THE COMPREHENSIVE HIV SERVICES PLAN FOR EAST TEXAS 2007-2009

Submitted by

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.

500 Lovett Boulevard, Suite #100
Houston, Texas 77006

Tel: 713.526.1016
Fax: 713.526.2369
E-mail: staff@hivresourcegroup.org
Web: www.hivresourcegroup.org

TABLE OF CONTENTS

Introduction ……………………………….. ………………………………… 4

Geography
Population Description

Section 1: Where Are We Now?.. 8

Epidemiologic Profile

Most Recent Needs Assessment Summary
Service Category Rankings and Explanation
Gaps in Care
Services
Barriers to Care Services
Regional Prevention Needs

Brief Summary of Current Care Resources in the Planning Area
Inventory Core Services and Number of Providers
Inventory of Funding Sources
Summary of Additional Services

Description of Current Care System
Priorities and Allocations Process Explanation
Brief Inventory of Core Services Providers
Brief Inventory of Core Services Funding Resources
Priorities and Allocations for Planning Area HSDAs

Section 2: Where Do We Need to Go?..40
Mission, Vision, and Shared Values

Section 3: How Will We Get There?...41
Long-term System Goals
Interim Goals

Section 4: How Will We Monitor and Evaluate Our Progress?......................44
Evaluation and Monitoring Process

ACKNOWLEDGEMENTS

This Comprehensive Plan was developed through successful collaboration between the Planning Administrative Agency and dedicated volunteer members of the Comprehensive Planning Workgroup. The time and knowledge they shared in this process are sincerely appreciated.

Workgroup Facilitators

M. Naomi Doyle-Madrid, Lead Facilitator
Tam Kiehnhoff, Co-Facilitator

Special thanks go to members of the Comprehensive Planning Workgroup for their countless hours of hard work in developing the continuum of care and comprehensive plan. In addition, thanks go to the Houston Part A Ryan White Planning Council for collaborating with Resource Group to develop the Houston Area HIV Services Comprehensive Plan, which has been adopted into this regional East Texas plan.

Workgroup Members

John Bailey, Nancy Miertschin, Michelle Verser
Andrew Crosson, Joey Pack, Tyronda Jones
Reed Hunsdorfer, Yolanda Tatum, Nickie Bell

Additional thanks go to the dedicated staff of the Planning Administrative Agency who coordinated community input efforts and developed the final written product.

Shannon Prudhomme, Chanel Moody

Thanks also to the Planners of the Texas Department of State Health Services (DSHS), all of whom provided extensive guidance and feedback in the development process of this plan.

Finally, very special thanks and appreciation go to the people living with HIV/AIDS (PLWH/A) who participated in community input sessions held throughout the East Texas HIV Administrative Service Area. Their willingness to contribute to the development of this plan is appreciated.

Introduction

<u>Geography</u>

East Texas HIV Administrative Service Area Map

The 51-county East Texas HIV Administrative Service Area (HASA) covers 38,166 square miles, which encompasses roughly 15% of the state's land. The majority of this area is considered to be rural.

This area is divided into six (6) HIV Service Delivery Areas (HSDA): Beaumont, Galveston, Houston, Lufkin, Texarkana, and Longview. *Figure A* below outlines the counties represented within each of the six HSDAs. The area borders Oklahoma and Arkansas to the North, Louisiana to the East, and the Gulf of Mexico to the Southeast.

According to the 2000 U.S. Census, the estimated population of this area was 6,611,054, which was 15% of the overall Texas state population (20,851,820).

The average county population for the planning area was 129,629, but ranged from 5,327 (Delta) to 3,400,578 (Harris). Harris County is home to the city of Houston, which is the largest city in Texas and the fourth largest in the nation (after New York, Los Angeles, and Chicago).

In 2000, Houston had a population of nearly two million, and there were 63 other places in the area with a population of 10,000 or more. Thus, for Part B planning purposes, the rest of the region outside of Harris County is considered rural.

Figure A: Counties Served					
Beaumont	**Galveston**	**Houston**	**Lufkin**	**Texarkana**	**Longview**
Hardin Jefferson Orange	Brazoria Galveston Matagorda	Austin Chambers Colorado Fort Bend Harris Liberty Montgomery Walker Waller Wharton	Angelina Houston Jasper Nacogdoches Newton Polk Sabine San Augustine San Jacinto Shelby Trinity Tyler	Bowie Cass Delta Franklin Hopkins Lamar Morris Red River Titus	Anderson Camp Cherokee Gregg Harrison Henderson Marion Panola Rains Rusk Smith Upshur Van Zandt Wood

Population Description
The average number of people living per square mile in the East Texas planning area was 127, with the most dense HSDA being the Houston HSDA. *Table A* below illustrates the geographic size, population, population change, and population density for each HSDA.

Population density is the number of persons per unit of area. For this table, population density was calculated as the number of persons per square mile in each HSDA.

Table A. Population and geographic size, by HSDA

HSDA	*2000 population*	*Square miles*	*Population density*	*% change 1990-2000**
Beaumont	385,090	2,154	179	9
Galveston	529,882	2,898	183	15
Houston	4,324,572	9,414	459	30
Lufkin	355,862	9,906	36	17
Texarkana	270,468	5,803	47	9
Tyler	745,180	9,720	77	16
East Texas	*6,611,054*	38,166	84	--
Texas	*20,851,820*	261,797	80	23
United States	*281,421,906*	3,537,438	80	13

*HSDA and East Texas numbers are the averages for the counties in that HSDA.
Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File (SF3).

Census data collected in the year 2000 indicates the estimated population of the East Texas service region to be 6,611,054. This population comprises approximately 15% of the overall Texas state population. The median age ranged from 30 to 47, and the average age was 37 in the East Texas area. In comparison to the median age for both Texas (32) and the U.S. (35), the median age of individuals in this region is slightly older.

The East Texas area's population was predominantly Anglo (66%) in 2000. People of color comprised the remaining percentage of the population. Specifically, African Americans accounted for 8%; Asian/Pacific Islanders, 3%; and Native Americans accounted for less than 1%. Overall, those that identified as being of Latino ethnicity accounted for 23% of the total East Texas population.

As noted in *Table B*, the Beaumont and Tyler HSDAs had the largest percentage of African Americans. Further, the Galveston and Houston HSDAs had the largest percentage of Latinos.

Table B. Racial/ethnic profile, by HSDA				
HSDA	*Hispanic*	*African American*	*Anglo*	*Asian/Pacific Islander*
Beaumont	8%	25%	68%	0.4%
Galveston	21%	12%	74%	1.9%
Houston	30%	3%	61%	4.1%
Lufkin	9%	17%	77%	0.5%
Texarkana	7%	17%	78%	0.7%
Tyler	9%	22%	77%	0.5%
East Texas	*23%*	8%	66%	3.0%
Texas	*32%*	11%	71%	2.7%
United States	*13%*	12%	75%	3.7%
Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File (SF3).				

Socioeconomic challenges greatly impact public health, particularly in rural areas. As noted in *Table C* below, the per capita income in each of the six East Texas HSDAs were lower than that of both the U.S. and state of Texas, which were $19,617 and $21,587, respectively.

Further, in the East Texas area a significant percentage of people were living below the poverty level in 2000. An average 16% of people in this service region were living below the poverty level.

Table C. Per capita income, poverty levels, and unemployment rates, by HSDA				
	Per capita income‡	*% Living Below Poverty‡*		*2003 Unemployment rates†*
HSDA		*Persons*	*Families*	
Beaumont	$17,696	14	12	9.7
Galveston	$19,099	14	11	10.5
Houston	$18,765	14	10	6.2
Lufkin	$15,350	19	14	8.3
Texarkana	$16,237	17	14	6.2
Tyler	$16,457	16	12	6.2
East Texas	*$16,838*	16	12	*7.8*
Texas	*$19,617*	15	12	*6.8*
United States	*$21,587*	12	9	*6.0*
*HSDA and East Texas per capita incomes, poverty percentages, unemployment rates are the averages for the counties in that HSDA.				
†Source: Texas Workforce Commission ‡Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File (SF3).				

Another important socioeconomic indicator is the unemployment rate. The 2003 unemployment rate for Texas and the U.S. was 6.8% and 6.0%, respectively. In comparison, half of the East Texas HSDAs had unemployment rates that were greater than both the U.S.and state of Texas. The Beaumont, Galveston, and Lufkin HSDAs, specifically, had the highest unemployment rates at 9.7%, 10.5%, and 8.3% respectively.

Section 1: Where Are We Now?

Epidemiologic Profile

The Ryan White CARE system focuses on providing services to people who are living with HIV/AIDS. Prevalence refers to the total number of cases of a disease in a given population, at a specific time. This profile aims to outline the reported distribution of the disease throughout the planning area. Information on living HIV/AIDS cases per HSDA through 2005 is outlined below, along with statistics for specific subgroups:

Table D. Prevalence or Living Reported HIV/AIDS Cases by HSDA, East Texas Planning Region – Through December 31, 2005

HSDA	2005 Living Cases	
	#	%
Beaumont	730	3.4
Galveston	788	3.7
Houston	18,362	85
Longview	404	1.9
Lufkin	301	1.3
Texarkana	1,004	4.7
Total	***21,589***	***100%***

Source: Data extracted from the 2005 HARS data sets, DSHS.

Table E. Prevalence or Living Reported HIV/AIDS Cases by Gender, East Texas Planning Region – Through December 31, 2005

Gender	2005 Living Cases	
	#	%
Male	15,775	73
Female	5,814	27
Total	***21,589***	***100%***

Source: Data extracted from the 2005 HARS data sets, DSHS.

Table F. Total Number of HIV/AIDS Cases by Age, East Texas Planning Region – Through December 31, 2005

Age Group	Male	Female	Total Number
<12	97	83	180
13-19	98	117	215
20-29	1,434	1,166	2,600
30-39	4,141	1,954	6,095
40-49	6,281	1,582	7,863
50-59	2,845	693	3,538
60-69	714	165	879
70+	164	50	214
Total	***15,775***	***5,810***	***21,589***

Source: Data extracted from the 2005 HARS data sets, DSHS.

Table G. Total Number of HIV/AIDS Cases by Gender and Race/Ethnicity, East Texas Planning Region – Through December 31, 2005

Race/Ethnicity	Male	Female	Total Number
White	6,141	1,001	7,141
African American	6,348	4,024	10,372
Hispanic	3,126	747	3,873
Asian/Pacific Islander	132	31	163
Amerian Indian/Alaska Native	16	4	20
Other	13	7	20
Total	15,775	5,814	***21,589***

Source: Data extracted from the 2005 HARS data sets, DSHS.

Table H. Total Number of HIV/AIDS Cases by Gender and Behavioral Risk, East Texas Planning Region – Through December 31, 2005

Behavioral Risk	Male	Female	Total
Men who Sleep with Men (MSM)	9,904	0	9,904
Intravenous Drug Users (IDU)	1,797	1,359	3,156
MSM&IDU	1,434	0	1,434
Heterosexual Contact	2,405	4,265	6,670
Blood Product/Other	71	36	107
Not Classified	0	1	1
Pediatric	163	152	315
Total	***15,776***	***5,813***	***21,589***

Source: Data extracted from the 2005 HARS data sets, DSHS.

2004/200505 Needs Assessment Summary

The Health Resources and Services Administration (HRSA) states that a comprehensive needs assessment must be completed once every three years. For HIV services planning, administrative agencies collect information for the comprehensive services plan by talking to people living with HIV disease (PLWH), their families, and service providers. The Texas Department of State Health Services (DSHS) required the use of a standardized needs assessment survey tool developed through the now-defunct Texas Statewide Coordinated Statement of Need (SCSN) project for all Part B services planning assemblies.

This SCSN-developed survey tool was utilized for the most recent needs assessment published in 2004. The survey was designed to identify the needs of PLWH, both those who are in care and those who are not receiving HIV services. The needs assessment was designed to be consistent with the Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) program principles, and to provide a comprehensive picture of HIV clients and underserved populations throughout the State. The survey contains core elements of an effective

needs assessment to provide information about barriers to accessing services, gaps in health care delivery, and perception of need. It was made available and was facilitated in two languages: English and Spanish.

New Solution, Inc., was the consultant charged with implementing the needs assessment, while Sage Associates, Inc., carried out the needs assessment. For the Houston area assessment, a 29 member field team was used for survey administration, which was comprised of outreach workers, counselors, PLWH/A and others. This field team was recruited an managed by Families Under Urban and Social Attack (FUUSA), a non-profit social service organization with ties to both Houston and the surrounding rural areas.

For the other regional HSDAs, each HASA or planning area established a group of survey administrators to help them plan and conduct the needs assessment. Sage Associates trained the administrators in administering the client survey, analyzed the data, and compiled a final Needs Assessment report. In completing the steps of the needs assessment process, Texas faced some unique challenges in assessing statewide needs. Because of the size and diversity of the State, Texas previously required multiple regional planning assembly groups.

The process developed by SCSN attempted to balance the need for some degree of uniformity with the need for the seven planning areas to tailor individual needs assessment processes to their respective communities. Therefore, each planning area developed methods to complete the needs assessment that best suited their area. Planning assemblies then had the option to use additional survey questions, focus groups, and key informant interviews as needed to supplement data from the client surveys.

A comprehensive needs assessment includes both a resource inventory and a profile of provider capacity and capability. The resource inventory describes the current HIV services in the HSDA. The profile of provider capacity and capability builds upon the resource inventory by providing additional information about availability, accessibility, and appropriateness of services for PLWH. While the resource inventory might be viewed as describing the broadest possible network of caregivers within the service area, the provider profile includes information about providers that are most likely to be a part of the actual service and referral network for PLWH/A.

Together, the resource inventory and provider profile determine the extent to which the needs identified for specific target populations are being met by existing services, as well as the unmet needs or gaps in the service delivery system. Planning assemblies had the option of choosing a short or long version of a provider survey tool developed by the SCSN project.

Needs Assessment Process

In 2004, the previous planning assembly known as the State of Texas Assembly Group East (STAGE) included a Needs Assessment Committee (NAC). STAGE's Needs Assessment Committee (NAC) began the process of conducting the first comprehensive regional needs assessment in the East Texas Planning Area. NAC worked with local groups of survey administrators located in each of the five rural HSDAs, relying on them to provide input into survey development and implementation.

For East Texas, two needs assessment have traditionally been carried out: 1) one for the Houston HSDA, which is collaboratively coordinated and financed with the local Part A Ryan White Planning Council; and 2) one focused on the other five HSDAs. Together both of these documents represent our complete six-HSDA East Texas region. The two complimentary reports are the S*tate of Texas Assembly Group East 2004 Needs Assessment Report* and the *2005 Houston Area HIV/AIDS Needs Assessment*.

In Houston, the Joint Part A/Part B Needs Assessment Group (NAG) guided the needs assessment process and was made up of representatives of all partner organizations, consumers, service providers and other community members. The tasks of the NAG were distributed among the following four working groups: Joint Epidemiology Group, Joint Data Collection Group, Joint Resource Inventory Group, and the Joint Gaps Analysis Group.

In the East Texas Planning Area, each NAC member reviewed the SCSN surveys and made suggestions for additional questions, before finalizing a client survey with 49 questions and a provider survey with 29 questions, many of which had multiple parts. Budget constraints limited the total number of surveys to be collected in the other five HSDAs to 780. A goal for a completed number of surveys was set for each HSDA based on that HSDA's proportion of the total reported HIV/AIDS cases in all five HSDAs. To help keep track of the surveys, each one was coded with the HSDA name. Stand groups of survey administrators in all six HSDAs were trained to administer the client survey one-on-one or in small group settings and recruited respondents through such means as flyers, newspaper advertisements, and mailings to clients.

Surveys were typically administered at service provider sites, but staff was not allowed to participate. Before completing the survey, respondents were given a form explaining the reason for the survey and completion of the survey was interpreted as consent. The survey was confidential and did not ask for any information that could identify a respondent. Each client received a gift certificate for Wal-Mart or a local grocery store in appreciation for their time ($15 in the non-HSDAs).

The most recent Houston HSDA Needs Assessment was published in 2005. A total of 654 client surveys and 85 providers surveys were collected, and 97 individuals participated in eleven focus groups. A total of 651 consumer surveys were collected; 8 were invalidated due to incomplete, missing, or unverifiable responses, leaving a data set of 643 valid survey responses. In addition, 66 valid provider surveys were completed in the other five HSDAs. All completed surveys were collected by the LNATFs and returned to the planning administrative agency and analyzed by staff using the SPSS statistical package. In the Houston HSDA, surveys were collected and analyzed by support staff for the Part A Planning Council.

As with any survey, there are limitations that must be considered when analyzing the results. As mentioned in the Houston area report, limitations to the client survey include: 1) the possibility of selecting contradicting responses, 2) leading questions, 3) unclear terms, 4) forced selection of responses without the options of "not applicable" or "do not know", 5) confusing formatting, and 6) the inappropriateness of the survey for special populations, such as children. Administrative and analytical measures were taken to overcome these limitations and the survey provides a large quantity of information important to community planning.

There also were limitations to the provider survey. In the Houston HSDA, providers "reported difficulties in determining appropriate time periods for funding and budget information and found questions about client counts…unclear." There also was confusion in about whether or not to check major service categories and/or subcategories. Although there was no formal mechanism for feedback from providers outside the Houston HSDA, based on the fact that very few of the survey questions were completed by very few respondents, the challenges to completing the survey seemed insurmountable at that time. Consequently, the Administrative Agency will revisit the use of this survey for 2007 needs assessment activities.

Client Survey Findings

As previously mentioned, 654 PLWH returned surveys in the Houston HSDA and 643 valid surveys were returned in the other five HSDAs. Because of the large number of surveys returned in the Houston HSDA as compared to the other five, those results are analyzed and reported separately so as not to skew the results.

The Table below shows the distribution of returned surveys by HSDA, both by those in care and out-of-care (or "unmet need" population) for the needs assessment completed in the non-Houston HSDAs. Approximately 7% of respondents met the criteria for unmet need. The majority of out-of-care respondents hailed from the Houston and Texarkana HSDA. As illustrated in the table the low number of out-of-care respondents prevents the ability to complete useful analysis of this population, nor useful comparison to the in care population. Consequently, most of the needs assessment findings information in this section may not specifically compare responses between in-care and out-of-care respondents.

Distribution of valid survey respondents for rural HSDAs			
HSDA	*Number In Care*	*Number Out of Care*	*Percent of total in 5 rural HSDAs* (n=652)
Beaumont	183	6	29%
Galveston	100	13	17%
Houston	--	–	--
Lufkin	91	12	16%
Texarkana	59	4	10%
Tyler	171	13	28%
	604	48	
Total	652		*100%*
Source: State of Texas Assembly Group East - 2004 Comprehensive Needs Assessment Report			

In an effort to provide a comprehensive outline of surveys returned throughout the East Texas HASA, the Table below shows the distribution of returned surveys for both the Houston HSDA and rural HSDA needs assessment reports. For the Houston HSDA, approximately 30% of respondents reported being out-of-care. For the entire region (i.e., both needs assessment reports), approximately 19% of respondents met the criteria for being out-of-care or being of unmet need. The majority of out-of-care respondents hailed from the Houston HSDA.

Distribution of valid survey respondents for the all HSDAs			
HSDA	*Number In Care*	*Number Out of Care*	*Percent of total in East Texas HSDAs (n=1,306)*
Beaumont	183	6	14%
Galveston	100	13	9%
Houston	452	202	50%
Lufkin	91	12	8%
Texarkana	59	4	5%
Tyler	171	13	14%
	1,056	250	
Total	*1,306*		*100%*
Sources: 2005 Houston Area HIV/AIDS Needs Assessment, State of Texas Assembly Group East - 2004 Comprehensive Needs Assessment Report			

<u>*Needs Assessment-Based Service Category Rankings*</u>
The multi-component, 49-question survey allowed for the results to provide a complex level of information about specific service categories. To help organize the data and make them easier to understand in a way that is meaningful to the planning assembly, the results are presented according to three basic categories: need, access, and use. Within each category there are “top ten” service lists based on the total number of people who marked the boxes in the tables in Question #47 of the client survey. The Tables that follow show the top ten services based on need, access, and use.

MOST NEEDED SERVICES

Top Ten client-reported most needed service categories†	
5 Rural HSDAs Ranking	*Houston HSDA Ranking*
1 Case Management	1 Ambulatory/Outpatient Medical Care
2 Primary Care/Infectious Disease	2 Vision Care
3 Health Insurance	3 Oral Health/Dental Care
4 Food Bank and Oral Health/Dental Care*	4 Transportation (Gas/taxi vouchers)
5 Vision Care	5 Case Management and Food Bank
6 Utility Assistance	6 Bus Passes
7 Rental Assistance	7 Rental Assistance
8 Nutritional Supplements	8 Utility Assistance
9 Household Items	9 Household Items
10 Transportation (Van)	10 Nutritional Counseling and Support Groups*
** Both services received equal percentage of reported need from survey respondents*	

There are some noteworthy similarities between the two needs assessment reports for the region. Dental care, medications/pharmacy, primary care/infectious disease, vision care, rental assistance, household items, transportation, and case management were among the top ten needed services throughout the East Texas HASA. Though health insurance ranked third for the non-Houston HSDAs, it was not identified as one of the top ten needed services for the Houston HSDA needs assessment.

MOST USED SERVICES

Top Ten client-reported most used service categories	
5 Rural HSDAs Ranking	*Houston HSDA Ranking*
1 Case Management	1 Primary Care/Ambulatory Outpatient Services
2 Primary Care/Infectious Disease	2 Support services
3 Utility Assistance	3 Emergency medical services
4 Food Bank	4 Oral Health/Dental care
5 Oral Health/Dental Care	5 Case Management
6 Transportation (Van)	6 Drug Reimbursement
7 Health Insurance	7 Inpatient services
8 Vision Care	8 Mental health therapy/counseling
9 Referral	9 Nutritional services
10 Early Intervention	10 Rehabilitation*

For both the 5 HSDAs and the Houston HSDA, the following services were in the top ten lis of most used services: oral health/dental care, primary care/infectious disease, case management, and mental health services. Drug reimbursement, vision care, mental health therapy/counseling, and nutritional counseling appear in the Houston HSDA list but not in the rural HSDAs' list, and nutritional services and rehabilitation services were identified as among in the Houston HSDA list, but not the 5 HSDA list.

ACCESSIBILITY OF SERVICES

Top Ten service categories by client-reported difficult to access†	
5 HSDAs Ranking	*Houston HSDA Ranking*
1 Transportation (Van) 2 Rental Assistance 3 Health Insurance and Oral Health/Dental Care* 4 Utility Assistance 5 Vision Care 6 Nutritional Supplements and Legal Services* 7 Housing-related Services 8 Primary Care 9 Shelter Vouchers, Drug Reimbursement, Psychological/psychiatric treatment/counseling, Household Items, Referrals* 10 Food Bank	1 Rental Assistance 2 Health Insurance 3 Housing Related Services 4 Utility Assistance 5 Gas/Taxi Vouchers 6 Primary Care - Inpatient care 7 Social case management 8 Patient education services 9 Home health care* 10 Mental health therapy/counseling
** Services received equal percentage of reported need from survey respondents*	

Barriers to Care

The outline below lists the top three client survey results for clients who reported not receiving HIV-related medical care from a doctor or nurse.

Beaumont HSDA

1) not wanting to receive medical care
2) not believing that medical care was needed due to not being sick
3) not knowing where to go for medical care

Galveston

1) not believing that medical care was needed due to not being sick
2) not wanting medical care
3) financial reasons

Houston

1) not believing that medical care was needed due to not being sick
2) not wanting medical care
3) financial reasons

Lufkin

1) not believing that medical care was needed due to not being sick
2) not knowing where to go for medical care
3) not wanting medical care

Longview

1) not feel that medical care would do any good
2) not wanting to receive medical care
3) other unidentified reasons

Texarkana

1) not believing that medical care was needed due to not being sick
2) not knowing where to go for medical care
3) not having anyone tell the individual that medical care was needed

Unmet Need Estimates

The overall unmet need percentages for each HSDA are referenced from a report issued by DSHS. Specific barriers and populations of interest are noted within the profile for each HSDA. Specifically, HRSA defines unmet need as the need for health services by PLWH/A who are aware of their HIV status but are not receiving regular primary health care.

The determination of not receiving primary care is defined as having no evidence of the following in the past 12 months:

a) having no evidence of a CD4 test
b) a viral load test
c) being on antiretroviral therapy.

According to DSHS, these 2003 unmet need estimates were generated using living cases in the HIV/AIDS Reporting System (HARS), and matched this information to other data systems. The most recent residence information was also used to assign living cases to specific areas. In addition, information from both the electronic lab reporting system and the Uniform Reporting System were matched against HARS data to determine unmet need estimates.

Number and proportion of living HIV cases with unmet need by HSDA, 2003-2004

HSDA	*2003*		*2004*	
	#	*%*	*#*	*%*
Beaumont/Port Arthur	209	2.7	244	2.9
Galveston	314	4.0	331	3.9
Houston	6,969	88.0	7,381	87.7
Lufkin	90	1.1	90	1.1
Texarkana	91	1.1	93	1.1
Tyler/Longview	246	3.1	277	3.3
Total	*7,919*	*100%*	*8,416*	*100%*

Prevention for HIV Positive Individuals

Prevention needs for positives has only recently become recognized by both care and prevention planning groups. The *2004 East Texas Needs Assessment* provided information on prevention needs in the region. Respondents were asked to check all conditions/infections they had received medical care for within the previous 12 month period. Twenty-five percent (161)of respondents indicated that they had received medical care for an STI or an infection that can be transmitted through sexual activity.

Among the 161 respondents, 61% (98) had hepatitis C, 35% (51) had hepatitis A or B, and 32% (51) had an STI (syphilis, gonorrhea, and chlamydia were listed as examples). Over half of respondents reported having and STI were men. Individuals of Anglo descent represented the

largest racial/ethnic group with STIs (49%), followed by African Americans (42%) and those of Hispanic/Latino descent (10%).

HIV Prevention Needs

Since 1993, the Centers for Disease Control and Prevention (CDC) has implemented HIV Prevention Community Planning. In Texas, the realization of this process has been implemented by DSHS and volunteer Community Planning Groups (GPGs). Similar to care planning, these CPGs are stratified into groups that represent six planning areas across the State.

The broad goals for HIV Prevention Community Planning are outlined as follows:

Goal One: Community planning supports broad-based community participation in HIV prevention planning.

Goal Two: Community planning identifies priority HIV prevention needs (a set of priority target population and intervention for each identified target population) in each jurisdiction.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV Prevention Plan.

Consistent with these CDC-developed goals, all CPGs are responsible for collecting community assessment data and developing a prevention-focused action plan. Core groups were established in what are referred to as High-Morbidity Analysis Zones (HMAZs) in East Texas region. The East Texas core groups were located and organized according to the following HMAZ areas:

- Houston Metroplex HMAZ (Ft. Bend, Liberty, and Montgomery counties)
- Harris County HMAZ
- Golden Triangle HMAZ (Hardin, Jefferson, and Orange Counties)
- Galveston HMAZ (Galveston and Brazoria counties)
- South Piney Woods HMAZ (Angelina, Jasper and Nacogdoches counties)
- North Piney Woods HMAZ (Cherokee, Gregg, Harrison and Smith counties)

In January 2006, the core group began selecting interventions to address behavioral factors that influence the prioritized populations in each area of East Texas. These area-wide selected interventions were ranked as High, Medium, or Low prioritized. In addition, the core group recommended that some interventions be linked via delivery or referral to appropriately address the priority populations of each area. The process for selecting interventions and a listing of the selected interventions are outlined in the *East Texas HIV Area Action Plan* published in March 2006. To retrieve a full copy of the *2006 East Texas HIV Prevention Area Action Plan*, please visit http://www.dshs.state.tx.us/hivstd/planning_profiles/default.shtm .

Current System of Care

A continuum of care can be described as a “picture” of what resources are available in a community or region, as well as how those resources are being used or could ideally be used. This continuum of care is designed to provide a brief summary of the available HIV services in the East Texas Planning Region, with an emphasis on core services. The following summer outlines the availability of service providers in each HIV Service Delivery Area (HSDA) and the known funding sources. Using such information, service providers and stakeholders in each HSDA may then work to determine approaches that ensure accessibility to these available services throughout the region.

Provider Input: Current Health System Issues and/or Anticipated Changes

Beaumont/Port Arthur: The primary medical care facility at which unfunded patients must seek medical specialty care, has cut numerous positions and is continuing to reduce professional staff. Further, this facility has gradually imposed stricter guidelines for proving eligibility for indigent services. Case managers must spend increasing amounts of time assisting clients in satisfying these requirements, causing delays in getting individuals into care and increasing the likelihood of losing newly diagnosed individuals to follow-up.

Medicare Part D has rolled out, and for some the process has been difficult and frustrating, and has necessitated much case management assistance, and caused some medication delays and interruptions.

Galveston: The main primary medical care facility has announced major job cuts and over the past several months has increased clinic co-pays and some medication co-pays. Clients that normally would have “screened down financially to no pay" are now receiving bills from this primary care location with threats of not scheduling new appointments if the bill is not paid. This is also true for clients that have Medicare coverage. Patients are also being discharged from inpatient care much sooner and without much discharge planning by the provider’s social work department. In the Galveston HSDA, transportation to appointments has become increasingly more expensive – and may continue to increase – due to gasoline prices.

Houston: In this service area there is insufficient psychiatric services for patient population, and a lack of substance abuse treatment options. Providers have reported transportation and a lack of bilingual staff at some provider locations as being barriers to care.

Lufkin: There is currently only one infectious disease doctor in this service area. In addition, there is HIV/AIDS phobia among existing doctors. Often these doctors are not educated about the virus and are unwilling to treat, uneducated about the virus. When a client is able to visit a doctor, the distance required for such visits are inconvenient. Other reported barriers to receiving care include challenges in securing transportation to appointments, lack of insurance coverage, and lack of lodging (if the doctor is too far away for a day trip).

In the future, providers expect certain funding reductions to present a challenge, and there a new van is currently needed for client appointment transportation services.

Longview/Tyler: There is currently only one infectious disease doctor in this service area. In addition, there have been recent funding shortfalls needed to continue implementing HIV programs. These shortfalls may leave over 300 people without HIV early intervention services in an 8 county region. Recently, the primary provider agency was awarded a grant to provide more comprehensive oral health services. This agency also serves the Texarkana/Paris HSDA.

Texarkana/Paris: There is currently only one infectious disease doctor in this service area. Recently, the primary provider agency was awarded a grant to provide more comprehensive oral health services. This agency also serves the Longview/Tyler HSDA.

Core HIV Services and Access Barriers

The following summary provides profiles of core services in each HSDA. In addition, the summary highlights certain barriers and issues reported through the regional 2004 Needs Assessment. In addition, 31 total consumers throughout the East Texas planning region participated in "community input sessions" that were focused on core services. Overall, consumers identified case managers and transportation (van and bus passes) as being crucial service linkages.

Primary Medical Care: Reportedly 15 agencies across the region provide this service. According to the 2004 Needs Assessment, 81% of respondents used primary care services. The two most frequently reported barriers were access/availability and information about the service.

Consumer Input Meeting Notes:

In some areas, participants stated that there were no Infectious Disease Specialists available to address certain health issues. Participants in the Longview/Tyler HSDAs stated that stigma among physicians in public clinic and hospital settings often cause them to receive poor services. In addition, participants from the Longview/Tyler HSDA expressed additional concerns regarding the expected closing of one of the major primary care facilities in March 2007.

Case Management: Based upon provider surveys and follow-up communications, 19 identified agencies across the East Texas planning region provide case management. Approximately 87% of respondents reported using this service in the needs assessment. The two most common reported barriers for both medical and psychosocial case management were access/availability and information.

Consumer Input Meeting Notes:

Case management services were identified as being a key component to linking clients to services throughout the region.

Substance Abuse: A total of 9 agencies have reported providing this service. In addition, needs assessment results illustrate that 17% of respondents reported using this service. Information was identified as the most common barrier to substance abuse services across the region.

Consumer Input Meeting Notes:

Participants in all areas reported a lack of knowledge regarding substance abuse treatment providers.

Drug Reimbursement: Throughout the planning region, 8 agencies provide drug reimbursement services. According to the 2004 Needs Assessment, approximately 19% of respondents indicated that they used this service. The two most common barriers reported were information and access/availability.

Consumer Input Meeting Notes:

Participants in all areas stated that Case Managers assisted them in ensuring that this need was met, particularly after the implementation of Medicaid Part D.

Mental Health: Reportedly 13 agencies across the region provide this service. According to the 2004 Needs Assessment, 28% of respondents throughout the East Texas planning region reported using psychological/psychiatric counseling/treatment services. The most common barrier reported was information.

Consumer Input Meeting Notes:

In Texarkana, participants expressed concern regarding the lack of available mental health providers. In addition, the only Mental Health professional at the primary provider agency has resigned.

Oral Health: A total of 6 distinct agencies have been identified as providing this service. In addition to contract dentists available in some areas, consumers across the region also reported receiving extensive oral health services at Houston-based Bering Omega. In addition, needs assessment results illustrate that 45% of respondents reported using this service. Two barriers were frequently reported: information and access/availability, respectively.

Consumer Input Meeting Notes:

In Beaumont and Galveston, specifically, participants stated that transportation services were crucial to providing access to comprehensive oral health services in Houston. However, the participants stated that it would be helpful to expand oral health services locally to decrease travel to a different city.

Health Insurance: A total of 6 agencies have reported providing this service. Approximately 43% of respondents reported using this service in the needs assessment. However, it should be noted that when asked in question #22 if they had health insurance that covers their HIV/AIDS medical care, 63% responded "yes." The three significant and most frequently reported barriers to this service were information, access/availability, and service delivery, respectively.

Consumer Input Meeting Notes:

Participants in all areas reported having knowledge of health insurance providers in their areas.

Inventory of Regional Providers

The summary lists the number of service providers throughout the East Texas planning area. Specifically, this section focuses on core services provided in the HIV Service Delivery Areas (HSDA) of Beaumont/Port Arthur, Galveston, Houston, Lufkin, Longview/Tyler, and Texarkana/Paris. The Health Resources and Services Administration (HRSA) mandates specific "core service categories" be provided to PLWH/A. These six selected core medical services are among several outlined in the recently reauthorized Ryan White CARE Act. These services are: primary medical care, case management, substance abuse, drug reimbursement, mental health, and oral health services.

Primary Medical Care†	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	1
Galveston	1
Houston	6
Longview/Tyler	4
Lufkin	3
Texarkana/Paris	2

Case Management**	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	3
Galveston	2
Houston	10
Longview/Tyler	2
Lufkin	2
Texarkana/Paris	2

Substance Abuse	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	2
Galveston	1
Houston	1
Longview/Tyler	2
Lufkin	1
Texarkana/Paris	2

Drug Reimbursement	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	1
Galveston	1
Houston	1
Longview/Tyler	1
Lufkin	3
Texarkana/Paris	1

Mental Health	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	4
Galveston	2
Houston	2
Longview/Tyler	3
Lufkin	2
Texarkana/Paris	2

Oral Health	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	2
Galveston	1
Houston	1
Longview/Tyler	2
Lufkin	2
Texarkana/Paris	1

Health Insurance	
HSDA	***Number of Current Providers***
Beaumont/Port Arthur	1
Galveston	1
Houston	1
Longview/Tyler	2
Lufkin	1
Texarkana/Paris	2

Inventory of Identified Federal and State Funding Sources for Core Services

Primary Medical Care		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	RW Part B = 105,152 (Apr – Mar) RW Part C = 138,596 (July-June) EACP = 95,451 (Sep – Aug)	**$ 339,199**
Galveston	RW Part D = 49,378 (Aug-Jul) RW Part C = 45,561 (July-June)	**$ 94,939**
Houston	RW Part A = 10,265,025 (Mar – Feb) RW Part B = 213,298 (Apr – Mar) RW Part D (Y) = 148,755 (Sep – Aug)	**$ 10,627,078**
Longview/Tyler	RW Part B = 208,657 (Apr – Mar) RW Part C = 143,851* (July-June) RW Part C = 231,917* (Apr-Mar) State Services = 34,952 (Sep – Aug)	**$ 619,377**
Lufkin	RW Part C = 163,005 (July-June) RW SN = 30,038 (Apr- Mar) EACP = 14,602 (Sep – Aug)	**$ 207,645**
Texarkana/Paris	RW Part B = 90,391 (Apr – Mar) RW Part C = 143,851* (July – June) RW Part C = 231,917* (Apr-Mar) State Services = 8,201 (Sep – Aug) EACP = 110,000 (Sep – Apr)	**$ 584,360**

Case Management**		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	RW Part B = 182,680 (Apr – Mar) RW Part C = 62,556 (July - June)	**$ 245,236**
Galveston	RW Part B = 207,096 (Apr – Mar)	**$ 207,096**
Houston	RW Part A = 3,492,736 (Mar – Feb) RW Part B = 113,200 (Apr – Mar) RW Part D = 503,106 (Aug – July) RW Part D (Y) = 59,995 (Sep – Aug) State Services = 221,018 (Sep – Aug)	**$ 4,390,055**
Longview/Tyler	RW Part B = 233,948 (Apr – Mar) State Services = 75,496 (Sep – Aug)	**$ 309,444**
Lufkin	RW Part B = 251,491 (Apr – Mar) RW SN = 45,715 (Apr – Mar) RW Part C = 17,872 (July - June) EACP = 62,175 (Sep – Aug)	**$ 377,253**
Texarkana/Paris	RW Part B = 100,585 (Apr – Mar) State Services = 66,354 (Sep – Aug)	**$ 166,939**

† Local hospitals and public health clinics may also provide services to clients.
* Funding Level/Amount is for both Longview/Tyler and Texarkana/Paris HSDAs.
**Refers to both Medical and Social Case Management services (including Pediatric Case Management where applicable).
SAMHSA funding provides outpatient treatment for HIV positive individuals with both Substance Abuse and Mental Health issues.

Substance Abuse		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	Department of State Health Services (amount not available)	**-**
Galveston	RW Part B = 1,000 (Apr – Mar)	**$ 1,000**
Houston	RW Part A = 45,000 (Mar – Feb)	**$ 45,000**
Longview/Tyler	HEI = 189,446 * (Sep-Aug) SAMHSA = 244,663 *# (Sep 30-Sep 29)	**$ 434,109**
Lufkin	Information not available	**-**
Texarkana/Paris	HEI = 189,446 * (Sep-Aug) SAMHSA = 244,663 *# (Sep 30-Sep 29)	**$ 434,109**

Drug Reimbursement		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	State Services = 100,473 (Sept – Aug)	**$ 100,473**
Galveston	RW Part B = 1,000 (Apr – Mar)	**$ 1,000**
Houston	RW Part A = 2,496,000 (Mar – Feb) RW Part B = 371,115 (Apr – Mar)	**$ 2,867,115**
Longview/Tyler	RW Part B = 25,292 (Apr – Mar)	**$ 25,292**
Lufkin	RW Part B = 46,355 (Apr – Mar) RW Part C = 20,000 (July - June) EACP= 6,009 (Sep – Aug)	**$ 72,364**
Texarkana/Paris	RW Part B = 10,874 (Apr – Mar)	**$ 10,874**

Mental Health		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	RW Part B = 8,460 (Apr – Mar)	**$ 8,460**
Galveston	RW Part B = 12,000 (Apr – Mar)	**$ 12,000**
Houston	RW Part A = 234,000 (Mar – Feb) RW Part B = 80,000 (Apr – Mar)	**$ 314,000**
Longview/Tyler	RW Part B = 6,323 (Apr – Mar) SAMHSA = 244,663 *# (Sep 30-Sep 29)	**$ 250,986**
Lufkin	State Services = 3,229 (Sep – Aug) RW Special Needs = 8,663 (Apr- Mar)	**$ 11,892**
Texarkana/Paris	RW Part B = 2,719 (Apr – Mar) SAMHSA = 244,663 *# (Sep 30-Sep 29)	**$ 247,382**

† Local hospitals and public health clinics may also provide services to clients.
* Funding Level/Amount is for both Longview/Tyler and Texarkana/Paris HSDAs.
**Refers to both Medical and Social Case Management services (including Pediatric Case Management where applicable).
SAMHSA funding provides outpatient treatment for HIV positive individuals with both Substance Abuse and Mental Health issues.

Oral Health		
	Ryan White (RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	RW Part B = 26,170 (Apr – Mar)	**$ 26,170**
Galveston	RW Part B = 24,115 (Apr – Mar)	**$ 24,115**
Houston	RW Part A = 1,060,000 (Mar – Feb) RW Part B = 322,215 (Apr – Mar)	**$ 1,382,215**
Longview/Tyler	RW Part B = 75,875 (Apr – Mar) RW Part C = 15,000* (July-June)	**$ 90,875**
Lufkin	RW Part B = 39,205 (Apr – Mar) RW Special Needs = 8,243 (Apr- Mar) EACP = 3,275 (Sep – Apr)	**$ 50,723**
Texarkana/Paris	RW Part B = 19,030 (Apr – Mar) RW Part C = 15,000* (July-June)	**$ 34,030**

Health Insurance		
	Ryan White(RW) and State-Provided Funding	***Total Identified Funding***
Beaumont/Port Arthur	RW Part B = 40,500 (Apr – Mar)	**$ 40,500**
Galveston	RW Part B = 30,000 (Apr – Mar)	**$ 30,000**
Houston	RW Part A = 200,000 (Mar – Feb) RW Part B = 618,526 (Apr – Mar)	**$ 818,526**
Longview/Tyler	RW Part B = 24,027 (Apr – Mar)	**$ 24,027**
Lufkin	State Services = 12,367 (Sept-Aug)	**$ 12,367**
Texarkana/Paris	RW Part B = 8,155 (Apr – Mar)	**$ 8,155**

† Local hospitals and public health clinics may also provide services to clients.
* Funding Level/Amount is for both Longview/Tyler and Texarkana/Paris HSDAs.
**Refers to both Medical and Social Case Management services (including Pediatric Case Management where applicable).
SAMHSA funding provides outpatient treatment for HIV positive individuals with both Substance Abuse and Mental Health issues.

Summary of Additional Available Health Care and Support Services

The following list outlines additional care and support services available in the East Texas Planning Area. All of the services may not be available in every HSDA. More information about the availability of services and/or specific providers in each HSDA can be obtained by referencing a local directory or contacting a local Case Manager.

- Adult Day Care
- Early Intervention Services
- Food Bank
- Health Education/Risk Reduction
- Home Health Care
- Household Items
- Interpreter Services
- Legal Assistance
- Nutritional Supplements
- Nutritional Supplements
- Nutritional Counseling
- Psychosocial Support Services
- Referrals
- Rental Assistance
- Transportation
- Utility Assistance
- Vision Care
- Volunteerism/Buddy Companion Services
- Employment Assistance

Service Category Ranking Explanation

Consistent with Department of State Health Services (DSHS) principles, documented consumer perspectives were of major consideration. Prior to each Priorities and Allocations meeting the Health Planning Coordinator conducted a consumer focus group session (the average group session included six consumers). During each session consumers were informed of the top ten priorities and asked several questions as to their needs and any possible barriers surrounding the top ten priorities. The results of the focus group were presented during the priorities meeting as public comment. Additionally, consumers were strongly encouraged to attend the priorities and allocations meeting to give further comments if they wished to do so.

In efforts to include area community based and AIDS service organizations in the priorities and allocations process, the Planner contacted several [1]non-conflicted community based organizations to solicit participation for the meeting panel. This panel would consist of 3-5 non-conflicted individuals who would give a recommendation for both priorities and allocations. The Health Planning Coordinator distributed flyers and public notices in local newspapers for the priorities and allocations meetings in each HSDA. During each meeting the Planner provided copies of the Priorities and Allocations manual, the most current Needs Assessment, and service category definitions which was used to explain the process to the meeting panel and the present public.

Consistent with DSHS principles, decisions were responsive to the epidemiology of HIV. In order to achieve priorities that reflected the *current* epidemic of the HSDA the PAA utilized the results of the consumer based focus group, as well as public comments from community members and area providers. This public comment was a vital tool to the priority setting process in that the most current Needs Assessment was distributed in 2004 and might not have presented the most accurate picture of each HSDAs current condition.

In order to achieve allocations that most accurately reflected the conditions of each HSDA, an HSDA profile was presented to the panel that included area CBOs and ASOs, funding streams, and service gaps. Further, the PAA provided panel members with 5 yr. Allocations history and client utilization history that enabled them to give recommendations that they believed would follow each HSDAs spending patterns.

[1] For purposes of this document non-conflicted will be defined as any individual who has an immediate family member may benefit from a an advisory group recommendation because: 1) s/he is affiliated with an organization as a staff member, board member, volunteer, contractor, officer, trustee, partner, investor, or owner; or 2) s/he is negotiating with any persons or organizations or has an arrangement concerning prospective employment or affiliation as listed in item 1.

2008-2009 SERVICE CATEGORY RANKINGS AND ALLOCATIONS

Beaumont HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 610,652

Total State Services allocation: $ 118,521

Grand Total allocations: $ 729,173

All decisions made were based on the service priorities set, public comment, and input from local providers

Ryan White Part B

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
2	Ambulatory/Outpatient Medical Care	$204,400	33%	Services are co-funded by RW Part C. Provider now contracts directly for the new Nurse Practitioner, which has caused an increase in PC service costs.
3	Medical Case Management	$186,000	30%	Service is co-funded by RW Part C, creating a decrease in need for Part B funds for this category. Prevention and Part C absorbs most of the Med. CM costs. A full time CM position has been replaced with a part-time CM making less than the previous CM.
7	Mental Health Services	$10,280	2%	Majority of service is funded by RW Part C.
4	Dental/Oral Health Care	$26,432	4%	Funds local dental clinic services due to documented difficultly for clients to utilize Houston-based dental clinic.
1	Health Insurance	$36,907	6%	The number of clients with high premiums have decreased.
9	Home Health Care	$29,256	5%	Though fewer clients, provider is utilizing a more higher priced agency for this service.
12	Medical Transportation	$117,377	19%	This allocation represents a 6% decrease from FY07. Service category is partially supplemented with 30K from a county grant and 50K from a MAC AIDS grant. The MAC grant will end in June 2008.
	TOTAL	**$610,652**	**100%**	

State Services

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
13	Emergency Financial Services	$6,529	6%	Level percentage of funding as per consistent historical client utilization and public comment.
14	Food Vouchers/Food Bank	$17,283	15%	Level percentage of funding as per consistent historical client utilization and public comment.
5	Medication Assistance	$94,709	80%	Level percentage of funding as per consistent historical client utilization and public comment.
	TOTAL	**$118,521**	**100%**	

Galveston HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 614,473

Total State Services allocation: $ 121,177

Grand Total allocations: $ 735,650

All decisions made were based on the service priorities set, public comment, and input from local providers

Ryan White Part B

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
1	Medical Case Management	$192,724	31%	Decrease in Part B percentage allocation due to increase in SS funding for this service. Due to the large service area, more CM are needed to interact with and serve clients.
14	Food Pantry	$87,411	14%	Slight decrease from previous year due to having alternate resources to provide service.
12	Medical Transportation	$45,675	7%	Increase in monetary allocation from prior year due to the need to hire a full-time van driver. Agency currently employs part-time driver.
8	Medication Assistance	$109,390	18%	Increase in monetary allocation from prior year due increased demand and cost for services.
3	Ambulatory/Outpatient Medical Care	$52,226	8%	Increase in monetary allocation from prior year due increased demand and cost for services.
4	Mental Health Services	$44,695	7%	Funds individual therapy sessions and support groups.
7	Health Insurance	$47,352	8%	7K increase from previous year due to increased premium costs.
13	Emergency Financial	$5,000	1%	Keep allocation amount consistent with prior year due to consistent client utilization.
14	Food Pantry/Nutritional Supplements	$5,000	1%	Keep allocation amount consistent with prior year due to consistent client utilization.
6	Dental/Oral Health Care	$25,000	4%	Keep percentage consistent with prior year due to consistent client utilization.
	TOTALS	**$614,473**	**100%**	

State Services

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
1	Medical Case Management	$121,177	100%	Increase in allocation percentage from previous grant year due to decrease in part B allocation for this category
	TOTALS	**$121,177**	**100%**	

Houston HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 2,984,008

Total State Services allocation: $ 1,750,114

Grand Total allocations: $ 729,173

All decisions made were based on the service priorities set, public comment, and input from local providers

Priority	SERVICE CATEGORY	PART B Allocation	Percent of Total Part B FY08 Allocation	State Services Allocation	% of Total SS FY08 Allocation	Justifications and Comments
1	**Outpatient/Ambulatory Primary Care**	$260,000	9%			Primary Care (Part B): Slight increase above FY06 expenditures
2	**Oral Health**	$420,325	14%			
3	**Medical Case Management**	$186,000	6%			Medical CM (Part B): Allocate enough to cover cost of 2 FTEs
3.a	Clinical Case Management			$199,794	11%	Clinical CM (SS): Per the HTBMTN process, funding was moved from non-medical CM.
4	**Local Drug Program**	$862,882	29%			Local Drug Pgm (Part B): Absorb the decrease from Part A ($475 from FY06 expenditures) and response to public comment.
5	**Mental Health Services**			$155,000	**9%**	Mental Health (SS): Level with FY07 allocation. Best way to make up for loss of SAMHSA dollars is thru Part A Clinical CM at MH & SA sites, SS dollars and possibly HOPWA dollars.
6	**Health Insurance**	$618,526	21%	$246,929	**14%**	Health Insurance (SS): Added to the Part B allocation to bring the total equal to the current FY07 allocation.
8	**Medical Nutritional Therapy**	$60,000	2%			Med Nut (Part B): Level funding for FY07 allocation
9	**Early Medical Intervention**			$166,211	**9%**	Early Med Intervention (SS): Level with FY07 allocation
10	**Home and Community Based Services***	$242,000	8%			Home & Comm Based Services (Part B): Absorb the decrease from FY08 Part A. In-home = $20,000. Facility based = $222,000.

11	**Hospice Services***			$323,600	**18%**	Hospice (SS): Absorb decrease from Part A ($123,600)
12	**Transportation**	$188,000	6%			Transportation - Rural (Part B): Increase Part B to absorb decrease from Part A ($136,000) and have Part B fund to reduce admin burden and avert accidental double billing.
13	**Food Bank***	$93,795	3%	$550,580	**31%**	Food Bank (Part SS): *Level funding for FY07 allocation, absorb Part A decrease and have Part B fund to reduce admin burden and avert accidental double billing.*
15	**Legal Assistance**	$52,480	2%	$80,000	**5%**	Legal Assistance (Part B and SS): Level fund at FY07 allocation
16	**Interpreter Services**			$28,000	**2%**	Interpreter Services (SS): Level fund at FY07 allocation
Total Service Dollar Allocations		**$2,984,008**		**$1,750,114**		

Lufkin HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 415,411 Total State Services allocation: $ 107,201

Grand Total allocations: $ 522,612

All decisions made were based on the service priorities set, public comment, and input from local providers.

Ryan White Part B

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
5	Medication Assistance	48,354	11.64%	Other supplementary funding sources are available to provide patients with this service.
6	Dental/Oral Health Care	51,469	12.39%	Historical spending does not warrant an increase.
1	Ambulatory/Outpatient Medical Care	11,964	2.88%	Per provider profile and public comments, supplementary resources are used to fund the majority of this service in the HSDA care. Part B funds are used to provide opthamology and vision care for clients.
2	Medical Case Management	303,624	73.09%	Slight increase in allocation. Due to the large service area, more MCM are needed to interact with and serve clients.
	Total	**$415,411**	**100.00%**	

State Services

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
4	Health Insurance	8,855	8.26%	Keep percentage consistent with prior year due to consistent client utilization.
12	Medical Transportation	37,982	35.43%	Keep percentage consistent with prior year due to consistent client utilization.
14	Food Bank	36,675	34.21%	Keep percentage consistent with prior year due to consistent client utilization.
7	Mental Health Services	15,600	14.55%	This service was previously funded by both a 5K State Services and 10K Ryan White II Special Population Grant (RWSP), the latter of which was not renewed by DSHS. Because the need and utilization are expected to remain about the same, Part B funds will be used to accommodate the services.
13	Emergency Financial Assistance	8,089	7.55%	Supplements HOPWA funded services as per public comment
	Total	**107,201**	**100.00%**	

Texarkana HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 327,198

Total State Services allocation: $ 86,650

Grand Total allocations: $413,848

All decisions made were based on the service priorities set, public comment, and input from local providers

Ryan White Part B

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
5	Dental/Oral Health Care	19,632	6%	Funding for this service will be supplemented by an alternative resource in FY08.
1	Ambulatory/Outpatient Medical Care	134,151	41%	Current increase in percentage allocation is more consistent with historical spending.
2	Medical Case Management	114,519	35%	Slight increase in allocation. Due to the large service area, more MCM are needed to interact with and serve clients.
4	Medication Assistance	9,816	3%	Current increase in percentage allocation is more consistent with historical spending.
12	Medical Transportation	32,720	10%	Service category allocation provides for one full-time van driver, which was added to the budget last year. The increase in the allocation reflects an increase in cost and utilization.
3	Health Insurance	13,088	4%	Current increase in percentage allocation is more consistent with historical spending.
13	Emergency Financial Assistance	3,272	1%	Provides limited food vouchers to clients.
	Total	***$327,198***	***100%***	

State Services

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
1	Ambulatory/Outpatient Medical Care	34,660	40%	Keep percentage consistent with prior year.
2	Medical Case Management	51,990	60%	Keep percentage consistent with prior year.
	Total	**$86,650**	**100%**	

Tyler/Longview HSDA Allocations for FY 2008-2009

Total Part B allocation: $ 760,993

Total State Services allocation: $ 163,739

Grand Total allocations: $ 924,732

All decisions made were based on the service priorities set, public comment, and input from local providers

Ryan White Part B

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
1	Dental/Oral Health Care	76,099	10%	Funding for this service will be supplemented by an alternative resource in FY08.
3	Medical Case Management	273,957	36%	Slight increase in allocation. Due to the large service area, more MCM are needed to interact with and serve clients.
2	Ambulatory/Outpatient Medical Care	254,933	34%	Current increase in percentage allocation is more consistent with historical spending.
4	Health Insurance	22,830	3%	Current increase in percentage allocation is more consistent with historical spending.
12	Medical Transportation	68,489	9%	There is a documented increase in client load in this area, with nearly 100 new clients served in 2007. A new full-time van driver was hired to float between the Longview and Tyler offices. Due to the large service area, medical case managers were spending their time providing transportation, which was not efficient nor cost effective. The float position helps the Longview and Tyler offices based on clinic needs.
5	Medication Assistance	53,270	7%	Current increase in percentage allocation is more consistent with historical spending.
8	Mental Health Services	7,610	1%	Current increase in percentage allocation is more consistent with historical spending.
13	Emergency Financial Assistance	3,805	1%	Provides limited food vouchers to clients.
	Total	**$760,993**	**100%**	

State Services

Priority	Service Category	Allocation Amount	% of total allocation	COMMENTS
3	Medical Case Management	76,957	47%	Keep percentage consistent with prior year due to consistent client utilization.
2	Ambulatory/Outpatient Medical Care	54,034	33%	Keep percentage consistent with prior year due to consistent client utilization.
12	Medical Transportation	32,748	20%	Keep percentage consistent with prior year due to consistent client utilization.
	Total	**$163,739**	**100%**	

Section 2: Where Do We Need to Go?

Mission Statement

The Resource Group and Comprehensive Planning Workgroup is a collaborative partnership working to develop the Comprehensive HIV Services Plan for the 51-county East Texas HIV Planning Area. In addition, the Ryan White Planning Council is considered to be a collaborative partner, and as such information from the Houston EMA/HSDA Comprehensive Plan has been integrated into this regional Plan. As the regional Administrative Agency, the Resource Group is responsible to the Texas Department of State Health Services (DSHS) for HIV care and prevention planning in the East Texas HIV Planning Area.

Through multiple meetings and correspondences, this partnership with providers throughout the region considered needs assessment data and resource inventory information to better understand how to best proceed in ensuring that clients access available resources to maintain health and well-being. It is the mission of this partnership to assess the present and future extent, distribution, and impact of the HIV epidemic in the East Texas Planning Area and support the creation of a comprehensive delivery plan for HIV care and prevention services in that area.

Vision Statement

To provide people with seamless access to all the services they need, from preventive services to HIV health and social services. Seamless access means that everyone can use services regardless of their race/ethnicity, religion, disability (or special needs), sexual orientation, or gender; where they live; or how much money they have.

Shared Values

Shared values outline the guiding principles that will guide the development and delivery of HIV Services within the East Texas. The Resource Group and Comprehensive Planning Workgroup consider the well being of person(s) living with HIV or AIDS (PLWH/A) in the East Texas service region its primary responsibility. The shared values among this collaborative group are to:

- Require quality care for PLWH/A as defined by service and professional standards of care.
- Support approaches that respond to evolving community needs and serve to maximize available resources.
- Strive to empower PLWH/A through education and advocacy.
- Strive to ensure that existing services adhere to public health standards.

Section 3: How Will We Get There?

HOUSTON AREA GOALS AND OBJECTIVES

In an effort to address barriers to care and ensure the accessibility of services for the Houston HSDA, the Ryan White Planning Council and previous STAGE planning body representatives established goals and objectives as outlined below.

A copy of the complete Houston Area HIV Services Comprehensive Plan can be retrieved on the Resource Group website (http://www.hivresourcegroup.org/planning/pldocuments.php).

Comprehensive Plan Goal A:
By February 28, 2008, 100% of the clients who participate in the HIV services system in the Houston area will more easily understand the system and how to navigate through it, will experience a minimum of repetition and complication in the intake and eligibility process, and will be linked to all needed services as efficiently as possible.

Comprehensive Plan Goal B:
By February 28, 2008, services for clients will be improved through increased cooperation and coordination of service providers and improved administration functions.

Comprehensive Plan Goal C:
By February 28, 2008, the quality of care for PLWHA in the Houston area will be improved by clear standards of operation.

Comprehensive Plan Goal D:
By February 28, 2008, all HIV care, prevention and research will be fully funded, including new and innovative services.

Comprehensive Plan Goal E:
By February 28, 2008, reduce transmission of HIV by 25%.

Comprehensive Plan Goal F:
By February 28, 2008, increase the number of people who are receiving early and ongoing medical care for HIV/AIDS, in an attempt to close the gap between those who are receiving medical care and those who have an unmet need for medical care.

Comprehensive Plan Goal G:
By February 28, 2008, people with HIV/AIDS who are in the Houston area system of care will have an improved understanding of and access to all available therapeutic and treatment medications, including non-prescription drugs.

GOALS AND OBJECTS FOR RURAL HSDAS:

In an effort to address barriers to care and ensure the accessibility of services, Resource Group Planning staff and the provider workgroup established long- and short-term goals for the region. These goals have been appropriately divided into system- or community-wide goals and short-term attainable goals. Progress towards both goals will be measured appropriately.

LONG-TERM SYSTEM GOALS

Goal 1: To have a well informed public	
	Objective A: Develop, implement, and evaluate a public information campaign utilizing simple, targeted, and recurring messages designed to increase the community's knowledge of HIV service needs and availability.
	Objective B: Mobilize the community towards a documented increase in public involvement in local and national HIV-related activities.
Goal 2: Keep those with AIDS diagnosis from progressing to serious medical problems and opportunistic infections	
	Objective A: Set up program with a strong technological follow-up system for reminders of appointments, blood work and medication renewals.

Rationale: According to the 2004 regional needs assessment, lack of information was reported as one of the most common barriers to receiving care for all services. Provider input and focus group discussions indicate that social stigma in rural communities is due to a lack of knowledge about HIV among residents. Though social and community change is a gradual process, developing sustained educational and information campaigns will assist in partially addressing these barriers to receiving HIV care.

INTERIM/SHORT-TERM GOALS

Goal 1: To promote knowledge of individual serostatus	
	Objective A: Provide widespread public information about the HIV testing process and local availability. Objective B: Increase the number of people who receive and understand the results of their HIV test. Objective C: Utilize outdoor advertising and targeted Public Service Announcements to increase public awareness of HIV testing and HIV prevention. Objective D: Increase availability of anonymous and confidential HIV testing and counseling of results. Objective E: Provide for pre and post test counseling to assure correct information is disseminated and safe sex or abstinence is discussed.

Rationale: Both providers and consumers have stated that stigma and fear in rural areas prevents individuals from getting tested and seeking treatment. The aforementioned goal and associated objectives seek to address social stigma and encourage individual testing.

Goal 2: To ensure coordinated prevention efforts for HIV positive individuals	
	Objective A: Utilize effective and innovative primary prevention strategies to promote wellness and healthy living.

Rationale: Among respondents who reported having an STI, forty-three percent (n=69) reported having sexual with a regular male partner in the past two years, while 38% (24) reported a regular female partner. In addition, Twenty-six percent (n=41)of respondents having an STI reported having sex with a casual male partner, and 11% (n=8) with a casual female partner. The serostatus of partners was not asked in the client survey, but these findings indicate the needs to ensure that negative sexual partners remain negative, and that co-infections are not transmitted to HIV positive individuals.

Goal 3: To increase availability of centralized services for HIV/AIDS to rural underserved clients	
	Objective A: Develop and implement an ongoing community assessment of needs and gaps in HIV services. Objective B: Improve services for clients through increased facilitation and coordination between service providers and streamline the administrative process for HIV service delivery. Objective C: Utilize effective and innovative secondary prevention strategies to promote wellness and healthy living for PLWH/A. Objective D: Provide satellite services to remote locations that would be staffed on a part time scheduled basis. Objective E: Establish or maintain centralized client services program and case workers to provide direction and advocacy and empower clients to enter the support services programs such as SSI, SSDI, Medicare, Medicaid, and Food Stamps.

Rationale: During community input sessions conducted throughout the region, clients emphasized the need to decrease the number of separate agencies visited to receive services.

Goal 4: To ensure that clients in rural areas have transportation that allows them to access services.	
	Objective A: All clients will be given transportation resource information at intake and update. Objective B: All clients eligible for Medicaid transportation will be given Medicaid transportation contact and scheduling information. Objective C: Clients without Medicaid will be given agency transportation policies and information that requests they schedule 48hrs in advance.

Rationale:. Forty-six percent (n=288) of respondents for the needs assessment stated that they used this services. Further, the two most common barriers reported for van transportation were access/availability and information about the serve.

Chapter 4: How We Will Monitor and Evaluate our Progress?

Monitoring Procedures

The Resource Group's (TRGs) Programmatic Department manages a Site Visit Team, which includes a distinct quality management component. This team completes annual site visits to subcontracted providers throughout the region. Site visits monitor provider activities and progress according to contractually outlined guidelines, including specific goals and objectives.

If the Site Visit team identifies any areas of concern, the provider must submit a corrective action plan within thirty (30) days, which is reviewed by the Program Director (PD) and other needed members of the Site Visit Team. Additional site visits are scheduled and completed on an as needed basis. Some of the goals and objectives will be included in the request for proposals/application and subsequently incorporated into contracts between TRG and its contracted service providers. In addition, minimal adjustments to the existing monitoring tools will be made to incorporate assessment of progress made towards the outlined goals and objectives.

Evaluation Process

TRG's Planning Department staff will review progress towards the goals and objectives and update the plan as needed annually. Subcontractor agencies will be informed in writing regarding annual indicators of progress made towards the listed goals and objectives. The Quality Management Coordinator is responsible for coordinating the improvement planning process. Quarterly meetings are held at TRG, in which a Quality Management Committee reviews reports on relevant activities, and areas of concern are identified.

The drafting of recommendations for any needed improvement plans are carried out by the Clinical Coordinator, Medical Director, Quality Management Coordinator, and the Executive Director. Improvement activities are then implemented and reviewed on a quarterly basis.

References

1. New Solutions, Inc. (2005). *2005 Houston Area HIV/AIDS Needs Assessment*.

2. Sage Associates, Inc. (2004). State of Texas Assembly Group East: 2004 Comprehensive Needs Assessment Report.

3. Houston-area Ryan White Program. (February 2005). *2005 Integrated Epidemiological Profile for HIV/AIDS Prevention and Care Planning*.

4. Texas Department of State Health Services (2006). *East Texas HIV Prevention Area Action Plan: March 2006.*