2008 – 2010
Texas Statewide Coordinated Statement of Need

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Administrative Agency Representatives

Karin Petties
Dallas Co Health & Human Services
Parts A, B, State Services, HOPWA & MAI

Margie Drake
Tarrant County Health Department
Parts A B, C, D, F, State Services, HOPWA & MAI

Mark Peppler
Austin/Travis County
Health & Human Services
Parts A, C, HOPWA & MAI

Don Sharitz
Alamo Area Council of Governments
Parts A, B C, HOPWA, State Services & MAI

Charles Henley
Harris County Public Health & Environmental Services
Parts A, MAI & SPNS

Dr Joao Pinto
Planned Parenthood of El Paso
Part B, HOPWA & State Services

Sal Bursiaga
Lubbock Regional MHMR
Part B, HOPWA& State Services

Patrick Martin
Houston HIV/AIDS Resources Group
Parts B, C, D, HOPWA & State Services

Christopher Hamilton
Brazos Valley Council of Governments
Part B, HOPWA & State Services

Part A Office of Planning Council Support Representatives

Shalon Cox
Ryan White Planning Council of the Dallas Area

Jamie Schield
North Central Texas HIV Planning Council

Christopher Hamilton
Austin Area Planning Council

Jen Kim
Houston Area HIV Services Ryan White Planning Council

Part A Planning Council Representatives

Helen Zimba
Ryan White Planning Council of the Dallas Area

DeWayne Robertson
North Central Texas HIV Planning Council

John Fike
San Antonio HIV Health Services Planning Council

Bruce Turner
Houston Area HIV Services Ryan White Planning Council

Ryan White Program Grantee Representatives

Michelle M Verser
Special Health Resources for Texas
Parts B, C, SPNS & AETC

Bob Smith
Valley AIDS Council
Parts B, C, D & AETC

Sylvia A Moreno, RN
Dallas County Hospital District
Parts A, B, C, D & AETC

Teresa Talley
Bexar County Hospital District
dba University Health System
Parts A, B, D & MAI

Betty Cabrera
University of Texas Southwestern
Medical Center
Part D

Leeanna Bartlett
Baylor College of Dentistry
Part F

Pete Rodriguez, RN, ACRN
Harris County Hospital District
Parts A, C, D, AETC & SPNS

Katy Caldwell
Legacy Community Health, FQHC
Parts A, B & MAI

America Jones
La Fe CARE Center of El Paso
Parts B, C & AETC

Dwayne Haught
Department of State Health Services
Texas HIV Medications Program

Henry Pacheco, M.D.
Dallas County Hospital District
Texas/Oklahoma AETC

Oscar Gonzalez
Dallas County Hospital District
Texas/Oklahoma AETC
Texas/Mexico Border

Dan Rawlins
Department of State Health Services
Substance Abuse and Mental Health Association (SAMSHA)

Diana Turner
Veterans Affairs Administration

Michael Timcisco
Panhandle AIDS Support Organization
Part B

Delfina Ponce
Permian Basin MHMR
Part B

Community Representatives

John Rodriquez Corpus
Positive Voices Coalition
North Central Texas HIV Planning Council (Fort Worth)

Helen Zimba
Consumer Council Committee
Ryan White Planning Council of the Dallas Area

Barbara Massington
Austin Area Comprehensive HIV Planning Council

Reachelian Ellison
Affected Communities Committee
Houston Area HIV Services
Ryan White Planning Council

Bruce Turner
Affected Communities Committee
Houston Area HIV Services
Ryan White Planning Council

John Fike
People's Caucus Committee
San Antonio HIV Health Services Planning Council

Contact Information:

For questions regarding this document, please contact:

Ann Robbins, Ph. D.
Manager
HIV/STD Comprehensive Services Branch
Texas Department of State Health Services
PO Box 149347
Austin TX 78714-9347

ann.robbins@dshs.state.tx.us

W John Waara
Planner III
HIV/STD Comprehensive Services Branch
Texas Department of State Health Services
PO Box 149347
Austin TX 78714-9347

john.waara@dshs.state.tx.us

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Section I: Introduction

Purpose of the Statewide Coordinated Statement of Need (SCSN)

The creation of the Statewide Coordinated Statement of Need (SCSN) provides a collaborative mechanism to maximize coordination, integration, and effective linkages across the Ryan White Program and to identify strategies to address significant HIV care issues statewide. The document supports HIV care services planning statewide by providing a comprehensive description of the HIV/AIDS epidemic, issues confronting persons living with HIV/AIDS (PLWHA), an inventory of all Ryan White and state-directed resources, and strategies to address significant crosscutting issues, emerging trends, and critical gaps that affect HIV care in Texas.

Overview of the Content and Focus of the Texas SCSN

The 2008-2010 Texas Statewide Coordinated Statement of Need is an update of the previous SCSN, which covered the years 2004 - 2007. Section I of the SCSN contains introductory information, and explains how the current SCSN was developed. In Section II, the summary of the *Texas Epidemiologic Profile for HIV/AIDS Prevention and Services Planning*, outlines the characteristics and trends of the HIV/AIDS epidemic in Texas in years 2000 to 2006; including HIV care service and discussion of unmet need for HIV-related medical care in Texas. in 2006. The complete *Epidemiologic Profile* can be viewed on the DSHS website at: http://www.dshs.state.tx.us/hivstd/default.shtm or in the appendices

Section III provides a broad summary of the most recent needs assessments findings from across the state and of the key informant interviews conducted with the SCSN representatives for this document. Links to assessments by service area are available on the DSHS website at: http://www.dshs.state.tx.us/hivstd/planning/default.shtm.

In Section IV, there is an overview of the crosscutting issues identified in Texas and a charted outline that lists specific crosscutting issue, barriers to care, critical gaps, emerging trends and recommended strategies to address these issues. This section also contains issues identified by the SCSN representatives as needing more study. Section V contains a statewide summary of Ryan White and State Direct Service program funds allocated by service category. Section VI provides the summary, conclusions and statewide goals. And finally, the appendices in Section VII contain resource materials used to complete the document.

Participants in the Process

Participants in the development of the SCSN included representatives from all Ryan White Program grantees, State Direct Services grantees, people living with HIV/AIDS, Ryan White funded service providers and select state and federal agencies. The names of the members and their affiliations are listed in the acknowledgements.

Part A had representation from the grantee's office, the Office of Planning Support, and the planning councils from each of the five Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). Part B representation included the HRSA grantee (DSHS) and representatives from each of the grantee's administrative agents. Parts C, D, F & HOPWA grantees were included as well as representation from the Texas/Oklahoma AIDS Education and Training Center (AETC), and current funded Special Projects of National Significance (SPNS) programs operating in the State. Several participants represented multiple perspectives such as Part A/PLWHA/Planning Council, and many sub-grantees represented multiple grants for Parts A, B, C, D & F.

People living with HIV/AIDS were represented from each of the EMA/TGA consumer councils and Planning Councils. Despite multiple recruiting efforts, DSHS was unable to recruit PLWHA representation from outside the EMAs/TGAs. While DSHS had no specific demographic goals for PLWHA representation, every effort was made to ensure that representation reflected the epidemic in Texas and provided a broad perspective of PLWHA issues from across the state.

Public agency representatives included substance abuse prevention/treatment, the Veterans Administration, and Federally Qualified Health Centers (FQHCs).

Process for Updating the Texas SCSN

Activities to update the 2008-2010 SCSN began in January 2007 with updates and improvements to the data in the statewide resource inventory of Ryan White funded services. Requests based on fiscal grant cycles were sent out over a six month period to all Ryan White program grantees requesting current information on the funding levels and providers associated with services supported with Ryan White funding amount allocated to each provider by service category. DSHS developed a database for this information, and in August, 2007 DSHS populated the new database with the updated data.

Recruitment of participants began in March 2007. The Chair of each Part A Planning Council selected Planning Council representatives as did the Chair of each Part A Consumer Council. DSHS recruited individual Ryan White program grantees based on several factors, including, but not limited to, geography, diversity of funding streams, and client demographics. Only one HRSA direct funded grantee declined to participate because of staff capacity constraints. Despite multiple attempts, DSHS was unable to recruit participants from the Texas Department of Criminal Justice or the Medicaid/Medicare system. The reasons they did not participate are not known as both entities were unresponsive to DSHS requests.

Once all representatives were confirmed, DSHS convened a conference call in June, 2007 to provide an orientation on the SCSN, its purpose, the development steps and timeline for developing the document, and a question and answer session. As part of the orientation, DSHS provided all representatives with a copy of the most recent HRSA SCSN Guidance and the 2006-2007 Texas Statewide Coordinated Statement of Need. After orientation, each representative was sent a list of questions (see Appendix 1) designed to gather their perspectives on the major issues associated with the delivery of services to PLWHA in their service area. Representatives consulted their local Consumer Councils, Planning Councils and agency staff to gather input on the questions and reach consensus regarding the most pressing issues relevant to their area. DSHS also culled information on needs and priorities from existing services plans from the various areas in the state, using information from the plans as examples of local response to common issues, where common concern was found. In August, 2007 a preliminary draft of the document was sent to all representatives for review before a scheduled meeting in September.

In September, 2007, DSHS convened the SCSN representatives in Austin to create consensus on the crosscutting issues, gaps, barriers, and emerging trends compiled by DSHS and to conduct guided discussions to gather representative input on suggested strategies to address the issues. Representatives who were unable to attend this meeting submitted their comments to DSHS in writing. DSHS then used this information to make significant revisions to the first draft of the document.

In October 2007 the revised draft of the SCSN was sent to all SCSN representatives for review. Once again several SCSN representatives from Consumer Councils, Planning Councils and Administrative Agencies presented the second draft to stakeholders to solicit additional comments and input. DSHS then reconvened the SCSN representatives in Dallas in November to conduct a final round of guided discussions and collect additional comments and suggestions for the final revision to the document. Again, representatives who were unable to attend the meeting submitted their comments in writing to DSHS.

DSHS then used the HRSA review of the 2006 SCSN document and the input collected at the November meeting of the SCSN stakeholders to make final revisions to the document. The final draft of the SCSN was sent to all SCSN representatives and appropriate DSHS staff for a final review in January 2008. The purpose of this final review was not to gather additional stakeholder input for further revisions, but rather to allow SCSN representative to provide input on the overall quality of the document and to provide suggestions on how to improve future iterations of the document. The completed SCSN was sent to HRSA in June, 2008 and posted on the DSHS website.

Limitations of the Document

Data on barriers to services remain limited for those planning authorities that used the outdated SCSN assessment tool to gather data. The answer set for questions on barriers to service in the tool did not allow respondents to report specific barriers. Instead, the tool forced respondents to choose from four barrier types; access/availability, service delivery, information, and personal/cultural based on examples listed under each type of barrier. For instance, the survey gave examples of access/availability barriers as: "The services available were too far from your home or work. Services were not open at the hours you could get there. There was no child care. Waiting times for appointments or to see the person you needed to see were too long." Even though a respondent may have identified service hours as a barrier, they could only indicate on the tool that the barrier was access/availability. Because of this it is difficult to understand the exact nature of the barriers to care. DSHS dropped the requirement that this tool be used for assessing need for Ryan White Part B and the future assessments planned for Part B include data collection on specific barriers to care.

Also Part A Maintenance of Effort (MOE) and prevention funds directed toward linking newly diagnosed to care were not included in the analysis as they are reported retroactively. While the amount of funds allocated toward this effort can never go below the largest amount reported in past years, MOE is related to how much was expended, not how much is budgeted, and is therefore not a reliable data source for compiling a resource inventory.

It should also be noted that much of the data used in this document were from assessments completed before the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (TMA). Therefore, some service category names in assessment and resource inventory data may be different than what are currently funded across the state, and some data was collected on service categories that are no longer allowable under Ryan White. To maintain consistency with the data, no service category names or definitions were changed.

Section II: Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning January 2008

This executive summary presents an overview of information on known HIV/AIDS cases in Texas for 2006. The complete Epidemiologic Profile, along with profiles by Health Service Delivery Area (HSDA) can be viewed on the DSHS website at: http://www.dshs.state.tx.us/hivstd/planning/Epi_Profile_02012008.pdf

Morbidity

In 2006, persons living with HIV/AIDS (PLWHA) in Texas totaled 60,571. Over the past few years PLWHA show a net increase of about 4,000 cases per year with about 5,000 new cases and 1,000 deaths per year.

In 2006 Blacks accounted for the largest proportion of cases (38.2% compared to 37.0% White and 23.8% Hispanic). The rate of Blacks living with HIV/AIDS in 2006 (868 per 100,000) was over four times the rate in Whites (197) and about five times the rate in Hispanics (170).

Mode of exposure refers to the most likely way that someone became infected with HIV. The most common exposure groups are men who have sex with men (MSM), injection drug use (IDU), and heterosexual transmissions. In 2006 **MSM accounted for half of PLWHA,** followed by 24% attributed to heterosexual sex, and 17% to IDU.

Over half of people living with HIV/AIDS were in the Dallas and Houston areas. Black males age 35 – 44 had a prevalence of 3.8% in Houston and of 3.2% in Dallas.

Concurrent Diagnoses of HIV and AIDS

From 2002-2006 over one quarter of newly diagnosed persons in Texas received an AIDS diagnosis within one month of their HIV diagnosis. One third of all newly diagnosed received AIDS and HIV diagnoses within one year. **This finding indicates that substantial numbers of new cases were not diagnosed until late in the progression of HIV disease.** A larger proportion of Hispanics had both diagnoses within one month (33%) and within one year (43%) compared to Whites and Blacks.

New Diagnoses of HIV

From 2002 to 2006, the number of new diagnoses remained fairly stable for both sexes: from around 4,200 to 3,600 diagnoses per year among males and about 1,100 to 1,000 diagnoses each year for females. Rates of infection showed a 3:1 male/female ratio that remained constant over the years. **Blacks had the highest number and rate of new infections. The 2006 rate of new cases in Blacks (76 per 100,000) was approximately five to seven times higher than the rates for Hispanics (15) and Whites (11).**

By mode of exposure, 51% of new diagnoses were in MSM in 2006, 30% in heterosexuals, and 14% in IDU. The overwhelming majority of infections among White males were MSM (78%). Hispanic male cases were also predominantly MSM (65%), but 18% were heterosexual and 12% IDU. While the majority of Black males infected in 2006 were classified as MSM (56%), nearly 21% of Black male cases were heterosexual exposure, and 17% were IDU. Female cases across race/ethnicity were predominantly from heterosexual exposure.

Table 1: Select Characteristics of Persons Living with HIV/AIDS by Area, Texas 2006

	Eligible Metropolitan Area (EMA)/Transitional Grant Area (TGA)										Non-EMA/TGA						
	Austin		Dallas		Fort Worth		Houston		San Antonio		East Texas		U.S.-Mexico Border		Other		TDCJ
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate	number
Total	3,951	268.8	14,709	355.1	3,909	200.6	19,444	406.1	4,162	237.1	3,609	143.1	3,024	122.9	3,908	89.3	3,855
Disease Status																	
HIV	1,519	103.3	6,348	153.3	1,672	85.8	7,918	165.4	1,603	91.3	1,436	56.9	1,098	44.6	1,526	34.8	2,060
AIDS	2,432	165.4	8,361	201.8	2,237	114.8	11,527	240.7	2,559	145.8	2,172	86.1	1,926	78.3	2,382	54.4	1,796
Sex																	
Male	3,330	443.2	12,029	577.9	2,959	304.5	14,307	596.5	3,529	410.5	2,471	194.5	2,506	207.7	2,929	133.7	3,315
Female	621	86.4	2,681	130.1	950	97.2	5,137	215.0	633	70.7	1,138	90.9	518	41.3	979	44.7	541
Race/Ethnicity*																	
White	1,968	231.4	6,692	306.7	1,836	157.3	5,897	300.8	1,288	199.1	1,591	95.5	333	117.6	1,876	70.8	959
Black	984	867.8	5,492	918.8	1,462	644.9	9,479	1,180.3	606	529.8	1,662	382.5	83	291.2	1,012	294.2	2,338
Hispanic	955	216.9	2,342	206.5	560	122.9	3,861	227.2	2,226	234.6	331	89.1	2,596	122.3	995	76.6	550
Other	43	65.6	181	79.4	50	50.1	207	63.7	42	92.4	24	48.9	12	45.1	25	28.9	8
Age Group*																	
< 2	1	2.4	1	0.8	2	3.6	6	4.0	2	4.0	1	1.6	0	0.0	1	0.8	0
2-12	15	6.7	45	6.5	29	9.1	134	16.9	12	4.3	24	6.5	17	3.7	19	2.9	0
13-24	129	48.4	537	77.8	158	46.2	842	97.9	153	47.3	203	45.3	119	22.9	162	18.9	101
25-34	697	272.3	2,655	392.8	668	225.5	3,716	487.1	701	275.1	704	224.9	593	169.2	65	110.3	805
35-44	1,545	631.4	5,776	810.3	1,413	468.1	6,843	927.5	1,581	637.3	1,228	358.6	1,104	346.9	1,383	248.4	1,591
45-54	1,180	582.1	4,217	743.9	1,185	431.9	5,551	819.6	1,244	528.7	1,038	288.0	849	313.2	1,180	203.5	1,126
55+	383	165.2	1,478	220.9	455	128.7	2,352	297.2	469	133.0	410	66.0	342	79.3	510	50.5	232
Mode of Exposure^	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number
MSM	2,359	59.7	9,693	65.9	1,807	46.2	9,039	46.5	2,611	62.7	1,428	39.6	1,661	54.9	1,740	44.5	359
IDU	552	14.0	1,321	9.0	828	21.2	2,710	13.9	545	13.1	645	17.9	426	14.1	774	19.8	2,276
MSM/IDU	367	9.3	726	4.9	305	7.8	1,224	6.3	209	5.0	292	8.1	153	5.1	408	10.4	843
Heterosexual	612	15.5	2,776	18.9	854	21.9	6,143	31.6	738	17.7	1,135	31.5	708	23.4	887	22.7	369
Perinatal	29	0.7	69	0.5	50	1.3	230	1.2	20	0.5	48	1.3	32	1.1	37	1.0	0
Other	31	0.8	124	0.8	64	1.6	99	0.5	39	0.9	59	1.6	44	1.4	62	1.6	7

* Small numbers of unknown race/ethnicity and age have been excluded. Category totals will not match.

^Rates are not calculated because there are no good estimates of population sizes for behavioral risk groups. Proportions are shown instead

Risk Behaviors

People who live in areas with higher HIV prevalence and engage in risky behaviors are more likely to become infected with HIV. Confidential and anonymous HIV testing is offered through the Texas Counseling and Testing Program which collects data on participants being tested including behavioral data such as unprotected sex, substance use, sexual or injection drug user partner risk behaviors, and exchange money for drugs or sex. Unprotected sex was more frequently reported among those whose primary risk was heterosexual sex or IDU than among MSM. However MSM comprise the largest percent of those being tested and among those found to be HIV positive.

STDs can be used as secondary markers for risk of HIV infection, indicating unprotected sex in a population or area. Reported gonorrhea cases increased from about 24,000 cases in 2004 to just over 30,000 in 2006. Primary, secondary and early latent syphilis cases reported have also slowly increased each year, from 1,900 and 2,400 cases reported from 2004 to 2006.

In 2005, the Texas Behavioral Risk Factor Surveillance System (BRFSS) included questions about HIV testing practices, HIV-related risk behavior, and gender of sexual partners. Thirteen percent (13.3%) of respondents reported that they had been tested for HIV in the past year. Overall, 4.7% of respondents reported having engaged in a high risk activity in the past year.

Services

During 2006, more than 28,000 PLWHA received services from Ryan White funded providers in Texas. Of these clients, 73% were male; 40% were Black, 30% were White, 28% were Hispanic; and 39% were between 35 and 44 years old. When the population receiving services is compared to those living with HIV/AIDS, females and Hispanics comprise a greater proportion of services clients than they do PLWHA.

Eighty-one percent of clients received a core medical service during the year. Ambulatory/outpatient medical care (61%) and social case management (55%) were the two service categories most widely accessed during 2006. No major difference in use of services was found between males and females in 2006. Among the racial/ethnic groups, a smaller proportion of Black clients than White or Hispanic clients received social case management, oral health, mental health, or drug reimbursement services during the year.

Unmet Need

In 2006, 39% (22,000) of PLWHA had no evidence of medical care. (Framework does not include Medicare, VA and some private payers.) Men and women showed similar proportions out of care; however, because PLWHA remain predominantly men, men comprised 78% of those out of care.[1]

Among PLWHA, Blacks had the greatest number with unmet need (8,779). Additionally, Blacks had the greatest proportions of their population with unmet need, 43% compared with 36% of Whites and 37% of Hispanics.

Among cases with known modes of transmission, IDU had the highest proportion of cases out of care (46.8%). This group, however, was relatively small compared to the number of MSM. There are 3.2 MSM cases out of care for every IDU case out of care and there are 2.7 MSM cases out of care for every heterosexual transmission case with unmet need.

[1] Out-of-care and unmet need are synonymously

Table 2: Unmet Need Among PLWHA, by Disease Status, by Select Characteristics, Texas 2006

	Statewide (TDCJ excluded)				Statewide (TDCJ excluded)	
	HIV		AIDS		HIV/AIDS	
	#	%	#	%	#	%
Total	10,083	44.3	11,691	34.5	21,774	38.5
Sex						
Male	7,287	43.6	9,634	35.3	16,921	38.4
Female	2,796	46.5	2,057	31.4	4,853	38.7
Race/Ethnicity						
White	2,957	35.2	4,733	35.9	7,690	35.6
Black	4,748	52.7	4,031	34.6	8,779	42.5
Hispanic	2,221	44.2	2,805	32.1	5,026	36.5
Other	137	50.4	119	39.4	256	44.6
Unknown	20	76.9	3	75.0	23	76.7
Age						
<2	1	7.7	1	100.0	2	14.3
2-12	105	42.5	17	32.1	122	40.7
13-24	719	45.4	126	21.1	845	38.8
25-34	2,967	49.7	1,206	28.5	4,173	40.9
35-44	3,517	43.5	4,146	32.3	7,663	36.6
45-54	2,064	40.6	4,089	35.6	6,153	37.1
55+	710	40.3	2,106	45.0	2,816	43.7
Exposure Category						
MSM	3,812	36.2	5,585	32.7	9,397	34.1
IDU	1,087	54.5	1,826	43.1	2,913	46.8
MSM/IDU	396	42.7	951	39.1	1,347	40.1
Heterosexual	1,838	44.3	1,628	30.1	3,466	36.2
Perinatal	151	42.2	44	27.5	195	37.6
NIR/Other	2,799	58.5	1,657	36.4	4,456	47.7

Section III: Summary of Needs Assessments Findings

Data used for this section include data from the most recent A and B assessments from key informant interview data collected from SCSN representatives and existing data sources such as the most recent Part A and B assessments, the Texas Integrated Epidemiologic Profile for HIV/AIDS Prevention and Services Planning, February 2006, and the Estimates of Unmet Need for HIV-Related Medical Care in Texas, 2006. Comprehensive assessments were completed by Part B in all non-EMA Health Service Delivery Areas (HSDAs) in 2006. The exceptions were the Abilene, Wichita Falls, and the Sherman Denison HSDAs as they are administered by Part A Planning Councils and follow the Part A assessment schedule. The most recent Part A assessment data varies across EMA/TGAs from Dallas and Fort worth in 2004 to Austin and Houston in 2005, to San Antonio in 2006 and includes the special studies described below in Dallas in 2005 and in Houston in 2006. It should be noted that the data is collected at least one year prior to publication of all assessments.

All Part B assessments were conducted using the now-defunct SCSN tool that was revised by the former SCSN Steering Committee in 2005. In order to reduce duplication of effort, Part B Administrative Agencies did not conduct assessments in their respective EMAs. Rather, they incorporated into their assessment, data from the most recent assessments completed by Part A Planning Councils. Additional data from targeted assessments with providers in the Dallas Planning Area on barriers to care for those with unmet need and a special study in the Houston EMA on barriers for HIV positive youth are included in this summary. Questionnaires were also sent by DSHS to all SCSN representatives to gather key informant data on the major issues affecting the delivery of HIV services in their service area. The questionnaire is in Appendix I. Of the thirty-nine (39) surveys sent, twenty-nine (29) were completed and returned by SCSN representatives; a seventy-four percent (74%) return rate. There was no assessment data available specific to Parts C, D, or F so DSHS conducted key informant interview data from respective SCSN grantee representatives for each of these program grantees. It should be noted that in areas where assessments are completed by Parts A and/or B, Parts C, D & F use this data to determine service priorities.

For both Part A and B assessments, respondents were roughly two-thirds (2/3) male and one-third (1/3) female. All service areas reported that one to five percent (1-5%) of clients assessed identified as trans-gendered, with the exception being the Panwest service area which reported no transgendered respondents. For both Part A & B assessments, the largest age group assessed was thirty and forty-nine (30 and 49). In EMAs, respondents were evenly split between white and African American, with roughly one-third of whites identifying as Hispanic. The exception was Fort Worth, where fifty-seven percent (57%) of white respondents identified as Hispanic. In non-EMA areas, the majority of respondents were white. Of those respondents in non-EMAs who identified as white, the overall majority identified as Hispanic, from sixty-seven to eighty-four percent (67 to 84%). It should be noted that the data for Hispanic respondents in non-EMA/TGA areas may appear skewed as the data is inclusive of several major urban centers along the border such as El Paso, Brownsville/McAllen, and Laredo where Hispanics constitute a majority of the PLWHA population. The exception was Panwest where only seventeen percent (17%) identified as Hispanic. And finally approximately two-thirds (2/3) of all respondents in both A & B assessments identified as HIV positive. Of these, one third (1/3) identified as HIV/AIDS with one to five percent (1-5%), with variation among plan areas, stating they did not know their status.

A comparison of client identified needs from across the state shows little variance across service areas, between Part A and B assessments, or between the previous SCSN assessment summary and the data used to develop this document. Outpatient Ambulatory Care, Case Management, and Food Bank were again ranked in the top five service categories across all areas of the state, with Oral Health Care, Local Drug Reimbursement and Transportation rounding out the remaining categories, with the exception of Houston that ranked Vision and Health Insurance in the top five, and South Texas that ranked Heath Education and Risk Reduction (HERR) and Emergency Financial Assistance in the top five.

Table 3 Top Five Assessed Client Needs by Planning Area in 2006[2]

Area 1 West Texas	Area 2 Panwest	Area 3NE Dallas	Area 3NW Fort Worth	Area 4 East Texas	Area 5 Central Texas	Area 6 South Texas
Oral Health	Oral Health	Outpatient Ambulatory Medical Services	Food Bank/Home Delivered Meals	Outpatient Ambulatory Medical Services	Outpatient Ambulatory Medical Services	Emergency Financial Assistance
Medical Co-pay Assistance	Case Management	Oral Health	Case Management	Infectious Disease Medical Care	Food Bank/Home Delivered Meals	Food Bank/Home Delivered Meals
Outpatient Ambulatory Medical Services	Food Bank/Home Delivered Meals	Case Management	Dental care	Health Insurance	Local Drug Reimbursement	Outpatient Ambulatory Medical Services
Local Drug Reimbursement	Outpatient Ambulatory Medical Services	Food Bank/Home Delivered Meals	Outpatient Ambulatory Medical Services	Vision	Housing Assistance	Health Education Risk Reduction
Case Management	Transportation	Transportation	Transportation	Food Bank Home Delivered Meals	Transportation	Case Management

The two most frequent gaps in services identified by clients in six of the seven HSDAs assessed are oral health care, and housing. The next highest frequencies identified in four of the seven HSDAs are transportation and health insurance services. What is of particular interest is that oral health care and transportation are listed as high need in several service areas *and* in the top five assessed gaps in the same service areas. Also of interest is that while housing is listed in six of the seven HSDAs as a gap in service, it is only listed in one HSDA as a needed service.

Table 4 Top Five Assessed Service Gaps by Plan Area[3]

Area 1 West Texas	Area 2 Panwest	Area 3NE Dallas	Area 3NW Fort Worth	Area 4 East Texas	Area 5 Central Texas	Area 6 South Texas
Pain Management	Housing Assistance	Food Bank/Home Delivered Meals	Vision/eye Care	Oral Health Care	Emergency Financial Assistance	Oral Health
Oral Health	Ambulatory Outpatient Medical Services	Ambulatory Outpatient Medical Services	Housing/ housing payments	Health insurance	Oral Health	Housing Assistance
Medical Co-pay Assistance	Emergency Financial Assistance	Housing Assistance	Oral Health	Rental assistance	Health Insurance	Home Health Care
Substance Abuse Services	Mental Health Services	Oral Health	Information/ referral	Housing related services	Housing Related Services	Health Insurance
Case Management	Transportation	Transportation	Transportation	Vision care	Transportation	Case Management

[2] In rank order
[3] In rank order

As stated in the limitation section, information on specific barriers to care in areas that used the SCSN tool to collect data is not available; therefore a summary of the top five identified barriers across the state is not possible. However, when the data is reviewed separately, some trends within each data set do emerge. The most frequently cited barrier across all service categories in assessments is information and access barriers. For areas that collected data on specific barriers to service in their most recent assessments, being worried that someone would find out that they are HIV positive, and not knowing what services they needed or where to go to get them were the top identified barriers by consumers. In key informant interviews the top cited barrier was transportation followed by clients not knowing what services were available or how to access them, and other issues taking priority such as food, shelter, and family issues such as child care and employment.

The assessment data for the reasons clients' state for being out-of-care shows little difference across EMA/TGA and non-EMA/TGA areas of the sate. The most frequent reasons clients stated for not being in care, or coming late to care are: their doctor or nurse told them they did not currently need medical care; they did not want medical care because they did not believe it was necessary or because they felt healthy; and financial reasons i.e., believing they couldn't afford care. In contrast to the 2006-2007 SCSN, actively using drugs and/or alcohol was not cited by clients in all areas as reasons for being out-of-care by clients, but was a top reason cited in key informant responses and appears in three of the seven service areas.

Table 5 Top Five Assessed Reasons for Being Out-of-Care[4]

Area 1 West Texas	Area 2 Panwest	Area 3NE Dallas	Area 3NW Fort Worth	Area 4 East Texas	Area 5 Central Texas	Area 6 South Texas
My doctor said I do not currently need medical care	Worried that other people will find out/Privacy	Actively using alcohol or drugs or relapsed	Was told I do not need medical care	I do not need medical care currently	Actively using alcohol or drugs or relapsed.	Worried that other people will find out/Privacy
I do not need medical care currently because I am not sick	Fear of telling someone else	You were not sick	I am not sick	I do not believe medical care would do me any good	The medication had too many side effects	Fear of telling someone else
I stopped treatment due to lack of confidentiality	Feel healthy	You didn't like the way you were treated by the doctor or the nurse	Financial Reasons	I was actively using street drugs or alcohol	I do not need medical care currently because I am not sick	Can't afford it
I use alternative therapies	Can't afford it	You didn't want to take medication	There is no doctor I want to treat me	Financial reasons	Financial reasons	Don't have transportation
Lack of insurance	Don't have transportation	It was hard to keep appointments	Worried that other people will find out/Privacy	Did not receive referrals when diagnosed	It was hard for you to keep appointments	Don't want to take HIV medications

[4] In rank order

Section IV: Statewide Emerging Trends, Crosscutting Issues, and Barriers to Care, Critical Gaps, and Recommended Strategies to Address the Issues

The Department of State Health Services used a multi-faceted approach to gather data on emerging trends, crosscutting issues and critical gaps for the current SCSN. Updates to this section were made using data from the most recent Parts A and B needs assessments; epidemiologic and unmet need data; special studies data, and key informant interview data submitted by SCSN representatives across the state.

Several new emerging trends were added as a result of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 such as the effect of 75/25 requirement on critical support services and the need to transition case management in Texas from a social case management model to a combined medical/social case management model. Some emerging trends identified in the previous SCSN document were moved to cross cutting issues as they remain concerns, such as the multiple health issues associated with an aging PLWHA population, the continued disproportionate effect of HIV on minorities, especially African Americans, and the continued problem of early syphilis diagnosis in MSM previously diagnosed with HIV.

This version of the SCSN has a significantly expanded the section on barriers to care as DSHS had access to data from special studies on barriers to care and data from key informant interviews on reasons clients cite for being out-of care. Also, as a result of key informant interviews, the critical gap regarding the "donut hole" for Medicare Part D was modified to include the effects of the State Pharmaceutical Assistance Program on clients above 200% of the federal poverty level. And finally, two new gaps identified from key informant interviews are, the lack of available health care choices in non-urban service areas and the effect on access to care, especially for specialty services and the availability of affordable housing.

Several issues identified in the 2006-2007 SCSN document no longer supported by current statewide or local data were removed, such as the impact of undocumented immigrants on the care system and disparities in health care outcomes for racial and ethnic minorities. Data for undocumented immigrants is unavailable and client utilization data suggests that minorities in Texas access health care for HIV in the same proportions as other populations. Other issues in the previous SCSN document that were temporary or short term were removed, such as the impact on care systems of hurricane Katrina evacuees in 2006.

And finally, there are recommendations for further study on specific barriers to care, investigating perceived PLWHA indifference regarding management of their HIV disease, and the effect of Medicare Part D co-pays and premiums and increases to COBRA premiums on health insurance services.

Crosscutting Issues

A substantial number of PLWHA across Texas are diagnosed late in the progression of HIV disease	Suggested activities or strategies to address the issue
According to the 2007 DSHS Epidemiologic Profile, almost one quarter of all PLWHA across Texas received an AIDS diagnosis within one month of their HIV diagnosis. One third of all PLWHA received an AIDS diagnoses within one year of being diagnosed with HIV. This indicates that substantial numbers of PLWHA were not diagnosed until late in the progression of HIV disease. A larger proportion of males than females received HIV and AIDS diagnosis within one month and within one year. Nearly one third of Hispanics with HIV/AIDS had both diagnoses within one month compared to 22% of White and Black PLWHA. Of the major risk categories, MSM were slightly more likely to receive concurrent diagnoses within one month, but the difference in proportion was negligible at one year.	Promote routine testing in private sectors and in other public health clinics by partnering with the AETC, insurers, FQHCs, indigent clinics, and other key health care provider sites. Promote rapid testing in ECs (Emergency Centers). Ensure prevention messages and rapid testing services are available in Spanish. Promote anonymous testing for those afraid of deportation or immigration issues. Ensure that information on available medical & psychosocial services is on hand at key points of entry and testing sites for persons who test positive, including access to 211, a comprehensive statewide referral system. Conduct targeted social marketing to promote the benefits of testing and early access in maintenance into medical care.
The aging population of PLWHA (>35) present for care with multiple health issues	**Suggested activities or strategies to address the issue**
As the population of PLWHA ages, so do the number of clients with medical complications associated with aging such as diabetes, high cholesterol, and high blood pressure. In Texas the average age of PLWHA has continued to increase .5 (½) a year, each year, since 2000. Since the last SCSN update, there has been no significant change in the overall statistics. Currently 70% of all people living with HIV in Texas are over 35, with 40% of this population over 45, and 10% of this population 55 years or older. With recent and expected advances in Highly Active Antiretroviral Therapy (HAART), this issue is expected to remain a concern for some time as clients continue to live with HIV/AIDS.	Ensure that planning authorities allocate adequate funds to AIDS Pharmaceutical Assistance programs that provide medications that treat co-morbid conditions. Encourage local planning authorities to examine local care systems to identify best practice strategies for treating co-morbid conditions.

Oral health care is listed in the top five service needs and gaps in four of the six plan areas.	Suggested activities or strategies to address the issue
Key informants state that new clients entering the system have acute, extensive and expensive initial oral health needs and also that many clients forego oral health care and then present with emergency needs that require expensive salvage treatments. Data also suggests that there is a lack of providers in rural and semi-urban areas willing to serve PLWHA. Access issues are also being reported in urban & semi urban areas as providers and administrative agents state the current oral health service system is operating at capacity and that to increase capacity providers would need to build infrastructure which current allocations do not support. And finally, Part F reports being reimbursed at less than 50% for service provided in fiscal year 2007.	All PLWHA in the Ryan White service system should be screened, referred, and followed for prophylaxis oral health services to help reduce the need for more expensive acute and/or emergency services. Contract administrators should explore increasing capacity by using fee-for-service contracts with private providers that don't required building infrastructure. Administrators should conduct assessments to determine the specific barriers to care in their area and develop strategies to address their findings. In areas where there are limited private providers, administrators should partner with local clinics such as FQHCs and dental clinics that use a fee for service reimbursement system based on established Medicaid rates.
The incidence of early syphilis among previously HIV positive MSM is increasing, especially in major urban centers.	**Suggested activities or strategies to address the issue**
Data for the first half of 2007 shows that 1,424 persons were diagnosed with early syphilis in Texas. Of that number 941 were male. Of the 869 diagnosed males who were interviewed, 473 (54%) identified MSM as their primary risk behavior. Of those MSM, 224 (47%) had been previously diagnosed with HIV. 92% of all previously positive MSMs are in EMAs with the following numbers: Houston (108), Dallas (51), Austin (23), San Antonio (15), and Fort Worth (8). These numbers reflect an increase in the data collected for the previous SCSN in 2005. Co-infection with an STD has been shown to have negative effects on the health status of PLWHA. Also, this indicates evidence of high-risk behavior in PLWHA that carries significant risks for transmitting HIV.	Encourage sexual risk screening and/or assessments by medical case management providers for sexually active HIV+ clients to identify at-risk clients and recommend appropriate STD testing and treatment as a part of the client's medical care team. Encourage medical and social case management service providers to assure that risk reduction needs of sexually active clients are met either though incorporating risk reduction counseling/prevention case management into their services or through referral to prevention case management and other risk reduction resources for clients identified as engaging in high risk behaviors. Ensure medical case management and other providers have referral resources to prevention case management and other HIV risk reduction resources for PLWHA identified as being at risk.

The effect of substance abuse on entry and maintenance in care.	Suggested activities or strategies to address the issue
Assessment results show substance abuse as one of the top reasons clients cite for dropping out of care. For youth ages 18 to 24, this is especially true and is the top reason for this population entering care late. Substance abuse clients usually have very few resources, have criminal histories related to substance using behaviors and 80% of the DSHS HIV Prevention SAMHSA caseload shows indicators for impaired mental health.	Encourage substance abuse screening and/or assessments in the service system to identify active HIV+ substance users and recommend and/or initiate appropriate interventions as a part of the client's medical care team. Use outreach services to locate HIV+ substance abusers who were connected to medical care but dropped out and re-connect these clients back into care by linking them to the resources necessary for their maintenance in care. Encourage linkage with substance abuse providers to link people into care once they are released from substance abuse facilities. Encourage local areas to develop strategies to address the issues of substance abuse and care specific to their area.
The effect of mental health issues on entry and maintenance in care	**Suggested activities or strategies to address the issue**
Key informant data shows that 80% of the **HIV prevention** substance abuse caseload in the DSHS funded system have indicators for impaired mental health. These populations are often indigent, have histories of chemical dependency, usually have very few resources and often have criminal histories related to substance using behavior. According to HRSA in its Guide To Primary Care For People With HIV/AIDS, 2004 edition, "The high rates of pre-morbid mental health problems in persons with HIV and mental health problems related to HIV disease make mental health services a key component of HIV care."	Require mental health screening and/or assessment in the service system to identify PLWHA with mental health issues and recommend and/or initiate appropriate interventions as a part of the client's medical care team. Use outreach services to locate PLWHA with known mental health issues who were connected to medical care but dropped out and re-connect these clients back into care by linking them to the resources necessary for their maintenance in care. Encourage linkage with mental health care providers to link people into care once they are released from substance abuse facilities. Encourage local areas to develop strategies to address the issues of mental health care specific to their area.

African Americans continue to be disproportionately affected by HIV/AIDS.	Suggested activities or strategies to address the issue
By 2005 Blacks became the largest proportion of cases in Texas. The rate of Blacks living with HIV/AIDS in 2005 (821 per 100,000) was over four times the rate in Whites and about five times the rate in Hispanics. Blacks had the highest number and rate of new infections every year from 2001 to 2005. The 2005 rate of new cases in Blacks (78 per 100,000) was approximately five times higher than the rate in Whites and Hispanics. This is especially true for African American women who make up 60% of all new cases in Texas. The rate in Black females was about twice as high as the rates in White and Hispanic males and about 10 to 15 times higher than the rates in White and Hispanic females. In Houston, East Texas, and TDCJ, the largest numbers of living cases were among Blacks.	Encourage local planning authorities to identify specific local barriers to care for African Americans, especially women, and develop local strategies to address the barriers. Identify opportunities for testing and prevention messages on a local level and develop strategies to provide those services. Integrate HIV and STD prevention and testing in venues frequented by African Americans. Enhance the capacity of African American providers to address HIV prevention, testing, and access to medical care. Ensure state prevention activities address prevention issues for African Americans in prevention plans.
Texas/Mexico Border Issues	**Suggested activities or strategies to address the issue**
While border populations cite the same service needs and barriers to care as PLWHA in other areas of the state, what is unclear is how many PLWHA clients in border cities cross the border for health care or other HIV related services. One significant difference in barriers along the border is the higher percentage of clients who cite fear of deportation as a primary barrier to care. Higher poverty rates along the Texas/Mexico border creates the need for increased social and supportive services for PLWHA living in these service areas. Also, key informant data suggests that immigrant populations, especially undocumented, have an inability to navigate the service system and have misperceptions of requirements of the system such as paperwork, eligibility determination, identification, etc. and that these become barriers to care.	Encourage collaboration among the providers on both the US and Mexico side of the border to develop a connection between providers and build the capacity of providers to supply information on available services and the ability for US providers to make referrals to providers in Mexico and other countries in Central America. Implement round tables and meeting with local provider to discuss how to address bi-national and cross border HIV/AIDS cases. Expand culturally competent patient education programs to increase patients' knowledge of how to best access care, ask the right questions during clinical encounters, and participate in treatment decisions. Ensure that allocation of resources addresses the need to provide social and support services necessary to get and maintain border populations in health care services.

Barriers to Care

Assessment data consistently rate access to transportation as a primary barrier to care.	Suggested activities or strategies to address the issue
Transportation is one of the most frequent barriers to care cited by both in-care and out-of care consumers, especially in rural areas. In addition, since reauthorization, Ryan White funds, with the exception of Part D, may only be used to transport clients to medical services; leaving limited resources to transport clients to support services known to help maintain them in care. Publicly funded HIV health care services in Texas are concentrated in larger cities and individuals living outside these communities must travel long distances to access needed care and services. This creates demand for transportation services and increased costs for transportation services. There are also barriers within cities because of the large geographic area of the city and there is often no public transportation from suburbs to inner cities. Allocations for transportation in Texas continue to be in the top three funded support service categories, yet clients continuously rank transportation in the top five assessed gaps in six of the seven service areas.	Use non-Ryan White funds to provide transportation to non-medical services. Partner with local volunteer agencies that provide transportation services to people on Medicare/ Medicaid, and those with diagnosed disabilities. Use Medicaid transportation services for Medicaid eligible clients to leverage Ryan White and State Direct Services transportation funds. Conduct targeted assessments to determine specific reasons why transportation is cited as a service gap when it receives the third highest funding of all support services across the state, and develop strategies to overcome these barriers. Encourage local planning authorities to contact local transit planning authorities to coordinate efforts and ensure that the transportation needs of PLWHA are considered in the decision making process.
Not feeling sick or not believing medical care was necessary are the most common reasons cited for clients not accessing care or coming late to care.	**Suggested activities or strategies to address the issue**
Assessment data continues to show that not feeling sick and not believing they needed medical care were the primary reasons clients gave for not being in care or coming late to care. SCSN representatives from Part D report that this reason is particularly prevalent among youth ages 18-24.	Develop and deliver, in post-test, routine medical, and social service settings, educational messages on the importance and benefits of early access and maintenance in medical care. Encourage planning authorities to explore through local assessment effective strategies to counter these perceptions and then develop and implement strategies unique to their area. Develop and deliver targeted educational and marketing campaigns on the importance and benefits of early access and maintenance in medical care.

The effect of stigma for PLWHA creates barriers to access for care	Suggested activities or strategies to address the issue
Stigma, in various forms, continues to be cited as a barrier to care for portions of the PLWA population. Key informant interviews with service providers in non-EMAs and needs assessment data cite clients concern of privacy when accessing services to be an issue and fear of being identified as HIV positive. Other stigma related barriers cited by key informant consumers include a reluctance to seek services for fear of being deported for having HIV (especially in service areas along the Texas/Mexico border), fear of being reported to authorities for active drug use, fear of having children removed from the home, and distrust of the Federal government.	Form local work groups, in collaboration with HIV prevention and service providers, to develop local strategies designed to combat HIV/AIDS stigma using the HRSA identified successful strategies as a starting point. Also, make sure that multiple grantees, including SAMHSA grantees, are included. Encourage Ryan White Program Grantees to develop strategies that enable clients to be seen at alternative community sites other than traditional AIDS Service Organizations. Encourage Ryan White funded agencies to examine their service systems and develop strategies to reduce stigma within the populations they serve.
PLWHA recently released from incarceration report significant barriers in access to care and report lower levels of treatment adherence than other populations.	**Suggested activities or strategies to address the issue**
According to assessment data and key informant interviews there continues to be barriers to care for PLWHA recently released from incarceration. Representatives cite a lack of coordination between service providers and TDCJ release programs that creates barriers in access to service. Other barriers cited were substance abuse, stigma regarding HIV and felon status, a lack of information on available services, and an unwillingness on the part of providers to serve former inmates.	Develop collaborative partnerships between the various local agencies that provide HIV care and correctional services to identify, develop, and implement best practice models for linking and retaining in care current and formerly incarcerated PLWHA transitioning back into the community.

Poor health literacy affects access and adherence to medical care and is associated with disparities in health outcomes	Suggested activities or strategies to address the issue
Health literacy continues to be a challenge for populations such as the homeless, uneducated, and those with substance abuse and/or mental health issues, as these conditions compromise their ability to understand and manage treatment adherence requirements. Also, assessment data indicates that PLWHA not fluent in English often receive health information at medical visits translated by non medical personnel and this has the potential to result in inaccurate or misleading information. In addition, service providers cannot always translate technical language used to describe medical issues, translate information into culturally appropriate/client understandable language, or provide health education to non English speaking clients. It must be noted that due to the complexity of health care regimens, PLWHA in general may also have difficulty with health literacy and all patients should be partners in their health care. And finally, PLWHA with co-morbid conditions often have to manage multiple health care regimens which may contribute to health literacy issues.	Implement targeted educational programs that provide and reinforce information about medications, treatment, and other topics relevant to HIV healthcare needs. Incorporate client education on medications, treatment, and other topics relevant to HIV healthcare needs into standards of care for medical care system. Ensure that language and graphics used to provide health education and instruction in all mediums are culturally appropriate and understandable by the widest possible audience. Ensure that service providers identify the health literacy issues facing the populations they serve and have strategies in place to address them. Include health literacy as part of the Quality Management process.
Clients often do not know where to go to get the services they need, or what services are needed.	**Suggested activities or strategies to address the issue**
Among the top three barriers to care cited by clients in needs assessments are information and access barriers, including not knowing what services they needed or where to go to get them.	Create social marketing campaigns that let people know what services are available and what resources are available to fund them, such as the use of 211 and local service directories. Design local systems in collaboration with clients to disseminate service access information in ways that are appropriate and usable to the local population, including resources and strategies for newly diagnosed individuals. Explore further what specific barriers are regarding access to services as the SCSN tool used for assessment did not allow respondents to cite specific barriers.

Critical Gaps	
The lack of available health care choices in non-urban service areas affects access to care, especially for specialty services.	**Suggested activities or strategies to address the issue**
According to key informant interviews, the lack of health care options within a large, primarily rural HSDA often leads to clients not accessing care or dropping out of care. Also, the providers that are in operation are often dependent on one funding source and vulnerable to fluctuations in funds. A related issue is that there are often limited or no providers for specialty HIV care, mental health, and/or substance abuse services in large rural HSDAs. Key informants from urban areas cite this as a potential problem if there are a small number of providers and clients are not comfortable accessing services from any of them.	Increase options for health care access in all areas of the state through developing partnerships and collaborations with eligible service providers such as Federally Qualified Health Centers (FQHCs) qualified Medicaid providers, and other public and privately funded health care providers. Ensure all PLWHA in Texas are screened for Medicaid and Medicare eligibility, and referred to approved health care providers.
Medicare Part D continues to pose the potential for creating gaps in medication services for PLWHA enrolled in Medicare	**Suggested activities or strategies to address the issue**
Clients with Medicare Part D pay from $1to $5 in co-pays per prescription. Co-pay costs will vary depending on the plan chosen and whether the drug is a generic or brand name. Clients with the standard benefit have an initial coverage limit of $2,510 in Medicare drug benefits, after which they must pay $3,216.25 in out of pocket costs to qualify for catastrophic coverage, with the requirement to pay a $275 deductible and 25% coinsurance on the remaining $2,235 to reach the initial coverage limit of $2,510. In other words, the current out-of-pocket threshold or the amount an individual must pay to reach catastrophic coverage is $4,050. Ryan White funded AIDS pharmaceutical assistance program funds cannot be used to take PLWHA out of the donut hole. This has the potential of creating a huge gap in services for some PLWHA. While the Texas HIV Medication Program HIV State Pharmacy Assistance Program (SPAP) will help eliminate the “donut hole” issue for a large number of current Medicare Part D clients, beneficiaries in the community with incomes above 200% of FPL won’t be eligible for the SPAP and may have difficulty with out of pocket expenses.	Ensure that allocations to Ryan White Health Insurance funds are adequate to cover the need. Provide assistance to clients to complete enrollment requirements and paperwork for drug company medication assistance programs. Encourage all Ryan White program grantees to review local drug formularies to identify gaps in medication coverage for PLWHA enrolled in Medicare Part D and revise local formularies as appropriate. The Texas HIV Medication Program (THMP) implemented an HIV State Pharmacy Assistance Program (SPAP), using General Revenue funds, in January 2008 that will help eliminate these issues for the 850 current clients with Medicare Part D who were denied the full low income subsidy that are still on the THMP program. However, there are many Medicare Part D beneficiaries in the community with incomes above 200% of FPL who won’t be eligible for the SPAP and are having difficulty with out of pocket expenses.

The availability of safe affordable housing	Suggested activities or strategies to address the issue
Data indicate that there is a gap in the availability of affordable housing for PLWHA in Texas, especially in major urban centers. For certain PLWHA, specifically for single women and single men without children, the availability of Ryan White & HOPWA funded housing is a particular problem. Also, many HIV+ women with children who have had access to stable housing through Ryan White funds, will lose this benefit once their children turn 18 and leave home. Key informant interview data suggests that discrimination in housing, and reimbursement rates below fair market rents for housing place clients into housing in high crime/low income areas which may lead to substance abuse issues, crime, and other factors that are known to affect access and maintenance in care.	Responses to this issue should be developed on a local level as housing issues are often unique to each area. Encourage local areas to become involved in local housing consortiums / HUD continuums to leverage housing funds. Ensure HOPWA funds are allocated, tracked and reallocated to ensure funds follow service needs and trends and that no fund go unspent.

Emerging Trends	
The challenge of maintaining critical support services under Ryan White Treatment Modernization where only twenty-five percent (25%) of funds may be spent on support services	**Suggested activities or strategies to address the issue**
Ryan White Reauthorization allows only 25% of funds to be spent on support services, and funders must link these services to client access to medical care. In addition, increases in the number of clients and cost per patient create challenges to funding critical support services that maintain clients in care and support treatment adherence.	Maximize the use State Services funds for support services. Develop, disseminate, and keep current, information on services available through other funding sources and make this information available to case managers and PLWHA directly. Stronger collaboration in all phases from planning, to implementation, to evaluation among all funding sources is needed to reduce duplication, promote efficiency, effective linkages, and care service delivery systems that are able to respond to client need. Encourage Ryan White program grantees to provide networking and collaborative opportunities with non-program grantee provider staff to increase individual collaboration and understanding of service options. Examine allocations versus final expenditures to determine the most efficient funding strategies for support services. Monitor spending trends and ensure reallocations are made in timely manner to prevent unexpended funds in support service categories.
Transitioning to a medical case management model	**Suggested activities or strategies to address the issue**
Case management is currently the second largest allocation behind medical care. The Treatment Modernization Act created a Medical Case Management category as part of core medical services. DSHS is currently moving toward a medical case management model which will improve client care as the Medical Case Manager becomes part of the client's medical care team. However, this does not reduce the role of social case managers who meet non-medical episodic service needs such as bus pass renewals, utility payments, etc., that are associated with maintaining clients in medical care.	Assess current case management delivery systems to ensure that case management service are appropriately funded and reported and that clients are able to access an array of case management services from medical to psychosocial. Identify, develop and implement best practice models on effective medical case management service systems. Ensure medical case management standards enable local authorities to design service systems that best fit their local needs.

Areas Needing More Study	
Assessment of actual barriers for those areas that used the most recent SCSN survey tool in their last assessment.	**Suggested activities or strategies to address the issue**
Recent assessment data consistently identified informational and access barriers to services. However, for those AAs that used the SCSN survey tool, data on barriers did not provide specific information on what information and access barriers exist. Because of this it is difficult to understand what the real barriers to care are in these assessments.	Conduct targeted assessments using multiple data gathering techniques to identify specific barriers to care.
Perceived PLWHA indifference regarding management of their HIV disease	**Suggested activities or strategies to address the issue**
Key informant data from providers indicate a perception that PLWHA who are long term survivors are becoming indifferent toward managing their HIV disease and may be suffering from depression and survivor's guilt. Providers also speculate that PLWHA indifference may be due to a number of factors such as not seeing tangible symptoms and feeling well in their day-to-day activities. Providers also speculate that the advancement of medications help the clients maintain more control in their lives which creates less dependence on the service system, and this lessened dependence may be interpreted by providers as indifference. Key informants also suggests that service provider staff are becoming apathetic also because they see increases in high risk sexual behaviors by their clients coupled with unwillingness to change the behavior.	Ensure that clients are aware of and have access to mental health care services that target issues faced by long-term survivors. Conduct studies to determine if these perceptions are accurate and if so, the cause of the behaviors. Conduct studies to examine the possible connection between client indifference and increases in new HIV infections among young MSM and increases in syphilis in HIV+ MSM. Investigate other chronic health conditions to identify possible best practice models for addressing the issues.
The effect of Medicare Part D and increases in COBRA Premiums on health insurance allocations	**Suggested activities or strategies to address the issue**
Key informants from all Part A TGA and EMAs report that costs for health insurance have increased due to Medicare Part D premiums, medication co-pays and increases in COBRA rates. AAs are also beginning to question the cost/benefit of paying COBRA premiums because in larger metropolitan areas, AAs may be paying more for COBRA premiums than it would cost for those same clients to be enrolled in the Ryan White care system.	Complete an analysis of the cost benefit ratio of paying COBRA premiums and report outcomes to local planning authorities and DSHS to use in making planning and implementation decisions. Ensure that the allocation and reallocation of all service area funds are coordinated to cover the costs of health insurance services.

Section V: Resource Inventory: 2007 Allocation of State, Ryan White Program, and HOPWA Funds in Texas

This resource inventory represents the most current information about resources available for local delivery of HIV medical and psychosocial support services in Texas for the 2007-2008 funding year. It includes information about services funding for all Ryan White program grantees in Texas, for Texas General Revenue (GR) allocated, MAI funding for both Part A & B and state and direct funded HOPWA. It should be noted that the data provided for this inventory is current as of September 30, 2007 and that allocations fluctuate continuously as new sources of funding becomes available and funds are reallocated to meet service needs. Therefore, the data in this inventory may not exactly match current service allocations in a given plan area. However, based on historical evidence, neither the amount of new funds entering the care system nor funds reallocated statewide are enough to affect the overall funding trends presented in this inventory.

Part A Maintenance of Effort (MOE) funds and prevention funds directed toward linking newly diagnosed to care were not include in the analysis as they are reported retroactively is therefore not a reliable data source for compiling a resource inventory. Also, funds allocated to administrative costs are not included in this inventory as they are not direct client services.

Based on the HRSA evaluation of the previous inventory in the 2006-2007 SCSN, DSHS made several changes to the methods used to collect the data, and expanded the data collected to include HOPWA funds. In addition, the DSHS developed a database to better enable storage, analysis and manipulation of care services funding data. Previous data was entered into Microsoft Excel, and while this was sufficient, it did not allow for cross tabulation and other complex data queries.

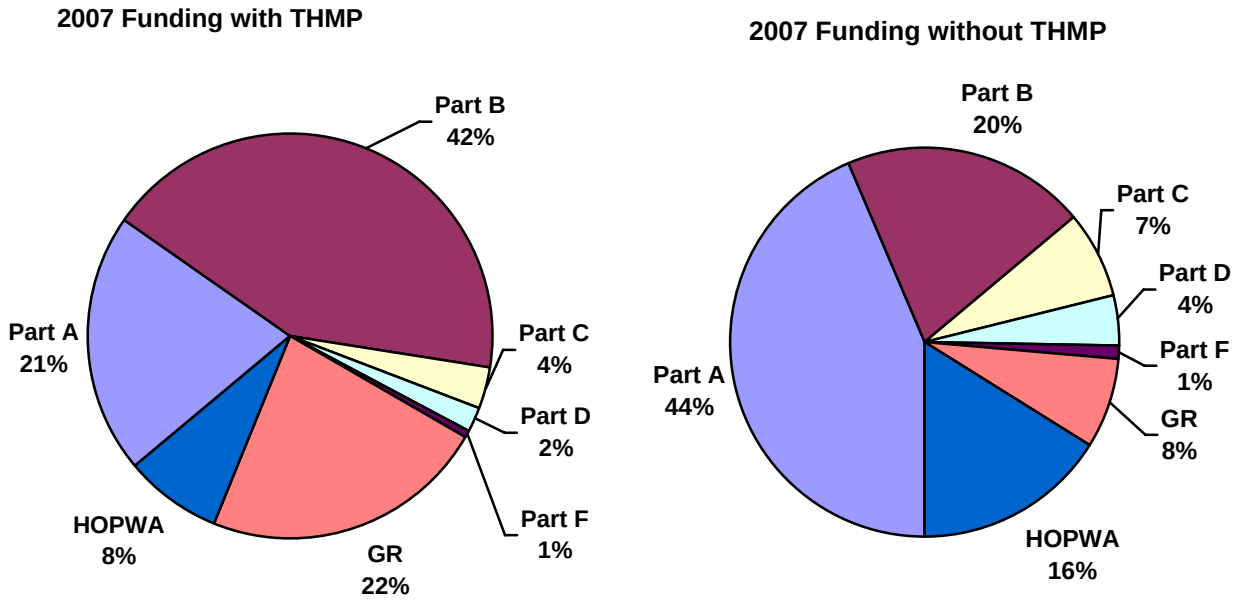
In 2007, more than **$185 million** was available for direct client services in Texas through the Ryan White Program (Parts A, B, C, D and F), state and direct HOPWA, and general revenue funds[5]. Table 1 and Figure 1 show the amounts allocated to direct client services for 2007 from these various sources and the proportion of available funds that each source represented.; these figures were drawn from Coordinated List of Contracts (CLC) reports provided by Part A and B grantees or from self reports of other grantees. The first set of direct services amounts in Table 6 includes allocations for the Texas HIV Medications Program (THMP), the program that uses ADAP and earmarked state general revenue to provide access to medications for low income Texans living with HIV/AIDS. When including THMP allocations (about $96 million), Part B Ryan White represented about 43% of all direct services allocations, Texas general revenue about 23%, and Part A Ryan White contributed 21%; HOPWA funds made up almost 8% of direct client services funds. When THMP funds are not considered, Part A funds make up a much larger proportion of direct client services funds (about 44%), and Part B and general revenue smaller proportions (20% and 8%, respectively).

[5] Funds for administrative services are not included in this analysis.

Table 6: Ryan White Program, HOPWA, and State Services and Medication Funds in Texas, 2007[6]

Funding Source	Direct Services Amounts with THMP	Direct Services Amounts *without* THMP
Part A (including MAI)	$38,846,249	$38,846,249
Part B (including MAI)	$79,189,811	$18,009,285
Part C	$6,518,256	$6,518,256
Part D	$3,670,052	$3,670,052
Part F (Dental & SPNS)	$935,627	$935,627
Direct HOPWA	$11,562,211	$11,562,211
State HOPWA	$2,730,560	$2,730,560
State General Revenue	$41,980,247	$6,782,520
TOTAL	**$185,433,013**	**$89,054,760**

Figure 1: Funding Proportions with and without THMP, 2007



[6] Does not include AETC or Administrative funds

Table 7 shows how client services funds were allocated by service category. The table includes allocations for the THMP in the line marked *Drug Reimbursement- State Administered.* The service categories are divided into two groups. First are the core medical services, followed by supportive services. State administered and direct HOPWA are included in the supportive services category of *Housing*. The first column of figures shows the total allocation for the category, the second shows the percentage of all funds allocated to that service, and the third shows the percentage of allocated funds when THMP funds are not considered. When THMP funds are included, about **84%** of available funds in Texas were allocated to core medical services, with allocations for medications making up about 57% of all funds.

Because medication assistance so dominates the funding landscape, it is helpful to examine the proportionate share of allocations for remaining services when THMP funding is excluded. Without THMP funds, allocations to core medical services still make up about **2 out of every 3 dollars** across all funding sources. The largest single allocation category was outpatient care (about 30% of available funds), followed by housing (16%), and medical case management and local drug (9% each). Non medical (social) case management received allocations of about 8% of the funds, oral health services received about 6% of the available funds, allocations to health insurance made up almost 5%, and food and medical transportation each made up about 3% of the total.

Table 7: Allocations of Ryan White Program, HOPWA, State Services and Medication Funds in Texas, 2007

Service Category	Total Allocation	% of Total (with THMP)	% of Total (without THMP)
Ambulatory/Outpatient Medical Care	$26,740,307	14.4%	30.1%
Medical Case Management	$7,965,243	4.3%	9.0%
Counseling & Testing Services[7]	$ 833,343	0.4%	0.9%
Drug Reimbursement Local/Consortium	$ 8,434,836	4.5%	9.5%
Drug Reimbursement State Administered	$ 96,645,171	52.1%	----
Health Insurance	$ 4,124,991	2.2%	4.6%
Home & Community Based Health Services	$ 291,625	0.2%	0.3%
Home Health Care	$ 349,449	0.2%	0.4%
Medical Nutrition Therapy	$ 584,293	0.3%	0.7%
Mental Health Services	$ 1,869,612	1.0%	2.1%
Oral Health Care	$ 5,264,172	2.8%	5.9%
Hospice Care	$ 753,883	0.4%	0.8%

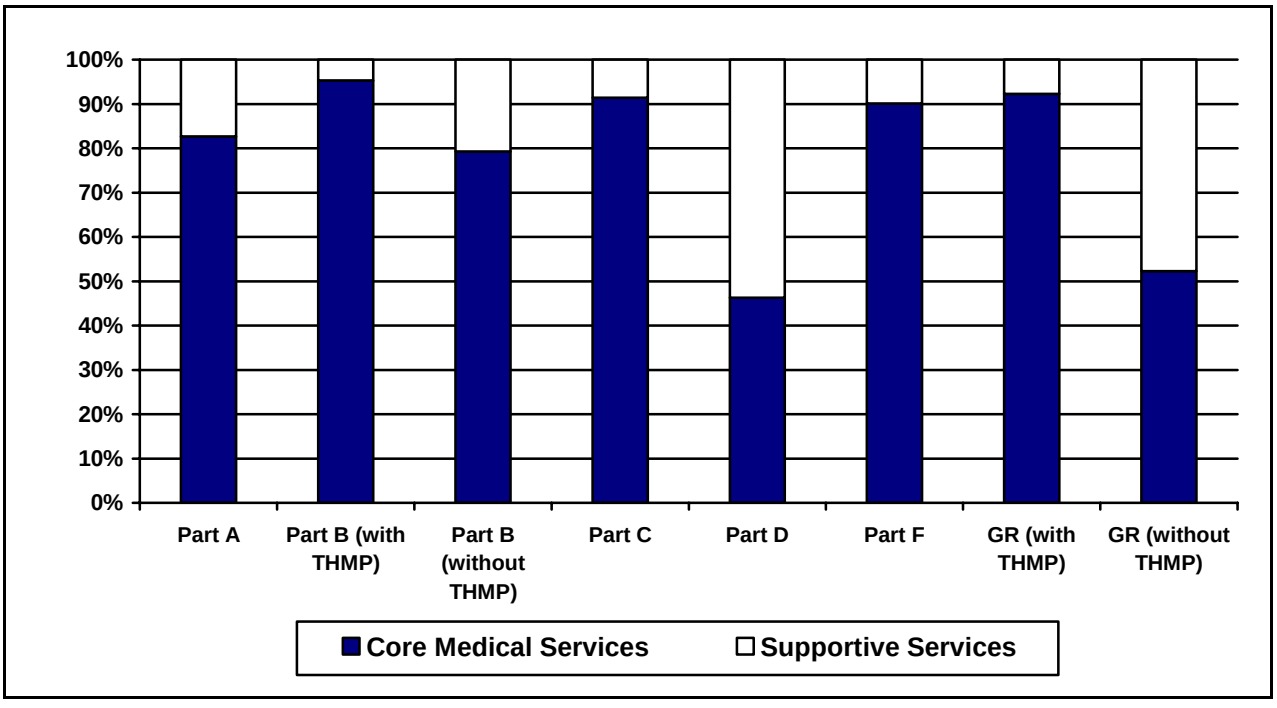
[7] Early Intervention Services

Service Category	Total Allocation	% of Total (with THMP)	% of Total (without THMP)
Substance Abuse Services - Outpatient	$ 965,637	0.5%	1.1%
Total Core Services	**$ 154,822,563**	**83.5%**	**65.5%**
Social Case Management	$ 6,935,260	3.7%	7.8%
Child Care Services	$280,068	0.2%	0.3%
Client Advocacy	$205,618	0.1%	0.2%
Emergency Financial Assistance	$134,001	0.1%	0.2%
Food Bank/Home-delivered Meals	$2,443,959	1.3%	2.8%
Health Education/Risk Reduction	$386,344	0.2%	0.4%
Housing	$14,765,131	8.0%	16.6%
Legal Services	$564,512	0.3%	0.6%
Linguistic Services	$ 43,289	0.0%	0.0%
Medical Transportation	$ 2,365,488	1.3%	2.7%
Other Direct Support Services	$ 244,751	0.1%	0.3%
Outreach Services	$1,193,793	0.6%	1.3%
Psychosocial Support Services	$148,861	0.1%	0.2%
Referral to Health Care/Supportive Services	$82,943	0.0%	0.1%
Rehabilitation Services	$110,480	0.1%	0.1%
Respite Care	$405,838	0.2%	0.5%
Transportation Services	$232,492	0.1%	0.3%
Treatment Adherence Counseling	$ 67,621	0.0%	0.1%
Total Support Services	***$30,610,450***	***16.5%***	***34.5%***
Total Direct Services	**$185,433,013**		

The proportion of direct client services funds allocated to core medical services varies across the sources of funding. The authorizing legislation for the Ryan White Program stipulates that at least 75% of direct client services funds for Parts A, B and C must be expended on core medical services, and it appears that overall, Texas grantees of these Parts have allocated funds in accordance with this requirement. About 83% of the Part A funds are allocated to core medical services, as are about 91% of Part C funds. When the ADAP earmark is included, about 95% of Part B funds are allocated to core medical services, but with ADAP excluded, this drops to 79%; however, it should be noted that HRSA allows inclusion of the ADAP earmark when evaluating adherence to the 75% requirement. Although Part F grantees are exempted from the 75% expenditure requirement, allocations from these grantees indicates that they plan to expend 90% of their client services funds in core medical categories. Part D grantees, also exempt, plan to expend about 46% in core medical services.

DSHS recognizes the central and enabling nature of support services, and did not place a minimum allocation of these funds for core medical services, allowing them to serve as a "safety valve" to ease achievement of the 75% minimum allocation requirement for Ryan White funds. When state THMP funds are considered in the mix, 92% of general revenue is allocated to core medical services, which is the most accurate direct comparison of the use of state and federal funds in Texas. When THMP funds are taken out of the mix, state funds are more evenly allocated between core medical (52%) and support services (48%).

Figure 2: Percent Allocated to Care Medical and Support Service by Funding Source



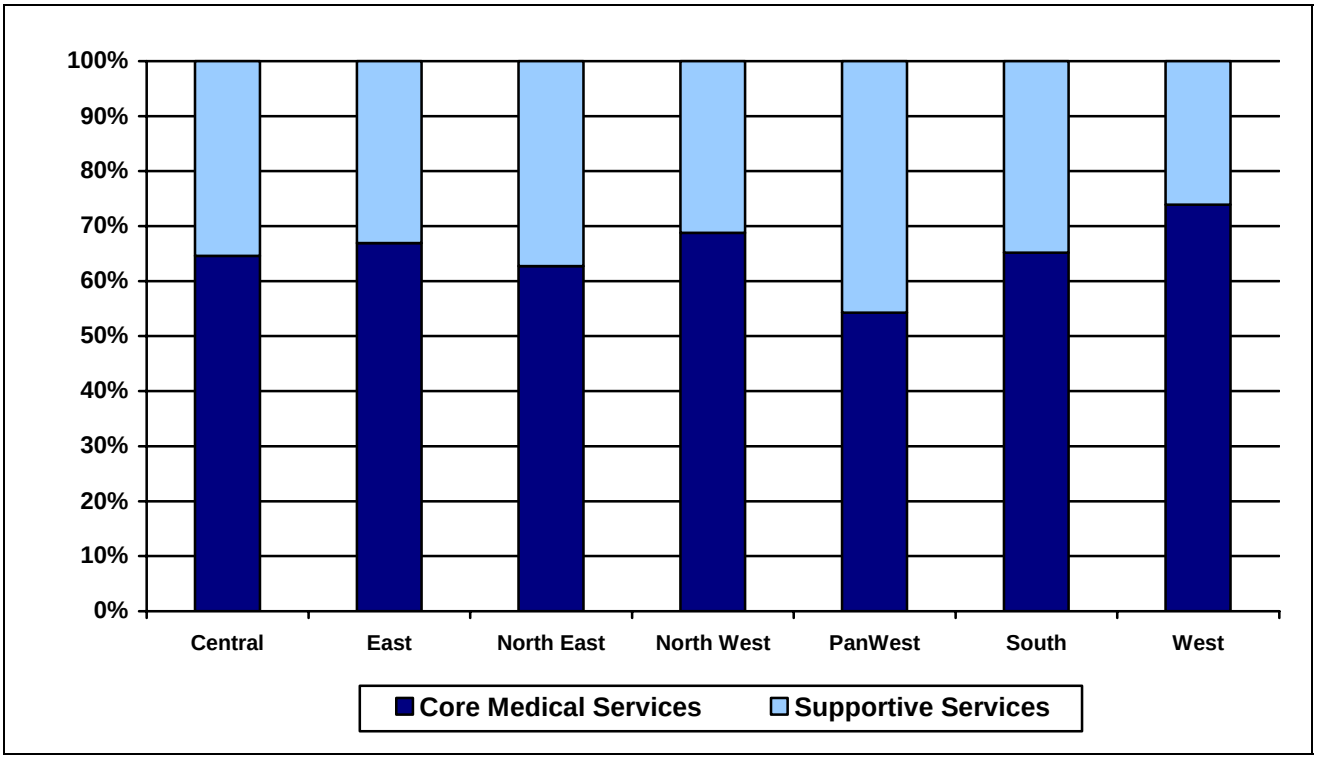
The funds available in different areas of the state vary as does the number of living cases. HRSA allocates funds to eligible Part A areas largely according to living HIV/AIDS cases, although Part A funds are also competitively awarded. DSHS allocates non-THMP state and Part B funds using a formula that includes HIV/AIDS prevalence, client case loads, and a measure of poverty. Funds for Parts C, D, and F are awarded directly to service providers through a competitive process. HOPWA funds are also distributed according to morbidity, both for directly funded jurisdictions and those receiving HOPWA funds from DSHS. Table 8 below shows the amounts across all federal and state funds available in various areas of the state; this does not include estimated THMP expenditures.

Table 8: Allocations, Sources of Funds and per Case Allocations in Texas, 2007

Service Area	Health Service Delivery Areas (HSDAs)	Sources	Funding Available	% of All Funding	Living Cases	Allocation per case
Central Texas	Austin, College Station, Waco, Temple/Killeen, San Angelo	A, B, C; SS, HOPWA	$7,842,146	8.8%	5,222	$1,502
East Texas	Texarkana, Tyler, Nacogdoches, Houston, Galveston, Beaumont	A, B, C, D, F; SS, HOPWA	$35,472,822	40.0%	23,367	$1,518
North-East Texas	Dallas, Sherman/Denison	A, B, C, F; SS, HOPWA	$22,678,842	25.5%	14,695	$1,543
North-West Texas	Fort Worth, Wichita Falls, Abilene	A, B, C, D; F SS, HOPWA	$6,789,011	7.6%	4,539	$1,496
Pan-West	Amarillo, Lubbock, Midland	B, SS, HOPWA	$1,633,773	1.8%	1,124	$1,454
South Texas	San Antonio, Victoria, Brownsville/Harlingen, Laredo	A, B, C, D; SS, HOPWA	$11,925,892	13.4%	2,263	$5,270
West Texas	El Paso	B, C, D; SS, HOPWA	$2,445,356	2.8%	1,294	$1,890

Allocations to medical services ranged from 54% (Panwest) to 74% (West Texas), with most areas allocating about 66% of available funds. In all areas but Panwest, ambulatory/outpatient medical care made up the single largest service allocation; in Panwest, housing was the largest allocation. Large allocations to housing were not unique to the panhandle, as allocations to housing absorbed 15% or more of available funds in Central, East, South, and West Texas as well.

Figure 3: Percent of Allocation to Core and Support Services by Plan Area[8]



[8] Does not include AETC or Administrative funds

Table 9 below summarizes these allocations by showing the proportions of available funds allocated to various categories in each area.

Table 9: Proportions of 2007 Direct Client Services Allocated to HIV-Related Service Categories by Area, Texas

Service Category	Central Texas	East Texas	North East Texas	North West Texas	Pan West	South Texas	West Texas
Ambulatory/Outpatient Medical Care	34.1%	32.0%	27.5%	22.7%	19.7%	29.5%	45.2%
Medical Case Management	3.4%	10.1%	6.4%	17.3%	15.1%	8.5%	10.0%
Counseling & Testing Services	1.0%	1.0%	1.4%	0.8%		0.3%	
Drug Reimbursement - Local/Consortium	8.3%	9.8%	10.2%	8.2%	8.3%	9.5%	7.0%
Health Insurance	2.6%	4.0%	6.8%	6.5%	2.8%	3.4%	3.3%
Home & Community Based Health Services			0.8%	1.0%			2.0%
Home Health Care		0.5%	0.4%	0.4%		0.4%	
Medical Nutrition Therapy	0.1%	0.9%		2.2%	1.1%	0.9%	
Mental Health Services	3.8%	1.3%	2.2%	2.9%	2.6%	2.9%	2.0%
Oral Health Care	8.2%	5.8%	5.8%	5.4%	4.2%	6.3%	3.2%
Residential or In-home Hospice Care	0.9%	1.6%				0.6%	1.2%
Substance Abuse Services - Outpatient	2.2%	0.1%	1.4%	1.4%	0.5%	2.8%	
Total Core Services	***64.6%***	***66.9%***	***62.7%***	***68.8%***	***54.3%***	***65.2%***	***73.9%***
Social Case Management	16.5%	5.2%	8.8%	1.5%	15.3%	10.3%	8.4%
Housing	15.4%	18.9%	14.2%	13.5%	23.5%	16.6%	14.8%
Food Bank/Home-delivered Meals	1.1%	2.3%	3.9%	5.1%	5.5%	2.0%	
Medical Transportation	1.1%	2.5%	3.7%	3.6%	1.1%	2.2%	1.5%
Transportation Services	0.4%	0.3%	0.2%	0.0%		0.5%	
All Other Supportive Services	1.0%	3.9%	6.5%	7.5%	0.3%	3.3%	1.4%
Total Support Services	***35.4%***	***33.1%***	***37.3%***	***31.2%***	***45.7%***	***34.8%***	***26.1%***
TOTAL ALLOCATION	**$7.8M**	**$35.4M**	**$22.6M**	**$6.7M**	**$1.6M**	**$11.9M**	**$2.4M**

Table 10: SCSN Resource Inventory Analysis by Service Category[9] [10]

Service Category	Central	East	North-East	North-West	Pan-West	South	West
Ambulatory/Outpatient Medical Care	$2,673,570	$11,342,361	$ 6,231,762	$1,541,874	$ 322,451	$ 3,523,554	$1,104,735
Medical Case Management	$ 267,768	$ 3,566,790	$ 1,443,513	$1,176,151	$ 246,464	$ 1,019,419	$ 245,138
Counseling & Testing Services	$ 75,557	$ 359,182	$ 308,354	$ 51,502		$ 38,748	
Drug Reimbursement - Local/Consortium	$ 647,839	$ 3,485,897	$ 2,304,890	$ 556,510	$ 136,269	$ 1,133,083	$ 170,348
Health Insurance	$ 206,935	$ 1,407,748	$ 1,535,005	$ 439,362	$ 45,816	$ 409,961	$ 80,164
Home & Community Based Health Services			$ 173,744	$ 67,778			$ 50,103
Home Health Care		$ 187,373	$ 90,526	$ 24,358		$47,192	
Medical Nutrition Therapy	$ 10,000	$ 302,943		$ 151,960	$ 17,265	$ 102,125	
Mental Health Services	$ 294,578	$ 444,592	$ 498,066	$ 194,967	$ 41,766	$ 345,540	$ 50,103
Oral Health Care	$ 645,560	$ 2,044,821	$ 1,313,564	$ 369,400	$ 68,011	$ 745,373	$ 77,443
Residential or In-home Hospice Care	$ 74,106	$ 572,400				$ 77,316	$ 30,061
Substance Abuse Services - Outpatient	$ 170,777	$ 33,635	$ 323,514	$ 95,503	$ 8,460	$ 333,748	
Total Core Services	**$5,066,690**	**$23,747,742**	**$14,222,938**	**$4,669,365**	**$ 886,502**	**$ 7,776,060**	**$ 1,08,095**
Social Case Management	$1,293,764	$ 1,850,962	$ 2,006,656	$ 102,128	$ 250,042	$ 1,226,771	$ 204,937
Housing	$1,205,235	$ 6,705,854	$ 3,220,052	$ 915,085	$ 383,360	$ 1,974,185	$ 361,360
Food Bank/Home-delivered Meals	$ 83,041	$ 800,292	$ 886,533	$ 348,290	$ 89,791	$ 236,012	
Medical Transportation	$ 86,059	$ 890,112	$ 832,007	$ 241,691	$ 18,623	$ 259,677	$ 37,319
Transportation Services	$ 30,000	$ 104,500	$ 34,887	$ 3,300		$ 59,805	
All Other Supportive Services	$ 77,357	$ 1,373,360	$ 1,475,769	$ 509,152	$ 5,455	$ 393,382	$ 33,645
Total Support Services	**$2,775,456**	**$11,725,080**	**$ 8,455,904**	**$2,119,646**	**$ 747,271**	**$ 4,149,832**	**$ 637,261**
Total Direct Services	***$7,842,146***	***$35,472,822***	***$22,678,842***	***$6,789,011***	***$1,633,773***	***$11,925,892***	***$2,445,356***

[9] Includes all funding sources except ADAP
[10] Does not include AETC or administrative funds

Section VI: Conclusions and Goals

The updated 2008-2010 SCSN document provides an overview of the issues affecting the HIV care service system in Texas and provides strategies for state and regional planning authorities to use when developing goals and objectives for their comprehensive plans.

The considerable efforts made to improve the participation of stakeholders resulted in DSHS meeting all but three of the SCSN requirements for representative participation; the Texas Department of Criminal Justice, the Medicaid/Medicare system, and rural PLWHA. The result was a diversified group of representatives that were able to provide well rounded and valuable input into the development of this document. Significant improvement were made to all sections of the SCSN and the improved document provides clear direction and guidance on developing strategies to address gaps in service, barriers to care, and linking and maintaining PLWHA in care. For future updates, DSHS should make a concerted effort to recruit representation from perspectives that were lacking in the process of updating this document, especially from the criminal justice system as data suggests that providing a continuum of services for clients recently released from incarceration is an issue across the state.

The epidemic in Texas remains concentrated in the EMA/TGAs and the number of PLWHA has increased each year due to the lower number of deaths among those infected and a stable number of new cases. Blacks now make up the largest proportion of cases while men-who-have-sex-with-men (MSM) account for half of all PLWHA and account for the most common route of exposure. While assessment and outreach activities should continue to capture as wide an audience as possible, special emphasis should be placed on assessing the need and barriers specific to providing prevention and care services to African American and MSM populations. In addition, efforts should be made to ensure that local service systems are able to provide culturally competent services to African American PLWHA, especially heterosexual African American Females.

Almost one quarter of all PLWHA in Texas received an AIDS diagnosis within one month of their HIV diagnosis and one third of all PLWHA received AIDS and HIV diagnoses within one year; with a larger proportion of Hispanics being diagnosed with AIDS within one year of their HIV diagnoses. Efforts should be made to deliver HIV testing and screening services in medical care settings, testing sites for STD and other venues where STD testing is performed, in non-traditional venues such as street outreach, and should include efforts to target the Hispanic population. Also, providers should connect with local emergency care centers and substance abuse treatment facilities to provide prevention services, including rapid testing services, and to locate and bring into care those who do not know their status, those who know their status and are not in care, and those who have dropped out of care.

In Texas overall there is a larger portion of people with HIV out of care than people with AIDS with data mirroring the epidemic. Blacks and Hispanics have a much greater proportion of people living with HIV out of care than persons living with AIDS and Blacks have the greatest number and the highest proportions out of care. For risk groups, MSM have the smallest proportion out of care, yet they have the largest number of unmet need cases due to the size of the population. Among persons exposed through heterosexual contact or injecting drug use,

males have a greater proportion of unmet need than females and among heterosexual males Blacks have the greatest proportion out of care. For heterosexual females Blacks have the greatest numbers and proportions out of care. Perinatal exposure comprises only 1% of living HIV/AIDS cases in Texas. Based on assessment data for out of care populations, not feeling sick or not thinking medical care was necessary are still the most common reasons cited for not seeking medical care. Actively using drugs and an inability to connect with service when released from incarceration were other reasons frequently given. Youth tended to have higher proportions out of care and were more likely to come late to care. PLWHA out of care tended to use emergency rooms to access medical care and were more likely to have been diagnosed with an STD in the past twelve months. Epidemiologic and assessment data suggests that while messages about the benefits of early access and maintenance in medical care would be beneficial across all populations, special efforts should be made to target Hispanic and African American males of all populations and risk groups and African American females. Further, messaging activities should be delivered at points of entry into the Ryan White funded system including testing sites for STD, and non-traditional settings such as emergency care centers, substance abuse treatment facilities, street outreach venues and social service agencies.

A comparison of service rankings by clients across all Parts in 2002, 2005 and 2006, along with current key informant interview data suggests that service needs and gaps ranked by clients remain stable over time. Therefore it is likely that any future assessments focused on ranking services will produce the same results and will not provide data that will be helpful for planning and developing local service systems. Future assessment activities should be smaller in scale, qualitative in nature, and target specific issues and/or populations. With service costs rising, funding remaining stable or reducing and restrictions on how federal funds may be spent, it will be important to assess local service systems to ensure that planning and contracting authorities have the information available to make informed service priority & resource allocation decisions that will maximize the use of all funding sources.

The following SCSN goals support the Texas Statewide Plan for Delivery of HIV Medical and Psychosocial Support Services, goals in the Center for Disease Control's Advancing HIV Prevention Initiative and Program Announcement 04012, Healthy People 2010 and the broad HRSA goals to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve quality of life for those affected by the epidemic. DSHS did not include specific priorities to support the goals in this section of the document as the strategies listed in Section V accomplish this. Another reason is because the Administrative Agencies that act as local business agents on the State's behalf are required to develop local priorities based on the issues and goals in the SCSN and to provide lists of specific priorities and/or activities would tie their hands to specific preselected priorities which may not be appropriate, feasible, or effective for their local service systems. This strategy will allow local planning authorities to use relevant strategies suggested in Section V to develop local priorities strategies and/or work plans that are responsive to their local service environment and effective toward reaching the goals set in the SCSN.

The first goal is to increase the proportion of HIV-infected adolescents and adults who know their status and receive care for HIV/AIDS; whether the care is provided through the Ryan White funded system or other systems of care.

The second goal is to ensure local care systems provide a continuum of services that are considered by the community to have a high priority and have a strong relation to enrolling and maintaining clients in HIV related medical services.

The third goal is to ensure that local care systems facilitate access to care for populations experiencing disparities such as substance abuse, mental health and recently incarcerated populations and includes mechanisms to treat co-morbid conditions such as tuberculosis, hepatitis and those conditions associated with aging.

The fourth goal is to increase consistent sexual risk assessments as a part of routine medial care for new and continuing PLWHA and ensure that local care systems have the resources and protocols to provide screening and treatment for STDs and referrals for prevention services for PLWHA when appropriate.

The fifth, and final goal, is to ensure local and state administrative systems provide consistent and effective oversight and technical assistance to ensure that the use of Ryan White and HOPWA funds is responsive to locally assessed need and supports a system of care that address the health care needs of PLWHA, reduces barriers to service, and facilitates entry and maintenance in high-quality care that meets or exceeds minimum public health standards.

The intent of this document is to provide an overview of the epidemic and the issues facing PLWHA in Texas while still including regional differences found across the state and the subtle variations among local populations of PLWHA. While developing this document, DSHS attempted to balance multiple concerns, issues, and needs and all parties involved recognize that not all issues identified in this document are applicable to all areas of the state, nor will every suggested strategy to address an issue be effective, financially feasible, or desired in all areas. It is anticipated that this document will provide regional and state planning entities with the information necessary to assist them in developing and implementing a comprehensive service delivery system designed to address the local issues faced by PLWHA. Improvements made to local delivery systems will bring the state of Texas closer to the goal of maintaining a seamless continuum of care.

Section VII: Appendix

Appendix 1: The SCSN Survey

As you are answering the questions below, please keep in mind that the purpose of the SCSN is to create a consensus statement about the most pressing and cross cutting issues associated with the delivery of services to people living with HIV/AIDS (PLWHA) in Texas by Ryan White Program grantees.

1. From your perspective, what are the most significant issues that affect care for PLWHA in your area?

   If you have implemented any strategies to address them, what are they?

2. What are the major barriers to entry and maintenance in medical care in your area?

   If you have implemented any strategies to address them, what are they?

3. What are the critical service gaps for PLWHA in your area?
   If you have implemented any strategies to fill the gaps, what are they?

4. What are the emerging trends/issues affecting HIV care and service delivery in your area?

   If you have implemented any strategies to address them, what are they?

5. What are the issues that affect coordination of services across Ryan White Program grantees in your area?

   If you have implemented any strategies to address them, what are they?

6. Is there anything else you'd like to add?

Appendix 2: Glossary of Acronyms and Terms

ADAP - AIDS Drug Assistance Program (state-operated program to provide medications to those who financially and medically qualify) also known as Texas HIV Medication Program **(THMP).**

Administrative Agency (AA) - also known as the Lead Agency - the Tarrant County Public Health Department is the designated agency or 'grantee' to administer the grants received for HIV services in the north central Texas region.

ARIES - AIDS Regional Information and Evaluation System - Texas database collecting HIV/AIDS client information.

ASO - AIDS Service Organization.

CBO - Community Based Organization.

CDC- Center for Disease Control and Prevention

CPG-Community Planning Group (often referred to as PPG- Prevention Planning Group) plans for HIV prevention activities in a designated area.

DSHS- Department of State Health Services. Texas state bureau which coordinates HIV/AIDS issues. Grantee for all TMA Part B funds and State Services Funds

EMA - Eligible Metropolitan Area. Geographic areas most severely affected by the HIV/AIDS epidemic that have 2,000 cases of AIDS. Texas has two EMAs: Dallas and Houston.

HOPWA- Housing Opportunities for People with AIDS, grants to organizations to help provide housing assistance to clients infected with HIV.

HRSA *(pronounced- her'suh)* - Health Resources & Service Administration - the federal agency that administers the Ryan White CARE Act funds.

HSDA - Health Services Delivery Area. The geographic areas eligible to receive Part B TMA and State Services funds in Texas.

MAI - Minority AIDS Initiative – originally legislated by the Congressional Black Caucus **(CBC**) to provide funds targeting underserved communities of color.

Needs Assessment – a study conducted in an area to understand a particular issue in order to facilitate making proactive and needed planning decisions.

Outcome Measures: Tools to measure the benefits or changes in clients during or after receiving services.

Planning Council - A mandated council made up of various community representatives, consumers, providers and professionals. A minimum of 33% of the membership must be HIV-positive.

PLWH/A –**PWA**- Persons Living With HIV/AIDS.

QM - Quality Management – assesses the quality of programs provided.

RFP- Request for proposals. RFPs are issued to solicit potential providers for a variety of activities that range from service provision to conducting planning functions.

Ryan White HIV/AIDS Treatment Modernization Act (TMA) formerly known as the CARE Act - Legislation which authorized the various funds for HIV/AIDS services in local communities:

- **Part A** (or **Title I**) to the largest EMA's and TGA's (56 areas);
- **Part B** (or **Title II**) to states for ADAP and other programs within the state;
- **Part C** (or **Title III**) for Early Intervention (primarily medical);
- **Part D** (or **Title IV**) for women, children and pediatric AIDS programs;
- **Part F** MAI programs, for certain state dental programs and AIDS Education Training Center's.

Standards of Care: A document composed of several elements, which identifies and defines minimum acceptable requirements that service providers and their staff must meet. The standards of care include such areas as licensure, knowledge, skills, experience, client confidentiality, care, access to service, Quality Assurance and Quality Improvement, and staff training.

State Services - A grant provided by DSHS for HIV health and social services.

TGA – Transitional Grant Areas. Urban areas throughout the U.S. which have between 1,000 – 1,999 documented cases of persons living with AIDS. TGA's receive TMA funding from HRSA through Part A and from DSHS for Part B and State Services. Texas has three TGAs: Fort Worth, Austin and San Antonio.

Unmet Need – A term used to measure the number of clients not in primary HIV medical care.

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