigma and discrimination.

The NHAS provides the framework and foundation for this Plan. The CPCC Committee, the Planning Council and the AA considered NHAS goals, strategies and outcomes during their deliberations.

- All NHAS goals were adopted by the Planning Council with minor translation to the local level.
- Many of the NHAS strategies are included, with expansion and/or modification for local conditions.
- NHAS outcomes serve as targets for this Plan.

Table III.2 presents the NHAS goals, strategies and actions and supporting SAHASA strategies and actions.

Table III.2
Comparison of National HIV/AIDS Strategy and
SAHASA Comprehensive Plan Strategies

NHAS Strategies	SAHASA Comprehensive Plan Strategies
Goal: Reduce New HIV Infections	*<u>Goal II</u>: Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.*
• Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.	• II.A. Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, resulting in reduction in the number of consumers with unmet need and reduced HIV transmission rates.
• Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.	• II.C. Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education as evidenced by documentation of referrals annually.
• Educate all Americans about the threat of HIV and how to prevent it.	• III.B. Develop and implement a three-year community education plan to reduce HIV stigma. • III.C. Update and distribute the HIV Resource Guide and Mini-Resource Guide. Identify mechanisms to incorporate regular updates of provider information to all guides. • III.C.2 Develop an updated version of the Resource Guide for use by consumers that includes provider information and consumer sexual health education.
Goal: Increase Access to Care and Improving Health Outcomes for PLWHA	*<u>Goal I</u>. Increase access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA).*
• Establish a seamless delivery system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.	• I.A. Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care. • II.B. Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a

NHAS Strategies	SAHASA Comprehensive Plan Strategies
	2% annual increase in the percentage of newly diagnosed linked to care within three months.
• Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for PLWHA.	• I.B Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES.
• Support PLWHA with co-occurring health conditions and those who have challenges meeting basic needs, such as housing.	• I.D Expand the mental health continuum of care available to people living with HIV/AIDS in conjunction with the Mental Health Consortium, rural providers and rural telemedicine. • I.E Evaluate residential substance abuse treatment options, identifying and implementing the most cost-effective service strategy. • I.F. Increase the number of Ryan White HIV/AIDS program clients with stable housing from 51% to 55% by 2015.
Goal: Reduce HIV-Related Disparities and Health Inequities	*<u>Goal III</u>. Reduce health disparities resulting from the stigma of HIV in the region.*
• Reduce HIV-related mortality in communities at high risk for infection. • Adopt community-level approaches to reduce HIV infection in high-risk communities.	• II.A Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, resulting in reduction in the number of consumers with unmet need and reduced HIV transmission rates.
• Reduce stigma and discrimination against people living with HIV.	• III.A Develop and implement a three-year education and training plan for non-Ryan White funded providers. • III.B Develop and implement a three-year community education plan to reduce HIV stigma. • III.C Update and distribute the HIV Resource Guide and Mini-Resource Guide. Identify mechanisms to incorporate regular updates of provider information to all guides. • III.D Increase use of the HIV210.org website by consumers, providers and the general public by at least 10% annually. • III.E Revitalize the People's Caucus to expand participation.

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

Goal V provides strategies to monitor changes that might occur as a result of the Affordable Care Act, state and local budget changes. Specifically:

- Evaluate and report on changes resulting from the Affordable Care Act that will affect funding for HIV/AIDS services. Both the AA and the FMRA Committee will be responsible for the monitoring and reporting changes associated with this strategy. (Strategy V.A)

- By establishing a third-party payer verification system to easily share consumers' insurance statuses between funded providers, the AA will ensure Ryan White is the payer of last resort. This will ensure that funds from all sources are maximized. (Strategy V.B)
- Similarly, by requiring Medicare and Medicaid certification of all Ryan White funded providers of outpatient/ambulatory medical care (OAMC), oral health, hospice, medical case management, mental health services, and substance abuse services, all available funding sources will be utilized and available funds will be maximized. (Strategy V.C)
- Recruiting a Medicaid representative as a Planning Council member will increase timely information about changes occurring at the state and federal levels for Medicaid and possibly other funding sources. It will also provide an immediate resource when questions arise. (Strategy V.D)

IV. HOW WILL WE MONITOR OUR PROGRESS?

A. Improved Use of Client Level Data/Using Data for Evaluation

The Planning Council and the BCDCR have consistently increased their use of client level data. They currently use it for quality management, utilization trends, identification of emerging trends, priority setting, and allocations.

The primary client level data collection instrument for the planning area is ARIES. Actions in this plan require monitoring of additional ARIES data to evaluate progress toward accomplishing the goals.

BCDCR staff has provided training and technical assistance to Ryan White funded service providers to ensure the most accurate information possible. ARIES data is used for:

- Identifying opportunities for provider performance improvement
- Determining service utilization overall, by specific population and by provider
- Identifying clients' service needs

Other sources that will be used include:

- TDSHS HIV/AIDS surveillance data
- Comprehensive Needs Assessment data
- Information available from collaborative partners

In 2010, technical assistance was provided to the Planning Council to better understand and use available data. New members of the Planning Council receive training on data sources and uses in their orientation.

B. How Do We Monitor and Evaluate Our Progress?

Monitoring and evaluation of the 2012 - 2015 Comprehensive HIV/AIDS Services Plan will be the joint responsibility of the Planning Council and the BCDCR. Joint monitoring and evaluation is essential because the Plan's action steps and tasks involve many different entities within the service system.

Monitoring

Monitoring is the regular observation and recording of activities taking place in the Plan. It is a process of routinely gathering information to measure progress toward accomplishing the strategies and goals.

The Plan's Goals, Strategies and Actions are presented in a Plan Implementation Matrix (Refer to Section II and Section III Appendix 1).

- In Section II, the Implementation Matrix presents the overall plan.
- An Implementation Matrix has been developed with all of the actions, responsible parties, start dates completion dates and monitoring intervals. This Matrix will facilitate the monitoring process.

- It can be sorted chronologically and by responsible party so that everyone involved is clear about their actions and timeframes.

The Planning Council and the BCDCR will jointly monitor this plan using the following process:

1. **Planning Council Monitoring Role**
    - Each Planning Council committee is responsible for fulfilling its responsibilities as outlined in the Plan.
    - The Plan will result in regular agenda items for each committee based on the time frames in the Plan.
    - Each month the Planning Council Liaison will work with the committee chairs to include Comprehensive Plan action items on each committee's agenda.
    - Progress in accomplishing each action item will be monitored by the responsible committee.
    - The committees will submit a quarterly Progress Report to the Comprehensive Planning and Continuum of Care (CPCC) Committee. This oversight group will review progress, make recommendations back to the committee(s) and forward the Progress Report to the Executive Committee with their comments, if any.

2. **BCDCR Monitoring Role**
    - Many of the Plan's actions are the responsibility of the Administrative Agency or the Quality Management Committee.
    - These groups will monitor their progress in accomplishing requirements of the Plan at least quarterly.
    - They will submit their quarterly Progress Report to the CPCC Committee to allow a snapshot of progress in accomplishing the actions, strategies and goals of the Plan. As appropriate, the CPCC Committee may make recommendations, suggestions and/or assign appropriate tasks to Planning Council Committees.

3. **Quarterly Oversight by BCDCR and the Planning Council**
    - Each quarter the BCDCR leadership and the Planning Council's Executive Committee will jointly review the Progress Report and the recommendations of the CPCC Committee. Any adjustments/changes to the Plan's actions, timetable, or responsible parties can be made at this joint session.

Progress toward goals, strategies and actions contained in this Comprehensive Plan will be reported to:

- HRSA through reports submitted by the Administrative Agency.
- HRSA through information contained in the TGA's annual Part A application.
- Texas DSHS for Part A and Part B through reporting requirements.

Evaluation

This 2012 – 2015 Comprehensive HIV/AIDS Services Plan will be evaluated on an annual basis using two approaches: process evaluation and goal-based evaluation.

- The evaluations will be the joint responsibility of the CPCC Committee, Executive Committee and Administrative Agency.
- These evaluations will be conducted in January of each year in preparation for the Part A funding cycle.

Process Evaluation

Process Evaluation reviews how well the defined actions allow achievement of the strategy. It asks the questions:

- Are the actions being accomplished and are they resulting in accomplishing the strategy?
- Will the strategies, once accomplished, result in accomplishing the goal?

The Plan's Implementation Matrix makes the process evaluation easy.

- Each strategy has a series of tasks to achieve the objective.
- Each task has a timeline, a responsible party and a measure, or evidence of completion.
- Once all tasks for any strategy have been completed and a measure or evidence of completion has been achieved, the CPCC Committee, Executive Committee and AA can evaluate whether the strategy will support the accomplishment of the goal.

Goal-Based Evaluation

Goal-based evaluation determines whether the goals with their defined strategies and actions achieve the goal and produce the desired result.

Goal-based evaluation will be conducted annually to ensure that the strategies will ultimately lead to goal accomplishment. Each year the CPCC Committee, Executive Committee and AA will jointly ask the following questions:

1. Have these strategies resulted in increasing access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA)?
2. Have the targeted early intervention and outreach resulted in reduced new HIV infections, ensuring all people who were newly diagnosed or were not receiving HIV medical care were effectively linked to appropriate services?
3. Have these strategies and actions resulted in reduced health disparities and HIV stigma in the region?
4. Do all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction?
5. Were all available funding sources coordinated as a result of these strategies, preparing for possible funding changes resulting from state and municipal budget cuts and implementation of the Affordable Care Act (ACA)?

C. Measuring Clinical Outcomes

The BCDCR has established the Quality Management (QM) Plan to improve the health outcomes of all PLWHA in the SAHASA by incorporating the HIV/AIDS Bureau (HAB) performance measures, other clinical outcomes and supportive services into the plan of service for each consumer.

The QM Plan is overseen by the QM Committee. This committee is composed of 14 members, including representatives from the following: Parts A, B, C, D and F funded programs, private practitioners, consumers, Planning Council members, and other community stakeholders (mental health, service providers, substance abuse providers).

- The QM Committee oversees the implementation of QM strategies through the annual review of the local Standards of Care (SOC).

The CPCC Committee of the Planning Council develops the SOC for all service categories and provides perspective to the QM staff.

- The SOC include outcomes and performance measures for each service category.
- The SOC were benchmarked in 2009 against the national standards. The benchmarks formed the baseline for performance measurement of the service providers.

The progress in meeting performance measurements is monitored annually.

- A minimum of one and no more than three performance measurements are selected by the service provider. The lowest performing measures are targeted by the service providers for improvement throughout the program year.

Each service provider has a dedicated QM Single Point of Contact (SPOC) whose purpose is to ensure that improvement is made on the selected measurements.

- This process includes the development of an internal QM plan particular to the agency and the establishment of an agency committee to oversee the implementation of its plan through continuous feedback and improvement procedures.
- The development of customer satisfaction surveys and the process by which customer input is included in the continuous quality improvement process is also the responsibility of the SPOC**.**

Primary medical care providers participate in the QM Committee's semi-annual quality monitoring reviews which ensure Primary Medical Care services reflect treatment guidelines as outlined in the SAHASA SOC.

- Primary medical care service providers are required to develop a QM plan to assess quality of primary medical care and corresponding health outcomes, providing quality measure outcomes specific to the treatment protocols.

San Antonio Planning Area Ryan White Parts A & B
2012-2015 Comprehensive HIV/AIDS Services Plan

PART TWO: COMPREHENSIVE HIV/AIDS SERVICES PLAN

San Antonio Planning Area Ryan White Parts A & B
2012-2015 Comprehensive HIV/AIDS Services Plan

I. MISSION, VISION & SHARED VALUES STATEMENTS

Mission

To create a broad-based community response to the HIV epidemic affecting people within the Transitional Grant Area and to ensure the availability and coordination of high quality, comprehensive health and social services to individuals infected or affected by HIV.

Vision

To have the San Antonio HIV/AIDS Administrative Services Area (SAHASA) become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have immediate access to a high quality continuum of HIV care and services, free from stigma and discrimination.

Shared Values

- Strive for a seamless system of coordinated care meeting consumer needs.
- Provide the highest quality care and services in the most cost-effective manner.
- Ensure equal and easy access to services.
- Ensure that all services are culturally competent and sensitive.
- Treat all consumers with compassion and respect.

II. GOALS

- Increase access, engagement and retention in quality care and services for people living with HIV/AIDS (PLWHA).

- Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

- Reduce health disparities resulting from the stigma of HIV in the region.

- Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

- Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

San Antonio Planning Area Ryan White Parts A & B 2012-2015 Comprehensive HIV/AIDS Services Plan

III. GOALS AND STRATEGIES

Goal I

Increase access, engagement and retention in quality care and services for persons living with HIV/AIDS (PLWHA).

Strategies

I.A. Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care[7].
Responsible Party: Comprehensive Planning/Continuum of Care (CPCC) Committee

I.B. Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers documented in ARIES in 2011.
Responsible Party: Administrative Agency (AA)

I.C. Increase demand for and capacity to provide oral health care as evidenced by at least 50% of consumers accessing at least one visit annually by 2015.
Responsible Party: AA

I.D. Expand the mental health continuum of care available to people living with HIV/AIDS in conjunction with the mental health stakeholders, rural providers and rural telemedicine.
Responsible Party: Needs Assessment (NA) Committee

I.E. Evaluate residential substance abuse treatment options, identifying and implementing the most cost-effective service strategy.
Responsible Party: NA Committee

I.F. Increase the number of Ryan White HIV/AIDS program clients with stable housing[8] from 51% to 55% by 2015
Responsible Party: NA Committee/Service Providers

I.G. Develop a multi-faceted transportation strategy, evaluating options for alternative funding for medical transportation in both the urban and rural regions in compliance with HRSA mandates.
Responsible Party: AA/Ad Hoc Transportation Committee

[7] PLWHA in HIV medical care are defined as consumers receiving two or more medical visits more than three months apart.
[8] Stable housing is defined by ARIES as anyone living in a house, apartment, trailer or room that they own or rent and anyone living in a board care or assisted living facility.

Goal II

Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

Strategies

II.A. Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, reducing the number of consumers with unmet need and reducing HIV transmission rates.
Responsible Party: AA/NA Committee

II.B. Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a 2% annual increase from the 2011 baseline in the percentage of newly diagnosed PLWHA linked to care within three months.
Responsible Party: AA

II.C. Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education, as evidenced by documentation of referrals annually.
Responsible Party: AA

Goal III

Reduce health disparities resulting from the stigma of HIV in the region.

Strategies

III.A. Develop and implement a three-year education and training plan for non-Ryan White funded providers.
Responsible Party: Quality Management (QM)

III.B. Develop and implement a three-year community education plan to reduce HIV stigma.
Responsible Party: Executive Committee

III.C Update and distribute the HIV Resource Guide and Mini-Resource Guide with versions targeting case managers/providers and consumers. Identify mechanisms to incorporate regular updates of provider information to all guides.
Responsible Party: AA

III.D. Increase use of the HIV210.org website by consumers, providers and the general public by at least 10% annually as determined by website visits.
Responsible Party: Ad Hoc Website Committee

III.E. Revitalize the People's Caucus to expand participation.
Responsible Party: People's Caucus

Goal IV

Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

Strategies

IV.A. Use data to determine progress toward the quality measurement benchmarks incorporated into the standards of care for each service category.
Responsible Party: Quality Management Committee (QMC)

IV.B. Implement the patient/client satisfaction surveys throughout the San Antonio HASA, improving overall patient/client satisfaction annually.
Responsible Party: QM/QM Single Point of Contact (SPOCs)

IV.C. Participate in partnership with all Ryan White Program Parts to coordinate quality management activities.
Responsible Party: QM/QMC

Goal V

Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

Strategies

V.A. Evaluate and report on changes resulting from the Affordable Care Act that will affect funding for HIV/AIDS services.
Responsible Party: AA/Fiscal Monitoring and Reallocations (FMRA) Committee

V.B. Establish a third party payer verification system to easily share consumers' insurance status between funded providers and ensure Ryan White is the payer of last resort.
Responsible Party: AA

V.C. Require Medicare and Medicaid certification of all Ryan White funded providers of outpatient ambulatory medical care (OAMC), oral health, hospice, medical case management, mental health services, and substance abuse services.
Responsible Party: AA

V.D. Recruit a Medicaid representative as a Planning Council member by March 2013.
Responsible Party: Membership, Nominations and Elections (MNE) Committee

San Antonio Planning Area Ryan White Parts A & B

2012-2015 Comprehensive HIV/AIDS Services Plan

IV. ACTION PLANS

GOAL: I. Increase access, engagement and retention in quality care and services for PLWHA.

***STRATEGY*:** I.A. Support and enhance a seamless service system resulting in at least 85% of Ryan White clients accessing and maintaining HIV medical care.[9]

Completion Date: March 2016 and Ongoing

Responsible Party: Comprehensive Planning / Continuum of Care Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.A.1.	Increase the percentage of Ryan White clients receiving HIV medical care from 74% to 85% as documented in ARIES, using calendar year 2011 as the baseline.	AA/QM	March 2012	March 2016	Semi-Annually		• HIV Treatment Cascade SATGA 2014 78% with at least one medical visit. • Implementation Plan
I.A.2	Provide training to local internists and family practitioners about current HIV treatment issues, offering at least one program annually.	AA/QM	March 2012	March 2016	Semi-Annually	Completed	• HIV Routine Testing Summit (2013) • Oral Health & HIV Symposium (2013) • Beyond Case Management Workshop (2013) • Condom Training (2013) • Health Literacy Conference (2014) • Texas HIV Case Management (2014) • Standards of Care (2014) • Treatment Cascade (2015) • Mental Health Summit (2015)

[9] PLWHA in HIV medical care are defined as consumers receiving two or more medical visits more than three months apart.

I.A.3	Build capacity in rural locations, possibly with the support of telemedicine, in order to increase the number of rural clients receiving medical services in their local communities by 5% annually.	AA/QM	March 2012	February 2015	Semi-Annually	Completed	MCHD – From 2012 to 2014 there was a 42% increase in the number of clients receiving medical care VCCHD – From 2012 to 2014 there was a 33% decrease in the number of clients receiving medical care.
I.A.4	Identify and reduce barriers to accessing case management at rural providers, resulting in a 5% annual increase in rural case management utilization.	AA/QM	March 2012	March 2016	Semi-Annually	Completed	MCHD NMCM– From 2012 to 2014 there was a 278% increase MCHD MCM – From 2012 to 2014 there was a 265% increase VCCHD NMCM – From 2012 to 2014 there was a 54% increase VCCHD MCM- From 2012 to 2014 there was a 14% decrease *The decrease in VCCHD clients can be attributed to geographical relocation.
I.A.5	Identify and engage co-located primary care and medical specialists to efficiently and effectively treat PLWHA with co-morbid conditions and complications as evidenced by additional proposals during the 2015 - 2016 RFP process.	AA	October 2013	October 2014	Quarterly	Completed	• The AA met with local FQHCs for participation in the RW Care System and rural expansion • Dr. Kaspar co-location to Victoria to serve clients • A new RFP will be released Nov. 5, 2015

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.B. Increase collaboration with and education of community partners that provide primary medical care and other support services to Medicaid and low-income clients annually through 2015 as evidenced by annual increases in consumer referrals to non-Ryan White funded providers as documented in ARIES in 2011.

Completion Date: March 2016 and Ongoing

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.B.1	Increase collaboration with five entities that provide Medicaid services in 2013.	AA	March 2012	March 2013	Quarterly	Completed	
I.B.2	Maintain or expand these collaborations while adding at least two additional partners annually.	AA	March 2013	March 2016	Semi-Annually	Completed	
I.B.3	Increase collaboration with additional community partners that assist with self-sufficiency (i.e., financial literacy, job skills, etc.) as documented by signed Memorandums of Understanding with at least 10 agencies in 2013 and ongoing.	AA/Service Providers	March 2012	March 2016 and Ongoing	Quarterly	Completed	
I.B.4	Identify collaborative partners' training needs related to HIV care and treatment, conducting at least one training annually through 2015.	AA/QM	March 2012	March 2016 and Ongoing	Semi-Annually	Completed	• HIV Routine Testing Summit (2013) • Oral Health & HIV Symposium (2013) • Beyond Case Management Workshop (2013) • Condom Training (2013) • Health Literacy Conference (2014) • Texas HIV Case Management (2014) • Standards of Care (2014) • Treatment Cascade (2015) • Mental Health Summit (2015)

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.C. Increase demand for and capacity to provide oral health care as evidenced by at least 50% of consumers accessing at least one visit annually by 2015.

Completion Date: 2015 and Ongoing

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.C.1	Increase capacity for oral health care throughout the region by partnering with FQHC(s) in underserved areas with a high concentration of PLWHA.	AA	2013	Ongoing	Quarterly	Completed	Centro Med
I.C.2	Provide training to dentists and dental hygienists about current HIV treatment issues, offering at least one program annually.	QM	2013	2015	Semi-Annually	Completed	Oral Health Symposium
I.C.3	Increase referrals to oral health by educating physicians, nurses, and case managers about the importance of oral health to overall health by 10% annually.	AA	2012	2015	Quarterly	Completed	The providers have been educating their medical staff to increase oral health referrals.
I.C.4	Track oral health referrals and utilization using ARIES.	AA	2012	Ongoing	Quarterly	Ongoing	Providers track their oral health referrals as well as monitoring reports.
I.C.5	Develop and/or identify consumer educational information about oral health care and services on the HIV210.org website, updating annually.	Ad Hoc Website Committee	September 2013	February 2014	Quarterly	Completed	Resource Guide is available on the HIV210.org

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.D. Expand the mental health continuum of care available to people living with HIV/AIDS in conjunction with the mental health stakeholders, rural providers and rural telemedicine.

Completion Date: March 2016 and Ongoing

Responsible Party: Needs Assessment Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.D.1	Appoint two Planning Council representatives to the Mental Health Consortium to expand collaboration and enhance communication.	Executive Committee	March 2012	Ongoing	Annually		
I.D.2	Report the mental health services continuum of care available in San Antonio HASA and providers offering these services to PLWHA in conjunction with mental health stakeholders.	AA/QM	March 2012	October 2012	Semi-Annually	Completed	Mental Health Needs Assessment Mental Health Study Mental Health Directory Mental Health Summit
I.D.3	Identify and coordinate data sources regarding service and geographic gaps.	AA/QM	October 2012	February 2013	Quarterly	Completed	Mental Health Needs Assessment
I.D.4	Review all available needs assessment information to identify consumer perceptions of gaps in mental health care therapy and counseling services.	NA Committee	October 2012	February 2013	Monthly	Completed	Mental Health Study
I.D.5	Review barriers to accessing mental health therapy and strategies to overcome these barriers.	NA Committee	October 2012	February 2013	Monthly	Completed	Mental Health Study Mental Health Summit
I.D.6	Develop recommendations to expand and enhance the available mental health continuum of care throughout the region.	NA Committee	October 2012	February 2013	Monthly	Completed	Mental Health Study Mental Health Summit

I.D.7	Support and advocate for the recommendations outlined in I.D.6 in order to develop strategies to expand the mental health continuum of care, increasing access and reducing barriers for PLWHA throughout the region.	NA Committee/ Executive Committee	March 2013	March 2016 and Ongoing	Semi-Annually	Completed	Mental Health Summit
I.D.8	Conduct a Mental Health Forum for providers, consumers and the general community to inform them of available mental health services.	AA/QM	March 2013	March 2014	Quarterly	Complete	Mental Health Summit

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.E. Evaluate residential substance abuse treatment options, identifying and implementing the most cost-effective service strategy.

Completion Date: October 2014

Responsible Party: Needs Assessment Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.E.1	Compile and organize available data to support the evaluation of residential substance abuse services.	AA/NA Committee	October 2013	December 2013	Quarterly	Completed	RFP was released in 2011 and three providers were selected. The lack of funded prevented any one provider to bid on the money.
I.E.2	Review consumer need for residential substance abuse services.	AA/NA Committee	October 2013	February 2014	Quarterly	Completed	Needs Assessments and PSRA
I.E.3	Identify alternatives to effectively meet the need for residential substance abuse treatment and the costs of each.	AA/NA Committee	December 2013	March 2014	Quarterly		
I.E.4	If appropriate, formulate an RFP to support Ryan White funding of this service.	AA	March 2014	October 2014	Semi-Annually	Completed	RFP was released in 2011 and three providers were selected. The lack of funded prevented any one provider to bid on the money.

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.F. Increase the number of Ryan White HIV/AIDS program clients with stable housing[10] from 51% to 55% by 2015.

Completion Date: March 2016

Responsible Party: Administrative Agency/Service Providers

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
I.F.1	Conduct an assessment of housing resources in the region.	AA/NA Committee	October 2014	March 2015	Monthly	In progress	
I.F.2	Identify gaps in the housing continuum.	NA Committee	October 2014	March 2015	Monthly	In progress	
I.F.3	Develop recommendations to reduce housing barriers and gaps.	NA Committee	December 2014	March 2015	Monthly	In progress	
I.F.4	Implement strategies to increase housing access and reducing housing barriers and gaps.	AA	March 2015	March 2016	Quarterly	In progress	
I.F.5	Collaborate with housing advocates to provide training and sharing of housing resources to Ryan White case managers and other providers in a Provider Housing Forum.	AA	March 2015	March 2016	Monthly	In progress	
I.F.6	Collaborate with housing advocates to provide education and information about housing resources to PLWHA in a Consumer Housing Forum.	AA	March 2015	March 2016	Monthly	In progress	

[10] Stable housing is defined by ARIES as anyone living in a house, apartment, trailer or room that they own or rent and anyone living in a board care or assisted living facility.

GOAL: I. Increase access, engagement and retention in quality care for people living with HIV/AIDS.

STRATEGY: I.G. Develop a multi-faceted transportation strategy, evaluating options for alternative funding for medical transportation in both the urban and rural regions in compliance with HRSA mandates.

Completion Date: March 2014 and Ongoing

Responsible Party: Administrative Agency/Ad Hoc Transportation Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	
I.G.1	Identify other organizations serving low-income consumers with medical/behavioral health conditions to establish a "collaborative pool" to negotiate with VIA to provide reduced fares.	AA/Executive Committee	September 2012	February 2013	Quarterly	Completed	Due to VIA policies, PLWHA were not considered to be disabled therefore they are not eligible for a reduced fare
I.G.2	Negotiate with VIA to reduce fares for PLWHA and clients of the "collaborative pool" agencies.	AA/Executive Committee	January 2013	July 2013	Quarterly	Completed	Due to VIA policies, PLWHA were not considered to be disabled therefore they are not eligible for a reduced fare
I.G.3	Collaborate with AACOG and rural transportation providers to access reduced fares for PLWHA.	AA/Ad Hoc Transportation Committee	July 2013	March 2014	Quarterly		
I.G.4	Identify Medicaid and Medicare transportation benefits for medical and other services.	AA	September 2012	March 2013	Quarterly	Completed	Before clients are given transportation services, providers are required to verify third party payers
I.G.5	Once the third-party payer verification system is implemented (refer to V.B), require eligible consumers of third-party payers to use those payer sources for medical transportation services per HRSA mandate.	AA	March 2013	Ongoing	Quarterly	Ongoing	Before clients are given transportation services, providers are required to verify third party payers
I.G.6	Educate both consumers and providers about the HRSA medical transportation mandates and the process to access transportation	AA	March 2013	March 2016 and Ongoing	Quarterly		

	services from other payers with at least one training session annually.						
I.G.7	As consumers use other funding sources, shift Ryan White funds to expand medical transportation in rural areas.	AA	March 2014	March 2016 and Ongoing	Quarterly	Ongoing	The monthly fiscal monitoring and agency reviews

GOAL: II. Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

STRATEGY: II.A. Prioritize early intervention, outreach, counseling and testing services targeting populations or geographic areas annually, reducing the number of consumers with unmet need and reducing HIV transmission rates.

Completion Date: March 2016 and Ongoing

Responsible Party: Administrative Agency/Needs Assessment Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
II.A.1	Identify annual targeted/focus populations through data review including viral load mapping, unmet need analysis, and the needs assessment results.	AA/NA Committee	March 2012	June 2012 and Ongoing	Monthly during the first quarter of each FY then Semi-Annually	Ongoing	HIV Needs Assessment was completed June 2015 Augmentation of the Needs Assessment completed July 2015 Viral mapping conducted annually Mental Health needs assessment (2012) Mental Health Study (2014) Mental Health Summit (2015)
II.A.2	Develop an annual plan to reach the targeted population(s), setting implementation priorities in conjunction with collaborative partners.	AA/NA Committee	June 2012	September 2012 and Ongoing	Monthly while annual plan is being developed then Annually	Ongoing	Youth Strategy plan
II.A.3	Implement the annual plan in conjunction with collaborative partners.	AA	September 2012	September 2013 and Ongoing	Quarterly during Implementa-tion then Annually	Ongoing	Youth Initiative Task Force
II.A.4	Evaluate the plan prior to beginning the process for the next fiscal year.	AA/NA Committee	February 2013	March2013 and Ongoing	Annual Review	Ongoing	

GOAL: II. Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

STRATEGY: II.B Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a 2% annual increase from the 2011 baseline in the percentage of newly diagnosed PLWHA linked to care within three months.

Completion Date: March 2016 and Ongoing

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
II.B.1	Educate and support all counseling and testing providers to ensure HIV positive clients are linked to appropriate services, providing at least two training programs annually in conjunction with collaborative partners.	AA/QM/Planning Council	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	Referral workshop (2015) Mental Health Summit (2015) Mental Health Directory Resource Guide
II.B.2	Monitor newly diagnosed and returned-to-care clients to ensure HIV medical care utilization for at least six months from referral.	AA/QM	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	AARC monitors the newly diagnosed clients for at least 6 months
II.B.3	Expand the patient navigator program to support newly diagnosed and returned to care PLWHA for at least six months after beginning HIV medical care (Refer to III.)	AA/QM and People's Caucus	March 2013	March 2016 and Ongoing	Semi-Annually	Ongoing	AARC Return to Care Specialist position was created to reach out of care clients
II.B.4	Evaluate effectiveness of programs annually and develop strategies to build on successes.	AA/QM	March 2013	March 2016 and Ongoing	Semi-Annually	Ongoing	AARC evaluates the EIS program through the increase of client numbers.

GOAL: II. Use targeted early intervention and outreach to reduce new HIV infections, and ensure all people who are newly diagnosed or are not receiving HIV medical care are effectively linked to appropriate services.

STRATEGY: II.C. Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education, as evidenced by documentation of referrals annually.

Completion Date: March 2016 and Ongoing

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
II.C.1	Maintain and expand collaborations with HIV prevention providers to provide appropriate referrals to all clients with HIV negative test results.	AA/QM	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	
II.C.2	Ensure a documentation system is in place for recording all HIV negative tested client referrals. Improve/enhance the documentation system as necessary.	AA	March 2013	March 2016 and Ongoing	Semi-Annually		
II.C.3	Collaborate with prevention intervention programs to distribute the expanded Resource Guide for education and referral of HIV negative client education (refer to III.B) in the areas of harm reduction/risk reduction.	AA	June 2013	March 2016 and Ongoing	Annually	Ongoing	We distribute the Resource Guide to all community agencies.
II.C.4	Use HIV210.org for education and referral of HIV negative clients (refer to III.C) in the areas of harm reduction/risk reduction.	Ad Hoc Website Committee	March 2012	March 2016 and Ongoing	Annually	Ongoing	The website information is disseminated throughout the community

GOAL: III. Reduce health disparities resulting from the stigma of HIV in the region.

STRATEGY: III.A. Develop and implement a three-year education and training plan for non-Ryan White funded providers.

Completion Date: March 2016

Responsible Party: Quality Management

Actions	Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
III.A.1 Evaluate education and training needs for non-Ryan White funded providers targeting at least two groups annually. Consider social service, substance abuse treatment, housing, prevention, and long term care (nursing homes) providers.	AA/QM	September 2012	March 2016	Quarterly	Completed	• HIV Routine Testing Summit (2013) • Oral Health & HIV Symposium (2013) • Condom Training (2013) • Health Literacy Conference (2014, 2015) • Texas HIV Case Management (2014) • Treatment Cascade (2015) • Mental Health Summit (2015) • Referral Workshop (2015)
III.A.2 Identify appropriate training resources and implement at least one training annually.	AA/QM	March 2013	March 2016	Quarterly		Average of 4-5 trainings annually
III.A.3 Evaluate each training program and modify future plans based on feedback.	AA/QM	March 2013	March 2016	Quarterly	Completed	Attendee evaluations are conducted at each training

GOAL: III. Reduce health disparities resulting from the stigma of HIV in the region.

III.B. Develop and implement a three-year community education plan to reduce HIV stigma.

Completion Date: March 2016

Responsible Party: Executive Committee

Actions	Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
III.B.1 Evaluate the effectiveness of the Planning Council and Administrative Agency's current community educational activities.	AA and Executive Committee	March 2012	June 2013	Quarterly		
III.B.2 Continue successful educational activities annually, if appropriate.	AA and Executive Committee	June 2013	March 2016 and Ongoing	Quarterly		
III.B.3 In conjunction with community partners, implement annual community education programs that support stigma reduction in targeted communities. Involve key neighborhood community organizations such as faith based organizations, community centers, etc.	AA	March 2013	March 2016	Quarterly		
III.B.4 Implement a People's Caucus Speaker's Bureau that can respond to community speaker requests and that will support educational programs and strive to dispel myths about PLWHA.	AA and People's Caucus	March 2013	March 2016	Quarterly		

GOAL: III. Reduce health disparities resulting from the stigma of HIV in the region.

STRATEGY: III.C. Update and distribute the HIV Resource Guide and Mini-Resource Guide with versions targeting case managers/providers and consumers. Identify mechanisms to incorporate regular updates of provider information to all guides.

Completion Date: March 2016 and Ongoing

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
III.C.1	Develop an updated version of the Resource Guide for use by case managers and other providers with information needed to make appropriate client referrals to the complete continuum of care and services.	AA	June 2012	June 2013	Quarterly	Completed	Updated and released in March 2015
III.C.2	Develop an updated version of the Resource Guide for use by consumers that includes provider information and consumer sexual health education.	AA and People's Caucus	June 2012	December 2013	Quarterly	Completed	Updated and released in March 2015
III.C.3	Evaluate the option to publish all guides on HIV210.org.	Ad Hoc Website Committee	June 2013	Ongoing	Quarterly	Ongoing	Updated and released in March 2015
III.C.4	Update provider Resource Guide information annually.	AA	June 2014	Ongoing	Quarterly	Ongoing	Updated and released in March 2015
III.C.5	Evaluate options to allow providers to update their Resource Guide entries on-line with password protection. Implementing as appropriate.	Ad Hoc Website Committee	March 2015	March 2016	Quarterly		

GOAL: III. Reduce health disparities resulting from the stigma of HIV in the region.

STRATEGY: III.D. Increase use of the HIV210.org website by consumers, providers and the general public by at least 10% annually as determined by website visits.

Completion Date: March 2016 and Ongoing

Responsible Party: Ad Hoc Website Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
III.D.1	Include a People's Caucus representative on the Ad Hoc Website Committee to monitor and update the HIV210.org website relative to consumer needs and interests.	People's Caucus	March 2012	Ongoing	Quarterly	Ongoing	Note: There is no Ad Hoc Committee for the HIV210.org website
III.D.2	Create an online forum on HIV210.org for Ryan White case managers to share information and insights.	Ad Hoc Website Committee	March 2012	February 2013	Quarterly		
III.D.3	Evaluate rural consumers' current use and suggestions for expansion of HIV210.org during the 2012 Needs Assessment.	AA/NA Committee	March 2012	June 2012	Monthly		
III.D.4	Implement rural consumers' suggestions for HIV210.org.	Ad Hoc Website Committee	June 2012	June 2013 and Ongoing	Quarterly		
III.D.5	Create a consumer online forum to share information and education, linking to the People's Caucus.	Ad Hoc Website Committee	March 2013	September 2013	Quarterly	Ongoing	The implementation of the Facebook page
III.D.6	Develop and implement a Planning Council social media plan using HIV210.org as the foundation.	Ad Hoc Website Committee	September 2012	September 2013 and Ongoing		Ongoing	The implementation of the Facebook page
III.D.7	Work with all Ryan White funded providers and community partners to include a link to HIV210.org on	Ad Hoc Website Committee	March 2013	March 2014 and Ongoing	Semi-Annually		

	their websites.						
III.D.8	Upgrade HIV210.org to make it mobile ready by September 2012.	Ad Hoc Website Committee	March 2012	February 2013	Quarterly		
III.D.9	Create a HIV210.org mobile phone app.	Ad Hoc Website Committee	March 2014	February 2015	Quarterly		
III.D.10	Monitor website use by topic or category website visits.	Ad Hoc Website Committee	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	Planning Council Liaison is working on a contract with the previous webhost consultant to continue monitoring.

GOAL: III. Reduce health disparities resulting from the stigma of HIV in the region.

STRATEGY: III.E. Revitalize the People's Caucus to expand participation.

Completion Date: March 2016 and Ongoing

Responsible Party: People's Caucus

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
III.E.1	Identify Ryan White Planning Councils with consumer committees with high levels of participation and evaluate the components of these successful programs for use in San Antonio.	AA/People's Caucus	March 2012	September 2012	Monthly	Completed	Collaboration with other Planning Councils
III.E.2	Develop a plan to increase participation.	People's Caucus	October 2012	March 2013	Monthly	Completed	The plan includes the development of an announcement, printed and displayed in all HIV clinics (Ryan White and non-Ryan White providers), more timely announcement.
III.E.3	Evaluate the response to each component of the plan, making necessary changes/adjustments.	People's Caucus	March 2014	March 2016	Quarterly	Completed	Evaluated through the increase number of attendance.

GOAL: IV. Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

STRATEGY: IV.A. Use data to determine progress toward the quality measurement benchmarks incorporated into the standards of care for each service category.

Completion Date: Ongoing

Responsible Party: Quality Management Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
IV.A.1	Assess and review program and clinical monitoring measures annually.	AA/QM Committee	March 2012	Ongoing	Annually	Ongoing	The review is based on the five year trending data to assess measures.
IV.A.2	Develop benchmark report for review by QM Committee and Planning Council.	AA	March 2012	Ongoing	Semi-Annually	Ongoing	Trending report
IV.A.3	Develop recommendations for training and technical assistance to improve performance.	AA/QM/QM Committee	March 2012	Ongoing	Annually	Ongoing	Captured in QM and program monitoring reports
IV.A.4	Non-compliant agencies develop corrective action plans using Plan-Do-Study-Act (PDSA).	AA/QM	March 2012	Ongoing	Semi-Annually	Ongoing	Providers submit management action plans
IV.A.5	Maintain the approach in which each agency has a designated QM single point of contact (SPOC) that reviews the monitoring report, clinical report, data improvement plan and consumer satisfaction survey results and develops the	QM/QM SPOCs	March 2012	Ongoing	Semi-Annually	Ongoing	Each agency appoints an SPOC to attend, review and report

agency QM plan which is shared with the QM Committee annually.						

GOAL: IV. Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

STRATEGY: IV.B. Implement the patient/client satisfaction surveys throughout the San Antonio HASA, improving overall patient/client satisfaction annually.

Completion Date: Ongoing

Responsible Party: Quality Management/Quality Management SPOCs

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
IV.B.1	Implement the patient satisfaction survey annually to measure satisfaction, building on the 2011 satisfaction survey and results.	QM/QM SPOCs	March 2012	Ongoing	Annually	Ongoing	Service providers submit the results of the client satisfaction surveys annually.
IV.B.2	Using the satisfaction survey results, identify and implement changes to improve client satisfaction using PDSA.	QM/QM SPOCs	March 2012	Ongoing	Semi-annually	Ongoing	Results from the survey help to dictate the issues that will be addressed in the agency's annual QM plan.
IV.B.3	Evaluate and compare results between annual patient satisfaction surveys.	QM/QM SPOCs	March 2012	Ongoing	Annually	Ongoing	QM staff evaluates and compares results.
IV.B.4	Correlate the system wide satisfaction survey results with providers' internal satisfaction survey results and internal quality management plan results to evaluate the impact of changes using PDSA.	QM/QM Committee	March 2012	Ongoing	Annually	Ongoing	QM staff responsible for correlating the system with providers.

GOAL: IV. Ensure that all Ryan White funded services conform to measurable standards of care and achieve optimal consumer satisfaction.

STRATEGY: IV.C. Participate in partnership with all Ryan White Program Parts to coordinate quality management activities.

Completion Date: March 2016 and Ongoing

Responsible Party: Quality Management/Quality Management Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
IV.C.1	Link with Part C and Part D providers for South Texas HIVQual Regional Group.	AA/QM Committee	March 2012	Ongoing	Quarterly	Ongoing	Clinical Team Meeting (UHS) monthly, QM Meetings quarterly , QM SPOC Meetings quarterly, SouthTexas HIV Qual meetings
IV.C.2	Maintain Quality Management Committee with Parts A, B, C, D, F and non-Ryan White funded providers.	QM	March 2012	Ongoing	Quarterly	Ongoing	Clinical Team Meeting (UHS) monthly, QM Meetings quarterly , QM SPOC Meetings quarterly, SouthTexas HIV Qual meetings

GOAL: V. Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

STRATEGY: V.A. Evaluate and report on changes resulting from the Affordable Care Act that will affect funding for HIV/AIDS services.

Completion Date: March 2016

Responsible Party: Administrative Agency/Fiscal Monitoring and Reallocations Committee

Actions	Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
V.A.1 Methodically evaluate expected changes in funding for HIV/AIDS services that will affect Ryan White funding and Planning Council activities.	Executive Committee	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	PSRA, FMRA, Planning Council, CPCC, Executive Committee meetings.
V.A.2 Provide reports to the Planning Council at least semi-annually.	Executive Committee	March 2012	March 2016 and Ongoing	Semi-Annually	Ongoing	PSRA, FMRA, Planning Council, CPCC, Executive Committee meetings.

GOAL: V. Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

STRATEGY: V.B. Establish a third-party payer verification system to easily share consumers' insurance statuses between funded providers and ensure Ryan White is the payer of last resort.

Completion Date: February 2013

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
V.B.1	Evaluate third-party payer verification systems, outlining strengths and weaknesses of each and sharing information with service providers.	AA	March 2012	December 2012	Monthly	Completed	
V.B.2	Inventory and evaluate providers' third-party payer verification systems for core services, determining if it is feasible and cost-effective to implement an existing provider system.	AA	June 2012	March 2013	Monthly	Completed	
V.B.3	Implement the selected verification system throughout the San Antonio HASA.	AA	March 2013	September 2013	Monthly	Completed	Capario/Emdeon One

GOAL: V. Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

STRATEGY: V.C. Require Medicare and Medicaid certification of all Ryan White funded providers of outpatient/ambulatory medical care (OAMC), oral health care, hospice, medical case management, mental health services, and substance abuse services.

Completion Date: March 2014

Responsible Party: Administrative Agency

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
V.C.1	Assess current OAMC, oral health care, hospice, medical case management, mental health services and substance abuse service providers' status for third-party reimbursement.	AA	May 2012	December 2012	Quarterly	Completed	All providers are capable of billing third party payors
V.C.2	All providers who are not certified must develop and implement plans and timelines for becoming Medicare/Medicaid certified.	AA	December 2012	March 2013	Quarterly	Completed	UHS, Centro Med, AARC (In progress), SAAF (grandfathered in)
V.C.3	All Ryan White funded providers will be Medicare and Medicaid certified.	AA	December 2013	March 2014	Annually	In progress	UHS, Centro Med, AARC (In progress), SAAF (grandfathered in)

GOAL: V. Coordinate with all available funding sources, preparing for possible funding changes resulting from state and municipal budget changes and implementation of the Affordable Care Act (ACA).

STRATEGY: V.D. Recruit a Medicaid representative as a Planning Council member by March 2013.

Completion Date: March 2014

Responsible Party: Membership, Nominations and Elections (MNE) Committee

Actions		Responsible Party(ies)	Start Date	Completion Date	Monitoring Interval	Status	Activity
V.D.1	Identify options for a Medicaid representative to serve on the Planning Council who will provide information and updates on Medicaid.	MNE Committee	May 2012	September 2012	Quarterly	Completed	Annie Johnson (UHS) was appointed to the Planning Council on 6/03/14.
V.D.2	Orient the Medicaid representative to allow full Planning Council membership.	MNE Committee	September 2012	March 2013	Quarterly	Completed	Annie Johnson (UHS) was appointed to the Planning Council on 6/03/14. Per the bylaws members must complete a membership orientation within three months.
V.D.3	Encourage the Medicaid representative's active Planning Council participation on an ongoing basis.	Planning Council	March 2013	Ongoing	Semi-Annually	Completed	Annie Johnson (UHS) was appointed to the Planning Council on 6/03/14.