South Texas Development Council is focused on providing a cost effective means to plan, coordinate, and implement regional strategies that will improve the health, safety, and general welfare of our communities.

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Ryan White Part B – Administrative Agency

- The STDC South Texas HIV Services Program serves in providing a means to plan, coordinate, and implement regional strategies that will improve the health; quality of living; access to high quality standards of services and care, in order to provide a comprehensive and coordinated continuum of services and opportunities for people and families living with and affected by HIV/AIDS.
- Since 2002, the STDC has contracted with the Texas Department of State Health Services as the Administrative Agency (AA) for the South Texas HIV Administrative Service Area (HASA) in the provision of services through contract with area direct service providers within Health District 11. Funds are applied from both Federal and State allotments, with Ryan White funds coming from the Human Resources Services Administration (HRSA) at the federal level and HIV State Health and Social Services funds deriving from State allocations.

South Texas Administrative Agency

Laredo
Corpus Christi
Brownsville

FUNDING STREAMS

- Ryan White Base Services
- State Services
- State Rebate
- HOPWA

2018-2023 COMPREHENSIVE NEEDS ASSESSMENT RESULTS

JUNE 30, 2019

EXECUTIVE SUMMARY

- The 2018-2023 Comprehensive Needs Assessment was conducted for the South Texas Development Council as the representative of the South Texas HIV Administrative Service Area (HASA) and as the Administrative Agency (AA) for the three (3) respective Health Service Delivery Areas (HSDAs) which began in late October/early November 2018 and ended in June of 2019. The scope of the assessment was to specifically identify:
  - Emerging needs on Medical, Psychosocial Support, and Housing Services among People Living with HIV/AIDS (PLWH) in the South Texas HASA;
  - Access to quality HIV/AIDS care, barriers, and gaps; and
  - Utilization of funds granted through Ryan White Part B, State Services, and HOPWA programs.

EXECUTIVE SUMMARY (CONTINUED)

- The sample methodology yielded a target of 180 responses collectively for the HASA to provide an 80% confidence level for statistical soundness in reflection of responses to the HASA population as a whole and was inflated to account for the total prevalence population, not just those PLWH who were or have used Ryan White services.
- A total of 125 responses were collected by survey throughout the HASA, with an additional 61 responses collected through focus groups and one-on-one discussions (key informant interviews) conducted in each HSDA.

- Surveys were designed to eliminate the issue of consumer-led questions that were specific to Ryan White funded services, but rather to collect needs/gaps/barriers based on consumer real and/or perceived needs.

INTRODUCTION AND METHODOLOGY

- The survey design in this assessment was not specifically outlined by Ryan White funded service categories, rather it was designed to collect data to help achieve the goals and objectives of the HASA.
- The 2018-2023 Comprehensive Needs Assessment will identify:
  - Emerging needs on Medical, Psychosocial Support, and Housing Services among People Living with HIV/AIDS in the South Texas HASA.
  - Access to quality HIV/AIDS care, barriers, and gaps.
  - Utilization of funds granted through Ryan White Part B, State Services and HOPWA programs.

INTRODUCTION AND METHODOLOGY

- This sample frame was developed using a larger target number for out of care specifically based on prevalence data, rather than an anticipated response rate based on the ARIES Starr reports, within each HSDA for those not retained in care (2017 HIV Treatment Cascade data).
- Consumer surveys, consumer focus groups, and key informant interviews were conducted in each HSDA.
- 40 total client surveys were collected for the Corpus Christi HSDA, 5 were out of care client surveys and 4 were newly diagnosed and in care. Consumer focus group and key informant interviews were held in the HSDA during the assessment.

HSDA	In Care Sample Size	Out of Care Sample Size	Newly Diagnosed Sample Size
Brownsville	31	31	1
Corpus Christi	39	20	1
Laredo	21	33	3

HASA GOALS

- The South Texas HASA's dedication to achieve positive outcomes for the goals outlined in the Texas HIV Plan, the *Achieving Together* initiative, and the National HIV/AIDS Strategy (NHAS) goals are measured specifically by the AA as follows:
  - Successful linkage of care measured by the percentage of people newly diagnosed with HIV to be linked to Care within 3 months of their diagnosis;*Aligns with the NHAS goal: Increase timely linkage to HIV-related treatment for those newly diagnosed with HIV.*
  - Retention in care measured by the percentage of HIV positive clients that make at least two contacts with the care system during the year (either a HIV medical appointment, HIV lab work, and/or lab prescription);*Aligns with the NHAS goal: Increase continuous participation in systems of treatment among PLWH.*
  - Viral suppression measured by the percentage of PLWH who achieve a viral load that is less than or equal to 200 copies/mL; *Aligns with the NHAS goal: Increase viral suppression among people living with HIV.*

CONSUMER FOCUS GROUPS & KEY INFORMANT INTERVIEW SUMMARY

- One consumer focus group was conducted in each HSDA to determine additional needs, gaps and barriers. Across the entire South Texas HASA, the top need was determined to be Support Groups. Clients in each region reported that they would be interested in engaging in routine meetings with other PLWH in their community.

- Top reasons stated for this need include peer to peer emotional support and sharing knowledge of available HIV services. Additionally, several clients expressed that they were concerned about experiencing, or have experienced, discrimination due to the existing stigma surrounding HIV and/or sexual orientation within their communities.

- The top gap in services reported was dental services, with the top barrier to care reported as a need for gas cards for transportation.

PROVIDER SURVEY AND FOCUS GROUP RESULTS

- One provider survey was conducted in each HSDA to determine outreach, linkage to care, client retention, available services and continuum of care. All respondents listed referrals as the main method of linkage to care through means of self-referral, DIS, outreach, and referral from testing sites. Providers attribute maintaining contact, building relationships and education as the top means for ensuring clients remain in care until viral suppression is achieved.

- The most common theme reported in each of the three provider focus groups was the lack of resources for individuals who are undocumented and those who are uninsured. All three HSDA provider groups reported that specialty care resources are needed in the area, along with mental health services. There is a general consensus among the three HSDAs that providers not directly funded for RWHAP Part B and/or State Services do not necessarily want to work with PLWH, thus making it increasingly difficult to find care for their respectively communities for resources needed.

Ranked needs, gaps, and barriers for the overall South Texas HASA resulted in the following as identified by PLWH survey results:

Needs	Gaps	Barriers
Insurance	Health Education/Risk Reduction	Transportation
Dental	Outreach	Housing
Financial Assistance		
Support Groups		

Note: This needs/gaps/barriers ranking is NOT specific to Ryan White funded service categories.

RECOMMENDATIONS

- Increase Outreach and Health Education/Risk Reduction Services in the three HSDAs: Stigma was reported consistently throughout all HSDAs as a reason for clients not to engage in care. Outreach and HE/RR strategies play a vital role in increasing HIV awareness in the community, as well as improving linkage efforts. It is important to partner with HIV Prevention programs in each HSDA to ensure no duplication of effort occurs. Social media interventions, increased participation in community health fairs, and coordination with the HIV Prevention programs are all venues that would increase HIV awareness in the HSDAs, and would align with the NHAS goal to "Increase HIV awareness among members of the general public, community leaders, stakeholders, and policy makers".

- Increase Linkage Efforts: Linkage to Care is the second step of the HIV Treatment Cascade using HHS indicators. Studies have shown that increase rates of retention and viral suppression are more likely to occur when PLWH are linked to care as quickly as possible upon diagnosis. There are several Evidence-Based Interventions (EBIs) and Evidence-Informed interventions (EIIs) available to research that provide strategies and activities for improving linkage efforts, including strategies and activities designed specifically for priority populations. Developing strategies and activities to increase access to needed services aligns with the NHAS goal, "Increase timely linkage to treatment for newly diagnosed PLWH".

RECOMMENDATIONS

- Retention in Care Efforts: Retention in care is linked to improved rates of viral suppression for PLWH. Although many of the survey respondents reported being adherent to their medical care appointments, retention rates for the priority populations continue to struggle as evidenced in the respective HSDAs 2017 HIV Treatment Cascades.
- Focus on Financial Assistance Programs (Dental, Health Insurance, and Housing Assistance): Both needs and barriers were reported with regard to issues with financial assistance for dental care, health insurance copays and/or premiums, and housing assistance specific to utility assistance. It is recommended that the AA increase training with the respective HSDA RWHAP Part B funded subrecipients in capacity and use of funds for these programs. Outside resources were reported by providers as scarce or difficult for PLWH to qualify for additional assistance, thus in planning for capacity, it would be increasingly beneficial to review uses of dental, health insurance, and housing funds to determine how best to reduce this barrier and yet still provide access to assistance for PLWH with unmet need.
- Expansion of Provider Base: Currently there are three RWHAP funded subrecipients for the entire South Texas HASA; one in each HSDA. Although these programs are recognized in their respective areas, there is a need to expand provider resources, giving PLWH more choices in where they can access care

RECOMMENDATIONS

- EIS/DIS to work in conjunction to increase linkage and retention efforts: Early Intervention Services (EIS) should be funded in each HSDA. EIS services could increase linkage efforts, as well as provide a venue for the above recommended EII and EBI activities in addition to Outreach and HE/RR. EIS workers should be trained to provide intensive linkage assistance with PLWH to achieve positive outcomes, as well as work with local Disease Intervention Specialists (DIS) HIV Prevention teams to help coordinate activities that aim in improving overall health outcomes. EIS and DIS workers need to develop a community forum to openly discuss strategies and activities that each group would undertake so as not to duplicate effort, but to also have a more coordinated effort in linking PLWH to services.

- Training on resources in the HSDAs as well as providing information to the clients: As a result of the consumer survey results indicating that PLWH were not made aware of services or did not know about services, training should be provided by the AA to each subrecipient on the additional resources in each HSDA. This training should be provided at least quarterly and would provide an in depth review of resources known, including discussion regarding barriers to these resources for PLWH in their respective HSDAs. This would aide in planning for future needs and would provide a consistent venue for the AA and each RWHAP subrecipient to meet. In addition, the AA should provide each HSDA with copies of the mini resource guides for each region to hand out to the clients. These mini resource guides are available in print from the Texas Department of State Health Services.

2018 2023 Needs Assessment Application

Company Name South Texas Development Council
Project Lead: Dora V. Inclan, Program Planner

Project Start Date:	7/30/2018
Scrolling Increment:	292

Milestone Description	Category	Assigned To	Progress	Start	No. Days
Phase 1					
Strategic Planning Meetings	On Track	AA Staff	100%	8/1/2019	60
Do research On actual practices in regards to categories related to Needs, Gaps, and barriers	Goal	Program Planning, QM and Data Management	100%	8/12/2019	90
Discuss results and recomendations with Each Service Provider (key Staff)	Milestone	Program Planner	100%	11/1/2019	90
Allocations/ Open up categories related to Needs Gaps and barriers and/ or add funding	On Track	Program Planner	100%	11/1/2019	365
Public Forums / report - Follow up	Low Risk	Program Planner	100%	12/15/2019	30
Phase 2					
Increase AA Connection with other resources in the community	Goal	Program Planner	50%	12/1/2019	365
Aling and/ or update Comprehensive plan objectives / needs assessment recommendations	High Risk	Program Planner	80%	1/1/2020	120
Provide TA and ask providrers to update their yearly strategic plan to include current goals and objectives	On Track	Program Planner	70%	7/1/2020	180
promote service providers involvement in allocations and tracking accomplishements 19-20 and 20-21	On Track	Program Planner / Service Providers	30%	10/1/2020	365
Work with providers/ setting public forums and mini needs assessment with clients .	Goal	Program Planner	10%	11/1/2020	60
Phase 3					
Align Recommendations / successfult interventions with Next Comprehensive plans 21-25	Goal	Program Planner		6/1/2021	365
Task 2	Med Risk			6/1/2021	365
Task 3	On Track			6/1/2021	365
Task 4	Goal			6/1/2021	365
Task 5	Low Risk			6/1/2021	365

AA/ South Texas Regional Planning Updates 10/2020

Activities recommended in comprehensive plan are in blue Color
Activities recommended in Regional Needs Assessment are in magenta color.

1. **Our regional Comprehensive Plan is been updated up to 07/30/2020 and the following Goals and objectives need to be completed by STDC and Service Providers by end of FY 2021.**

- Improved the Case Management System in the South Texas HASA

  Pending objective: Improve client's acuity and knowledge of their disease process to help strength self-management.

  - Activity: Work with service providers to develop strategies (list of activities) that promote self-health management in order to affect positively clients' acuity scores and viral suppression rates.

  - Activity: Increase Support groups and individual interventions. Add psychosocial Services, Support groups/ target Peer to Peer strategies, Provide follow ups and documentation of progress.

2. Increase continuous participation in systems of treatment among people living in the South Texas HASA

Objective in progress: By 2021, increase the number of individuals who are retained in care from 68% to 85% (from 2,255 to 2,803) in the South Texas HASA

Objective in progress: By 2021, decrease the number of PLWHA who have had no HIV care from 26% in 2015 to 20% for the whole South Texas HASA.

- Activity: Develop a report/ table with yearly progress on each objective to compare retention rate, access to care time rate (based on date of diagnosis and starting treatment date), desertion rate, etc.
- Activity: Please find, share and implement a method to identify individuals who are at risk of falling out of care and how to prevent it.
- Activity: Implement and document Outreach and Case management interventions that can clearly show positive effects in retaining individuals in care and bringing people back into care.

3**. Increase viral suppression among the people living with HIV in the South Texas HASA.**

Objective in Progress: By 2021, increase the number of individuals who are virally suppressed to 81 % (from 1,992 to 2,270) in the South Texas HASA

- Activities: Same than above.

4. Prevent homelessness among PLWHA in the region (Added to Comprehensive plan)

Objective in Progress: Continue to provide Housing services utilizing HOPWA funds and RW Housing Services.

- Activity: Each agency needs to create a flowchart indicating the process for identifying housing needs and at-risk clients, the assessments used to determine eligibility, other agencies that provide housing services around the community (work in MOUs), referrals for external training for clients if needed (budget management, work search/ etc. Other agencies needed), follow up process and self sufficiency and or Municipal housing outcomes.

- Activity: Continue working with Waiting lists for HOPWA and advice the AA any change on demand and possible reasons in a promptly manner.

Unduplicated Clients Served

HSDA	RW B 18-19	RW B 19-20	State R 18-19	State R 19-20	State Service 18-19	State Service 19-20
CLHD	199	221	212	206	199	114
CBWF	552	495	335	177	542	493
VAC	870	958	857	722	1167	1307