OMB Number: 4040-0004
Expiration Date: 03/31/2012

## Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 10/19/2010

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier: H89HA00036

**State Use Only:**

6. Date Received by State:

7. State Application Identifier:

**8. APPLICANT INFORMATION:**

* a. Legal Name: City of Austin HHSD

* b. Employer/Taxpayer Identification Number (EIN/TIN): 74-6000085

* c. Organizational DUNS: 9456072650000

**d. Address:**

* Street1: 7201 Levander Loop, Building E
Street2:
* City: Austin
County/Parish:
* State: TX: Texas
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 78702-4101

**e. Organizational Unit:**

Department Name: Austin/Travis County HHSD

Division Name: Human Services Division

**f. Name and contact information of person to be contacted on matters involving this application:**

Prefix: Mr.
* First Name: Mark
Middle Name:
* Last Name: Peppler
Suffix:

Title: Manager, HIV Resources Administration Unit

Organizational Affiliation: Austin/Travis County HHSD

* Telephone Number: 512-972-5081
Fax Number: 512-972-5082

* Email: mark.peppler@ci.austin.tx.us

## Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

C: City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

**11. Catalog of Federal Domestic Assistance Number:**

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-11-062

* Title:

Ryan White Part A HIV Emergency Relief Grant Program

**13. Competition Identification Number:**

4254

Title:

**14. Areas Affected by Project (Cities, Counties, States, etc.):**

AreasAffectedbyProject.doc

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI, HIV Emergency Relief Grant Program for the Austin Transitional Grant Area. Project Abstract attached.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

## Areas Affected by Project

City of Austin, Counties of Bastrop, Caldwell, Hays, Travis, and Williamson, located in the State of Texas

## Project Abstract

Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A, including MAI, HIV Emergency Relief Grant Program; HRSA Grant Number H89HA00036
City of Austin, Austin/Travis County Health and Human Services Department
7201 Levander Loop, Bldg. E, Austin, Texas 78702-4101
(512) 972-5081 Voice; (512) 972-5082 Fax
mark.peppler@ci.austin.tx.us

Located in central Texas, the Austin Transitional Grant Area (TGA) covers 4,281 square miles and encompasses the five counties of Bastrop, Caldwell, Hays, Travis, and Williamson. Data show that the Austin TGA is one of the fastest growing areas in the United States. The Austin TGA population has increased from 1.4 million in 2005, to over 1.7 million in 2010. The racial/ethnic distribution is as follows: 54.1% White; 33.1% Hispanic; 7.8% African American; and 5.0% reported as Other. The TGA is predominately young; 68.1% of all persons are less than 45 years old.

The number of persons living with HIV in the Austin TGA continues to increase every year. As of December 31, 2009, there were 1,750 persons living with HIV (not AIDS) and 2,663 persons living with AIDS in the TGA. The demographic characteristics of persons with HIV/AIDS in the TGA continue to change, indicating a shift in the populations most affected by HIV/AIDS. Although comprising only 7.8% of overall population, African Americans accounted for 20.9% of new HIV cases and 20.2% of new AIDS cases for the period 2008-2009. Of all HIV/AIDS cases diagnosed in the TGA for the two-year period 2008-2009, 81% were reported from within Travis County. HIV services providers, primarily located along the Interstate Highway 35 corridor in the TGA, offer service facilities that are accessible to the TGA's underserved populations. African American and Hispanic are the two populations served with Minority AIDS Initiative (MAI) funds.

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A and MAI HIV Emergency Relief Grant Program, the Austin TGA has developed a coordinated service delivery system with a comprehensive range of services for persons living with HIV infection, in order to meet their primary medical care and related needs throughout all stages of disease. Although this continuum of care is largely supported with Ryan White Program funds, it also relies on additional support from multiple funding sources including local city and county funding.

The Austin Area Comprehensive HIV Planning Council has set priorities and allocated funds for FY 2011 to HIV service categories that address the growing number of clients with more complex disease, inadequate knowledge of HIV, and multiple socio-economic problems. The priority primary health care services for FY 2011 include outpatient/ambulatory medical care, oral health care, local AIDS pharmaceutical assistance, medical case management, mental health services, and medical nutrition therapy, as well as food bank, medical transportation, and other health-related support services designed to facilitate access and retention in care. The Austin TGA has received Ryan White Program Title I/Part A funding for sixteen (16) years.

## Application for Federal Assistance SF-424

**16. Congressional Districts Of:**

* a. Applicant: 10th | b. Program/Project: 10th

Attach an additional list of Program/Project Congressional Districts if needed.

AdditionalCongressionalDistricts.doc | Add Attachment | Delete Attachment | View Attachment

**17. Proposed Project:**

* a. Start Date: 03/01/2011 | * b. End Date: 02/29/2012

**18. Estimated Funding ($):**

| | |
|---|---|
| * a. Federal | 4,348,975.00 |
| * b. Applicant | 0.00 |
| * c. State | 0.00 |
| * d. Local | 0.00 |
| * e. Other | 0.00 |
| * f. Program Income | 100,000.00 |
| * g. TOTAL | 4,448,975.00 |

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☒ a. This application was made available to the State under the Executive Order 12372 Process for review on 10/15/2010.

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

**21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

**Authorized Representative:**

Prefix: Honorable | * First Name: Lee

Middle Name:

* Last Name: Leffingwell

Suffix:

* Title: Mayor

* Telephone Number: 512-974-2250 | Fax Number: 512-974-2337

* Email: lee.leffingwell@ci.austin.tx.us

* Signature of Authorized Representative: Mark Peppler | * Date Signed: 10/19/2010

# Additional List of Program/Project Congressional Districts

## Additional Congressional Districts of Applicant

21st
25th

## Additional Congressional Districts of Program/Project

15th
21st
25th
28th
31st

# CHECKLIST

**NOTE TO APPLICANT:** This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: ☐ New ☐ Noncompeting Continuation ☒ Competing Continuation ☐ Supplemental

**PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.**

| | Included | NOT Applicable |
|---|---|---|
| 1. Proper Signature and Date on the SF 424 (FACE PAGE) | ☒ | |
| 2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690) | | |
| ☒ Civil Rights Assurance (45 CFR 80) | 06/10/1991 | |
| ☒ Assurance Concerning the Handicapped (45 CFR 84) | 01/10/1991 | |
| ☒ Assurance Concerning Sex Discrimination (45 CFR 86) | 06/10/1991 | |
| ☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) | | |
| 3. Human Subjects Certification, when applicable (45 CFR 46) | ☐ | ☒ |

**PART B: This part is provided to assure that pertinent information has been addressed and included in the application.**

| | YES | NOT Applicable |
|---|---|---|
| 1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? | ☐ | ☒ |
| 2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100) | ☒ | |
| 3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)? | ☒ | |
| 4. Have biographical sketch(es) with job description(s) been provided, when required? | ☒ | ☐ |
| 5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included? | ☒ | |
| 6. Has the 12 month narrative budget justification been provided? | ☒ | ☐ |
| 7. Has the budget for the entire proposed project period with sufficient detail been provided? | ☒ | ☐ |
| 8. For a Supplemental application, does the narrative budget justification address only the additional funds requested? | ☐ | ☒ |
| 9. For Competing Continuation and Supplemental applications, has a progress report been included? | ☐ | ☒ |

**PART C: In the spaces provided below, please provide the requested information.**

Business Official to be notified if an award is to be made

Prefix: Ms. First Name: Melanie Middle Name:
Last Name: Miller Suffix:
Title: Chief Administrative Officer
Organization: City of Austin HHSD
Street1: 7201 Levander Loop, Building H
Street2:
City: Austin
State: TX: Texas ZIP / Postal Code: 78702 ZIP / Postal Code4: 4101
E-mail Address: melanie.miller@ci.austin.tx.us
Telephone Number: 512-972-5045 Fax Number: 512-972-5033

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: Mr. First Name: Mark Middle Name:
Last Name: Peppler Suffix:
Title: Manager
Organization: City of Austin HHSD
Street1: 7201 Levander Loop, Building E
Street2:
City: Austin
State: TX: Texas ZIP / Postal Code: 78702 ZIP / Postal Code4: 4101
E-mail Address: mark.peppler@ci.austin.tx.us
Telephone Number: 512-972-5081 Fax Number: 512-972-5082

**PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.**

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* on *(Date)*

## INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

## EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

**BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.**

**THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:**

**Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352),** as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

**Handicapped Individuals** – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

**Sex Discrimination** – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

**Age Discrimination** – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

**Debarment and Suspension** – Title 2 CFR part 376.

**Certification Regarding Drug-Free Workplace Requirements** – Title 45 CFR part 82.

**Certification Regarding Lobbying** – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

**Environmental Tobacco Smoke** – Public Law 103-227.

**Program Fraud Civil Remedies Act (PFCRA)**

## Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** AustinTGAProjectNarrativeFY2011.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

## Table of Contents: Project Narrative

## 1) Demonstrated Need

### 1.a. HIV/AIDS Epidemiology

Demographic Characteristics of General Population in the TGA

Over 1.7 million people reside in the Austin Transitional Grant Area (TGA) and the majority (58.0%) lives in Travis County. The TGA is predominately White (54.1%) and young; 68.1% of all persons are less than 45 years old. The racial/ethnic composition of the TGA is slowly changing. In 2000, White non-Hispanics accounted for 61.5% of the population and Hispanics 26.2%. In 2010, Hispanics comprise 33.1% (Table B). In 2000, 20.3% of Spanish-speaking households were linguistically isolated; by 2008, a total of 31,263 Spanish-speaking households or 24.0% were linguistically isolated (source: *US Census Bureau*). Over two-thirds (69.0%) of all African American TGA residents live in Travis County; similarly, 77.0% of all individuals of other races/ethnicities reside in Travis County.

**Table A: Distribution of the Austin TGA general population, by sex and age, 2010.**

| Age (yrs) | Male (N=883,071) | Female (N=829,576) | Total (N=1,712,647) |
|---|---|---|---|
| 0-12 | 149,064 | 144,473 | 293,537 |
| 13-19 | 80,871 | 76,871 | 157,742 |
| 20-44 | 383,823 | 331,138 | 714,961 |
| ≥45 | 269,313 | 277,094 | 546,407 |

Source: *Texas State Data Center & Office of the State Demographer, 2010.*

**Table B: Percentage distribution of Austin TGA population by race/ethnicity and county, 2010.**

| Race/ Ethnicity | Bastrop N=81,717 | Caldwell N=38,724 | Hays N=164,078 | Travis N=992,773 | Williamson N=435,355 | TGA N=1,712,647 |
|---|---|---|---|---|---|---|
| White | 59.6 | 43.7 | 62.2 | 46.6 | 68.1 | 54.1 |
| African American | 8.2 | 8.7 | 3.4 | 9.3 | 5.9 | 7.8 |
| Hispanic | 31.2 | 46.9 | 32.8 | 37.4 | 22.3 | 33.1 |
| Other | 0.9 | 0.8 | 1.6 | 6.7 | 3.7 | 5.0 |

Source: *Texas State Data Center & Office of the State Demographer, 2010.*

**Table C: HIV cases & rates per 100,000 among persons in Austin TGA, by race/ethnicity and sex, diagnosed 2008-2009.**

| | Males | | | Females | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| **Race/ethnicity** | **N** | **%** | **Rate** | **N** | **%** | **Rate** | **N** | **%** | **Rate** |
| White | 188 | 45.9 | 20.6 | 21 | 26.6 | 2.3 | 209 | 42.7 | 11.6 |
| African American | 68 | 16.6 | 53.2 | 34 | 43.0 | 26.3 | 102 | 20.9 | 39.7 |
| Hispanic | 144 | 35.1 | 25.6 | 22 | 27.8 | 4.5 | 166 | 34.0 | 15.8 |
| Asian-Pacific Is.& Multiracial | 10 | 2.4 | 12.4 | 2 | 2.5 | 2.5 | 12 | 2.5 | 7.5 |
| **Total** | 410 | 100.0 | 24.4 | 79 | 100.0 | 5.0 | 489 | 100.0 | 14.9 |

Source: *Texas eHARS (unadjusted for reporting delays), 2010.*

HIV/AIDS Cases by Demographic Characteristics and Exposure Categories

During 2008-2009, HIV infection was diagnosed for 489 persons of whom 83.8% were male and 16.2% were female (Table C). For this two year period, less than half of newly diagnosed HIV cases were White non-Hispanic (42.7%), about one-fifth were African American (20.9%), and 34.0% were Hispanic. Rates were significantly higher among African Americans, approximately three times higher than among both Whites and Hispanics. Table D shows that the distribution of risk differs by race/ethnicity in the TGA. The most common risk factor was male-to-male sexual contact (70.8%) for all races/ethnicities. Among African Americans (46.3%), Hispanics (75.4%), and Whites (78.5%), most new HIV cases were in the male-to-male sexual contact exposure category.

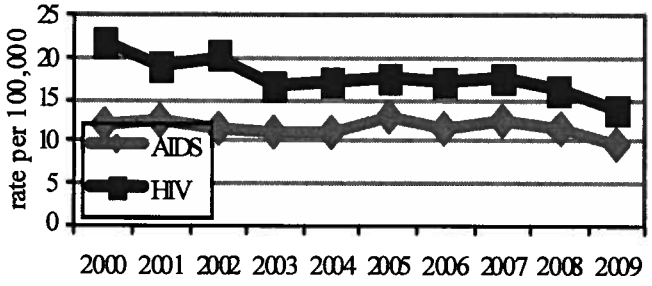
**Table D: HIV cases among persons in the Austin TGA, by exposure category and race/ethnicity, diagnosed 2008-2009.**

| | White | | African American | | Hispanic | | Asian-PI & Multi racial | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Exposure Category** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** |
| Male-to-male sex | 164 | 78.5 | 47 | 46.3 | 125 | 75.4 | 10 | 83.3 | 346 | 70.8 |
| Injection drug use | 12 | 5.7 | 9 | 8.6 | 7 | 4.2 | 1 | 8.3 | 29 | 5.9 |
| MSM & IDU | 13 | 6.4 | 1 | 0.9 | 5 | 2.7 | 0 | 0.0 | 19 | 3.9 |
| Heterosexual | 20 | 9.3 | 42 | 41.3 | 29 | 17.7 | 1 | 8.3 | 92 | 18.8 |
| Other/Perinatal | 0 | 0.0 | 1 | 1.0 | 0 | 0.0 | 0 | 0.0 | 1 | 0.2 |
| Not Classified | 0 | 0.0 | 2 | 2.0 | 0 | 0.0 | 0 | 0.0 | 2 | 0.4 |
| **Total** | 209 | 100.0 | 102 | 100.0 | 166 | 100.0 | 12 | 100.0 | 489 | 100 |

Source: *Texas eHARS (risk statistically redistributed), 2010.*

The unadjusted rates of newly diagnosed HIV and AIDS cases decreased slightly from 2008 to 2009 (Figure 1). This may be a result of extensive cleaning and updating of the Texas HIV/AIDS Reporting System (HARS). Texas transitioned to a new surveillance system (HARS to eHARS) in 2009, which affected all years of data. Additionally, several other de-duplication and death updates were performed. Subsequently, many records were deleted from Texas eHARS because they represented deceased cases, were duplicate records, represented out-of-state cases, changed diagnostic status to seroreverters, or the cases' respective race could not be confirmed. Approximately 81% of all newly diagnosed cases of HIV and AIDS were reported in Travis County, and the county accounts for about 58% of the TGA population.

**Figure 1: Rate per 100,000 of Diagnosed HIV and AIDS by year, Austin TGA 2000-2009.**




Source: *Texas eHARS (unadjusted for reporting delays), 2010.*

In 2008-2009, according to Texas eHARS, a total of 342 new AIDS cases were diagnosed. Over 80% of those cases were male. By race/ethnicity, 42.4% of cases were White non-Hispanic, 20.2% of cases were African American, and 34.5% were Hispanic. The highest rates of cases were among African American males and females, which were substantially higher than rates among White non-Hispanics (Table E).

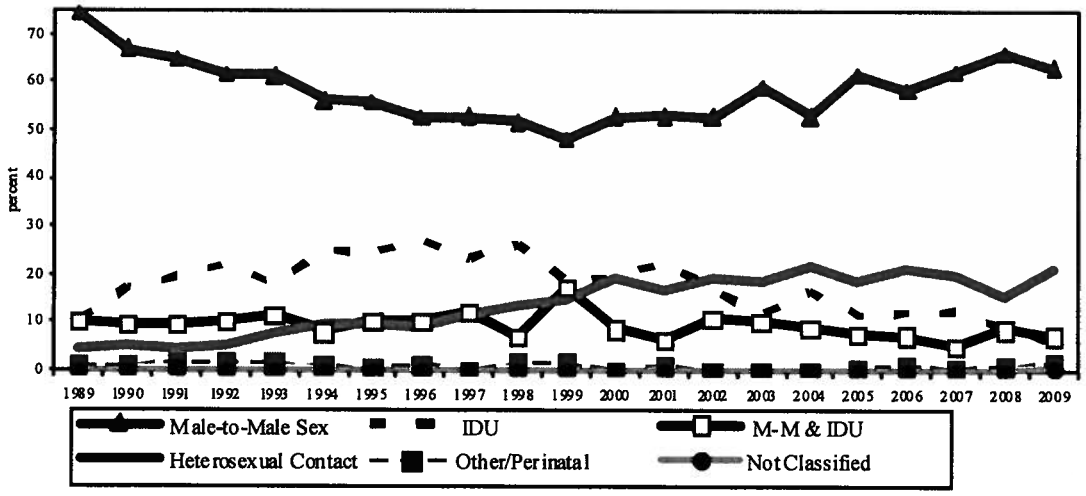
**Table E: AIDS cases and rates per 100,000 among persons in Austin TGA, by race/ethnicity & sex, diagnosed 2008-2009.**

| | Males | | | Females | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| **Race/ethnicity** | **N** | **%** | **Rate** | **N** | **%** | **Rate** | **N** | **%** | **Rate** |
| White | 130 | 45.8 | 14.2 | 15 | 25.9 | 1.7 | 145 | 42.4 | 8.0 |
| African American | 43 | 15.1 | 33.7 | 26 | 44.8 | 20.1 | 69 | 20.2 | 26.8 |
| Hispanic | 104 | 36.6 | 18.5 | 14 | 24.1 | 2.9 | 118 | 34.5 | 11.3 |
| Other | 7 | 2.5 | 8.7 | 3 | 5.2 | 3.8 | 10 | 2.9 | 6.3 |
| **Total** | 284 | 100.0 | 16.9 | 58 | 100.0 | 3.7 | 342 | 100.0 | 10.5 |

Source: *Texas eHARS (unadjusted for reporting delay), 2010.*

The risk for the majority of AIDS cases reported each year in the TGA is male-to-male sexual contact (Figure 2). The percent of cases with male-to-male sexual contact as the risk has been steadily increasing in the TGA, reversing a significant decreasing trend throughout the 1990s. The proportion of AIDS cases reporting MSM risk in 2009 is similar to the proportion that reported MSM risk in 1993. One reason for this change may be the increase in risky sexual activities with anonymous or pseudonymous partners who meet over the Internet. In Austin and Travis County, male-to-male sexual activity was associated with Internet partners (source: Vest et al, *Sexually Transmitted Disease,* 2007).

**Figure 2: Proportion of AIDS Cases by Exposure Category and Diagnosis Year, 1989-2009.**

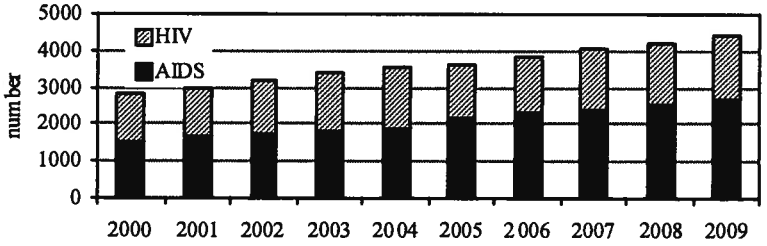



Source: *Texas eHARS (risk statistically redistributed), 2010.*

A total of 4,413 persons in the TGA were living with HIV infection as of 12/31/2009 (Attachment 3). Of those, a total of 1,750 persons were living with HIV (not AIDS). The steady increase in the prevalence of HIV infection since 2000 is illustrated below in Figure 3.

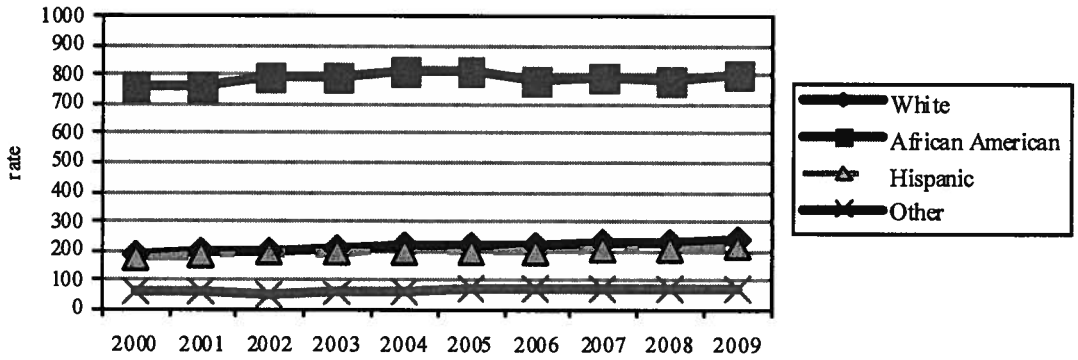
According to the Texas Department of State Health Services (DSHS) the prevalence of AIDS has increased 67.5% since 2000. Figure 4 indicates that highest prevalence rates of persons living with HIV infection (PLWH/A) are consistently among African Americans. Rates among African Americans living with HIV are approximately 3.5 times higher than other groups.

**Figure 3: Number of Persons Living with HIV/AIDS, Austin TGA**




Source: *Texas eHARS (unadjusted for reporting delays), 2010.*

**Figure 4: Rate per 100,000 of Persons Living with HIV Infection by race/ethnicity, Austin TGA**




Source: *Texas eHARS (unadjusted for reporting delays), 2010.*

Almost half of PLWH/A are White non-Hispanic (49.1%), and 84.3% are males. The highest burden of disease is among African Americans. The prevalence rate of HIV infection among African American males is 2.5 times higher than among White males, and the rate among African American females is almost twelve times higher than among White females (Table F).

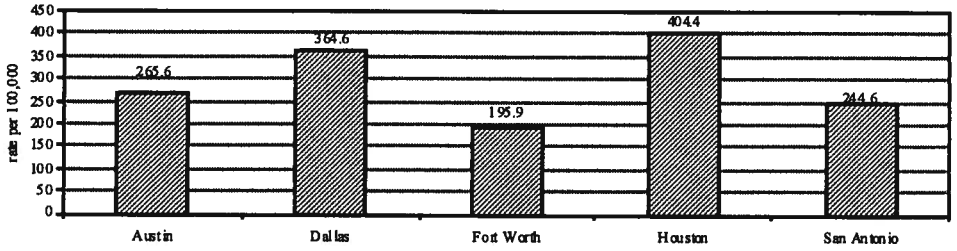
**Table F: Prevalence rate per 100,000 of HIV infection in the Austin TGA, by race/ethnicity and sex, 2009.**

| | Males | | | Females | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| **Race/ethnicity** | **N** | **%** | **Rate** | **N** | **%** | **Rate** | **N** | **%** | **Rate** |
| White | 1968 | 52.9 | 427.6 | 199 | 28.8 | 44.1 | 2167 | 49.1 | 237.8 |
| African American | 709 | 19.1 | 1093.9 | 337 | 48.8 | 514.5 | 1046 | 23.7 | 802.7 |
| Hispanic | 998 | 26.8 | 345.3 | 142 | 20.6 | 57.1 | 1140 | 25.8 | 212.0 |
| Other | 47 | 1.3 | 113.7 | 13 | 1.49 | 32.1 | 60 | 1.4 | 73.3 |
| **Total** | 3722 | 100.0 | 435.1 | 691 | 100.0 | 85.7 | 4413 | 100.0 | 265.6 |

Source: *Texas eHARS (unadjusted for reporting delays), 2010.*

The Austin TGA is not the most populous Texas TGA, but its burden of HIV infection is high. The prevalence of PLWH/A is the third highest in the state, higher than the more populous San Antonio and Fort Worth TGAs (Figure 5). Only the Austin, Houston, and Dallas EMAs/TGAs have HIV (not AIDS) prevalence rates in the triple digits (source: *Texas DSHS, 2010*).

**Figure 5: Prevalence of Persons Living with HIV/AIDS, Texas EMAs/TGAs, 2009**




Source: *Texas DSHS (unadjusted for reporting delays), 2010.*

Disproportionate Impact of HIV/AIDS on Populations in the TGA

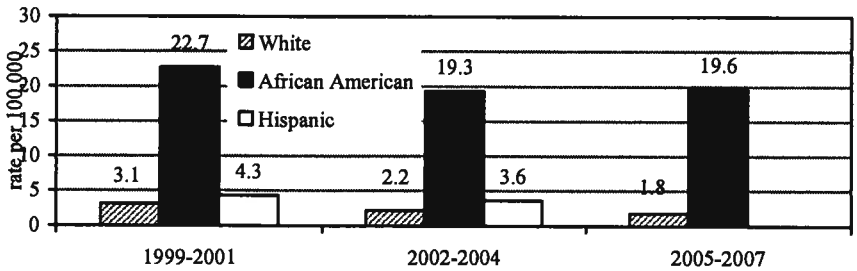
HIV/AIDS disproportionately impacts African Americans in the Austin TGA. The burden of disease is evident in disease incidence, prevalence, mortality, and by sex.

- In 2008-2009, African Americans accounted for only 7.8% of the TGA's population (source: *Texas State Data Center & Office of the State Demographer*), but 20% of new cases of both AIDS and HIV (Attachment 3 and Tables C and E).
- The 2008-2009 incidence rate of new AIDS cases is 3.5 times higher among African Americans than Whites and 2.5 times higher than Hispanics (Table E).
- The prevalence rate of HIV infection among African Americans is 3.4 times higher than Whites and 3.8 times higher than Hispanics (Table F).
- Figure 4 shows that race/ethnicity disparity consistently has remained wide since 2000.
- The 2005-2007 age-adjusted HIV mortality rate among African Americans is eleven times higher than among Whites (Figure 6).

In addition to these disparities by race/ethnicity, the greatest burden of HIV/AIDS remains among the MSM populations (see Attachment 3).

- In 2008-2009, the majority (64.4%) of new AIDS cases were among MSMs.
- Six out of ten persons living with HIV infection have MSM as a risk factor.
- Among all men living with HIV infection, 8 in 10 (85.1%) have MSM as a risk factor.
- MSM is an increasingly more common risk factor among cases in the TGA (Figure 2).

**Figure 6: Age-adjusted HIV mortality rate by race/ethnicity, Austin TGA.**




Source: *Texas DSHS, http://soupfin.tdh.state.tx.us/death10.htm, 2010.*
*The 2005-2007 age-adjusted HIV mortality rate among Hispanics was not calculated because the number of deaths was too small for a stable rate to be calculated (n = 18).*

Populations of PLWH in the TGA Underrepresented in Ryan White Funded System of HIV Primary Medical Care

Total unduplicated HIV patients seen by the Ryan White-funded HIV primary medical care provider in 2009 were compared to prevalence data in Attachment 3, to determine the level of representation by race/ethnicity, gender and risk. Data indicate primary medical care use by HIV (not AIDS) and AIDS patients is generally representative for gender and for all racial/ethnic groups (Table G). Differences exist, however, when examining primary risk factors. The proportion of MSMs in the Ryan White system is slightly lower than in the TGA. The lower percentage of IDUs in the Ryan White system than in the TGA (10.7% vs. 11.8%) may be attributed to difficulty of IDU retention in care.

**Table G: Persons living with HIV infection in the TGA distribution compared to Ryan White Program medical care patient distribution.**

| Demographic Group | TGA % | Ryan White % |
|---|---|---|
| **Race/Ethnicity** | | |
| White | 49.1 | 39.2 |
| African American | 23.7 | 29.0 |
| Hispanic | 25.8 | 30.0 |
| Other / Unknown | 1.4 | 2.3 |
| **Gender** | | |
| Male | 84.3 | 79.6 |
| Female | 15.7 | 19.2 |
| Transgender | -- | 1.2 |
| **Primary risk factor** | | |
| MSM | 63.3 | 52.4 |
| IDU | 11.8 | 10.7 |
| Heterosexual | 15.5 | 11.0 |

Source: *Texas DSHS (eHARS July 2010 data unadjusted for reporting delays) and AIDS Regional Information and Evaluation System (ARIES), 2010.*

Estimated Level of Service Gaps among PLWH in the TGA

For a discussion of service gaps, refer to Assessment of Emerging Populations with Special Needs below on pages 10-17.

### 1.b. Impact of Co-morbidities on the Cost and Complexity of Providing Care

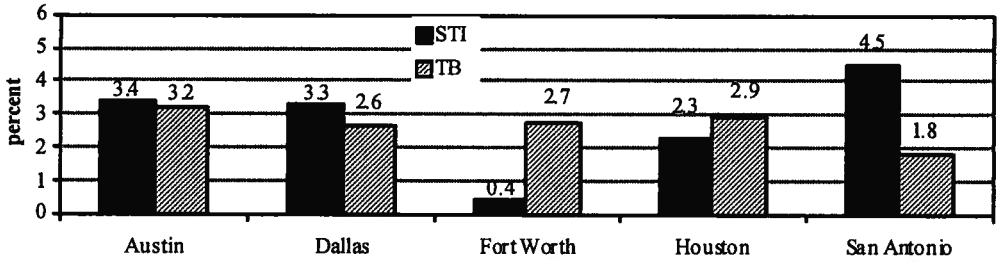
Data on Infectious Disease, Homelessness, Health Insurance, Poverty, Substance Abuse, and Mental Illness are shown in Attachment 4.

Number and rate (per 100,000) of selected infectious diseases

The high STI rates are evidence of a large sexually active population engaged in risky sexual behaviors. The Austin TGA's 2009 rate of Chlamydia (485.5 per 100,000) is the second highest among other Texas EMAs/TGAs in 2009 (source: *Texas DSHS, 2010).* The higher rates may be

due to the younger age of TGA residents and the large number of college and university students in Austin. The substantial disparities in infectious disease by race/ethnicity are also seen in STI rates. Rates among African Americans and Hispanics are significantly higher than among White non-Hispanics. Syphilis transmission is increasing in the TGA. In 2000, the TGA saw 41 cases of early latent syphilis (source: *Texas DSHS, 2000).* By 2009, the number of new cases had increased to 500, or 12.2 times the 2000 number. Two facts make the increase particularly significant. First, since syphilis is relatively rare, STI transmission indicates frequent unprotected sexual activity with multiple sexual partners and other high-risk sexual practices through which HIV can be transmitted (source: *CDC, MMWR, 53, 2004*). Second, syphilis co-infection increases the risk of HIV transmission. Among Travis County primary and secondary syphilis cases, almost 25% were co-infected with HIV (source: *Texas STD*MIS, 2010*). Co-morbidity with TB is a greater problem in the Austin TGA. As Figure 7 indicates, the prevalence of TB co-infection, a risk factor for mortality and care complication, is higher than any other TGA in the state (source: *Texas DSHS, 2010*).

**Figure 7: Prevalence of co-morbid disease, Texas TGAs, 2009**




Source: *Texas DSHS STD*MIS and TB Program, 2010.*

Estimated number of homeless persons

The estimated number of homeless in the TGA is 8,265. Within the TGA there are 48 homeless individuals for every 10,000 persons. These numbers represent an undercount because they do not include homeless persons who do not seek services. Among PLWH/A, *Travis County Supplement to HIV/AIDS Surveillance (SHAS)* reports 5.1% with their living situation as "shelters or streets, " while participants identified housing-related services as the third-highest reported need (source: *2010 Austin TGA Comprehensive Needs Assessment*). Housing in the Austin TGA is expensive. The second quarter 2010 median home price is at least $40,700 higher than any of the other Texas EMAs/TGAs, and the median house price increased 1.3% from 2009 to 2010. In contrast, the San Antonio TGA median price decreased 3.2% during the same period (source: *Median Sales Price of Existing Single-Family Homes for Metropolitan Areas, National Association of Realtors, 2010*). The cost of services for homeless persons also has increased in the Austin TGA. From 2003 to 2006, the average cost per homeless client in the city of Austin has grown over 300% (source: *City of Austin FY 05-06 Performance Measures Volume 1, 2009).* Homeless individuals were among the most costly in the Ryan White Program system of care. The average homeless client cost 19% more than clients who were not homeless (source: *City of Austin ARIES, 2010*).

Number and percent of population (19-64 years old) without health insurance

Texas has the highest uninsured rate in the nation (source: *Income, Poverty, and Health Insurance Coverage in the United States: 2009, US Census Bureau*). Nearly 1 in 4 persons ages

19 to 64 do not have health insurance in the TGA. Among PLWH/A, estimates place the percent uninsured between 24.7% (source: *2010 Austin TGA Comprehensive Needs Assessment*) and 54.8% (source: *Travis County SHAS*). The percent of PLWH/A without documented public or private medical insurance within the Ryan White system of care was 72.0% in 2009 (source: *Austin ARIES, 2010*).

Number and percentage of persons living at or below 300 percent of the 2008 Federal Poverty Level, by race and ethnicity

53.0% of the Austin TGA lives at or below 300% of the 2010 Federal Poverty Level (FPL). A substantially larger percentage of African Americans (64.0%) live at or below 300% FPL level than Whites. Nearly three-fourths (73.1%) of Hispanics live at or below 300% FPL, which is significant because of the projected rapid growth of the Hispanic population the TGA (source: *Texas State Data Center & Office of the State Demographer, 2010*). According to the *Travis County SHAS*, 42.6% of PLWH/A reported a household income of less than $29,000, approximately 300% FPL for a single person household. Also, 92.2% of clients receiving services within the Ryan White funded system were at or below 300% FPL (source: *Austin ARIES, 2010*).

Number and prevalence of past year adult substance abuse among general population and persons living with HIV infection

The Austin TGA has the highest prevalence of illicit drug use of any Texas metropolitan area. One in five adults used an illicit drug in the past 12 months (Attachment 4). Following the high prevalence in the general population, a majority (75.3%) of *Travis County SHAS* respondents used an illicit drug in the past year and 49.8% reported past year injection drug use.

Prevalence of adult mental illness among the general population and persons living with HIV infection

21% of adults in the TGA live with some mental illness (Attachment 4). The proportion is substantially higher among PLWH/A. According to *Travis County SHAS*, 46.6% reported being diagnosed with a mental illness. Mental illness can complicate treatment adherence and getting individuals engaged in regular medical care. Within the Ryan White system, 52.2% of those seeking mental health services were MSM (source: *City of Austin ARIES, 2010*). This is congruent with the *Travis County SHAS* which reported 50.5% of MSM respondents had a least one diagnosed mental illness.

Individuals who were formerly Federal, State or local prisoners and were released from custody of the penal system during the preceding 3 years

In the previous three years, a total of 12,685 Austin TGA residents have been released by the Texas Department of Criminal Justice (source: *Texas Department of Criminal Justice, 2010*). Among the incarcerated population in Texas, the estimated prevalence of HIV infection is 2.1% (source: *Texas Department of Criminal Justice, 2010*). For a description of impact on the service delivery system by individuals who were released from incarceration during the past three years, see the Assessment of Emerging Populations with Special Needs section on pages 16-17.

## 1.c. Impact of Part A Funding: Funding Mechanisms and Impact of Decline in Ryan White Formula Funding

### (1) Report on Availability of Other Public Funding

Refer to Attachment 5 for dollar amounts and percentages of total available public funding for HIV-related services in the specified eight categories. There was no decline in Ryan White Part A formula funding between FY 2009 and FY 2010.

### (2) Coordination of Services and Funding Streams

Coordination with other Ryan White Programs

Most Ryan White programs in the Austin TGA are coordinated through the Austin/Travis County Health and Human Services Department (A/TCHHSD) which serves as the Administrative Agency for Ryan White Part A, including the Minority AIDS Initiative (MAI) Program, and Part C. There is no Ryan White Part D or Part F funding in the Austin TGA. Although the A/TCHHSD does not serve as Administrative Agency for Ryan White Part B, a Part B representative fills a designated slot on the Part A HIV Planning Council to assure optimal coordination with Part B and Texas HIV State Services funding. Staff and Planning Council members also have participated in the development of the Texas Statewide Coordinated Statement of Need (SCSN).

Centralized coordination enables the HIV Planning Council to ensure that services provided by Part A, including MAI, do not duplicate those provided by other Ryan White funded grant programs. The Administrative Agency provided detailed information on funding from other Ryan White programs for consideration during the FY 2011 Part A and MAI priority setting and allocation processes. Prior to setting service priorities and allocating Part funds, the Planning Council was able to identify gaps in services and allocate dollars for the best use by examining all sources of funding for all eligible services.

Coordination with Other State and Federal Resources

In addition to serving as Administrative Agency for Ryan White Program funds, the A/TCHHSD receives Housing Opportunities for Persons with AIDS (HOPWA) and City of Austin funding for HIV services. To maximize coordination, the Austin HIV Planning Council provides input into development of the City of Austin Consolidated Plan for Housing Services, which includes funding for the HOPWA Program. The A/TCHHSD has oversight of major CDC Prevention Programs in the TGA, thereby facilitating close coordination of both HIV prevention and HIV care activities. Moreover, some Part A grant subrecipients have received funding under a Centers for Disease Control (CDC) Initiative to provide counseling, testing and referral, prevention case management, and evidence-based interventions with high-risk and HIV positive persons. The HIV Planning Council carefully considered services duplication during its planning process.

The David Powell Community Health Center (DPCHC) for HIV primary medical care is an active Medicaid provider that has signed contracts with multiple Medicaid managed care

companies. Texas Medicaid covers all clinical visits and provides some coverage for laboratory testing and prescription drugs for eligible clients. A three prescriptions per month limit under Medicaid is particularly problematic for persons with HIV whose medication regimen can include many more drugs than allowed. Medicaid will not pay for certain lab tests that are a critical part of HIV care. Since DPCHC does not allow patients to forgo needed drugs or procedures because of inability to pay, Ryan White Part B and Part C funds, as well as Part A, are combined for the purchase of pharmaceuticals. Patients are screened at intake for Medicaid and Medicare coverage or eligibility. DPCHC bills for all covered services and receives an enhanced reimbursement rate due to its status as a Federally Qualified Health Center. For additional information on third party reimbursement mechanisms, see page 52.

Texas has a State Children's Health Insurance Program (CHIP), which generally covers children up to age 19 with family income less than 200 percent of poverty. In addition, the Texas Healthy Kids program covers children above 200 percent of poverty, ages 2 through 17, who have been uninsured for 90 days or more. HIV-infected children are referred to CHIP when eligible; with fewer than 50 pediatric cases of HIV/AIDS in the TGA, the impact of CHIP is not significant.

DPCHC screens individuals for Veterans Administration (VA) benefits as part of its intake process. However, since eligible veterans cannot be compelled to receive their medical treatment through the VA, medical case management staff can only educate patients about care available through the VA. If a veteran living with HIV prefers to receive care at DPCHC and has no other potential third-party payer, he/she is placed on the same sliding fee scale as any other uninsured patient. The regional VA estimates that approximately 40 veterans with HIV in the TGA are seen at its small outpatient clinic in Austin or, for specialty or inpatient care, at VA hospitals in nearby Temple or San Antonio, Texas.

A Part A subcontractor coordinates their Substance Abuse and Mental Health Services Administration (SAMHSA) funds with Ryan White Part A funds in order to deliver a comprehensive range of substance abuse services to persons with HIV in the TGA. SAMHSA-funded services include: HIV counseling and testing; early intervention; lab testing; street outreach; case management; prevention for HIV positive persons; and health education and risk reduction education. Part A complements these programs by funding other components of the substance abuse treatment spectrum.

### 1.d. Assessment of Emerging Populations with Special Needs

Six populations in the TGA have been selected for discussion of their special needs: injection drug users, substance users other than injection drug users, men of color who have sex with men, White men who have sex with men, African American women, and the recently released from jail/prison. Mental health issues were identified as significant barriers to care, with an estimated 47% of PLWH/A suffering from a mental illness. Therefore, mental health issues will be discussed within each special needs population.

Injection Drug Users (IDU)

There were 20,983 injection drug users in the Austin TGA in 2010, representing a significantly larger percentage in comparison to other areas (source: *Texas Commission on Drugs & Alcohol*).

Of PLWH/A in the TGA, estimates place the percent of IDU between 6% (source: *2010 Austin TGA Comprehensive Needs Assessment*) and 27% (source: *Travis County SHAS*). Men interviewed for the Travis County Supplement to HIV/AIDS Surveillance (SHAS) project outweighed the number of women in injection drug use (29% compared to 22%). Using the prevalence information presented in Attachment 3, it is estimated that 4.3% of the IDU population is HIV positive.

*Unique Challenges*
The greatest challenges for providers to HIV-positive IDUs are risky behavior, the dual stigma of HIV and drug addiction, mental health problems, and adherence to treatment plans. The majority of all IDUs in the TGA share needles. More than 9 in 10 women, 7 in 10 Hispanics, and 8 in 10 African Americans who had ever used injection drugs had shared needles. Of people who shared needles, 43.5% shared with people they did not know, 14.1% with people they knew to be HIV positive, and 44.7% with people they knew to be men who have sex with men (source: *Travis County SHAS*). Drug abuse is also associated with disruption in daily living, making it difficult for PLWH/A to keep vital appointments or follow treatment regimens. Evidence of high unmet need can be seen when examining unmet need by exposure category (Table J, p. 20). In 2009, IDU had the highest percent of unmet need (37%). Within PLWH/A reporting exposure as IDU, males of all race/ethnicity groups had a higher percent of unmet need than females.

The 2005 HIV Needs Assessment identified barriers to care as: not wanting medical care; fear HIV status being discovered by others; cannot afford medical care; and actively using drugs/alcohol. Although not self-identified as a barrier, 75% of IDU respondents were experiencing a mental health problem. Depression and anxiety were the most common diagnoses.

*Service Gaps*
Significant service gaps found in the 2010 Austin HIV Needs Assessment include psychosocial (non-medical) case management; AIDS drug assistance; transportation; and oral health services. With three-quarters identified as having a mental health problem, the IDU population has high need for mental health services. Gaps in oral health care, substance abuse services, mental health services, and medical transportation are common for several emerging populations including IDUs.

*Estimated Costs for Delivering Services*
Identifying HIV-positive IDUs and maintaining them in care requires extensive, long-term commitment of support, especially for substance abuse and mental health treatment. In the Ryan White funded system, the total costs for all services to IDUs in 2009 was $877,782; an increase of 12.5% from the prior year (source: *City of Austin ARIES, 2009 & 2010*). Among IDUs, service costs were higher among men, Whites, and African Americans.

<u>Substance Users other than injection drug users</u>
The Austin TGA has the highest rates of drug use in the state of Texas (Table H). The overall rate of illicit drug use in the Austin TGA was twice that of any other Texas TGA/EMA, and drug use in the TGA is increasing (source: *2000 Texas Survey of Substance Use Among Adults;*

*Substance abuse trends in Texas, June 2009*). In 2008, 28,224 arrests in the TGA (or 28.0% of all arrests) were for drug and alcohol offenses (source: *Texas DSHS, 2009).*

**Table H: Past-year prevalence of substance use and abuse among adults by Texas metropolitan area**

| Drug | Austin | Dallas | El Paso | Fort Worth | Houston | San Antonio | Texas |
|---|---|---|---|---|---|---|---|
| Any illicit drug | 21.3 | 10.1 | 8.2 | 8.9 | 10.7 | 10.3 | 9.4 |
| Marijuana | 18.8 | 7.4 | 6.1 | 6.9 | 7.7 | 8.0 | 7.0 |
| Cocaine/crack | 4.6 | 2.4 | 1.1 | 1.2 | 1.8 | 5.5 | 2.0 |
| Drug problems | 10.7 | 5.2 | 4.8 | 5.0 | 6.1 | 7.6 | 5.2 |
| Alcohol | 76.9 | 70.7 | 67.8 | 63.4 | 71.8 | 69.4 | 65.7 |
| Heavy alcohol | 7.0 | 6.1 | 4.9 | 5.0 | 6.0 | 8.3 | 5.7 |
| Alcohol problems | 20.5 | 16.4 | 16.5 | 13.0 | 18.7 | 20.3 | 15.7 |

Source: *Texas DSHS, 2000.*

Substance Users represented 29.7% of respondents in the 2010 Austin TGA Comprehensive Needs Assessment. Overall, 79% of Travis County SHAS respondents reported ever using non-injection drugs. Substance abuse can lead to risky behavior. The Texas Department of State Health Services reported: "Of the Austin women tested for HIV in 2004, 2% of African Americans and 4% of Hispanics had used methamphetamine while having sex" (source: *Substance Abuse Trends in Texas, January 2006*).

*Unique Challenges*

The greatest challenges for care providers to HIV-positive Substance Users are risky behavior, the dual stigma of HIV and drug addiction, mental health problems, and adherence to treatment plans. Risky behavior is inherent when under the influence of drugs or alcohol. Twelve percent (12%) of 2005 Needs Assessment respondents reported commercial sex work as their mode of HIV transmission, and forty seven percent (47%) reported heterosexual sex as their mode of transmission. Approximately 29% of Travis County SHAS respondents had received money for sex.

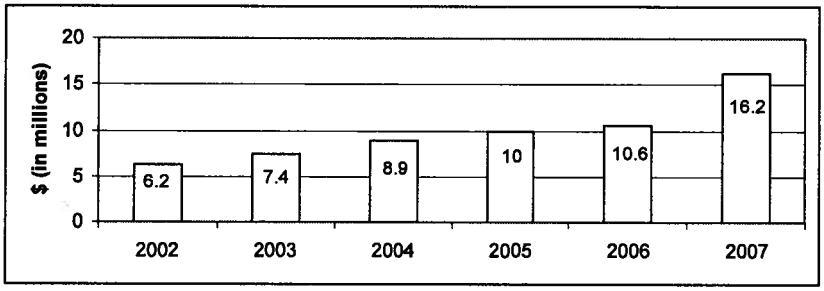
Substance Users living with HIV face the dual stigma of HIV and substance abuse; they report feeling stigmatized by providers, other PLWH/A, in their neighborhoods and on the streets (source: *2005 Austin Area Comprehensive HIV Needs Assessment*). One respondent stated: "Substance abuse treatment that is available does not understand how to deal with people living with HIV." Moreover, in the 2005 HIV Needs Assessment, 70% of substance using respondents report mental health problems, with depression and anxiety being the most common. Substance abuse often is accompanied by disruptions to daily life, thereby significantly compromising treatment adherence. In Travis and Williamson Counties, 25.4% of homeless persons were substance abusers (source: *Austin/Travis County Continuum of Care Application, 2008*).

The 2005 HIV Needs Assessment identified barriers to care as: fear HIV status being discovered by others; cannot afford medical care; fear one's children discovering HIV status; and believe medical care not necessary. Mental health problems may be additional barriers, given the high rate of respondents with this co-morbidity.

*Service Gaps*
The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. Housing Service providers in the 2005 HIV Needs Assessment stressed the inadequate capacity of all services, especially mental health and substance abuse treatment. Additionally, treatment adherence is important in helping PLWH/A who are experiencing chaotic lifestyles.

*Estimated Costs for Delivering Services*
Like IDUs, Substance Users require extensive, long-term commitment of support to stay in care. The high cost is demonstrated by hospitalization data where, in 2007, substance use-related hospitalization costs for TGA residents exceeded $16 million (Figure 8). Overall, the inpatient hospital costs in the TGA for substance use related admission have increased by 161% since 2002, with a substantial increase of 53% since 2006. These figures do not account for the added cost of emergency room and private physician visits, or hospital admission where drug use was noted but not the primary reason for admission.

**Figure 8: Total Inpatient Hospitalization Costs (in millions) from substance use related admission, Austin TGA**




Source: *Texas Hospital Inpatient Discharge Public Use Data File, 2002-2007. Texas DSHS, Center for Health Statistics-THCIC, Austin, Texas, 2010 & Agency for Healthcare Research & Quality CCS-MHSA software.*

Men of color who have sex with men
Of the 222 men of color diagnosed with HIV in 2008-2009, 84.7% had a risk factor of MSM, including MSM & IDU (source: *Texas eHARS, 2010*). Among men of color living with HIV, MSM (including MSM and IDU) was the most common risk factor (77.0%). MSM was the most common risk factor among men of color for African Americans (52.6%), Hispanics (77.0%), and Asian and Pacific Islanders (84.3%). The average age of men of color MSMs at age of HIV diagnosis was 32.7 years, while the average age of White-non Hispanic MSMs at HIV diagnosis was 34.6 years. Although representing a small percent of all PLWH/A, the majority of male youths (13-24 years old) reported with HIV during this period were men of color (75.0%) (source: *Texas eHARS, 2010*).

*Unique Challenges*
The greatest challenges for providers of services to HIV-positive men of color MSMs are stigma, lack of HIV education, and risky behavior. Men of color MSMs face the multiple stigmas of being MSM, HIV-positive, and racial/ethnic minority. This translates into a higher number of men of color MSMs with unmet need in the TGA; in 2009, 748 MSM had unmet need (source: *Texas DSHS, 2010*). Stigma extends beyond health care providers and the larger society to their

own communities, where many men of color MSMs do not identify as gay, making them a 'hidden population'. TGA provider data reported that minorities had a lower level of knowledge about HIV/AIDS, found out about their HIV status at a later stage of disease, or knew their status but chose not to use services until a late stage of disease. These factors increase the cost and complexity of providing services to clients. The 2005 HIV Needs Assessment identified barriers to care as: cannot afford medical care, fear HIV status being discovered by others, and fear of their children discovering HIV status.

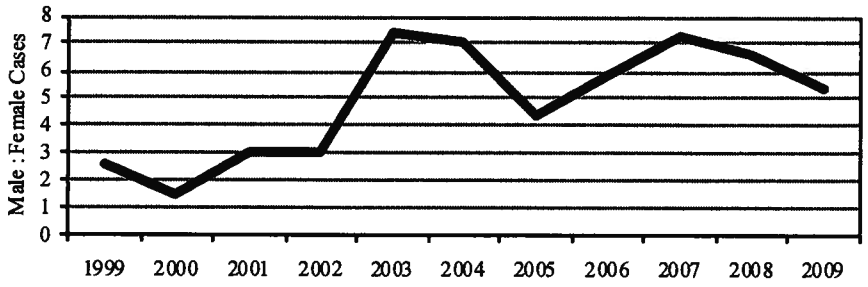
*Service Gaps*
The 2010 HIV Needs Assessment identified service gaps as: psychosocial (non-medical) case management, AIDS drug assistance, outpatient/ambulatory medical care, and oral health services. According to ARIES data, African American and Hispanic men had more service visits than White men. African American men averaged 65 visits and Hispanic men 58 visits, compared to White men who averaged 46 visits.

*Estimated Costs for Delivering Services*
Identifying and bringing into care men of color MSMs requires additional focus on unmet need as well as outreach and adherence services. City of Austin Disease Intervention Specialists performing HIV case investigation report men of color are more likely to deny male to male sexual contact. For 2009, ARIES data from all funding sources and all providers indicated 612 African American and Hispanic MSMs accessed services for a total cost of $2,550,871 (source: *City of Austin ARIES, 2010*). The average expenditures for African American and Hispanic MSMs were higher than for White non-Hispanics.

White men who have sex with men
White men who have sex with men comprised 36.6% of all PLWH/A in the TGA. When White MSMs who are injection drug users are included, the percentage increases to 41.1%. In 2008-2009, 35.1% of all newly diagnosed AIDS cases were White MSM. (source: *Texas eHARS, 2010*). HIV-positive White MSMs also have the largest number of persons with unmet need among all race/ethnicity groups in the TGA (source: *Texas DSHS, 2010*). The total size of the MSM population is not known, but an estimated 8.1% of the male TGA population is MSM (source: *Holmberg SD, American Journal of Public Health 36(5), 1996*).

*Unique Challenges*
White MSMs continue to constitute the largest number of PLWH/A in the TGA. Risky sexual behavior and substance abuse present significant challenges for providers of care to HIV-positive White MSMs. Figure 9 demonstrates the increased risky sexual behavior among White MSMs in the area. In 2000, there was only one case of early syphilis among men for each female. In 2009, for every one white female case of early syphilis, there were 5 male cases. From 2003 to 2007, the ratio of white male to white female early syphilis cases was much wider, an indication of transmission primarily in males (source: *Texas STD*MIS, 2010).* The present decrease in the ratio may indicate that whites of both sexes are engaging in riskier sexual behavior, exposing more women to syphilis. The larger number of early syphilis cases reported in women may also be due to efforts to increase active surveillance. The 2005 HIV Needs Assessment found that 22% of White MSM had a history of IDU and 59% reported substance abuse, thereby presenting another challenge.

**Figure 9: Ratio of White Male to White Female Early Syphilis Cases, Travis County.**




Source: *Texas DSHS, STD*MIS, 2010*

*Service Gaps*

Significant service gaps found in the 2010 HIV Needs Assessment include: oral health services, medical case management, outpatient/ambulatory medical care, and AIDS drug assistance. In addition to these self-reported needs, providers and surveys indicate that significant numbers of White MSM need mental health, substance abuse, and health education/risk reduction services.

*Estimated Costs for Delivering Services*

Within the Ryan White funded system of care, more dollars are spent on White MSMs than on any other risk group/ethnicity combination (source: *City of Austin ARIES, 2010*). White MSMs accounted for 49% of funding spent on services within this system of providers, for a total cost of $1,971,264.

African American Women

In 2009, 56% of all women in the TGA were White, 31% were Hispanic, 8% African American, and 5% other races/ethnicities (source: *Texas State Data Center and Office of the State Demographer, 2010).* Although among the smallest race/ethnic groups in the TGA, just under half (48%) of all females living with HIV/AIDS were African American (source: *Texas eHARS, 2010*). This disparity is also evident among young women. Among women living with HIV/AIDS who were 13 to 24 years old at time of diagnosis, the majority (56.4%) were African American (source: *Texas eHARS, 2010*). Heterosexual contact (66%) and injection drug use (30%) are the primary modes of transmission among African American women (source: *Texas eHARS, 2010*).

*Unique Challenges*

Several factors complicate access to care for African American women. The percent of African American women living in poverty (25.2%) was 2.9 times that of White non-Hispanic women (8.7%) in the Austin TGA (source: *US Census Bureau 2008 American Community Survey).* Additional challenges include care for children, responsibility to family, and domestic violence. According to the 2005 HIV Needs Assessment, 23% of out-of-care women reported not seeking care out of fear from being abused by a partner. African American women also reported a fear of revealing their HIV status to the community and family. As previously noted, intravenous drug use is the second major mode of transmission, highlighting substance abuse as a significant challenge. These problems may contribute to African American women living with HIV/AIDS

having a higher number with unmet need than other race/ethnicity groups in the TGA in 2009 (source: *Texas DSHS, 2010*).

*Service Gaps*

According to the 2005 HIV Needs Assessment, a higher percent (36%) of African American women were out-of-care than among women overall. Service gaps reported in the 2010 HIV Needs Assessment included: oral health services, mental health services, transportation, utility assistance, and AIDS drug assistance. Comments from focus group participants also suggested that support groups facilitated by a mental health professional would be beneficial.

*Estimated Costs for Delivering Services*

Within the Ryan White funded system of providers, 255 African American, 121 Hispanic and 23 women of other races/ethnicities sought care for services. The average cost per Hispanic female client was $3,755, which was the highest average cost for any gender and race-ethnicity combination. The average cost for African American women was slightly higher than the cost for White non-Hispanic women ($3,304 vs. $3,181) (source: *City of Austin ARIES, 2010*).

Incarcerated / Recently Released

The incarcerated and the recently released from jail/prison are populations disproportionately affected by HIV/AIDS. The 2009 estimated prevalence of HIV/AIDS in the overall Texas incarcerated population was 2.1% (source: *Texas Department of Criminal Justice, 2010*). The prevalence of HIV in the incarcerated population is substantially higher than the overall HIV prevalence in the Austin TGA. It is estimated that 5% of the incarcerated HIV positive population reside in Travis County (source: *Access to Correctional Health Care, American Civil Liberties Union of Texas, 2009*). The number of Austin TGA residents incarcerated in 2009 was 7,031. The distribution of incarcerated residents by race/ethnicity and sex is presented below in Table I. The majority of incarcerated Austin TGA residents were male. Rates of incarceration per population indicate a higher prevalence among African Americans.

**Table I: Currently incarcerated and recently released Austin TGA residents by sex and race/ethnicity, 2009.**

| | Incarcerated | | | Recently Released | | |
|---|---|---|---|---|---|---|
| | **N** | **%** | **Prevalence** | **N** | **%** | **Prevalence** |
| White | 2,191 | 31.2 | 0.2 | 1,313 | 31.3 | 0.1 |
| African American | 2,146 | 30.5 | 1.7 | 1,382 | 33.0 | 1.0 |
| Hispanic | 2,658 | 37.8 | 0.5 | 1,481 | 35.3 | 0.3 |
| Other | 36 | 0.5 | 0.0 | 18 | 0.4 | 0.0 |
| | | | | | | |
| Male | 6,653 | 94.6 | 0.8 | 3,614 | 86.2 | 0.4 |
| Female | 378 | 5.4 | 0.1 | 580 | 13.8 | 0.1 |
| **Total** | **7,031** | **100** | 0.4 | **4,194** | **100.0** | **0.3** |

Source: *Texas Department of Criminal Justice, 2010.*

The recently released represent a fast-growing and sizable population in need of services and HIV care. Table I describes characteristics of the recently released in the TGA. A total of 4,194 Austin TGA incarcerated were released into the community in 2009, a slight decrease of 5.3% from the previous year. The vast majority of individuals released in the TGA (68.5%) were

Travis County residents. Most of the recently released were men (86.2%) and persons of color (68.7%). During the past three years, the total number of individuals released from incarceration in the TGA was 12,685. This population's HIV prevalence results in a disproportionate burden of recently released PLWH/A seeking services in the TGA, many with co-morbidities such as substance abuse and mental illness which complicate their care. The recently released also require effective transition programs to help them avoid re-incarceration and continue the HIV treatment received while incarcerated.

*Unique Challenges*
Numerous challenges exist in managing and preventing HIV/AIDS among the recently released. Substance abuse presents a challenge in getting these individuals into care, with 52% of out-of-care recently released reporting alcohol and drug use as their most frequently identified reason for being out of care. Recently released have lower levels of educational attainment when compared to the population as a whole. Among recently released, 38% have not graduated from high school (source: *2005 Austin Area Comprehensive HIV Needs Assessment*).

*Service Gaps*
According to the 2010 HIV Needs Assessment, the recently released population ranked transportation first among their most frequently identified service gaps. There is a significant gap for basic needs services as well. Other service gaps included: utility assistance, housing, food bank, and oral health services. Focus group participants indicated that services are needed to help the recently released navigate housing barriers and criminal justice obstacles. Furthermore, 89% of recently released participants were not provided with transitional services to assist them in accessing HIV medical and social services, obtaining prescriptions, and entering into case management (source: *2010 Austin TGA Comprehensive Needs Assessment*).

*Estimated Costs for Delivering Services*
In the Ryan White funded system, the total expenditure on those who have been recently released increased significantly between 2008 and 2009. Last year, more than $336,029 was spent on services for persons who were identified as in prison in the previous 12 months, representing a 28% increase from the previous year (source: *City of Austin ARIES, 2010*). This amount is an underestimate, since all providers do not uniformly or systematically collect this information.

**1e. Unique Service Delivery Challenges**

Co-morbidities, high poverty, and low rates of health insurance coverage increase the challenge of providing care to PLWH/A in the TGA in three main ways. First, these factors tend to complicate the prevention and management of HIV infection and AIDS. Second, they are associated with inadequate information about the disease, its prevention and treatment, availability of services, and reduced ability to navigate the care system. Third, historically underserved and hard-to-reach clients are disenfranchised from health and other social service systems in general. Moreover, they may not access care regularly or adhere to treatments because of impaired judgment from substance abuse or mental illness. The high prevalence of injection drug and other substance abuse in the TGA not only complicates the management of HIV/AIDS but it also puts the user at risk for other infections. Homelessness reduces the ability of the care system to reach patients and often leads to poor adherence to treatment regimens.

These factors also are associated with diagnosis at a later stage of the disease, and multiple social problems.

The growing numbers of PLWH/A and the cost of antiretroviral therapies also are affecting the TGA's ability to provide services. The need for expensive genotypic and phenotypic assay and other laboratory testing imposes an additional cost burden on the primary medical care system. Early intervention is now more critical because of effective treatment options; however, those most in need of care often are least willing or able to access and remain in primary medical care. Other factors that complicate service needs and impair effective service delivery in the TGA include changes in managed care, effects of the economic downturn, and cutbacks in basic social services previously funded by the Ryan White Program.
Additional service delivery challenges unique to the Austin TGA are summarized below:

- Many PLWH/A move to Austin to seek care, with nearly 1 in 4 newly reported cases of HIV and AIDS in the TGA already documented as cases in other jurisdictions.
- Continuity of care remains a critical problem, with clients experiencing barriers in accessing specialty care within the local indigent health care system. More subspecialty care providers are reluctant to accept Medicaid or Medicare clients.
- Increasingly, patients diagnosed with AIDS while in the hospital are started on antiretroviral (ARV) medications without regard to payment sources. Upon discharge, these patients come to David Powell Community Health Center (DPCHC) needing to continue treatment but with no payment source.
- Nearly 1 in 4 persons ages 19 to 64 do not have health insurance in the TGA; more than half (53.0%) lives at or below 300% of the 2010 Federal Poverty Level (FPL).
- Of 254 Texas counties, Travis County is the fourth most common county of residence for the newly released HIV positive incarcerated population. Since clients leave the prison system with no more than a ten-day supply of ARV medications, the DPCHC incurs significant pharmaceutical cost.
- The TGA has the highest prevalence of illicit drug use of any Texas metropolitan area.
- The DPCHC reports that more than 40% of its HIV patients have injection drug use and/or mental illness co-morbidity.
- The high rates of STDs, and particularly Chlamydia which is the second highest rate among the other Texas EMAs/TGAs, are evidence of high levels of risky sexual behavior in the TGA, especially among White MSMs.
- The percent of HIV and AIDS cases with male-to-male sexual contact as the risk has been steadily increasing, reversing a significant decreasing trend throughout the 1990s.
- In 2008-2009, the rate of newly diagnosed HIV cases among African Americans in the TGA was almost 3.5 times higher than the rate among Whites, and 2.5 times higher than the rate among Hispanics.
- The prevalence rate of HIV infection among African American males is 2.5 times higher than among White males; the rate among African American females is almost twelve times higher than among White females.

### 1.f. Impact of Decline in Ryan White Formula Funding

For FY 2010, the Austin TGA did not experience a decline in Ryan White Part A formula funding.

## 1.g. Unmet Need

The Unmet Need Framework for 2009 is shown in Attachment 6.

Unmet Need Estimate

The Texas Department of State Health Services (DSHS) estimates the number of PLWH/A with unmet need at 1,501 persons, or 34.0% of the entire PLWH/A population. Unmet need for medical care is identified using the HRSA definition: a person living with HIV has unmet need for medical care if there is no evidence of either a CD4 count, a viral load test, or antiretroviral therapy during the 12 months of interest. If there is evidence of any one of these three events being present, the person is considered to have their medical needs met. DSHS supplies these data to Texas EMAs and TGAs, since the local health departments do not have the capacity to perform the analysis.

Estimation Methods

DSHS HIV/STD Epidemiology and Surveillance Branch (DSHS, Part B grantee), Texas Part A Administrative Agencies and HIV Planning Council staffs collaboratively developed the specific methodology used to determine the quantitative estimate of unmet need.

The unmet need estimate matched individuals from four datasets representing different funding streams:

- HIV/AIDS Enhanced HIV/AIDS Reporting System (eHARS)
  This is the data source that is used as the universe of cases for estimating unmet need. The first assessment of met need begins with eHARS by examining cases for evidence of CD4 or viral load testing. If CD4 count was within two (2) months of an AIDS diagnosis, or a detectable viral load was within two (2) months of initial HIV diagnosis, these instances were not included as a met medical need.
- Texas AIDS Drug Assistance Program (ADAP)
  If ADAP provided antiretroviral (ARV) medications for a client, then that person was considered to have met medical need for the year in which the medication was provided.
- Electronic Lab Reporting (ELR)
  The largest providers of laboratory services throughout the state report CD4 and viral load measurements to the DSHS. Name based matching of these reports was used to determine if individuals received a CD4 count or viral load test during 2009.
- AIDS Regional Information and Evaluation System (ARIES)
  Services provided to Ryan White eligible clients by funded service providers are reported in ARIES. If a client received a viral load, CD4 count, laboratory service, ARV medication, or an outpatient/ambulatory medical care visit during 2009, the client was reported as having a met medical need during that year. When available, name based matching was used to determine persons with a met medical need during 2009. When client names were not available, matching was based on a unique record number generated in ARIES and eHARS.

Personal identifiers such as names, dates of birth, etc., and unique record numbers, depending on the database, were used in the matching process. The midyear 2009 eHARS dataset (06/30/2010) was used for the 2009 unmet need analysis. Diagnosed HIV/AIDS cases that had

been entered and were living on or before 12/31/2009 were included for the total population for unmet need in 2009. Using the datasets and matching methods described above, persons living with HIV were identified as having a met medical need if they received a relevant service through any of these data sources. Medicaid and private insurance data were not available or incorporated in the development of the unmet need estimates presented here and produced in September 2010. Once other data sources are acquired, an update of the 2009 unmet need estimates will be released.

The 2007-2009 unmet need estimate is shown in Table J below.

**Table J: Number and Percent of Living HIV, AIDS, and HIV and AIDS with Unmet Need for Medical Care, 2007-2009.**

| | Living with HIV & unmet need | | | | | | Living with AIDS & unmet need | | | | | | PLWH & unmet need | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2007 | | 2008 | | 2009 | | 2007 | | 2008 | | 2009 | | 2007 | | 2008 | | 2009 | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| **Sex** | | | | | | | | | | | | | | | | | | |
| Male | 438 | 33 | 529 | 38 | 649 | 44 | 540 | 27 | 620 | 29 | 653 | 29 | 978 | 29 | 1,149 | 33 | 1,302 | 35 |
| Female | 67 | 28 | 85 | 33 | 105 | 39 | 81 | 21 | 95 | 24 | 94 | 22 | 148 | 24 | 180 | 27 | 199 | 29 |
| **Race/Ethnicity** | | | | | | | | | | | | | | | | | | |
| White | 270 | 32 | 301 | 34 | 391 | 43 | 357 | 31 | 407 | 35 | 420 | 34 | 627 | 32 | 708 | 34 | 811 | 37 |
| African American | 115 | 35 | 159 | 45 | 174 | 46 | 130 | 21 | 152 | 24 | 157 | 24 | 245 | 26 | 311 | 31 | 331 | 32 |
| Hispanic | 111 | 30 | 142 | 36 | 178 | 42 | 127 | 21 | 149 | 22 | 161 | 23 | 238 | 24 | 291 | 27 | 339 | 30 |
| Other/Unknown | 9 | 45 | 12 | 50 | 11 | 46 | 7 | 23 | 7 | 23 | 9 | 25 | 16 | 32 | 19 | 35 | 20 | 33 |
| **Age** | | | | | | | | | | | | | | | | | | |
| < 2 | . | . | . | . | . | . | . | . | . | . | . | . | . | . | . | . | . | . |
| 2-12 | 2 | 29 | 2 | 25 | 2 | 20 | 2 | 50 | 2 | 50 | 1 | 100 | 4 | 36 | 4 | 33 | 3 | 27 |
| 13-24 | 25 | 22 | 55 | 45 | 53 | 47 | 3 | 14 | 4 | 14 | 5 | 13 | 28 | 20 | 59 | 40 | 58 | 38 |
| 25-34 | 133 | 35 | 175 | 43 | 207 | 49 | 44 | 16 | 51 | 19 | 44 | 16 | 177 | 27 | 226 | 34 | 251 | 36 |
| 35-44 | 210 | 36 | 211 | 36 | 254 | 44 | 226 | 25 | 210 | 25 | 211 | 26 | 436 | 29 | 421 | 29 | 465 | 33 |
| 45-54 | 98 | 28 | 131 | 33 | 181 | 40 | 242 | 27 | 317 | 32 | 322 | 31 | 340 | 28 | 448 | 32 | 503 | 33 |
| 55+ | 37 | 30 | 40 | 29 | 57 | 35 | 104 | 32 | 131 | 35 | 164 | 35 | 141 | 31 | 171 | 33 | 221 | 35 |
| **Category** | | | | | | | | | | | | | | | | | | |
| MSM | 355 | 34 | 424 | 37 | 532 | 44 | 386 | 28 | 427 | 29 | 464 | 29 | 741 | 30 | 851 | 32 | 996 | 36 |
| IDU | 46 | 39 | 53 | 44 | 58 | 47 | 109 | 28 | 132 | 34 | 134 | 34 | 155 | 31 | 185 | 36 | 192 | 37 |
| MSM / IDU | 26 | 21 | 37 | 32 | 40 | 34 | 49 | 20 | 68 | 27 | 61 | 24 | 75 | 21 | 105 | 29 | 100 | 27 |
| Heterosexual | 71 | 30 | 96 | 37 | 117 | 42 | 72 | 20 | 82 | 22 | 84 | 21 | 143 | 24 | 179 | 28 | 201 | 29 |
| Perinatal | 5 | 28 | 3 | 19 | 5 | 31 | 4 | 40 | 4 | 36 | 3 | 21 | 9 | 32 | 7 | 26 | 8 | 27 |
| Other | 1 | 17 | 1 | 17 | 2 | 33 | 1 | 20 | 2 | 40 | 1 | 13 | 2 | 18 | 3 | 27 | 3 | 21 |
| **Total** | 505 | 32 | 614 | 37 | **754** | **43** | 621 | 26 | 715 | 28 | **747** | **28** | 1,126 | 28 | 1,329 | 32 | **1,501** | **34** |

Source: *Texas Department of Health & Human Services, as of 12/31/2009.* Note: Numbers may not sum to totals due to rounding error and risk statistically redistributed.

Limitations

Estimates are limited by several factors: 1) they do not include all the HIV-related care provided by the Veterans Administration, Medicare, and all private providers; 2) matches conducted between eHARS and the Uniform Reporting System (URS) were based on a unique identifier rather than client name, which may underestimate the true number of clients with met need; 3) the state does not have a systematic way of identifying and removing out-migrated cases that remain in the denominator and inflate the unmet need estimate; 4) the death match for 2009 is pending and, until it is complete, cases deceased in 2009 may remain in the denominator; and 5) cases diagnosed in the Texas Department of Criminal Justice are excluded from these analyses. Although some diagnosed within the prison system have since been released and live in Texas, the state excludes them because it has no source of information on those receiving care within the prison nor can it distinguish between incarcerated and released persons.

Caution is warranted when interpreting the apparent differences in unmet need from previous estimates and in those age 55 years and older. Fluctuations in unmet need across different years could be a result of changes in data reporting or matching returns, identification of duplicates, and a cleaner Texas eHARS file. De-duplication of records within Texas and with other states, a major death update, and matching eHARS records with vital statistics resulted in updates to a substantial number of cases. The 55 and older age group has the highest proportion of unmet medical need in the other Texas EMAs/TGAs, and much of this group is eligible for Medicare benefits. DSHS is currently working on acquiring access to Medicare data and incorporating this data piece when calculating unmet need estimates.

Assessment of Unmet Need Trends, 2007-2009

- In 2009, 1,501 PLWH/A had unmet need, or 34%, representing a 33.3% increase from 2007.
- The majority of PLWH/A with unmet need from 2007-2009 are males. The number of male PLWH/A increased from 978 in 2007 to 1,302 in 2009, or a 33% increase.
- The percent with unmet need from 2007-2009 did not vary greatly by race/ethnicity, but each group experienced an increase over the three years. Similar proportions of White (37%), African American (32%), and Hispanic (30%) PLWH/A had unmet need in 2009.
- The exposure category with the highest percentage of unmet need from 2007-2009 was injection drug users (37% in 2009). The number of IDU PLWH/A with unmet need increased 24% from 2007 to 2009. IDU males of all races/ethnicities had higher numbers of persons with unmet need than IDU females for 2007-2009.
- The most common age with unmet need is 13-24 years old (38%). This represents a large subpopulation who may seek services over a longer period of time than older age groups. Austin TGA is the only Texas EMA/TGA with this age group having the highest proportion of unmet need.
- The proportion of PLWH (not AIDS) not receiving medical care is greater than the proportion of PLWA with unmet need for 2007-2009. The number of PLWH increased by 49.3% from 2007 to 2009, while the number of PLWA increased 20.3%. In 2009, 43% of PLWH had unmet need, compared to 28% of PLWA. This difference may be attributable in part to the large proportion of AIDS cases that meet the case criteria for AIDS as a result of CD4 testing, which is also an indicator of met need. AIDS cases with met need may also be

due to the fact that infected individuals receiving medical care are more likely to have an AIDS diagnosis as a result of that care.

- Whites exhibit smaller differentials when comparing HIV and AIDS unmet need proportions (43% vs. 34% in 2009); the proportion of cases with unmet need among African American and Hispanic HIV cases is much higher than it is for AIDS cases in the TGA.
- The ten most common ZIP codes with unmet need (2008 data) were identified based on residence at the time of their most recent diagnosis. All ten ZIP codes with the most individuals with unmet need were within Travis County; the percent of PLWH/A with unmet need was greater than 35% in some of these ZIP codes.
- The increases in the number and percent of PLWH/A with unmet need from 2007-2009 may be due to several factors. Limitations of the unmet need estimate methods result in deceased, out-migrated, Medicaid or privately insured cases remaining in the denominator and inflating the unmet need estimate because these data were unavailable for use in the estimation. Expanded outreach and testing initiatives may identify new cases of HIV or AIDS who are not in care. The nationwide recession may have increased the number of PLWH/A without any type of insurance.

The HIV Needs Assessment evaluated unmet need, service gaps, and barriers to care for HIV-positive persons not in care. Information on specific populations was presented above, beginning on p. 10. The needs, gaps and barriers for the entire out-of-care population are summarized in Table K, below. Service needs include basic assistance and assistance with health insurance. The most important gap in services for the out-of-care population was health insurance. Barriers to getting into care took several different forms: fear in having HIV status revealed; perceptions care was not necessary; and other factors such as substance abuse and financial concerns.

**Table K: Leading service need, gaps and barriers for the out-of-care population, Austin TGA.**

| Service Need | Gap | Barrier |
|---|---|---|
| Psychosocial case management | Health insurance | Fear of disclosure of HIV status |
| Primary medical care | Emergency financial assistance | Don't want medical care |
| Oral Health care | Housing assistance | Not currently sick |
| HIV medication assistance | Oral health | Financial reasons |
| Mental health services | Food bank | Current substance use |

Source: *2005 Austin Area Comprehensive HIV Needs Assessment and 2010 Austin TGA Comprehensive Needs Assessment*

For information on how results of the Unmet Need assessment have been used in planning and decision making about priorities, resource allocations, and the system of care, refer to Section 5, Planning and Resource Allocation on p. 54 and p. 56.

## 2) Early Identification of Individuals with HIV/AIDS (EIIHA)

### 2)a. Description of Austin TGA EIIHA strategy to identify individuals who are unaware of their HIV status

The Austin Transitional Grant Area's (TGA) overall strategy is to collaborate with existing organizations performing EIIHA activities to develop a coordinated and seamless system which identifies, informs, refers, and links high-risk unaware HIV positive persons to care. Successful development and implementation of this system involves collaboration between HIV prevention and testing service providers and HIV treatment and care service providers. The Austin Area HIV Planning Council (AAHPC) will serve as the lead organization in developing this coordinated system through the establishment of an EIIHA collaborative. The collaborative will be composed of representatives from the major EIIHA service providers in the TGA. In the Austin TGA, HIV prevention and testing services have not historically been well coordinated with Ryan White care services due to, among other things, separate and exclusive funding requirements. Thus, the proposed strategy represents the area's initial effort to engage in active and deliberate coordination activities that will result in a more efficient system.

### 2)a.(1) Description of specific goals to be achieved

The TGA has adopted goals from the National HIV/AIDS Strategy which will ensure that the TGA's overall strategy is achieved. The specific goals are listed below.

- *Increasing the number of individuals aware of their HIV status*
- *Reducing HIV Related Health Disparities*
- *Increasing the number of HIV positive individuals who are in care*
- *Increasing Access to Care and Improving Health Outcomes for People Living with HIV*
- *Reducing New HIV Infections*

### 2)a.(1)a Description of how each goal is consistent with making individuals who are unaware of their HIV status aware of their status

All of the goals are consistent with making individuals who are unaware of their HIV status aware of their status in the following manner. The goal of increasing the number of individuals aware of their HIV status is apparent and will be achieved through activities addressed in the next three goals. The goal of reducing HIV-related health disparities cannot be achieved until factors which cause TGA residents to avoid learning their HIV status are addressed. Recent studies in the TGA indicate that stigma associated with HIV remains high and fear of discrimination may be causing some unaware racial and ethnic groups from testing. Additional studies reveal that these heavily impacted populations may not view HIV as a primary concern. They are experiencing problems with reentry into the community following incarceration, unemployment, lack of housing, and other pressing socioeconomic issues. The goals of increasing the number of HIV positive individuals who are in care and increasing access to care will result in improved health outcomes for people living with HIV. This entails getting unaware HIV positive individuals into care as early as possible after being infected. The TGA's strategy to collaborate and coordinate with EIIHA service providers will result in a seamless system to

immediately link people to the area's existing continuum of care when they are diagnosed with HIV. Reducing new HIV infections in the TGA can be achieved by strategically concentrating area resources in communities at high risk for HIV infections. Additionally, by increasing the number of individuals in care, the risk of transmitting the virus to others is reduced. In order to address these issues, the TGA will develop community-level collaborations that integrate HIV prevention and care with its more comprehensive responses to social service needs.

**2a.(2) Description of how this strategy coordinates with RW Part B counterpart with regard to the following:**

**2a.(2)a Identifying HIV positive unaware individuals**
The Part B Grantee, the Texas Department of State Health Services (DSHS), and Part A Grantees meet on a quarterly basis to collaborate in addressing common service delivery issues. DSHS's EIIHA Plan is in the process of being developed and will be coordinated with the Part A plans after completion.

The Brazos Valley Council of Governments (BVCOG) is the counterpart to the Austin/Travis County HHSD. BVCOG serves as the Part B Administrative Agency for a multi-county area which includes the Austin TGA. The HIV Services Planner at BVCOG is a member of the Austin HIV Planning Council. This relationship enhances program planning and service delivery coordination between the Part A and Part B administrative agencies. EIIHA activities are provided in the rural areas of the TGA by BVCOG through a contract with Community Action, Inc. Targeted outreach and testing activities are provided by Community Action, Inc. Through coordination and collaboration with other HIV testing organizations in the rural areas, high-risk HIV positive unaware individuals will continue to be targeted for services.

**2a.(2)b Informing HIV positive unaware individuals of their status**
Outreach and testing staff from Community Action, Inc. informs HIV positive unaware individuals of their status after receipt of results from laboratories.

**2a.(2)c Referring HIV positive unaware individuals to care**
Community Action, Inc. outreach and testing staff refer clients to its case management system. Client advocates and non-medical case managers provide advice and personal assistance in obtaining medical and support services and work closely with the clients to ensure continuity of care.

**2a.(2)d Linking HIV positive unaware individuals to care**
Case managers the rural areas of the TGA complete clinical intakes for all clients who are being referred to the David Powell Community Health Center in Austin. They also access records from previous medical providers in order to build and understand a client's medical history. Follow up with clients after each medical appointment is another activity which case managers engage in. They obtain physician notes to assess changes in the client's health and keep these notes in the case file, and enter appropriate information into the ARIES data base. This can include accompanying clients to case management and medical appointments.

**2a.(2)e EIIHA Data Collection and Sharing**

Data on individuals receiving EIIHA services are capture and shared in the following manner. Staff members at local, state, and federally funded testing sites collect information about the number of tests provided, the results of those tests, and information about the demographics and behavioral risk factor of those persons tested. After unaware persons are tested and confirmed positive, they are entered into the HIV/STD surveillance system in Texas. The Enhanced HIV/AIDS Reporting System (eHARS) captures HIV/AIDS data to monitor the epidemic in Texas and to report required data to CDC to monitor the epidemic nationally. eHARS incorporates major advances in database organization and data presentation and is a document based system, meaning that data from multiple documents are entered for each case and those documents are linked with a unique identification number. eHARS enables the HIV/AIDS surveillance program to gather and store information from birth certificates, death certificates, and laboratory reports . Finally, eHARS allows for evaluation of data pertaining to HIV and AIDS case ascertainment methods.

Once an unaware person is connected to care (i.e., support services or primary medical care) client level data is entered into the AIDS Regional Information and Evaluation System (ARIES). ARIES collects and reports demographic, clinical, and service utilization data. Examples of demographic data collected include race, ethnicity, date of birth, gender, city, county and state of residence, ZIP code, living situation, financial, and insurance information.

A number of clinical data elements are also available in the system, including CDC disease stage, risk factors, CD4's, viral loads, sexually transmitted infections (STI), hepatitis, tuberculosis, (including multi-drug resistant TB), immunizations, ART therapy, and medications taken to treat/prevent opportunistic infections. ARIES enhances the provision of HIV services by helping providers automate, plan, manage, and report on client data.

**2a.(3)a Description of how this strategy coordinates with prevention and disease control/intervention programs in regard to the following:**

**2a. (3)a Identifying HIV positive unaware individuals**

This strategy will enhance the ability of the TGA's prevention and disease control/intervention programs by enabling them to work more collaboratively with all EIIHA service providers in the area. The Austin/Travis County Health and Human Services Department (A/TCHHSD), because of its legislatively mandated surveillance and disease intervention role, is a key provider of services to the HIV unaware, along with three HIV services agencies located in Austin and one agency serving the rural areas of the TGA. Many of these activities are performed by disease intervention specialists, who are responsible for partner notification, and include referral for HIV testing. In addition to their early identification activities, these HIV services agencies provide a range of services including Ryan White Program Part A, B, & C core medical and health-related support services, as well as CDC funded HIV prevention activities.

**2a.(3)b Informing HIV positive unaware individuals of their status**
Successful collaboration between prevention and care service providers will improve the TGA's process of informing clients of their HIV status after receipt of test results. Coordinating service provider activities and efforts in getting individuals to return to test sites to be informed of their HIV status is one activity. DIS will follow-up with clients who do not return for results, to ensure they are made aware of their status.

**2a.(3)c Referring HIV positive unaware individuals to care**
The TGA's processes of referring HIV positive individual to care will be greatly enhanced with collaboration and coordination between prevention programs and care and treatment programs. The EIIHA Collaborative will enable the organizations to have standard procedures in place for making referrals and identify and address referral to care barriers in a constructive manner.

**2a.(3)d Linking HIV positive unaware individuals to care**
Linking HIV positive unaware individual to the existing continuum of care through increased collaboration and coordination between existing prevention and care service providers in the area will increase the number of individuals in care. Procedures are in place to confirm clients make their appointments. Interagency procedures are in place follow-up to follow-up on clients who fail to keep medical appointments.

**2a.(3)e EIIHA Data Collection and Sharing**
Section **2a.(2)e** above describes the data collection and sharing methods used in the TGA. These systems are the same for prevention and disease control/intervention programs.

**2a.(4) Description of how this strategy coordinates with other programs/facilities and community efforts**
The overall strategy of collaborating with existing EIIHA service providers to develop a better coordinated system will enhance the following community efforts: The following initiatives will be coordinated with the TGA's overall EIIHA strategy in 2011.

**Social Marketing Campaign**
In 2009, SUMA/Orchard Social Marketing, Inc. (SOSM) conducted research to develop a social marketing campaign targeted toward African Americans and young MSM in the Austin/Travis County service area. This study, funded by the City of Austin identified gaps and opportunities to provide information and outreach regarding HIV prevention, testing and care services for the targeted populations. Nine focus groups were conducted with a total of 96 respondents including gatekeepers and healthcare professions, HIV outreach workers, African American men, African American Women, African American MSM, and MSM of all races. Additionally, 19 in-depth one-on-one interviews were conducted with HIV service provider organizations, other stakeholders, and DIS.

As a result of this formative research, the following products/programs have been developed for early intervention use in FY 2010: seventeen-minute HIV video: *Living with HIV is Not Dying of AIDS*; website: www.AustinHIV.com which includes testing and referral information; four-color tri-fold brochure: *Living with HIV is Not Dying of AIDS*; four-color desk kiosk: *Trained as an HIV Care Messenger*; and a three-hour HIV Continuing Education Units (CEU) program for social service agency staff, including those with professional licensure, on HIV resources, testing

issues, and referral to care. Other social marketing campaign activities for FY 2010 will focus on getting African Americans and MSMs who do not know they are HIV positive tested and linked to medical care and health-related support services. Additional research will be conducted with Spanish-dominant populations in the Austin TGA, in order to develop strategies to better reach them with HIV testing and care messages.

**Test Austin Initiative**

An HIV testing campaign has been developed in collaboration with the A/TCHHSD Communicable Disease Unit (CDU). *Test Austin* is an initiative to test as many individuals as possible in a focused period of time. For the pilot event, SOSM was employed to assist with the planning and media campaign. The campaign was highly publicized on radio, television, local newspapers and media outlets with a race/ethnic minority focus. Twenty dollar gift card incentives were used to entice individuals to take advantage of the services.

The highlight of the campaign was a walk-in testing event at the RBJ Health Center conducted on December 21 with the support of Sexually Transmitted Infection (STI) Clinic staff. During the one-day *Test Austin* event, 152 individuals tested for HIV and STIs. One new and two previous HIV positives were identified and interviewed by DIS staff on site. During the time of the *Test Austin* campaign, from December 14 to December 31, excluding the December 21 event, 91 more individuals were tested for HIV. From these, two new HIV positives were identified. All have been notified and are being referred for care. This highly successful program will be replicated during FY 2010.

**Opt-Out Testing**

In FY 2010, the local network of FQHCs, CommUnityCare, began implementing CDC-recommended opt-out HIV testing, a project funded by the Travis County Healthcare District (Central Health). CommUnityCare has over 50,000 patients; nearly 2,000 of those patients are at the David Powell Community Health Center and already have a diagnosis of HIV or AIDS. Of the remaining patients, 30,000 are between the ages of 18 and 64. This screening approach could identify several hundred currently high risk unaware HIV positive patients.

Using demographic and surveillance data and information from HIV testing programs, three clinics were identified as the pilot sites. These clinics have a high percentage of Hispanic and African American patients, two populations that are disproportionately HIV-infected in the Austin TGA (see Demonstrated Need Section, p. 5).

CommUnityCare will be using a mix of testing types including send-out HIV lab testing when screening for other chronic diseases and rapid testing at locations serving a transient population such as the Austin Resource Center for the Homeless (ARCH). Initial education has been given to the staff and providers at the pilot sites with more in-depth education scheduled over the next two months. All staff will be educated on the program to ensure a consistent message that this is a screening program, just like cholesterol or diabetes, and not a targeted testing. Targeted testing can, however, be ordered by any provider at any time.

In FY 2010, the A/TCHHSD's STI Clinic will continue its successful HIV opt-out testing program. In the most recent six month period for which data are available, 5,171 persons were tested for STIs at the clinic. Of those, 5,091 consented to an HIV test.

**2a.(5) Description of how EIIHA activities and strategies will be incorporated into the program's Requests for Proposals (RFP's)**

For FY 2011, Planning Council has allocated funds to the Early Intervention Services (EIS) category in order to support EIIHA activities. Following review of the EIIHA Plan, Planning Council will develop directives that define a scope of work focused on one or more of the previously untested high-risk subgroups in the EIIHA Matrix. Program activities will be designed to meet specific needs of each subgroup, in order to effectively refer and link newly diagnosed HIV positive individuals to care. RFP's will also require applicants to describe how proposed program activities support EIIHA goals. The Administrative Agency will initiate a Request for Applications (RFA) procurement process in compliance with Planning Council Guidance and applicable City of Austin policies and procedures. EIS subcontractor(s) will be selected by the City on an objective basis, following review and scoring of applications based on responsiveness to the scope of work and other specific evaluation criteria listed in the RFA.

**2a.(6) Description of how ADAP resources will be considered in order to accommodate the needs of new positives**

The Planning Council has a Rapid Reallocation Policy that enables the Administrative Agent to make a timely fiscal response to an emerging need. During the fiscal year, unexpended funds can be reallocated to the Local AIDS Pharmaceutical Assistance program in order to provide rapid response to medication needs of newly diagnosed HIV-infected clients. Again in FY 2011, the City of Austin will enter into an Interlocal Agreement with the Texas Department of State Health Services (DSHS). Eligibility under this contract will be limited to HIV positive clients residing in the TGA. Based on evident need, the contract will allow the City to use Ryan White Part A funds to increase funding for essential formulary medications supplied by Texas AIDS Drug Assistance Program (ADAP). An Austin TGA representative will also attend regularly scheduled Texas HIV Medication Program (ADAP) Advisory Committee meetings regarding access related issues as well as program changes affecting clients, e.g. eligibility, formulary.

**2a.(7) Description of the role of Early Intervention Services (EIS) in this strategy**

Coordinating EIS with the other EIIHA services is a key component of the TGA's overall strategy of identifying high-risk unaware HIV positive individual and linking them to care. EIS services provided in the TGA include outreach and HIV counseling and testing.

The overall strategy will allow further coordination of prevention and testing activities with EIS and the development of more linkage agreements with key points of entry for unaware clients. The key points of entry are the public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry, and federally qualified health centers.

**2a.(8) Description of how this strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.**

The strategy addresses disparities in access and services among affected subpopulations and historically underserved communities by targeting EIIHA activities to high-risk populations in the TGA. The high-risk populations targeted are African American Women (AAW), Men who have Sex with Men (MSM), Injection and Other Drug Users (IODUs), and persons recently

released from incarceration (RR). Racial and ethnic minority populations make up a disproportionate share of IODUs and the Recently Released.

**2b. Description of plan to identify individuals who are unaware of their HIV status**
The TGA's plan to identify individuals who are unaware of their HIV status is to collaborate and coordinate with existing organizations performing EIIHA activities. These efforts will result in the development of a better-coordinated and seamless system, which identifies high-risk unaware HIV positive persons. The coordination of existing testing and outreach activities will enhance the TGA's capability of identifying all of the unaware sub-groups listed above. As mentioned earlier, the Austin Area HIV Planning Council (AAHPC) will serve as the lead organization in developing this coordinated system through the establishment of an EIIHA Collaborative. The Collaborative will be composed of representatives from the major EIIHA service providers in the TGA and will guide the development of the system.

**2b.(1-2) Austin TGA EIIHA Matrix**
The matrix lists the targeted high-risk HIV positive unaware individuals for which the overall strategy will address. The targeted sub-groups are Injection and other Drug Users (IODUs), Men who have Sex with Men (MSM), African American Women (AAW), and the Recently Released (RR). The Austin TGA's EIIHA Matrix is included as Attachment 9.

**2b.(3): Description of how the TGA's overall strategy will be customized for each sub-group in regards to IDENTIFYING HIV positive unaware individuals:**
The TGA's overall strategy and goals are general and applicable to each of the subgroups. Activities specific to achieving these goals will be based on characteristics and other high-risk behavioral factors both common and unique to each subgroup. Identification of unaware individuals in each sub-group will be customized based on their specific needs and challenges as shown by the planned activities for each group discussed below.

**2b.(4): Description of the TGA's challenges associated with identifying HIV positive unaware individuals in each sub-group**

<u>African American Women (AAW)</u>
African American Women represent a sub-group having unique challenges related to identification efforts. Confounding factors such as sexual communication barriers, self worth/self-esteem, and substance use and mental health all, to some degree, contribute to the challenge. The three (3) most prevalent challenges associated with identifying African American women unaware of their HIV status are: (1) African-American women are not comfortable openly discussing the topic of sexuality from a personal perspective; (2) African-American women possess low self worth and self-esteem issues which prohibit them from engaging in and pushing condom use; and (3) African-American women who are dealing with the use of drugs or who have a mental health impairment, mostly undiagnosed, are resistant to outreach activities and public messages that promote identification efforts.

<u>Injection and Other Drug Users (IODUs)</u>
The major challenges associated with identifying persons in this sub-group are as follows: fear of learning one's HIV status; stigma of being seen at HIV testing sites; culture and language

barriers; lack of coordination between outreach service providers; socioeconomic problems; fear of confidentiality breaches; concerns about undocumented status; lack of basic HIV education; mental illness, continued substance abuse; timely access to drug treatment and HIV primary care services.

Men who have Sex with Men (MSM)
HIV positive gay, bisexual, and other men who have sex with men, collectively referred to as MSM, make up a high proportion of infected men who are unaware of their HIV status The plan for reaching this subgroup will require activities tailored to reach the unique populations that make up this subgroup.

The major challenges associated with identifying individuals in the MSM sub-group are as follows: fear of stigma, homophobia, and discrimination; cultural and language barriers; socioeconomic status – the prevalence of HIV increases as education and income decreases; substance use, with increased risk for those who use drugs during sex; multiple sex partners, often anonymous; lack of awareness about risk of HIV infection; and high risk taking behaviors among young MSM.

Recently Released from Incarceration (RR)
The local and state penal systems do not currently support testing individuals upon entering the prison/jail system. Issues related to privacy, confidentiality, and stigma-induced reprisals have been cited as contributing factors to this challenge.

**2b.(5): Description of the TGA's essential activities which will be used to identify HIV positive unaware individuals in each sub-group**
Outreach and testing are the essential activities that will be used in the identification of HIV positive unaware individuals in each of the sub-groups. These activities are currently being provided by numerous organizations in the urban and rural areas of the TGA.

The major types of outreach activities include targeted street outreach, prison outreach, deployed case management outreach, outreach using mobile vans, and social networking. Testing activities include routine opt-out testing, anonymous testing and confidential testing. Other essential activities are listed in Section **2b.(5)a** below. The specific sub-group(s) impacted by the activity will be shown in parentheses.

**2b.(5)a: Description of the TGA's essential activities which can be implemented immediately to identify HIV positive unaware individuals in each sub-group**
The following essential activities can be implemented immediately

1. Complete Inventory of EIIHA Services and Identification of Service Gaps **(All Sub-Groups)**
2. Identification of EIIHA Collaborative Members **(All Sub-Groups)**
3. Continue current outreach and testing initiatives **(All Sub-Groups)**
4. Continued funding of Part A EIIHA Outreach Services **(All Sub-Groups)**
5. Continued funding of Part C Early Intervention Services **(All Sub-Groups)**
6. Begin collaboration and coordination with EIIHA Outreach and Testing Service Providers **(All Sub-Groups)**
7. Facilitate Quarterly EIIHA Collaborative Meeting **(All Sub-Groups)**

8. Explore the possibility of using FY2010 MAI funds to create/identify a program that links unaware PLWHA to appropriate medical care **(All Sub-Groups)**
9. Advocate for mandatory HIV testing procedures upon entering and exiting the penal system **(RR)**
10. Internet-based messaging to MSM, encouraging HIV testing and importance of knowing your status **(MSM)**
11. Encourage HIV testing among MSM at least once every twelve months, and more frequently for MSM who engage in high risk behaviors **(MSM)**
12. Increase awareness among healthcare providers of the need to provide annual HIV testing for all MSM patients, and more frequent HIV testing for minority MSM who are more likely to be infected and unaware of their status **(MSM)**
13. Targeted HIV awareness micro-campaigns within the MSM subgroup **(MSM)**
14. Develop a collaborative relationship w/key officials working in the local and state penal system **(RR)**
15. Establish a grassroots advocacy group to bring awareness to the importance of HIV testing in jails/prisons. **(RR)**
16. Update and publish a new Resource Guide that contains relevant resources for the prisoner/jail population **(RR)**
17. Create a list of jails/prisons in the TGA and provide with Resource Guides in bulk **(RR)**

**2b.(5)b: Description of TGA's essential activities which are proposed but can not be implemented immediately to identify HIV positive unaware individuals in each sub-group**
Following is a list of essential activities which are proposed but can not be implemented immediately.

1. Update Comprehensive Plan to include specific achievable coordinated activities, deliverables, and timeline related to the identification of HIV positive unaware individuals, making them aware of their HIV positive status, and linking them to care **(All Sub-Groups)**
2. Complete feasibility study of using peers in outreach programs **(All Sub-Groups)**
3. Seat HIV Partner Notification and Prevention Specialist on the Planning Council**(All Sub-Groups)**
4. Implement parent circles to help women educate their children on topics of sexuality and HIV. **(AAW)**
5. Design social media websites targeting AAW: Face book, Twitter, etc. **(AAW)**
6. Develop cultural and linguistic competency training for non-HIV service providers who are likely to have frequent contact with the MSM subgroup **(MSM)**
7. Convene a community discussion series on relevant AAW topics **(AAW)**

**2b.(5)bi.: Description of the TGA's timeline associated with implementing essential activities**
Essential activities #1-17 will be implemented in FY2011. Essential activities which are proposed but can not be implemented immediately (1-7) will be developed in FY2011 and initiated in FY2012

**2b.(5)bii.: Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline**
The AAHPC, the Grantee, and the EIIHA Collaborative will jointly be responsible for ensuring that the essential activities are implemented according to the timeline.

**2c. Description of the TGA's Plan to Inform Unaware Individuals of Their HIV Status**
The TGA's plan to inform unaware individuals of their HIV status is to use existing methods and service providers. Coordinating activities among these providers is expected to increase the number of clients informed of their status.

**2c.(1): Description of how the TGA's overall strategy will be customized specific to INFORMING each sub-group of their HIV status:**
The TGA's overall strategy and goals for informing are general and applicable to each of the subgroups. Activities specific to achieving these goals will be based on characteristics and other high-risk behavioral factors both common and unique to each subgroup. Informing unaware individuals in each sub-group will be customized based on their specific needs and challenges as shown by the planned activities for each group discussed below. Coordinating and collaborating with existing organizations will enable more clients to be informed of their status.

**2c.(2): Description of the TGA's challenges associated with informing HIV positive unaware individuals of their status (including any local legislation or policies)**
The major challenges associated with informing all of the sub-groups of their status are as follows: busy practice environments; length of time to confirm test results; getting all sub-groups to return to get results; anonymous testing policies; privacy and confidentially issues; and language and cultural barriers. Other challenges are the inability to follow-up with the sub-group populations through traditional communication means, due to disconnected home phones, inactive cell phones, and issues related to the transient nature of the individuals. Unstable housing is also a constant challenge.

**2c.(3): Description of the TGA's essential activities which will be used to inform HIV positive unaware individuals of their status**
The essential activity to inform each of the targeted sub-groups of their HIV status is to use the existing methods and organizations. Most of the organizations provide testing in publicly-funded sites. These sites include health care settings (such as ATCHHSD public health department clinics, drug treatment facilities, family planning clinics, prenatal clinics, STD clinics, community health clinics) and non health care settings (counseling and testing sites, support services providers). After test results are received, trained personnel at testing sites will continue to inform individuals of their results.

**2c.(3)a: Description of the TGA's essential activities which can be implemented immediately to inform HIV positive unaware individuals of their status**
The following essential activities can be implemented immediately.

1. Ensure that Counseling and Testing staff are culturally and linguistically competence **(All Sub-Groups)**
2. Continue Protocol-Based Prevention Counseling and Testing services **(All Sub-Groups)**
3. Continue Comprehensive Risk Counseling Services(CRCS) **(All Sub-Groups)**

4. Ensure that organizations providing counseling and testing activities meet CLAS standards **(All Sub-Groups)**
5. Ensure that privacy and confidentially laws do not become barriers to informing sup-group populations of their HIV Status **(All Sub-Groups)**
6. Expand Rapid Testing Initiatives **(All Sub-Groups)**
7. Develop a centralized and progressive communication system to inform (e.g. step 1-call, step 2-visit, etc.) **(All Sub-Groups)**

**2c.(3)b: Description of the TGA's essential activities which are proposed but can not be implemented immediately to inform HIV positive unaware individuals of their status**

1. Research and determine the feasibility of implementing the Louisiana Public Health Information Exchange (LaPhie) model in the FQHCs **(All Sub-Groups)**
2. Research and determine the feasibility of using peers to assist in informing individual in each sub-group of their HIV status **(All Sub-Groups)**
3. Expand the number of counseling and testing sites and ensure staff are thoroughly trained in laboratory procedures, interpreting preliminary results and reporting results **(All Sub-Groups)**

**2c.(3)bi.: Description of the TGA's timeline associated with when essential activities will be implemented**

Essential activities #1-7 will be implemented in FY2011. Essential activities which are proposed but can not be implemented immediately (1-3) will be planned in FY2011 and initiated in FY2012.

**2c.(3)bii.: Description of parties responsible for ensuring each of the essential activities are implemented according to the timeline**

The AAHPC, the Grantee, and the EIIHA Collaborative will jointly be responsible for ensuring that the essential activities are implemented according to the timeline.

**2d. Description of plan to REFER unaware individuals of their HIV status to care**

The plan to refer high-risk HIV positive individuals to care takes a variety of forms depending on the needs of the newly diagnosed client. In the Austin TGA, the majority of referrals into medical care or other HIV support services are done through its case management system. HIV counseling and testing staff, client advocates and non-medical case managers provide advice and personal assistance in referring to medical and support services.

**2d.(1): Description of how the TGA's overall strategy will be customized specific to referring each sub-group to care:**

The TGA's overall strategy and goals for referring are general and applicable to each of the subgroups. Activities specific to achieving these goals will be based on characteristics and other high-risk behavioral factors both common and unique to each subgroup. Referring unaware individuals in each sub-group will be customized based on specific needs and challenges as shown by the planned activities discussed below. The coordination of existing activities and the collaboration with existing organizations will enable the TGA to achieve its goals.

**2d.(2): Description of the TGA's challenges associated with referring HIV positive unaware individuals to care (including any local legislation or policies)**
The major challenges in referring all sub-groups to care include: lack of transportation; lack of a coordinated referral system, overcoming fear; lack of language skills; lack of knowledge regarding the HIV treatment and care system; lack of knowledge regarding the drug treatment system; and lack of knowledge concerning cost of care.

**2d.(3)a: Description of the TGA's essential activities which can be implemented immediately to refer HIV positive unaware individuals of their status**
The essential activities which will be used to refer HIV positive unaware individuals to care are listed below. Some of the activities are designed to improve the overall system while other center on addressing client barriers to being referred.

1. Coordinate and standardize the referral process at all case management service providers **(All Sub-Groups)**
2. Coordinate the referral process at correctional institutions **(RR)**
3. Initiate HIV/AIDS stigma reduction activities **(All Sub-Groups)**
4. Initiate social marketing campaign plan**(All Sub-Groups)**
5. Ensure that services are available and accessible **(All Sub-Groups)**
6. Increase service provider knowledge **(All Sub-Groups)**
7. Educate all sub-group populations on the availability of HIV care and drug treatment programs **(All Sub-Groups)**
8. Educate all sub-group populations on the cost of care and treatment **(All Sub-Groups)**
9. Create a survey tool to assess healthcare provider preferences **(All Sub-Groups)**
10. Develop memorandums of understanding between referral organizations **(All Sub-groups)**

**2d.(3)b: Description of the TGA's essential activities which are proposed but can not be implemented immediately to refer HIV positive unaware individuals to care**
The following proposed activity will not be immediately implemented
1. N/A

**2d.(3)bi.: Description of the TGA's timeline associated with when essential activities will be implemented**
Essential activities #1-10 will be implemented in FY2011.

**2d.(3)bii.: Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline**
The EIIHA Collaborative, Grantee, and AAHPC will be jointly responsible for ensuring that essential activities are implemented according to the timeline.

**2e. Description of the TGA's plan to LINK unaware individuals to care**
The plan for linking all of the sub-groups to care will be done by utilizing the TGA's case management system operated by existing service providers. Linkage to care will continue to be facilitated through the case management/care coordination system.

**2e.(1): Description of the TGA's essential activities that will be used to link HIV positive unaware individuals to care**

Case management and care coordination activities are the essential activities which will be used to link all of the sub-group individuals to care. These activities will be provided by utilizing the TGA's existing service providers. Other essential activities are discussed below.

**2e.(1)a: Description of the TGA's current activities used to link HIV positive unaware individuals to care**

Individual service and treatment plans are the vehicles used to direct client's linkage to primary medical care. These plans identify and address possible barriers to care and treatment. For the IODUs sub-group, substance abuse counselors monitor client adherence to both psychiatric and medical treatment. Treatment plans are updated every six months so that a client's successes and challenges can be easily addressed in a timely manner.

Substance abuse counselor conducts a monthly caseload review to ensure that clients are maintaining regular attendance at appointments and following their treatment plans. Education about medical care and adherence are a regular part of substance treatment programming. Treatment staff confers on a regular basis with both the program's Psychiatrist and the client's primary medical care providers in order to monitor adherence to treatment regimens.

The other sub-group individuals are linked to care by case managers/care coordinators via development of service plans. They assist clients in accessing HIV primary care and support services and work closely with the clients to ensure continuity of care. Case managers the rural areas of the TGA complete clinical intakes for all clients who are being referred to the David Powell Community Health Center in Austin.

They also access records from previous medical providers in order to build and understand a client's medical history. Follow up with clients after each medical appointment is another activity which case managers engage in. They obtain physician notes to assess changes in the client's health and keep these notes in the case file, and enter appropriate information into the ARIES data base. Client advocates and non-medical case managers provide advice and personal assistance in obtaining medical and support services. This can include accompanying clients to case management and medical appointments.

**2e.(1)b: Description of the TGA's proposed activities to link HIV positive unaware individuals to care**

The activities below are proposed and will enhance linkage to care activities

1. Coordinate services required to implement service plans by referring clients to appropriate resources and ensuring resource linkage **(All Sub-Groups)**
2. Ensures linkage by educating clients about eligibility criteria and process **(All Sub-Groups)**
3. Assisting in completion of applications **(All Sub-Groups)**
4. Advocating on the client's behalf **(All Sub-Groups)**
5. Following up on referrals to monitor client progress and address barriers, as needed **(All Sub-Groups)**

6. Research and determine if ARIES can be used to enhance the linkage to care process **(All Sub-Groups)**
7. Continue funding case management/case coordination activities in the TGA **(All Sub-Groups)**
8. Coordinate service provider linkage to care activities **(All Sub-Groups)**

**2e.(1)bi.: Description of the TGA's timeline associated with when essential activities will be implemented**
All essential activities will be implemented in FY2011.

**2e.(1)bii.: Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline**
The EIIHA Collaborative, Grantee, and AAHPC will be jointly responsible for ensuring that essential activities are implemented according to the timeline.

**2e.(2): Description of the activities undertaken (post-referral) to verify that care/services were accessed for newly identified HIV positive individuals**
All newly identified HIV positive individuals undergo agency intake and assessment procedures. Case management staff verifies access to services by confirming appointments were kept when meeting with clients and also following up with care/service provider agencies to confirm.

**2e.(2)a: Description of current activities**
During this process, clients sign a document allowing the agency to share or not to share their information with other agencies providing HIV services. Client level services data are entered into ARIES. If client agrees to share information, agency staff can use ARIES to verify access to medical or support services electronically. If clients do not agree to share information, they are required to get referral service providers to sign forms documenting receipt of services. These forms are returned to the referring service provider.

**2e.(2)b: Description of proposed activities**
The TGA will investigate the use of case coordinators or peers as members of a care coordination team who would assist clients in keeping appointments and in the verification of care.

**2e.(2)bi.: Description of the TGA's timeline associated with when essential activities will be implemented**
The essential activities described above will continue to be provided in FY 2011 and thereafter.

**2e.(2)bii.: Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline**
The AAHPC, grantee, and the EIIHA collaborative will ensure that the essential activities will be carried out according to the timeline.

**2e.(3): Description of the activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed care post-referral**

TGA service providers have developed working relationships with private care providers over the years. These relationships have enabled providers to refer clients to care and receive information on the care received by clients.

**2e.(3)a: Description of current efforts**

Case managers in the TGA have developed relationships with the Blackstock Clinic, local hospitals, physicians in private practice serving individuals with HIV, and correctional facilities. Blackstock is the largest private clinic providing primary medical care to HIV positive individuals in the area. Currently, the relationships are informal and verification that services have been accessed is intermittently collected.

**2e.(3)b: Description of proposed efforts**

The EIIHA Collaborative will target more participation from private sector organizations and private practices to expand the TGA's ability to identify and link more HIV positive unaware individuals into care and to obtain verification that service was accessed by patients referred for care. A plan to hold a CME training for medical providers on HIV care will be planned in collaboration with the Texas/Oklahoma AIDS Education and Training Center and will include information on patient referral and follow-up.

**2e.(3)bi.: Description of the TGA's timeline associated with when essential activities will be implemented**

Initiation of more private sector participation will begin in FY2011.

**2e.(3)bii.: Description of parties responsible for ensuring each of the essential activities is implemented according to the timeline**

The EIIHA Collaborative, Grantee, and AAHPC will be jointly responsible for ensuring that essential activities are implemented according to the timeline.

**2e.(4): Description of the efforts to remove legal barriers, including State laws and regulations, to routine testing**

There are not any efforts to remove legal barriers, including State of Texas laws and regulations, to routine testing. The State of Texas' rules and regulations are conducive to implementing routine testing. The only barriers are funding and sustainably of existing initiatives.

**2) f. Data**

Table A on the following page shows the estimated number of HIV positive individuals unaware of status, the number of HIV tests conducted, and HIV test results by number and percentage.

**(1-2) Table A: Estimated number of HIV positive individuals unaware of status, number of HIV tests conducted, and HIV test results by number and percentage**

| Number Living and Undiagnosed | | Value | | Data Source(s) |
|---|---|---|---|---|
| A. | Number of persons living with HIV/AIDS (PLWH/A), as of 12/31/2008 | 4,214 | | eHARS, cases living on or before 12/31/2008; cases in Texas Department of Criminal Justice removed. |
| B. | (1) Estimated number PLWH/A who were unaware of their status as of 12/31/2008 | 1,120 | | Estimated Back Calculation (EBC) Methodology applied to number of PLWH/A as of 12/31/2008. |
| **Number Tested, Total and by Results and Informed Status** | | **Value** | **%** | **Data Source(s) and/or Calculation** |
| C. | (2) Total number of HIV tests conducted using local, state, and federal funds as of 12/31/2009 | 15,464 | | DSHS, includes both Routine and Targeted testing. |
| D. | (2)(a) Of total number tested, number and percentage informed of HIV status | 12,985 | 84.0% | Value: DSHS, includes both Routine and Targeted testing. Percent: Value D/Value C. |
| E. | (2)(a)i) Of tested and informed of HIV status, number and percentage of HIV positives | 124 | 1.0% | Value: DSHS, includes both Routine and Targeted testing. Percent: Value E/Value D. |
| F. | (2)(a)i)a. Of number informed of HIV positive status, number and percentage referred into care | 43 | 58.9 | Value: DSHS, includes Routine testing only. Percent: Routine Testing number of positives referred to care/Routine Testing number of positives = 43/77. |
| G. | (2)(b) Of total number tested, number and percentage not informed of HIV status | 1,764 | 11.4% | Value: DSHS, includes both Routine and Targeted testing. Percent: Value G/Value C. |
| H. | (2)(b)i) Of tested but not informed of HIV status, number and percentage of HIV positives | 6 | 0.3% | Value: DSHS, includes both Routine and Targeted testing. Percent: Value H/Value G. |
| I. | Total number of HIV positives | 130 | 0.8% | Value: Value E + Value G. Percent: Value I/Value C |

Source: *Texas Department of State Health Services (DSHS), 2010.*

3) **Description of how data impact the Quality Management Plan**

The data shown above will impact the Austin TGA's Quality Management Plan with the challenge of maintaining high quality HIV primary medical care while expanding capacity to

meet the care needs of the newly diagnosed. Opt-Out Testing is a local initiative to increase the number of emergency departments and primary care clinics that adopt routine, opt-out HIV testing. The local network of federally qualified health centers (FQHCs) has over 50,000 patients; 30,000 are between the ages of 18 and 64. Of the estimated 1,120 PLWH/A living in the TGA who were unaware of their status as of 12/31/2008, a significant number may be identified during FY 2011, when efforts to test and link HIV positives to care will be greatly accelerated. To help maintain quality care, the Grantee is preparing to respond, as needed, by increasing the capacity of the current HIV primary care provider, procuring other providers, and/or developing a Care Coordination Team consisting of medical case managers, non-medical case managers, and services linkage workers. Another impact to the Quality Management Plan is the need to develop new service delivery standards for EIIHA Plan activities that will be funded by Ryan White Part A, including MAI.

Quality improvement initiatives will be developed as necessary to address performance issues in areas identified through data reporting and based on progress meeting relevant, evidence-based benchmarks. As an example, no show rates for HIV test result appointments greater than 10% may require a Plan, Do, Study, Act improvement plan.

## 3) Access to HIV/AIDS Care and the Plan for FY 2011

### 3) a. The EMA/TGA Established Continuum of HIV/AIDS Care and Access to Care

### (1) Description of the TGA continuum of care for FY 2011

The current system of care in the Austin Transitional Grant Area (TGA) is driven and supported by what is termed the pillars of "Access" and "Address." The pillar of "Access" establishes mechanisms that promote the availability of affordable and equitable healthcare for newly affected and underserved populations, thereby leveling the healthcare playing field. Likewise, the pillar of "Address" provides a systematic approach that takes into account the service needs of special populations, including communities of color who are disproportionately impacted, MSM, emerging populations, and out-of-care individuals who know their HIV status. Together, the two 'pillars' provide a deliberately constructed framework that facilitates the continuum of care's affect in producing maximum health outcomes for all clients.

Established through the provision of high quality, coordinated services, the foundation of the Austin TGA care system is characterized by sustainability and growth. This structured system is built to effectively accommodate the varying treatment, care, and supportive needs of eligible PLWH/As. A strategically developed care system comprised of appropriate core and support services is the hallmark of HIV/AIDS service delivery in the Austin TGA. Nearly 3,000 people living with HIV/AIDS are maintained in a system of care where specific service needs are met. Of this number, over 15% of clients are new to the care system, having been afforded an opportunity to access care, as barriers to care have been reduced or fully eradicated.

Key components of the Austin TGA's continuum of care are discussed below:

Integration and Coordination of Other Available Services or Programs with Part A Funded Services

In order for a care system to be constructed with supporting pillars that increase accessibility and address special service needs, as well as one that provides a foundation of quality services, it must be supported with reliable and diversified resources. While the Austin TGA care system relies primarily on Part A funds, a significant amount of support is derived from other federal, state, and local funding sources. This integration and coordination of Part A funded services with other services and programs contributes to the viability and strength of the continuum of care. By filling in funding and service gaps, complementary services ensure that the needs of those currently in care are met, while the needs of those newly infected, underserved, hard-to-reach, and emerging are also addressed. For more information on coordination of resources, see the Demonstrated Need section, p. 9.

Mechanisms that Enable Newly Infected, Underserved, Hard-to-Reach, Emerging and/or Disproportionately Impacted Communities of Color to Access and Remain in Primary Medical Care

A collaborative project of the Planning Council and the Black Faith-based Health Initiative, entitled "Lift Up A Standard," is designed to engage hard-to-reach African Americans in care by

communicating through local churches and faith-based organizations. "Lift Up A Standard" is a series of discussion forums that address the topic of HIV in the African American community. Through the project, information related to the epidemic and how to access services in the Austin TGA are offered. Similarly, information is gathered from the African American community about how to provide better access and care to African Americans living with HIV/AIDS. Covering five counties in the area, the discussion series is pivotal in laying a foundation for the development of local public/private strategies in increasing access to and retention in care.

The David Powell Community Health Center (DPCHC) provides primary medical care on an outpatient basis to approximately 2,000 HIV positive residents of the Austin TGA. DPCHC works with MAI program non-medical case managers and outreach services providers who target HIV-infected African Americans and Latinos. MAI non-medical case managers may accompany patients to their medical visits, and provide transportation. In another initiative, DPCHC is improving coordination between both the state and local criminal justice systems so that HIV infected patients will have improved access to care and HIV medications. A DPCHC physician will provide pre-release services at the Del Valle Correctional Center and act as a liaison between the jail medical staff and DPCHC providers.

The DPCHC has identified a need to engage patients lost to care. Approximately 300 of 2,000 patients at the clinic fail to return to the clinic for care each year. DPCHC has successfully developed a program to assess the status of each client and to identify and re-engage those patients who have dropped out of care. A process has been implemented to refer these patients to Medical Case Managers throughout the system for contact and re-entry into care. A multidisciplinary, cross-agency team is engaged in this effort. Another project underway in conjunction with this effort is the identification and quantification of reasons patients were lost to care. This information will be useful going forward to develop strategies to reduce the lost-to-care rate.

Diversity of race/ethnicity, age, gender, and sexual orientation throughout the system of care lends itself to establishing and maintaining relationships in which PLWH/A feel safe, comfortable, and empowered to take part in their own medical care, thereby leading to increased treatment adherence. DPCHC medical providers, pharmacy staff, and social services staff offer a variety of backgrounds and skills that enhance patient care. Because the Austin area has a significant number of residents who read, write, and/or speak only Spanish, DPCHC has successfully recruited Spanish-speaking providers, nurses, social workers, behavioral health consultants, lab technicians, pharmacists, and administrative staff. The clinic also has access to a translation service via telephone that provides real-time translation in dozens of other languages in order to assist in the interaction between patients and staff.

AIDS Services of Austin's (ASA) Jack Sansing Dental Clinic, the sole provider of dental services specifically for PLWH/A in the TGA, has experienced a number of new oral health care patients with devastated dentition and a history of little or no prior dental care. Retention in care is maximized by offering appointments that accommodate patients' schedules and transportation needs. To make this possible, the dental clinic has coordinated with transportation services in order to accommodate underserved patients, particularly those from outlying areas. A reminder appointment card is given at clinic departure, and reminder phone calls are made prior to the next

appointment date. Patients are provided with culturally and linguistically appropriate educational information and print materials concerning the importance of oral health in their overall health and well being.

In order to increase access to care, the dental clinic offers a one-hour open slot during the early afternoon four days a week. Patients may walk-in for treatment services rather than schedule an appointment, which facilitates access to treatment. A dentist triages walk-in patients, and patients are seen based on the urgency of their condition. In another access option, patients may wait at the clinic to see if an appointment slot opens up due to late cancellations or no-shows. Those who decide not to wait are scheduled with an appointment, usually in the next day or so. This open scheduling method has improved access to care for vulnerable populations, and the quality of care for those with urgent oral health care needs.

The Austin TGA continues to expand its horizons when it comes to issues relating to access to care. An HIV Social Marketing Campaign to target populations including MSMs of all races/ethnicities and ages, and African American men and women, is mobilizing stakeholders to reach the following goals: 1) increase awareness of HIV risk, importance of knowing HIV status, and benefit of accessing medical care and treatment; and 2) promote HIV testing and early intervention and treatment using four implementation strategies:

Strategy 1: Brand a City initiative – HIV/AIDS Free Austin
Strategy 2: Coordinate HIV/AIDS service providers around brand
Strategy 3: Initiate outreach and education campaign to non-HIV and social service providers
Strategy 4: Prioritize and initiate micro-campaigns such as radio spots, and informational brochures

For the past two years, the MAI Program has operated under a newly developed system which includes activities provided in two service categories: Outreach and Non-Medical Case Management. MAI clients are engaged in the HIV/AIDS system of primary care and social support services with the following MAI objectives:

- Reduce barriers to African American and Latino PLWH/A remaining in the system of medical care;
- Increase the number of African American and Latino PLWH/A who enter medical care;
- Reduce the number of African American and Latino PLWH/A who drop out of the system of care.

**3) b. Table: FY 2011 Implementation Plan**

The TGA's FY 2011 Implementation Plan in table format is located in Attachment 7. The table lists the four core medical services and two support services categories with the highest amount of funding for FY 2011. An overall goal and a time-limited, measurable objective are listed for each service priority. Additionally, service unit definitions, number of persons to be served, units of service to be delivered, and the estimated cost of meeting the objective are also listed. Eighty percent (80%) of the planned allocations are for core medical services. Planning Council created two subcategories for Non-Medical Case Management. The first, Tier 1 (Service Priority 1), is psychosocial case management that may include initial screening, development of a service plan, coordination of services, assessing efficacy of the plan, and periodic plan updates. The

second subcategory, Tier 2 (Service Priority 4), is the provision of advice and assistance in obtaining needed services. It does not involve coordination of and follow-up on medical treatments, but may include coordination with Tier 1 case managers.

**3) c. Narrative**

**(1) Narrative based upon the FY 2011 Implementation Plan**

(a) Connections between Needs Assessment, Comprehensive Plan, service priorities, and the FY 2011 Implementation Plan

The FY 2011 Plan is designed to support the continuum of care discussed above with Part A funding for the six service categories listed and other core medical services not listed. Funding emphasis is placed on four core medical service categories: (1) Outpatient/Ambulatory Medical Care; (2) Oral Health; (3) Local AIDS Pharmaceutical Assistance; and (4) Mental Health. Two support services also are addressed: (1) Case management – non-medical; and (2) Substance abuse - residential. These support services facilitate access and continued engagement in medical care, thus ensuring maximum health outcomes.

Altogether, the highest funded core and support services listed in the implementation plan are consistent with goals outlined in the Austin TGA's current Comprehensive Plan, as well as with findings from a recently conducted Comprehensive Needs Assessment. For example, contained within the Comprehensive Plan are specific goals and objectives developed by the Planning Council to ensure the availability of quality core and support services to eliminate disparities in access for disproportionately affected sub-populations and historically underserved communities. FY 2011 funding decisions reflect an increase in non-medical case management from the previous year, based in part on the service needs identified by a significant number of surveyed minority respondents in the 2010 Comprehensive Needs Assessment project. This component of the plan was developed to ensure increased access to the HIV continuum of care for special populations, including minority communities where HIV prevalence has disproportionate impact.

(b) Prioritized Core Medical Services not Funded

Based on the Planning Council's priority setting and resource allocations process, there were no services in the top 20 priorities that were not funded for FY 2011. Only two (2) core services in the top 27 priority listing (home health, ranked #23; home and community based health, #21) were at zero funding. Both of these services were identified as being sufficiently funded through public and private insurance options.

(c) Increased Access to the HIV Continuum of Care for Minority Communities

The Austin TGA's high HIV prevalence rate in minority communities creates a profound and disproportionate affect on those living with HIV/AIDS. The specific issues and burdens faced by minority communities are detailed in the Demonstrated Need section, beginning on page 13. The FY 2011 Plan is designed to increase access to the HIV continuum of care for minority communities through the TGA's Minority AIDS Initiative (MAI) programs and through the activities outlined in the Comprehensive Plan. Findings from the Comprehensive Needs Assessment and subsequent recommendations also inform the FY 2011 Plan regarding access. For example, Psychosocial Support was identified in the Needs Assessment as a support service among African Americans that would enable them to access and stay in care. In response, the

Planning Council has ensured that the function of support is delivered through psychosocial support groups. Similarly, MAI funding resources and activities target two minority populations: Latino and African American. These two communities are found to have a higher burden of poverty, are reluctant to enter the system of care, and prone to fall out of medical care if not provided with extensive support services and personal intervention. Immigrant Latino clients face immigration issues and language barriers in accessing services. Furthermore, African Americans in the TGA have a higher proportion of substance use issues than other racial/ethnic groups.

(d) Emerging Populations

The needs of the following priority populations were examined in the Comprehensive Needs Assessment: African American men and women, Latino men and women, injection drug users, non-injection drug users, the out-of-care population, White men who have sex with men, (MSM), Men of color MSM, persons recently released from jail/prison, rural residents, and youth. The FY 2011 Plan focuses on unmet need and service gaps for the following six populations: 1) injection drug users, 2) substance users other than injection drug users, 3) Men of Color MSMs, 4) White MSMs, 5) African American women, and 6) persons recently released from jail/prison. Each population represents unique challenges that must be addressed in order to improve HIV health outcomes.

An additional initiative currently being undertaken by the Planning Council is a strategic planning effort among community stakeholders, particularly those working in the HIV prevention arena. The purpose of the strategic planning is to address health disparities in the minority community. The goal is to ultimately develop and implement evidence-based strategies, consistent with those listed in the National HIV/AIDS Strategy, in the Austin TGA.

(e) Remaining in Primary Medical Care

The Planning Council identified two services as key to ensuring PLWH/A remain engaged in primary medical care and adhere to HIV treatments:

*Medical Case Management including Treatment Adherence Services*

The Care Strategy Committee first designated Medical Case Management, along with treatment adherence, as an "essential" service category which promotes the likelihood of PLWH/A remaining in primary medical care. The Planning Council continues to recognize that treatment adherence services are crucial for successful antiretroviral treatment and the subsequent improved health outcomes including improved CD4 cell count, viral load suppression, and reduced risk of developing drug-resistant virus. The increasing complexity of primary care for PLWH/A means that there is less time in primary care visits to address issues such as treatment adherence and therefore the provision of treatment adherence counseling by medical case managers becomes more critical.

*Local AIDS Pharmaceutical Assistance*

Clients who are out of care and attempting to enter or re-enter the care system face many challenges in obtaining antiretroviral medications. In the HIV Needs Assessment, survey respondents were asked to rate the services based on their "importance to you." Drug reimbursement/pharmaceutical assistance was the fourth most important service identified:

- Among in-care consumers, the seventh most frequently identified need and the sixth most frequently identified unfulfilled need;

- Among African-American women and women of childbearing age, the fourth most frequently identified unfulfilled need; and
- Among White MSM, the fifth most frequently reported need.

The allocation to Local AIDS Pharmaceutical Assistance was first increased in the Austin TGA in FY 2009, with the increase sustained in FY 2010. For the current funding year, FY 2011, the allocation pattern continues as in previous years. This consistency in funding for local AIDS Pharmaceutical Assistance is allowing the Planning Council to track utilization trends and, subsequently, respond to the needs of PLWH/A.

(f) Parity of HIV Services

The plan addresses parity of HIV services in several ways. First, geographic parity is addressed by continuing to give priority for funding to providers located in heavily impacted areas. Households receiving public assistance and with high rates of poverty and unemployment are heavily concentrated in tracts east of Interstate-35, south of the Colorado River, and surrounding the University of Texas campus. The majority of residents in these neighborhoods are African American and Latino. All of the Ryan White Part A service providers in Travis County are located within these geographic areas. Secondly, parity in quality of services is addressed by establishing quality of care guidelines and examining research on quality of care issues that impact special populations. The Planning Council received research reports on physician to patient ethnic concordance and quality of care, the impact of treatment adherence programs on quality of care, and the impact of cultural competency training on quality of care. The Planning Council used these reports in determining service and funding priorities to establish the 2009-2011 Comprehensive Plan goals and objectives. Thirdly, the comprehensiveness of services is addressed in the continuum of care model, which links all services in a manner that brings people into primary care and maintains them in care. It categorizes services based upon how they serve the specific needs of clients, particularly those out-of-care.

(g) Culturally and Linguistically Specific Services Delivered by Subcontractors

The Planning Council strives to meet the challenges posed by populations with special cultural or linguistic needs by establishing a system which effectively addresses and eradicates existing barriers to care. Primarily accomplished through the work of the Planning Council's re-established Community Access and Care Strategy Committees, services are assessed and studied through client surveys and public forums hosted by the Planning Council. The committees' joint responsibilities include: investigating out-of-care issues, documenting barriers to care, documenting special needs such as cultural proficiency issues, and working with the Quality Management Coordinator to study standards of care and other issues. The Planning Council's goal is to attain a high level of cultural proficiency reflective of the composition of the communities served. In order to achieve this level, there is ongoing review and revision of cultural competency, sensitivity, and proficiency standards that govern the provision of services funded by Ryan White Part A. Subcontractors' staffs are also required to participate in annual Cultural and Linguistic Competency training.

(h) Comparison Healthy People 2010 and FY 2011 Implementation Plan Goals

The Planning Council has identified the following two overarching goals in its Comprehensive Plan:

- GOAL 1: a) To engage out-of-care persons living with HIV/AIDS (PLWHA) and maintain in-care PLWHA in the system of care by providing full access to medical care and other eligible core service; b) Administration of care shall focus on cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard to reach populations.
- GOAL 2: a) To optimize the continuum of care by ensuring all Ryan White funded services, particularly mental health therapy and substance abuse treatment, are of the highest quality; and b) coordinated with non-Ryan-White organizations for linkage to other funding sources.

These two overarching goals address the service needs, gaps, and barriers to care consistently identified in previous needs assessments, as well as in the current Comprehensive Needs Assessment. In order to reach each goal, a comprehensive list of objectives is included in the Comprehensive Plan. Each objective has long and/or short term activities, action steps, strategies, or initiatives designed to maintain and improve the TGA's system of HIV care. Finally, the FY 2011 Implementation Plan goals and objectives are responsive to the Healthy People 2010 Objectives for HIV Infection as shown in the table below.

**Table A: Relationship between Healthy People 2010 HIV Objectives and FY 2011 Plan**

| Healthy People 2010 Objectives for HIV Infection | Related Goals FY 2011 Implementation Plan |
|---|---|
| 13-1: Reduce AIDS among adolescents and adults. | Goal 1.a. & 2.b. |
| 13-2: Reduce the number of new AIDS cases among adolescents and adult men who have sex with men. | Goal 1.a. & 2.b. |
| 13-3: Reduce the number of new AIDS cases among females and males who inject drugs. | Goal 1.a., 1.b. & 2.b. |
| 13-4: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men and inject drugs. | Goal 1.a., 1.b. & 2.b. |
| 13-5: (Developmental) Reduce the number of new cases of HIV/AIDS diagnosed among adolescents and adults. | Goal 1.a. & 2.b. |

(i) Resource Allocations for Services to Women, Infants, Children, and Youth (WICY)
HIV services providers contractually are required to submit units of service delivered to WICY populations by entering data in the AIDS Regional Information and Evaluation System (ARIES). This system captures various levels of service utilization and spending data on every client served including age, gender, date of service delivery, number of units delivered, and HIV service objectives. Data show the utilization of primary medical care and health-related support services for these four specific populations. To track the amount expended, the number of actual units delivered is multiplied by the unit cost for each service objective for each WICY population. The actual amount of Part A funds expended on each WICY priority population is monitored by the Administrative Agent and reported to the HIV Planning Council and to HRSA as required in the Part A and B Ryan White HIV/AIDS Program Guidelines for Implementing the Minimum Expenditure Requirement to Provide Services to Women, Infants, Children and Youth.

(j) Use of Minority AIDS Initiative to Enhance Quality of Care

MAI-funded activities are an integral part of the overall FY 2011 Implementation Plan. The Planning Council continues to use MAI funds to support programs designed to improve client care quality and health outcomes for members of targeted minority racial and ethnic communities. African Americans and Latinos are two populations disproportionately impacted by HIV/AIDS in the Austin TGA. Quality of care can be linked to client satisfaction; therefore, to gauge the relative effectiveness of MAI-funded services, the Planning Council assigns a sub-committee or convenes an ad hoc committee to study and address results from the current year's client satisfaction survey. The two service categories focused on are outreach and non-medical case management, both of which are funded by MAI funds. Whenever appropriate, the Planning Council issues guidance about how the services are provided in order to enhance the quality of services. Quality of care standards and service category performance measures are also used to determine whether intended client health outcomes are being achieved.

(k) MAI funding to Improve Quality of Care and Client-level Outcomes

African American and Latino PLWH/A often have multiple service needs, can be reluctant to enter systems of care, and are at risk for falling out of medical care if not provided with extensive support services. Some of these clients also have substance abuse challenges, and a significant number suffer from mental health problems. To address these issues more effectively, approximately 85% of local MAI direct services funding is allocated to Non-Medical Case Management in FY 2011. Non-Medical Case Management assists clients by linking them to needed care services and other appropriate HIV support resources, including accompanying clients to medical or other appointments, and thereby improving client-level health outcomes.

(l) MAI funding to Reduce Disparities

Because traditional outreach methods have not brought significant numbers of people from the affected communities into the TGA's system of care, the remaining 15% of FY 2011 MAI direct services funding is used for targeted outreach activities which can more successfully address the economic, cultural, and linguistic challenges of racial and ethnic minority groups, including Latino and African American MSM. An additional strategy employed by the Planning Council to help reduce disparities, increase access, and improve health outcomes is the allocation of a portion of last year's resources for outreach to the Early Intervention Services (EIS) category. Funds allocated for EIS are intended to provide a broad array of activities that will effectively identify eligible PLWH/A and link them to care, thus increasing the likelihood of positive client-level health outcomes.

Finally, MAI funding will be used to reduce disparities by considering and using as a basis, specific strategies outlined in the National HIV/AIDS Strategy. As noted in the Strategy, *"there are differences in health care access and treatment outcomes by race/ethnicity . . . access to care and supportive services is particularly difficult for HIV-positive persons in rural areas."* Through the support of MAI funding, the Austin TGA plans to respond to the unique issues faced by minorities, many of them African American and Latino, by *"taking deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV."* One activity that will be pursued is a strategic capacity building effort for local gatekeepers and HIV-service providers not currently or historically funded through the Ryan White Part A Program. The goal is to reach HIV positive minorities who are out-of-care or unaware, by expanding the venues that currently exist.

## 4) Grantee Administration

### 4)a. Program Organization

Administrative Overview
The Chief Elected Official (CEO) of the five-county Austin TGA is the Mayor of the City of Austin, Texas. The Mayor/CEO has designated responsibility for all Ryan White Program Part A funds, including Minority AIDS Initiative (MAI) funds, in accordance with an Interlocal Cooperation Agreement between the City of Austin and Travis County. The City of Austin and Travis County are the only two political subdivisions in the TGA with more than 10% of the TGA's reported AIDS cases. In one provision of the Agreement, the CEO delegates Administrative Agent responsibilities for the Ryan White Program Part A, including MAI, to the Austin/Travis Health and Human Services Department (A/TCHHSD). The A/TCHHSD has designated its HIV Resources Administration Unit (HRAU) as the entity responsible for performing Ryan White Program Part A and MAI administrative functions.

The relationship of the Administrative Agent to the CEO is shown on the Organizational Chart, followed by the Staffing Plan and Personnel Requirements table which displays names, job titles, FTE allocations, job descriptions and rationale for amounts of time, education, licensure, experience and qualifications for all positions funded by Ryan White Part A including MAI (see Attachment 1). Since there are no new regular personnel in positions funded by Part A and/or MAI, biographical sketches are not required. There are no vacant positions. HRAU staff has responsibility for administering multiple HIV-related grant funds, as well as City general revenue funds for HIV-related services. These funding streams include: Ryan White Part A and MAI, Ryan White Part C, Housing Opportunities for Persons with AIDS (HOPWA), and City of Austin HIV Prevention and Care Services. The HIV Planning Council staff is responsible for supporting the Council in fulfilling its legislatively mandated roles and responsibilities including needs assessment, priority setting, planning, and resource allocation.

### 4)b.(1) Grantee Accountability Narrative

Process Used to Separately Track Formula, Supplemental, MAI, and Carry-Over Funds
The City of Austin Health and Human Services Department (City HHSD) accounting staff separately tracks formula and supplemental funds for Part A and MAI using the City's accounting system, Austin Integrated Management System (AIMS). The City Controller's Office is responsible for assigning a unique major program and program identifier number for each grant at the time of the grant budget set-up. All expenses for a particular program are posted at the program level. The budget profile includes: Fund Number, Department, Major Program, Program Number, and Program Period. Additionally, a distinctive task order number is created and set up to track grant personnel expenses for Administration, including HIV Planning Council, and for Quality Management. This allows for the tracking of formula and supplemental salary charges for each budget category. Salary expenditures are reported on a monthly accounting report. Each month, the City of Austin performs a month-end close of all expenses posted to AIMS. Departments are provided a detailed reporting of expenses posted by transaction at the program level. The monthly reports are reviewed by grant management and accounting staff prior to completion of the grant billing.

When the City's Purchasing Officer executes contracts, the contracted funds are individually encumbered and linked to the formula or supplemental fund number using the City's specific accounting profile. In addition, after contract execution, a document order is generated in lieu of a voucher, with a specific number that directly links the contract to the funding source. When a subcontractor's payment request is received, a unique number is assigned to the invoice in order to clearly link the payment request to the proper funding source.

Timely monitoring and redistribution of unexpended funds

Contract monitoring staff meets monthly to review expenditures-to-date and determine whether unexpended funds need to be reallocated, in accord with HIV Planning Council's Rapid Reallocation Policy, to services that have demonstrated a need for additional funding. When indicated, contracts are amended and the funds redistributed. At the end of the FY 2009 grant period, the Austin TGA had $116,060 in unobligated funds, primarily due to Planning Council support staff salary savings due to a vacancies and increased reimbursement by third party payors. A carry-over request was approved by HRSA; these FY 2009 funds have been redistributed and are being fully expended in FY 2010.

Fiscal and Program Monitoring Process

Administrative Agency staff performs fiscal monitoring through monthly reviews of payment requests and expenditure patterns for each subcontractor. Staff also reviews each subcontractor's annual independent financial audit to obtain an overview of the agency's financial position at the end of the most recent fiscal year. Provider site visits are performed at least annually to monitor fiscal management systems and document cost-effective performance. Staff reviews the agency's Board-approved financial policies and procedures, and ensures that subcontractors maintain an accounting system in accordance with Generally Accepted Accounting Principles (GAAP).

For FY 2010, fiscal monitoring visits to eight (8) subcontractors (100%) are scheduled for completion by January 2011, with assistance provided by a temporary employee (see Attachment 1) who will be responsible for monitoring fiscal performance and practices of subcontractors, and validating compliance with all federal, state, and local requirements. In addition, he will review and assess expenditure patterns, and conduct comprehensive fiscal monitoring in accord with the new Ryan White Fiscal Monitoring Standards. Per HRAU policy, a written report is issued to the subcontractor within 30 business days following an on-site monitoring visit. When a fiscal-related concern is identified, the report describes the finding and/or observations and includes recommendations for corrective action. The subcontractor is given 30 days to submit a written response to the monitoring report and must include a plan for corrective action. The agency is given a specified time period to implement corrective action(s). Implementation of recommended corrective action(s) is verified with a follow-up site visit. Implementation of minor corrective action(s) identified in the plan is verified no later than the next annual fiscal review. To date, fiscal monitoring has not resulted in any findings.

Program monitoring is conducted annually to ensure that service providers have systems in place to deliver high quality services in compliance with contract terms and conditions. Of particular interest during site visits is the demonstration of how services complement primary medical care

by facilitating access, encouraging adherence, and/or enhancing quality of life. Programmatic reviews address the following areas: general program expectations, intake, demographic information, eligibility, income verification, validation of client-level data in AIDS Regional Information and Evaluation System (ARIES), access to medical care, service plans, health education risk/reduction and treatment adherence, quality standards of care, and service coordination. Additionally, HRAU staff verifies compliance with Ryan White HIV/AIDS Program policies and HIV Planning Council guidance requirements.

Subcontractors are monitored to ensure compliance with program objectives including target populations, services provided, number of clients served, outcomes measured, and client-level data completeness and accuracy. During site visits, the monitoring team reviews client charts/files, interviews staff, and documents methods for collecting and reporting service outcomes. Monitors assess program operations through a review of program policies and procedures, standards of care, and the quality management plan. HRAU staff also review monthly and quarterly program performance reports and annual client satisfaction survey results.

The FY 2010 programmatic site visits to eight (8) contractors (100%) are scheduled for completion by January 2011. Monitoring visits have been primarily focused on three areas: 1) reviewing client records and files; 2) assessing provider performance with respect to TGA-wide standards of care and adherence; and 3) validating service utilization and correct invoicing for services based upon client records and ARIES data. Observations and recommendations are discussed with subcontractors during exit interviews and cited in program monitoring reports, which are issued within 30 business days following a site visit. When a program-related concern is identified, the report describes the finding and/or observations and includes recommendations for corrective action. The subcontractor is given 30-days to respond in writing to the report with a corrective action plan that includes timelines. The implementation of recommended corrective action(s) is verified with a follow-up site visit. HRAU staff offers technical assistance as needed to assist subcontractors in complying with program and contract requirements. An agency's failure to implement corrective action can result in contract suspension or termination as specified in the contract. To date, program monitoring of FY 2010 Part A and MAI subcontractors has yielded no significant program compliance issues.

Number of Subcontractors Receiving Technical Assistance (TA) FY 2010 and Types of TA
The types and time frames of technical assistance provided by the Administrative Agency in FY 2010, and the number of subcontractors receiving assistance are as follows:
Medical Case Management System Development, one eight-hour session and two four-hour sessions (8); Developing a Quality Management Plan, eight one-hour sessions (8); Quality Management Tools, 20 minutes monthly at meetings (8); Communication, four 15-minute sessions (8); ARIES training, two three-hour sessions (1); RSR Summer Upload Test Training, one two-hour session (4); ARIES Data Entry Policies, one two-hour session (4).

Audit Requirements
Subcontractors are required to arrange for an annual financial and compliance audit of funds received and performance rendered under their contract with the City of Austin in accordance with OMB Circular A-133. The annual independent audit must be submitted to the Administrative Agency within 120 days after the end of the subcontractor's fiscal year. In FY

2010, all eight (8) subcontractors (100%) have demonstrated compliance with the audit requirement in OMB Circular A-133, and there were no findings. However, when there are findings, the Administrative Agency requires subcontractors to forward a copy of their corrective action plan and tracks plan progress during the following year.

**4)b.(2) Fiscal Staff Accountability**

Subcontractors submit monthly payment requests to their assigned contract manager who reviews required back-up documentation: the HIV Services Monthly Performance and Budget Status Report, and the ARIES Report which shows units of service delivered and numbers of unduplicated clients served for each service category. Following review and approval, the invoice is submitted to the City HHSD Accounting Unit for processing as described below.

Fiscal accountability for the Ryan White Part A grant is supported by the City HHSD Administrative Support Services Division. Key staff are shown in the shaded boxes linked to the Administrative Agency box on the Austin TGA Organizational Chart (Attachment 1). These positions are not funded by the Ryan White Part A grant, but they perform critical roles in ensuring fiscal oversight and control.

At the HRAU level, a Financial Specialist serves as Grants and Contracts Financial Coordinator. This position prepares and monitors staff salary allocations, and ensures staff charge time to correct task orders by reviewing timesheet reports and tracking task order balances on eCombs/DXR accounting systems expenditure reports. In addition, the position reviews grant expenditures weekly on Austin Integrated Management System (AIMS), and reviews DXR reports monthly and quarterly until closeout. Contract expenditures are monitored by reviewing Document Orders (DOs) on a monthly basis. Following receipt of the Notice of Grant Award, this position prepares a request for fund amendment in order to direct budget allocations. The process used to separately track formula, supplemental, unobligated balances, and carry-over funds is described above on page 48.

In the Administrative Support Services Division's Budget Unit, the Financial Consultant sets up the approved grant award on AIMS, including funding codes and personnel task orders, in close collaboration with the HRAU Financial Coordinator. This position also reviews and approves grant budget amendments. The Accounting Unit's Accounting Associate reviews and prepares payment transaction documents for subcontractors' grant-eligible, approved invoices received from HRAU Grants Coordinators. The Accounting Manager's responsibilities include:

- Review grant contract for financial reporting purposes;
- Review monthly grant billing documents (financial reports from AIMS, Journal Vouchers, Accounts Receivables, spreadsheets, etc.) completed by accountant;
- Review and approve online AIMS Journal Vouchers and Accounts Receivable Transactions;
- Review and verify reconciliation of grant fund;
- Review and approve grant financial reports (Vouchers, Financial Status Reports) per contract requirements;
- Review/approve online AIMS payment transactions of grant-eligible invoices/travel claims/mileage reports received from program;

- Review/perform accounting approval online (WORKS) of grant-eligible credit card purchases approved by HRAU; and
- Maintain grant financial records for auditing purposes (Grant and Annual Single Audit).

The Accounting Manger also submits the annual Part A, including MAI, Federal Financial Report (FFR) to HRSA.

**4.c. Third Party Reimbursement**

Texas State Medicaid program eligibility is restrictive. Currently, the majority of patients enrolled in Texas' State Medicaid program become eligible as a result of qualifying for disability benefits or as a single female head of household. In Texas, the approval process takes a minimum of three months and can take as long as six months. All clients seeking medical care services at David Powell Community Health Center (DPCHC) are screened for coverage by third party payers, including Medicaid, Medicare, Veterans benefits, private insurance, or other programs such as the Medical Assistance Program (MAP), a locally funded health care benefit program. DPCHC staff verifies Medicaid or Medicare coverage online through the Centers for Medicare and Medicaid Services (CMS) website or by using the Medicader software.

Documentation of eligibility screening and coverage is maintained in individual client charts and/or electronic health records. Case managers assist clients in applying for SSI or SSDI, since they will be eligible for Medicaid if approved. When no coverage is available, the client is placed on a sliding fee scale based on current Federal Poverty Guidelines. An initial intake form is filed in the client's chart, along with a financial eligibility worksheet. During initial intake, clients sign a document that obligates them to update their financial and medical insurance coverage information at each follow-up visit or as requested. Staff reviews the client's eligibility status, and the updated information is recorded on the financial worksheet. This screening process, which occurs at least twice within each program year, ensures financial and proof of status eligibility.

Through its contract language, the Administrative Agency requires that all accounting information and records are available for review. Moreover, contract language states:

> "CONTRACTOR agrees not to use funds provided under this Contract to pay for Medicaid/Medicare covered services for Medicaid/Medicare beneficiaries. The CONTRACTOR that provides Medicaid/Medicare-covered services shall be certified and provide documentation of certification to the CITY. The CONTRACTOR shall bill all eligible or available third-party payers before seeking reimbursement from Contract funds."

Program income is collected in the form of co-pays, co-insurance, clinic use fees, and reimbursement from third-party payers and is deposited into designated accounts and tracked using the providers' accounting system. Program income is reported and divided monthly on a proportional basis, then reinvested in each funding source's account so that all program income is expended before grant funds are utilized. Since the amount collected can fluctuate considerably from month to month and year to year, program income is not budgeted but is utilized as collected to defray eligible program expenses such as laboratory tests and medications.

**4.d. Administrative Assessment**

The HIV Planning Council's methodology to assess the efficiency of the administrative mechanism changes from year to year, based on the organizational and service needs of the TGA. This year's process was an ongoing multi-month assessment of the administrative function. Each month the Planning Council received an Administrative Agency Report which provided information pertaining to service expenditures, quality management, contract monitoring, and overall system updates. This report is an official document listed on the agenda for the Planning Council executive committee and the business meeting each month. A representative of the Administrative Agency routinely goes over the report with the Planning Council, highlighting specific areas of importance or concern. The Planning Council then provides feedback to the Administrative Agency and, where necessary, supporting information or documentation is made available to the Planning Council within a set amount of time.

Using this new assessment methodology, the Planning Council has been able to address, in a timelier manner, crucial administrative issues that may exist with Part A or MAI funds expenditures. Moreover, the Planning Council is kept abreast of ongoing and relevant service delivery information and able to make planning decisions in response to current information. In the past, administrative mechanism assessments have focused on the following areas: 1) Paying Providers; 2) Executing Contracts; 3) Payor of Last Resort; 4) Service Priorities and Planning Council Directives; 5) Unexpended Funds; and 6) Evaluating the Effectiveness of Services. This year, while no formal surveys were administered to the Administrative Agent, providers, or Planning Council members, the monthly Administrative Agent Report was an effective mechanism and tool used to address all of the historically reported components. Using the Administrative Agent Report, the following assessment results were made for the period March 2009 through February 2010, using a simple rating of "Acceptable" or "Needs Improvement:"

1. Pay Providers – Acceptable
2. Executing Contracts – Acceptable, with recommendations to coordinate and meet contract execution timelines in a more effective manner
3. Payor of Last Resort – Acceptable
4. Service Priorities and Planning Council Directives – Acceptable
5. Unexpended Funds – Acceptable
6. Evaluating the Effectiveness of Services – Needs Improvement, with recommendations to plan for and implement a structured system of site and contract monitoring for FY 2011 focused on "evaluating effectiveness of services."

In response, to #6 above, the Administrative Agent has hired an auditor, on a temporary basis, to develop new tools and provide leadership for the Part A and MAI monitoring team, in order to more effectively address the evaluation of service effectiveness during regularly scheduled program and fiscal site monitoring visits. The Planning Council's Executive Committee will be consulted to ensure their specific interests are addressed in future reports.

## 5) Planning and Resource Allocation

### 5.a. Letter of Assurance from Planning Council Chair

The Letter of Assurance from Planning Council Chair is in Attachment 2.

### 5.b. Description of Priority Setting and Resource Allocation Process

(1-3) How needs of those not in care, unaware, and historically underserved were considered
Incorporated into the FY 2011 priority setting and resource allocation process were key activities and projects that systematically considered the needs and priorities of those in and out of care, unaware, and historically underserved. One such project was the 2010 Austin TGA Comprehensive Needs Assessment, in which more than three hundred (300) PLWH/As participated. A series of community forums were scheduled to share findings from the Needs Assessment with stakeholders, including PLWH/A. Additional input about the needs of PLWH/A was garnered through the community forums and consequently used in the priority setting and resource allocation process. The principles and guidance established by the Planning Council to consider various population needs were also duly discussed and made a part of the priority setting and resource allocation process.

The Planning Council also considered the needs of out-of-care, unaware, and underserved PLWH/As by participating in various community health fairs and other events that did not relate directly to HIV, but provided immediate access to individuals from minority communities or people residing in particular geographic areas targeted for HIV outreach. For example, the Planning Council participated in a women's health conference held in Williamson County, where the second highest HIV/AIDS prevalence and incidence is in the Austin TGA. The event provided an opportunity to gain insights into the needs of women who were HIV positive, when several conference attendees, discussed their needs with Planning Council staff. The above activities were promoted through use of social media sites such as Twitter and Facebook, which offer new opportunities to engage PLWH/A in discussions about their service needs..

(4) How PLWH/A were involved in priority setting and allocation process and how their priorities were considered
Throughout the planning year, the Planning Council worked to maintain a membership consisting of at least one-third (1/3) of required consumers. During occasions when PLWH/A membership was minimal, other methods were used to involve them in the planning process. For example, the Planning Council's sub-committees were chaired by PLWH/A and the lead decision-making body of the Planning Council, the executive committee, was comprised of 50% consumers. The leadership roles by consumers allowed the work and decision-making processes of the Planning Council to be consistently centered on the needs and priorities of PLWH/A.

The Planning Council's decision to fund Early Intervention Services (EIS) underscores the Austin TGA's goal to reach unaware and underserved populations, as the service was ranked among the top 10 of priorities (#8). A shifting of funds from traditional outreach services to EIS testing with outreach activities included, was a practical strategy of the Planning Council in response to the priorities identified by PLWH/A.

Finally, PLWH/As were involved in the process of updating the TGA's Comprehensive Plan. Since the Comprehensive Plan is a living document used by the Planning Council through 2011, PLWH/A involvement continues to be effectual. The Comprehensive Plan Taskforce was co-chaired by a person living with HIV/AIDS. It included current and former Planning Council members and community stakeholders who had participated in the development of the former Comprehensive Plan. This continuity of participation allowed for a more informed process built upon the knowledge of prior planning. Taskforce members also included representatives of faith and community-based organizations, rural populations, and other special populations such as racial/ethnic minorities and youth. Each stakeholder perspective contributed to the comprehensive planning update process in ways that ensured the voices of those underserved and typically underrepresented were amplified to make a resounding difference throughout the five-county service delivery area.

(5) How data were used in the priority setting and allocation processes

Data were used by all of the Planning Council committees involved in the priority setting and allocation process. All decisions and recommendations made by the committees were based on the best available and most current data. Planning Council committees review service utilization data for each service category from the previous 3-5 years, as well as demographic data on those utilizing the TGA's system of care and HIV/AIDS incidence and prevalence data. This review process enables the Planning Council to effectively assess the utility of services and to use the resulting information to guide the priority setting and allocation process.

The Planning Council also analyzed incidence and prevalence data by mode of exposure, race/ethnicity, sex, and age groups, and compared it to service category utilization data for the same period. In cases where a service category displayed significant access issues, these findings were considered and heavily weighed in the planning processes. In response to these findings, modifications were made to the previous year's allocations model to reflect the current and anticipated services needs in FY 2011. The complete FY 2011 service category allocation is shown in Attachment 8.

(6) How changes and trends in HIV/AIDS epidemiology data were used in priority setting and allocation process

Epidemiological data suggested a continued need for outreach efforts for minority groups, particularly for African Americans due to the disproportionate burden of HIV/AIDS on this population. Data also illustrated that outreach should be directed towards the MSM population, as this group continues to constitute the largest HIV/AIDS prevalence group. To address the needs suggested by epidemiological data, MAI funds leveraged support to non-medical case management and outreach services, both highly prioritized by the African American and MSM populations.

To reach the population of out-of-care individuals who know their HIV status, as well as effectively reach a portion of the 21% estimated to be unaware their HIV status, the funding level for traditional outreach services with Early Intervention Services (EIS) being newly funded by the same amount of the reduction. The Planning Council also engaged in strategic analysis of current epidemiological data by considering variables such as geographic location (rural), mode of exposure, and age. Improvements in the system of care to address confounding factors related to

epidemiological changes were reflected in resource allocations to services that addressed these significant trends or changes. One example of this was demonstrated in the analysis of data which indicated increased longevity for PLWH/As whose quality of life could be improved with basic needs support services such as housing. This particular trend translated to a strategic reduction in hospice service funding, with the amount of the reduction allocated to housing services.

(7) How cost data were used by Planning Council in making funding allocation decisions
The Planning Council's work is guided by a fundamental responsibility to leverage Ryan White Part A funds in providing quality medical care to all PLWH/As and increasing access to medical care. In fiscal years 2010 and 2011, funding for residential substance abuse remains level. The continuity in level funding for this service was justified by the utilization data, as well as findings from the most recent Comprehensive Needs Assessment. The cost benefit to deliver residential substance abuse is considered warranted in the Austin TGA, as a more intense approach to substance abuse treatment and is positively correlated with HIV treatment adherence.

The Allocations subcommittee reviewed current and historical unit cost data and data on other funding sources for the Part A service categories. The sources for these data included information from service provider contracts and utilization data from the ARIES system. The committee then proceeded with assessing the need for each service category prioritized, using various documented indicators including unit cost, units per client, and a service's ability to contribute to the requirements outlined in Early Identification of Individuals with HIV/AIDS (EIIHA). The Unmet Need Framework (Attachment 6) was used to project the number of FY 2011 Part A clients out of care and to produce a demographic breakdown of the out-of-care minority populations.

(8) How unmet need data were used by the Planning Council
The Unmet Need Framework Table (Attachment 6) illustrates that 1,501 PLWH/A have unmet need. The exposure groups of IDU and MSM/IDU represent 37% and 27% of unmet need, respectively. These data further support effort directed towards the emerging populations of MSM and IDU. As mentioned above, residential Substance Abuse Services funding has been increased in order to more fully address the needs of the IDU exposure group.

(9) How Planning Council's process will address prospective funding increase or decrease in the Part A award
The Planning Council developed the FY 2011 Plan with the assumption of level funding, however they also addressed prospective funding increases or decreases in the Part A award. Considering the set priorities and percentage of funds allocated to core medical services, the Planning Council proceeded with a contingency plan to address an increase or decrease in the Part A award. The strategies used by the Planning Council included ensuring the majority of resources would be devoted to core services, determining additional funding streams to support service categories, adhering to fundable service categories as they apply to the TGA's need, and confirming that certain service categories would not fall below a minimum level of funding regardless of the grant award amount. Additionally, a Contingency Allocation Plan was approved by the Planning Council as part of the priority setting and allocation process. For a decrease in funding, the plan will proportionally decrease across allocated service categories with the following exceptions: 1)

Hospice would not fall below $59,500; 2) Food Bank would not fall below $60,967, Medical Transportation would not fall below $25,000, and Housing would not fall below $10,500.

For an increase in funding, the plan is to proportionally increase allocations across all categories with the following exceptions: Outpatient/Ambulatory Medical Care would not receive an increase above $1,151,809; Medical Nutrition Therapy would not be above $72,474; ADAP would not be above $1,000; Outreach would not be above $67,185, and Medical Transportation would not receive an increase above $25,000.

(10) How MAI funding was considered during the planning process to enhance services to minority populations

The two focus populations of MAI funding are African American and Latinos. Services that effectively represent the "pillars of access" previously mentioned in the continuum of care subsection of this application (p. 40) are funded by MAI funds. Outreach and non-medical case management have both been identified as key services in the Austin TGA, to not only make the system of care accessible to disproportionately affected racial/ethnic populations, but to enable these populations to remain in care.

(11) How data related to persons unaware of HIV status was used in priority setting and allocation

The Planning Council used data provided by the Texas Department of State Health Services, along with estimations from the Centers for Disease Control, and elements derived from the National HIV/AIDS Strategy to develop a formula and system that related to the unaware population. Based on the Planning Council's figures, the Austin TGA is estimated to have at least 1,100 individuals who are unaware of their HIV status. Once the Planning Council determined an estimate of the unaware population, a demographic profile was developed and the needs of this population were quantified according to the same methodology used with PLWH/As aware their status.

**5) c. N/A**

**5) d. Funding for Core Medical Services**

The FY 2011 Planned Services Table, included as Attachment 8, resulted from Planning Council's priority setting and resource allocation process. The total amount for Core Medical Services (80.3%) exceeds the 75% core medical services expenditure requirement. Support Services represent 19.7% of the total services amount. Planning Council created two subcategories for Non-Medical Case Management. The first, Tier 1 (Service Priority 1), is psychosocial case management that may include initial screening, development of a service plan, coordination of services, assessing efficacy of the plan, and periodic plan updates. The second subcategory, Tier 2 (Service Priority 4), is the provision of advice and assistance in obtaining needed services. It does not involve coordination of and follow-up on medical treatments, but may include coordination with Tier 1 case managers.

## 6) b. Maintenance of Effort

| TGA: Austin, Texas | | Report for FY 2008 and FY 2009 | |
|---|---|---|---|
| Prepared by: Carmen Chronis, Financial Specialist | | Telephone: (512) 972-5078 | |
| **Item No.** | **Agency/Department/Other Unit of Government** | **FY 2008 Amount** | **FY 2009 Amount** |
| 1 | Austin Health and Human Services Department<br>Communicable Disease<br>HIV Education and Outreach Program<br>Fund 1000-9100-3030 | $300,370 | $292,944 |
| 2 | Austin Health and Human Services Department (HHSD)<br>HIV Social Services Contracts with CBOs<br>Fund 1000-4700-6161, 6162 and 6163 | $569,546 | $592,483 |
| 3 | Travis County Health Care District (TCHD)<br>David Powell Community Health Center (DPCHC)<br>Fund 7THD-952-3033,3034 and Community Care TX | $400,846 | $857,472[1] |
| 4 | Travis County<br>HIV Social Services Contracts CBOs<br>Dept. 58 – Div. 91 | $472,759 | $467,069 |
| | **TOTALS** | **$1,743,521** | **$2,209,968** |

[1]In FY 2009, the Healthcare District experienced an increase in pharmaceutical cost, units of medication dispensed at the DPCHC, and an increase in FTEs and personnel cost.

Austin HHSD uses the City of Austin accounting system, Austin Integrated Management System (AIMS), and a segmented chart of accounts to capture and monitor budget and expenditures. The main components of the chart of accounts are the fund, department and unit codes (FDU). Digital Express Reports (DXR) is used to view financial reports, which are produced using AIMS. Expenditures related to HIV/AIDS core medical and support services, as well as prevention services, have coding (FDU) and are tracked on a monthly basis. The TCHD CommUnityCare's accounting system, Sage MIP, uses a segmented chart of accounts to capture expenditures. One segment in the chart of accounts discerns the location within the network to which each transaction pertains. The only services provided at DPCHC are those related to the primary medical care of persons living with HIV/AIDS. Travis County uses the Sungard accounting system, a segmented chart of accounts that captures and monitors budget and expenditures. The components of the chart of accounts are the fund number, department/division numbers, activity/subactivity codes, and element and object numbers. Financial reports can be obtained from the system using the fourteen digit line item numbers. Expenditures for the HIV social services contracts are separated by using commodity subcommodity codes for HIV programs specified in the contract.

## 7) Clinical Quality Management

### 7.a. Description of Clinical Quality Management Program

The overall purpose and goals of the Austin TGA Clinical Quality Management (CQM) Program are to ensure HIV medical services are provided to patients consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections, to continuously improve clinical practice standards for vital health related supportive services, and to ensure that these supportive services enhance client linkages to HIV medical care and positive health outcomes. The Quality Model used throughout the Austin TGA is the PDSA model (Plan, Do, Study, Act).

Roles of Staff and Committees Responsible for Managing CQM Activities
The Administrative Agency's CQM Coordinator is responsible for implementing the CQM Program. The CQM Coordinator works under the direction of the HIV Resources Administration Unit Manager who is responsible for the overall administration of the Ryan White Program. Five percent (5%) of the Ryan White Part A grant award supports the CQM program, including salaries or portions of salaries for the CQM Coordinator, Data Manager, Health Planner and Manager (1.9 FTEs total) as well as related program support expenses.

The CQM Coordinator is responsible for facilitating activities related to the design, implementation, and revision of the CQM Plan, selecting project-specific continuous quality improvement outcomes, developing Requests for Proposals (RFP's) for specialized reviews, initiating a system to measure client satisfaction, establishing and maintaining a Continuous Quality Improvement (CQI) committee and developing and implementing service specific standards of care for funded service categories. The CQM Coordinator conducts client chart audits to ensure adherence to established PHS treatment guidelines, analyzes clinical and service utilization data, ensures target outcomes are achieved, develops quality improvement plans with health service providers, and monitors progress in implementing improvement strategies.

The Data Manager and Health Planner collaborate with the CQM Coordinator to ensure data integrity, analyze data and develop reports on client demographics and service utilization trends. QM staff also develops health outcome indicators and methods for collecting and analyzing health outcome data, programmatic monitoring, analyzing client satisfaction and chart review data for use in developing service improvement plans. The CQM staff review all RFPs and contracts to ensure CQM requirements are addressed, including: contractor grievance policies and procedures, standards of care, CQM plans, cultural competency, client satisfaction, and adherence to data collection requirements.

The CQI Committee and/or its working subcommittees meet at a minimum bi-monthly. Membership consists of the CQM Coordinator (RN), Part A, B, and C sub-grantee representatives, social workers and clinicians or representatives of clinicians, one consumer, 2 Planning Council members, and the Part B Planner/Quality Manager representative.

The CQI Committee provides input and direction to the Austin TGA CQM Program. The Committee is involved in determining CQM Program priorities, establishing and reviewing

health outcome indicators, assessing performance measures, making recommendations for performance improvement, reviewing and updating the CQM Plan. Additionally, the CQI Committee provides input into the development of quality improvement tools, (i.e. client satisfaction surveys, client grievance policies, case management acuity, client eligibility by service category and standards of care). The CQI Committee reports cumulative service outcome results to the Planning Council.

Consumers are involved in the CQM program through their participation on the CQI Committee, through their input on client satisfaction surveys, and participation in focus groups. There is currently one consumer member of the CQI Committee, active recruitment of consumers continues.

Internal Quality Processes

The CQM program is assessed annually by grantee staff and periodically by an outside consultant. The HIV Resources Administration Unit Program Manager assesses the program via a review of annual goals and objectives. Feedback is provided to the CQM Coordinator and adjustments are incorporated into the program/CQM Plan for the upcoming year. The process for providing feedback and implementing changes is continuous among the CQM program staff and the Ryan White Part A funded providers. The CQM staff also offer technical assistance to providers in the following areas: collecting and reporting of client-level data, standards of care implementation, and CQM plan development, use of CQI tools, and data interpretation. A more extensive TA is underway in medical case management and modeling. The CQM Coordinator conducts a CQI Committee review of the CQM program annually. As needed, program changes are implemented through performance improvement plans and contract amendments.

All Ryan White providers are required to have a CQM plan and to evaluate their program's performance in meeting their CQM goals and standards of care by analyzing results from output and outcome data, client satisfaction surveys, and client chart reviews. The David Powell Community Health Center (DPCHC) provides ambulatory outpatient medical care and is a part of the Federally Qualified Health Center (FQHC) network. DPCHC is required to perform regular chart audits and quality control reviews as set out in the FQHC Quality Management/Risk Management Plan. Additionally, chart audits are conducted by the CQM Coordinator and/or other external reviewers to ensure compliance with DHHS treatment guidelines and standards of care. This plan addresses quality management and improvements across all services provided within the FQHC network, including medical care, behavioral health, medical case management, pharmacy, and safety and risk management. Results of the CQI activities are presented through a chain of command, including the FQHC Board of Directors. Any adverse findings result in the creation of an immediate improvement plan.

Specific Indicators for Primary Medical Care and Medical Case Management

The indicators and current results for primary medical care and medical case management services are listed below. Each indicator is measured against a benchmark or target developed by the Administrative Agency with input from services providers, the Clinical Quality Improvement Committee and the Planning Council.

**Table A: Outpatient/Ambulatory Medical Care and Medical Case Management Indicators**

| Outpatient/Ambulatory Medical Care Indicators | Results |
|---|---|
| 1. 90% of clients with CDC-Defined AIDS will be prescribed an antiretroviral therapy (ART) regimen during the measurement year. Excluded patients newly enrolled in care during last three months of the measurement year. | **98%** of clients with CDC-Defined AIDS were prescribed an antiretroviral therapy (ART) regimen during measurement year. |
| 2. 95% of clients with an HIV infection and a CD4 T-Cell count < 200 cells/$mm^3$ will be prescribed PCP prophylaxis during the fiscal year. Excluded are patients with CD4 T-Cell count < 200 cells/$mm^3$ repeated within three months rose above 200 cells/$mm^3$ and patients newly enrolled in care during last three months of the measurement year. | **96%** of clients with an HIV infection and a CD4 T-Cell count <200 cells/$mm^3$ were prescribed PCP prophylaxis during the fiscal year. |
| 3. 90% of clients with an HIV infection will have 2 or more CD4 T-Cell counts performed during the fiscal year. Excluded are patients newly enrolled in care during last six months of the measurement year. | **81%** of clients with an HIV infection had 2 or more CD4 T-Cell counts performed during the fiscal year. |
| 4. 80% of clients with an HIV-infection will have two or more medical visits during the measurement year. Excluded are patients newly enrolled in care during the last six months of the measurement year. | **84%** of clients with an HIV-infection will had two or more medical visits during the measurement year. |
| 5. 100% of pregnant women with an HIV infection will be prescribed antiretroviral therapy during the measurement year. Excluded are patients whose pregnancy is terminated, and pregnant patients who are in the 1st trimester and newly enrolled in care during the last three months of the measurement year. | **100%** of pregnant women with an HIV infection were prescribed antiretroviral therapy during the measurement year. |
| **Medical Case Management Indicators** | **Results** |
| 80% of clients surveyed will report satisfaction with services provided | **89%** of medical case managed clients surveyed reported satisfaction with services received |
| 75% of clients receiving medical case management services will keep at least two subsequent medical provider visits over the course of the measurement year. Excluded are patients newly enrolled in care during the last three months of the measurement year. | **84%** of clients receiving medical case management services kept at least two subsequent medical provider visits over the course of the measurement year. |

Source: ARIES and Client Satisfaction Survey

### 7.b. Description of Data Collection and Results

The Administrative Agency's QM staff use several methods to collect client level outcome data and related information on program progress in meeting the goals and objectives outlined in the CQI Plan. Those methods include: 1) contract compliance site audits, 2) client satisfaction surveys, 3) formal chart reviews, and 4) the AIDS Regional Information and Evaluation System (ARIES).

ARIES is the current HIV/AIDS client-level information system utilized by all Texas Ryan White Programs and is administered by the Texas Department of State Health Services (DSHS). The system enhances services for clients with HIV by helping providers automate, plan, manage, and report on client data. ARIES collects and reports demographic, clinical, and service utilization data on HIV positive and HIV affected clients. Examples of demographic data collected include but is not limited to race, ethnicity, date of birth, gender, city, county and state of residence, ZIP code, living situation, and financial, and insurance information. A number of clinical data elements are also available in the system, including CDC disease stage, risk factors, CD4's, viral loads, sexually transmitted infections (STI), hepatitis, tuberculosis, (including multi-drug resistant TB), immunizations, ART therapy, and medications taken to treat/prevent opportunistic infections (see Indicator Results in Table A). ARIES currently contains information on more than 2,753 TGA clients.

Service utilization data is entered based on HRSA-defined service categories and the *Texas Department of State Health Services Glossary of HIV Services*. Service utilization data entered into ARIES can be aggregated for reporting and data analysis, while maintaining client confidentiality. Reporting capabilities are very extensive and allow for reporting on unduplicated clients by service category, demographics, TB infections summaries (including multi-drug resistant TB), average cost by service category, service units by funding source (including third-party sources), numbers of HIV-infected clients and their CDC disease stage, and risk factors analysis.

The results of primary medical care and medical case management indicators are noted in the previous table. Additionally, data collected described above is used to track the number of new clients entering medical care (including out of care clients) and to determine why clients delay receiving care.

Another aspect of our data collection strategy is data quality. Each month the data manager runs reports on ARIES data to determine the number of client records that have at least one missing or unknown/unreported required data element. These reports are then given to providers so they can correct missing or unknown/unreported data elements. The data manager conducts desktop and data quality monitoring site visits on a regular basis.

How Data Has Been Used to Improve or Change Service Delivery in the Austin TGA

The CQM Program has been successful in improving the quality of services to HIV positive clients in the Austin TGA by bringing all Ryan White providers together to collaborate on improving services to clients and developing quality tools to provide uniformity and consistency. The following activities have resulted in improvements or changes in service delivery:

1. Health literacy project - The ARIES client consent form that allows providers to share client data was reviewed to assess a client's ability to understand the consent form and to make appropriate decisions. As a result of the assessment, a brochure was developed that explained the information in the consent form that was more understandable to clients entering our care system. Spanish and English versions of the brochure are available.
2. The CQI Committee has ad hoc subcommittees to address targeted quality issues as needed to facilitate completion of the PDSA cycle. This year we focused on the following:

a. The Medical Case Management Subcommittee reviewed medical case management models and standards. Based on subcommittee findings, a HRSA consultant was requested and identified to assist with development of an integrated medical/non-medical case management service model. A transition plan will be developed by a stakeholder work group consisting of provider, Planning Council, and consumer representatives. The group has met two times. Goals for the 2011 grant year include implementation of a new case management model of care, revised standards of care, increased provider program accountability, and more efficient client intake process resulting in easier access to medical care and support services.
b. This grant year a new client satisfaction survey instrument was developed. The survey was administered by three part-time social work students and a master's level social worker. The goal was to reduce concerns about provider bias in the surveys administration and to ensure health literacy was not a barrier to client participation. The were 340 surveys administered with an overall satisfaction rate of 85% in the good to excellent range based on a Likert scale, 1 being the lowest satisfaction, 5 being the highest satisfaction. Several anecdotal comments were noted in the survey regarding a need for "better customer service." This will be explored with providers-and if warranted TA in customer service provided.
c. The Return to/Retention in Care Subcommittee was formed in September 2009 to focus on the return of clients to care who were previously in care or who are at risk of falling out of care. The return to care rate improved from 0%-5% to 65% over the first year of this project (Sept 2009 – Aug. 2010). Our improvements in client follow up and identification of those at higher risk for falling out of care are being formalized into policies and procedures. These are pending identification of a care model which should be identified at a TA session Oct. 2010.

Quality Efforts Used by Planning Council for Priority Setting and Allocations

The Administrative Agency provides data reports to the Planning Council on a monthly to quarterly basis. These reports include service utilization data from ARIES, results from the Retention in Care Collaborative and epidemiological data from the state of Texas and CDC. Results from the Client Satisfaction Survey are also reviewed along with the Needs Assessment update, and findings from fiscal and program monitoring reports.

Quality Management Program Development

The Austin Part A Ryan White Program manager was the leader of a Texas state-wide team of grantees who participated in a five-state HAB/NQC Cross-Part Quality Management Collaborative. The collaborative was designed to improve state-wide collaboration across all Ryan White Parts (Parts A, B, C, D and F). Through participation in this collaborative the Austin Part A QM program has 1) enhance alignment of QM goals to meet legislative mandates and expectations; and 2) carried out joint quality-related activities that result in better coordination of HIV services across Parts. The Texas Team has identified two performance improvement areas to work on: 1) Data Integrity; and 2) Retention in care. The Texas state-wide team continues to meet via conference calls and webinars to continue development of both local grantee as well as state-wide quality initiatives.

# BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

## SECTION A - BUDGET SUMMARY

| Grant Program Function or Activity (a) | Catalog of Federal Domestic Assistance Number (b) | Estimated Unobligated Funds | | New or Revised Budget | | |
|---|---|---|---|---|---|---|
| | | Federal (c) | Non-Federal (d) | Federal (e) | Non-Federal (f) | Total (g) |
| 1. Administration | 93.914 | $ 411,871.00 | $ | $ | $ | $ 411,871.00 |
| 2. Quality Management | 93.914 | 205,936.00 | | | | 205,936.00 |
| 3. Direct Services | 93.914 | 3,500,906.00 | | | | 3,500,906.00 |
| 4. Minority AIDS Initiative | 93.914 | 230,262.00 | | | | 230,262.00 |
| 5. Totals | | $ 4,348,975.00 | $ | $ | $ | $ 4,348,975.00 |

## SECTION B - BUDGET CATEGORIES

| 6. Object Class Categories | GRANT PROGRAM, FUNCTION OR ACTIVITY | | | | Total |
|---|---|---|---|---|---|
| | (1) Administration | (2) Quality Management | (3) Direct Services | (4) Minority AIDS Initiative | (5) |
| a. Personnel | $ 263,476.00 | $ 118,207.00 | $ 0.00 | $ 24,094.00 | $ 405,777.00 |
| b. Fringe Benefits | 110,676.00 | 44,984.00 | 0.00 | 9,981.00 | 165,641.00 |
| c. Travel | 5,650.00 | 4,305.00 | 0.00 | 464.00 | 10,419.00 |
| d. Equipment | 5,780.00 | 0.00 | 0.00 | 0.00 | 5,780.00 |
| e. Supplies | 11,208.00 | 2,400.00 | 0.00 | 0.00 | 13,608.00 |
| f. Contractual | 2,300.00 | 31,500.00 | 3,475,906.00 | 195,723.00 | 3,705,429.00 |
| g. Construction | 0.00 | 0.00 | 0.00 | 0.00 | |
| h. Other | 12,781.00 | 4,540.00 | 25,000.00 | 0.00 | 42,321.00 |
| i. Total Direct Charges (sum of 6a-6h) | 411,871.00 | 205,936.00 | 3,500,906.00 | 230,262.00 | $ 4,348,975.00 |
| j. Indirect Charges | | | | | $ |
| k. TOTALS (sum of 6i and 6j) | $ 411,871.00 | $ 205,936.00 | $ 3,500,906.00 | $ 230,262.00 | $ 4,348,975.00 |
| | | | | | |
| 7. Program Income | $ | $ | $ | $ | $ |

## SECTION C - NON-FEDERAL RESOURCES

| (a) Grant Program | (b) Applicant | (c) State | (d) Other Sources | (e)TOTALS |
|---|---|---|---|---|
| 8. Quality Management | $ | $ | $ | $ |
| 9. Direct Services | | | | |
| 10. Minority AIDS Initiative | | | | |
| 11. | | | | |
| 12. TOTAL (sum of lines 8-11) | $ | $ | $ | $ |

## SECTION D - FORECASTED CASH NEEDS

| | Total for 1st Year | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|---|---|---|---|---|---|
| 13. Federal | $ | $ | $ | $ | $ |
| 14. Non-Federal | $ | | | | |
| 15. TOTAL (sum of lines 13 and 14) | $ | $ | $ | $ | $ |

## SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

| (a) Grant Program | FUTURE FUNDING PERIODS (YEARS) (b)First | (c) Second | (d) Third | (e) Fourth |
|---|---|---|---|---|
| 16. Administration | $ 411,871.00 | $ 411,871.00 | $ 411,871.00 | $ 411,871.00 |
| 17. Quality Management | 205,936.00 | 205,936.00 | 205,936.00 | 205,936.00 |
| 18. Direct Services | 3,500,906.00 | 3,500,906.00 | 3,500,906.00 | 3,500,906.00 |
| 19. Minority AIDS Initiative | 230,262.00 | 230,262.00 | 230,262.00 | 230,262.00 |
| 20. TOTAL (sum of lines 16 - 19) | $ 4,348,975.00 | $ 4,348,975.00 | $ 4,348,975.00 | $ 4,348,975.00 |

## SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

## Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** BudgetNarrativeLineItemFY2011.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

## 6) a. FY 2011 Ryan White Part A Budget Justification Narrative

**A. Personnel** **$571,418**

*Administration* *$263,476*

- Manager (M. Peppler, $76,071 x 0.20 FTE = $15,214). Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure grant requirements are met; oversees data and quality management activities to ensure adherence to established policies.
- Grant Coordinator (B. Mendiola, $55,430 x 0.75 FTE = $41,573). Responsible for the coordination and preparation of the Part A grant application and preparation of grant related post-award reports. Coordinates the subcontracting process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.
- Grant Coordinator (H. Beck, $56,901 x 0.45 FTE = $25,605). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses
- including administrative caps, program income, payer of last resort, and imposition of charges for services.
- Grant Coordinator (D. Garza, $58,373 x 0.45 FTE = $26,268). Prepares and negotiates grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.
- Financial Specialist (C. Chronis, $54,190 x 0.57 FTE = $30,888). Responsible for administrative and fiscal aspects of the grant. Prepares grant application budget documents, develops final program budgets and monitors grant and contract expenditures. Compiles financial reports as needed to analyze grant and contract expenditures; coordinates grant close-out activities ensuring reports are submitted to HRSA, including end of year MOE reports.
- Planner II (G. Bolds, $66,087 x 0.36 FTE = $23,791). Research core medical and support services information and provide data for HIV Planning Council to support planning activities; develops and analyzes performance measures and service utilization data.
- Data Manager (C. Manor, $54,148 x 0.20 FTE = $10,830). Responsible for all aspects of maintaining the HIV services client-level data collection system. Collects and analyzes data, and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.
- Planning Council Community Services Program Manager (K. Pemberton, $60,320 x 1.0 FTE). Coordinates and supervise various aspects of the Planning Council's activities and mandated functions. Facilitates and ensures Planning Council processes adhere to federal, state and local laws. Supervise support staff.
- Planning Council Administrative Senior (K. Smith, $28,987 x 1.0 FTE). Assists the HIV Planning Council Coordinator to prepare Planning Council meeting agendas and supporting documents for approximately 25 meetings annually.

*Administration MAI* *$15,894*

- Grant Coordinator (H. Beck, $56,901 x 0.05 FTE = $2,845). Prepares and negotiates MAI grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.

- Grant Coordinator (D. Garza, $58,373 x 0.14 FTE = $8,172). Prepares and negotiates MAI grant subcontracts; assures compliance with conditions of grant by monitoring subcontracts; processes payment requests and monitors and analyzes contract expenses.
- Financial Specialist (C. Chronis, $54,190 x 0.09 FTE = $4,877). Responsible for overall administrative and fiscal aspects of the grant. Prepares grant application budget documents, develops program budgets and monitors grant and contract expenditures. Prepares financial reports as needed to analyze grant and contract expenditures; coordinates grant close-out activities ensuring reports are submitted to HRSA, including end of year MOE reports.

*Quality Management* *$118,207*

- Program Manager (M. Peppler, $76,071 x 0.10 FTE = $7,607). Responsible for the overall administration of Ryan White Part A quality management program. Supervises staff to ensure grant requirements are met and quality program procedures are followed; meets with subcontractors regarding TGA quality improvement issues; ensures adherence to established QM program policies. Participates in state Cross-Part QM collaborative.
- Quality Management Coordinator (D. Watts, $73,507 x 0.82 FTE = $60,276). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and established standards of care.
- Planner II (G. Bolds, $66,087 x 0.36 FTE = $23,791). Research information and data as requested or needed for QM planning; analyzes service utilization data, works in collaboration with QM coordinator in developing measures including implementing HRSA core clinical performance measures; tracks service utilization trends.
- Data Manager (C. Manor, $54,148 x 0.49 = $26,533). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.

*Quality Management MAI* *$8,200*

- Quality Management Coordinator (D. Watts, $73,507 x 0.06 FTE = $4,410). Coordinates Quality Management activities, including establishing and implementing a clinical quality management plan; ensures service provided by Part A funds adhere to Public Health Service treatment guidelines and establishes/updates standards of care.
- Data Manager (C. Manor, $54,148 x 0.07 = $3,790). Responsible for all aspects of maintaining a HIV services client-level data system that supports the QM program. Collects and processes QM data, e.g. client satisfaction survey and health indicator data; prepares and submits reports to HRSA, HIV Planning Council, and HIV Unit Manager.

**B. Fringe Benefits** **$165,641**

Fringe Benefits are calculated at various rates. This includes FICA at 6.2%, Medicare at 1.45% Retirement at 14% per 7 months and 16% per 5 months, Health Care Benefits at $9,481 per FTE for 7 months and $10,429 for 5 months due to fiscal year transition per 7.16 FTE. Incentive Pay for 4.28 FTE.

- Total Administration $110,676
- Total Administration MAI $6,747
- Quality Management $44,984
- Quality Management MAI $3,234

**C. Travel** **$10,419**

*Administration Local Travel:* *$1,650*

- Grantee: Staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 2,300 miles x 0.50 = $1,150.
- Planning Council: PC member's mileage to attend Planning Council meetings/functions approximately 1,000 miles x 0.50 = $500.

*Administration Local Travel MAI:* *$385*

- Grantee: Staff travel in local TGA to perform monitoring activities, attend meetings and coordinate grant activities approximately 770 miles x 0.50 = $385.

*Quality Management Local Travel:* *$1,275*

- QM staff travel in local TGA to perform QM activities, attend meetings and coordinate QM program activities approximately 2,550 miles x 0.50 = $1,275.

*Quality Management Local Travel MAI:* *$79*

- Staff travel in local TGA to perform QM activities, attend meetings and coordinate QM program activities approximately 158 miles x 0.50 = $79.

*Administration Out Of Town Travel:* *$4,000*

- Grantee: Attend three quarterly EMA/TGA meetings. Includes, lodging, meals, and travel related expenses for three persons from the Administrative Agency at $3,000.
- Planning Council: Attend 3 quarterly EMA/TGA meeting. Includes, lodging, meals, and travel related expenses for one (1) Planning Council representative at $1,000.

*Quality Management Out Of Town Travel:* *$3,030*

- One QM person attending two Texas EMA/TGA & Part B meetings. Attend the annual Institute of Health Care Improvement meeting. Includes, lodging, meals, and travel related expenses at $3,030.

**D. Equipment** **$5,780**

*Administration:* $5,780

- Grantee: Computer purchase to replace obsolete ones $2,000
- Planning Council: Rental of copier equipment to reproduce PC meeting materials $3,780

**E. Supplies** **$13,608**

*Administration:* *$11,208*

Grantee: $2,558

- Office supplies, usual and customary, each less than $100. $1,700
- Office furniture, to purchase or replace office chairs $473
- Postage for subcontractor's contracts and correspondence $75
- Micro Projector for meetings and presentations for staff and providers $310

Planning Council: $8,650

- Food and beverages for Planning Council members when HIV Planning Council and committee meetings extend through meal time. $6,000
- Postage for meeting minutes and announcements. $325
- Telephone basic system including equipment and calling charges. $925
- Office supplies, usual and customary, each less than $100. $1,400

*Quality Management*: *$2,400*

- Office supplies, usual and customary, each less than $100. $2,400

**F. Contractual** **$3,705,429**

*HIV Services* *$3,475,906*

Service contracts with local non-profit organizations for an array core medical and support services for $3,475,906.

*HIV Services MAI* *$195,723*

Service contracts with local non-profit organizations for MAI services for $195,723.

*Administration* *$2,300*

- Planning Council: subcontract for Parliamentarian services. $2,300.

*Quality Management:* *$31,500*

- Professional consultants to train providers in skills and knowledge needed to improve health outcomes, e.g. motivational interviewing, and adherence counseling. $7,000.
- Training to enhance skills and knowledge of case managers working with PLWHA in the areas of substance abuse and mental health issues. $4,500
- Quality review of outpatient medical care, oral health, substance abuse and mental health providers, including chart audits, reviews of care plans and compliance with standards of care. $20,000

**G. Construction** **$0**

**H. Other** **$42,321**

*Administration* *$12,781*

Grantee: *$3,150*

- Advertising of Public Notices for Request for Proposal announcements. $1,600
- Subscriptions to HIV-related publications. $750
- Purchase project management software. $800

Planning Council: *$9,631*

- HIV Planning Council advertising in community media to recruit and increase Council membership and promote awareness/encourage involvement in Council activities. $4,235
- Printing for HIV Resources Guide $4,000
- Training and Seminar Fees for staff development $1,396

*Quality Management*: *$4,540*

- Printing and reproduction expenses of program materials such as surveys $940.
- Subscriptions to HIV-related publications. $800
- Quality Management Personnel training and Seminar Fees for staff development. $2,000
- Purchase project management software. $800.

*HIV Services*: *$25,000*

Medical Transportation services provided in house through HHSD, covers personnel and cost of bus passes, taxi vouchers, gas debit cards and special transit system passes. $25,000

**Total amount $4,348,975**

## AUSTIN/TRAVIS COUNTY HEALTH & HUMAN SERVICES DEPARTMENT

### Ryan White Part A FY 2011

### FY 2011 LINE ITEM BUDGET

| Budget Item | Salary | % FTE | Administration | % FTE | Quality Management | HIV Services | % FTE | MAI Administration | MAI QM | HIV Services | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **PERSONNEL** | | | | | | | | | | | |
| Program Manager - Peppler | $76,071 | 0.20 | $15,214 | 0.10 | $7,607 | | | | | | |
| Grant Coordinator - Mendiola | $55,430 | 0.75 | $41,573 | | | | | | | | |
| Grant Coordinator - Beck | $56,901 | 0.45 | $25,605 | | | | 0.05 | $2,845 | | | |
| Contract Monitor - Garza | $58,373 | 0.45 | $26,268 | | | | 0.14 | $8,172 | | | |
| Grant Coordinator - Chronis | $54,190 | 0.57 | $30,888 | | | | 0.09 | $4,877 | | | |
| Planner II - Bolds | $66,087 | 0.36 | $23,791 | 0.36 | $23,791 | | *0.28* | | | | |
| Data Manager - Manor | $54,148 | 0.20 | $10,830 | 0.49 | $26,533 | | 0.07 | | $3,790 | | |
| Quality Management Coordinator - Watts | $73,507 | *2.98* | | 0.82 | $60,276 | | 0.06 | | $4,410 | | |
| Community Services Program Manager-Pemberton | $60,320 | 1.00 | $60,320 | | | | *0.13* | | | | |
| Planning Council Administrative Assistant - Smith | $28,987 | 1.00 | $28,987 | | | | | | | | |
| | | *4.98* | | *1.77* | | | *0.41* | | | | |
| **Personnel Subtotal** | | | $263,476 | | $118,207 | | | $15,894 | $8,200 | | $405,777 |
| **FRINGE** | | | | | | | | | | | |
| FICA calculated at 6.2% | | | $16,336 | | $7,329 | | | $985 | $508 | | |
| Medicare Tax calculated at 1.45% | | | $3,820 | | $1,714 | | | $230 | $119 | | |
| Retirement-Salaries x 14% for 7 months and 16% for 5 months x 7.16 FTEs | | | 36,868 | | $17,035 | | | $2,362 | $1,218 | | |
| Medical Benefits 7 months x $9,481 and 5 months x $10,429 x 7.16 FTE | | | 49,182 | | 17,481 | | | $2,765 | $1,284 | | |
| Stability Incentive Pay for 4.28 FTEs | | | $4,470 | | $1,425 | | | $405 | $105 | | |
| **Fringe Subtotal** | | | $110,676 | | $44,984 | | | $6,747 | $3,234 | | $165,641 |
| **Total Personnel** | | | $374,152 | | $163,191 | | | $22,641 | $11,434 | | $571,418 |
| **TRAVEL** | | | | | | | | | | | |
| Local Travel | | | $1,650 | | $1,275 | | | $385 | $79 | | |
| Out of Town Travel to Attend TGA/EMA Meetings and HRSA Sponsored Training/Meetings | | | $4,000 | | $3,030 | | | | | | |
| **Travel Subtotal** | | | $5,650 | | $4,305 | | | $385 | $79 | | $10,419 |
| **EQUIPMENT** | | | | | | | | | | | |
| Computer hardware purchased to replace absolete equipment | | | $2,000 | | | | | | | | |
| Rental of copier equipment | | | $3,780 | | | | | | | | |
| **Equipment Subtotal** | | | $5,780 | | $0 | | | | | | $5,780 |
| **SUPPLIES** | | | | | | | | | | | |
| Food and beverages | | | $6,000 | | | | | | | | |
| Postage | | | $400 | | | | | | | | |
| Office furniture | | | $473 | | | | | | | | |
| Telephone Base Cost | | | $925 | | | | | | | | |
| Purchase Micro Projector | | | $310 | | | | | | | | |
| Office supplies | | | $3,100 | | $2,400 | | | | | | |
| **Supplies Subtotal** | | | $11,208 | | $2,400 | | | | | | $13,608 |
| **CONTRACTUAL** | | | | | | | | | | | |
| Subcontracted Services | | | | | | $3,475,906 | | | | $195,723 | |
| Planning Council Parliamentarian Services | | | $2,300 | | | | | | | | |
| Training to promote and enhance motivational interviewing with multi-diagnosed clients to improve treatment adherence | | | | | $7,000 | | | | | | |
| Training to improve skills and knowledge of case managers working with PLWHA in the area of substance abuse and mental health | | | | | $4,500 | | | | | | |
| Specialized Quality Review of medical care, case management, substance abuse and mental health providers within the TGA | | | | | $20,000 | | | | | | |
| **Contractual Subtotal** | | | $2,300 | | $31,500 | $3,475,906 | | | | $195,723 | $3,705,429 |
| **OTHER** | | | | | | | | | | | |
| Advertising of Public Notices for RFP announcements | | | $1,600 | | | | | | | | |
| Subscriptions to HIV-related publications | | | $750 | | $800 | | | | | | |
| Printing and Reproduction expenses | | | $4,000 | | $940 | | | | | | |
| Training/Semminar Fees Staff Development | | | $1,396 | | $2,000 | | | | | | |
| Purchase project management software | | | $800 | | $800 | | | | | | |
| Advertising for PC Membership | | | $4,235 | | | | | | | | |
| Medical Transportation Services | | | | | | $25,000 | | | | | |
| **Other Subtotal** | | | $12,781 | | $4,540 | $25,000 | | | | | $42,321 |
| **GRAND TOTAL** | | | $411,871 | | $205,936 | $3,500,906 | | $23,026 | $11,513 | $195,723 | $4,348,975 |
| **Function Percentage** | | | 9.47% | | 4.74% | 80.50% | | 0.53% | 0.26% | 4.50% | 100% |

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

## ASSURANCES - NON-CONSTRUCTION PROGRAMS



**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**NOTE:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

| * SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | * TITLE |
|---|---|
| Mark Peppler | Mayor |
| * APPLICANT ORGANIZATION | * DATE SUBMITTED |
| City of Austin HHSD | 10/19/2010 |

OMB Number: 4040-0010
Expiration Date: 08/31/2011

# Project/Performance Site Location(s)

**Project/Performance Site Primary Location** ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: City of Austin, Austin/Travis County HHSD

DUNS Number:

* Street1: 7201 Levander Loop, Building E

Street2:

* City: Austin County:

* State: TX: Texas

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 78702-4101 * Project/ Performance Site Congressional District: TX-010

**Project/Performance Site Location** 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

**Additional Location(s)** Add Attachment Delete Attachment View Attachment

## CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,00 0 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subjec t to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

| | |
|---|---|
| * APPLICANT'S ORGANIZATION | City of Austin HHSD |
| * PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE | |
| Prefix: | Honorable |
| * First Name: | Lee |
| Middle Name: | |
| * Last Name: | Leffingwell |
| Suffix: | |
| * Title: | Mayor |
| * SIGNATURE: | Mark Peppler |
| * DATE: | 10/19/2010 |

# ATTACHMENTS FORM

**Instructions:** On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

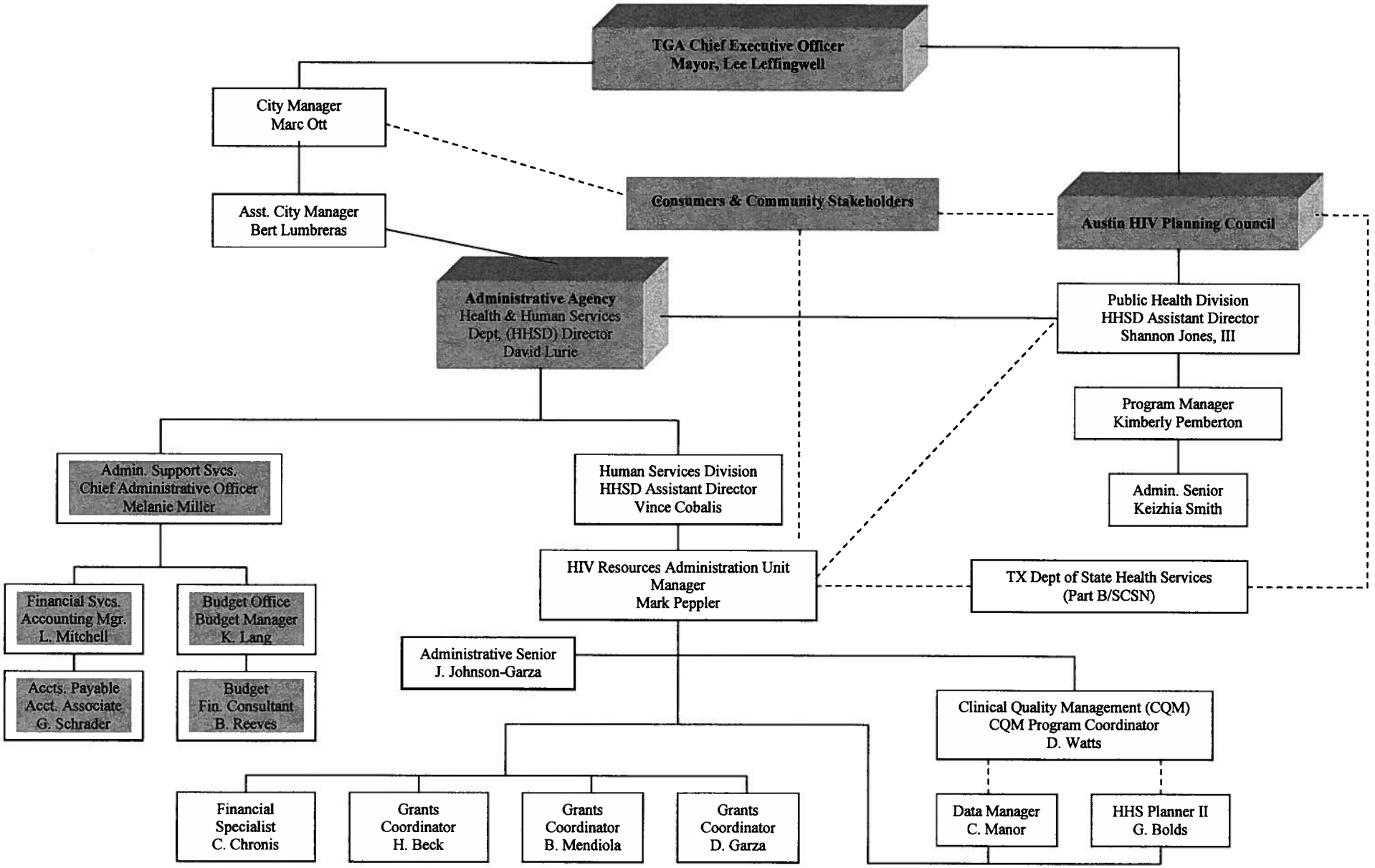
**Important:** Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

| | | | | |
|---|---|---|---|---|
| 1) Please attach Attachment 1 | TableContentsOrgChartStaffing | Add Attachment | Delete Attachment | View Attachment |
| 2) Please attach Attachment 2 | LetterPCChairIGAAgreementsAs | Add Attachment | Delete Attachment | View Attachment |
| 3) Please attach Attachment 3 | HIVAIDSEpidemiologyTableFY11 | Add Attachment | Delete Attachment | View Attachment |
| 4) Please attach Attachment 4 | ComorbiditiesTableFY11.doc | Add Attachment | Delete Attachment | View Attachment |
| 5) Please attach Attachment 5 | OtherPublicFundingTableFY11.c | Add Attachment | Delete Attachment | View Attachment |
| 6) Please attach Attachment 6 | UnmetNeedFrameworkFY11.doc | Add Attachment | Delete Attachment | View Attachment |
| 7) Please attach Attachment 7 | ImplementationPlanTableFY11.c | Add Attachment | Delete Attachment | View Attachment |
| 8) Please attach Attachment 8 | PlannedServicesTableFY11.doc | Add Attachment | Delete Attachment | View Attachment |
| 9) Please attach Attachment 9 | EIIHAMatrixFY11.doc | Add Attachment | Delete Attachment | View Attachment |
| 10) Please attach Attachment 10 | | Add Attachment | Delete Attachment | View Attachment |
| 11) Please attach Attachment 11 | | Add Attachment | Delete Attachment | View Attachment |
| 12) Please attach Attachment 12 | | Add Attachment | Delete Attachment | View Attachment |
| 13) Please attach Attachment 13 | | Add Attachment | Delete Attachment | View Attachment |
| 14) Please attach Attachment 14 | | Add Attachment | Delete Attachment | View Attachment |
| 15) Please attach Attachment 15 | | Add Attachment | Delete Attachment | View Attachment |

## Table of Contents: Attachments

# Attachment 1

## Austin Transitional Grant Area (TGA) Organizational Chart



## Staffing Plan and Personnel Requirements

Note: Refer to Organizational Chart for placement in the organization. All positions funded by Ryan White Program Part A, including MAI, are listed. FTE percentage is indicated by Administrative Agency (AA), HIV Planning Council (PC), or Clinical Quality Management (QM).

| | Name<br>Job Title<br>FTE % | Job Description<br>and<br>Rationale for Amount of Time Requested | Education and Licensure<br>Experience and Qualifications |
|---|---|---|---|
| | | **Administrative Agency** | |
| **1.** | M. Peppler<br>Manager<br>20% AA | Responsible for the overall administration of Ryan White Part A program activities. Oversees and manages staff to ensure adherence to established policies.<br>This position oversees and manages staff to ensure grant requirements are met, assesses the quality of services provided by subcontractors, and supervises data collection and quality management activities to ensure adherence to established policies. | M.A., Human Services; B.A., Healthcare management.<br><br>Over 29 years experience in HIV and STD services including work with programs of the Departments of Public Health for San Francisco and Denver. Served on San Francisco HIV Prevention Planning Council. Director of Social Services for Desert AIDS Project, a large HIV/AIDS services provider in Palm Springs, CA. |
| **2.** | B. Mendiola<br>Grants Coordinator<br>75% AA | Responsible for coordination and preparation of the Part A grant application and preparation of grant post-award reports. Coordinates procurement process by preparing and processing RFAs. Prepares and negotiates grant subcontracts; assures compliance with terms of grant by monitoring subcontracts. Processes payment requests, and monitors and analyzes contract expenses. | Master of Social Work, M.S.W.<br><br>Over 30 years of health and human services experience in administration, research, planning, and clinical services, including 12 years experience working in the Part A program. Manager, Community Health Education Dept., El Camino Hospital in Mountain View, CA; Assistant Director, Stanford Mid-Peninsula Urban Coalition; Research Associate and Counselor, Addiction Research Foundation. |
| **3.** | C. Chronis<br>Financial Specialist<br>66% AA | Responsible for conducting all fiscal activities of the grant. Establishes and monitors program budgets; ensures all fiscal reports are submitted to HRSA. Develops grant-related documents for Austin City Council action. Coordinates grant closeout activities and end-of-year reports. This position monitors Part A grant and subcontractor expenditures. | B.A., Accounting<br><br>General accounting experience in varied financial settings ranging from banking to hospital auditing and governmental systems, including 12 years supporting the Ryan White Part A program. |

| | | | |
|---|---|---|---|
| **4.** | C. Manor<br>Data Manager<br>20% AA | Responsible for all data management tasks related to the Part A grant; provide training and support of subcontracts on client level data collection and manages the HIV services data reporting system (ARIES), including data quality. Prepares service utilization data reports for use in monitoring contractor programs, and for HIV Planning Council; also prepares required HRSA/HAB grant reports (RSR/RDR) and other administrative reports for the HIV Resources Administration Unit Manager. | B.A., major in English and minor in Business Management<br><br>Over nine years of experience supporting the Ryan White program; experienced in the use of Microsoft Excel, Access, SPSS, and the ARIES client level software application. |
| **5.** | G. Bolds<br>Planner II<br>36% AA | Researches information related to delivery of core medical and support services; provides data to the HIV Planning Council to support priority setting and allocation processes. Develops and analyzes contract performance indicators to measure clinical care and support services. Collects and analyzes demographic, service utilization and outcome performance data in order to evaluate program effectiveness to ensure that program goals are accomplished. | B.A., Political Science; M.S., Urban Studies<br><br>Over 29 years of experience in health and human services program planning and administration, including seven years in the Ryan White program. Extensive experience in program assessment and evaluation, data collection and analysis, research methods and performance measures development. |
| **6.** | H. Beck<br>Grants<br>Coordinator<br>50% AA | This position provides Part A grant contract management and monitoring for contracts and assists with grant reporting activities. Performs site visits, processes requests for payment, ensures contractor compliance with contract performance requirements, and provides technical assistance to service providers regarding contractual, performance reporting, and capacity-building issues. | B.A., Business Administration<br><br>Over 19 years of HIV grants and contracts administration experience, with special expertise in all aspects of contract monitoring including provision of technical assistance. |
| **7.** | D. Garza<br>Grants<br>Coordinator<br>59% AA | See description for #6 above. Also serves as lead on MAI grant program including preparation of grant application and preparation and submission of grant post-award reports. | M.P.A. (Public Admin.); B.S., RTF Communication<br><br>Over 19 years of administrative experience, including management and program auditing, performance reporting, with additional expertise in public policy research and strategic planning. |

| | | | |
|---|---|---|---|
| | | **HIV Planning Council** | |
| **8.** | K. Pemberton<br>Program Manger<br>100% PC | Coordinates and supervises various aspects of the Planning Council's activities and mandated functions. Facilitates and ensures Planning Council processes adhere to federal, state and local requirements. Supervises support staff. This position oversees and manages the HIV Planning Council activities to ensure legislatively-mandated requirements are met. | Master of Public Administration (M.P.A.)<br><br>Site Director for Urban League of Greater Chattanooga; Patient Service Representative for Hamilton County Health Department; counselor and Case Manager with Volunteer Treatment Center. |
| **9.** | K. Smith<br>Admin. Senior<br>100% PC | Performs administrative support functions for HIV Planning Council staff and members, including meeting/event planning, posting of agendas, preparing meeting minutes and assisting in preparation of reports and documents. | Candidate for B.A. in Psychology; Certified Pharmacy Technician<br><br>Administrative experience; skill in computer software applications. |
| | | **Clinical Quality Management** | |
| **10.** | D. Watts<br>QM Coordinator<br>88% QM | This position oversees the Part A QM program and tasks related to Part A QM program reporting. Facilitates activities related to design and implementation of QM Plan, selecting project-specific continuous quality improvement evaluators, (e.g., clinical chart reviews for ambulatory outpatient medical care and oral health), initiating a comprehensive system to measure client satisfaction, and developing and implementing service-specific standards of care for funded service categories. | Bachelor of Social Science; Registered Nurse<br><br>Over 20 years of RN experience including 11 years in case management, quality management and administrative roles. Certified Professional in Healthcare Quality (CPHQ) since 2000 in 5 areas: case management; regulatory compliance; operational management; risk management; and utilization review. |
| **11.** | G. Bolds<br>Planner II<br>36% QM | Research information and data as requested for QM planning and QI activities. Analyzes service utilization data and works in collaboration with QM Coordinator in developing, monitoring, and analyzing measures. | See #5 above. |
| **12.** | C. Manor<br>Data Manager<br>56% QM | Responsible for all aspects of maintaining a comprehensive HIV Services data collection system that supports the QM program. Collates and processes QM data, e.g. client satisfaction survey and health indicator data. | See #4 above. |
| **13.** | M. Peppler<br>Manager<br>10% QM | See description in #1 above. Participates in Texas Ryan White Cross-Part QM Collaborative. | See #1 above. |

October 7, 2010

Austin Area Comprehensive HIV Planning Council

*The mission of the Austin Area Comprehensive HIV Planning Council is to develop and coordinate an effective and comprehensive community-wide response to the HIV/AIDS epidemic.*




**CONTACT INFORMATION:**
**Austin Area Comprehensive HIV Planning Council**
P.O. Box 1088, Austin, TX 78767
1520 Rutherford Lane, Austin, TX 78754

(512) 974-3419 (office)
(512) 974-2615 (office)
(512) 974-2409 (fax)
(512) 974-4400 (HIV Info Hotline)

**WEBSITE**
www.cityofaustin.org\hivcouncil

**E-mail**
HIVPlanningCouncil@gmail.com


Douglas H. Morgan, M.P.A.
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane Room 7A-55
Rockville, Maryland 20857

**SUBJECT: Chair Letter of Assurance – Austin, TX Transitional Grant Area**

Dear Mr. Morgan:

It is a pleasure to share with you my overarching support of the FY 2011 Ryan White Part A Grant Application. This Letter of Assurance signifies the application is an accurate account of current and planned activities in the Austin TGA, and consistent with programmatic requirements.

As Chair of the Austin Area Comprehensive HIV Planning Council, I also pledge my support for the paramount work being done under the auspices of the Part A Program. A summary of this work has been captured in the pages of the FY 2011 grant application and briefly referenced below:

- All awarded FY 2010 funds (Formula, Supplemental, and MAI) are currently being expended in accordance to the priorities established by the Planning Council.
- All FY 2010 Conditions of Award relative to the Planning Council's responsibilities have been addressed.
- FY 2011 priorities were determined by the Planning Council using the process established and approved by them.
- The Planning Council participated in a variety of membership trainings throughout the calendar year.

The Planning Council's planning processes and strategies are based on specific conditions outlined in the Part A grant award. For example, to ensure Part A funds are used in accordance with established priorities, a monthly reporting mechanism to readily assess service utilization and other relevant information has been implemented.

The Planning Council has made a commitment to membership training based on the individual and corporate need of the Council. Membership training has a positive affect on the overall planning and decision-making process, with the added benefit of increasing membership numbers in key areas. This was demonstrated by an increase in community participation and membership inquiries following a Planning Council training session on parliamentary procedures, which improved the overall meeting structure.

To engage and maintain Planning Council members who are representative and reflective of the epidemic, a membership recruitment campaign is spearheaded by the Planning Council annually. Targeted campaigns are held throughout the year to effectively address any membership deficiencies. A recruitment campaign is currently underway to bolster Planning Council membership in the areas of consumer and Hispanic representation, both of which are under-represented on the Council. To date, the Planning Council's recruitment strategies have proven successful, as indicated by a narrowing of the membership vacancy gap from 36% to 15% within the last 30 days.

I am proud to Chair a Planning Council that possesses the strength and versatility needed to effectively respond to the HIV epidemic in the Austin TGA.

Sincerely,

Christopher Hamilton, MPH
Chair, Austin Area Comprehensive HIV Planning Council

and legally to all terms, performances, and provisions in this Agreement.

15.0 CONFLICT OF INTEREST

15.01 The parties shall ensure that no person who is an employee, agent, consultant, officer, or elected or appointed official of City or County who exercises or has exercised any functions or responsibilities with respect to activities performed pursuant to this Agreement or who is in a position to participate in a decision-making process or gain inside information with regard to these activities, may obtain a personal or financial interest or benefit from the activity, or have an interest in any Agreement, subcontract or agreement with respect to it, or the proceeds under it, either for him or herself or those with whom he or she has family or business ties, during his or her tenure or for one year thereafter.

16.0 INTERPRETATIONAL GUIDELINES

16.01 Computation of Time. When any period of time is stated in this Agreement, the time shall be computed to exclude the first day and include the last day of the period. If the last day of any period falls on a Saturday, Sunday or a day that County or City has declared a holiday for its employees these days shall be omitted from the computation.

16.02 Number and Gender. Words of any gender in this Agreement shall be construed to include any other gender and words in either number shall be construed to include the other unless the context in the Agreement clearly requires otherwise.

16.03 Headings. The headings at the beginning of the various provisions of this Agreement have been included only to make it easier to locate the subject matter covered by that section or subsection and are not to be sued in construing this Agreement.

CITY OF AUSTIN

By: _____ Date: 9/18/98
Kirk Watson, Mayor

TRAVIS COUNTY

By: _____ Date: 9/15/98
Bill Aleshire, County Judge

# FY 2011 AGREEMENTS AND COMPLIANCE ASSURANCES
## Ryan White HIV/AIDS Treatment Extension Act of 2009
Part A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area,

Austin Transitional Grant Area, (hereinafter referred to as the EMA/TGA) assure that:

**Pursuant to Section 2602(a)(2)[1,2]**
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

**Pursuant to Section 2602(a)(2)(B)**
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

**Pursuant to Section 2602(b)(4)**
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

**Pursuant to Section 2603(c)**
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

**Pursuant to Section 2603(d)**
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

**Pursuant to Section 2604 (a)**
The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

**Section 2604(c)**
The EMA/TGA will expend not less than 75% of service dollars for core medical services, unless waived by the Secretary.

---

[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] The five new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in Section 2609(d)(1)(A).

**Pursuant to Section 2604(f)**
The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

**Pursuant to Section 2604(g)**
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

**Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)**
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

**Pursuant to Section 2604(h)(5)**
The EMA/TGA will establish a Clinical Quality Management Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5% of program funds or $3 million.

**Pursuant to Section 2604(i)**
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

**Pursuant to Section 2605(a)**
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV-related services as required in the above paragraph; and
d. documentation of this maintenance of effort will be retained.

**Pursuant to Section 2605(a)(3)**
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive.

**Pursuant to Section 2605(a)(5)**
The EMA/TGA will participate in an established HIV community-based continuum of care, if such continuum exists within the EMA/TGA.

**Pursuant to Section 2605(a)(6)**

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance policy, or any Federal or State health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

**Pursuant to Section 2605(a)(7)(A)**
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

**Pursuant to Section 2605(a)(7)(B)**
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

**Pursuant to Section 2605(a)(7)(C)**
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

**Pursuant to Section 2605(a)(8)**
The EMA/TGA has participated in the Statewide Coordinated Statement of Need process initiated by the State, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

**Pursuant to Section 2605(a)(9)**
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

**Pursuant to Section 2605(a)(10)**
The EMA/TGA will submit audits every two years to the lead state agency under Part B of Title XXVI of the Public Health Service Act.

**Pursuant to Section 2605(e)**
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

**Pursuant to Section 2681(d)**
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

**Pursuant to Section 2684**
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Lee Leffingwell Date Oct. 5, 2010
Signature
Mayor, City of Austin
Title

## Attachment 3

**HIV/AIDS Prevalence and Incidence Data – Austin TGA**

| | AIDS INCIDENCE: 01/01/08 to 12/31/09 | | AIDS PREVALENCE as of 12/31/09 | | HIV (NOT AIDS) PREVALENCE as of 12/31/09 | |
|---|---|---|---|---|---|---|
| | **No.** | **%** | **No.** | **%** | **No.** | **%** |
| **Race/Ethnicity** | | | | | | |
| White | 154 | 43.5 | 1,248 | 46.9 | 919 | 52.5 |
| African American | 74 | 20.9 | 665 | 25.0 | 381 | 21.8 |
| Hispanic | 116 | 32.8 | 714 | 26.8 | 426 | 24.3 |
| Other | 10 | 2.8 | 36 | 1.4 | 24 | 1.4 |
| **Sex** | | | | | | |
| Male | 291 | 82.2 | 2,240 | 84.1 | 1,482 | 84.7 |
| Female | 63 | 17.8 | 423 | 15.9 | 268 | 15.3 |
| **Age** | | | | | | |
| <2 years | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 2-12 years | 0 | 0.0 | 1 | 0.0 | 10 | 0.6 |
| 13 - 24 years | 22 | 6.2 | 40 | 1.5 | 112 | 6.4 |
| 25 - 34 years | 94 | 26.6 | 280 | 10.5 | 424 | 24.2 |
| 35 - 44 years | 115 | 32.5 | 826 | 31.0 | 583 | 33.3 |
| 45-54 | 82 | 23.2 | 1,053 | 39.5 | 456 | 26.1 |
| 55+ | 41 | 11.6 | 463 | 17.4 | 165 | 9.4 |
| **Exposure** | | | | | | |
| MSM | 228 | 64.4 | 1,583 | 59.4 | 1,209 | 69.1 |
| IDU | 29 | 8.3 | 395 | 14.8 | 125 | 7.2 |
| MSM/IDU | 27 | 7.7 | 257 | 9.7 | 117 | 6.7 |
| Heterosexual | 64 | 17.9 | 406 | 15.2 | 276 | 15.8 |
| Pediatric | 3 | 0.9 | 14 | 0.5 | 16 | 0.9 |
| Other | 3 | 0.9 | 8 | 0.3 | 6 | 0.3 |
| **Total** | **354** | **100** | **2,663** | **100** | **1,750** | **100** |

Source: *Texas Department of State Health Services* (eHARS as of July 2010, unadjusted for reporting delay. Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification. Other race/ethnicity includes Asian / Pacific Islander, Native American and Multi-Racial cases. Column totals may not accurately sum due to rounding. Incidence rates are annualized for the two-year period).

## Attachment 4

### Co-morbidities – Austin TGA

| Infectious Disease[1] | General Population | | Persons Living with HIV/AIDS | |
|---|---|---|---|---|
| | N | Rate per 100,000 | N | % PLWH/A Cases |
| Early Syphilis | 234 | 14.1 | 62 | 1.4 |
| White | 91 | 17.3 | 36 | 1.7 |
| African American | 56 | 43.0 | 9 | 0.9 |
| Hispanic | 76 | 14.1 | 16 | 1.4 |
| Other | 6 | 7.3 | 1 | 1.7 |
| Chlamydia | 8,065 | 485.5 | 35 | 0.8 |
| White | 2,009 | 486.3 | 14 | 0.6 |
| African American | 1,683 | 1,291.5 | 12 | 1.1 |
| Hispanic | 3,148 | 585.4 | 9 | 0.8 |
| Other | 239 | 292.1 | 0 | 0.0 |
| Gonorrhea | 1,906 | 114.7 | 53 | 1.2 |
| White | 421 | 77.3 | 31 | 1.4 |
| African American | 724 | 555.6 | 14 | 1.3 |
| Hispanic | 556 | 103.4 | 8 | 1.2 |
| Other | 28 | 34.2 | 0 | 0.0 |
| Tuberculosis | 70 | 4.2 | 142 | 3.2 |
| White | 12 | 1.0 | 29 | 1.3 |
| African American | 33 | 9.2 | 60 | 5.7 |
| Hispanic | 16 | 6.1 | 52 | 4.6 |
| Other | 9 | 19.6 | 1 | 1.7 |
| Hepatitis C | 84 | 4.9 | -- | **25.0** |
| White | 53 | 5.7 | -- | -- |
| African American | 7 | 5.2 | -- | -- |
| Hispanic | 24 | 4.2 | -- | -- |
| Other | 2 | 2.3 | -- | -- |
| **Homeless Persons[2]** | **N** | **%** | **N** | **% PLWH/A Cases** |
| General population | | | -- | -- |
| Bastrop | 101 | -- | -- | -- |
| Caldwell | 48 | -- | -- | |
| Hays | 750 | -- | -- | -- |
| Travis | 4,840 | -- | -- | -- |
| Williamson | 1,125 | -- | -- | -- |
| **Total** | **8,265** | -- | -- | -- |
| **PLWHA** | -- | -- | -- | **5.1** |

| **Persons no Health Insurance (19-64)[3]** | **N** | **%** | **N** | **% PLWH/A Cases** |
|---|---|---|---|---|
| General population | | | | |
| Bastrop | 11,703 | 22.3 | -- | -- |
| Caldwell | 6,782 | 28.5 | -- | -- |
| Hays | 33,616 | 29.1 | -- | |
| Travis | 166,581 | 24.5 | -- | -- |
| Williamson | 49,171 | 17.3 | -- | -- |
| **Total** | **271,644** | **23.5** | -- | -- |
| **PLWHA** | -- | -- | -- | **54.8** |
| **Persons living at or below 300 percent of the 2010 Federal Poverty Level[4]** | **N** | **%** | **N** | **% PLWH/A Cases** |
| White, not Hispanic | 33,587 | 36.0 | -- | -- |
| African American, not Hispanic | 85,769 | 64.0 | -- | -- |
| Hispanic | 413,845 | 73.1 | -- | |
| Other & multiracial, not Hispanic | 37,612 | 43.8 | -- | -- |
| **Total** | **907,703** | **53.0** | -- | -- |
| **Type of substance abuse[5]** | **N** | **%** | **N** | **% PLWH/A Cases** |
| General population | | | | |
| Any illicit drug use | 279,332 | 21.3 | -- | -- |
| Intravenous drug use | 20,983 | 1.6 | -- | -- |
| Heavy Alcohol | 91,800 | 7.0 | -- | |
| Cocaine/crack | 60,326 | 4.6 | -- | -- |
| Marijuana | 246,546 | 18.8 | -- | -- |
| Psychedelics | 32,786 | 2.5 | -- | -- |
| Inhalants | 10,492 | 0.8 | -- | -- |
| **Any illicit drug use** | -- | -- | -- | **75.3** |
| **Injection drug use** | -- | -- | -- | **49.8** |
| **Mental Illness Prevalence[6]** | **N** | **%** | | |
| General population | | | | |
| Any mental illness | -- | 21.0 | -- | -- |
| Schizophrenia | -- | 1.3 | -- | -- |
| Any anxiety disorder | -- | 16.4 | -- | |
| Bipolar disorder | -- | 1.7 | -- | -- |
| Severe cognitive impairment | -- | 1.2 | -- | -- |
| **PLWHA** | -- | -- | -- | **46.6** |

[1] *Texas Department of State Health Services, 2010; Centers for Disease Control and Prevention, estimate of persons co-infected with HIV and HCV, 2010. Syphilis includes primary, Secondary,*

*Early Latent. Other race/ethnicity includes Asian / Pacific Islander, Native American, Multi-Racial and other race/ethnicity cases. Total number of STI cases includes cases with unknown race/ethnicity.*

[2] *Helping America's homeless: emergency shelter or affordable housing, Washington DC, Urban Institute Press estimates applied to 2010 projected population; City of Austin / Travis County Health & Human Services Department 2007; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[3] *Texas Commission on Health & Human Services 2003 estimates applied to 2010 projected 19-64 year old population; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[4] *Federal Register, Vol. 75, No. 148, August 3, 2010, pp. 45628-45629; US Census Bureau 2008 American Community Survey Public Use Microdata Sample; & Texas State Data Center & Office of the State Demographer. Household size, income & race/ethnicity obtained for the state of Texas from the American Community Survey and were applied to 2010 projected TGA population.*

[5] *Texas Commission on Alcohol & Drug Abuse, 2000 Texas survey of substance use among adults prevalence estimates applied to 2010 projected ≥ 18-year-old population; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

[6] *Mental Health: A report of the Surgeon General; Travis County Supplement to HIV/AIDS Surveillance 2001-2004.*

## Attachment 5

**Other Public Funding – Austin TGA**

| Categories | Ryan White Program Part B, Part C, MAI | | Other Federal Funds | | State Funds | | Local Funds | | TOTAL FUNDS | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Funds | % | Funds | % | Funds | % | Funds | % | Funds | % |
| Outpatient/Ambulatory Medical Care | $1,229,442 | 16.36 | $0 | 0 | $159,760 | 9.77 | $1,015,295 | 44.87 | $2,404,497 | 16.39 |
| State AIDS Drug Assistance Programs | $5,813,479 | 77.34 | $0 | 0 | $0 | 0 | $0 | 0 | $5,813,479 | 39.63 |
| Home and Community Based Support Services | $101,287 | 1.35 | $2,102,024 | 64.63 | $255,699 | 15.63 | $892,322 | 39.43 | $3,351,332 | 22.85 |
| Other Outpatient/ Comm. Based Primary Medical Care Services | $64,562 | 0.86 | $0 | 0 | $501,560 | 30.67 | $125,053 | 5.53 | $691,175 | 4.71 |
| Oral Health Care | $238,177 | 3.17 | $0 | 0 | $0 | 0 | $0 | 0 | $238,177 | 1.62 |
| Substance Abuse/ Mental Health Services | $70,000 | 0.93 | $254,000 | 7.81 | $20,000 | 1.22 | $0 | 0 | $344,000 | 2.35 |
| Minority AIDS Initiative (MAI) (Parts B and C only) | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 |
| HIV Counseling and Testing Services | $0 | 0 | $896,365 | 27.56 | $698,518 | 42.71 | $230,216 | 10.17 | $1,825,099 | 12.44 |
| TOTAL PUBLIC FUNDING | $7,516,947 | 100 | $3,252,389 | 100 | $1,635,537 | 100 | $2,262,886 | 100 | $14,667,759 | 100 |

## Attachment 6

**Unmet Need Framework**

| | Population Sizes | Value | | Data Source(s) |
|---|---|---|---|---|
| **A.** | Number of persons living with AIDS (PLWA), for the period of January - December 2009. | 2,663 | | Unadjusted eHARS (06/30/2010), cases diagnosed and living as of 12/31/09; Cases diagnosed in Texas Department of Criminal Justice (TDCJ) removed and cases with unknown mode of exposure have been proportionately redistributed. |
| **B.** | Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of January - December 2009. | 1,750 | | Unadjusted eHARS (06/30/2010), cases diagnosed and living as of 12/31/09; Cases diagnosed in TDCJ removed and cases with unknown mode of exposure have been proportionately redistributed. |
| **C.** | Total number of HIV+/aware for the period of January - December 2009. | 4,413 | | |
| | **Care Patterns** | **Value** | | **Data Source(s)** |
| **D.** | Number of PLWA who received the specified HIV primary medical care during the 12-month period (calendar year 2009). | 1,916 | | Evidence of met need found in eHARS or through matches with AIDS Drug Assistance Program (ADAP), Ryan White program data (all Titles), or data from electronic laboratory reporting of viral load and CD4 results. |
| **E.** | Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (calendar year 2009). | 996 | | Evidence of met need found in eHARS or through matches with ADAP, Ryan White program data (all Titles), or data from electronic laboratory reporting of viral load and CD4 results. |
| **F.** | Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (calendar year 2009). | 2,912 | | |
| | **Calculated Results** | **Value** | **%** | **Calculation** |
| **G.** | Number of PLWA who did not receive the specified HIV primary medical care | 747 | 28% | Value: Value A - Value D. Percent: Value G/ Value A |
| **H.** | Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care | 754 | 43% | Value: Value B - Value E. Percent: Value H / Value B |
| **I.** | Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) | 1,501 | 34% | Value: Value C - Value F. Percent: Value I / Value C |

Source: *Texas Department of State Health Services*, 2010 using HRSA/HAB Unmet Need Framework Excel Worksheets.

## Attachment 7

# FY 2011 Implementation Plan

| Service Priority Number: 10 | | Service Priority Name: Outpatient/Ambulatory Medical Care | | | |
|---|---|---|---|---|---|
| **Service Goal:** Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations. | | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** | | **Time Frame** | **FY 2011 Funds** |
| | | Projected Clients | Projected Units | 3/1/11 to 2/28/12 | **$1,151,809** |
| a. Provide outpatient primary medical care consistent with PHS/NIH/IDSA guidelines to existing and new HIV positive clients in the TGA. | Per visit | 950 | 2,998 | | $929,380 |
| | Per laboratory test | 718 | 4,308 | | $222,429 |

| Service Priority Number: 7 | | Service Priority Name: Oral Health Care | | | |
|---|---|---|---|---|---|
| **Service Goal:** Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations. | | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** | | **Time Frame** | **FY 2011 Funds** |
| | | Projected Clients | Projected Units | | |
| a. Provide diagnostic, preventive, and therapeutic dental services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per visit | 720 | 2,878 | 3/1/11 to 2/28/12 | **$447,732** |

| **Service Priority Number: 12a** | **Service Priority Name: AIDS Pharmaceutical Assistance (local)** | | | |
|---|---|---|---|---|
| **Service Goal:** Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations. | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** | | **Time Frame** | **FY 2011 Funds** |
| | | Projected Clients | Projected Units | | |
| a. Provide FDA-approved medications to existing and new eligible clients including those awaiting approval of ADAP or Compassionate Use Programs. | Per prescription | 1,000 | 6,871 | 3/1/11 to 2/28/12 | **$365,987** |

| **Service Priority Number: 9** | **Service Priority Name: Mental Health Services** | | | |
|---|---|---|---|---|
| **Service Goal:** Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources. | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** | | **Time Frame** | **FY 2011 Funds** |
| | | Projected Clients | Projected Units | | |
| a. Provide mental health treatment and/or counseling services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per visit | 433 | 4,075 | 3/1/11 to 2/28/12 | **$334,166** |

| **Service Priority Number: 1 (Part A); 4 (MAI)** | **Service Priority Name: Non-Medical Case Management Tier 1 (Part A) and Tier 2 (MAI)** | | | |
|---|---|---|---|---|
| **Service Goal 1:** Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations.<br>**Service Goal 2:** Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources. | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** Projected Clients | **Quantity:** Projected Units | **Time Frame** | **FY 2011 Funds** |
| **Part A and MAI**<br>a. Provide non-medical case management services consistent with Standards of Care to existing and new eligible clients in the TGA. | Per 15 minutes | Part A 166 | Part A 12,800 | 3/1/11 to 2/28/12 | **Part A $256,017** |
| | | MAI 126 | MAI 6,546 | | **MAI $166,007** |

| **Service Priority Number: 13** | **Service Priority Name: Substance Abuse Services – residential** | | | |
|---|---|---|---|---|
| **Service Goal:** Optimize the continuum of care by ensuring all Ryan White funded services, particularly Mental Health Services and Substance Abuse Services, are of the highest quality and coordinated with non-Ryan White organizations for linkage to other funding sources. | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** Projected Clients | **Quantity:** Projected Units | **Time Frame** | **FY 2011 Funds** |
| a. Provide access to substance abuse treatment and/or counseling services in a residential setting to eligible existing and new eligible clients in the TGA. | Per 24-hour day | 31 | 602 | 3/1/11 to 2/28/12 | **$98,183** |

| **Service Priority Number: 14b (MAI)** | | **Service Priority Name: Outreach Services (MAI)** | | | |
|---|---|---|---|---|---|
| **Service Goal:** Engage out-of-care PLWH/A and maintain in-care PLWH/A in system of care by providing full access to outpatient medical care and other eligible services. Care shall focus on: cultural competency, sensitivity, and proficiency; removal of existing barriers; and evidence-based strategies that target underserved and hard-to-reach populations. | | | | | |
| **Objective:** | **Service Unit Definition:** | **Quantity:** | | **Time Frame** | **FY 2011 Funds** |
| | | Projected Clients | Projected Units | | |
| a. Provide outreach encounters to persons disproportionately at risk for HIV infection, in order to identify HIV positive persons who are not in care. | Per encounter | 35 | 3,480 | 3/1/11 to 2/28/12 | **$29,716** |

## Attachment 8

# Planned Services Table

| Priority | Core Medical Services | Amount |
|---|---|---|
| 2 | Medical Case Management | $217,393 |
| 5 | Substance Abuse Services – outpatient | $203,172 |
| 6 | Health Insurance Premium & Cost Sharing Assistance | $89,335 |
| 7 | Oral Health Care | $447,732 |
| 8 | Early Intervention Services | $25,484 |
| 9 | Mental Health Services | $334,166 |
| 10 | Outpatient / Ambulatory Medical Care | $1,151,809 |
| 12a | AIDS Pharmaceutical Assistance (local) | $365,987 |
| 12b | AIDS Drug Assistance Program (ADAP) | $1,000 |
| 22 | Medical Nutrition Therapy | $72,474 |
| 27 | Hospice Services | $59,500 |
| | **Total Core = 80.3%** | **$2,968,052** |

| Priority | Support Services | Amount |
|---|---|---|
| 1 | Non-Medical Case Management Tier 1 | $256,017 |
| 3 | Medical Transportation Services | $25,000 |
| 4 | Non-Medical Case Management Tier 2 (MAI) | $166,007 |
| 11 | Housing Services | $10,500 |
| 13 | Substance Abuse Services – residential | $98,183 |
| 14a | Outreach Services (non-MAI) | $67,185 |
| 14b | Outreach Services (MAI) | $29,716 |
| 17 | Psychosocial Support Services | $15,000 |
| 19 | Food Bank / Home-Delivered Meals | $60,967 |
| | **Total Support = 19.7%** | **$728,575** |
| | **TOTAL SERVICES** | **$3,696,627** |

## Attachment 9

# EIIHA Matrix

<table>
<tr><th colspan="6">All Individuals Unaware of their HIV Status (HIV Positive & HIV Negative)</th></tr>
<tr><th colspan="3">Tested</th><th colspan="3">Untested</th></tr>
<tr><th colspan="2">Individuals Not Post-Test Counseled<br>(HIV Positive & HIV Negative)</th><th>Received Preliminary HIV Positive Results Only-<br>No Confirmatory Test</th><th colspan="3">High-Risk Individuals</th></tr>
<tr><th>Tested Confidentially</th><th>Tested Anonymously</th><th></th><th>Injection and Other Drug Users (IODUs)</th><th>Men who have Sex with Men (MSM)</th><th>Recently Released</th><th>African American Women</th></tr>
</table>