San Antonio
Transitional Grant Area
(Bexar, Comal, Guadalupe, and Wilson Counties)
and
Health Services Delivery Area
(Bexar, Comal, Guadalupe, and Wilson, Atascosa, Bandera, Frio, Gillespie, Karnes, Kendall, Kerr, and Medina Counties)
Integrated HIV Prevention and Care Plan

2017-2021

Contents

Executive Summary

Bexar County Department of Community Resources Ryan White Program (RWP) Administrative Agency (AA), the San Antonio Ryan White Planning Council (PC) and Integrated HIV Prevention and Care Plan Stakeholder Group (HPCG) presents this new City Only Integrated HIV Prevention and Care Plan, which responds to the planning guidance published by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) in June 2015. This plan serves as the guide for the integrations of prevention and care services for the San Antonio (SA) Transitional Grant Area (TGA) and Health Services Delivery Area (HSDA).

The *National HIV/AIDS Strategy Updated to 2020* (NHAS) outlines the national vision and action plan for curtailing the HIV epidemic and improving health outcomes of all people living with HIV, including AIDS (PLWH) in the United States. The SATGA/HSDA's plan embraces this vision:

> *The United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination. (NHAS, August 2015)*

The SATGA/HSDA City Only Integrated HIV Prevention and Care Plan articulates this vision locally and presents a roadmap for HIV services over the next five years, identifying specific goals, objectives, and activities that are needed to radically interrupt transmission of HIV in the SATGA/HSDA and improve health outcomes of all PLWH. SATGA/HSDA's HIV Continuum of Care, which includes four HIV outcome measures (i.e., linked to care, retained in care, antiretroviral therapy and virally suppressed). This plan has become a cornerstone for planning and provides a useful tool for measuring SATGA/HSDA progress and success in achieving NHAS goals.

This plan is divided into three sections: (1) SATGA/HSDA Statement of Need, (2) Integrated HIV Services Plan; and (3) Monitoring and Improvement. The SATGA/HSDA Statement of Need describes the HIV epidemic in the 12 county area (i.e., Bexar, Comal, Guadalupe, Wilson, Atascosa, Bandera, Frio, Gillespie, Karnes, Kendall, Kerr, and Medina Counties); social determinants of health and their impact on PLWH; available financial resources for services delivered within the SATGA/HSDA; HIV workforce capacity needs; and the needs, barriers, and gaps of persons living with and at high risk of acquiring and/or transmitting HIV to others. This section also includes a description of the current and planned use of data to improve prevention and care services. The Integrated HIV Services Plan describes SATGA/HSDA's specific goals, measurable objectives, planned strategies, and core activities that are needed to curtail HIV transmission in the SATGA/HSDA and improve the health and well-being of all PLWH. These are closely aligned with the vision and goals articulated in the NHAS. This section also describes the collaboration of key stakeholders and the engagement of PLWH in the planning process. Lastly, the monitoring section outlines a specific method for monitoring progress of measurable objectives and how this information will be used to improve HIV services in SATGA/HSDA.

The SATGA/HSDA City Only Integrated HIV Prevention and Care Plan is a living document. The overall plan will be reviewed annually, as well as progress in achieving desired outcomes. The NHAS provides ambitious targets that SATGA/HSDA, over the next five years, will strive towards: for example, 90% of all persons living with HIV will know their serostatus, reduce new diagnoses by 25%, increase retention in care to 90%, increase viral suppression to 90%, etc. This plan represents an aggressive step forward towards ending HIV in the SATGA/HSDA.

Introduction

Development of the SATGA/HSDA 2017-2021 City Only Integrated HIV Prevention and Care Plan, including the SATGA/HSDA Statement of Need resulted from a cooperative process between the Bexar County Department of Community Resources RWP AA, the PC, the Integrated HIV Prevention and Care Plan Stakeholder Group (HPCG), the Texas Department of State Health Services (TDSHS), and the HIV Texas Syndicate.

Participants of the HPCG include the following community members: a Community Based Organization (CBO), AIDS Service Organization (ASO) not funded by Ryan White that does both prevention and linkage to care, the County Hospital District (including a RWP funded clinic), non-profit ASO that works with women and youth, PC Members, HIV Consumers, the San Antonio Police Department, the Local Public Health Planning Agency, a Rural Service Provider, Homeless Providers, LGBTQ Youth Center Provider, HIV/STI Prevention Providers, the Veterans Health Administration (VA), RWPC, RWPD, Local Substance Abuse and Mental Health Services Administration (SAMHSA) funded projects, the San Antonio Metropolitan Health District (MetroHealth), and Putting an End to Abuse through Community Efforts (PEACE) Initiative.

The TDSHS Texas HIV Syndicate serves as the statewide HIV/STD community planning group for Texas. Drawing from the broad recommendations in the Texas HIV Plan and related planning documents, Syndicate members make policy, system, and practice recommendations and create tools to help regional stakeholders address HIV and other STDs with evidence-based strategies tailored to meet regional needs. The Syndicate acts in an advisory capacity to TDSHS staff and ensures that Texas maintains an inclusive and participatory planning process for the delivery of prevention and care services.[1]

The work group provided a strong foundation for developing the goals of this plan to:

- Enhance collaborations between prevention and care funded agencies and other community organizations.
- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV/AIDS (PLWH)
- Reduce HIV-related disparities and health inequities
- Achieve a more coordinated response to the HIV epidemic
- Transfer knowledge and expertise throughout the community to improve HIV prevention.
- Transfer knowledge and expertise throughout the community to improve HIV care and services.
- Establish new community collaborations with prevention and care funded entities.
- Improve the quality of HIV care and services for PLWH through an enhanced quality management program.

Mission

The mission of the SATGA/HSDA Integrated City Only HIV Prevention and Care Plan for 2017 – 2021 is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the need of populations living with, affected by, or at risk for HIV.

[1] Texas. (2016, January 26). *Texas DSHS HIV/STD program - program improvement resources*. Retrieved September 14, 2016, from https://www.dshs.texas.gov/hivstd/dir/

Vision

The SATGA/HSDA will become a community with a coordinated system of HIV prevention and care, where new HIV infections are rare, and, when they do occur, where every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high-quality, life-preserving care, free of stigma and discrimination.

Shared Values

- Strive for a seamless system of coordinated HIV prevention and care needs.
- Provide the highest quality care and services in the most cost-effective manner to reduce duplication of services.
- Ensure equitable and easy access to services.
- Ensure that all services are linguistically, culturally competent and responsive.
- Treat all consumers with compassion and respect.

This plan serves as the guide for the integrations of prevention and care services for the SATGA/HSDA and describes the HIV epidemic in the San Antonio Region which includes a 12 county area (**Figure 1**).

Characteristics of this diverse region include: [2]

- With 1.5 million residents, Bexar County, home to San Antonio, is the population center of the region. It is also the epicenter of the HIV epidemic.
- The region combines urban and rural areas. Bexar County has a population density of 2,879 people per square mile. The San Antonio metro region had the sixth-fastest growth rate in the country among metros with a population of 1 million or more, growing by 2.2 percent, from 2,332,790 to 2,384,075 people last year. The metro area includes Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina and Wilson counties. [3]
- The SATGA/HSDA is minority-majority areas, with 63% Hispanic residents, respectively.
- In Bexar County, roughly 43% of residents speak a language other than English at home. Similar percentages are found in the other SATGA/HSDA.
- Literacy rates for the SATGA/HSDA are approximately 15%.
- Poverty rates for the SATGA/HSDA are approximately 20%.
- The RWP AA is housed in the Bexar County Department of Community Resources and is **not** a local health department; therefore, must reply on collaborations with local health departments and planning agencies to strengthen prevention and care programs in the SATGA/HSDA.
- The SATGA/HSDA is not a **direct** recipient of any CDC prevention funding, therefore the AA formulated in December 2009, along with MetroHealth and a local AIDS Service Organization (ASO), the HIV/Syphilis Testing Taskforce, which is composed of over 90 community partners providing prevention, intervention, and testing services and programs.
- The AA is funded for RWP Parts A, B, and HOPWA and collaborates with locally funded RWP Parts C, D, and F.
- The AA participates in the TDSHS HIV Texas Syndicate, a planning process for integrated prevention and care services across the state of Texas since 2012.

[2] (QuickFacts San Antonio, Texas)

[3] Davila, V., & Writer, S. (2016, March 24). *San Antonio area is no. 6 in population growth in the U.S. Among big metros*. Retrieved September 14, 2016, from http://www.expressnews.com/news/local/article/San-Antonio-area-is-No-6-in-population-growth-in-7030115.php

Please note as of May 12, 2016, AIDS Regional Information Evaluation System (ARIES) reports have been producing inaccurate results in "Production" impacting our AA, PC, HIV prevention and care providers, and other ARIES users. The AA's inability to complete HRSA reports (e.g. RSR since 2014) have been hindered by the ability to access reports in ARIES. AA's have been instructed by TDSHS to not utilize reports or publish data from ARIES until further notice, including reporting to PCs and to HRSA. Any reporting that utilizes data from an ARIES report is impacted, including reports for MAI, Part A, etc. The AA has notified the Part A HRSA Project Officer and continues to seek guidance with TDSHS on this matter (see **Appendix D** for letter from TDSHS regarding ARIES). Because of the aforementioned issue with ARIES, the HPCG Work Group decided to use data retrieved in September 2015 for the FY 2016-2017 Part A Grant Application. The baseline data used in the Integrated HIV Prevention and Care Plan is Calendar Year (CY) 2014, therefore does not cover the recommended 5 year trending data.

Please see **Appendix A** for a list of Commonly Used Terms

Section I: SATGA/HSDA Statement of Need

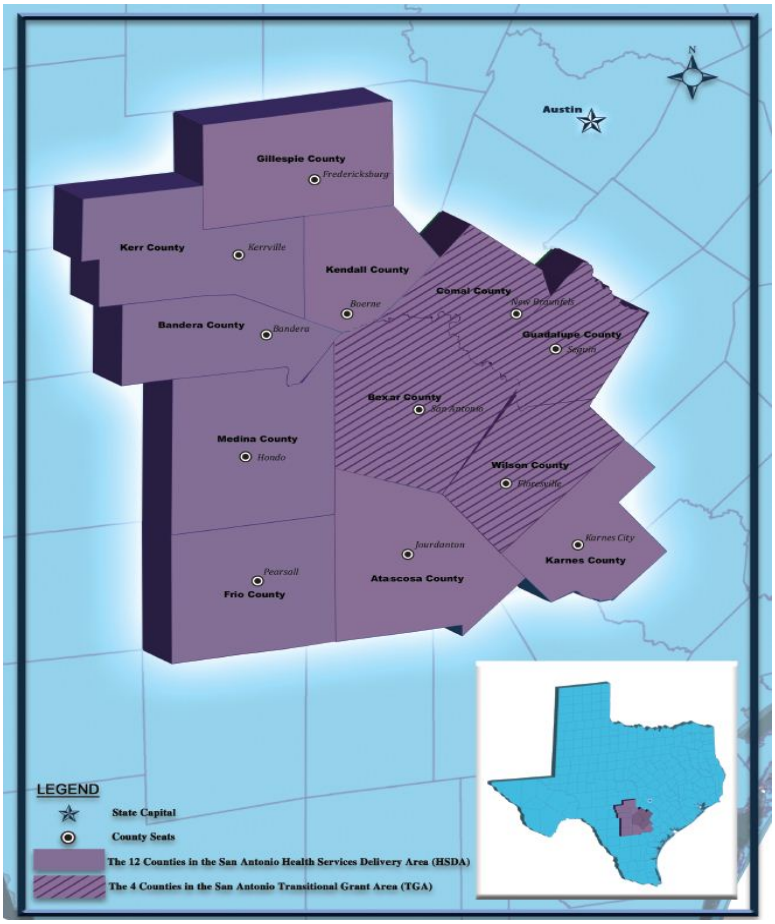
A. San Antonio TGA/HSDA Epidemiologic Overview

The Bexar County Department of Community Resources RWP AA has participated as a member of the TDSHS Texas HIV Syndicate since its inauguration in 2012. The purpose of the Texas HIV Syndicate is to reduce HIV infections in Texas by identifying strategies to enhance and expand work already being done across the spectrum of HIV prevention and treatment. Texas HIV Syndicate priority groups develop resources to advance the identified strategies across the state (Texas, 2016).

a. San Antonio TGA/HSDA Jurisdictional Profile

Figure 1: The San Antonio Region is divided into two areas (SATGA/HSDA) as follows:

- The RWP Part A funded SATGA is comprised of four (4) counties including Bexar, Comal, Guadalupe, and Wilson.
- The RWP Part B funded SAHSDA is comprised of twelve (12) counties including those in the SATGA and Atascosa, Bandera, Frio, Gillespie, Karnes, Kendall, Kerr, and Medina.



At end of 2014, there were more than 6,300 SATGA/HSDA PLWH, with about 350 new HIV diagnoses a year. Both the number of PLWH and new diagnoses rose over the past five years. Black, Hispanic, and White men who have sex with (MSM) and Black heterosexual women made up more than 7 in 10 of those with HIV in the SATGA/HSDA. Both Blacks and MSM of all races/ethnicities show persistently

higher burdens of HIV. In 2014, almost four in five PLWH had at least one HIV-related medical visit, and more than half had achieved viral suppression, increasing health outcomes and lowering HIV transmission through viral suppression and new prevention strategies.

Table 1 displays the overall trend-line for HIV/AIDS incidence and prevalence for the past three years in the SATGA/HSDA. A comparison of the demographic profile of PLWH and new HIV/AIDS cases clearly displays where the epidemic has disproportionately impacted the area.

TABLE 1. HIV/AIDS INCIDENCE AND PREVALENCE IN THE SATGA/HSDA, 2012-2014

AIDS INCIDENCE			HIV INCIDENCE			AIDS PREVALANCE			HIV PREVALANCE			TOTAL		
2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
168	165	142	334	392	347	3049	3145	3186	2225	2463	2628	5776	6165	6303

As of December 31, 2014, there were 2,628 PLWH in the SATGA/HSDA. Males represent 85% of incidence while females represent 15%. The Hispanic PLWH represent 56%; 23% are White; and another 17% are Black, less than 1% reported as “Other” which include Asian, Pacific Islander, Native American, and 3% did not report race or ethnicity. The largest age group for PLWH is 25-34, who make up 29%, followed by those 35-44, who make up 23%, and the ‘Aged’ 45+, at 37%. Seventy-one percent (71%) of PLWH reported MSM as the mode of exposure with heterosexual contact being the second highest category at 16%.

As of December 31, 2014, there were 3,186 persons living with AIDS (PLWA) in the SATGA/HSDA. Of the cases reported, Hispanics comprise 61% of the AIDS prevalence, while White represents 22%, “others” are less than 1%, and PLWA not reporting race or ethnicity are 3%. Blacks comprise 13% of AIDS prevalence. PLWA tend to be older than PLWH, with 66% aged 45 and older, compared to 37% of HIV cases. Among PLWA diagnosis, a “late tester” is defined as having an AIDS diagnosis that occurred in 12 months of the initial HIV diagnosis. In the SATGA/HSDA, this population is a subset of AIDS cases and is significant to the increasing rates of reported cases. In 2014, 29% of those who tested positive for HIV were diagnosed with AIDS during the year. This pattern is most evident in Bexar County, the largest single population county in the twelve-county San Antonio Region and the county with the highest incidence and prevalence of the disease.

Number of new AIDS cases reported in the past three years (2012 – 2014): There were 475 new AIDS diagnoses reported in the SATGA/HSDA between January 1, 2012 and December 31, 2014, including 168 new cases in 2012, 165 new cases in 2013, and 142 new cases in 2014. Among new AIDS cases reported January 1, 2012 through December 31, 2014, 83% were male and 17% were female; 61% Hispanic, 19% White, 11% Black and less than 1% “Other.” The largest age group was the ‘Aged’ who are 45+ years of age, with 37% of new AIDS cases. Individuals between the ages of 35-44, represent 22% of new AIDS cases. Individuals 25-34 years of age comprise 29%. MSM continue to represent the largest exposure category among new AIDS diagnoses with 67%, followed by heterosexual 15%, Intravenous Drug User (IDU) 11% and MSM/IDU 4%. The pediatric exposure group only accounts for less than 1% of new AIDS cases.

- Total number of funded CDC programs
- Total number of HIV testing sites (CDC/HRSA funded)
- Routine testing none since Dec 2014
- Needle exchange programs

b. Epidemiologic Overview

This overview presents information on known cases of HIV infection in the SATGA/HSDA diagnosed through December 31, 2014 and reported as of June 30, 2015.

The number of PLWH in Texas has increased because highly effective treatment has lengthened their lives – people with HIV who get early treatment (and stay on treatment) have lifespans nearly comparable with people without HIV. New diagnoses of HIV infection, on the other hand, have been stable.

As in the State, over the past five years, the number of SATGA residents living with diagnosed HIV infections has increased by about 5% a year, rising from about 4,700 in 2010 to more than 5,800 in 2014. In contrast to State trends, the number of new diagnoses in the SATGA also increased by about 8% over the past five years, although TDSHS estimates that the number of new *infections* in the area did not increase significantly.

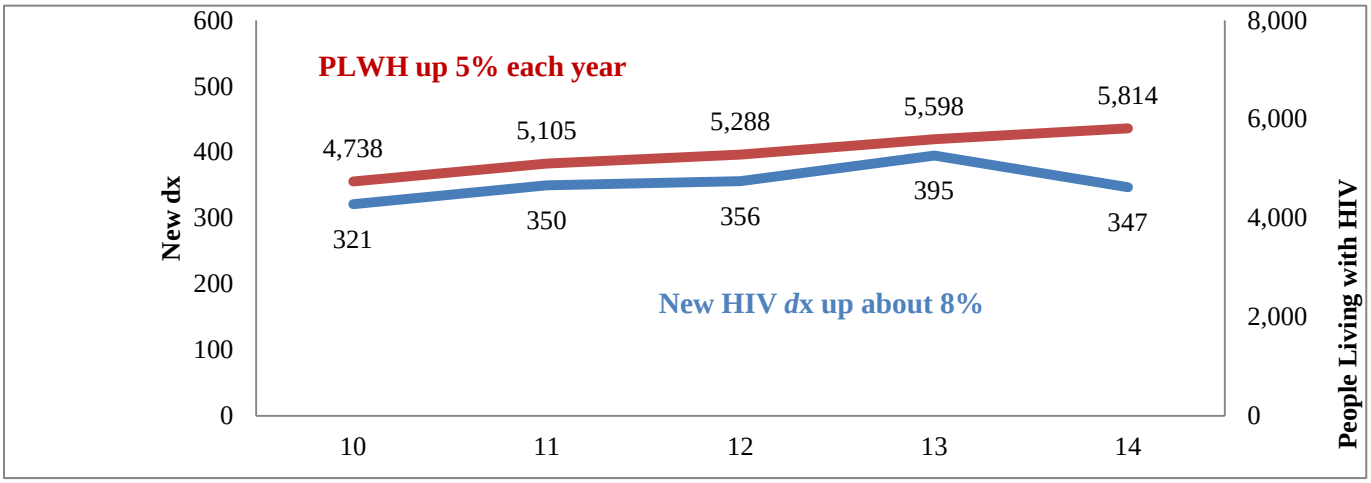


Figure 2: SATGA residents living with diagnosed HIV infections and residents with new HIV diagnoses, 2010-2014

Gay and bisexual men and other MSM made up more than two of every three SATGA residents living with diagnosed HIV infections in 2014; for Texas overall, the share for MSM is closer to half. Heterosexuals made up less than one in five PLWH. Hispanics made up the largest race/ethnic group of PLWH – about three in five. More than half the PLWH were 45 or older.

MSM have an even larger presence among those newly diagnosed, with MSM making about three in four SATGA residents newly diagnosed from 2010 to 2014. Heterosexuals made up about 13% of the new diagnoses, which is similar to their representation in PLWH, but the count of high risk heterosexual (HRH) diagnoses were flat from 2010 and 2013, as were new diagnoses in IDU and MSM/IDU. The only group to show increases in new diagnoses were MSM.

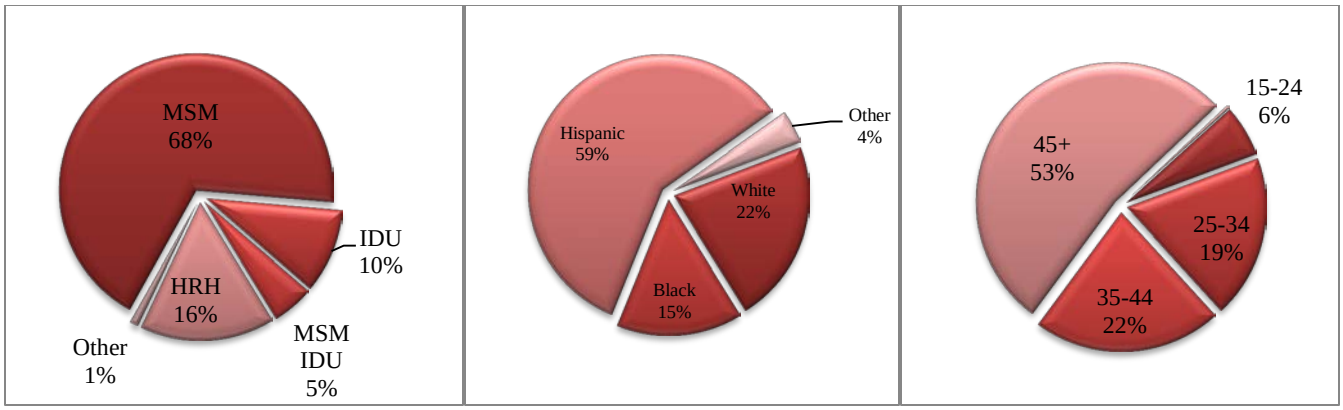


Figure 3: 2014 PLWH in the SATGA by mode of transmission, race/ethnicity, and age

Hispanics made up about three in five SATGA residents who were newly diagnosed between 2010 and 2014. The profile of Texans with new diagnoses is younger than the profile of PLWH – about one in three were 15-24 years old at the time of their diagnosis. This trend is driven by increased diagnoses in young MSM.

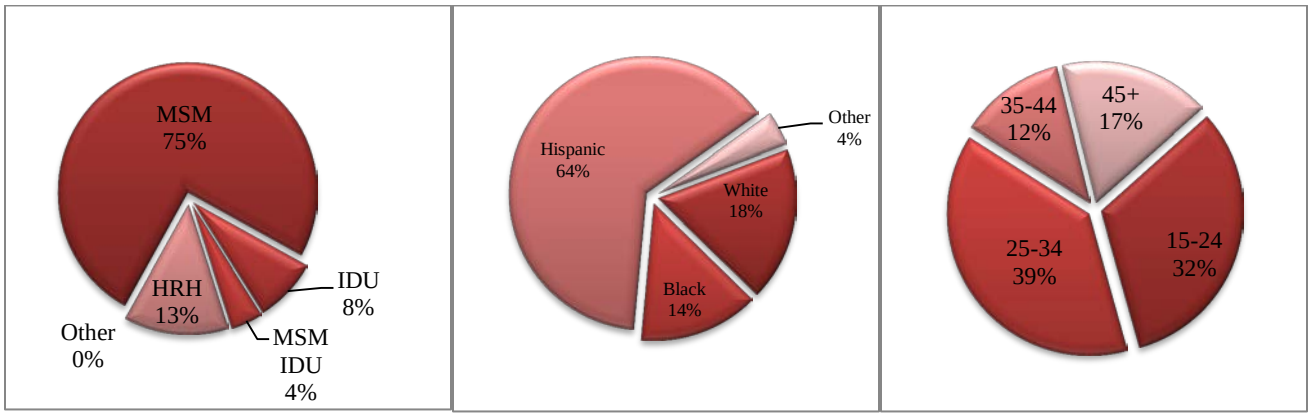


Figure 4: SATGA residents newly diagnosed with HIV from 2010-2014 by mode of transmission, race/ethnicity, and age at diagnosis

Four groups made up 70% PLWH in 2014 and more than three out of four new diagnoses over the last five years: Black MSM, Hispanic MSM, White MSM, and Black HRH women. Hispanic MSM alone made up around half of the PLWH and persons newly diagnosed with HIV. Please note that Hispanic heterosexual women make up a larger number of PLWH and new diagnoses in this SATGA than in the state overall (about 4% of prevalence and new diagnoses).

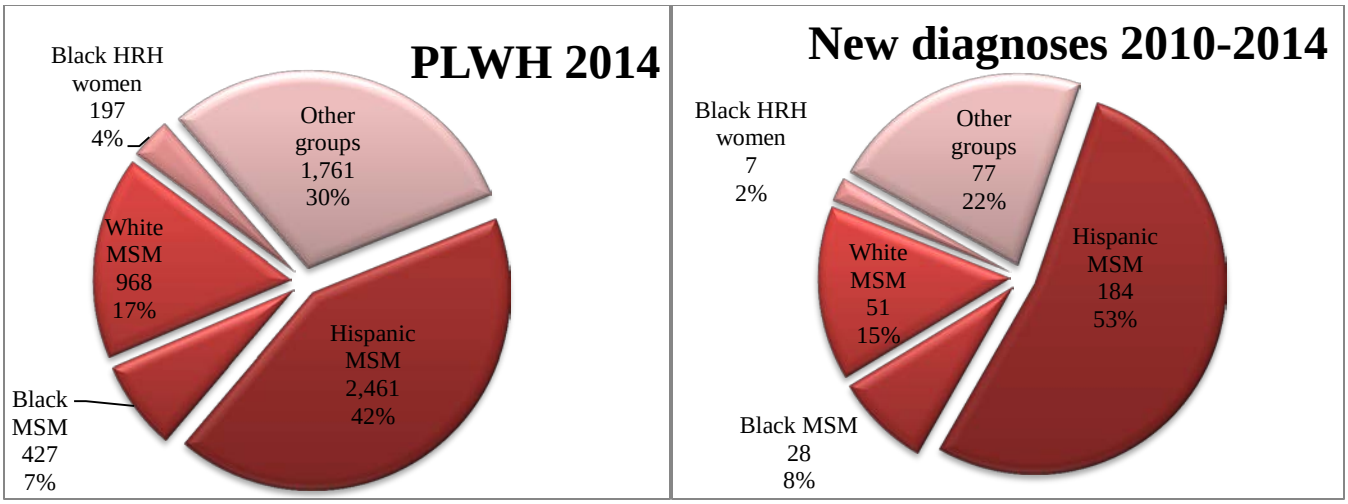


Figure 5: Priority populations in the SATGA PLWH and residents with new HIV diagnoses

Over the past five years, the number of Black and Hispanic MSM and Black HRH women living with diagnosed HIV infections increased by about 30%. Flat prevalence in a group is unusual, but this trend was also seen at the State level. New diagnoses in Hispanic MSM increased by a third, but diagnoses in all other groups were flat or decreased.

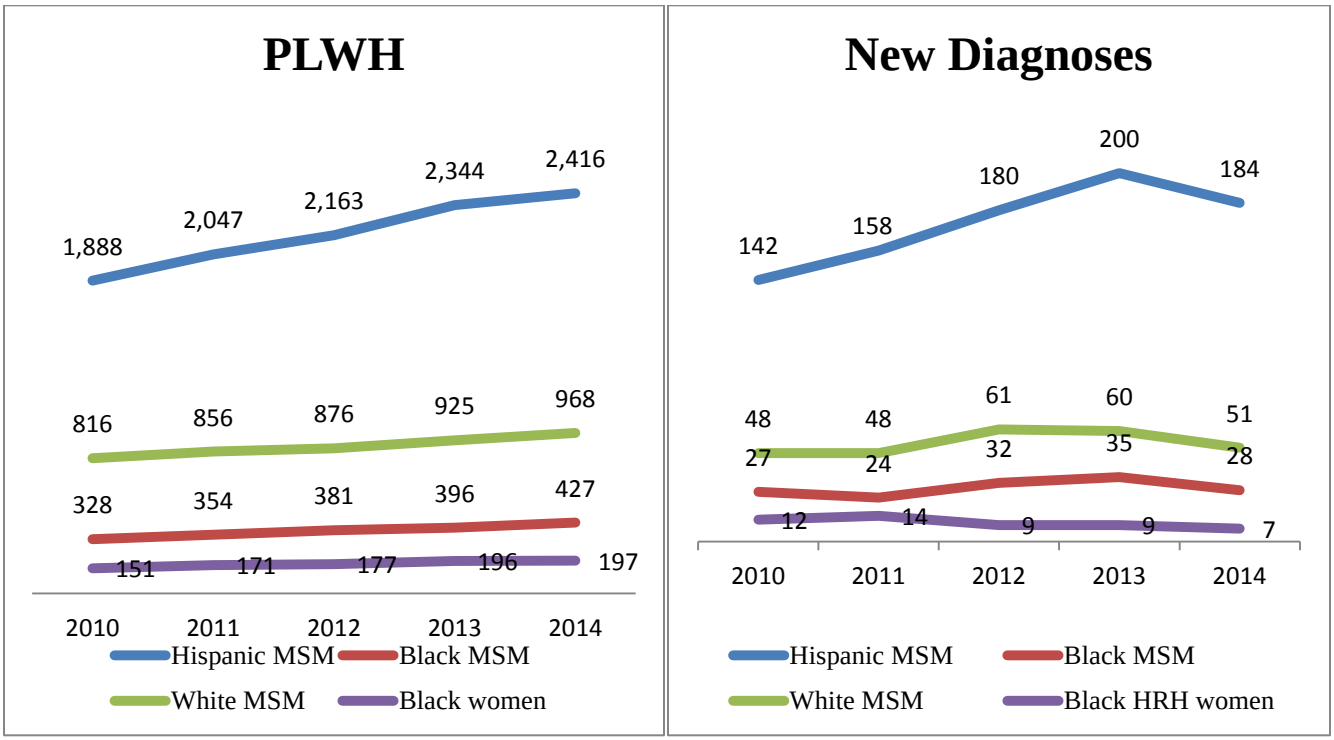


Figure 6: Changes in numbers of PLWH and new diagnoses in priority populations, SATGA 2010-2014

Hispanics make up half of the PLWH and almost two-thirds of those newly diagnosed with HIV. The prevalence rates for Blacks, demonstrates that they were two to three times higher than rates for Whites and Hispanics. Diagnosis rates were three times higher than rates for Whites and 1.6 times higher than rates for Hispanics.

It is estimated that 7% of the MSM in the SATGA were living with a diagnosed HIV infection in 2012-12.7% of the Black MSM, 8.15% of the Hispanic MSM, and 4.2% of the White MSM.

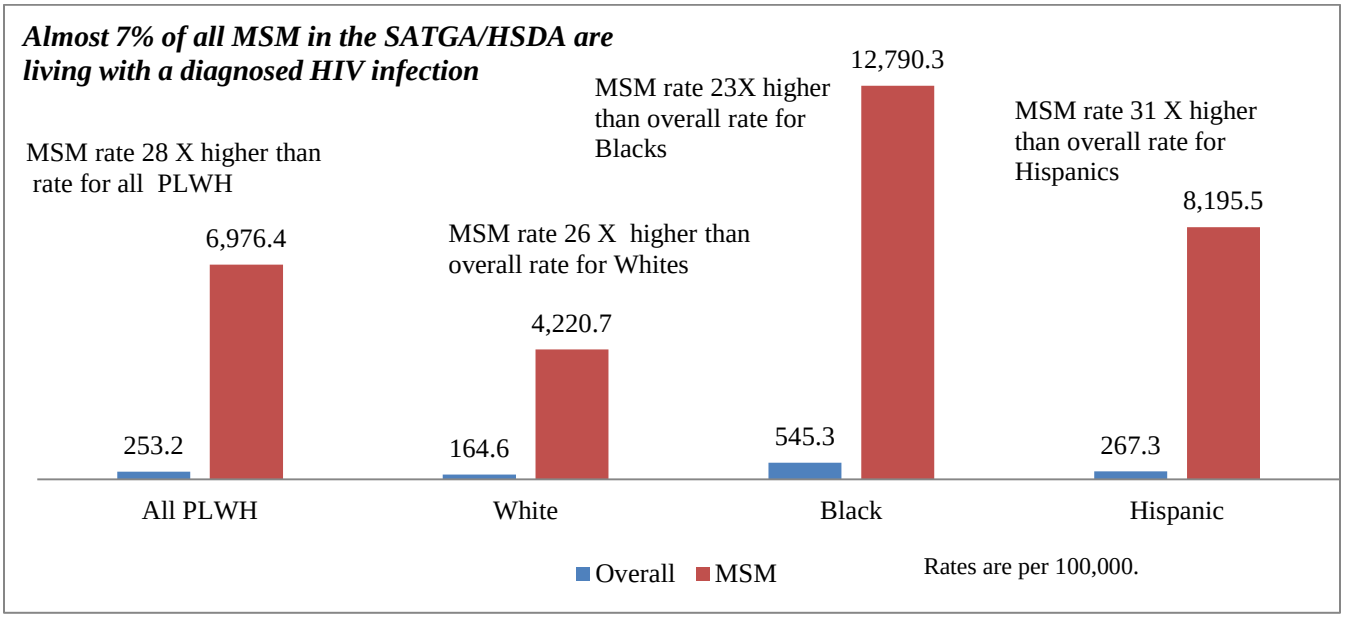


Figure 7: Prevalence rates in MSM in the SATGA/HSDA, 2012

Reducing new HIV infections rests in delivering targeted and effective prevention programs to Texans at very high risk; reducing the number of Texans living with undiagnosed HIV infections; and increasing access to effective and continuous treatment. The primary hallmark of good care is a suppressed HIV viral load – a sustained reduction in the amount of virus in an infected person's blood. A suppressed viral load not only benefits the PLWH, but also decreases the chance that HIV will be passed on to others.

It is estimated that between 11% and 17% of Texans with HIV are not yet diagnosed, and one in five SATGA residents first diagnosed in 2014 received a late diagnosis of infection. Hispanics have the highest estimated rate of undiagnosed infections in Texas overall, and in SATGA. Hispanics have the highest rate and number of late diagnosed infections.

In 2014, it is estimated that about three in four SATGA residents with diagnosed infections had at least one HIV-related episode of HIV treatment, leaving one in four with no care in 2014. Almost three in five PLWH had suppressed virus at the end of 2014. The remaining one in five SATGA residents received some HIV-related care, but did not have suppressed viral load. These outcomes were best for Hispanic MSM and those 35 or older, and much lower for Black MSM and those younger than 35 years old.

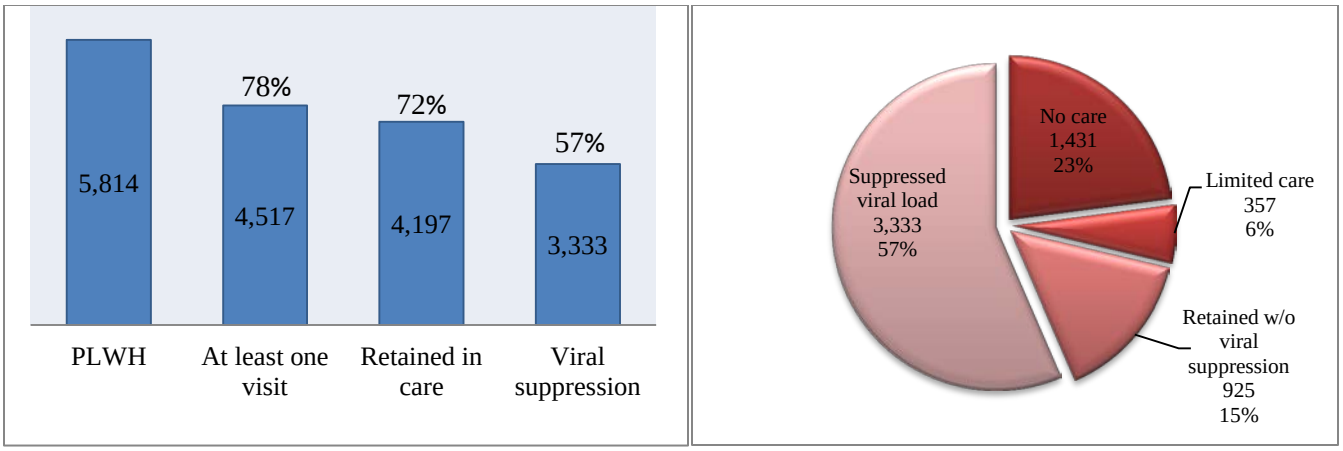


Figure 8: Participation in HIV treatment and viral load suppression in the SATGA, 2014

Data used in the Epidemiologic Overview

This overview presents information on known cases of infection with the HIV in the SATGA diagnosed through December 31, 2014 and reported as of June 30, 2015. Information on PLWH, or prevalence, represents the cumulative total of people diagnosed with HIV who are not known to have died and have a current residence in the SATGA. Information on new HIV diagnoses in 2014 includes people residing in the SATGA with a new diagnosed case of HIV infection. Cases are considered new diagnoses regardless of the stage of disease at the time of diagnosis. Statistics on new diagnoses of HIV are based on the earliest available diagnosis date.

The primary source of information for this report comes from routine disease surveillance. Texas laws and regulations require that certain health care professionals and laboratories report test results or results of diagnostic evaluation that indicate infection with HIV. These results are maintained in Texas' Electronic HIV/AIDS Reporting System (eHARS). eHARS does not include those unaware of their HIV infection or those who tested positive for HIV infection solely through anonymous testing.

Rates and counts

When making decisions about resource allocation and prioritizing action, HIV burden is compared across different population groups. When assessing groups of different sizes, direct comparisons of total PLWH, new HIV diagnoses; care outcomes become difficult to compare because of statistical variances. To compare groups of different sizes rates are used. This mathematically makes the size of the groups equal. If you want to compare the race/ethnic profiles of PLWH in two cities, showing the percentage of total PLWH fall into each transmission category, one would compare the profiles directly. Because HIV is rare in most groups, HIV rates are usually expressed in terms of 100,000 members of a population. Prevalence rates show the number of PLWH per 100,000 members of the population, and diagnosis rates show the number of new diagnoses per 100,000 members of the population. For example, the current prevalence rate for Texas is 302.1 per 100,000 – there are about 302 PLWH for each 100,000 Texans. The current case rate is 16.3 per 100,000 – there are approximately 16 new diagnoses for each 100,000 Texans. Comparing case rates demonstrates the relative difference of the burden of disease across groups with different population sizes reveals differences in demographic and geographic areas and those areas more vulnerable to HIV infection.

Sex and gender identity

The information in disease surveillance on sexual identity reflects biological sex. This report does not include information on transgender persons. TDSHS began collecting information on gender identity

during routine disease surveillance in 2014, and does not anticipate providing information on gender identity until 2017.

Mode of exposure

The mode of exposure assigned for each HIV case represents the most likely way that individuals became infected with HIV; solely based on the risk behaviors found during disease reporting or investigation. Nearly 15% of new HIV cases are reported without an identified risk factor. TDSHS uses multiple imputations to assign a risk factor for these. Multiple imputations replace missing risk factors with a range of possible values. Estimates of population sizes for risk behavior groups, with the exception of MSM, are not available at this time. Therefore, case rates were not calculated for IDU, persons engaging in high-risk heterosexual sex, and MSM/IDU. Census Data from 2014 calculated MSM population estimates were not available at the time of this report; therefore, only 2013 data on HIV rates in MSM were used. Preliminary examination of information demonstrates that most self-identified transgender women are assigned as MSM.

Information on the general population

The profile contains information on the overall population of San Antonio; the sources for those data are numerous, and cited within the text.

Information on linkage to treatment, retention in care, Antiretroviral Therapy (ART) prescription, and HIV viral suppression

This profile contains information on several aspects of treatment and care for PLWH that aligns with the HIV continuum of Care, such as linkage in care, prescription of ART and retention in treatment. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from publicly funded treatment providers in the RWP (Parts A-D, including the Texas AIDS Drug Assistance Program{ADAP}), information from Texas Medicaid and from some private health plans. For estimates of ART prescriptions, information from special surveillance studies were included, such as the Medical Monitoring Project, a project involving chart reviews and interviews with a representative sample of patients in care with Texas HIV medical providers.

STI/HIV and TB/HIV Comorbidity

A cross-registry match was performed between eHARS and Texas' Sexually Transmitted Infections (STI), Hepatitis C (HCV), and tuberculosis (TB) registries to identify PLWH co-infected with TB or any of three reportable STDs (chlamydia, gonorrhea, and syphilis) during 2014. A PLWH was considered to be co-infected if their co-infection was diagnosed ≥30 days prior to their HIV diagnosis or at any date in 2014 after their HIV diagnosis.

c. Socio-Demographic Profile of the SATGA

The information in this section is extracted from the National Center for Health Statistics and results from the Census Bureau's American Community Survey (information collected across 2010-2014) and Supplement to the Current Population Survey (2014).

The SATGA covers four counties and the SAHSDA covers twelve counties in south central Texas. The city of San Antonio sits in Bexar County, the largest in terms of general population and PLHW.

Demographics

Between 2010 and 2014, the population of the SATGA grew by about 175,000 (9%), reaching 2.1 million in 2014. The breakdowns of the population by sex, race/ethnicity, and age group are depicted in **Figure 9**.

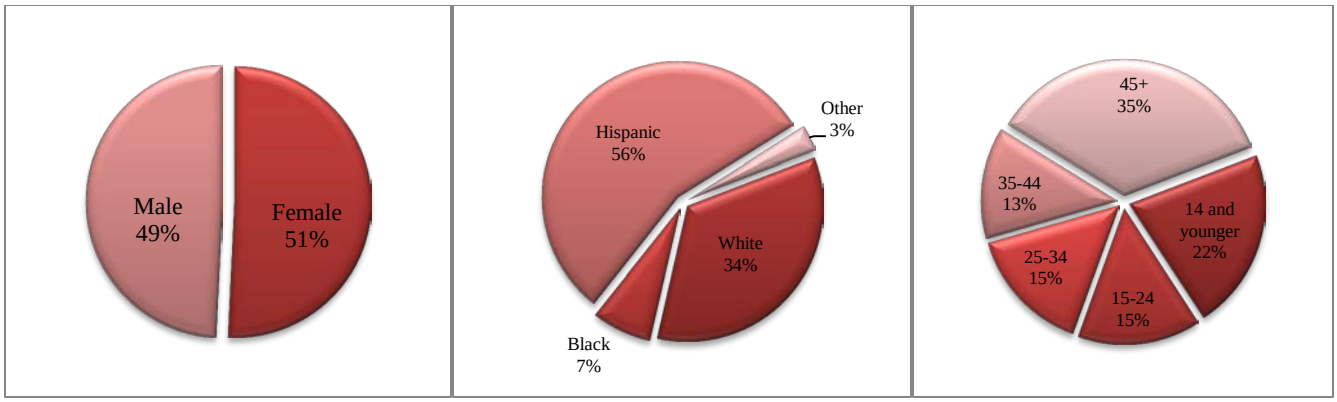


Figure 9: SATGA population in 2014 by sex, race/ethnicity and age

Social Determinants

Education

Social and economic forces, called social determinants, can increase vulnerability to illness and affect health outcomes. Education is one such factor - people with low levels of educational attainment (less than 12 years of formal schooling) have higher mortality rates from all causes than people with higher levels of educational attainment. About 16% of San Antonio residents 25 and older do not hold a high school diploma or GED. For Hispanic residents that proportion is higher – more than one in four have not completed high school. Racial/ethnic disparities persist in higher education: more than 25% White and Black residents compared to 15% of Hispanics. On average 19% of adult Texans can't read a newspaper. [4]

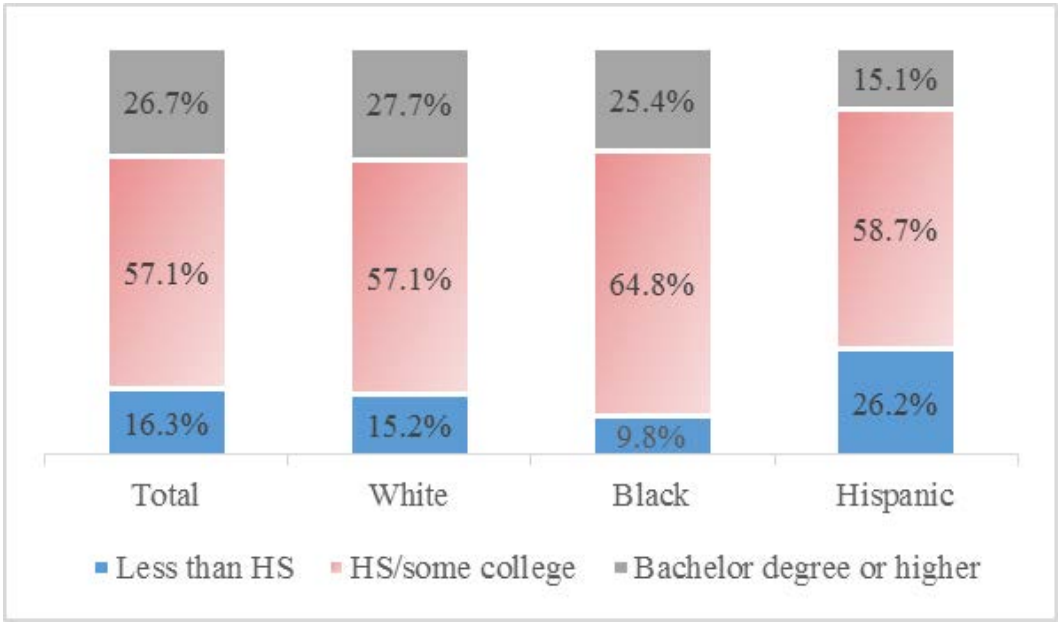


Figure 10: Levels of educational attainment in those 25 and older, SATGA 2010-2014

[4] Texas county map showing percentage by county of illiterate adult Texans. (2009). Retrieved September 6, 2016, from Texas Center for the Advancement of Literacy and Learning, http://www-tcall.tamu.edu/docs/09illitmap.html

Poverty

Poverty influences health directly and indirectly. Income directly affects the ability to pay for health care or health insurance. Low income is both a cause and effect of factors such as low educational attainment and housing and job instability that are associated with poor health.[5] In 2014, about 17% of SATGA residents were living in poverty. Racial/ethnic minorities exhibited a high burden of poverty – around one in five Hispanic and Black San Antonio residents lived in poverty compared to less than one in six Whites.

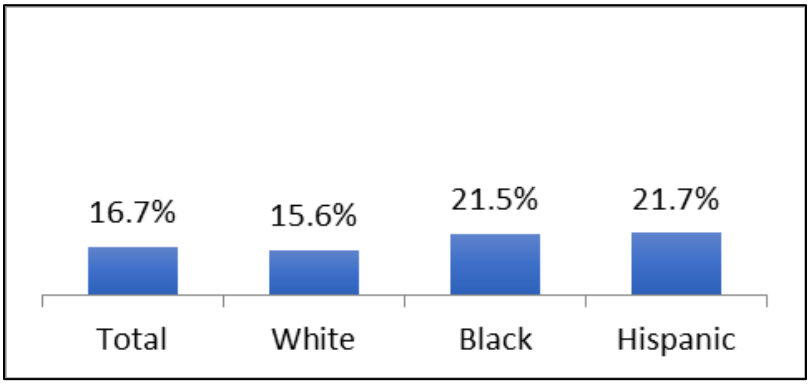


Figure 11: Poverty rates in the SATGA by race/ethnicity, 2010-2014

Health Insurance Coverage

Studies have shown that uninsured persons are less likely to have a regular source of health care, receive needed medical care, and are more likely to die from health-related problems. Chronically-ill uninsured adults delay or forgo checkups and therapies, including medications. Low rates of insurance coverage in a community can also impact the health of people with insurance through increasing insurance rates. Data demonstrates that privately insured working-age adults in areas with lower insurance rates are less likely to report having access to care when sick, obtaining routine preventive care, and accessing a specialist when needed.[6] Uninsured PLWH are especially vulnerable to poor health outcomes, including an increased risk of death.[7]

	Total	White	Black	Hispanic
Texas	*21.9%*	*21.0%*	*19.6%*	*33.7%*
Austin TGA	17.6%	16.7%	15.6%	29.6%
Dallas EMA	21.5%	19.8%	20.4%	39.0%
Fort Worth TGA	20.3%	18.7%	20.9%	36.4%
Houston EMA	23.5%	22.2%	20.0%	38.4%
San Antonio TGA	18.7%	17.9%	15.3%	23.9%
East Texas area	20.1%	19.4%	20.0%	36.5%
US-Mexico border	31.7%	31.6%	15.2%	34.3%

Table 2: Texans without health insurance coverage, 2010-2014

[5] Link B, & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Behavior*, (Extra Issue), 80-94.

[6] Institute of Medicine (2009). America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: The National Academies Press.

[7] Bhattacharya J. & Goldman D. (2003). The link between public and private Insurance and HIV-related mortality. *Journal of Health Economics* (22), 1105-1122.

Between 2010 and 2014, less than one in five SATGA residents did not have health insurance. The proportion of Blacks and Whites with health coverage was similar (around 84 %), but the proportion of Hispanics with health insurance was much lower – only about 76% had coverage. Supplemental data from the Census Bureau shows that the proportion of non- elderly Texans with insurance increased from 2013 to 2014, although these increases were primarily in Texans with higher incomes. The number of uninsured Texans decreased by 17%, while the number of uninsured persons living in poverty decreased by 10%.

The Medical Monitoring Project is a special surveillance study that focuses on a representative sample of PLWH receiving HIV-related care in Texas. In 2011, 25% of the respondents reported that they had no health insurance coverage.

PLWH stands for people living with HIV, which is also called *prevalence*. Annual prevalence is the number of people with diagnosed infections who were alive and residing in Texas as of the end of the year. It does not include people with undiagnosed infections.

New HIV diagnoses is shortened to new *dx*. An annual count of new diagnoses shows the number of people with first-time diagnoses of HIV infections in people who were residing in Texas at the time their diagnosis was made.

Rates allow direct comparison of HIV in groups of different sizes and show the intensity of HIV infection. Prevalence rates show the number of PLWH per 100,000, and diagnosis rates show the number of new HIV diagnoses per 100,000.

Other social and environmental factors

There are many other social determinants of health other than poverty, low educational attainment, and lack of health insurance. What they all have in common is that they isolate or separate people from the social support of their families, friends, and communities, and from institutions such as churches and schools. The most literal separation is incarceration and the attendant social disruption it creates. Personal and public expressions of racism and anti-gay and anti-transgender attitudes separate vulnerable groups from their support networks. The shame and stigma felt by MSM, transgender persons, and PLWH can also accelerate risk and decrease the likelihood of receiving treatment for infections. These isolating factors are also associated with behavioral health problems and substance abuse, which in turn intensifies risk and poor health outcomes. More information on social determinants of health may be found at http://www.cdc.gov/socialdeterminants/index.htm.

HIV in San Antonio: the Basics

This section provides information on the number of people living with diagnosed HIV infections as of 2014 and on new HIV diagnoses from 2010 – 2014. In addition to information tracking the annual number of new diagnoses, cumulative counts of all new infections in that five-year period were also used. Using five years of diagnoses provides a more reliable comparison point to prevalence than does a single year of new diagnoses.

The number of Texans living with a diagnosed HIV infection in the SATGA increased by 23% between 2010 and 2014. Because the number PLWH in the SATGA expanded faster than the overall population, the prevalence rate increased by 13%. Over the same time period, new diagnoses rose about 8%. Given the steady growth in population of the SATGA, the diagnosis rate was relatively steady.

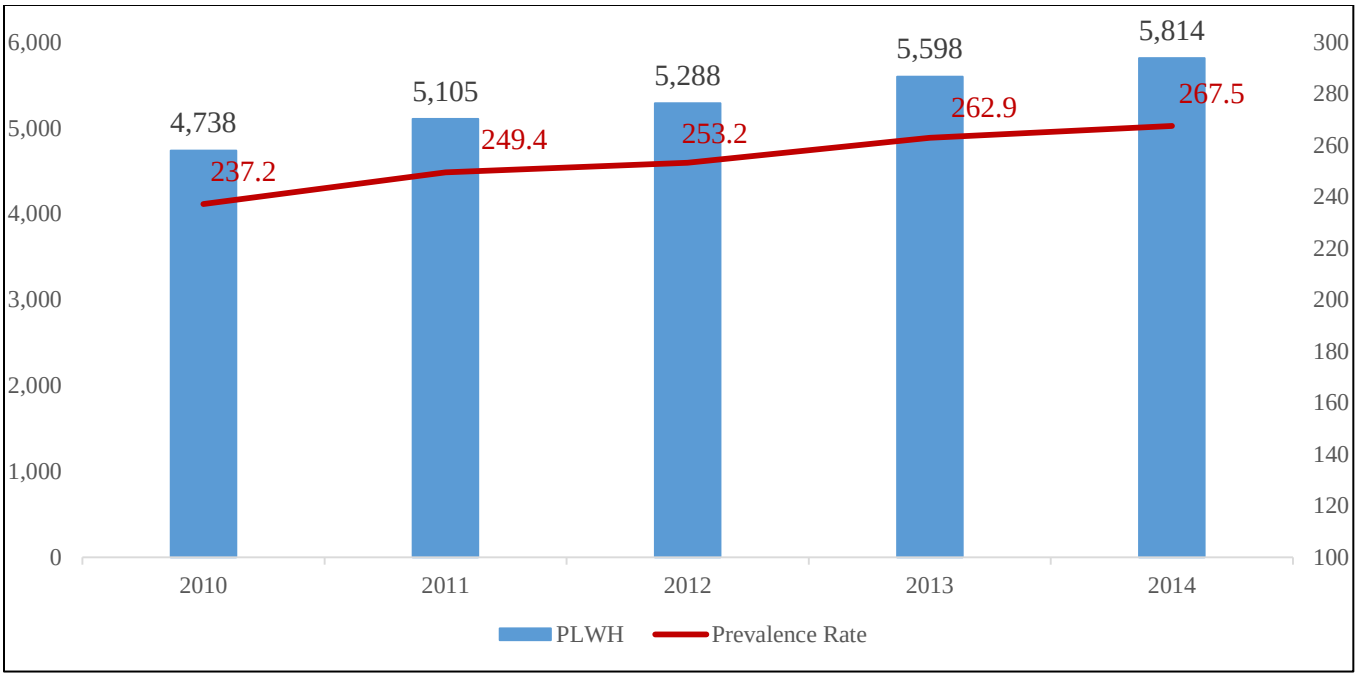


Figure 12: SATGA residents living with HIV and prevalence rates, 2010-2014

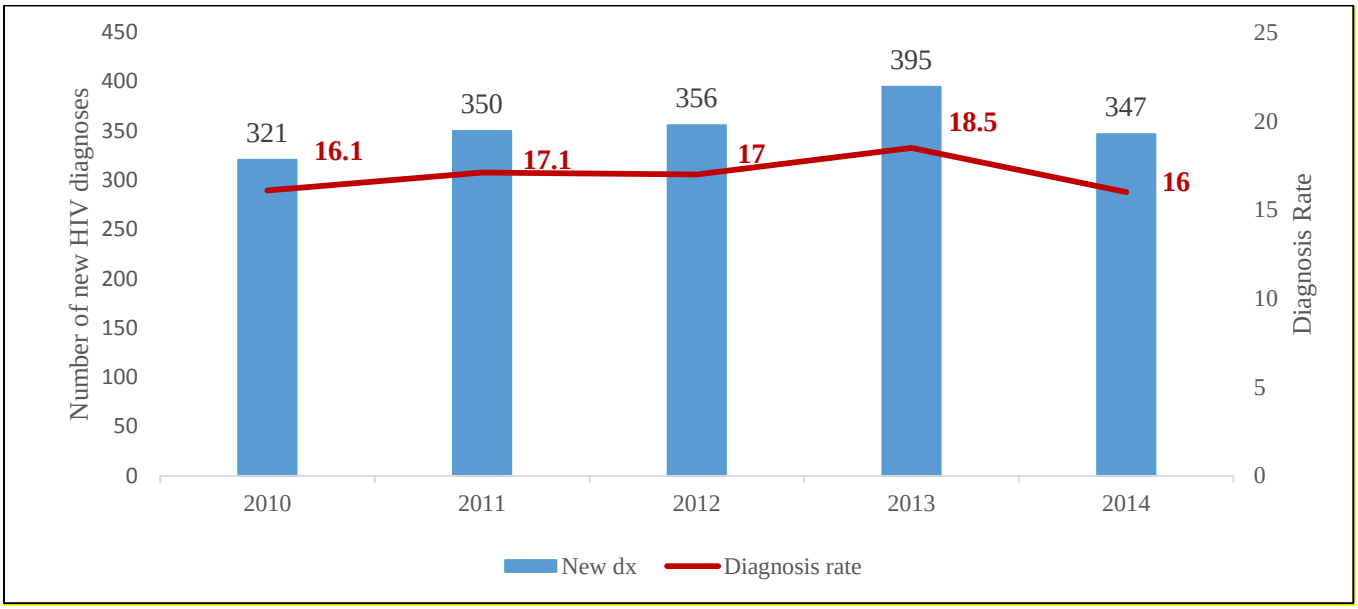


Figure 13: New HIV diagnoses and infection rates in the SATGA, 2010-2014

Snapshot of PLWH and newly diagnosed SATGA residents

As in years past, in 2014 more than four in five SATGA residents living with HIV were men. As previously stated, gay and bisexual men and other MSM made up more than two of every three SATGA residents living with diagnosed HIV infections in 2014; for Texas overall, the share for MSM is closer to half. Heterosexuals made up fewer than one in five PLWH. Hispanics made up the largest race/ethnic group of PLWH – about three in five PLWH. More than half the PLWH were 45 or older.

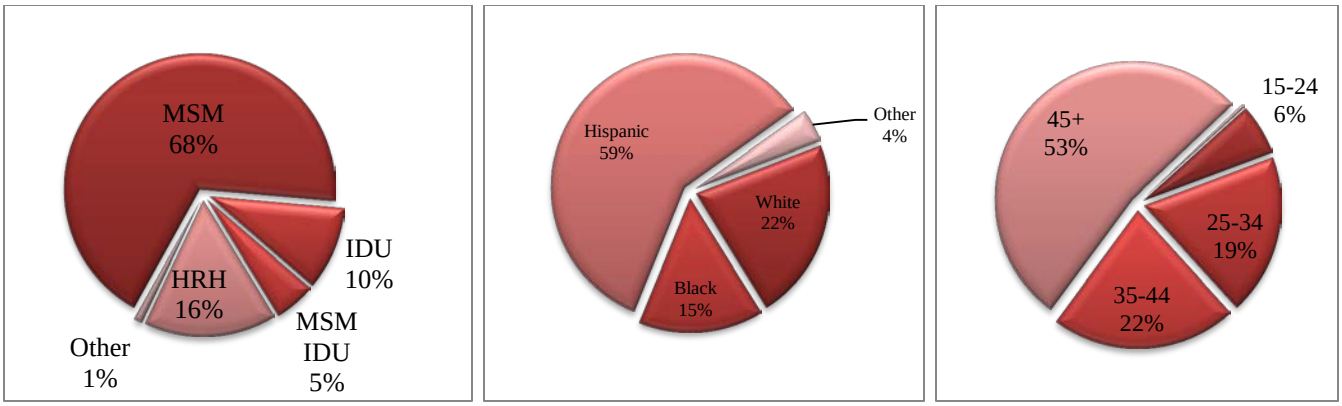


Figure 14: 2014 PLWH in the SATGA by mode of transmission, race/ethnicity, and age

MSM have an even larger presence among those newly diagnosed, with MSM making about three in four SATGA residents newly diagnosed from 2010 to 2014. Heterosexuals made up about 13% of the new diagnoses, which is similar to their representation in PLWH, but the count of heterosexual diagnoses was flat from 2010 and 2013, as were new diagnoses in IDU and MSM/IDU. The only group to show increases in new diagnoses were MSM.

Hispanics made up about three in five SATGA residents who were newly diagnosed between 2010 and 2014. Finally, the profile of Texans with new diagnoses is much more youthful than the profile of PLWH – about one in three were 15-24 years old at the time of their diagnosis. This trend is driven by increased diagnoses in young MSM. **Table 3** and **Table 4** provide more detail.

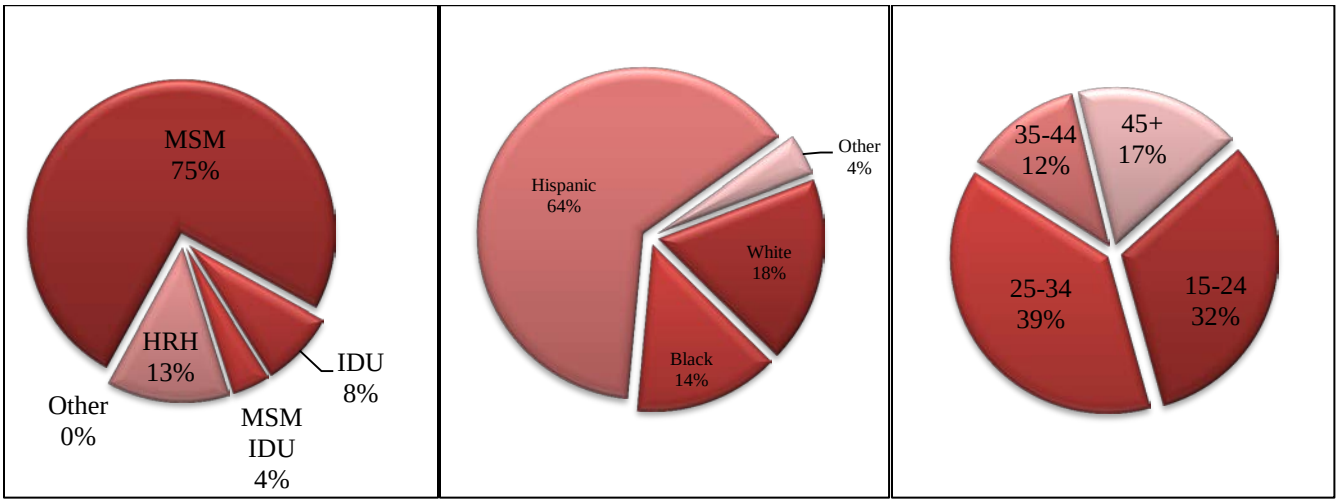


Figure 15: SATGA residents newly diagnosed with HIV from 2010-2014 by mode of transmission, race/ethnicity, age at diagnosis

	2010			2011			2012			2013			2014			Change
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	
Total	4,738	100.0%	237.2	5,105	100.0%	249.4	5,288	100.0%	253.2	5,598	100.0%	262.9	5,814	100.0%	267.5	23%
Female	751	15.9%	73.8	819	16.0%	78.6	831	15.7%	78.3	880	15.7%	81.4	895	15.4%	81.1	19%
Male	3,987	84.1%	406.7	4,286	84.0%	426.6	4,457	84.3%	434.2	4,718	84.3%	450.2	4,919	84.6%	459.7	23%
White	1,123	23.7%	158.0	1,180	23.1%	163.7	1,202	22.7%	164.6	1,250	22.3%	169.1	1,299	22.3%	173.7	16%
Black	693	14.6%	515.6	759	14.9%	545.2	789	14.9%	545.3	827	14.8%	555.7	876	15.1%	571.1	26%
Hispanic	2,739	57.8%	249.6	2,959	58.0%	262.2	3,079	58.2%	267.3	3,299	58.9%	280.1	3,411	58.7%	283.0	25%
Other	37	0.8%	66.8	37	0.7%	63.0	40	0.8%	65.4	40	0.7%	62.6	45	0.8%	67.4	22%
Unknown	146	3.1%	.	170	3.3%	.	178	3.4%	.	182	3.3%	.	183	3.1%	.	25%
MSM	3,144	66.4%		3,389	66.4%		3,561	67.3%		3,809	68.0%		4,007	68.9%		27%
IDU	530	11.2%		559	11.0%		562	10.6%		567	10.1%		567	9.8%		7%
MSM/IDU	255	5.4%		289	5.7%		279	5.3%		280	5.0%		274	4.7%		7%
HRH	762	16.1%		819	16.0%		836	15.8%		887	15.8%		904	15.5%		19%
Ped	36	0.8%		38	0.7%		41	0.8%		45	0.8%		52	0.9%		44%
Adult Other	11	0.2%		11	0.2%		10	0.2%		10	0.2%		10	0.2%		
0-14	19	0.4%	4.2	20	0.4%	4.4	21	0.4%	4.6	21	0.4%	4.5	23	0.4%	4.9	21%
15-24	261	5.5%	86.7	274	5.4%	89.3	289	5.5%	92.4	304	5.4%	96.0	326	5.6%	101.7	25%
25-34	842	17.8%	296.3	915	17.9%	310.1	973	18.4%	318.9	1,072	19.1%	339.4	1,127	19.4%	345.7	34%
35-44	1,326	28.0%	492.0	1,335	26.2%	488.3	1,289	24.4%	464.6	1,321	23.6%	468.6	1,265	21.8%	440.7	-5%
45+	2,290	48.3%	329.8	2,561	50.2%	357.3	2,716	51.4%	370.3	2,880	51.4%	383.5	3,073	52.9%	399.3	34%

Table 3: PLWH in the SATGA, 2010-2014

	2010			2011			2012			2013			2014			Change
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate	
Total	321	100	16.1	350	100	17.1	356	100	17	395	100	18.5	347	100	16	8%
Female	49	15.3%	4.8	51	14.6%	4.9	41	11.5%	3.9	39	9.9%	3.6	48	13.8%	4.4	-2%
Male	272	84.7%	27.7	299	85.4%	29.8	315	88.5%	30.7	356	90.1%	34	299	86.2%	27.9	10%
White	62	19.3%	8.7	60	17.1%	8.3	69	19.4%	9.4	71	18.0%	9.6	65	18.7%	8.7	5%
Black	51	15.9%	37.9	47	13.4%	33.8	49	13.8%	33.9	54	13.7%	36.3	47	13.5%	30.6	-8%
Hispanic	191	59.5%	17.4	225	64.3%	19.9	222	62.4%	19.3	257	65.1%	21.8	222	64.0%	18.4	16%
Other	4	1.2%	7.2	2	0.6%	3.4	4	1.1%	6.5	4	1.0%	6.3	2	0.6%	3	
Unknown	13	4.0%	.	16	4.6%	.	12	3.4%	.	9	2.3%	.	11	3.2%	.	
MSM	227	70.7%		244	69.7%		284	79.8%		305	77.2%		271	78.1%		19%
IDU	33	10.3%		28	8.0%		24	6.7%		31	7.8%		26	7.5%		-21%
MSM/IDU	17	5.3%		25	7.1%		4	1.1%		14	3.5%		9	2.6%		-47%
HRH	45	14.0%		52	14.9%		43	12.1%		45	11.4%		37	10.7%		-18%
0-14				2	0.6%	0.4	2	0.6%	0.4	1	0.3%	0.2	4	1.2%	0.9	
15-24	95	29.6%	31.5	93	26.6%	30.3	78	21.9%	24.9	94	23.8%	29.7	111	32.0%	34.6	17%
25-34	89	27.7%	31.3	99	28.3%	33.6	111	31.2%	36.4	146	37.0%	46.2	132	38.0%	40.5	48%
35-44	63	19.6%	23.4	68	19.4%	24.9	76	21.3%	27.4	62	15.7%	22	42	12.1%	14.6	-33%
45+	74	23.1%	10.7	88	25.1%	12.3	89	25.0%	12.1	92	23.3%	12.2	58	16.7%	7.5	-22%

Table 4: New HIV diagnoses in the SATGA, 2010-2014

Priority Populations

Achieving the goals of NHAS and the Texas HIV Plan requires a common focus on the groups at highest risk of acquiring or transmitting HIV – the priority populations for the Texas Plan are: Hispanic MSM, Black MSM, White MSM, and Black HRH women. All public health strategies for reducing new infections or improving outcomes must include actions for these groups.

The priority populations made up seven out of ten PLWH in the SATGA in 2014, and were 78% of the new infections over the past five years. From 2010-2014, the number of PLWH in these groups increased, but unevenly: the number of White MSM living with a diagnosed HIV infection increased by 19%, while the other three groups increased by about 30%.

Mode of transmission groups

Mode of transmission refers to the most likely way a person with HIV became infected. Major modes of transmission in Texas are

MSM: gay men, bisexual men, and other men who have sex with men
HRH: high-risk heterosexuals
IDU: heterosexual injection drug users
MSM/IDU: MSM who also inject drugs

New diagnoses in Hispanic MSM rose by almost a third from 2010-2014. Black and Hispanic MSM and Black heterosexual women living with diagnosed HIV infections increased by a third, but the number of White MSM was flat. New diagnoses in Black MSM increased by a third, but diagnoses in Hispanic MSM decreased and were flat in Black heterosexual women and White MSM.

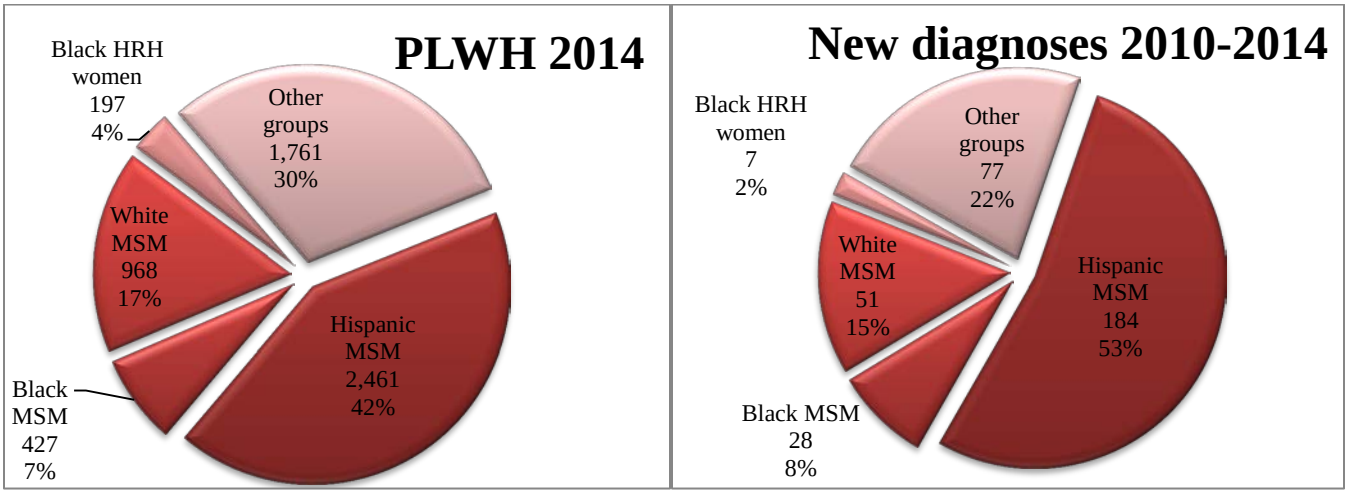


Figure 16: Priority populations in the SATGA PLWH and residents with new HIV diagnoses

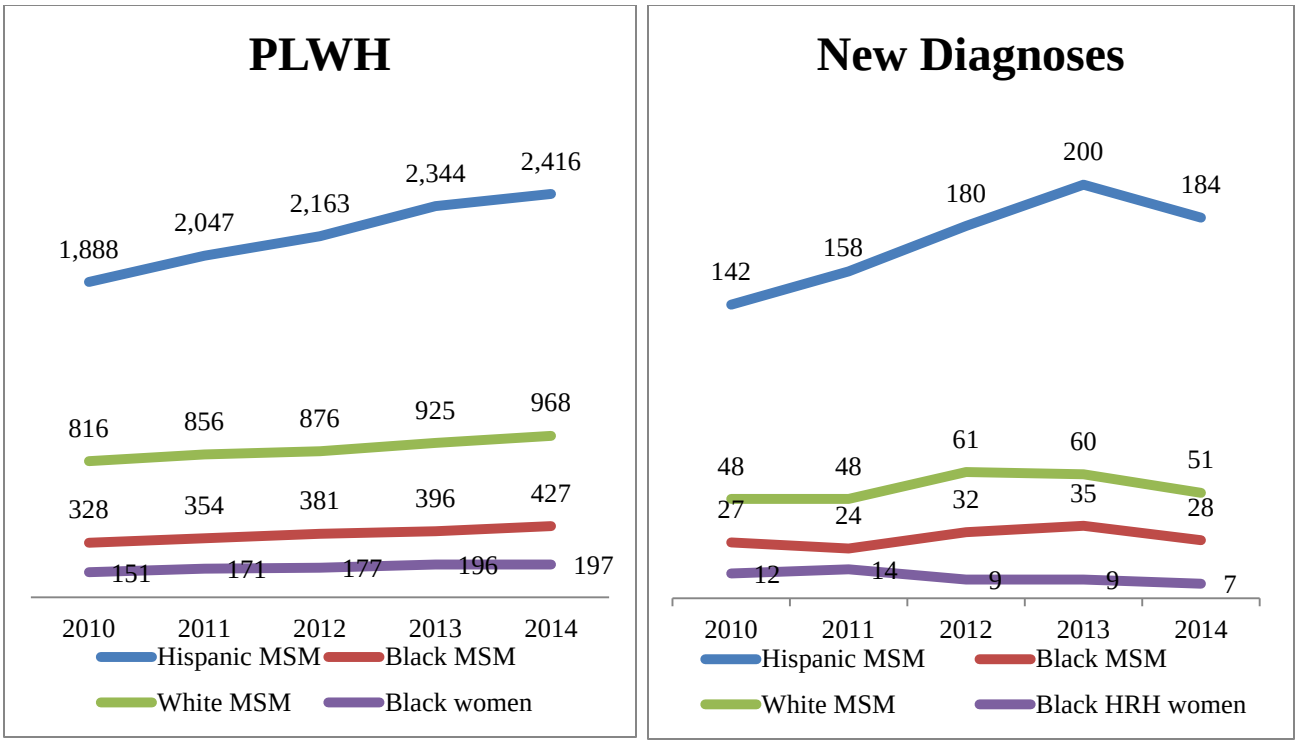


Figure 17: Changes in numbers of PLWH and new diagnoses in priority populations, SATGA 2010-2014

A Closer Look at HIV in the San Antonio TGA

Sex

More than four out of five PLWH in 2014 were men – the number of men living with a diagnosed HIV infection was more than five times higher than the number of women. The prevalence rate (the number of PLWH per 100,000 SATGA residents) was also more than five times higher than the rate for women. This difference in the intensity of prevalence in men and women is the sharpest in the state.

Men made up more than four of five new diagnoses – about 87%. The number of new diagnoses were five to nine times higher in men than in women. The differences in diagnosis rate tracked the changes in number of new diagnoses; the rate in men was five to nine times higher in men than in women. Again, the difference in intensity of new diagnoses in women and men is the sharpest in Texas.

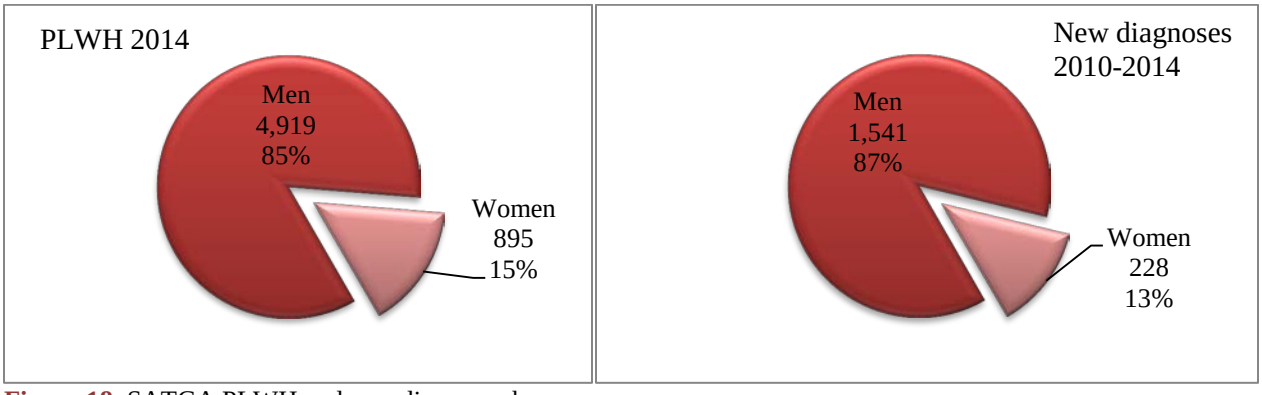


Figure 18: SATGA PLWH and new diagnoses by sex

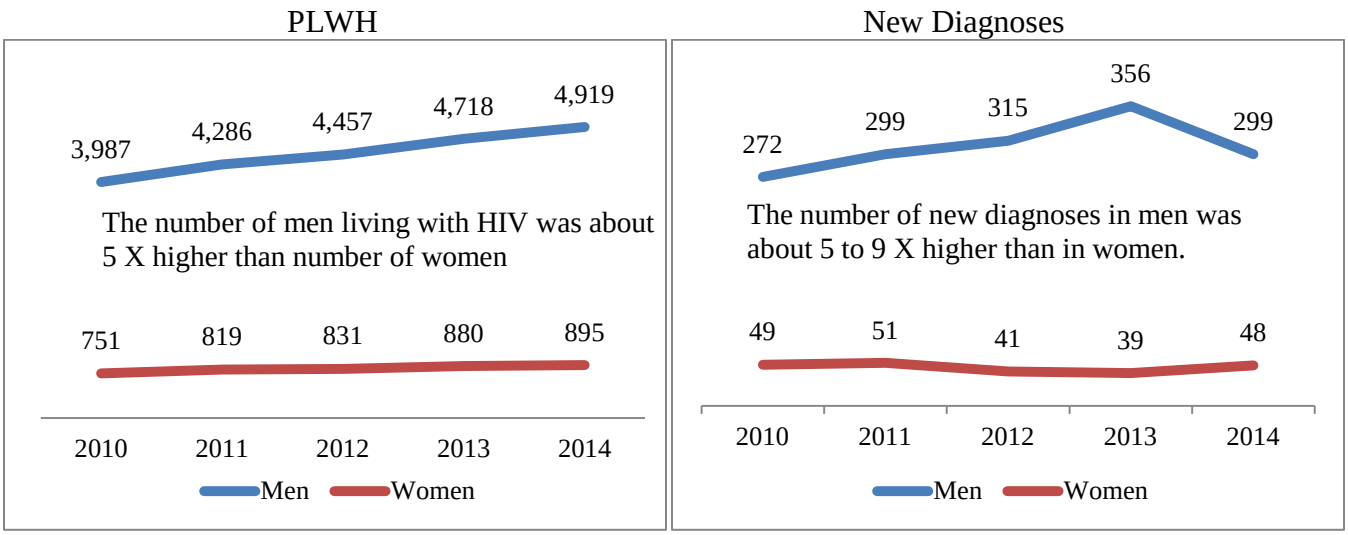


Figure 19: Changes in numbers of men and women in the SATGA living with diagnosed HIV infections and with newly diagnosed infections. 2010-2014

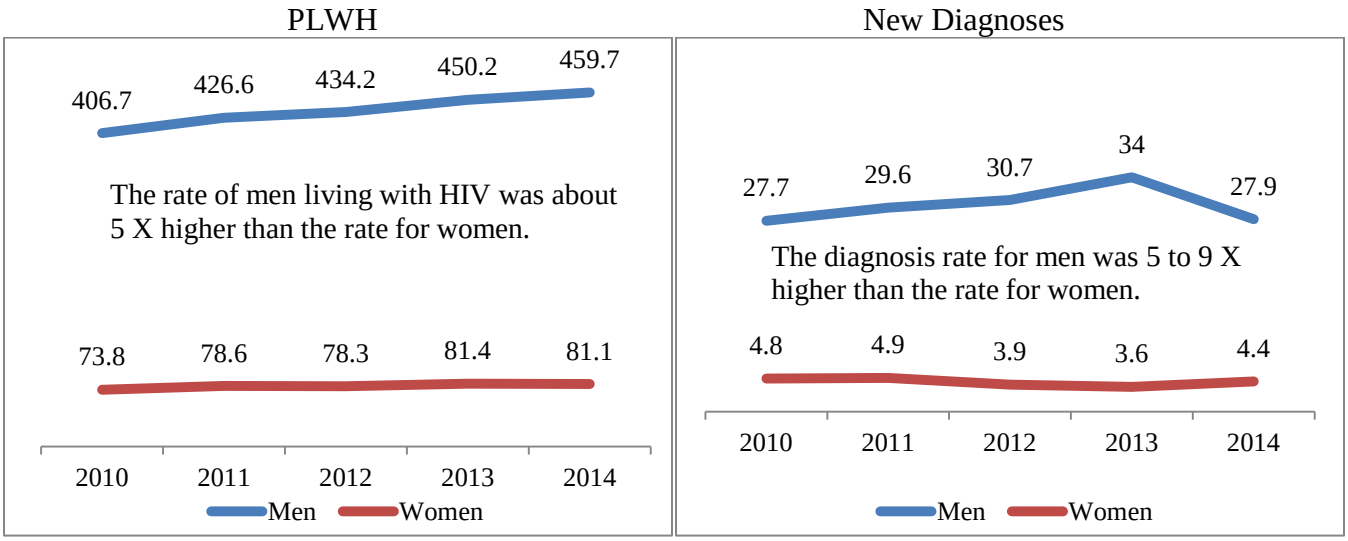


Figure 20: Changes in rates of men and women living with HIV and with newly diagnosed, SATGA 2010-2014

Race/Ethnicity

Hispanics were three out of five PLWH in the SATGA in 2014, as would be expected in an area where this group makes up almost three in five residents. Between 2010 and 2014, the numbers of Black and Hispanic PLWH in the SATGA rose by about a quarter, while the number of White PLWH rose less quickly (about a 16% increase). The number of Hispanic PLWH was consistently 2.5 times higher than the number of Whites and almost four times higher than the number of Black PLWH.

Hispanics also made up three out of five SATGA residents with new HIV diagnoses. New diagnoses in Hispanics rose about 16% but new diagnoses in Whites and Blacks were flat; the number of new diagnoses in Hispanics was consistently three times higher than new diagnoses in other race/ethnic groups.

Blacks make up about 7% of the population of the SATGA, but about 15% of the PLWH in the area. This disparity shows very clearly in the prevalence rates: the rates for Blacks were two to three times higher than for other groups. While diagnosis rates in Blacks were 3.5 times higher than the rate for

Whites and 1.6 times higher than the rate for Hispanics in 2014, the rate of new diagnoses in Blacks fell 19% from 2010-2014, which is slowly closing the gap in diagnosis rates.

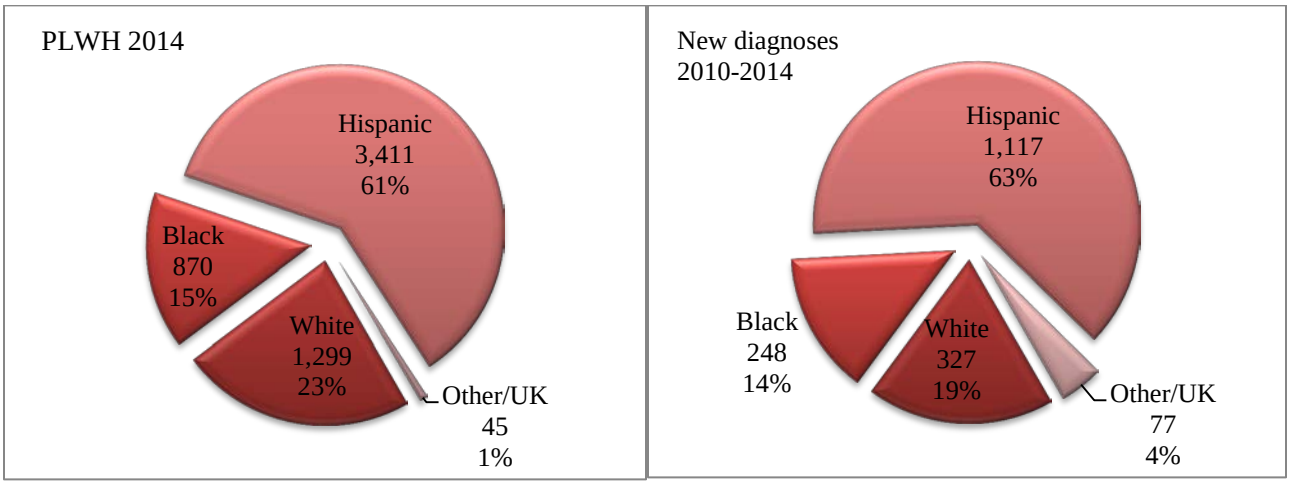


Figure 21: SATGA PLWH and new diagnoses by race/ethnicity

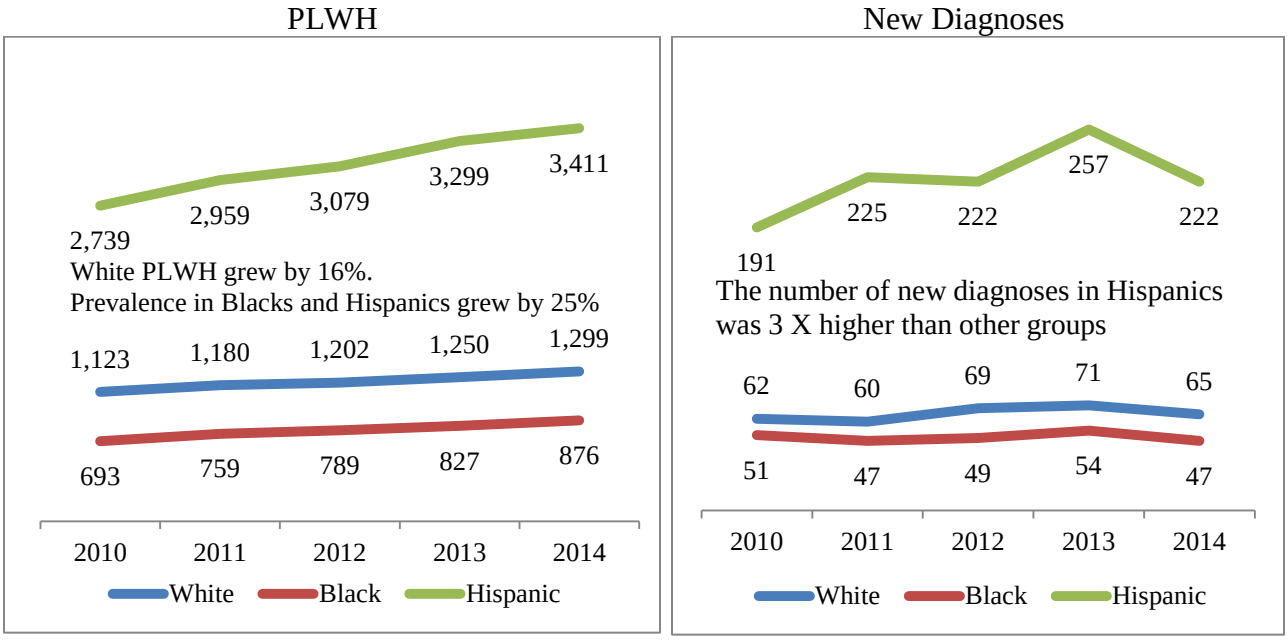


Figure 22: Changes in race/ethnicity of SATGA PLWH and residents with new diagnoses, 2010-2014

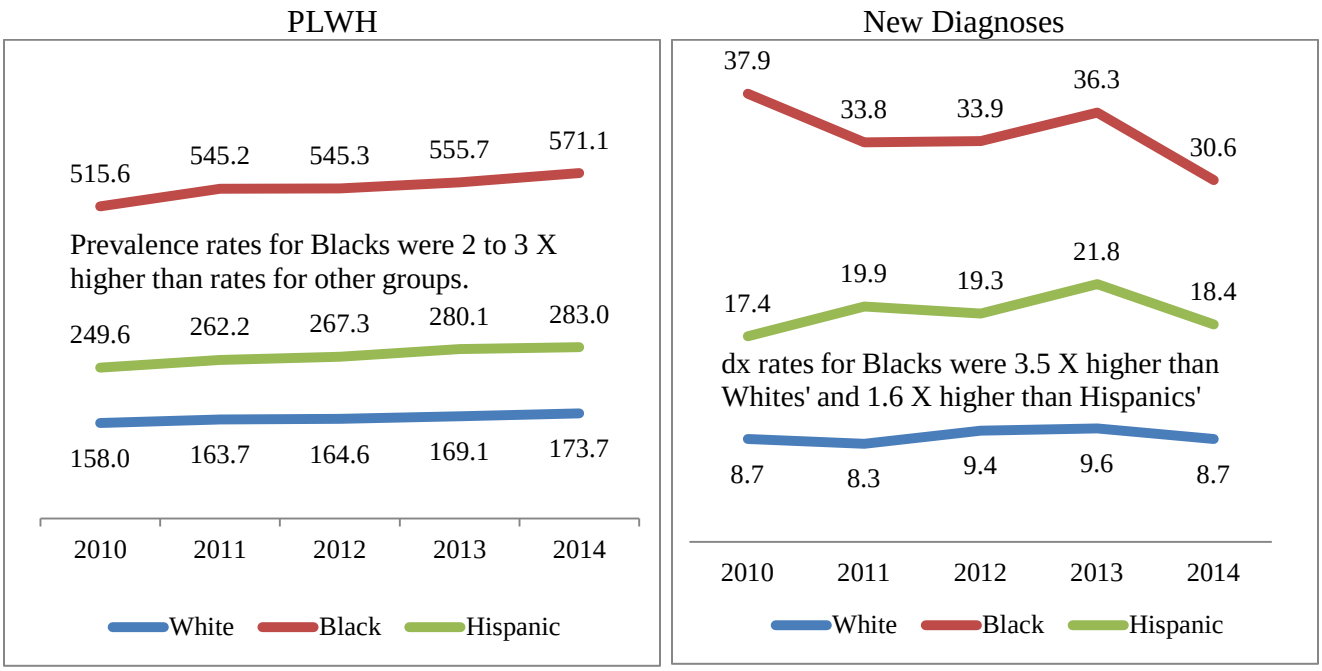


Figure 23: Changes in rates of PLWH and those newly diagnosed by race/ethnicity, SATGA 2010-2014

Mode of Transmission

Public health surveillance uses the term mode of transmission to group information about people with HIV based on the most likely way they became infected. The most common modes of transmission groups are gay and bisexual men and other MSM, HRH, IDU, and MSM/IDU.

In 2014, more than seven in ten PLWH and SATGA residents newly diagnosed with HIV were MSM. There were more than four times as many PLWH and new diagnoses in MSM than in heterosexuals, the next largest group. MSM were the only group to show increases in new diagnoses over the past five years. In 2012, almost 7% of all MSM in San Antonio were living with HIV, compared to 0.25% for the population overall. About 12% of the Black MSM were living with a diagnosed HIV infection, as were 4% of White MSM and 8% of Hispanic MSM.

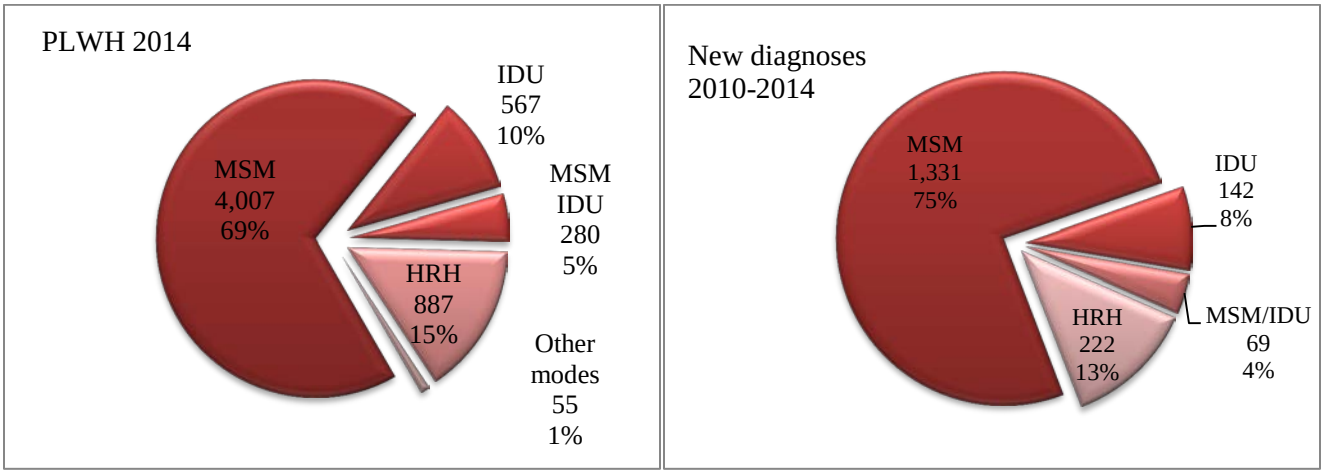


Figure 24: SATGA PLWH and new diagnoses by mode of transmission

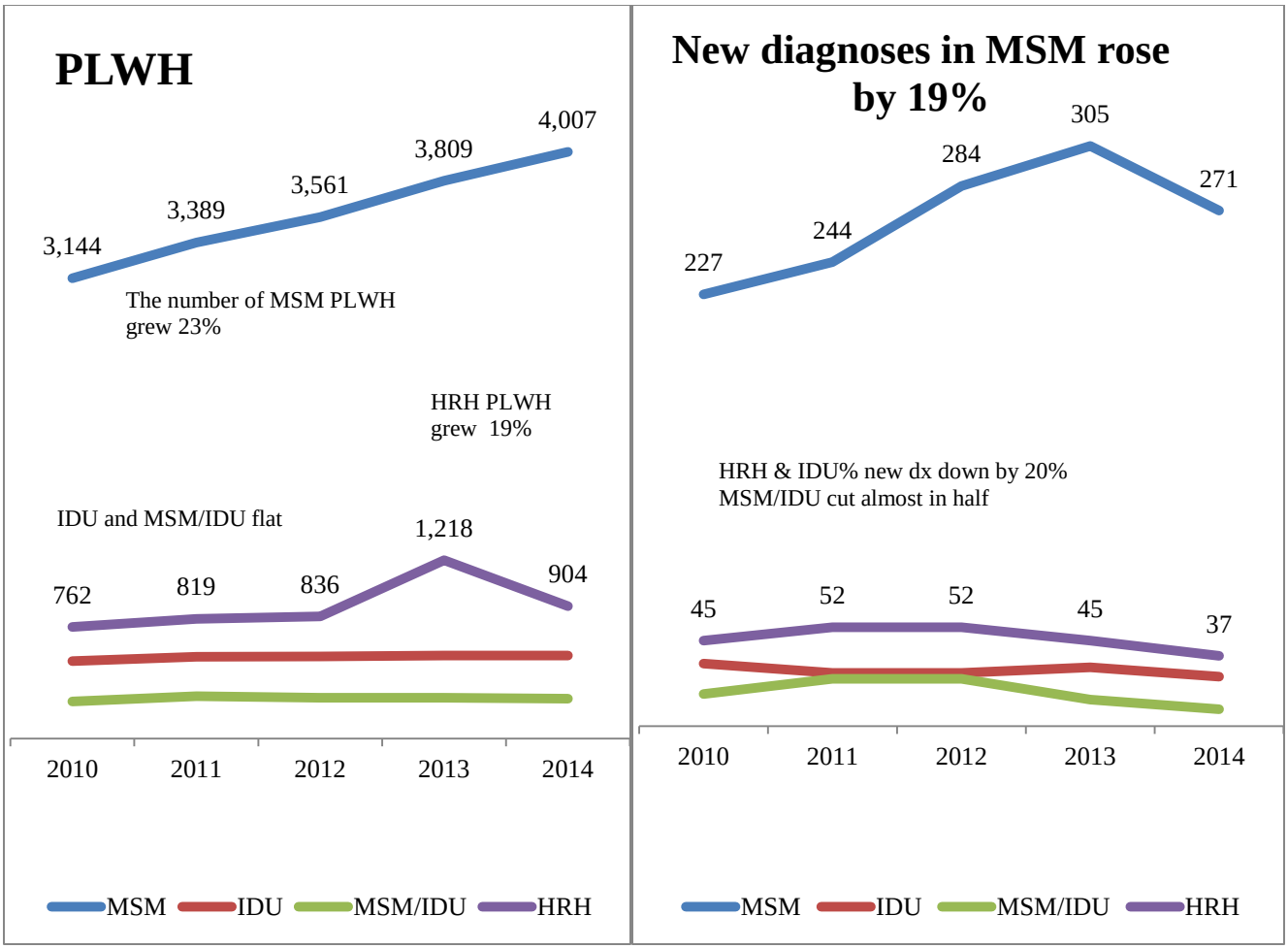


Figure 25: Changes in mode of transmission, SATGA 2010-2014

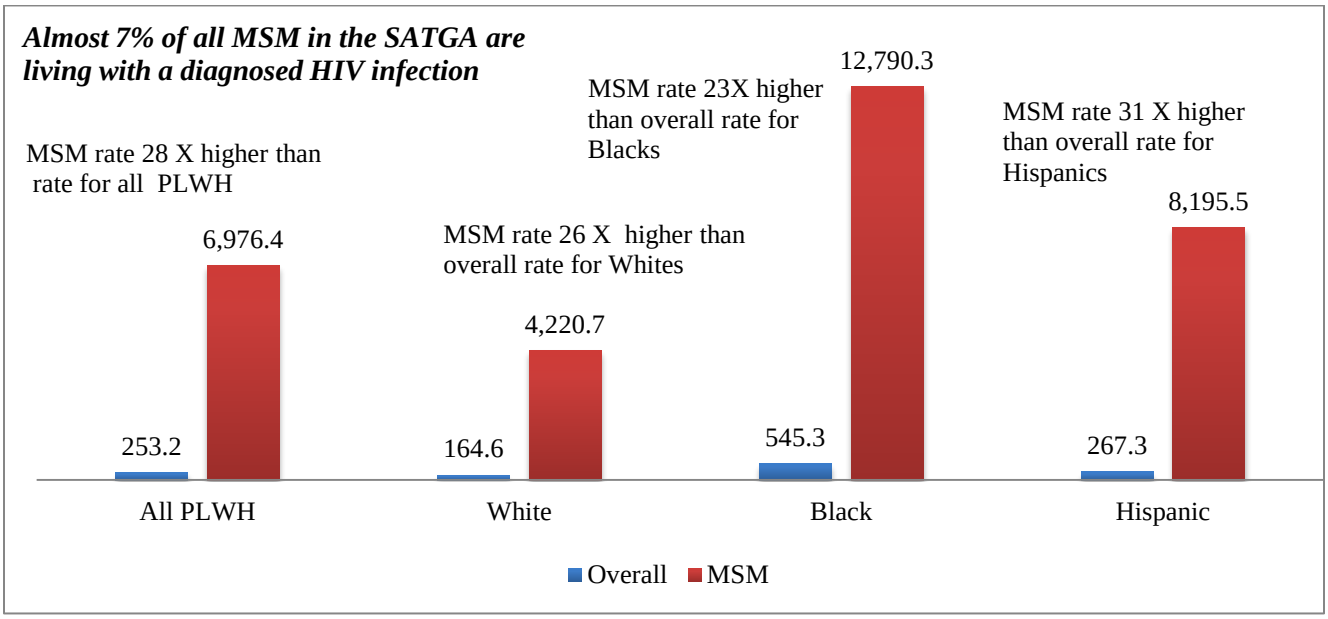


Figure 26: Prevalence rates in MSM in the SATGA, 2012

	All MSM	White MSM	Black MSM	Hispanic MSM
Texas	6,966.0	4,834.4	19,590.6	6,542.2
Austin	4,692.4	4,000.3	10,022.1	5,063.5
Dallas	7,575.0	5,765.3	17,997.7	6,462.5
Fort Worth	3,865.2	2,596.7	11,638.9	3,579.0
Houston	7,867.4	5,513.2	19,782.4	6,476.6
San Antonio	*6,976.4*	*4,220.7*	*12,790.3*	*8,195.5*

Table 5: Prevalence rates for Texas MSM by area of residence and race/ethnicity, 2012

A closer look at how race/ethnicity and mode of transmission interact

For both Whites and Hispanics, MSM make up at least three out of four PLWH or people with new HIV diagnoses. The increase in Hispanic new diagnoses was driven solely by increases in MSM. Black MSM makes up a smaller proportion of Black PLWH or people with new diagnoses, but was still more than half of the PLWH and new diagnoses.

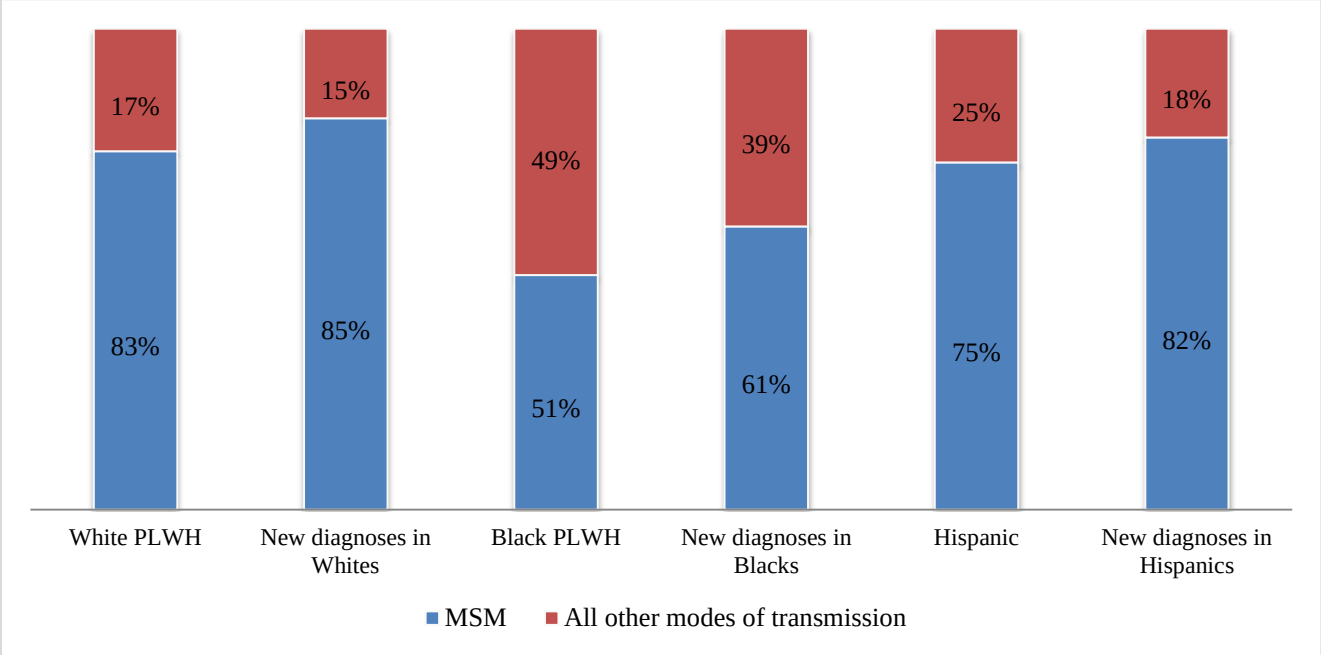


Figure 27: MSM as a proportion of all PLWH and new diagnoses in race/ethnic groups in the SATGA, 2014 for PWLH and 2010-2014 for new diagnoses

Table 6: Changes in new diagnoses by race/ethnicity and risk, 2010-2014 SATGA

	2010	2011	2012	2013	2014	Change
All new dx in Blacks	51	47	49	54	47	-8%
Black MSM	27	24	32	35	28	4%
Black HRH	14	16	13	14	10	-29%
Black IDU	10	4	2	5	5	
All new dx in Hispanics	191	225	222	257	222	16%
Hispanic MSM	142	158	180	200	184	30%
Hispanic HRH	21	27	23	26	19	-10%
Hispanic IDU	18	20	16	21	16	-11%
All new dx in Whites	62	60	69	71	65	5%
White MSM	46	48	61	60	51	11%
White HRH	11	8	3	7	10	-9%
White IDU	5	4	5	4	4	

Age

More than half the PLWH in the SATGA are 45 or older, but the ages of residents newly diagnosed are steadily divided. We usually expect the number of PLWH in an age group to rise, and that was the case for PLWH ages 15-34 and 45 and older. The number of 35-44 year olds was flat; age trends in new diagnoses showed increases in those under 35 and downward trends for those 35 and older.

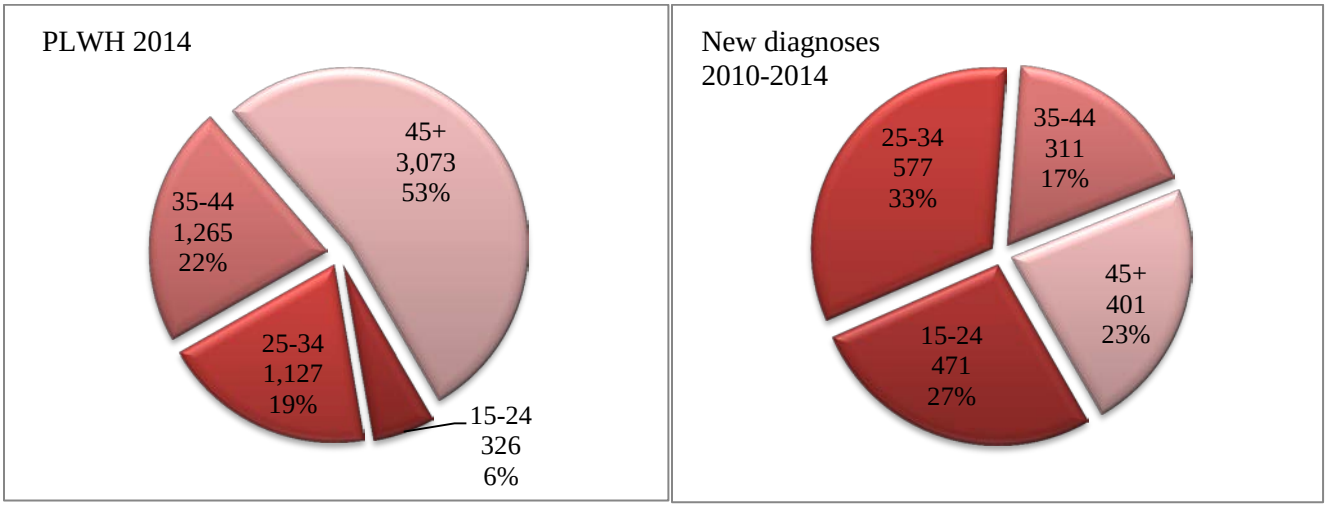


Figure 28: SATGA PLWH and new diagnoses by age

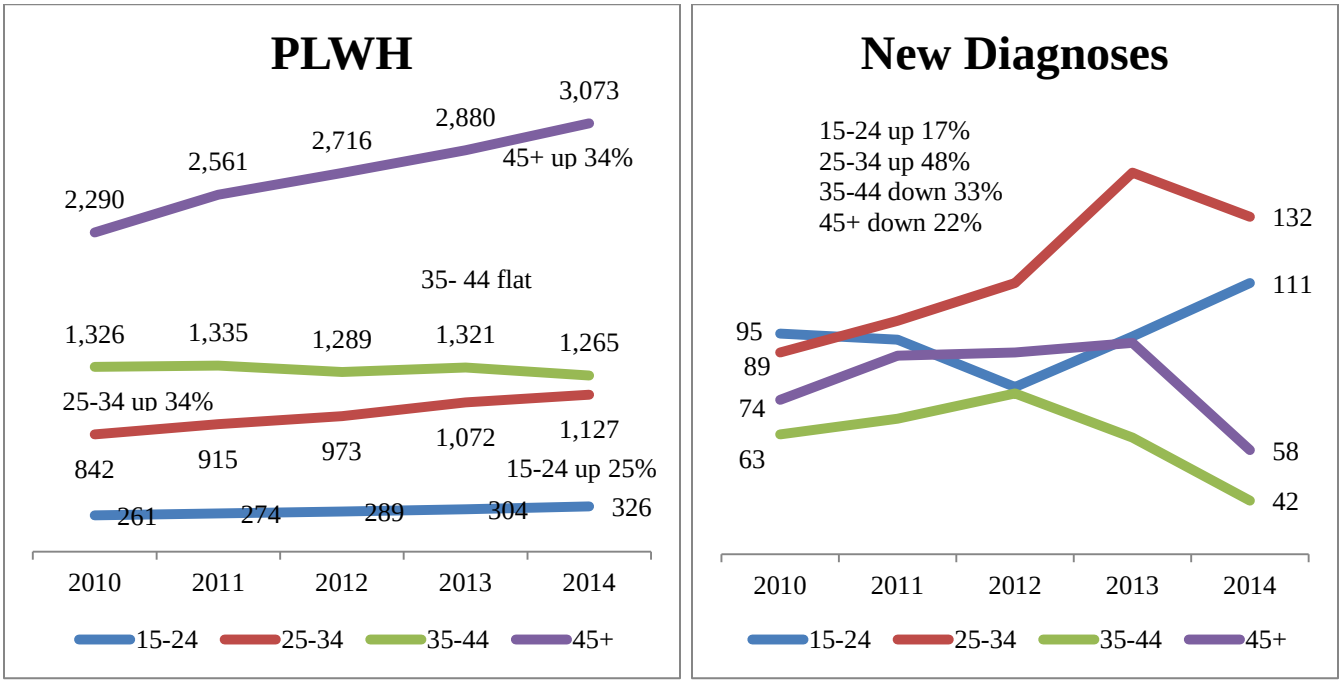


Figure 29: Changes in age of PLWH and new diagnoses in SATGA, 2010-2014

New Infections and Late Diagnoses in the SATGA

Most people live with an HIV infection for many years before diagnoses. Diagnosis rarely occurs close to the time of infection. Newly infected people rarely seek medical attention for common symptoms or report them to their doctor during medical visits.[8] Unaware populations are not receiving HIV treatment, and are more likely to transmit HIV. Studies have linked late HIV diagnosis to slower CD4 recovery,

[8] Sullivan PS, Fideli U, Wall KM, et al. Prevalence of seroconversion symptoms and relationship to set-point viral load: findings from a subtype C epidemic, 1995-2009. *AIDS* 2012; 26: 175-84.

faster disease progression, and higher mortality.[9] [10] [11] TDSHS estimates that about 11% to 17% of Texans living with HIV in 2013 had undiagnosed infections and that about 30% of the transmissions in that year were from people with undiagnosed infections.

Estimated HIV incidence from 2009 to 2013

Incidence is the total number of new HIV infections in a given period. The estimates are made using the results from a laboratory test and information from newly-diagnosed persons about HIV testing and treatment history to characterize an infection as *recent* or *long-term*. *Recent* means that the HIV infection occurred in the last 12 months, and *long term* means that HIV infection happened more than a year ago. Information on the diagnoses categorized as recent infections is combined to estimate HIV incidence (new HIV infections).[12]

Between 2009 and 2013, the estimated number and rate of new HIV infections were flat, with between 410 and 870 new infections estimated for 2013. (The midpoints for 2010-2013 fall inside the confidence interval for 2009.)

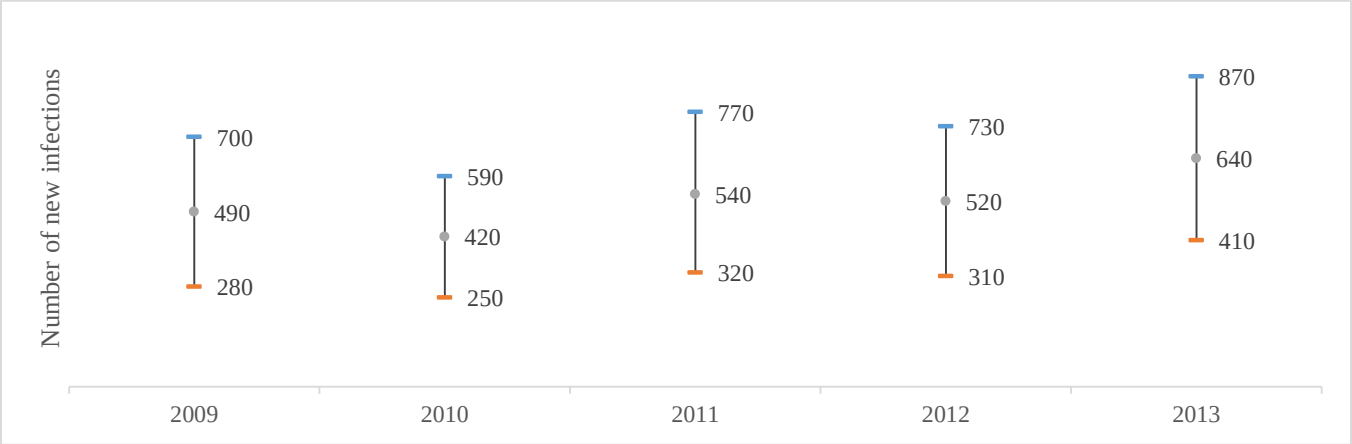


Figure 30: HIV incidence estimates for the SATGA, 2009-2013

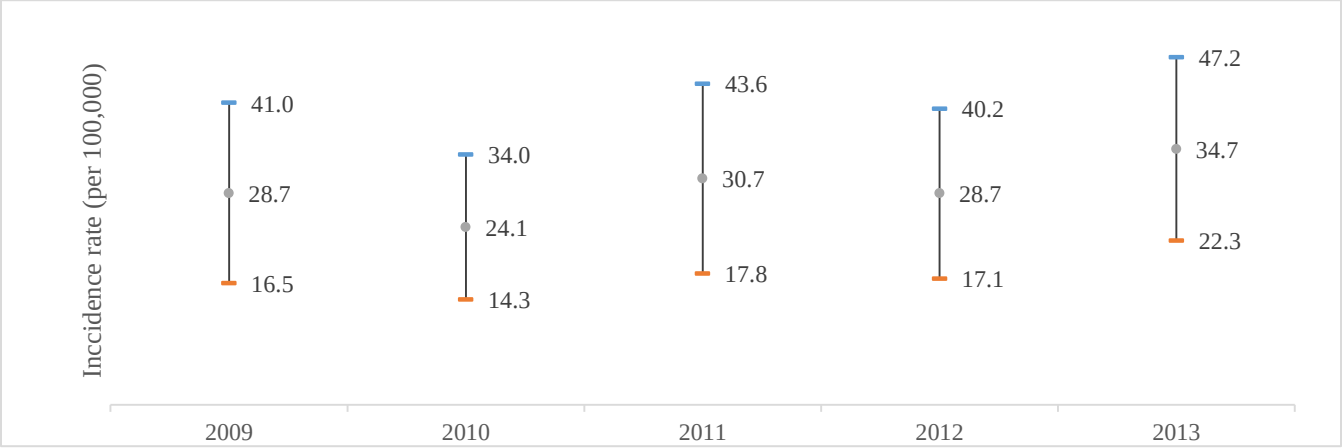


Figure 31: Incidence rates for the SATGA, 2009-2013

[9] Chadborn TR, Delpech VC, Sabin CA, Sinka K, Evans BG. The late diagnosis and consequent short-term mortality of HIV-infected heterosexuals (England and Wales, 2000-2004). *AIDS*. 2006; 20: 2371-2379.
[10] Gras L, van Sighem A, Bezemer D, Smit C, Wit F, de Wolf F, on behalf of the ATHENA national observational cohort study. Lower mortality and earlier start of combination antiretroviral therapy in patients tested repeatedly for HIV than in those with a positive first test. *AIDS*. 2011; 25:813-818.
[11] Waters L, Fisher M, Anderson J, et al. Responses to highly active antiretroviral therapy and clinical events in patients with a low CD4 cell count: late presenters vs. late starters. *HIV Med*. 2010; 12:289-298.
[12] More information about the methods is found at http://www.plosone.org/article/info:doi/10.1371/journal.pone.0017502.

Table 7 illustrates the profile of Texans with recently acquired HIV infections between 2009 and 2013; estimates are not available for local areas. The greatest numbers of new infections were in Hispanic MSM, followed by Black MSM and White MSM. There were between 2,000 and 3,000 new infections among Black HRH women over the past five years. Based on these estimates, each week in Texas between 2009-2013 there were:

25 new infections in Hispanic MSM;
21 new infections in Black MSM;
19 new infections in White MSM; and
10 new infections in Black HRH women.

Men												
	MSM			IDU			MSM/IDU			HRH		
	Est #	95% CI		Est #	95% CI		Est #	95% CI		Est #	95% CI	
White	4,921	4,117	5,725	171	58	284	318	164	471	125	27	223
Black	5,379	4,530	6,229	298	141	454	128	25	231	748	497	999
Hispanic	6,532	5,575	7,489	177	54	301	210	88	331	330	170	490

Women						
	IDU			HRH		
	Est #	95% CI		Est #	95% CI	
White	274	126	421	455	263	647
Black	355	181	529	2,553	2,035	3,070
Hispanic	181	62	300	972	691	1,253

Table 7: Estimates of Texas HIV incidence by sex, race/ethnicity, and mode of transmission, 2009-2013

Estimates of undiagnosed HIV infections in Texas

TDSHS has estimated the proportions of Texans with undiagnosed infections for 2009-2013; these estimates are not available for local areas. TDSHS based these estimates on complex algorithms developed by the CDC. With respect to estimates of incidence, data suggests the number and proportion of undiagnosed infections is 95% confidence interval (CI) for each group (**Table 8** and **Figure 32**). In 2013, it is estimated that 11% to 17% of Texas PLWH had undiagnosed infections.

	95% CI	
TOTAL	11.2%	16.8%
Men	12.9%	16.9%
Women	8.3%	15.9%
White	6.6%	13.0%
Hispanic	16.6%	22.8%
Black	10.4%	15.5%
MSM	13.0%	18.0%
IDU	2.5%	10.5%
MSM/IDU	0.1%	9.6%
HRH	11.6%	18.8%

Table 8: Estimates of the proportion of Texans living with undiagnosed HIV infection, 2013

The greatest numbers of estimated undiagnosed infections are in MSM. Two out of three Texans with undiagnosed infections are MSM who account for approximately 13% to 18% PLWH. Through increased HIV prevention/outreach and care, two groups in Texas are close to or have surpassed the NHAS 2020 90% diagnosis rate outcome: IDU and MSM/IDU.

Hispanics have the highest proportion of undiagnosed infections: about 17% to 23% have not yet been diagnosed. Two out of every five undiagnosed PLWH in 2013 were Hispanic MSM.

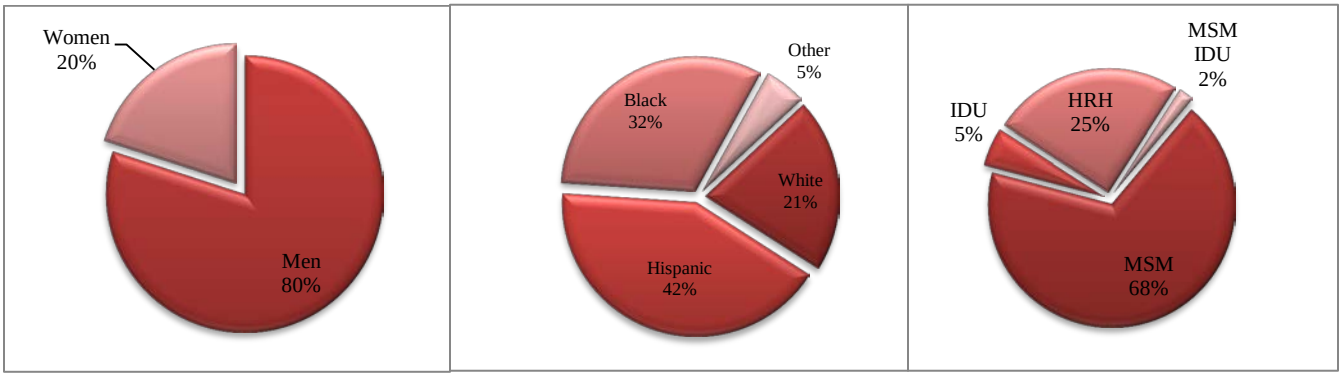


Figure 32: The profile of Texans estimated to be living with undiagnosed HIV infections, 2013

Late diagnosis

A best practice to improve the health of PLWH and to reduce further transmission is early diagnosis and treatment. The CDC classifies a Stage 3 HIV infection as severe immune suppression, more commonly known as AIDS. Persons with a Stage 3 classification within three months of their diagnosis have a late diagnosis.

In 2014, about one in five people newly diagnosed in the SATGA received a late diagnosis. Hispanics had both the greatest number and highest proportion of late diagnoses.

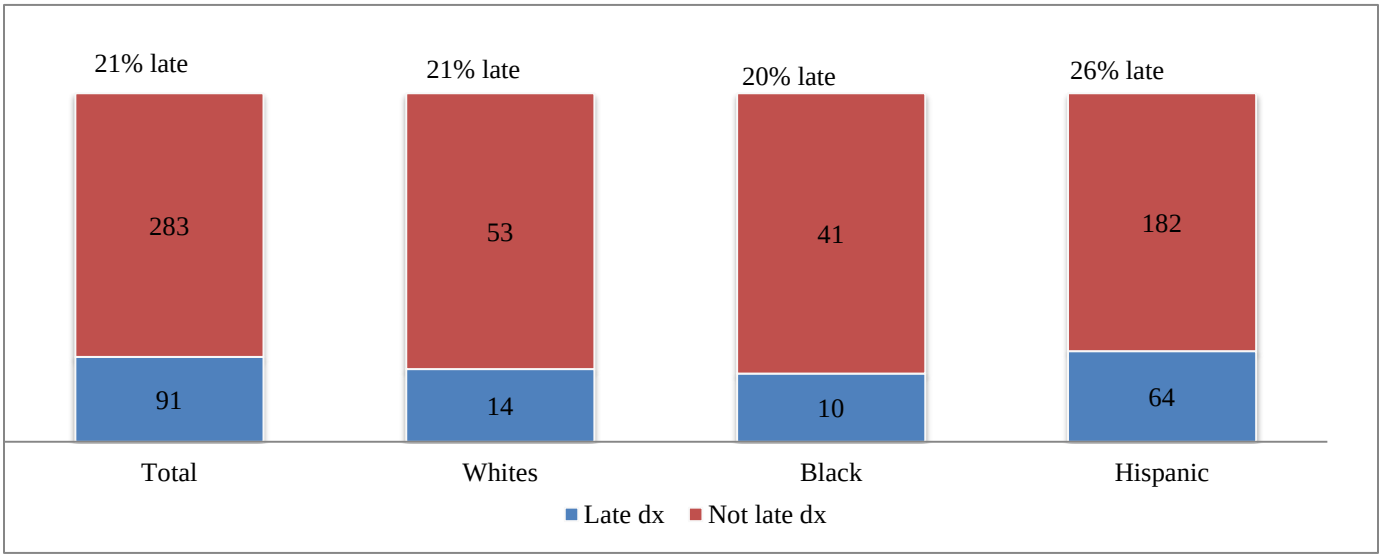


Figure 33: Late diagnoses of HIV infections, SATGA 2014

Linkage to HIV treatment for persons newly diagnosed in 2012 -2014

For this report, linkage to medical care is defined as HIV care within three months of diagnosis.CD4 and viral load tests, outpatient visits, and filled prescriptions for ART were used as markers of care. The counts of new diagnoses in this section exclude persons who have been reported as deceased before the end of the year of their diagnosis.

Figure 34 demonstrates that 83% of SATGA residents who were diagnosed in 2014 were linked to care within three months of their diagnosis, an increase from 74% in 2012. Most people were linked within 30 days of their diagnosis.

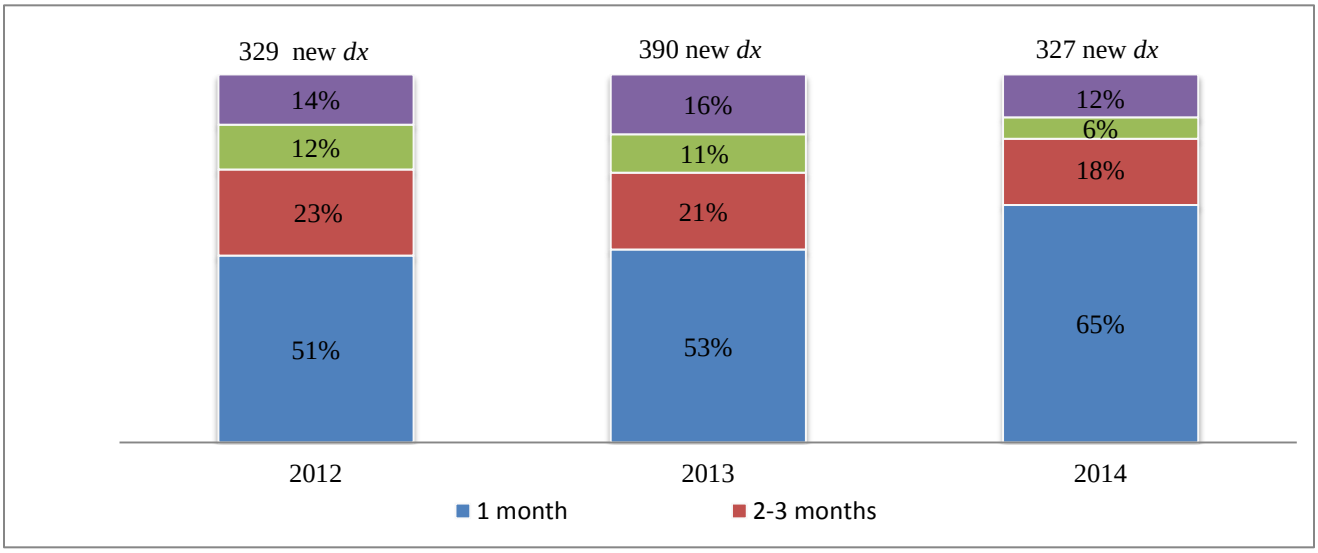


Figure 34: Time to linkage to care, SATGA 2012-2014

When evaluating timely linkage in subgroups, TDSHS combined information for 2012-2014. Black MSM linkage rates are lower than the other priority groups; about 67% compared to around 77%. Linkage rates for younger SATGA residents are also low (around 73%); most of the new diagnoses in those under 35 years of age are in Hispanic MSM.

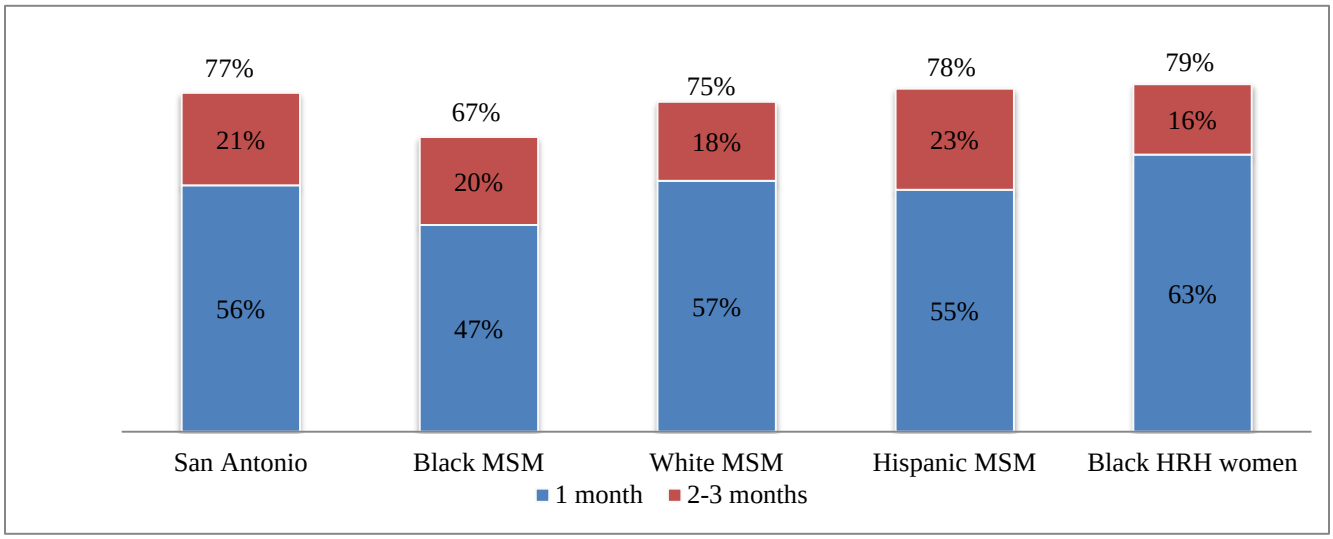


Figure 35: Timely linkage to care in HIV Plan priority populations, SATGA 2012-2014

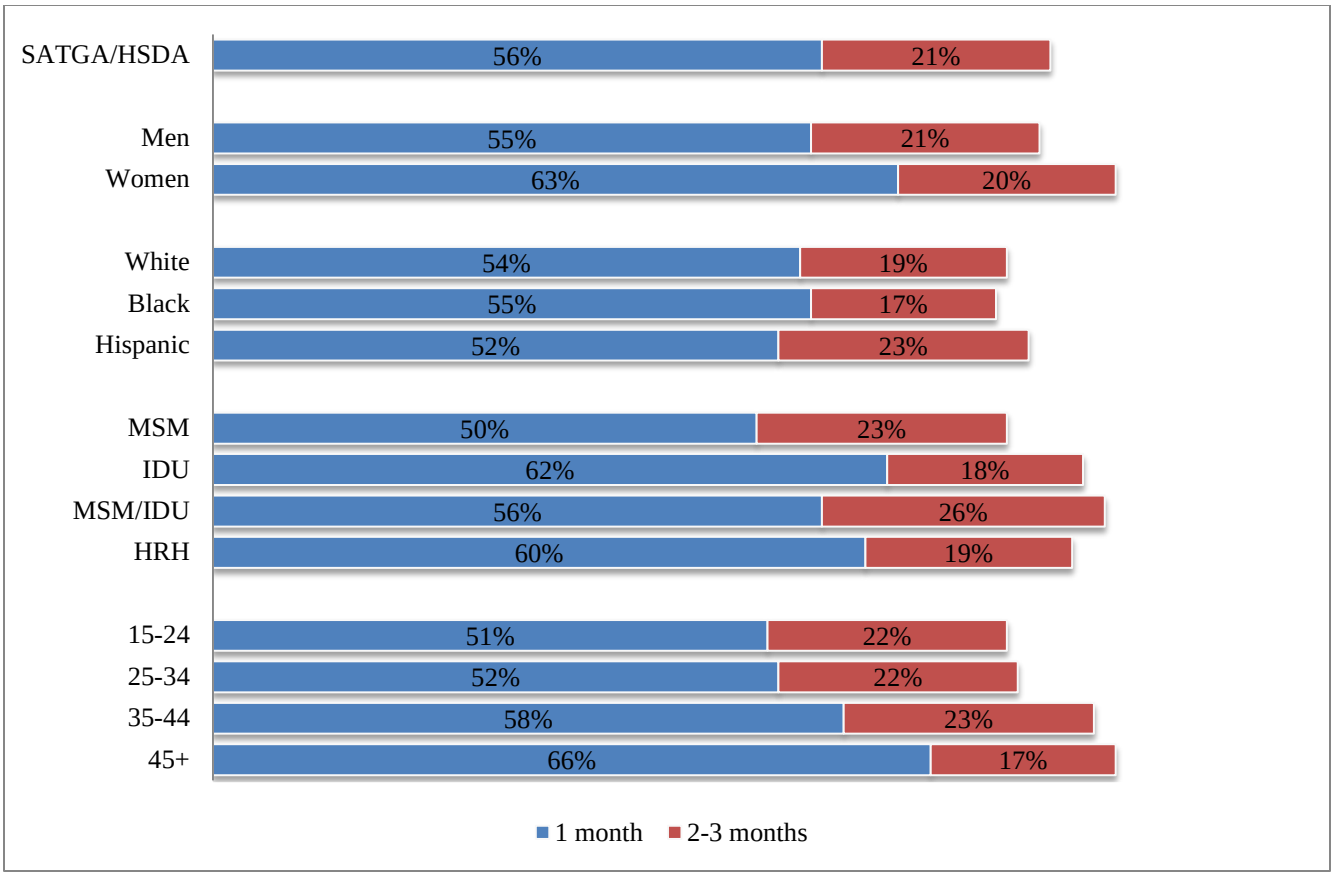


Figure 36: Timely linkage to care by selected characteristics, SATGA 2012-2014

Deaths among Texans with Diagnosed HIV infections

The development of effective ART has allowed PLWH to live longer. Nearly half of the deaths due to HIV in 2013 occurred in Blacks and almost 30% occurred in Hispanics. **Table 9** illustrates the age-adjusted rate of death due to HIV in Texas. The rate of deaths due to HIV in Blacks is 5.8 times higher than the rate for Whites and 3.8 times the rate for Hispanics. The rate for Hispanics is 1.5 higher than the rate for Whites.

Table 10 demonstrates the age-adjusted rate of death in Texas for PLWH. Many of these deaths are attributed to HIV comorbidities, including diseases associated with older age. In contrast to deaths attributed to HIV infections, the overall deaths in PLWH do not show the same race/ethnic differences. The highest rates of death in PLWH are in people who acquired their infections though injection drug use (including MSM/IDU). This may be due to comorbidities associated with injection drug use, such as Hepatitis B (HBV) and C.

Race/Ethnicity	Male Rate	Female Rate	Total Rate
Total	4.5	1.3	2.9
White	2.7	0.4	0.8
Black	13.2	5.5	4.6
Hispanic	4.0	1.0	1.2
Other Races	1.0	***	0.2
Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1) Deaths due to HIV are those where HIV is listed as the underlying cause on a death certificate (ICD Codes B20-B24) No deaths in females of other races were reported in 2012			

Table 9: Age-adjusted rate of death due to HIV per 100,000 population, Texas 2012

Race/Ethnicity & Risk Group	Male Rate	Female Rate	Total Rate
Total	19.3	25.5	20.5
White	26.5	27.2	25.4
Black	20.7	24.1	19.9
Hispanic	17.0	25.4	19.3
Other Races	9.6	**	7.8
MSM	16.2	N/A	16.2
IDU	25.3	25.3	25.0
MSM/IDU	30.9	N/A	30.9
Heterosexual	22.9	24.6	22.4
Pediatric	4.5	2.3	3.5
Age adjustments used the 2000 U.S. Standard Population (11 age groups, Distribution #1) No deaths in females of other Race or females with other risk were reported in 2012			

Table 10: Age-adjusted rate of death due to all causes in Texans living with a diagnosed HIV infection, Texas 2012

Comorbidities: HCV, STIs and TB

When a PLWH has other health conditions or disease diagnoses, such as tuberculosis or a behavioral health condition, it is called a co-infection or comorbidity. Infection with HIV can increase the vulnerability of PLWH to comorbidity with STIs, TB, and HCV, among others. Co-infection can complicate treatment, reduce its effectiveness, and hamper treatment adherence. New STIs or HCV infections may be an indicator of condomless sex, which can increase the chance of transmitting HIV, HCV, and other STIs.

To better understand comorbidities in Texas PLWH, TDSHS aligns the routine disease surveillance databases for HIV, STIs, TB, and HCV infections. This allowed TDSHS to compare the proportion of PLWH with reported comorbidities. These figures do not represent the proportion of all PLWH with STIs, HCV infections, or latent TB. The HIV treatment guidelines that recommend screening for HCV, STI, and TB are not uniformly followed, and asymptomatic STIs and HCV infections may go undetected. Clinicians may not test for STI in the rectum or throat, which also allows infections to go undetected. Finally, the way public health disease reporting is carried out can also affect the statistics on co-infection. For example, in Texas only acute HCV infections are reported, not chronic infections. Without knowing how many infections are ongoing, it is not possible to get a clear idea of the number of PLWH who are living with HCV infections.

Co-Infection with HCV

Because of the limited information on HCV infections, reports reflect only the number and proportion of co-infected persons in various geographic areas. The data represents reported PLWH with acute HCV infection in 2014 or earlier.

	PLWH with reported HCV infections	Proportion of PLWH with reported HCV infections
Texas	7,396	9%
Austin	622	10%
Dallas	1,598	27%
Fort Worth	502	8%
Houston	1,754	29%
San Antonio	578	10%
East Texas	567	9%
US-Mexico border	398	7%

Table 11: Texas PLWH with reported HCV infections, 2014

Co-Infection with TB

PLWH with latent TB co-infection are more likely to develop symptomatic TB due to a compromised immune system. In Texas, the rate of TB in PLWH is 16 times the rate in the general population. In 2014, almost 2% of Texas PLWH had received a TB diagnosis subsequent to their HIV diagnosis, and a little more than 2.7% of PLWH in the SATGA.

Co-Infection with STIs

PLWH were considered to have an STI co-infection if their STI diagnosis occurred before, during, or after their HIV diagnosis. PLWH may have more than one diagnosis of any STI over the course of a year. To calculate the rate of diagnoses among PLWH, TDSHS used the total number of STI diagnoses in PLWH as the numerator and the total number of PLWH as the denominator.

Table 12 illustrates the number and rate of selected STI diagnoses in Texas PLWH in 2014. (P&S syphilis is primary and secondary syphilis, and EL syphilis is early latent syphilis.) The rates are per 100,000 PLWH. In the SATGA, about 2.6% of PLWH had a chlamydia diagnosis and about 3.1% had a gonorrhea diagnosis. About 1.4% of the SATGA's PLWH had a P&S syphilis diagnosis.

		Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
	PLWH	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Total PLWH	80,073	1,362	1,700.9	1,596	1,993.2	538	671.9	803	1,002.8
Female	17,350	268	1,544.7	113	651.3	6	34.6	11	63.4
Male	62,723	1,094	1,744.2	1,483	2,364.4	532	848.2	792	1,262.7
15-24	3,983	282	7,081.1	323	8,109.5	100	2,510.7	122	3,063.0
25-34	14,914	568	3,807.7	683	4,578.7	215	1,441.3	292	1,957.5
35-44	19,763	302	1,528.1	330	1,669.8	110	556.6	201	1,017.1
45+	41,120	210	510.7	260	632.3	113	274.8	188	457.2
White	22,184	227	1,023.3	359	1,618.3	136	613.1	205	924.1
Black	29,895	590	1,973.6	688	2,301.4	193	645.6	258	863.0
Hispanic	24,607	474	1,926.3	459	1,865.3	181	735.6	305	1,239.5
Austin	5,304	140	2,639.5	198	3,733.0	66	1,244.3	89	1,678.0
Dallas	15,403	394	2,557.9	484	3,142.2	137	889.4	256	1,662.0
Houston	21,978	441	2,006.6	506	2,302.3	148	673.4	170	773.5
Fort Worth	4,635	70	1,510.2	86	1,855.4	56	1,208.2	75	1,618.1
San Antonio	*4,248*	*113*	*2,660.1*	*133*	*3,130.9*	*58*	*1,365.3*	*98*	*2,307.0*

Table 12: STI cases and incidence among Texans living with a diagnosed HIV infection, 2014

Table 13 demonstrates the high burden of STI among MSM PLWH. Rates are especially high for Black MSM; who are less likely to have consistent HIV treatment and may not have the benefit of recommended routine screening.

		Chlamydia		Gonorrhea		P&S Syphilis		EL Syphilis	
	PLWH	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
MSM	40,381	886	2,194.1	1,266	3,135.1	462	1,144.1	683	1,691.4
Black MSM	10,455	336	3,213.8	507	4,849.4	162	1,549.5	210	2,008.6
Hispanic MSM	13,751	331	2,407.1	394	2,865.2	156	1,134.5	268	1,948.9
White MSM	14,582	178	1,220.7	297	2,036.8	120	822.9	176	1,207.0

** The number of MSM PLWH differs from other reports because we did not adjust cases to assign mode of exposure to persons with no reported risk.*

Table 13: STI cases and incidence among Texas MSM living with a diagnosed HIV infection, 2014

Figure 37 illustrates that PLWH make up 1% - 5% of persons with chlamydia or gonorrhea co-infections, while accounting for more than a third of P&S and EL syphilis cases in 2014. Ongoing syphilis transmission is increasingly limited to MSM in Texas.

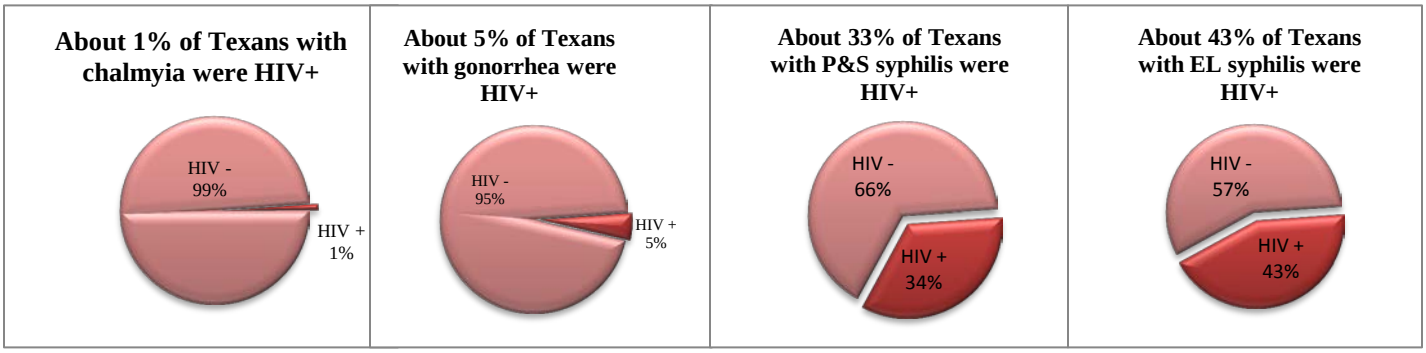


Figure 37: Proportions of Texans with diagnosed STI who are living with a HIV infection, 2014

Indicators of HIV Risk

HIV risk behaviors in high risk, HIV negative Texans

Data in this section has been extracted from the National HIV Behavioral Survey (NHBS) as a pilot survey in Dallas, TX. This information may not be reflective of other jurisdictions in the state of Texas.

In Texas, young Black MSM has the highest rates of new HIV diagnoses. However, NHBS data indicate that White and Hispanic MSM in Dallas are more likely to engage in high-risk behaviors. Though White and Hispanic MSM seem to be engaging in riskier behavior, they may have less exposure to HIV in sexual networks consisting of other White and Hispanic MSM, among whom HIV prevalence is lower. Results are shown in **Table 14**.

		Ave. number of male sex partners	Condomless anal sex						Used injection or non-injection drugs		Self-reported syphilis infection	
			With a male partner		With a male partner of unknown HIV status		With an HIV-positive male partner					
	N	N	N	%	N	%	N	%	N	%	N	%
Total	368	7	227	62%	79	21%	19	5%	211	57%	129	35%
White	141	8	89	63%	25	18%	13	9%	83	59%	52	37%
Black	111	5	60	54%	25	23%	3	3%	59	53%	30	27%
Hispanic	86	6	54	63%	21	24%	3	3%	47	55%	33	38%
15-24	65	8	41	63%	13	20%	4	6%	41	63%	25	38%
25-34	116	8	82	71%	34	29%	10	9%	65	56%	50	43%
35-44	89	5	53	60%	18	20%	2	2%	50	56%	33	37%
45+	98	5	51	52%	14	14%	3	3%	55	56%	21	21%

Table 14: HIV risk behaviors in HIV-negative MSM over the last 12 months, Dallas 2014

IDUs increase the risk of HIV transmission through needles and other paraphernalia. Many substances lower inhibition and increase the likelihood of engaging in high-risk sexual behavior. A large proportion of Dallas respondents reported sharing needles or other paraphernalia, exchanging money or drugs for sex, and having condomless sex. All of these activities are also risk factors for HCV and HBV infections, which can increase the chance of complications from HIV. Results are shown in **Table 15**.

		Ave. number of sex partners	Shared needles		Shared drug paraphernalia		Exchanged money or drugs for sex		Had condomless sex	
	N		N	%	N	%	N	%	N	%
Total	506	6	202	40%	343	68%	198	39%	238	47%
White	52	22	28	54%	35	67%	16	31%	13	25%
Black	426	4	161	38%	288	68%	165	39%	212	50%
Hispanic	13	12	5	38%	11	85%	11	85%	7	54%
15-24	4	6	3	75%	3	75%	1	25%	2	50%
25-34	48	10	24	63%	29	76%	22	58%	14	37%
35-44	54	24	26	48%	39	72%	28	52%	24	44%
45+	410	3	149	36%	272	66%	147	36%	198	48%

Table 15: HIV risk behaviors in HIV-negative IDU over the past 12 months, Dallas 2012

A high proportion of HRH study participants reported having condomless sex. Older respondents were more likely to report exchanging sex for money or drugs. Results are shown in **Table 16**.

		Ave. number of opposite-sex partners	Had condomless sex with a partner of the opposite sex		Exchanged money or drugs for sex		Had condomless sex with an HIV+ partner	
	N	N	N	%	N	%	N	%
Total	545	3	233	43%	110	20%	211	57%
White	22	5	12	55%	3	14%	83	59%
Black	467	4	195	42%	103	22%	59	53%
Hispanic	49	2	22	45%	3	6%	47	55%
15-24	65	8	41	63%	13	20%	0	0%
25-34	116	8	82	71%	34	29%	1	0%
35-44	89	5	53	60%	18	20%	0	0%
45+	98	5	51	52%	14	14%	0	0%

Table 16: HIV risk behavior in HIV-negative HRH over the last 12 months, Dallas 2013

HIV risk behaviors in PLWH currently in care

Data in this section has been extracted from the Texas and Houston Medical Monitoring Project (MMP) sites. Data is representative of PLWH receiving care in Texas.

White MSM report a higher average number of sex partners than other race/ethnicity groups; a large proportion of sexually active MSM PLWH report having condomless anal sex with other PLWH over the past 12 months. This may be an indication of serosorting, a practice of selecting sexual partners of the same HIV status. Serosorting for condomless anal sex make both partners more susceptible to acquiring STI infections. Disclosure of syphilis infection among sexually active MSM is low, however, latent infections can be asymptomatic and may go unnoticed in the absence of regular screening. A third of MSM respondents also reported drug use, especially IDU, in the past 12 months. This is concerning, as drug use can lower inhibitions and contribute to high-risk sexual behavior. The proportion of MSM reporting high-risk behavior did not decrease with age. Results in **Table 17**.

		Ave number of male sex partners	Condomless anal sex with male partner		Condomless anal sex with male partner whose HIV status was discordant or unknown		Self-reported syphilis infection		Used injection or non-injection drugs	
	N	N	N	%	N	%	N	%	N	%
Total	**130**	**5**	**59**	**45%**	**17**	**14%**	**21**	**13%**	**38**	**30%**
White	45	8	25	54%	7	17%	6	10%	13	30%
Black	42	2	20	45%	5	11%	7	13%	13	27%
Hispanic	40	3	13	34%	5	13%	7	14%	10	29%
18-29	26	7	12	51%	6	24%	3	12%	7	29%
30-39	36	3	20	52%	4	13%	8	16%	14	36%
40-49	39	4	11	29%	3	9%	5	8%	6	17%
50+	29	3	16	52%	4	11%	5	15%	11	38%
*** Cell suppressed for numbers less than 3 ** Percentages are weighted**										

Table 17: Indicators of HIV risk in the last 12 months among MSM in care for their HIV infections, Texas 2013-2014

Sexually active heterosexual PLWH also reported high levels of risk behavior in the past 12 months. While HRH reported fewer sexual partners on average, a higher proportion of HRH PLWH reported sex with an HIV-negative or status unknown partner compared to MSM PLWH. Unlike MSM PLWH, the proportion of heterosexual PLWH who engage in high-risk behavior decreased with age. Drug use among heterosexuals PLWH in the 18- 29 age group is comparatively higher to other age groups and methods of identified exposure.

		Ave number of opposite - sex partners	Condomless vaginal or anal sex with partner of the opposite sex		Condomless vaginal or anal sex with partner of discordant or unknown HIV status		Used injection or non-injection drugs	
	n		n	%	n	%	n	%
Total	122	2	43	36%	28	23%	28	24%
White	18	1	8	47%	4	23%	4	26%
Black	65	1	24	38%	19	30%	16	23%
Hispanic	37	3	11	29%	5	14%	6	20%
18-29	10	2	4	41%	4	41%	6	64%
30-39	26	1	12	44%	8	31%	6	25%
40-49	43	1	16	35%	11	24%	13	30%
50+	43	2	11	30%	5	13%	3	9%
*** Cell suppressed for numbers less than 3 ** Percentages are weighted Cell sizes less than 10 may produce unstable estimates**								

Table 18: Indicators of HIV risk in the last 12 months among sexually active heterosexuals in HIV care, Texas 2013-2014

ADAP

The Texas HIV Medication Program (THMP) provides medications for the treatment of HIV and its related complications for low-income Texans. The THMP is the official ADAP for the State of Texas. The THMP has been in existence since 1987 and provides medications approved by the Food and Drug Administration (FDA) for the treatment of illnesses caused by HIV and other opportunistic infections in HIV-infected individuals as prescribed by their doctor. THMP also operates the Texas HIV State Pharmaceutical Assistance Program (SPAP) which helps HIV-positive individuals that do not qualify for the full Low Income Subsidy (extra help) with their out-of-pocket costs associated with Medicare Part D prescription drug plans, including co-payments, deductibles, coinsurance, and during the coverage gap.[13] In San Antonio, there are approximately 1,064 active ADAP clients, with a median of 14 new clients per month. There is an average of 37 total pharmacies that participate with the ADAP program.

Testing Events

Table 19: Newly Diagnosed HIV Positive Test Events in SATGA, Jan.-June 2015 By Target Population

INDICATOR	HISPANIC MSM	BLACK MSM	Women of Color (WoC) OF CHILD BEARING AGE (15-44)
Number of test events	1,302	169	3172
Number of newly diagnosed positive test events	29	6	40
Number of newly diagnosed positive test events with client linked to HIV medical care	16	3	24
Number of newly diagnosed confirmed positive test events	29	6	40
Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services*	***Not Available***	***Not Available***	***Not Available***
Number of newly diagnosed confirmed positive test events with client referred to prevention services#	***Not Available***	***Not Available***	***Not Available***
Total # of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing^	***Not Available***	***Not Available***	***Not Available***

**All people diagnosed with HIV in Texas are referred to partner services through the HIV surveillance system. To determine whether an interview was conducted, the testing data and STD*MIS would have to be matched. Names are not currently collected in the testing data, so a match cannot be made at this time.*

#*The SATGA is not a health department, and therefore, has no mechanism for the collection of this data. Testing data provided to the SATGA by TDSHS did not include this information and was not available.*

^*To determine if CD4 and VL testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data, so a match cannot be made at this time.*

[13] Texas. (2016, September 9). *Texas DSHS HIV/STD program - Texas HIV medication program*. Retrieved September 14, 2016, from https://www.dshs.texas.gov/hivstd/meds/

Table 20: Previously Diagnosed HIV Positive Test Events in SATGA, Jan.-June 2015 By Target Population

INDICATOR	HISPANIC MSM	BLACK MSM	WoC OF CHILD BEARING AGE (15-44)
Number of test events	1,302	169	3172
Number of previously diagnosed positive test events	0	0	0
Number of previously diagnosed positive test events with client re-engaged in HIV medical care	0	0	0
Number of previously diagnosed confirmed positive test events	0	0	0
Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services*	***Not Available***	***Not Available***	***Not Available***
Number of previously diagnosed confirmed positive test events with client referred to prevention services#	***Not Available***	***Not Available***	***Not Available***
Total # of previously diagnosed confirmed positive test events linked to and accessed to CD4 cell count and viral load testing^	***Not Available***	***Not Available***	***Not Available***

** All people diagnosed with HIV in Texas are referred partner services through the HIV surveillance system. To determine whether an interview was conducted, the testing data and STD*MIS would have to be matched. Names are not currently collected in the testing data, so a match cannot be made at this time.*

 # The SATGA is not a health department, and therefore, has no mechanism for the collection of this data. Testing data provided to the SATGA by TDSHS did not include this information and was not available.

^ To determine if CD4 and VL testing was completed testing data would have to be matched with lab data in eHARS. Names are not currently collected in the testing data, so a match cannot be made at this time.

B. San Antonio TGA/HSDA HIV Care Continuum

The 2014 HIV Continuum of Care for local areas has four bars. The first is the number of living PLWH as of the end of 2014. The second bar is the number of PLWH who had at least one care marker for HIV-related treatment (to include laboratory and/or medical visit). The third bar depicts PLWH retained in care, meaning that there were at least two care markers at least 90 days apart or who had suppressed viral load regardless of the number or spacing of visits. The fourth bar depicts the proportion of PLWH who are virally suppressed at the end of the year. This information is created by merging information from disease surveillance with several sources of information on treatment and care. They include program data from treatment providers in the RWP, information from Texas Medicaid, and from some private health plans. TDSHS also used this data to describe the intensity of engagement with the care system: PLWH with no HIV-related care, limited care (only one visit for PLWH with non-suppressed viral load), PLWH who are retained in treatment but who are not virally suppressed, and those who have suppressed viral load.

In 2014, almost four in five of the SATGA PLWH had at least one HIV-related health visit, 72% were retained in care, and 61% were virally suppressed at the end of the year (**Table 22**). The best outcomes are for Whites and those 35 years and older, two groups with a great deal of overlap.

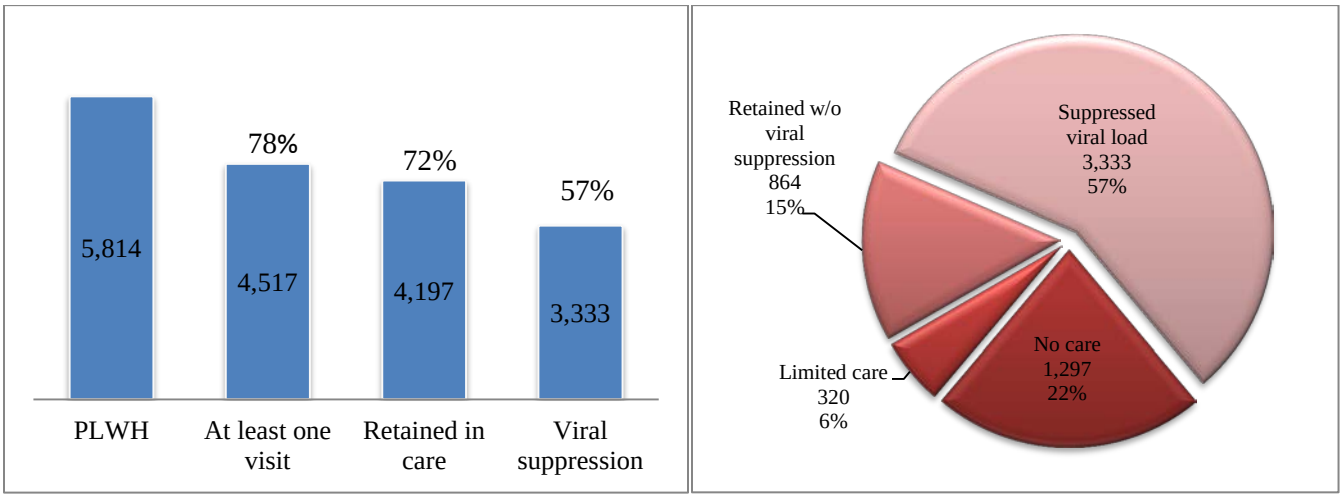


Figure 38: Treatment Cascade and participation in treatment, San Antonio TGA 2014

Of the priority populations, Black MSM have the lowest levels of viral suppression, and are more likely to have limited care. Black women have similar rates of retention in comparison to White and Hispanic MSM; however, levels of viral suppression are lower in Black women. TDSHS estimates use of ART is indicative of viral suppression outcomes for Black MSM and can be partially justified by a lower estimated level of ART use (50% of PLWH); the level of estimated ART use among Black women (70% of all PLWH and 91% of Black women in care) does not justify the low levels of suppression in this group.

Group	% ART use in PLWH with at least one visit	% ART in PLWH
Total	89.1%	68%
Women	98.2%	76%
Men	87.6%	67%
White	92.6%	75%
Black	85.8%	64%
Hispanic	89.4%	66%
MSM	87.1%	68%
HRH	90.4%	68%
Black HRH women	91.3%	70%
Black MSM	73.1%	54%
White MSM	92.6%	76%
Hispanic MSM	84.6%	64%

Table 21: Estimates of ART prescription in Texas PLWH, 2013 Texas MMP

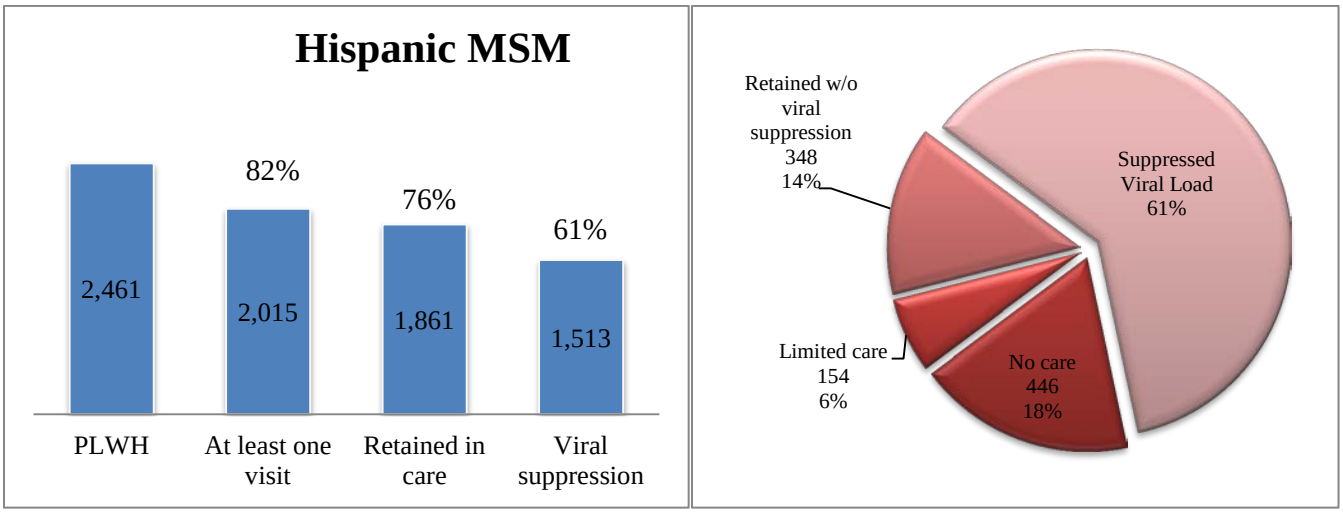


Figure 39: Treatment cascades for HIV Plan priority groups, 2014

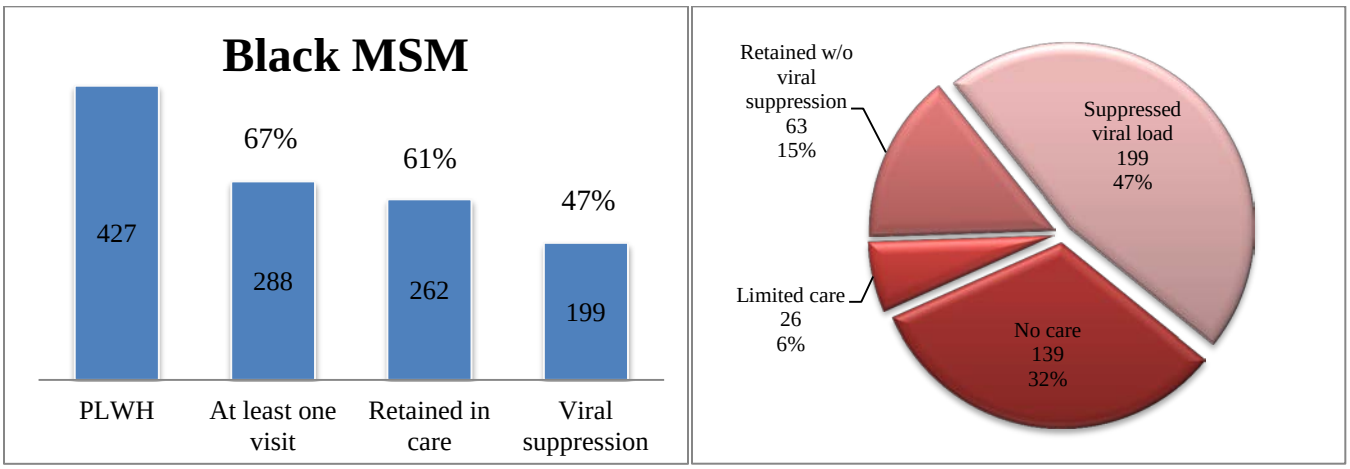


Figure 40: Treatment cascades for HIV Plan priority groups, 2014

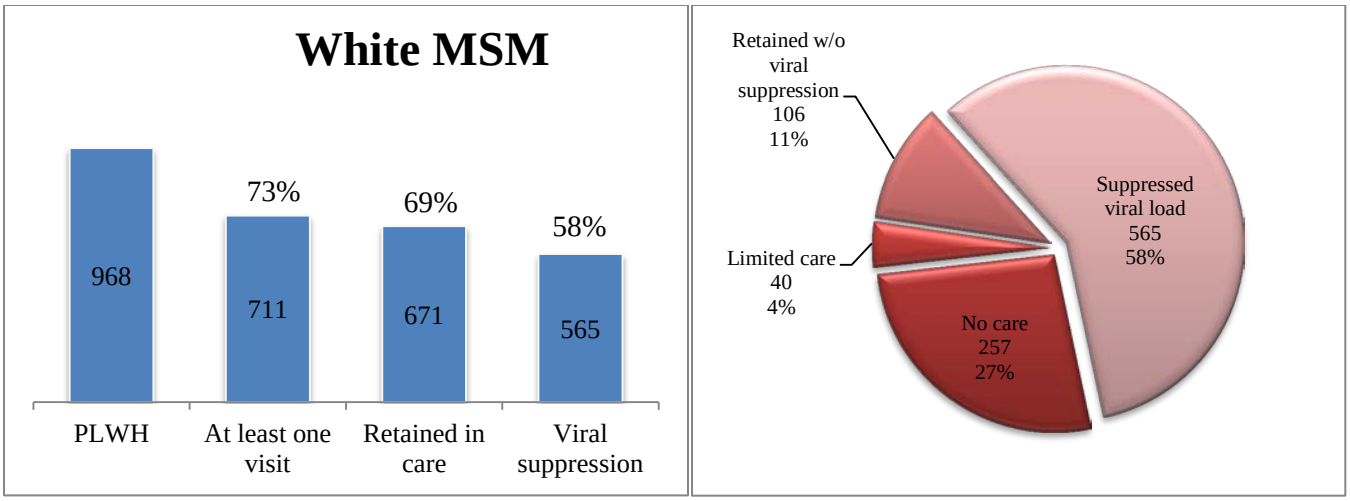


Figure 41: Treatment cascades for HIV Plan priority groups, 2014

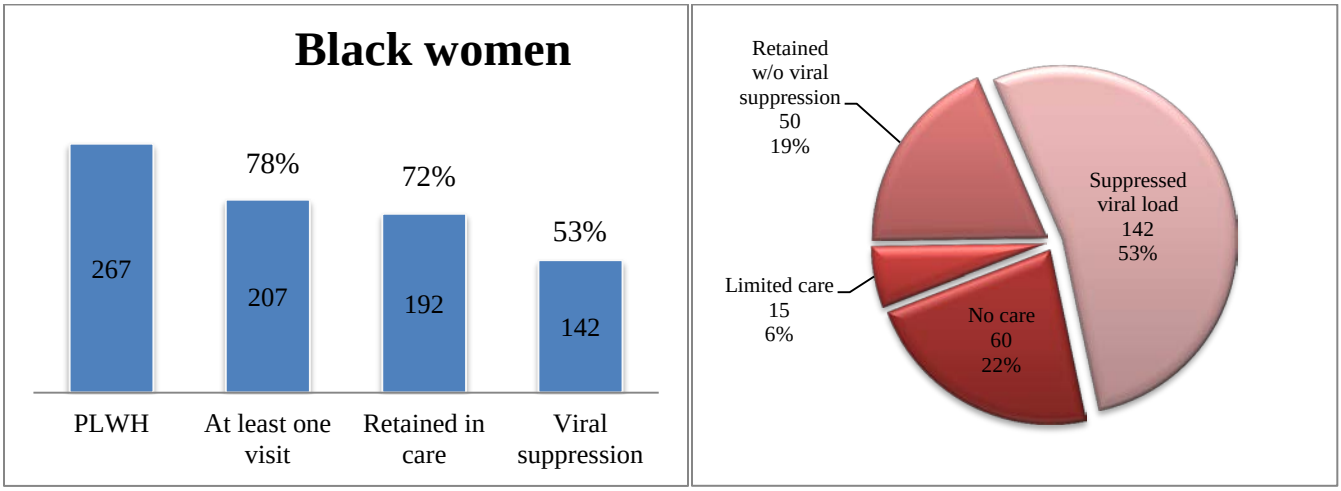


Figure 42: Treatment cascades for HIV Plan priority groups, 2014

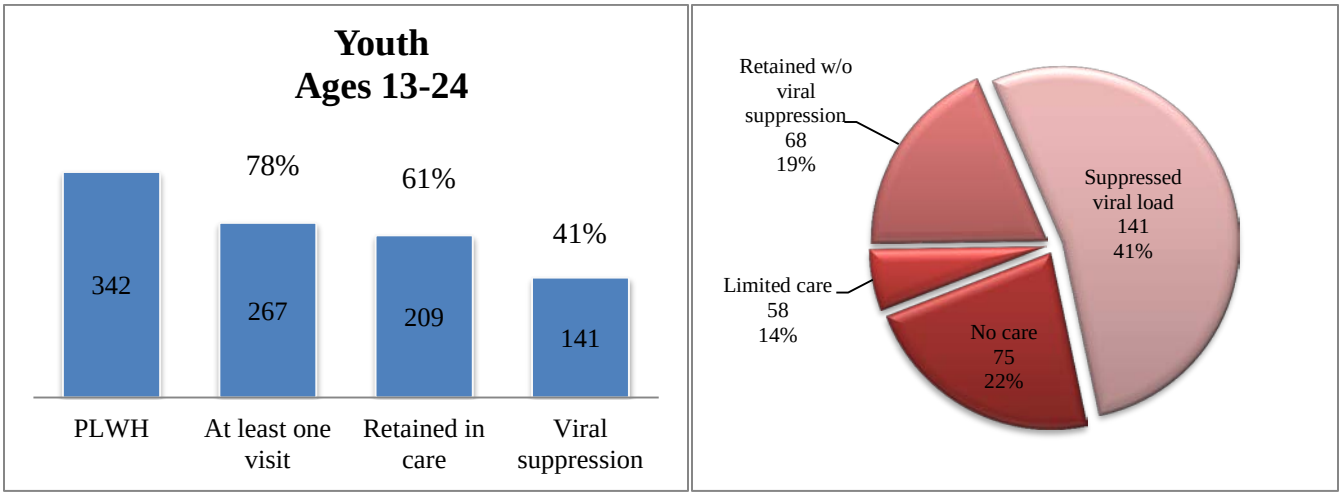


Figure 43: Treatment cascades for HIV Plan priority groups, 2014

	PLWH	At least one visit		Retained in care		Suppressed VL	
		#	%	#	%	#	%
All PLWH	5,814	4,517	78%	4,197	72%	3,333	57%
Males	4,919	3,803	77%	3,531	72%	2,836	58%
Females	895	714	80%	666	74%	497	56%
Whites	1,299	950	73%	889	68%	731	56%
Blacks	876	617	70%	568	65%	425	49%
Hispanics	3,411	2,770	81%	2,575	75%	2,052	60%
Other/Unknown	228	180	79%	165	72%	125	55%
0-14	27	18	67%	17	63%	14	52%
15-24	322	253	79%	200	62%	132	41%
25-34	1,127	853	76%	756	67%	545	48%
35-44	1,265	983	78%	909	72%	696	55%
45-54	1,891	1,499	79%	1,434	76%	1,188	63%
55+	1,182	911	77%	881	75%	758	64%
MSM	4,007	3,137	78%	2,907	73%	2,363	59%
IDU or MSM-IDU	841	613	73%	574	68%	420	50%
Heterosexual	904	723	80%	676	75%	521	58%
All Other	62	44	71%	40	65%	29	47%
White MSM	968	711	73%	671	69%	565	58%
Black MSM	427	288	67%	262	61%	199	47%
Hispanic MSM	2,461	2,015	82%	1,861	76%	1,513	61%
Black Women	267	207	78%	192	72%	142	53%

Table 22: Treatment cascades in SATGA by subpopulations, 2014

	PLWH	No Care		Limited care		Retained no suppression		Suppressed viral load	
		#	%	#	%	#	%	#	%
All PLWH	5,814	1,297	22%	320	6%	864	15%	3,333	57%
Males	4,919	1,116	23%	272	6%	695	14%	2,836	58%
Females	895	181	20%	48	5%	169	19%	497	56%
Whites	1,299	349	27%	61	5%	158	12%	731	56%
Blacks	876	259	30%	49	6%	143	16%	425	49%
Hispanics	3,411	641	19%	195	6%	523	15%	2,052	60%
Other/Unknown	228	48	21%	15	7%	40	18%	125	55%
0-14	27	9	33%	1	4%	3	11%	14	52%
15-24	322	69	21%	53	16%	68	21%	132	41%
25-34	1,127	274	24%	97	9%	211	19%	545	48%
35-44	1,265	282	22%	74	6%	213	17%	696	55%
45-54	1,891	392	21%	65	3%	246	13%	1,188	63%
55+	1,182	271	23%	30	3%	123	10%	758	64%
MSM	4,007	870	22%	230	6%	544	14%	2,363	59%
IDU or MSM-IDU	841	228	27%	39	5%	154	18%	420	50%
Heterosexual	904	181	20%	47	5%	155	17%	521	58%
All Other	62	18	29%	4	6%	11	18%	29	47%
White MSM	968	257	27%	40	4%	106	11%	565	58%
Black MSM	427	139	33%	26	6%	63	15%	199	47%
Hispanic MSM	2,461	446	18%	154	6%	348	14%	1,513	61%
Black Women	267	60	22%	15	6%	50	19%	142	53%

Table 23: Participation in HIV Treatment, SATGA 2014

Use of the HIV Care Continuum as an education tool in the SATGA/HSDA

In early 2015, the AA designed and developed an HIV Treatment Cascade Training for consumers, service providers, PC members, the Quality Management (QM) Committee, and community stakeholders to demonstrate how the cascade can be used for planning, prioritizing, targeting, and monitoring available resources. This interactive training presented information from the National HIV/AIDS Strategy Improving Outcomes: Accelerating Progress Along the HIV Care Continuum 2013, the Texas Spectrum of HIV Engagement for the 2014-2015 Texas Plan, the Treatment Cascades for the SATGA 2013, including those for Latino Males, African American Males, and Young MSM of Color, and the Treatment Cascades for SAHSDA 2013, including those for Latino Males, African American Males, and Young MSM of Color. Participants were encouraged to develop and implement agency level Treatment Cascades. In addition, the AA developed a low literacy treatment cascade tool to be displayed at community events.

C. San Antonio TGA/HSDA Financial and Human Resource Inventory

Financial Resource Inventory

In an effort to have a complete financial resource inventory of the SATGA/HSDA, the PC and AA sent a survey (**Appendix B**) to numerous community stakeholders requesting the following information:

1. Agency Name
2. Funded Program Name
3. Type of Program
4. Program Funding Source
5. Funded Program Amount
6. Program Begin Date
7. Program End Date
8. Program Narrative/Abstract
9. HIV Care Continuum Step(s) Impacted

Table 24 displays the results of the Financial Resource Inventory Survey.

Table 24: Financial Resource Inventory Survey Results

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
Alamo Area Resource Center	HOPWA Housing Program	HIV Care/Treatment	HOPWA - Housing Opportunities for People living with HIV/AIDS	$137,000	10/1/14	9/30/16	Linked to Care, Retained in Care
Program Narrative/Abstract	Provide affordable housing search and placement. Utilizing housing case management, facilitate client towards housing stability.						
Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
Alamo Area Resource Center	HOPWA Medical Transportation Program	HIV Care/Treatment	HOPWA - Housing Opportunities for People living with HIV/AIDS	$178,000	10/1/95	9/30/16	Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression
Program Narrative/Abstract	Provide transportation to and from medical and core services for individuals with HIV.						
Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
Alamo Area Resource Center	State HOPWA Program	HIV Care/Treatment	HOPWA - Housing Opportunities for People	$108,200	2/1/08	1/31/17	Linked to Care, Retained in Care, Viral

			living with HIV/AIDS				Suppression
Program Narrative/Abstract	Provide short term rental and mortgage assistance (STRMU) and long term rental assistance to assist clients maintain their housing.						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
Alamo Area Resource Center	P.U.S.H.	HIV Prevention	TDSHS Prevention - Texas Department of State Health Services	$200,000	1/1/12	12/31/16	HIV Testing and Diagnosis
Program Narrative/Abstract	Provide HIV/STD testing and counseling, focusing on minority men who have sex with men, and link them to Early Intervention and medical care.						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
Alamo Area Resource Center	THRIVE Early Intervention Program	HIV Care/Treatment	Other (Public/Private Funding Source) Ryan White Parts A, B	approx $400,000	3/1/08	2/28/17	Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression
Program Narrative/Abstract	Engage newly diagnosed and returning to care HIV positive individuals in intensive case management and linkage to medical care.						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
BEAT AIDS Coalition Trust	Project CLEAN (Community Led Engagement and Action Network)	HIV Prevention	SAMHSA - Substance Abuse and Mental Health Service Administration	$550,000	9/30/15	9/29/18	HIV Testing and Diagnosis, Linked to Care, Retained in Care
Program Narrative/Abstract	Project CLEAN (Community Led Engagement and Action Network) is a collaborative effort between Black Effort Against the Threat of AIDS Coalition Trust (BEAT AIDS), Lifetime Recovery Therapeutic Treatment Center, Centro Med, the FFACTS (Family Focused AIDS Clinical Treatment and Services) clinic and other local minority serving Community-Based Organizations to utilize social networking strategy to link, engage, and retain YMSM and MSM at high risk for HIV or HIV positive into comprehensive prevention, treatment and support services. The project will provide an integrated intervention by utilizing an array of evidence based practices and high impact interventions.						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
BEAT AIDS Coalition Trust	Engaging People Into a	HIV Prevention	CDC – Center for Disease	$702,500	7/1/15	6/30/20	HIV Testing and

	Continuum of Care (EPICC)		Control and Prevention				Diagnosis, Linked to Care, Retained in Care
Program Narrative/Abstract	In compliance with the State HIV Prevention Plan and state testing protocols, BEAT AIDS (Black Effort Against the Threat of AIDS), in collaboration with San Antonio Area Fighting Back (SAFB), and other key local agencies proposes to: 1) enhance and expand the existing HIV/STD testing, prevention, and support services currently provided at BEAT AIDS and SAFB; and 2) coordinate more productively with local MSM and HIV/AIDS-serving organizations in order to offer a high-impact preventative and comprehensive cascade of care approach to services. Unduplicated Number to be Served: 1,500 YMSM/MSM annually.						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
BEAT AIDS Coalition Trust	Project SMMART (Supporting Minority Men's Access to Resources and Treatment)	HIV Prevention	OMH – Office of Minority Health	$375,000	9/1/14	8/31/17	HIV Testing and Diagnosis, Linked to Care, Retained in Care
Program Narrative/Abstract	Project SMMART (Supporting Minority Men's Access to Resources and Treatment) is an Integrated Comprehensive Center for Care and Support Services by Black Effort Against the Threat of AIDS Coalition Trust (BEAT AIDS) in collaboration with the San Antonio Metropolitan Health District (SAMHD), CentroMed, The FFACTS Clinic (Family Focused AIDS Clinical Treatment and Services), The Center for Health Care Services (CHCS), and The University of Texas at San Antonio (UTSA).						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
Heverly Medical Inc.	Implementation Evaluation for 1115 Medicaid Waiver HIV/STD Project for San Antonio Metropolitan Health	HIV Prevention	TDSHS Prevention - Texas Department of State Health Services	$19,950	7/1/16	9/30/16	HIV Testing and Diagnosis, Linked to Care
Program Narrative/Abstract	The San Antonio Metropolitan Health District (SAMHD) HIV/STD Project is one of six projects focusing on improving various aspects of San Antonio community health. Funding for these projects was received as a result of the Medicaid Program 1115 Waiver called the "Texas Healthcare Transformation and Quality Improvement Program." Texas received federal funding for this Medicaid waiver to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). The Texas Health and Human Services Commission (HHSC) divided Texas into 20 regional healthcare partnerships (RHPs) to implement this waiver. Bexar County and 19 other counties comprise RHP 6 and the University Health System serves as its anchor organization. All waiver providers throughout the RHP work to implement projects aimed at improving healthcare through simultaneous pursuit of the "triple aim": improving the experience of care, improving the health of populations, and reducing per capital costs of health care. The SAMHD STD/HIV Project was developed to cover Project Area 2.7 of the Waiver "Implement Evidence-based Disease Prevention Programs," and the Project Area Option 2.7.1 "Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations." This project was developed in response to the critical need within San Antonio for enhanced, targeted HIV and syphilis prevention, control and treatment strategies. These strategies would reduce the burden of sexually transmitted diseases and						

HIV and improve the health status of San Antonio's adolescents and adults 13 years of age and older.

The target populations for this project include: high risk adults and adolescents (13 years and older), high risk pregnant women, persons exposed or infected with HIV or syphilis, and local medical providers. This project focuses on expanding HIV and syphilis screenings, with a special focus on high risk populations in Bexar County in order to reduce their spread. There are four intervention components at work in this project: Field testing of high risk populations, Case management for high risk pregnant women, Medical provider outreach, and Expansion of STD clinic hours.

HHSC measures and metrics being used to track project activities and outcomes include:

- Category 1 or 2 expected patient benefits including yearly project goals for:
    - HIV and syphilis screening among high risk individuals,
    - third trimester syphilis screening for high risk pregnant women,
    - Linkage to care for those identified as infected, and
    - Expansion of clinic services.
- Category 3 Measure: Outcome Domain 15 – Infectious Disease Management
    - IT-15.11: Follow-up after Treatment for Primary or Secondary Syphilis
    - Quantified Patient Impact (QPI) Metric:
    - Number of high risk adults and adolescents (13 years of age or greater) screened for HIV infection and/or syphilis in the field

Other measures capturing the activities and process indicators of the project are also being collected.

Evaluation Plan Overview
Heverly Medical will provide implementation evaluation services for the San Antonio Metropolitan Health District HIV/STD Project by assessing project implementation, including activities and operations, and by determining the impact of project interventions on the participants, staff and overall community. This will include evaluation of the four intervention components previously mentioned as well as the Healthy Beats case management project for high risk pregnant women.

The specific evaluation aims presented in the RFP are noted below along with our proposed method of accomplishing each. Details regarding the activities that will be conducted for each service are presented in the work plan table and deliverables section to follow.

Evaluation aims and proposed actions for their achievement:
Aim 1: To systematically assess the implementation of the project.
To evaluate the implementation of this project, our evaluation team will broadly focus on three key areas: Program foundation, Implementation system and Program monitoring. With respect to program foundation, the fundamental goals, objectives and implementation timeline of the project will be reviewed so that our team is familiar with the intended implementation and operation of the project.

The implementation system will be assessed by analyzing five (5) implementation domains: Adherence, Dosage, Quality of Delivery, Participant Responsiveness, and Program Differentiation. These domains will be analyzed through multiple forms of data collection such as observational, self-report and participant report, and our findings will be linked to program outcome data in order to provide greater insights into program efficacy.

Program monitoring will be achieved by review of the system developed to measure the integrity of the project. Here, our team will review documentation of aspects of program performance to determine how the program was implemented, how it operates, and whether the program is functioning as intended.

As part of our evaluation, our team will assess the implementation of the four project intervention components, process and planning measures, and the case management program Healthy Beats. Measures to be used in this assessment will include the QPI metric, Category 3 measure, and all other measures of documented project activities. A detailed list of activities proposed for the Healthy Beats sub- evaluation is included in Appendix A.

Aim 2: To gain new knowledge about project activities.

Our team will gain new knowledge about the project activities through our implementation evaluation, and

specifically our analysis of the five (5) implementation domains mentioned in Aim 1. Additionally, analysis of evaluation measures will be coupled with analysis of participant data such as age, gender, sexual orientation, race, ethnicity, language, socio-economic status indicators, access to health care, health literacy, and any pertinent health indicators that are available on an aggregate level. By coupling analysis of outcome measures with participant data, we will yield new knowledge about project activities and the target population. If available, longitudinal data, or data stratified by year may provide additional insights into apparent trends in the community or impact of the project.

Aim 3: To improve or fine-tune existing project operations e.g., processes or strategies.

Our team will achieve this aim through information obtained during our implementation assessment and through interviews with SAMHD staff members. This information will help us identify any barriers that may have surfaced during the project that we might work to alleviate, or identify operational aspects of the project that may be streamlined. It is our aim, as an outside entity, to provide unbiased insights and perspective that may be difficult to achieve from the perspective of an internal evaluator working closely with the project.

Aim 4: To determine project effects by providing evidence concerning the program's contributions to a long-term goal. Completing aims 1 and 2 of this evaluation will yield our assessment of the overall project, the four intervention components, the Healthy Beats case management program and the new knowledge obtained from each. By synthesizing this information, we will be able to take a more broad perspective of the project's impact, and contribution to a long-term goal. Impact questions to explore may include:

1. Could the improved access to care of field-testing be replicated on a larger scale?
2. What was the quality of care impact of the Healthy Beats case management project?
3. Could any models be revised to further improve health outcomes?

Findings from the completion of aim 3 will be incorporated in any recommendations for revision of current models.

Aim 5: To assess project effects on participants, staff, partners, and overall community health.

The foundation of this assessment will come from interviews conducted with SAMHD project staff, STD clinic and case management staff and participants. The synthesis this information with the project's impact from aim 4 will provide a broad perspective of the project's effects on overall community health. Our team plans to provide a $20 gift card survey incentive to case management participants. A list of our suggested interview questions is included in Appendix B.

Frequent and ongoing communication between evaluation staff and SAMHD project staff will occur throughout the duration of the project. This will commence with a series of 2-3 project planning meetings during the first month of the project that will refine and focus the evaluation activities. The agreed-upon activities will be summarized in a detailed draft work plan during the first month of the project. Our staff will proceed with the activities outlined in the work plan once reviewed and finalized by SAMHD staff.

Heverly Medical will provide monthly, written updates of evaluation activities, progress and challenges along with any other content deemed pertinent by SAMHD staff. The results and findings of our evaluation activities will be incorporated into an initial draft of the project evaluation report and delivered to SAMHD staff by September 16th, 2016, with a final report to be delivered by September 30th, 2016. The content for this final report will be established and agreed upon by month three of the project.

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
San Antonio AIDS Foundation	City of San Antonio-HOWPA	HIV Care/Treatment	HUD via City of San Antonio	$869,438	10/1/15	9/30/16	Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral

							Suppression
Program Narrative/Abstract	There are three areas of impact: The targeted population for the first program is persons with HIV/AIDS, who are either SAAF's skilled nursing/hospice residents, or are residents of SAAF's transitional housing program, who were homeless. The second program is: SAAF's Long Term Tenant Based Rental Assistance (TBRA) for Persons with HIV/AIDS TBRA Program provides up to 30 months continuous rental assistance of either full or a portion of fair market value rent, for clients who meet the criteria and are in need of on-going rental assistance in order to remain stably housed. The third program are community-based persons with HIV/AIDS in Bexar, Comal, Guadalupe and Wilson Counties, who are currently homeless; who are being discharged from a medical or correctional facility, residential drug treatment program or institution of some kind without a source of income and/or housing; who are residing in SAAF's Special Care Nursing Facility for HIV/AIDS and are medically appropriate for discharge back to the community, but have no source of income/housing; and who have just located to San Antonio and have no housing or acquaintance with whom to reside.						
Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
San Antonio AIDS Foundation	Special Care Nursing/Hospice Care	HIV Care/Treatment	University Health System	Payment is by patient admitted for maximum stay of 42 days: 42 x $181/day per unduplicated patient.	1/1/16	12/31/16	Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression
Program Narrative/Abstract	Provide nursing care to patients discharged from University, stabilize medication routine and begin suppression of viral load.						
Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
San Antonio AIDS Foundation	Targeted HIV Testing and Linkage to Medical Care	HIV Prevention	Texas Department of State Health Services (TDSHS)	$214,450	1/1/16	12/31/16	HIV Testing and Diagnosis, Linked to Care
Program Narrative/Abstract	Conduct HIV testing for the target population, with a focus on MSM in high morbidity areas to identify people who are infected with HIV; establish enhanced linkage to HIV medical care systems for members of the target population who are infected with HIV; reduce associated morbidity and mortality among HIV-infected persons in the target population and their partners assuring referral to medical, social, and preventative services; and integrate condom distribution activities into HIV testing programs for the target population.						
Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
San Antonio AIDS Foundation	"You're the Cure" & Special Care Nursing	HIV Care/Treatment	United Way	$286,622	7/1/16	6/30/17	Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression
Program Narrative/Abstract	"You're the Cure" Program provides prevention education curriculum in school districts to teach students about HIV: its transmission and how to prevent acquiring it. The Nursing Program provides recuperation for patients who are discharged from local hospitals with an HIV diagnosis to reduce readmission and to stabilize care to obtain viral suppression and adherence to anti-retroviral therapies.						

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
University Health System (UHS)	BREATHE (Bridging Risk Education and Treatment Helps Everyone)	Targeted Capacity Expansion: Substance Abuse Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS	SAMHSA - Substance Abuse and Mental Health Service Administration	$520,000 per year	10/1/13	9/30/16	HIV Testing and Diagnosis, Linked to Care
Program Narrative/Abstract	BREATHE will expand substance abuse treatment, provide HIV and viral Hepatitis screening, and HIV/AIDS risk reduction education, screening and linkage to medical care for 182 adult racial/ethnic minority women in Bexar County, Texas who are at risk for HIV/AIDS through the use of Motivational Interviewing, Seeking Safety, SISTA/HERMANAS, and brief strength based case management for recovery support. **Population:** BREATHE will serve 182 adult racial/ethnic minority women, predominately Latina and African American, who have substance use or co-occurring substance use and mental health disorders and are living with or at risk for HIV/AIDS and reside in Bexar County, Texas. Fifty-six women will be enrolled in YR01, 84 in YR02, and 42 in YR03. Recruitment will take place through referral of women from community service programs. **Interventions:** Prospective participants will be screened for substance use using the CAGE AID. If a women screens positive, she will be offered the opportunity to consent to the study and will be given baseline measures including the Governmental Performance Results Act and some other local measures. After intake, participants will receive Motivational Interviewing, Seeking Safety, SISTA/HERMANA, brief strength-based case management for recovery support, and HIV and viral Hepatitis screening and linkage to care from staff at our partner organizations, University Health System-Family Focused AIDS Clinical Treatment Services (FFACTS) Clinic Family Service Association, Alamo Area Resource Center , and BEAT AIDS. Participants will complete 6- and 12-month follow-up assessments. Participants will receive a $20 gift card for completing the 6-month follow-up and $5 for participation in each HIV education session. **Goals and Objectives:** The primary goal of BREATHE is to prevent/reduce the use of and problems associated with substance use among BREATHE participants (**Goal #1**). It is expected that at 6- and 12-month follow-up a significantly lower proportion of women will report risk behaviors associated with binge drinking and illegal drug use as well as report fewer episodes of binge drinking and drug use compared to baseline. By 6- and 12-month follow-up it is also expected that increased access to support services will improve participant quality of life (**Goal #2**) and participants will report less trauma-related distress, fewer service needs and gaps, improved mental and general health, and improved family functions when compared to baseline. Finally, BREATHE seeks to reduce HIV risk among participants. Through the SISTA/HERMANA intervention, compared to baseline, participants at 6- and 12-month follow-up will report increased awareness of safe sex practices. Increased access to rapid HIV testing (**Goal #3**) is expected to result in 70% of participants and 50% of their partners will be tested for HIV. All participants who test positive for HIV will be linked to medical care through the FFACTS Clinic.							

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
University Health System (UHS)	¡DALE!	Minority Serving Institutions (MSI) Partnerships with Community-Based Organizations (CBO)	SAMHSA - Substance Abuse and Mental Health Service Administration	$300,000 per year	10/1/14	9/30/17	HIV Testing and Diagnosis, Linked to Care

Program Narrative/Abstract	¡DALE! is designed as a collaborative effort among two universities and two community agencies in San Antonio, Texas to prevent and reduce substance abuse problems as risk factors for the transmission of HIV/AIDS and Hepatitis C (HCV) in minority young adults. Our Lady of the Lake University (OLLU) is the identified MSI and the two participating MCBOs are Black Effort Against the Threat of AIDS Coalition Trust (BEAT AIDS), and San Antonio AIDS Foundation (SAAF). The University of Texas Health Science Center at San Antonio, Division of Community Pediatrics (UTHSCSA-CP) will provide evaluation services for the project. **Problem:** Alcohol abuse and illicit drug use among young adults on college campuses is an ongoing issue associated with substantial personal and societal costs. Substance abuse has been linked to risky sexual behaviors, resulting in increased likelihood of HIV transmission. IDU is associated with increased risk for acquiring HCV. Many individuals who are infected with HIV and/or HCV do not realize they are infected. Young minority adults in the targeted geographical area are considered to be at high risk for HIV/HCV due to multiple factors including: a) relatively high rates of HIV/STD infections in the local community; b) financial, religious, and/or stigma barriers that interfere with being tested; b) relatively high rates of IDU compared to other young Texan adults; and high rates of sexual activity without protection or under the influence of substances**. Population to be served:** ¡DALE! will provide culturally competent services to at least 600 unduplicated minority adults, ages 18 to 24 who attend OLLU or reside in four high-risk and high-need zip codes (78207, 78201, 78228, and 78237) within a two- mile radius of the campus. Participants will be recruited from introductory psychology courses, student organizations, or other campus and community venues where young adults congregate. **Aim:** This project aims to prevent or reduce the onset of alcohol, tobacco, and other drug (ATOD) problems and reduce the risk of HIV/HCV infection among members of the target population. **Intervention:** ¡DALE! will provide an integrated intervention by utilizing a comprehensive array of evidence-based substance abuse/HIV/HCV prevention strategies, including: culturally, gender, and developmentally-appropriate evidence-based prevention curricula; 2) HIV and HCV screening, testing, counseling and linkage to care, 3) direct environmental prevention strategies designed to change social norms, and 4) indirect environmental prevention strategies designed to elicit policy and practice changes at the campus and/or community level. A Strategic Prevention Framework process will guide implementation of project activities. **Assessment Strategies:** In addition to collecting SAMHSA required NOMS, ¡DALE! will utilize additional outcome and process measures to conduct a comprehensive local performance assessment of the project.

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
University Health System (UHS)	¡Hazlo!: Por Su Salud (Do It for Your Health)	Minority Serving Institutions (MSI) Partnerships with Community-Based Organizations (CBO)	SAMHSA - Substance Abuse and Mental Health Service Administration	$300,000 per year	10/1/15	9/30/18	HIV Testing and Diagnosis, Linked to Care

Program Narrative/Abstract	¡Hazlo!: Por Su Salud (Do It for Your Health) is a collaborative effort between San Antonio College (SAC), The University of Texas Health Science Center at San Antonio- Division of Community Pediatrics (CP), and minority serving Community-Based Organizations- the San Antonio AIDS Foundation (SAAF) to prevent and reduce substance abuse and transmission of HIV/AIDS and Hepatitis C (HCV) among minority young adults. The project will provide an integrated intervention by utilizing a comprehensive array of evidence-based substance abuse and HIV prevention strategies, including implementing culturally competent education curricula, HIV testing services, HCV testing and environmental prevention strategies developed under a Strategic Prevention Framework. **Problem:** Alcohol abuse and illicit drug use among young adults on college campuses is an ongoing issue associated with substantial personal and societal costs. Substance abuse has been linked to risky sexual behaviors, resulting in increased likelihood of HIV transmission. IDU is associated with increased risk for acquiring HCV. Many individuals who are infected with HIV and/or HCV do not realize they are infected. Young minority adults in the targeted geographical area are considered to be at high risk for HIV/HCV due to multiple factors including: a) relatively high rates of HIV/STD infections in the local community; b) financial, religious, and/or stigma barriers that interfere with being tested; b) relatively high rates of IDU compared to other young Texan adults; and high rates of sexual activity without protection or under the influence of substances. **Population to be served:**

	¡Hazlo! will provide culturally competent services to at least 700 unduplicated minority adults, ages 18 to 24 who attend SAC or reside in the high-risk and high-need zip code, 78212, within a one- mile radius of the campus. Participants will be recruited from student organizations, or other campus and community venues where young adults congregate. **Aim:** This project aims to prevent or reduce the onset of alcohol, tobacco, and other drug (ATOD) problems and reduce the risk of HIV/HCV infection among members of the target population. **Intervention:** ¡Hazlo! will provide an integrated intervention by utilizing a comprehensive array of evidence-based substance abuse/HIV/HCV prevention strategies, including: culturally, gender, and developmentally-appropriate evidence-based prevention curricula; 2) HIV and HCV screening, testing, counseling and linkage to care, 3) direct environmental prevention strategies designed to change social norms, and 4) indirect environmental prevention strategies designed to elicit policy and practice changes at the campus and/or community level. A Strategic Prevention Framework process will guide implementation of project activities. **Assessment Strategies:** In addition to collecting SAMHSA required NOMS, ¡Hazlo! will utilize additional outcome and process measures to conduct a comprehensive local performance assessment of the project.

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
University Health System (UHS)	The PLAY Campaign	HIV/PREVF HIV-Prevention Services-Federally Funded	Texas Department of State Health Services (TDSHS)	$281,985 per year			HIV Testing
Program Narrative/Abstract	The PLAY (Please Look After Yourself) Campaign is a Department of State Health Services funded prevention program dedicated to reducing the spread of HIV and other STD's in San Antonio by expanding free condom access and improving condom knowledge in a collaborative effort among local businesses, medical providers, AIDS Service Organizations and community members. The PLAY Campaign is coordinated out of University Health System, Department of Community Initiatives and Population Health and addresses the DSHS HIV/STD prevention strategies of condom distribution and health education/risk reduction through condom and education availability, acceptability, and accessibility. **Target Population:** PLAY focuses services on heterosexual African American men and women, men who have sex with men (MSM) and intravenous drug users (IDU) in 16 zip codes in each of the four quadrants of Bexar County; 78201, 78202, 78207, 78210, 78220 (central); 78211, 78223, 78224 (south); 78218, 78233 (northeast); 78227, 78228, 78237 (far west); 78229, 78240, 78249 (northwest). **Intervention:** The project distributes condoms to individuals through a website, organizations and businesses and at community health events. PLAY has developed a condom distribution website that provides access to free condom ordering and mailing, information on where to obtain free condoms, and HIV/STD testing information in Bexar County. The VOICES/VOCES curriculum will be used to meet the health education/risk reduction component of the program. PLAY staff implements VOICES/VOCES at various community sites throughout Bexar County. **Measures:** By the end of the grant period, PLAY will have distributed more than one million condoms in Bexar County and educated 1,500 individuals. **Expected Outcomes:** At the end of the grant period, it is expected that availability and access to condoms will be improved compared to baseline community needs assessment; PLAY will be able to track improved access through decreased HIV/STD incidences in target locations, recognition will be high and widespread in the targeted zip codes; and there will be improvement in all areas measured on the VOICES/VOCES pre/post survey after participants have completed the intervention.							

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
University Health System (UHS)	Project *Precious*	Services Grant Program for Residential Treatment for Pregnant and Postpartum Women	SAMHSA - Substance Abuse and Mental Health Service Administration	$500,000 per year	10/1/14	9/30/17	
Program Narrative/Abstract	Project *Precious* will provide residential substance abuse treatment and other services to 100 adult, primarily Hispanic, low-income, pregnant and postpartum (PPW) women, and an estimated 75 of their children, in San						

	Antonio, Texas. *Precious* will provide a trauma-informed, family-centered, culturally-competent continuum of services to aid women in attaining long-term recovery while reuniting and strengthening their families. In partnership with Volunteers of America, *Precious* will efficiently expand the substance abuse, parenting, and recovery services available to substance-using PPW. The project will integrate a number of evidence-based models: Trauma Recovery and Empowerment Model, a trauma-informed recovery program; Motivational Enhancement Therapy, a person-centered counseling approach; Nurturing Parenting, a family skills training program for families in substance abuse treatment and recovery; Pathways to Family Reunification and Recovery, a skills building module addressing child custody issues; and, finally, process groups, a time when participants integrate and process what they have learned. Services will also be provided to children and other family members of the participating women, such as screenings and referrals for physical and mental health needs, including substance abuse treatment. Comprehensive, strength-based case management will guide women through their services and link them to outside resources. These interventions support SAMHSA's goals of reducing substance use; increasing safe, healthy pregnancies; improving mental and physical of women and children; improving family functioning; and decreasing crime, violence, abuse, and neglect. A total of 285 women, men, and children will be served over the life of the project. As required by SAMHSA, Participants will complete a 6-month follow-up assessment. Participants will receive a $30 gift card for participation in 6-month data collection.

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
UTSA Institute for Health Disparities Research	Oh Snap!	HIV Prevention	SAMHSA - Substance Abuse and Mental Health Service Administration	$900,000	10/1/13	9/30/16	HIV Testing and Diagnosis
Program Narrative/Abstract	Oh Snap! is a collaborative effort between The University of Texas at San Antonio (UTSA), The University of Texas Health Science Center at San Antonio- Division of Community Pediatrics (CP), and minority serving Community- Based Organizations- Black Effort Against the Threat of AIDS Coalition Trust (BEAT AIDS) and San Antonio Fighting Back, Inc. (SAFB) to prevent and reduce substance abuse and transmission of HIV/AIDS among minority young adults. The project will provide an integrated intervention by utilizing a comprehensive array of evidence-based substance abuse and HIV prevention strategies, including implementing culturally competent education curricula, HIV testing services, and environmental prevention strategies developed under a Strategic Prevention Framework. Oh Snap! will provide education to 300 unduplicated minority college students over the three years (FY1:50,FY2:125;FY3: 125). In addition, 500 students will receive testing per year for a total of 1500 over 3 years. Problem: Alcohol abuse and illicit drug use among young adults on college campuses is an ongoing issue. Substance abuse has been linked to risky sexual behaviors, resulting in increased likelihood of HIV transmission (Zablotska et al., 2006). UTSA students are considered to be at risk due to a) an increase in reported HIV /STD infections on campus and in the surrounding area and b) UTSA reports reflecting high rates of underage drinking, increased drug use, and an elevated number of driving under the influence incidents at a rate that is twice the national average. Population to be served: Oh Snap! will provide culturally competent services to African-American, Hispanic/Latino and other minority young adults, ages 18-24 who are enrolled at UTSA. Students will be recruited from freshman orientation, freshman level courses, established organizations, and Student Judicial Affairs. Oh Snap! will also educate the entire UTSA student population with environmental prevention strategies. Objectives: This project aims to prevent and reduce the onset of substance use and HIV infection. The objectives of this project are to provide 1) culturally, gender, age-appropriate, and integrated evidenced based substance abuse and HIV prevention education; 2) Rapid HIV testing and counseling; 3)environmental substance use and HIV prevention strategies (e.g. social marketing campaign). Assessment Strategies: The evidence-based prevention curriculum will be tailored to the needs of the UTSA population and assessed using the Center for Substance Abuse Prevention's Adult National Outcome Measures administered at baseline, exit, and follow-up. The environmental prevention strategies will be assessed using the Community Level National Outcome Measures instrument (CLI).						

Agency Name	Funded Program Name	Type of Program	Program Funding Source	Funded Program Amount	Program Begin Date	Program End Date	HIV Care Continuum Step(s) Impacted
UTSA Institute for	Project AHHA!	HIV	SAMHSA -	$900,000	10/01/2015	10/01/2018	HIV Testing

Health Disparities Research		Prevention	Substance Abuse and Mental Health Service Administration				and Diagnosis
Program Narrative/Abstract	AHHA! (Alcohol, HIV, Hepatitis Awareness) is a collaboration between The University of Texas at San Antonio (UTSA), a minority serving institution (MSI) and tobacco-free campus, and community based organization (CBO) Alamo Area Resource Center (AARC) to prevent and reduce substance abuse (SA), HIV/AIDS and Hepatitis-C (HCV) among minority young adults, aged 18-24. The project will provide an integrated intervention by utilizing a comprehensive array of evidence-based SA, HIV and HCV prevention strategies, HIV and HCV testing services, and environmental prevention strategies developed under a Strategic Prevention Framework. AHHA! will provide education to 300 unduplicated minority young adults over three years (FY1: 50, FY2: 125, FY3: 125). In addition, a total of 1500 will receive HIV testing, and a total of 510 will receive HCV testing over three years. Problem: Alcohol abuse and illicit drug use among young adults on college campuses is an ongoing issue. Substance abuse has been linked to risky sexual behaviors, resulting in increased likelihood of HIV transmission (Zablotska et al., 2006). UTSA students are considered to be at risk due to a) an increase in reported HIV/STD infections on campus and in the surrounding area and b) UTSA reports reflecting high rates of underage drinking, increased drug use, and an elevated number of driving under the influence incidents at a rate that is twice the national average. Population to be served: AHHA! will provide culturally competent services to African-American, Hispanic/Latino, and other minority young adults, aged 18-24 who are enrolled at UTSA or living within a 1 mile radius of the UTSA campus. Students will be recruited from freshman orientation, freshman level courses, UTSA minority and veteran-focused student organizations, UTSA Student Judicial Affairs, and the Veteran's Association (VA). AHHA! will also educate the entire UTSA student population and surrounding community with environmental prevention strategies. Objectives: This project aims to prevent and reduce the onset of substance use, HIV infection and HCV infection. The objectives of this project are to provide 1) culturally, gender, age-appropriate, and integrated evidenced based substance abuse, HIV and HCV prevention education; 2)rapid HIV and HCV testing and counseling; and 3) environmental prevention strategies for substance use, HIV and HCV (e.g. social marketing campaign). Assessment Strategies: The evidence-based prevention curriculum will be tailored to the needs of the UTSA population and assessed using the Center for Substance Abuse Prevention's Adult National Outcome Measures administered at baseline, exit, and follow-up. The environmental prevention strategies will be assessed using the Community Level National Outcome Measures instrument (CLI).						

Agency Name	**Funded Program Name**	**Type of Program**	**Program Funding Source**	**Funded Program Amount**	**Program Begin Date**	**Program End Date**	**HIV Care Continuum Step(s) Impacted**
University of Texas Health Science Center San Antonio (UTHSCSA)	South Texas Family AIDS Network (STFAN)	HIV Care/Treatment	Ryan White Part D	$1,169,097.00	8/1/15	7/31/17	HIV Testing and Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression
Program Narrative/Abstract	The South Texas Family AIDS Network (STFAN)- a collaborative, multi-disciplinary partnership serving a highly impoverished, 28-county region in south Texas that includes the city of San Antonio, the nation's 7th largest city- requests Ryan White Part D funding through the University of Texas Health Sciences Center at San Antonio to support a comprehensive, coordinated system of family-centered, culturally and linguistically competent care designed to improve the quality and length of life for low-income women, infants, children, and youth living with HIV. Over a proposed two-year contract period from August 1, 2015 through July 31, 2017 and through five separate agency subcontracts and a broad range of complementary and referral relationships, the STFAN Network will provide a spectrum of vital HIV services for individuals and families in critical need of our support, including direct HIV specialist medical care; medical case management; treatment adherence services; mental health and counseling referrals and services; substance abuse referral and treatment; client outreach and case finding; research access and advocacy; and health and psychosocial services for HIV-affected caregivers,						

	partners, children, and family members. Requested funding will enable our Network to care for an unduplicated annual population of at least 1,357 low-income, HIV –positive and HIV-affected women, infants, children, and youth, approximately 712 of whom will receive Part D-funded medical services through the proposed grant. Approximately 70.9% of the STFAN medical services population will consist of women over the age of 25 while 28.8% will be young people between the ages of 13 and 24. The STFAN network as a whole will serve nearly two-thirds of all HIV –positive young people 13-24 living in our region and over 80% of all women over 25 known to be living with HIV in our region. The overarching goal of the South Texas Family AIDS Network is to expand the quality and length of life for low-income HIV-infected and affected women, infants, children, youth, caregivers, and family members in the South Texas region. STFAN will accomplish this goal through five principal activity areas, including developing, expanding, and supporting a state-of-the-art, comprehensive, coordinated, and culturally and linguistically competent system of HIV care that increases access to care for all target groups and continually locating individuals who are HIV –infected or at high risk for HIV infection but are not receiving primary care, and linking them to a comprehensive range of services while providing HIV prevention and education services to seropositive and seronegative clients. Key STFAN partners include the Alamo Area AIDS Resource Center; BEAT AIDS; CentroMed; the University Health System's Family Focused AIDS Clinical Treatment and Services (FFACTS) Clinic; and the Maverick County Hospital District at the US/Mexico Border. STFAN is requesting a one-year Part D Supplemental Award in the amount of $41, 173 to implement an intensive, network-wide Motivational Interviewing training and certification intervention involving 25 staff from across the STFAN network, with the goal of increasing HIV continuum outcomes related to retention in care and adherence to H IV medications.

The Ryan White HIV/AIDS Program legislation requires Part A Recipients to maintain, as a Condition of Award, SATGA/HSDA political subdivision expenditures for HIV-related core medical services and support services, known as the Maintenance of Effort (MOE). The SATGA/HSDA is a unique jurisdiction in that funds reported in the MOE are primarily non-profit private donations, fundraising, and/or non-Federal/State/Local funds. The MOE can fluctuate from year to year depending on the fundraising efforts of community partners and/or other social enterprise activities within non-profit organizations.

Table 25 displays the SATGA/HSDA Maintenance of Effort for Fiscal Year (FY) 2013 and 2014

Item No.	Item Description	Agency/Department/Other Government Unit	FY 2013	FY 2014
1	Medical Case Management	Alamo Area Resource Center	$ 36,350	$ 40,500
2	Medical Case Management	The Center for Health Care Services	NA	$ 5,333
3	Outpatient Ambulatory Medical Care	Centro Med	$ 57,836	$ 55,791
4	Outpatient Ambulatory Medical Care	University Health System – CareLink Bexar County Indigent Health Care Program	$ 1,447,055	$ 1,197,310
5	AIDS Pharmaceutical Assistance (Local)	BEAT AIDS	$ 700	$ 1,500
6	Health Insurance Premiums & Co-Pays	Alamo Area Resource Center	$ 25,000	$ 92,500
7	Mental Health Services	Alamo Area Resource Center	$ 35,000	$ 40,000
8	Mental Health Services	BEAT AIDS	$ 5,000	$ 5,500
9	Early Intervention Services	Alamo Area Resource Center	$ 10,000	$ 10,000
10	Early Intervention Services	BEAT AIDS	$ 50,000	$ 62,000

11	Early Intervention Services	The Center for Health Care Services	NA	$ 5,333
12	Early Intervention Services	San Antonio AIDS Foundation	$ 45,008	$ 37,698
13	Substance Abuse Services	Alamo Area Resource Center	$ 25,000	$ 25,000
14	Substance Abuse Services	The Center for Health Care Services	NA	$ 5,333
15	Hospice Services	San Antonio AIDS Foundation	$ 167,631	$ 171,822
		Total	$ 1,904,580	$ 1,755,620

Table 26 displays the SATGA/HSDA Financial and Human Resource Inventory that was developed by TDSHS.

Table 26: SATGA/HSDA Financial and Human Resource Inventory

CDC Directly Funded Community Based Organizations FY 2015

FOA#	Category	PA Title	Recipient	Annual Funding Amount	Overarching Primary Target Population	Detailed Primary Target Population	Overarching Secondary Target Population	Detailed Secondary Target Population
Comprehensive High Impact HIV Prevention Projects for CBOs	B	Comprehensive High Impact HIV Prevention Projects for CBOs	BEAT AIDS Coalition	$702,501	Non-Hispanic/Latino, Black/AA MSM, ages 13-55, All HIV Status	Non-Hispanic/Latino, Black/AA YMSM/MSM , ages 13-55, All HIV Status	Hispanic/Latino, Black/AA MSM, ages 13-55, All HIV Status	Black/AA and Hispanic/Latino YMSM/MSM, ages 14-55, HIV+, HIV-, Status Unknown

SAMHSA Directly Funded Community Based Organizations FY2013

Grant ID #	Ending Year	Type of Program	Agency Name	Funding Amount	Population	Center
TI0248572	7/31/16	Targeted Capacity HIV/AIDS	San Antonio Fighting Back, Inc	$250,000	Family and Juvenile Court	Center for Substance Abuse Treatment (CSAT)

SAMHSA Directly Funded Community Based Organizations FY2014

Grant ID #	Ending Year	Type of Program	Agency Name	Funding Amount	Population	Center
SP020647	3/23/17	MSI/CBO HIV/HCV	Our Lady of the Lake University	$899,999	Minority Young Adult	Center For Substance Abuse Prevention (CSAP)

SAMHSA Directly Funded Community Based Organizations FY2015

Grant ID #	Ending Year	Type of Program	Agency Name	Funding Amount	Population	Center
SP021252	9/29/20	Capacity Building Initiative	Center For Health Care Services	$283,875	Young MSM (LGBT)	Center For Substance Abuse Prevention (CSAP)
SP021293	9/29/20	Capacity Building Initiative	University of Texas At San Antonio	$283,875	Young Minority Adults	Center For Substance Abuse Prevention (CSAP)
SP021351	3/23/18	MSI/CBO HIV/HCV	University of Texas At San Antonio	$300,000	Minority Young Adults	Center For Substance Abuse Prevention (CSAP)
SP021336	9/29/18	MSI/CBO HIV/HCV	San Antonio College	$300,000	Young Minority Adults	Center For Substance Abuse Prevention (CSAP)
TI025268	8/31/16	Targeted Capacity HIV/AIDS	University of Texas San Antonio HSC	$590,000	Minority Women	Center for Substance Abuse Treatment (CSAT)
TI026237	3/23/16	TCE-HIV 2015	BEAT AIDS, Inc.	$500,000	YMSM/MSM at high risk	Center for Substance Abuse Treatment (CSAT)

DSHS Mental Health and Substance Use Services funding to Community based organizations (Pass through SAMHSA)

Attachment #	Region	Program ID	Recipient	Contract Amount
2014-044707-001A	8	SA/HEI	Center for Health Care Services Bexar County MHMR Center	$338,488
2014-044593-001A	8	SA/HIV	Center for Health Care Services Bexar County	$367,735

			MHMR Center				
2015 - HIV Prevention – Federal (DSHS)							
Contract Type	Start Date	End Date	Organization Name	Contract Amount	*Number of outreach and brick and mortar testing sites	Number of targeted tests January 1, 2014 - December 31, 2014	Number of Expanded Tests January 1, 2014 - December 31, 2014 (Supports expanding HIV testing efforts in STD and clinical sites)
HIV/PREVF	1/1/15	12/31/15	Alamo Area Resource Center	$201,222	1	1007	
HIV/PREVF	1/1/15	12/31/15	Bexar County Board of Trustees for Mental Health Mental Retardation Services d/b/a The Center for Health Care Services	$353,244	14	1069	
HIV/PREVF	1/1/15	12/31/15	The University of Texas Health Science Center at San Antonio	$281,385	N/A not funded for testing		

HIV Prevention Targeted State and Federal contractors are funded to perform a variety of interventions including: Targeted HIV and syphilis testing, Linkage to HIV medical care, Expanded HIV testing, Condom Distribution, and Community Mobilization Coordination. Contractors are also funded to conduct interventions for high risk populations including: Popular Opinion Leader (POL), Video Opportunities for Innovative Condom Education & Safer Sex (VOICES/VOCES), and Empowerment. DSHS also funded interventions for Persons Living with HIV (PLWH) including: Healthy Relationships, Comprehensive Risk Counseling, Anti-Retroviral Treatment and Access to Services (ARTAS), and Choosing Life: Empowerment! Action! Results! (CLEAR).

*Number of outreach and brick and mortar testing sites: Please note that these sites are as reported in our testing data base. The contractor enters where the testing activity occurred. This varies depending on the site, counselor and staff that enters the data.

2015 - HIV Prevention - State						
Contract Type	Start Date	End Date	Organization Name	Contract Amount	*Number of outreach and brick and mortar testing sites	Number of targeted tests September 1, 2014 - August 31, 2015
HIV/PREVS	3/1/14	8/31/15	San Antonio Metropolitan Health District	$250,000	2	1778

*Number of outreach and brick and mortar testing sites: Please note that these sites are as reported in our testing data base. The contractor enters where the testing activity occurred. This varies depending on the site, counselor and staff that enters the data.

2015 - Other						
Contract Type	Start Date	End Date	Organization Name	Contract Amount	Number of routine HIV testing sites (includes jail health, teen clinics, and emergency, community health and urgent care centers)	Number of routine tests January 1, 2014 - December 31, 2014
HIV/TESTLINK SVC	1/1/16	12/31/16	San Antonio AIDS Foundation	$214,450	No 2014 HIV testing data. 2015 testing data incomplete	

* Program ID Descriptions:	
HIV/PREV-PPT	Federal funded HIV prevention activities to prevent mother to child HIV transmission
HIV/PREVF	Federal funded Targeted HIV Prevention activities that include targeted HIV and syphilis testing and linkage to care, Expanded HIV testing and linkage to care, condom distribution, prevention interventions for HIV infected individuals and community mobilization. Program are funded for one or more of the interventions.
HIV/PREVS	State funded Targeted HIV Prevention activities that include targeted HIV and syphilis testing and linkage to care, condom distribution, prevention interventions for HIV infected individuals and community mobilization. Program are funded for one or more of the interventions.
HIV/ROUTN	Federal Funded routine HIV screening in health care settings and linkage to care.
HIV/SAMH-MAI TCE	State funded HIV prevention activities including case management and mental health counseling for HIV infected persons with substance abuse and mental health diagnoses.
HIV/TESTLINK SVC	Federal funded targeted HIV testing and linkage to care and condom distribution.

Human Resource Inventory / Workforce Capacity

The information used for the Human Resource Inventory / Workforce Capacity was provided by TDSHS. The workforce capacity for the SATGA/HSDA includes but is not limited to: patient care (DPC) physicians, psychiatrists, community health workers (CHWs), professional counselors (LPC), licensed chemical dependency counselors (LCDC), dental hygienists (DH), physician assistants (PAs), dental assistants (DA), dietitians, Licensed Vocational Nurses (LVNs), nurse practitioners (NP), clinical nurse specialists (CNSs), psychologists, and social workers (SW).

In 2015, there were 49,122 actively DPC in Texas. This number represents a 19.3% increase since 2010 and a 37.2% increase since 2005. Over the past ten years, the ratio of population to direct patient care physicians declined by 12.2%. Despite these improvements, Texas still has fewer physicians than the national average.[14]

There were 2,052 actively licensed psychiatrists providing direct patient care in Texas.
This number represented a 21.6% increase since 2010 and a 39.1% increase since 2004. Relative to population growth, the size of the psychiatrist workforce has improved by 12.7% over the past ten years. Despite these improvements, Texas still had fewer psychiatrists than the national average and the majority of the state was federally-designated as a mental Health Professional Shortage Area. (2015 Health Professions Fact Sheets)

There were 3,457 actively licensed CHWs in Texas. This number represented a 285.0% increase since 2010 and a 564.8% increase since 2005. Relative to population growth, the size of the CHW workforce has improved by 71.6% over the past ten years. Despite these improvements, Texas still has slightly fewer CHWs than the national average. (2015 Health Professions Fact Sheets)

There were 21,271 actively LPC providing direct patient care in Texas. This number represented a 34.8% increase since 2010 and a 95.2% increase since 2005. Relative to population growth, the size of the LPC workforce has improved by 38.3% over the past ten years. Despite these improvements, Texas still had fewer licensed professional counselors than the national average. (2015 Health Professions Fact Sheets)

There were 9,752 actively LCDC in Texas. This number represented a 34.7% increase since 2010 and a 133.0% increase since 2005. Relative to population growth, the size of the LCDC, workforce had improved by 48.3% over the past ten years. Despite these improvements, Texas still has fewer licensed chemical dependency counselors than the national average. (2015 Health Professions Fact Sheets)

There were 9,948 actively licensed general dentists practicing in Texas. This number represented a 23.5% increase since 2004. Though the number of general dentists has been increasing, Texas still only had 87.0% of the national average. (2015 Health Professions Fact Sheets)

There were 12,230 actively licensed DH providing care in Texas. This number represented a 20.9% increase since 2010 and a 43.1% increase since 2005. Despite these improvements, Texas still had fewer dental hygienists than the national average. (2015 Health Professions Fact Sheets)

[14] 2015 Health Professions Fact Sheets. Retrieved from http://www.dshs.texas.gov/chs/hprc/Publications/2015FactSheets.aspx

There were 7,067 actively licensed PAs providing direct patient care in Texas. This number represented a 43.0% increase since 2010and a 125.9% increase since 2004.Despite these improvements, Texas still had fewer PAs than the national average. (2015 Health Professions Fact Sheets)

There were 33,360 actively licensed DA providing care in Texas. This number represented a 31.9% increase since 2011. Despite these improvements, Texas still had slightly fewer dental assistants than the national average. (2015 Health Professions Fact Sheets)

There were 4,742 actively licensed dietitians providing care in Texas. This number represented a 15.9% increase since 2010 and a 40.1% increase since 2005. Despite these improvements, Texas still had fewer dietitians than the national average. (2015 Health Professions Fact Sheets)

There were 79,154 active LVNs in Texas. This number represented a 11.3% increase since 2010 and a 28.5% increase since 2004. Texas has more LVNs than the national average. (2015 Health Professions Fact Sheets)

There were 12,421 actively practicing NP with Texas RN licenses in Texas. This number represented a 114.2% increase since 2007 and a 13.6% increase from 2014. Relative to population growth, the size of the NP workforce has increased by 45.5% over the past eight years. (2015 Health Professions Fact Sheets)

There were 1,182 actively practicing CNSs in Texas. This number represents an 8.5% decrease since 2007 and a 2.3% decrease from 2014.Relative to population growth, the size of the CNSs workforce has decreased by 27.6% over the past eight years. (2015 Health Professions Fact Sheets)

There were 7,452 psychologists with active licenses, across four license types, practicing in Texas. This number represented a 13.8% increase since 2010 and a 33.9% increase since 2005. Relative to population growth, the size of the psychologist workforce has improved by 10.0% over the past ten years. Despite these improvements, Texas still has fewer psychologists than the national average. (2015 Health Professions Fact Sheets)

There were 21,812 actively licensed SW in Texas. This number represented a 28.6% increase since 2010 and a 39.1% increase since 2005. Relative to population growth, the size of the social worker workforce has improved by 13.4% over the past ten years. Despite these improvements, Texas still had fewer licensed social workers than the national average. (2015 Health Professions Fact Sheets)

Please see **Appendix C** for the Ryan White PC/AA Resource Guide. The Resource Guide was originally developed in 2009 by the Ryan White PC and AA. It was updated in 2015. It contains provider information for numerous services within the SATGA/HSDA.

Interaction between Funding Sources

The SATGA/HSDA relies on its many community partnerships to direct care and prevention programs by systemic approaches at the stage of HIV prevention and diagnosis to include: conducting HIV/Syphilis testing by members of the HIV/Syphilis Testing Taskforce, increasing the number of certified phlebotomists within the SATGA/HSDA, targeted mobile testing for underserved populations, and provider initiated HIV testing, counseling, and integration of primary care.

MetroHealth STD/HIV Prevention and Control Branch has an internal STD/HIV Mobile Outreach Team that operates out of a mobile unit to provide free and confidential HIV, Syphilis, Chlamydia, and Gonorrhea screenings for anyone 13 years of age and older. The Mobile Outreach Team travels throughout all of Bexar County to provide these services. The team also provides risk reduction counseling, STD/HIV education, and condom distribution.

Strategies developed for the Linked to Care stage include, the development of a bilingual referral cards, referral trainings and workshops for non-RW providers to link into the RWP system; posting bilingual testimonial videos on HIV treatment and care on HIV210.org, establishment of the RW Continuum of Care Maintenance of Effort (MOU) with 22 participating agencies to enhance linkage to care, and the Enroll Texas ACA initiative.

Retained in Care stage strategies include bilingual medical/dental appointment cards, pill boxes, oral health care kits, support of community research and studies, such as UHS Missed Visit Study, skills building for case managers, and consumer education trainings such as Post Exposure Prophylaxis (PEP) / Pre-exposure Prophylaxis (PrEP).

Viral Suppression stage strategies include the development of geo-maps that will enable providers to focus interventions in zip codes with the highest viral loads, consumer involvement in the development of low literacy tools, materials, and social media, and the expansion of support for the underserved population. The SATGA/HSDA and their community partnerships are confident that the use of these strategies will strengthen efforts to enhance every stage of the Continuum of Care in support of the NHAS with a goal of linkage to care, retention in care, ART, and ultimately viral suppression.

Needed Resources/Services

The SATGA/HSDA has been designated as a Health Professional Shortage Area (HPSA) by HRSA. A HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care.[15]

Despite the presence of the County's large medical center, the University of Texas Health Science Center at San Antonio (UTHSCSA), one of the largest military healthcare systems in the country, and home to two Federally Qualified Health Centers (FQHCs), the SATGA has a number of federally designated Medically Underserved areas. All of Wilson County is a HRSA designated Medically Underserved Area/Population as are numerous census tracts within Bexar County and Guadalupe County. Wilson County does not have a hospital or health department. This intensifies access to care barriers for all residents. In addition a need for bilingual and bicultural health professionals in the SATGA/HSDA will help increase access and retention in care. Currently available census figures, 14.2 percent of the U.S. population is Latino, but they make up only about 6.4 percent of the students coming out of the country's medical schools, according to the Association of American Medical Colleges (AAMC). That means there are roughly 3,000 Latino patients to each Latino physician. In comparison, for non-Latinos, the ratio is 335 patients to 1 doctor. That means that Latinos, who may not speak

[15]Health Resources and Services Administration Health Workforce. (n.d.). Frequently Asked Questions. Retrieved from http://bhpr.hrsa.gov/shortage/hpsas/faq.html

English as their first language and who may relate to medical professionals differently because of cultural reasons, are at risk of becoming even more marginalized by the health-care system.[16]

A forecasted decline in the number of primary care and infectious disease physicians managing HIV care in 2015will adversely affect an increase in non-physician clinicians providing HIV care. A decline in the HIV workforce over the next few years, left by clinicians leaving the HIV workforce due to retirement and mortality, could decrease the total number of patient medical visits. The decline in supply is also due to the demographic shift in the HIV workforce toward female clinicians. A disproportionate number of new entrants is female and on average female clinicians work 11.2% fewer hours per week than their male counterparts (40.3 hours for women versus 45.4 hours for men).[17]

Needle Exchange has been an ongoing barrier throughout the State of Texas due to the inability of the State legislature to pass a drug paraphernalia bill to allow for the program. The SATGA/HSDA has no pilot or needle exchange programs. A needle exchange program to help reduce the spread of HIV and HCV may finally be a reality for Bexar County.[18] Texas has one of the highest HIV/AIDS rates in the country and would best be served by a statewide program, but starting with a limited pilot program in the larger counties is a move in the right direction. Needle exchange programs are not about condoning illicit or risky behavior. It's a public health issue. The improper discarding of needles is a health risk for law enforcement officers, paramedics and even members of the general public who may encounter them during an outing to a public park (Texas needs needle exchange program - San Antonio Express-News, 2015). San Antonio Metropolitan Health District (Metro Health) is currently working on a letter to the CDC reflecting the need for the Needle Exchange Program. If the CDC agrees there is a need in the SATGA/HSDA, they can send a certificate that allows all HRSA funded programs to participate in the needle exchange program. It will allow the purchase of sharps containers, etc. but will NOT allow the purchase of needles.

A long standing barrier has been the lack of reimbursement for routine testing by health insurance providers. This barrier has been partly removed because HIV testing was given an "A" grade from the United States Preventative Taskforce, meaning that Medicare, Medicaid, and private insurance are either required or incentivized to cover this service. In December 2014, TDSHS ceased funding for HIV routine testing in two of the HIV medical providers in the SATGA/HSDA, thus eliminating crucial HIV routine testing access points. In response, the AA, in collaboration with the HIV/Syphilis Testing Taskforce, has expanded targeted testing to include additional high risk areas. The Taskforce meets monthly and addresses issues of assessment, data collection, planning, coordination, cooperation, and builds the capacity of those who provide targeted testing activities in the SATGA/HSDA. This increases linkage and retention in care along the care continuum.

With a literacy/education rate of approximately 15% in the SATGA/HSDA, the AA has developed the use of low literacy, educational tools known as *fotonovelas*. The purpose of the *fotonovela* is to have the reader realize the need for protection from HIV, identify steps to take to protect themselves from HIV (condom usage-male and female), as well as identify resources to access more information on HIV, testing sites, if positive, how to get linked to care, and if negative, how access PrEP. The Latina *fotonovela* was produced targeting three variations of age appropriate and relevant information focusing on condom usage and HIV testing for *Jovencitas* (young Latinas), *Damas* (adult Latinas), and *Doñas* (older Latinas). The Latinas *fotonovela* has received positive reaction from the community and has

[16] Hispanic Doctor Shortage: A Community in Need. (2010.). Retrieved from http://www.newsweek.com/hispanic-doctor-shortage-community-need-73465
[17] Gilman, B., Hogan, P., Trent-Adams, S., Cheever, L., Bouchery, E., & Negrusa, S. (2016). The HIV Clinician Workforce in the United States. The American Academy of HIV Medicine, 3-9.
[18] Texas needs needle exchange program - San Antonio Express-News. (2015, February 18). Retrieved from http://www.mysanantonio.com/opinion/editorials/article/Texas-needs-needle-exchange-program-6088348.php

increased open dialogue on education and protection of Latina women of all ages. With the increased infection rates among Youth of Color (YoC) MSM, the AA sought to use the *fotonovela* as a low literacy tool to also address this target population. The AA conducted a youth focus group to provide feedback on the characters, message, language and visual components. *Barbershop Talk* bilingual/bicultural *fotonovela* targeting young men (ages 13-24) of color who have sex with men (MSM) that focuses on HIV testing, condom usage, if positive-linkage to care, and if negative-asking about PrEP. A *fotonovela* is regarded as a familiar, culturally, and historically accepted form of delivering low literacy health care information in Latino communities.

Client's knowledge of how to access HIV prevention and care has always been a long standing problem within the SATGA/HSDA. Over the last several years, the AA and the PC have developed the following bilingual, low literacy tools in order to assist clients in accessing prevention, testing, care, and early intervention services. Listed below are some examples of the tools used to enhance access to services:

1. Stay Negative Card – lists local testing sites;
2. Large Resource Guide (**Appendix C**)– lists social, HIV prevention, and HIV care services; primarily for use by Case Managers, Criminal Justice, Hospital and Social Service personnel;
3. Small Resource (Pocket) Guide – lists social, HIV prevention, and HIV care services; and illiterates VIA bus routes for easy access by clients and their families;
4. The PC website, www.hiv210.org – which contains video testimonials in both English and Spanish of approximately 8 HIV positive individuals;
5. Client Referral Cards – lists out items clients will need to bring to their first appoint to receive RW services; and
6. Appointment Cards – a single card that can be used for both Medical and Dental appointments.

D. San Antonio TGA/HSDA Needs, Gaps, and Barriers

TDSHS provided the HIV surveillance (e.g., HIV prevalence data, HIV incidence estimates, etc.) and HIV Continuum of Care measures for SATGA/HSDA for specific subpopulations. This data provided invaluable quantitative input regarding needs for persons at risk for HIV as well as PLWH. The RWP AA augmented this data with a number of qualitative data sources. These included but are not limited to: (1) HIV/Syphilis Testing Taskforce (includes 69 representatives of prevention, Early Intervention Services (EIS) and testing organizations and 69 representative of HIV Care and support services organizations) who focused on identification of needs, barriers, and gaps including annual epidemiology from the San Antonio Metro Health; (2) Bexar County Health Collaborative stakeholders group for safe communities, behavioral and mental well-being and sexual health; (3) HPCG Group focused on identification of needs, barriers, and gaps; (4) RWP AA/PC-facilitated public forums; (5) dissemination of a SurveyMonkey survey via email assessing resource inventory and finance inventory; (6) dissemination of a consumer survey targeting PLWH with an emphasis on Youth and Housing; (7) People's Caucus conducting a number of focus groups and semi-structured interviews targeting PLWH; (8) Bexar County Community Development Block Grant (CDBG) stakeholders 5 year comprehensive plan to Department of Housing and Urban Development (HUD); (9) Comal and Guadalupe County's needs, barriers and gaps; and (10) cross RWP collaboration with (A, B, C, D and F).

Consumer and Provider Surveys and Focus Groups

The overall purpose of the needs assessment was to explore HIV prevention and care service needs, gaps in services and barriers to care for PLWH as well as those at risk of HIV. In addition to assessing the needs of PLWH, the barriers faced by providers to provide medical and support services to PLWH were also assessed to gauge service gaps. This assessment utilized a mixed methods design.

The findings of various needs assessment were presented to the HPCG Group for feedback and prioritization of need. The strategies and activities outlined in the work plan are outcomes of an integrated working session, which is comprised of representatives from cross collaboration RWP, CBOs, ASOs, mental and behavioral health providers, homeless service institutions, HIV prevention and care providers, academic institutions, psychosocial support and treatment service providers, local and state health departments, and other stakeholders. Participants at the HPCG Group meeting were asked to review initial strategies and activities and to provide feedback.

Except for the online provider survey, all focus groups, semi-structured interviews, and questionnaires were completed at pre-scheduled meetings and training events that brought together PLWH, high risk HIV individuals including youth, HIV prevention and care providers, and other stakeholders. These events included the cross-parts collaborative HIV/Syphilis Testing Task Force, Bexar County Health Collaborative, Bexar County HUD/CDBG stakeholder group, People's Caucus, AA Quality Management Committee, RWPD Consumers "Family-to-Family", and the local health care and support service providers. As a result of the focus groups, interviews and surveys the HPCG Group partnered with providers with a large Black and Latino client base in order to capture more emerging populations living with and at risk for HIV.

HIV Prevention and Care Service Needs

TDSHS reported that there are 6,303 PLWH in the SATGA/HSDA of December 31, 2014. The SATGA/HSDA is a minority majority area as evidenced by the demographic profile. Hispanics comprise 41% of the general population in the SATGA/HSDA and represent 59% of PLWH. Blacks comprise 5% of the general population, yet 15% of the total PLWH.

The SATGA/HSDA occupies an area of 3,555 square miles and is located approximately two hours from the U.S-Mexico border. Distances to Bexar County's urban core, where the majority of services exist, extend as far as 120 miles round trip. Unique characteristics include a high proportion of bilingual and monolingual Spanish speaking residents. The SATGA/HSDA is home to five large military installations, whose PLWH numbers are not reflected in the epidemiological profile due to non-reporting by the Department of Defense. Ninety-one percent (91%) of the PLWH who receive services reside in Bexar County. Hispanics and Blacks are the most distinctly disproportionate minority communities.

In the SATGA/HSDA 18% of the general population live below the federal poverty level (FPL), compared to 61% of PLWH. People living in poverty tend to delay entry into HIV care which increases the cost of treatment from $27,275 to $61,615 over the first seven years of treatment as compared to those who did not delay entry into care according to a recent Johns Hopkins study.[19] In the SATGA/HSDA 27% of newly diagnosed in 2014 entered care and were given an AIDS diagnosis within one year.[20] The RWP EIS expends $1,495 per client for linkage and referral efforts. The goal is to engage out of care, late to care and newly diagnosed clients; retain them in care and ultimately virally suppress them. Texas is one of two states whose ADAP does not fund Health Insurance Premium and Cost Sharing Assistance (HIPCSA) at the State level.

The cost of medical care continues to rise and prolongs the strain on the nation's economy. Approximately 25% of persons living in the SATGA/HSDA do not have health insurance, compared to the uninsured rate of 19% for Texas. Many uninsured and indigent people who lack insurance resort to using emergency rooms or express clinics for care. Of the 11 public health districts in Texas, Region 8-that primarily includes the Bexar County population, had the highest rate of uncompensated health care. The University Health System provides the most uncompensated health care for public hospitals in Texas. For PLWH in the SATGA/HSDA, these increased costs in medical care create additional stress and worry when coupled with multifaceted issues of poverty, lack of health insurance, housing instability, and unemployment. In the U.S. Census Bureau's report entitled Health Status, Health Insurance, and Medical Services Utilization: 2010 released July 2013, the relationship between income and the number of medical provider visits revealed that 39% of the population surveyed below 100% of the FPL went without seeing a medical provider over the previous twelve month period; as compared to only 24% of people who earned 300-399 percent of the FPL. Similarly, in the same report, 66% of people in poverty reported having never taken prescription medication in the previous year due to cost considerations. Insufficient access to medical care and medications for PLWH place them at a higher risk for acquiring viral mutations which may result in complex ART once care is initiated.

Emerging populations in the SATGA/HSDA include Youth MSM, Transgender, Hispanic MSM, Black MSM, and WoC. MSM, especially those who are young and of color, constitute a risk group with increasing rates of HIV/AIDS. Black MSM are disproportionately impacted by HIV. Of the 450 Black males with HIV in the SATGA/HSDA, 297, or 66%, are MSM. Hispanic MSM are disproportionally impacted by HIV. Of the 1,994 Hispanic males who are HIV positive in the SATGA/HSDA, 1,518, or 76% are MSM. In conjunction with incidence and prevalence data for the SATGA/HSDA, an 11% increase in HIV infections in 2013 from 2012 and a 58% increase in positive

[19] Fleishman, John A. PhD*; Yehia, Baligh R. MD†; Moore, Richard D. MD, MHSc‡; Gebo, Kelly A. MD, MPH‡; for the HIV Research Network. The Economic Burden of Late Entry Into Medical Care for Patients With HIV Infection

[20] Texas Department of State Health Services, Late-Concurrent Diagnosis 2014, October 2014

tests in Youth of Color (YoC), 15-19 years of age.[21] Minority women have disproportionately higher rates of HIV infection and bear the additional risk of perinatal infection. In the SATGA/HSDA, minority women are more likely than their male counterparts to enter care late, indicating a need for earlier testing, intervention, education, and linkage to treatment. Further, 15% are not virally suppressed and 53% have not had a viral load test in the last year.

The PC conducted a Comprehensive Needs Assessments in 2011 and 2014, a Mini-Needs Assessment in 2015, and are currently working on a Housing Needs Assessment for 2016.

The Comprehensive Needs Assessments in 2014 found that education on health and stigma were huge barriers to care for PLWH. The focus groups discussed "community awareness" at great length and the common theme was addressing stigma, educating the community, and a greater emphasis on youth.

The final Mini-Needs Assessment by the PC for FY 2015-2016 focused on the following groups: 1. Out of Care, 2. Late to Care, 3. Recently Diagnosed, 4. Monolingual Spanish Speakers, 5. HIV positive individuals in the other SATGA Counties, 6. Transgender, and 7. HIV positive minorities.

The Needs Assessment found that that the Transgender group took longer to link to care; most Transgender individuals were linked within six months; whereas the other groups were linked within one month of diagnosis. The Out of Care group reported the lowest medication usage and lowest medication adherence within the last 30 days. All groups reported "forgetfulness" as the reason for missing medication doses. The Transgender and Monolingual Spanish Speaking groups reported having the most trouble affording their medications. The Out of Care (OoC) group had the lowest rate of understanding what "undetectable" viral load means.

The Needs assessment identified the top three Core medical services needed but not received were: 1. Oral Health Care, 2. HIPCSA, and 3. Mental Health Services. The top three support services needed but not received were: 1. Housing Services, 2. Emergency Financial Assistance, and 3.Food Bank/Home Delivered Meals. Across all services, the most commonly reported reason for not receiving a needed service was "not knowing about the service".

The AA in 2014 conducted a youth (ages 13-29) survey to identify individual sexual social interaction using social media habits and mobile applications. The data was analyzed by the AA with special attention reflecting the young men who have sex with men of color (YMSMoC) aged 13-29. Of the 516 total surveys completed, the participants were 55.8% male, 81.6% were in the age group of 18-24, 54.1% were Hispanic, 39% identified as gay, and 38.3% identified as HIV positive. The majority preferred hanging out at home (80.2%). Facebook was the most popular application or website of those included in the survey (83.3%), and Google or online searches were the most common sources of HIV/STI information (62%). The majority of respondents had been tested for HIV previously (54.1%), with most reporting 1-3 months since their last HIV test (18.6%). The most frequently reported HIV testing location was the doctor's office (12%). However, the majority of respondents selected "other" as their testing site (19%). The majority of those surveyed were HIV negative (71.7%).

Service Gaps and to HIV Prevention

Barriers identified through data extracted from the SATGA/HSDA resource and financial inventory suggests that rural areas, outside of Bexar County, have limited access to HIV and STI testing and

[21] Salinas, R. (2014, August 29). HIV on the rise in Bexar County. San Antonio Express-News. Retrieved September 7, 2014, from http://www.mysanantonio.com/news/local/article/HIV-on-the-rise-in-Bexar-County-5721429.php

condom distribution efforts. This limited access requires high risk individuals to travel great distances for HIV/STI testing, prevention and intervention services.

Service gaps from the Missed Visits Project indicated that missed medical visits were common among HIV patients initiating or re-initiating care, employment and engagement in CM predicted attendance of the IMV, and younger patients who had not been recently hospitalized took longer to engage in care. Patients who failed to engage in medical care within 100 days were at high risk for non-engagement.

Needle Exchange has been an ongoing barrier throughout the State of Texas due to the inability of the State legislature to pass a drug paraphernalia bill to allow for the program. The SATGA/HSDA has no pilot or needle exchange programs. A needle exchange program to help reduce the spread of HIV and HCV may finally be a reality for Bexar County.[22] Texas has one of the highest HIV/AIDS rates in the country and would best be served by a statewide program, but starting with a limited pilot program in the larger counties is a move in the right direction. Needle exchange programs are not about condoning illicit or risky behavior. It's a public health issue. The improper discarding of needles is a health risk for law enforcement officers, paramedics and even members of the general public who may encounter them during an outing to a public park (Texas needs needle exchange program - San Antonio Express-News, 2015). San Antonio Metropolitan Health District (Metro Health) is currently working on a letter to the CDC reflecting the need for the Needle Exchange Program. If the CDC agrees there is a need in the SATGA/HSDA, they can send a certificate that allows all HRSA funded programs to participate in the needle exchange program. It will allow the purchase of sharps containers, etc. but will NOT allow the purchase of needles.

A long standing barrier has been the lack of reimbursement for routine testing by health insurance providers. This barrier has been partly removed because HIV testing was given an "A" grade from the United States Preventative Taskforce, meaning that Medicare, Medicaid, and private insurance are either required or incentivized to cover this service. In December 2014, TDSHS ceased funding for HIV routine testing in two of the HIV medical providers in the SATGA/HSDA, thus eliminating crucial HIV routine testing access points. In response, the AA, in collaboration with the HIV/Syphilis Testing Taskforce, has expanded targeted testing to include additional high risk areas. The Taskforce meets monthly and addresses issues of assessment, data collection, planning, coordination, cooperation, and builds the capacity of those who provide targeted testing activities in the SATGA/HSDA. This increases linkage and retention in care along the care continuum.

Service Gaps and Barriers to HIV Care

Barriers identified by PLWH for "falling out of care" are: 1. Financial, 2. Clinic Facility, 3.Health, 4. Housing/Responsibility, and 5. Knowledge/Belief. Those that reported financial reasons said that [they] 'didn't have enough money'. Those that reported clinic as a barrier stated [they] 'didn't know where to get care'. Those that reported health as a barrier said 'that having depression and/or anxiety prevented their trip to the clinic'. Those that reported housing/responsibility as a barrier said [they] 'are homeless'. Those that reported knowledge/belief stated that [they] 'didn't want to think about or even acknowledge they are HIV positive'.

The SATGA/HSDA has been designated as a HPSA by HRSA. A HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a

[22] Texas needs needle exchange program - San Antonio Express-News. (2015, February 18). Retrieved from http://www.mysanantonio.com/opinion/editorials/article/Texas-needs-needle-exchange-program-6088348.php

shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care.[23]

Despite the presence of the County's large medical center, the University of Texas Health Science Center at San Antonio (UTHSCSA), one of the largest military healthcare systems in the country, and home to two Federally Qualified Health Centers (FQHCs), the SATGA has a number of federally designated Medically Underserved areas. All of Wilson County is a HRSA designated Medically Underserved Area/Population as are numerous census tracts within Bexar County and Guadalupe County. Wilson County does not have a hospital or health department. This intensifies access to care barriers for all residents. In addition a need for bilingual and bicultural health professionals in the SATGA/HSDA will help increase access and retention in care. Currently available census figures, 14.2 percent of the U.S. population is Latino, but they make up only about 6.4 percent of the students coming out of the country's medical schools, according to the Association of American Medical Colleges (AAMC). That means there are roughly 3,000 Latino patients to each Latino physician. In comparison, for non-Latinos, the ratio is 335 patients to 1 doctor. That means that Latinos, who may not speak English as their first language and who may relate to medical professionals differently because of cultural reasons, are at risk of becoming even more marginalized by the health-care system.[24]

A forecasted decline in the number of primary care and infectious disease physicians managing HIV care in 2015will adversely affect an increase in non-physician clinicians providing HIV care. A decline in the HIV workforce over the next few years, left by clinicians leaving the HIV workforce due to retirement and mortality, could decrease the total number of patient medical visits. The decline in supply is also due to the demographic shift in the HIV workforce toward female clinicians. A disproportionate number of new entrants is female and on average female clinicians work 11.2% fewer hours per week than their male counterparts (40.3 hours for women versus 45.4 hours for men).[25]

Other Gaps and Barriers to HIV Prevention and Care

Stigma, language, low literacy, poverty, lack of health insurance, access to care, isolation, low education, co-occurring disorders remain social and behavioral barriers to HIV prevention and care services. The legislative atmosphere in Texas, which does not openly support reproductive health and does not allow comprehensive sex education in schools, is often perceived as a barrier to HIV prevention and care. The inadequacy in the client-level data system, ARIES, at the state level since 2014 has caused tremendous hardships in planning, reporting, and reflecting the SATGA/HSDA needs in HIV prevention and care. Preliminary results from the current PC Housing Study demonstrate that of the 317 persons surveyed, 90% reported that they had been homeless within the past 3 years. Given the rural nature of the geographic are of the SATGA/HSDA, transportation remains a barrier because outside of the urban area (City of San Antonio) there exists no mass transportation system. The RWP Part C, a federally qualified health center, began providing PrEP in 2015 to approximately 70 clients. The AA conducted a workshop on PrEP and other harm reduction strategies to all case managers, consumers, and community stakeholders in 2015. Two ASO's have also received funding from pharmaceutical companies to provide PrEP education to high risk populations. However, none of these small initiatives

[23]Health Resources and Services Administration Health Workforce. (2013.). Frequently Asked Questions. Retrieved from http://bhpr.hrsa.gov/shortage/hpsas/faq.html
[24] Hispanic Doctor Shortage: A Community in Need. (2010.). Retrieved from http://www.newsweek.com/hispanic-doctor-shortage-community-need-73465
[25] Gilman, B., Hogan, P., Trent-Adams, S., Cheever, L., Bouchery, E., & Negrusa, S. (2016). The HIV Clinician Workforce in the United States. The American Academy of HIV Medicine, 3-9.

have the resources to reach the entirety of the underserved populations, including Latinos, Blacks, and Women.

Service Provider Barriers

The HPCG Group identified service providers of PLWH and high risk individuals to participate in the planning process. The groups identified by the HPCG Group would like to have had more participation in the planning process from faith based organizations, LGBTQ services providers and transgender high risk and PLWH.

E. San Antonio TGA/HSDA Data: Access, Sources, and Systems

TDSHS provided the HIV surveillance (e.g., HIV prevalence data, HIV incidence estimates, etc.) and HIV Continuum of Care measures for SATGA/HSDA for specific subpopulations. Client level data for the SATGA/HSDA is collected and reported using ARIES. All providers receiving funding, specifically Outpatient Ambulatory Medical Care (OAMC) and Medical Case Management (MCM), are contractually required by the AA to enter both client level data and clinical data into ARIES. Throughout the SATGA/HSDA, each provider has identified an ARIES standard point of contact (SPoC) and a designated SPoC backup to serve as a liaison between the AA Data Analyst and the providers. The ARIES SPoC is responsible for data integrity and can respond to and address any issues relative to data needs or information.

Please note as of May 12, 2016, ARIES reports have been producing inaccurate results in "Production" impacting our AA, PC, HIV prevention and care providers, and other ARIES users. The AA's inability to complete HRSA reports (e.g. RSR) have been hindered by the ability to access reports in ARIES. The Texas Public Health Information Network (PHIN) which identifies individuals that are no longer eligible or enrolled in the ADAP system. AA's have been instructed by TDSHS to not utilize reports or publish data from ARIES until further notice, including reporting to PCs and to HRSA. Any reporting that utilizes data from an ARIES report is impacted, including reports for MAI, Part A, etc. TDSHS will postpone due dates as needed for items that require ARIES reports and will allow sufficient time for AA's to complete reports once the ARIES issues are resolved. The AA has notified the Part A HRSA Project Officer and continues to seek guidance with TDSHS on this matter (see **Appendix D** for letter from TDSHS regarding ARIES). Because of the aforementioned issue with ARIES, the HPCG Work Group decided to use data retrieved in September 2015 for the Part A Grant Application. The baseline data used in the Integrated HIV Prevention and Care Plan is Calendar Year (CY) 2014.

TDSHS recently began collecting data on the Transgender population; therefore data included in the Integrated HIV Prevention and Care Plan does not adequately reflect the needs of this subpopulation.

This data summarized in **Table 27** was provided by the TDSHS for the time period ending December 31, 2014, and illustrates the impact of the epidemic on severe need populations within the SATGA/HSDA.

TABLE 27: HIV/AIDS INCIDENCE AND PREVALENCE IN THE SATGA/HSDA, 2012-2014

Demographic Group/Exposure Category	AIDS INCIDENCE			HIV INCIDENCE			AIDS PREVALANCE			HIV PREVALANCE		
	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
Age at Diagnosis (Years)												
<13 years	-	-	1	2	1	4	1	1	2	16	14	15
13-24 years	15	12	12	76	95	111	73	69	58	219	244	274
25- 34 years	42	57	45	111	142	132	338	365	370	639	714	757
35-44 years	39	35	34	67	63	42	736	720	659	546	585	606
45-54 years	49	41	34	56	63	42	1241	1254	1273	532	576	618
55+	23	20	16	22	28	16	660	736	824	273	330	358
Total	***168***	***165***	***142***	***334***	***392***	***347***	***3049***	***3145***	***3186***	***2225***	***2463***	***2628***
Race/Ethnicity	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
White, not Hispanic	36	34	23	64	75	65	712	716	698	519	557	601
African-American, not Hispanic	25	23	8	50	58	47	422	429	430	377	426	446

Hispanic	96	101	102	208	244	222	1811	1891	1945	1233	1368	1466
Asian/Pacific Islander	-	-	-	-	-	-	-	-	-	-	-	-
American Indian/Alaska Native	-	-	-	-	-	-	-	-	-	-	-	-
Other	2	2	-	4	6	2	15	17	16	23	28	29
Unknown	9	5	9	8	9	11	89	92	97	73	84	86
Total	***168***	***165***	***142***	***334***	***392***	***347***	***3049***	***3945***	***3186***	***2225***	***2463***	***2628***
Gender	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
Male	146	141	117	295	353	299	2601	2691	2730	1832	2038	2189
Female	22	24	25	39	39	48	448	454	456	393	425	439
Total	***168***	***165***	***142***	***334***	***392***	***347***	***3049***	***3145***	***3186***	***2225***	***2463***	***2628***
Exposure Category	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
Men who have sex with men	124	108	98	268	302	271	2022	2101	2146	1526	1718	1861
Injection drug users	18	20	17	20	31	26	348	346	342	194	212	225
Men who have sex with men and inject drugs	4	9	5	5	14	9	180	176	172	97	97	101
Hemophilia/coagulation Disorder	-	-	-	-	-	-	-	-	-	-	-	-
Heterosexuals	21	29	21	39	44	37	473	496	496	380	406	408
Receipt of blood transfusion, blood components or tissue	-	-	-	-	-	-	-	-	-	-	-	-
Adult/Other	-	-	-	-	-	-	10	10	10	1	1	1
Risk not reported or identified	-	-	-	-	-	-	-	-	-	-	-	-
Pediatric	1		2	2	1	4	16	16	20	27	29	32
Mother with/at risk for HIV Infection	-	-	-	-	-	-	-	-	-	-	-	-
Total	***168***	***166***	***143***	***334***	***392***	***347***	***3049***	***3145***	***3186***	***2225***	***2463***	***2628***

Table 28: Other Federal, State, Regional, and Local documents, reports, or planning efforts considered when preparing the Integrated HIV Prevention and Care Plan, CY 2017-2021.

Name of Document	Lead Organization	How the document was considered/used in this plan?
2016-2020 Five Year Consolidated Plan	Bexar County Department of Community Resources Community Development and Housing Division	Data and trends from this plan influenced the Integrated HIV Prevention and Care Plan
Comprehensive Needs Assessment 2014	Bexar County Department of Community Resources Ryan White Planning Council	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Comprehensive Needs Assessment 2015 Augmentation	Bexar County Department of Community Resources Ryan White Planning Council	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Comal and Guadalupe Counties Needs Assessment	City of New Braunfels	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Early Identification of Individuals with HIV/AIDS (EIIHA) Plan	HIV/Syphilis Testing Taskforce	Data and trends from this plan influenced the Integrated HIV Prevention and Care Plan
Ten Attributes of Health Literate Health Care Organizations	Institute of Medicine of the National Academies	Data and trends from this plan influenced the Integrated HIV Prevention and Care Plan

San Antonio 2020	SA2020	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Community Health Improvement Plan	San Antonio Metro Health District	Data and trends from this plan influenced the Integrated HIV Prevention and Care Plan
Strategies for Health Annual Report 2016	San Antonio Metro Health District	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
2013 Texas STD and HIV Epidemiologic Profile	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
2015 Texas HIV Quarterly Report - 3rd Quarter	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
2015 Texas STD Surveillance Report	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Dallas National HIV Behavioral Surveillance System 2007 Annual Data Report High Risk Heterosexuals	Texas Department of State Health Services	Narrative/Data provided by Texas Department of State Health Services to be included in Section I of the Integrated HIV Prevention and Care Plan
Latino MSM	Texas Department of State Health Services	Data provided by Texas Department of State Health Services to be included in Section I of the Integrated HIV Prevention and Care Plan
SCADA Plan	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Texas HIV Plan	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Texas HIV Surveillance Report 2015 Annual Report	Texas Department of State Health Services	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
DSHS Region 8 Annual Report	Texas Department of State Health Services – Region 8	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
Texas 1115 Waiver – RHP6 Learning Collaborative Summit	Texas Department of State Health Services – Region 8	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
HIV in the San Antonio TGA 2010-2014	Texas Department of State Health Services - TB, HIV/STD and Viral Hepatitis Unit	Narrative/Data provided by Texas Department of State Health Services to be included in Section I of the Integrated HIV Prevention and Care Plan
Community Health Assessment	The Health Collaborative	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan
National HIV/AIDS Strategy 2020	The Office of National AIDS Policy	Plan developed and provided by The Office of National AIDS Policy used to guide Section II of the Integrated HIV Prevention and Care Plan
Missed Visit Project	University of Texas Health Science Center at San Antonio	Data and trends from this report influenced the Integrated HIV Prevention and Care Plan

Section II: Integrated HIV Prevention and Care Plan

A. Integrated City-Only HIV Prevention and Care Plan

Goal I **NHAS 2020 Goal:** Reducing New HIV infections

Objective A **NHAS 2020 SMART Objective (National):** Increase the percentage of people living with HIV who know their serostatus to at least 90.
2017 – 2021 SMART Objective (Local): Increase the percentage of people living with HIV who know their serostatus from 701 (54.80%) to at least 1,151 (90%), using CY2014 as baseline..

Rationale The estimated number of PLWHA who were unaware of their status as of December 31, 2014, in the SA TGA/HSDA is 1,279. This figure was determined using the estimate back-calculation from the Center for Disease Control and Prevention (CDC) and applying the national estimate for "Unaware and HIV positive" to the total number of PLWHA from December 31, 2014.

0.173/(.827) x 6,116 diagnosed living = 1,279 undiagnosed or Unaware in the SA TGA/HSDA

History of aware per eHARS data received from TDSHS: CY2014 was 701 (54.80%) individuals were aware of their status in the SATGA/HSDA.

Strategy I.A.1 Increase access to Routine HIV Testing in the SATGA/HSDA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Establish Routine HIV Testing in the SATGA/HSDA hospital emergency rooms and minor emergency/walk in clinics.	Unaware Population	Number of hospital emergency rooms and minor emergency/walk in clinics that have established Routine HIV Testing in the SATGA/HSDA
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop mandatory "Opt Out" HIV testing in all hospital emergency departments and minor emergency/walk in clinics.	Unaware Population	Number of hospital emergency departments and minor emergency/walk in clinics that have developed "Opt Out" HIV Testing in the SATGA/HSDA

Strategy I.A.2 Prioritize early intervention services, outreach services, counseling and testing services targeting special populations and geographic areas annually, reducing the number of consumers with unaware of their status

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Expand HIV testing to county jails, city detention center, adult probation/detention, and specialty courts.	Unaware Population	Number of county jails that have incorporated HIV Testing in the SATGA/HSDA
,By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one outreach initiative annually for a specific target population encouraging persons to get tested or link to medical care	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Number of initiatives implemented each year – minimum of 5 total by 2021

Strategy I.A.3 Increase access to Harm Reduction in the SA TGA/HSDA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed • Bexar Area Harm Reduction Coalition	Data/demographic collection to advocate and implement a needle exchange program	High Risk Behaviors Populations	Data/demographics collected and implementation of a needle exchange program
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive sexual health education training/event annually for a specific target populations	High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Number of trainings/events held each year – minimum of 5 total by 2021

Goal I **NHAS 2020 Goal:** Reducing New HIV infections

Objective B **NHAS 2020 SMART Objective (National):** Reduce the number of new diagnosis by at least 25 percent
2017 – 2021 SMART Objective (Local): Reduce the number of new diagnosis by at least 1,529 (25%), using CY2014 as baseline.

Rationale History of newly diagnosed per data received by TSDHS: CY2013 there were 557 individuals newly diagnosed (increased by 10.38% from 2012), and CY2014 there were 489 individuals newly diagnosed (decreased by 13.00% from 2013).

Strategy I.B.1 Ensure linkage for those testing negative with appropriate community resources to provide risk reduction strategies and education

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one Harm Reduction Education training/event annually for a specific target populations	High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive sexual health education training/event annually for a specific target populations	High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Number of trainings/events held each year – minimum of 5 total by 2021

Strategy I.B.2 Expand access to Pre-Exposure Prophylaxis (PrEP)

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Integrate culturally and linguistically appropriate and low literacy PrEP Education/Training into Case Management, Prevention Counseling, and Outreach Services	High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Documentation of PrEP being integrated
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	PrEP Education/Training for Community Health Professionals, Stakeholders, and Consumer Groups that is culturally and linguistically appropriate and low literacy	High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations	Documentation of PrEP Education/Trainings

Strategy I.B.3 Reduced Stigma associated with HIV/AIDS

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Expand HIV Testing and Education to "mainstream" areas. Examples: outside Barber Shops, Day Labor Camps, Tattoo Parlors, Malls, Amusement Parks, etc.	All	Number of negative and positive HIV Tests performed and location of education events
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one Stigma Reduction Education training/event annually for a specific target populations	All	Number of trainings/events held each year – minimum of 5 total by 2021

Goal II **NHAS 2020 Goal:** Improving Access to Care and Health Outcomes

Objective A **NHAS 2020 SMART Objective (National):** Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%
2017 – 2021 SMART Objective (Local): Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%, using CY2014 as a baseline.

Rationale History of newly diagnosed per data received by TSDHS: CY2013 there were 557 individuals newly diagnosed (increased by 10.38% from 2012), and CY2014 there were 489 individuals newly diagnosed (decreased by 13.00% from 2013).

History of persons linked to care per TDSHS HIV Care Continuum: TDSHS defines Linked to Care (Evidence of Care) as the number of PLWHA in the SATGA/HSDA who received at least one medical visit. According to TDSHS HIV Care Continuum for CY 2014, there were 4,517 (77%) PLWHA who received at least one medical visit.

Strategy II.A.1 Support and enhance a seamless service system resulting in at least 85% newly diagnosed clients linking to HIV medical care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Newly Diagnosed	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Patient Navigator Program	Newly Diagnosed	Documentation of an evidence based model Patient Navigator Program developed and implemented

Strategy II.A.2 Ensure immediate linkage for all newly diagnosed PLWHA with a seamless service system, resulting in a 5% annual increase from the 2014 baseline in the percentage of newly diagnosed PLWHA linked to care within one month

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Clinic Capacity Building Activity/Plan	Newly Diagnosed	Documentation of Clinic Capacity Building Activity/Plan developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork	Newly Diagnosed	Documentation of Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Patient Navigator Program	Newly Diagnosed	Documentation of an evidence based model Patient Navigator Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Newly Diagnosed	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented

Strategy II.A.3 Expand education and training for PLWHA, Community Stakeholders, and Service Providers

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed • UTHSCSA Center for Medical Humanities and Ethics	Develop and implement at least one Health Insurance/ACA Literacy Education training/event annually for PLWHA, Community Stakeholders, and Service Providers	Eligible PLWHA	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed • UTHSCSA Center for Medical Humanities and Ethics	Develop and implement a comprehensive, accessible, and culturally appropriate health literacy resources for high-risk negatives, PLWHA, Community Stakeholders, and Service Providers	Eligible PLWHA	Number of new comprehensive, accessible, and culturally appropriate health literacy resources for high-risk negatives, PLWHA, and Service Providers created/available

Goal II **NHAS 2020 Goal:** Improving Access to Care and Health Outcomes

Objective B **NHAS 2020 SMART Objective (National):** Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent
2017 – 2021 SMART Objective (Local): Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care from 4,362 (71%) to at least 5,504 (90%), using CY2014 as a baseline.

Rationale History of persons retained in care per TDSHS HIV Care Continuum: TDSHS defines Retained in Care (2 Visits, Labs, ARTs) as of those that received at least one medical visit, the number of PLWHA in the SATGA/HSDA that received at least two medical visits, 90 days apart. According to TDSHS HIV Care Continuum for CY 2014, there were 4,362 (71%) PLWHA that received at least two medical visits, 90 days apart.

Strategy II.B.1 Support and enhance a seamless service system resulting in at least 90% of HIV positive clients maintaining HIV medical care

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork	Eligible PLWHA	Documentation of Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Clinic Capacity Building Activity/Plan	Eligible PLWHA	Documentation of Clinic Capacity Building Activity/Plan developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Addressing access to care barriers for rural clients	Eligible PLWHA	Number of new rural clients increased

Strategy II.B.2 Increase supportive services which impact a client's ability to effectively be retained in medical care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Eligible PLWHA	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a strategy for a seamless referral process for HIV positive clients with co-morbidities (i.e. clinic that offers wrap around services, centralized eligibility/referral process)	Eligible PLWHA	Documentation of the development and implementation of a seamless referral process for HIV positive clients with co-morbidities.
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork	Eligible PLWHA	Documentation of Centralized Eligibility Process, Eligibility Worker, or Reduce Eligibility Paperwork developed and implemented

Strategy II.B.3 Address barriers to accessing HIV medical care services

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a strategy for a seamless referral process for HIV positive clients with co-morbidities (i.e. clinic that offers wrap around services, centralized eligibility/referral process)	Eligible PLWHA	Documentation of the development and implementation of a seamless referral process for HIV positive clients with co-morbidities.
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive sexual health education training/event annually for a specific target populations	Eligible PLWHA	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Promote utilization of HIV care, prevention, and PrEP Continuum of Care models to medical practices outside of Ryan White providers.	Eligible PLWHA	Documentation of promotion of utilization of HIV care, prevention, and PrEP Continuum of Care models to medical practices outside of Ryan White providers.

Goal II **NHAS 2020 Goal:** Improving Access to Care and Health Outcomes

Objective C **NHAS 2020 SMART Objective (National):** Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to as least 80 percent
2017 – 2021 SMART Objective (Local): Increase the percentage of persons with diagnosed HIV infection who are virally suppressed from 3,462 (57%) to as least 4,893 (80%), using CY2014 as a baseline.

Rationale History of persons achieved viral suppression per TDSHS HIV Care Continuum: TDSHS defines Achieved Viral Suppression as those who received one medical visit, the number of PLWHA in the SA TGA/HSDA who have an HIV viral load less than 200 copies/ml at last viral load test in CY14. According to TDSHS HIV Care Continuum for CY 2014, there were 3,462 (57%) PLWHA who achieved viral suppression.

Strategy II.C.1 Support and enhance a seamless service system resulting in at least 80% of HIV positive clients achieving viral suppression

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Eligible PLWHA	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Promote utilization of HIV care, prevention, and PrEP Continuum of Care models to medical practices outside of Ryan White providers.	Eligible PLWHA	Documentation of promotion of utilization of HIV care, prevention, and PrEP Continuum of Care models to medical practices outside of Ryan White providers.
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a comprehensive, accessible, and culturally appropriate viral suppression educational training/event for PLWHA, Community Stakeholders, and Service Providers	Eligible PLWHA	Documentation of a comprehensive, accessible, and culturally appropriate viral suppression educational training/event for PLWHA and Service Providers developed and implemented

Strategy II.C.2 Increase the number of PLWHA accessing housing services

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Identify barriers and strategies for PLWHA accessing housing services	Eligible PLWHA	Barriers and strategies for PLWHA accessing housing services identified
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a comprehensive, accessible, and culturally appropriate housing resources for PLWHA and Service Providers	Eligible PLWHA	Number of new comprehensive, accessible, and culturally appropriate housing resources for PLWHA and Service Providers created/available
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Establish Memorandums of Understanding (MOUs) with housing resource providers outside the Ryan White Program	Eligible PLWHA	Documentation and number of MOUs with housing resource providers outside the Ryan White Program signed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Explore partnership with TDSHS and HOPWA to seek additional funding opportunities	Eligible PLWHA	Documentation of additional funding opportunities completed
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Housing Education training/event for PLWHA and Service Providers	Eligible PLWHA	Documentation of a Housing Education training/event for PLWHA and Service Providers developed and implemented

Strategy II.C.3 Address barriers to accessing HIV medical care services

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a Clinic Capacity Building Activity/Plan	Eligible PLWHA	Documentation of Clinic Capacity Building Activity/Plan developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a strategy for a seamless referral process for HIV positive clients with co-morbidities (i.e. clinic that offers wrap around services, centralized eligibility/referral process)	Eligible PLWHA	Documentation of the development and implementation of a seamless referral process for HIV positive clients with co-morbidities.
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive sexual health education training/event annually for a specific target populations (i.e. High Risk Negatives, Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender Populations)	Eligible PLWHA	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one Stigma Reduction Education training/event annually for a specific target populations	Eligible PLWHA	Number of trainings/events held each year – minimum of 5 total by 2021

Goal III **NHAS 2020 Goal:** Reducing HIV Related Health Disparities

Objective A **NHAS 2020 SMART Objective (National):** Reduce disparities in the rate of new diagnosis by at least 15%
2017 – 2021 SMART Objective (Local): Reduce disparities in the rate of new diagnosis by at least 15%

Rationale History of newly diagnosed per data received by TSDHS:

- CY2012:
  - there were 2 Youth under the age of 13 newly diagnosed
  - there were 91 Youth between the ages of 13 and 24 newly diagnosed
  - there were 304 Latinos newly diagnosed
  - there were 75 Blacks newly diagnosed
  - there were 61 Females newly diagnosed
  - there were 392 MSMs newly diagnosed
  - there were 38 IDUs newly diagnosed
  - there were 9 MSMs and IDUs newly diagnosed
- CY2013
  - there were 1 Youth under the age of 13 newly diagnosed (decreased by 0.22% from 2012)
  - there were 107 Youth between the ages of 13 and 24 newly diagnosed (increased by 1.08% from 2012)
  - there were 345 Latinos newly diagnosed (increased by 1.38% from 2012)
  - there were 81 Blacks newly diagnosed (decreased by 0.40% from 2012)
  - there were 63 Females newly diagnosed (decreased by 0.84% from 2012)
  - there were 410 MSMs newly diagnosed (decreased by 4.48% from 2012)
  - there were 51 IDUs newly diagnosed (increased by 1.59% from 2012)
  - there were 23 MSMs and IDUs newly diagnosed (increased by 2.34% from 2012)
- CY2014
  - there were 5 Youth under the age of 13 newly diagnosed (increased by 0.84% from 2013)
  - there were 123 Youth between the ages of 13 and 24 newly diagnosed (increased by 5.94% from 2013)
  - there were 324 Latinos newly diagnosed (increased by 4.32% from 2013)
  - there were 55 Blacks newly diagnosed (decreased by 3.29% from 2013)
  - there were 73 Females newly diagnosed (increased by 3.62% from 2013)
  - there were 369 MSMs newly diagnosed (increased by 1.85% from 2013)
  - there were 43 IDUs newly diagnosed (decreased by 0.36% from 2013)
  - there were 14 MSMs and IDUs newly diagnosed (decreased by 1.27% from 2013)

Strategy III.A.1 Develop and implement an education and training plan

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a comprehensive, accessible, and culturally appropriate HIV care training / education event to Ryan White and Non-Ryan White Service Providers, county detention staff, city detention staff, adult probation/detention staff, and specialty courts staff annually	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender, Special Needs Population	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender, Special Needs Population	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one outreach initiative for a specific target population encouraging individuals to get tested or link to medical care	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender, Special Needs Population	Documentation and number of trainings/events

Strategy III.A.2 Develop and implement a community education plan to reduce HIV stigma

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	In conjunction with community partners, implement community education programs that support stigma reduction in targeted communities. Involve key neighborhood community organizations such as faith based organizations, community centers, etc.	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender	Documentation of education and trainings
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one Stigma Reduction Education training/event annually for a specific target populations	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender	Number of trainings/events held each year – minimum of 5 total by 2021

Strategy III.A.3 Increase access to Harm Reduction

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed • Bexar County Harm Reduction Coalition	Data/demographic collection to advocate and implement a needle exchange program	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender	Data/demographics collected and implementation of a needle exchange program
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive sexual health education training/event annually for a specific target populations	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Integrate culturally and linguistically appropriate and low literacy PrEP Education/Training into Case Management, Prevention Counseling, and Outreach Services	Youth, Latino MSM, Black MSM, Women of Color of Childbearing Age, Transgender	Documentation of PrEP being integrated

Goal III **NHAS 2020 Goal:** Reducing HIV Related Health Disparities

Objective B **NHAS 2020 SMART Objective (National):** Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%
2017 – 2021 SMART Objective (Local): Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%

Rationale History of persons achieved viral suppression per TDSHS HIV Care Continuum: TDSHS defines Achieved Viral Suppression as those who received one medical visit, the number of PLWHA in the SA TGA/HSDA who have an HIV viral load less than 200 copies/ml at last viral load test in CY14. According to TDSHS HIV Care Continuum for CY 2014, there were 140 (41%) Youth PLWHA who achieved viral suppression.

Strategy III.B.1 Develop and implement an education and training plan

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement a comprehensive, accessible, and culturally appropriate HIV care training / education event to Ryan White and Non-Ryan White Service Providers, county detention staff, city detention staff, adult probation/detention staff, and specialty courts staff annually	Youth, Persons who inject drugs	Number of trainings/events held each year – minimum of 5 total by 2021
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Peer Mentor Group or Peer Mentorship Program	Youth, Persons who inject drugs	Documentation of an evidence based model Peer Mentor Group or Peer Mentorship Program developed and implemented
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement an evidence based model Patient Navigator Program	Youth, Persons who inject drugs	Documentation of an evidence based model Patient Navigator Program developed and implemented

Strategy III.B.2 Develop and implement a community education plan to reduce HIV stigma

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	In conjunction with community partners, implement annual community education programs that support stigma reduction in targeted communities. Involve key neighborhood community organizations such as faith based organizations, community centers, civic organizations, etc.	Youth, Persons who inject drugs	Documentation and number of trainings/events
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one Stigma Reduction Education training/event annually for a specific target populations	Youth, Persons who inject drugs	Number of trainings/events held each year – minimum of 5 total by 2021

Strategy III.B.3 Increase access to Harm Reduction

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed • Bexar County Harm Reduction Coalition	Data/demographic collection to advocate for the implementation of a needle exchange program and data/demographic collection on IDU population.	Youth, Persons who inject drugs	Data/demographics collected and implementation of a needle exchange program
By 2021	• HPCG • RWP A, B, C D, and F • PC • HIV/Syphilis Testing Taskforce • Consumers • Other Community Stakeholders • Resource Consultant(s): as needed	Develop and implement at least one comprehensive, accessible, and culturally appropriate sexual health education training/event for a specific target populations	Youth, Persons who inject drugs	Documentation and number of trainings/events

B. Collaborations, Partnerships, and Stakeholder Involvement

A series of work group meetings, focus groups, surveys, and assessments were conducted through September 30, 2016 to discuss issues and opportunities related to the Integrated HIV Prevention and Care Plan and community needs. An ongoing standing work group was formed, and individuals representing numerous community resources and areas were invited to participate, known as the Integrated HIV Prevention and Care Stakeholder Group (HPCG). This standing group, who will continue to meet on a regular basis to review updates and outcomes from the strategies outlined in the plan. The HPCG has a unique representation of community members and stakeholders to include: CBOs, ASOs not funded by Ryan White that does both prevention and linkage to care, the County Hospital District (including a RWP funded clinic), non-profit ASO that works with women and youth, PC Members, HIV Consumers, the San Antonio Police Department, the Local Public Health Planning Agency, a Rural Service Provider, Homeless Providers, LGBTQ Youth Center Provider, HIV/STI Prevention Providers, the Veterans Health Administration (VA), RWPC, RWPD, Local Substance Abuse and Mental Health Services Administration (SAMHSA) funded projects, the Local Health Department (MetroHealth), and Putting an End to Abuse through Community Efforts (PEACE) Initiative.

Table 29 – Agencies, groups, organizations who participated in the HPCG.

1	**Stakeholder Representative**	Benavides, Holly
	Stakeholder's Title	Program Manager
	Stakeholder's Agency Name	University Health System (UHS)
	Stakeholder Representation	HAZLO! (SAMHSA Funded Prevention Programs) Planning Council Member – Recipient under other Federal HIV Programs

2	**Stakeholder Representative**	Bustamante, Lucia
	Stakeholder's Title	Program Manager
	Stakeholder's Agency Name	University Health System (UHS)
	Stakeholder Representation	Ryan White Part D Planning Council Co-Chair – Ryan White Part D

3	**Stakeholder Representative**	Carmona, Carlos
	Stakeholder's Title	Co-Chair
	Stakeholder's Agency Name	People's Caucus
	Stakeholder Representation	Consumer

4	**Stakeholder Representative**	Collier, Kourtney
	Stakeholder's Title	Member
	Stakeholder's Agency Name	San Antonio Area HIV Health Services Planning Council
	Stakeholder Representation	Planning Council Member – Consumer Transgender Alliance Group

5	**Stakeholder Representative**	Diaz, Aaron
	Stakeholder's Title	Clinical Director
	Stakeholder's Agency Name	Bluebonnet Trails
	Stakeholder Representation	Guadalupe County Mental Health Services

6	**Stakeholder Representative**	Doria-Ortiz, Charlene
	Stakeholder's Title	Program Manager
	Stakeholder's Agency Name	Bexar County Ryan White Program
	Stakeholder Representation	Ryan White Part A Administrative Agency

7	**Stakeholder Representative**	Flores, Enrique
	Stakeholder's Title	Linkage Coordinator
	Stakeholder's Agency Name	Center for Health Care Services (CHCS)
	Stakeholder Representation	Prevention, Linkage; Planning Council Needs Assessment Committee Co-Chair – Community Based ASO

8	**Stakeholder Representative**	Garcia, Ramon
	Stakeholder's Title	Member
	Stakeholder's Agency Name	San Antonio Area HIV Health Services Planning Council
	Stakeholder Representation	Planning Council Member - Consumer

9	**Stakeholder Representative**	Gloria, Mary Helen
	Stakeholder's Title	Executive Director
	Stakeholder's Agency Name	Mujeres Unidas, Inc.
	Stakeholder Representation	Planning Council Co-Chair – Non-Elected Community Leader

10	**Stakeholder Representative**	Hester, LaKeisha
	Stakeholder's Title	Licensed Clinical Social Worker
	Stakeholder's Agency Name	South Texas Veterans Health Care System Audie L. Murphy Division - Immunosuppression/ID Clinic
	Stakeholder Representation	Veterans Health Administration Planning Council Member – Health Center

11	**Stakeholder Representative**	Juarez, Gyna
	Stakeholder's Title	Prevention Resource Center Director
	Stakeholder's Agency Name	San Antonio Council on Alcohol and Drug Abuse (SACADA) TDSHS Region 8
	Stakeholder Representation	SACADA TDSHS Region 8

12	**Stakeholder Representative**	Lopez, Vanessa
	Stakeholder's Title	Program Supervisor
	Stakeholder's Agency Name	The Health Collaborative
	Stakeholder Representation	Health Planning Agency

13	**Stakeholder Representative**	Lutz, Elizabeth
	Stakeholder's Title	Executive Director
	Stakeholder's Agency Name	The Health Collaborative
	Stakeholder Representation	Health Planning Agency

14	**Stakeholder Representative**	Mangla, Anil
	Stakeholder's Title	Assistant Director of Health
	Stakeholder's Agency Name	San Antonio Metro Health District
	Stakeholder Representation	Health Department

15	**Stakeholder Representative**	Manning, Steven
	Stakeholder's Title	Vice Chair (PC) Co-Chair (HIV/Syphilis Testing Taskforce)
	Stakeholder's Agency Name	San Antonio Area HIV Health Services Planning Council HIV/Syphilis Testing Taskforce
	Stakeholder Representation	Planning Council Vice Chair – Consumer HIV/Syphilis Testing Taskforce Co-Chair

16	**Stakeholder Representative**	Morris, Dorothy
	Stakeholder's Title	Chief Financial Officer
	Stakeholder's Agency Name	SAMMinistries
	Stakeholder Representation	Homelessness Provider Staff

17	**Stakeholder Representative**	Moutria-Nino, Andrea
	Stakeholder's Title	Director of Testing
	Stakeholder's Agency Name	San Antonio AIDS Foundation (SAAF)
	Stakeholder Representation	Testing Ryan White Provider Staff

18	**Stakeholder Representative**	Perales, Robert
	Stakeholder's Title	Medical Case Manager
	Stakeholder's Agency Name	San Antonio AIDS Foundation (SAAF)
	Stakeholder Representation	Ryan White Provider Staff

19	**Stakeholder Representative**	Rosas, Frank
	Stakeholder's Title	Committee Chair
	Stakeholder's Agency Name	San Antonio Area HIV Health Services Planning Council
	Stakeholder Representation	QM Committee Member; TDSHS Formulary Committee Member; Planning Council Member – Consumer

20	**Stakeholder Representative**	Sanaseros, Ana
	Stakeholder's Title	Director of Community Clinics
	Stakeholder's Agency Name	Centro Med
	Stakeholder Representation	Ryan White Part C Federally Qualified Health Center

21	**Stakeholder Representative**	Sides, James
	Stakeholder's Title	Lieutenant VICE
	Stakeholder's Agency Name	San Antonio Police Department (SAPD)
	Stakeholder Representation	Law Enforcement

22	**Stakeholder Representative**	Solis, Monica
	Stakeholder's Title	Outreach Specialist (AARC) Co-Chair (HIV/Syphilis Testing Taskforce)
	Stakeholder's Agency Name	Alamo Area Resource Center (AARC) – EIS HIV/Syphilis Testing Taskforce
	Stakeholder Representation	Linkage; Ryan White Provider Staff HIV/Syphilis Testing Taskforce

23	**Stakeholder Representative**	Stewart, Teresa
	Stakeholder's Title	Prevention Resource Center Community Liaison
	Stakeholder's Agency Name	San Antonio Council on Alcohol and Drug Abuse (SACADA) TDSHS Region 8
	Stakeholder Representation	SACADA TDSHS Region 8

24	**Stakeholder Representative**	Sunil, Thankam
	Stakeholder's Title	Professor of Sociology Director, Institute for Health Disparities Research
	Stakeholder's Agency Name	University of Texas San Antonio (UTSA)
	Stakeholder Representation	SAMHSA Funded Prevention Programs

25	**Stakeholder Representative**	Valdez, Richard
	Stakeholder's Title	Prevention
	Stakeholder's Agency Name	B.E.A.T. AIDS Coalition Trust
	Stakeholder Representation	Prevention Provider Youth

26	**Stakeholder Representative**	Venegas, Yvonne
	Stakeholder's Title	FFACTS Clinical Director
	Stakeholder's Agency Name	University Health System (UHS) FFACTS Clinic
	Stakeholder Representation	Ryan White Provider Staff

27	**Stakeholder Representative**	Walker, Fuji
	Stakeholder's Title	Executive Assistant
	Stakeholder's Agency Name	The Health Collaborative
	Stakeholder Representation	Health Planning Agency

28	**Stakeholder Representative**	Whitehead, Charles
	Stakeholder's Title	HIV Prevention Director
	Stakeholder's Agency Name	B.E.A.T. AIDS Coalition Trust
	Stakeholder Representation	Prevention Provider

The HPCG met on a regular basis to review needs, barriers and gaps for HIV prevention and care; reviewed other data sources for needs, barriers and gaps; ranked priorities; developed strategic plans for HIV prevention and care; reviewed and developed responses to the guidance for the City Only Integrated HIV Prevention and Care plan; engaged community stakeholders for input on prevention and care strategies; completed activities/worksheets to identify strategies and activities for achieving the goals and objectives set forth by the NHAS 2020; and finalized this living work plan.

To ensure community stakeholders input were integrated into the planning process, Community Meetings, such as the HIV/Syphilis Testing Taskforce, Quality Management (QM) Single Point of Contact (SPOC) Committee, and the QM Committee were held. These meetings were developed to focus on completing a Stakeholder Worksheet #1 (**Appendix E**) as a means to inform the HPCG on HIV prevention and care needs, barriers and gaps within the SATGA/HSDA. This worksheet identified services/programs needed to end the epidemic and reduce HIV infections. Further, the worksheet identified issues and opportunities related to the strategic programs in HIV prevention and care to inform outcomes during the development of SMART goals.

Table 30 – Bexar County AA/PC staff and consultants who supported the HPCG by writing narratives, formatting tables, requesting data, facilitating meetings, etc.

1	**Bexar County Staff**	Lira, Marissa
	Bexar County Staff's Title	HIV Contract Analyst, Ryan White Program Department of Community Resources

2	**Bexar County Staff**	Marek, April
	Bexar County Staff's Title	HIV Coordinator, Ryan White Program Department of Community Resources

3	**Bexar County Staff**	Newman, Mary Kay
	Bexar County Staff's Title	Planning Council Liaison, Ryan White Planning Council Department of Community Resources

4	**Bexar County Staff**	Ortega, Eddie
	Bexar County Staff's Title	Director Department of Community Resources

5	**Bexar County Staff**	Pett, Sandra
	Bexar County Staff's Title	HIV Planner, Ryan White Program Department of Community Resources

6	**Bexar County Consultant**	Collaborative Research
	Consultant Staff	Jeff Daniel Thomas Schucker

Table 31 – Agencies, groups, organizations who were unable to participate in the HPCG

1	**Stakeholder Representative**	Castillo, Patricia
	Stakeholder's Title	Executive Director
	Stakeholder's Agency Name	PEACE (Putting An End to Abuse through Community Efforts) Initiative
	Stakeholder Representation	Community Based Organization Domestic Violence

2	**Stakeholder Representative**	Coody, Tess
	Stakeholder's Title	Chief Elected Officer
	Stakeholder's Agency Name	Resolute Health
	Stakeholder Representation	Comal/Guadalupe Needs Assessment Advisory Member

3	**Stakeholder Representative**	Whitley, Sandra
	Stakeholder's Title	Executive Director
	Stakeholder's Agency Name	THRIVE Youth LGBTQ Center HAVEN for Hope
	Stakeholder Representation	Youth LGBTQ Homelessness Provider

See **Appendix F** for the Letter of Concurrence signed by the Planning Council Co-Chairs.

C. People Living With HIV (PLWH) and Community Engagement

The HPCG is reflective of the PLWH population in the SATGA/HSDA. The population has been reviewed by the following categories: 1.) race/ethnicity; 2.) gender; and 3.) age. A noticeable difference is in gender, where the epidemic suggests a male (84.61%) and female (53.57%) representation the HPCG reflects male (42.86%) and female (53.57%). All other categories are correspondingly reflective with no more than a 5% variance.

Table 32 Demographics of the PLWH and HPCG.

Race/Ethnicity	Living with HIV/AIDS in SATGA/HSDA		HPCG	
	Number	Percentage	Number	Percentage
White, not Hispanic	1299	22.34%	6	21.43%
Black, not Hispanic	876	15.07%	4	14.29%
Hispanic	3411	58.67%	16	57.14%
Asian/Pacific Islander	0	0.00%	0	0.00%
American Indian/Alaska Native	0	0.00%	0	0.00%
Multi-Race	0	0.00%	0	0.00%
Other/Not Specified	228	3.92%	2	7.14%
Total	5814	100	28	100%
Gender	**Living with HIV/AIDS in SATGA/HSDA**		**HPCG**	
	Number	Percentage	Number	Percentage
Male	4919	84.61%	12	42.86%
Female	895	15.39%	15	53.57%
Transgender	0	0.00%	1	3.57%
Unknown	0	0.00%	0	0.00%
Total	5814	100%	28	100%
Age	**Living with HIV/AIDS in SATGA/HSDA**		**HPCG**	
	Number	Percentage	Number	Percentage
<13 years	17	0.29%	0	0.00%
13-24 years	332	5.71%	1	3.57%
25- 34 years	1127	19.38%	4	14.29%
35-44 years	1265	21.76%	5	17.56%
45-54 years	1891	32.52%	10	35.71%
55+	1182	20.33%	8	28.57%
Total	5814	100%	28	100%

Participants of the HPCG include the following community members, many of whom are consumers to include, but not limited to: CBO, ASO not funded by RW that does both prevention and linkage to care, the County Hospital District (including a RWP funded clinic), non-profit ASO that works with women and youth, PC Members, HIV Consumers, the San Antonio Police Department, the Local Public Health Planning Agency, a Rural Service Provider, Homeless Providers, LGBTQ Youth Center Provider, HIV/STI Prevention Providers, the VA, RWPC, RWPD, Local SAMHSA funded projects, MetroHealth, and PEACE Initiative.

The AA/PC jointly conducted two consumer based activities using a unique group process tool titled ***25 to 10 activity*** a liberating structure process. Liberating Structures (LS) sparks inventiveness by minimally structuring the way individuals interact, while liberating content or subject matter. Very simple constraints unleash creative adaptability, generating better than expected results. Individual brilliance and collective wisdom are unbridled throughout this process. Groups quickly generate and sort their bold ideas into actions. Though it is fun, fast and casual, it is a serious and valid way to generate an uncensored set of ideas and then to tap the wisdom of the whole group to identify the top ideas.

The AA HIV Planner conducted the *25 to 10 activity* on two separate occasions with different groups. The first group included the People's Caucus, the consumer planning committee of the PC; and the RWPD family network support group, a consumer infected and affected support group. Before beginning this activity, the HIV Planner provided a brief overview on the RWPA/B program, eligibility, requirements, the treatment cascade and a review of the Integrated HIV Prevention and Care Plan. The HIV Planner conducted the 25 to 10 activity following the presentation. The question that the attendees in both groups where asked is as follows; "If we were ten times bolder, what is the one thing we could do to decrease HIV in Texas?" "What first step would we take to get started?" Items used included; instructions for completing the exercise, *25 to 10 question*, 3x5 index cards, and writing utensils. The instructions for this activity are as follows:

1. Pass out cards
   - Pass out 3X5 index cards and ask participants to take one each
2. Introduce the exercise to the participants
3. Ask the Question
   - Read the prompt question and ask participants to take a moment to think about their response
   - After a moment, ask participants to write their response on one side of the 3X5 index card
4. Mix and mingle
   - Ask participants to stand, begin mingling around the room and as they do so, to exchange cards with one another
   - Allow participants enough mingle time to sufficiently "shuffle" the cards
5. Stop and score
   - Ask participants to stop mingling and ensure that everyone has a card
     (TIP: ask participants to make sure they didn't end up with their own card)
   - Ask participants to read the response on the card they are holding
   - Explain the scoring system:

     1 ⟷ 5

     Okay Idea ⟷ Great Idea
   - Ask participants to score the idea anywhere from a "1" (an okay idea), through a "5" (a great idea). Then have them write their score on the back of the card
6. Repeat
   - Repeat steps ❹ and ❺ for 4 more rounds of scoring
   - At the end of these rounds, each card should have 5 individual scores written on the back
7. Add it up

- After the final round of individual scoring, ask each person to add up the individual scores on the back of the card they are holding
- Ask participants to write the total score on the back of the card
- Each card should now have a total score between 5 and 25 on the back

8. Collect the cards from all participants
9. Read the responses out loud starting from the highest number and give time to discuss

The People's Caucus and the RWPD Family to Family Network Support Group yielded similar responses to the question; "What is the one thing we could do to decrease HIV in Texas? What first step would we take to get started?"

- More ads about HIV/AIDS prevention and medications on TV
  - Talk to pharmaceutical companies
- Educate and inform people about seriousness of this epidemic
  - Remove the stigma surrounding HIV
- Better public information from the State about HIV; like public service announcement ads on TV, social media sites, etc.
  - Have contacts from the State work with the local city officials to start the programs
- Education
  - Go to schools, elementary, middle and high schools
- Bring HIV sex education and prejudice to the forefront and be able to discuss these topics openly
  - Involve the community to a greater extent through information and activism
- Invest more time at schools. Kids are still having unprotected sex
  - The first step is start at middle schools on how STIs affect you and family
- I would actually inform people of my status to show them by example that you can actually enjoy life no matter your status
- Safe sex
  - Get tested
- Education of facts
  - More public service announcements during the day, city magazines, bill boards in high risk areas
- Free medications for anyone/everyone
  - Make our clients facing that barrier aware so that they can begin taking their meds
- Teach HIV/STI prevention in high schools and distribute condoms and risk reduction counseling
  - Petition our local and state political officials
- Testing
  - TV commercials for public awareness
- Educate individuals at an early age by starting in schools
- More educational information given out to the high risk community about using protection. We can get there by passing out condoms and clean needles for IV users.
- Presentations in schools on what HIV is and possibly have celebrities visit schools to talk about HIV
- Education on safe sex practices in high school
- Educate more people and start as young as middle school
- Talk to middle school kids on practicing safe sex
- Education is key, getting educated at the middle school level
- Give more information about HIV, especially to teens. Possibly having more educational classes.

- If funds were there I would request for individuals to be tested regularly and if found positive have people start taking medication as soon as possible
- AIDS awareness and protection. Possibly use commercials during pro sporting events and games – wrap it before you tap it!

The overarching themes of their responses included more education at an earlier age and the use of media to raise awareness. During the discussion portion additional ideas were produced that included educating parents, educational material to already existing community events (such as during Fiesta Week), increase social media, television strategies, and incorporating educational classes for federally mandated programs (WIC, food stamps, etc.).

The PC conducted a Comprehensive Needs Assessments in 2011 and 2014, a Mini-Needs Assessment in 2015, and are currently working on a Housing Needs Assessment for 2016. Using data from these needs assessment has allowed the PC and the AA to respond to consumer needs, reduce gaps in the HIV Care Continuum and enhance the quality of care and services available to PLWHA in the region.

The AA held a Community Input Forum at the Planning Council's People's Caucus Meeting in January 2016 that was attended by twenty consumers. The survey revealed that most of the consumers ranked AIDS Pharmaceutical as the highest service category although utilize Medical Case Management the most. The lowest ranked and least used service category by consumers was listed as Linguistics, but the SATGA/HSDA currently does not fund this category but it remains open and subject for ranking and utilization data.

The AA in 2014 conducted a youth (ages 13-29) survey to identify individual sexual social interaction using social media habits and mobile applications. The data was analyzed by the AA with special attention reflecting the young men who have sex with men of color (YMSMoC) aged 13-29. Of the 516 total surveys completed, the participants were 55.8% male, 81.6% were in the age group of 18-24, 54.1% were Hispanic, 39% identified as gay, and 38.3% identified as HIV positive. The majority preferred hanging out at home (80.2%). Facebook was the most popular application or website of those included in the survey (83.3%), and Google or online searches were the most common sources of HIV/STI information (62%). The majority of respondents had been tested for HIV previously (54.1%), with most reporting 1-3 months since their last HIV test (18.6%). The most frequently reported HIV testing location was the doctor's office (12%). However, the majority of respondents selected "other" as their testing site (19%). The majority of those surveyed were HIV negative (71.7%).

Section III: Monitoring and Improvement

Monitoring and evaluation of the City Only Integrated HIV Prevention and Care Plan, CY 2017-2021 will be the joint responsibility of the PC, AA, and the HPCG. Joint monitoring and evaluation is essential to the Plan's efficacy and efficiency.

The Comprehensive Planning/Continuum of Care (CPCC) Committee of the PC will monitor the Integrated HIV and Prevention Care Plan quarterly and updates will be sent via e-mail to the HPCG twice a year. Any feedback provided by the HPCG will be received by the PC Liaison who will then update the CPCC Committee and the plan as needed.

The HPCG will meet yearly to discuss the progress and implementation of the Integrated HIV Prevention and Care Plan. The HPCG will review the goals and assess if adjustments need to be made, affirm activities are working, and monitor performance of goals.

Distribution

The Integrated HIV and Prevention Care Plan, once completed and reviewed, will posted on the HPCG, PC website, www.hiv210.org, will be presented to the PC, QM, QMSPoC, People's Caucus, and the HIV/Syphilis Testing Taskforce in a printed and bound format. An easy reference highlights will be developed by the AA and PC in a low literacy, culturally appropriate format.

Monitoring

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

The PC, AA, and HPCG will jointly monitor this plan using the following process:

1. **PC/CPCC Monitoring Role**
   - This will result in standing agenda item for the committee, which meets monthly.
   - Quarterly the PC Liaison will work with the CPCC committee chair to include action items on the committee's agenda.
   - Progress in accomplishing each action item will be monitored by CPCC committee.
   - The CPCC committee will submit a quarterly Progress Report to the PC, AA, and HPCG.

2. **AA Monitoring Role**
   - Some of the action items are the responsibility of the AA.
   - The AA will monitor the progress in accomplishing their requirements of the plan at least quarterly.
   - The AA will submit their quarterly Progress Report to the CPCC Committee and HPCG to allow a snapshot of progress in accomplishing the activities, strategies, and goals.

3. **HPCG Monitoring Role**
   - Yearly the HPCG will review the reports and the recommendations of the AA and the PC/CPCC Committee. Any adjustments/changes to the actions, timetable, or responsible parties can be made at this time.

Progress toward goals, strategies and activities contained in this Integrated HIV and Prevention Care Plan will be reported to:

- HRSA through reports submitted by the AA.
- HRSA through information contained in the SATGA's annual Part A application.
- TDSHS for Part A and Part B through reporting requirements.
- The HPCG through progress reports from the AA and PC/CPCC Committee.

Improvement

This 2017-2021 Integrated HIV and Prevention Care Plan will be evaluated on an annual basis using two approaches: process evaluation and goal-based evaluation.

- The evaluations will be the joint responsibility of the CPCC Committee, the AA, and the HPCG.
- These evaluations will be conducted in December of each year in preparation for the Part A funding cycle.

Process Evaluation

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

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

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

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

Goal-Based Evaluation

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

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

1. Have these strategies resulted in reduced new HIV infections, reduced engagement in HIV-risk behaviors, and increased knowledge of HIV positivity by those infected?
2. Have these strategies resulted in increased knowledge regarding HIV Prevention?
3. Have these strategies resulted in increased HIV testing?
4. Have these strategies and activities resulted in increased persons linked to HIV medical care within one month of their HIV diagnosis?
5. Have these strategies resulted in ensuring all people who were newly diagnosed or were not receiving HIV medical care were effectively linked to appropriate services?
6. Have these strategies resulted in increasing access, engagement, retention in quality care and services for PLWH?

7. Have these strategies resulted in increased viral suppression for those who are HIV positive?
8. Have these strategies and actions resulted in reduced health disparities and HIV stigma in the region?

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

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

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

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

Other sources that will be used include:

- TDSHS HIV/AIDS surveillance data
- Comprehensive Needs Assessment data
- Information available from the HPCG
- Information for the HIV/Syphilis Testing Taskforce
- Information received from Community Stakeholders
    - Including but not limited to:
        - EIS Data
        - Testing Data
        - Prevention Data

Appendix A: Commonly Used Terms

Table 33: Commonly Used Terms

Acronym	Meaning
AA	Bexar County Department of Community Resources Administrative Agent
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
ARIES	AIDS Regional Information Evaluation System
ART	Antiviral Therapy (Medication)
ASO	AIDS Service Organization
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
CPCC	Comprehensive Planning/Continuum of Care Committee of the Planning Council
CY	Calendar Year
dx	HIV diagnoses
eHARS	Electronic HIV/AIDS Reporting System
EIS	Early Intervention Services
FPL	Federal Poverty Level
FY	Fiscal Year
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Service
HIPCSA	Health Insurance Premium and Cost Sharing Assistance
HIV	Human Immunodeficiency Virus
HPCG	Integrated HIV Prevention and Care Plan Stakeholder Group
HPSA	Health Professional Shortage Area
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
HSDA	Health Services Delivery Area
IDU	Intravenous Drug User
MCM	Medical Case Management
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MSM	Men who have sex with Men
NHAS	National HIV/AIDS Strategy 2020
NHBS	National HIV Behavioral Survey
OAMC	Outpatient Ambulatory Medical Care
PC	San Antonio Area HIV Health Services Planning Council
PEP	Post Exposure Prophylaxis
PLWA	People Living with AIDS
PLWH	People Living with HIV
PLWHA	People Living with HIV/AIDS

PrEP	Pre-exposure Prophylaxis
QM	Quality Management
RW	Ryan White
RWP	Ryan White Program
SA	San Antonio
SAMHSA	Substance Abuse and Mental Health Service Administration
SPoC	Standard Point of Contact
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TB	Tuberculosis
TDSHS	Texas Department of State Health Services
TGA	Transitional Grant Area
VA	Veterans Health Administration
WoC	Women of Color
YoC	Youth of Color

Appendix B: Financial Resource Inventory Survey

Integrated HIV Prevention and Care Plan - Financial and Human Resource Inventory Survey

San Antonio Area HIV Health Services Planning Council

This section of the San Antonio HIV Prevention and Care Plan will provide an inventory of the financial and service delivery provider resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. This section will describe the CDC-funded high impact prevention services and the HRSA-funded core medical and support services. Other funding sources (e.g., Substance Abuse and Mental Health Administration [SAMHSA Office of Rural Health Policy, and Housing and Urban Development [HUD] Housing Opportunities for People with AIDS [HOPWA]) in the jurisdiction will also be described. **PLEASE COMPLETE THIS SURVEY FOR EACH PROGRAM YOU ARE CURRENTLY FUNDED FOR. YOU MAY NEED TO COMPLETE THIS SURVEY MULTIPLE TIMES FOR EACH PROGRAM AND FUNDING SOURCE.**

1. Agency Name	
2. Funded Program Name	
3. Type of Program	
4. Program Funding Source Example: SAMHSA - Substance Abuse and Mental Health Service Administration	
5. Funded Program Amount ($)	
6. Program Begin Date	
7. Program End Date	

8. Program Narrative/Abstract (as submitted in your grant application to the funder)

Example: ABC Program provide transportation for clients to and from HIV Medical Care Appointments.

Goal 1: Increase number of clients accessing HIV Medical Care Appointments.

Goal 2: Increase number of clients newly diagnosed linking to HIV Medical Care Appointments.

9. HIV Care Continuum Step(s) Impacted

- ☐ HIV Testing and Diagnosis
- ☐ Linked to Care
- ☐ Retained in Care
- ☐ Prescribed Antiretroviral Therapy
- ☐ Viral Suppression

If you have any questions please contact the Planning Council Liaison, Mary Kay Newman, at 210-335-7056 or e-mail marykay.newman@bexar.org. All surveys are due to the Planning Council Liaison by close of business on Friday, August 19, 2016.

Thank you!!!!

Appendix C: The San Antonio TGA/HSDA Resource Guide, 2015

THE RESOURCE GUIDE

HEALTH AND COMMUNITY RESOURCES FOR THE SAN ANTONIO AREA

REVISED 2015

This Resource Guide is provided to you courtesy of the San Antonio Area HIV Health Services Planning Council.
For more information, please visit our website at
www.HIV210.org

i

Acknowledgement

This guide is provided by the San Antonio Area HIV Health Services Planning Council, a division of the Community Health – Ryan White Program in the Bexar County Department of Community Resources, with funding through the Ryan White Part A and Minority AIDS Initiative (MAI) grant from the U.S. Department of Health and Human Services.

The information provided in this guide is intended to be a resource for people with HIV/AIDS and their families. When considering services at any provider, please remember to contact the agency first to verify services, eligibility, referral criteria, hours of operation and any other pertinent information.

The Planning Council

The San Antonio Area HIV Health Services Planning Council was established in 1994. Its responsibility is to determine the needs of persons living with HIV/AIDS in the San Antonio Transitional Grant Area (TGA) and to develop priorities and set percentages of funds. The purpose of the Planning Council is to ensure the availability of quality comprehensive health and social services to individuals affected by the HIV epidemic.

San Antonio's Planning Council is a 30-member planning body made up of volunteer community members who have been appointed by the County Judge of Bexar County, Texas, to serve a two-year term. The County Judge appoints individuals who have a wide range of viewpoints and expertise. At least one-third (33%) of the Planning Council members are people living with HIV.

For more information about the San Antonio Area HIV Health Services Planning Council, please contact:

Planning Council Liaison
Community Health Division - Ryan White Program
Bexar County Department of Community Resources
Vista Verde Plaza
233 N. Pecos Ste. 590, San Antonio, TX 78207
Phone: 210-335-7056 • Fax: 210-335-1514

Book design and production by Fishead Design Studio & Microgallery

What is HIV?

HIV Stands for Human Immunodeficiency Virus (HIV) and is the virus that causes AIDS. HIV attachs the body's immune system, the part of the body that fights off infection. HIV specifically attacks a white blood cell called the CD4 or T cell, which the body needs to fight off diseases.

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome and is the last stage of an HIV infection. When someone is diagnosed with AIDS it means that HIV has destroyed the body's immune system so much that the body cannot fight infections. When a person is diagnosed with one or more specific diseases or cancers and has a very low CD4 count he/she is diagnosed with AIDS.

How is HIV transmitted?

HIV is found in blood, semen or pre-ejaculate (pre-cum), vaginal fluids and breast milk. A person becomes at risk for HIV when he or she has unprotected sex, either vaginally, orally, or anally. Sharing needles and syringes with an infected person is also a risk. Pregnant mothers can pass HIV on to their babies during pregnancy. HIV is not spread through sweat, tears, urine or saliva. You cannot get HIV from casual contact such as hugging, shaking hands or casual kissing. You also cannot get HIV from toilet seats, drinking fountains, door knobs, glasses and silverware, family pets or mosquitoes. Since 1985, all blood donated in the United States is tested for HIV.

How can HIV be prevented?

Abstaining from, or not having, vaginal, oral or anal sex is the best way of preventing sexual transmission of HIV. If you choose to have sex, use latex or polyurethane condoms and a water-based lubricant. Natural condoms (lamb skin) do not protect from HIV or sexually transmitted diseases (STDs).

If you inject drugs use only clean needles, syringes and other equipment; never share needles or other equipment with others.

HIV Testing:

There are no early symptoms of HIV. The only way to know you have HIV is to get tested. It is very important to talk about safer sex with your partners and ask your partners if they have been tested for HIV. If you think you have been exposed to another STD like Gonorrhea, Chlamydia or Syphilis get tested and treated. Having one STD increases your risk of contracting HIV if you are ever exposed. You can locate an HIV testing provider by visiting Change website from **http://gettested.cdc.gov** or calling **1-800-CDC-INFO (1-800-232-4636)**.

What is PrEP?

Pre-exposure prophylaxis, or PrEP, is a way for HIVnegative people who are at very high risk to prevent getting an HIV infection by taking a pill every day. The pill, Truvada, contains both Tenofovir and Emtricitabine, which are both used to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can keep the virus from establishing a permanent infection.

For more information on PrEP, please visit www.cdc.gov/hiv/prevention/research/prep/irCDCat 800-CDC-INFO, or 800-232-4636.

Who was Ryan White?

Ryan White contracted HIV at age 13 following a blood transfusion he received as a result of hemophilia. Growing up HIV-positive in Indiana, Ryan experienced discrimination as a result of his status. His brave fight to educate others about HIV and end the discrimination of which he was a victim made national and international headlines.

In 1984, Ryan was expelled from his school in Kokomo, Indiana due to fear of AIDS. Ryan was forced to participate in classroom activities via telephone. His family fought the superintendent's decision in court and Ryan was able to return to school following a judge's ruling in his favor; however, he was tormented when he returned to school. Students frequently insulted him and wrote degrading statements on his locker. His mother experienced widespread discrimination as well, including store clerks who refused to hand her change in order to avoid touching her. Restaurants discarded plates and silverware used by the White family, and someone even fired a gun into a window of the family home.

The Whites moved to Cicero, Indiana in 1987, where Ryan was treated as a regular student. The school board in Cicero held conferences for parents and residents to discuss HIV/AIDS in an effort to educate the community and encourage compassion rather than fear and discrimination. A student at Ryan's new high school was quoted as saying, "When he first came a lot of people were really scared, but Ryan helped all of us to understand." In 1988, Ryan testified before the President's Commission on AIDS and stated, "Because of the lack of education on AIDS, discrimination, fear, panic and lies surrounded me. I was labeled a troublemaker, my mom an unfit mother, and I was not welcome anywhere. People would get up and leave so they would not have to sit anywhere near me. Even at church, people would not shake my hand. This brought on the news media, TV crews, interviews and numerous public appearances. I became known as the AIDS boy. I received thousands of letters of support from all around the world, all because I wanted to go to school."

Ryan fell ill during his senior year of high school. Several celebrities and public figures, including Vice President Dan Quayle, President George H.W. Bush, Donald Trump, Michael Jackson and Elton John, called while Ryan was in the hospital and offered their support to him.

Ryan's mother, grandparents and Elton John were with him when he passed away on April 8, 1990; he was 18 years old. Even in death Ryan could not escape the hatred and discrimination; by 1992 his gravesite was vandalized four times.

Within a few months of his death, the United States Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The Act provided Federal funds to cities, states and community-based organizations for medical and social services for individuals living with HIV/AIDS. The CARE Act was reauthorized in 1996, 2000, 2006, and again in 2009 when its name was changed to the Ryan White HIV/AIDS Treatment Extension Act. Administered by the Department of Health and Human Services, HIV/AIDS Bureau, the Ryan White program serves over 500,000 people annually.

Ryan's story was told in a number of magazines and television shows; his life was even the subject of a TV movie. Those who work in the HIV/AIDS field credit Ryan White with opening dialogue on the disease and reducing prejudice. At a time when HIV was considered a gay disease or a drug addict's disease, Ryan would say, "I'm just like everyone else with AIDS, no matter how I got it."

Ryan White Biography 06/27/09

Health Resources and Services Administration. The HIV/AIDS programs: Who was Ryan White? Retrieved on June 27, 2009 from http://hab.hrsa.gov/about/ryanwhite.htm

Johnson, Dirk. (1990). Ryan White dies of AIDS at 18; His struggle helped pierce myths. *New York Times*. Retrieved on June 27, 2009 from http://www.nytimes.com/1990/04/09/obituaries/ryan-white-dies-of-aids-at-18-his-struggle-helped-pierce-myths.html

Witchel, Alex. (1992). At home with Jeanne White-Ginder; A son's AIDS and a legacy. *New York Times*. Retrieved on http://www.nytimes.com/1992/09/24/garden/at-home-with-jeanne-white-ginder-a-son-s-aids-and-a-legacy.html

Cordero, Robert. (2004). The Ryan White CARE Act: AIDS is still an emergency. The Body. Retrieved on June 27, 2009 from http://www.thebody.com/content/art14544.html

Witchel, Alex. (1992). At home with Jeanne White-Ginder; A son's AIDS and a legacy. *New York Times*. Retrieved on June 27, 2009 from http://www.nytimes.com/1992/09/24/garden/at-home-with-jeanne-white-ginder-a-son-s-aids-and-a-legacy.html

Ryan White Eligibility

HIV Status: Verification of HIV-positive status shall be in written form and must be documented in a client's file.

The following are acceptable documents:
- HIV lab results; or
- Written statement from a physician or medical record, pending confirmatory testing within three (3) months of receipt of statement or record.

Financial: Client must meet financial eligibility requirements as defined by the San Antonio Area HIV Health Services Planning Council, which is currently up to 300% of the Federal Poverty Level. There is no financial eligibility requirement for case management services. Financial eligibility must be documented in a client's file.

The following are acceptable documents:
- Benefit award letter;
- Pay stubs;
- Standardized declaration of income statement;
- Standardized supporter statement;
- Standardized statement of no income;
- Tax forms (i.e.W2, tax returns);
- Texas Workforce Commission unemployment benefits letter; or
- Prison release paper within 30 days of release date.

Residency: To receive services funded by Part A, client should reside in the San Antonio Transitional Grant Area (TGA), which includes the following counties: Bexar, Wilson, Comal and Guadalupe. However, since service providers should not turn away any clients who live outside of the TGA, providers must report to the Administrative Agent (AA) reasons for client seeking services outside of their TGA. Part B funding eligibility is state residency. Residency must be documented in a client's file.

The following are acceptable documents:
- Current government-issued ID or Driver's License noting Texas address;
- Utility bills;

- Benefits award letter in name of client showing address;
- Voter registration;
- Lease or mortgage in client's name;
- Notarized affidavit;
- Verification on letterhead from residential programs (e.g., nursing homes, treatment centers, halfway houses, hospice); or
- For homeless and/or undocumented, temporary affidavit signed and dated by the client which must be updated every 90 days.

Services to individuals not infected with HIV, but are affected by HIV, may be provided in the following circumstances only:

- The primary purpose of the service is to enable the affected individual to participate in the care of someone living with HIV or AIDS. Examples include support groups and individual mental health counseling;

- The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care; or

- The service promotes family stability in coping with the unique challenges posed by HIV/AIDS. Examples include mental health services and substance abuse services which focus on equipping affected family members and caregivers to manage the stress and loss associated with HIV.

Client's file must document the relationship to an infected Ryan White client.

Table of Contents

LEGEND FOR SYMBOLS IN THIS GUIDE


Case Management


Childcare/Parenting Services


Early Intervention Services


Emergency Assistance (food, clothing, etc)


Emergency Financial Assistance


Employment Services


Family Violence Services


Food Bank/Home Delivered Meals/Food Programs


Health Insurance


Home and Community Based Health Services


Home Health Care


Homeless Services


Hospice


Housing Services/Transitional Housing


Legal Aid


Linguistic Services


Medical Nutrition Therapy


Mental Health and Counseling Services

LEGEND FOR SYMBOLS IN THIS GUIDE


Mental Health


Oral Health Care


Outpatient/ Ambulatory Medical Care/Medical Care Services


Outreach/Prevention/Health Education Services


Permanency Planning


Pharmaceutical/Prescription Assistance


Referrals


Rehabilitation Services


Senior Services


Respite Care


Substance Abuse Services


Support Groups


Transportation/Medical Transportation


Treatment Adherence Counseling


Vision Care


Women


Youth

Appendix D: TDSHS ARIES Letter, May 20, 2016

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

JOHN HELLERSTEDT, M.D.
COMMISSIONER

May 20, 2016

Dear Part B Administrative Agencies and other Partners,

The Texas Department of State Health Services (DSHS) continues to experience technical difficulties with the AIDS Regional Information and Evaluation System (ARIES) reports. It appears that as of Thursday, May 12, 2016, reports have been producing inaccurate results in "Production" impacting our Administrative Agencies, HIV care providers, and other ARIES users. Administrative Agencies have been instructed to not utilize reports or publish data from ARIES until further notice, including reporting to Planning Councils and to the Health Resources and Services Administration (HRSA). Any reporting that utilizes data from an ARIES report is impacted, including reports for MAI, Part A, etc. DSHS will postpone due dates as needed for items that require ARIES reports and will allow sufficient time for Administrative Agencies to complete reports once the ARIES issues are resolved. Items that do not require ARIES report data can still be submitted.

The ARIES Data Team continues to conduct testing and is receiving testing results from around the state but are still seeing some critical reporting errors. At this time, the cause of this issue and estimates on a resolution timeline are unknown. DSHS will follow up with Administrative Agencies and HRSA once the reporting issue is corrected.

DSHS formally requests that any payment, reimbursement, or billing submissions that utilize ARIES data for verification or validation be honored without delay and that ARIES data verification be waived. The waiver of data verification is only a temporary measure and we ask that you reconcile and validate these submissions and make any necessary adjustments once the ARIES is again producing accurate reports.

Please accept our sincere apologies for this anomaly and many thanks for your continued cooperation.

Sincerely,

Shelley Lucas, M.P.H.
Manager
HIV/STD Prevention and Care Branch

cc: William Bryant, Part B Project Officer, HRSA
Frances Hodge, Part A Project Officer, HRSA
Greg Bolds, HIV Resource Administration Manager, Austin-Travis County Part A

An Equal Opportunity Employer and Provider

Appendix E: Stakeholder Activity Worksheet #1

Stakeholder Activity Worksheet Location: _____

Current Comprehensive Plan Strategies – Please select all that you believe should be incorporated into the new Integrated HIV Prevention and Care Plan.

Reducing New HIV Infections

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

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

Improving Access to Care and Health Outcomes

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

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

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

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

_____ Increase the number of Ryan White HIV/AIDS program clients with stable housing from 51% to 55% by 2015.

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

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

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

_____ Implement the patient/client satisfaction surveys throughout the San Antonio HASA, improving overall patient/client satisfaction annually.

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

Reducing HIV Related Health Disparities

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

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

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

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

_____ Revitalize the People's Caucus to expand participation.

Page 1

6/27/16

Stakeholder Activity Worksheet Location: _____

Integrated HIV Prevention and Care Plan – Please describe strategies that you believe should be incorporated into the new Integrated HIV Prevention and Care Plan.

Examples

- Housing Strategies
- Youth Strategies
- Out of Care Strategies
  - Latinos
  - Transgender

NOTES/COMMENTS for Current Comprehensive Plan: _____

NOTES/COMMENTS for New Integrated Plan: _____

Appendix F: Letter of Support and Concurrence

To: CDC/HRSA Project Officer

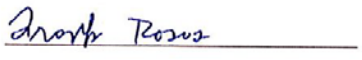
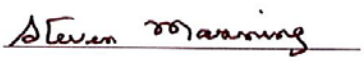
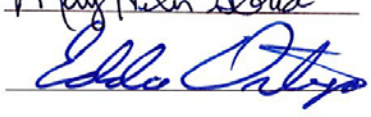
The San Antonio Area HIV Health Services Planning Council concurs with the following submission by the Bexar County Department of Community Resources Ryan White Program (Administrative Agency) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS 12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Comprehensive Planning/Continuum of Care (CPCC) Committee of the Planning Council will monitor the Integrated HIV and Prevention Care Plan quarterly and updates will be sent via e-mail to the Integrated HIV Prevention and Care Plan Stakeholder Group (HPCG) twice a year. Any feedback provided by the HPCG will be received by the Planning Council Liaison who will then update the CPCC Committee and the Integrated HIV Prevention and Care Plan as needed. The HPCG will meet yearly to discuss the progress and implementation of the Integrated HIV Prevention and Care Plan. The HPCG will review the goals and assess if improvements need to be made, affirm activities that are working, and monitor performance of goals.

Participants of the HPCG include the following community members: a Community Based Organization (CBO), AIDS Service Organization (ASO) not funded by Ryan White that does both prevention and linkage to care, the County Hospital District (including a RWP funded clinic), non-profit ASO that works with women and youth, Planning Council Members, HIV Consumers, the San Antonio Police Department, the Local Public Health Planning Agency, a Rural Service Provider, Homeless Providers, LGBTQ Youth Center Provider, HIV/STI Prevention Providers, the Veterans Health Administration (VA), RWPC, RWPD, Local Substance Abuse and Mental Health Services Administration (SAMHSA) funded projects, the San Antonio Metropolitan Health District (MetroHealth), and Putting an End to Abuse through Community Efforts (PEACE) Initiative.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Name/Title:	Signature:	Date:
Frank Rosas CPCC Committee Chair		September 15, 2016
Steven Manning Planning Council Vice Chair HIV/Syphilis Testing Taskforce Co-Chair		September 15, 2016
Mary Helen Gloria Planning Council Co-Chair		September 15, 2016
Eddie Ortega Director Department of Community Resources Bexar County		September 15, 2016