



***BEXAR COUNTY-
SAN ANTONIO RYAN WHITE
PROGRAM***

***2009-2010 Comprehensive
Needs Assessment***

July 2009





***BEXAR COUNTY-
SAN ANTONIO RYAN WHITE
PROGRAM***

***2009-2010 Comprehensive
Needs Assessment***

Executive Summary

July 2009



EXECUTIVE SUMMARY

The San Antonio Area HIV Health Services Planning Council (Planning Council) and the Bexar County Department of Community Investment (BC DCI) are responsible for planning services that support the use of HIV medical care among people living with HIV/AIDS (PLWHA) in a 28-county region. The Planning Council is responsible for the four-county San Antonio Transitional Grant Area (TGA) which includes Bexar, Comal, Guadalupe, and Wilson counties. The BC DCI is the administrative agency for the entire region. In order to effectively plan services, set funding priorities, and fulfill federal mandates, the Planning Council and the BC DCI require information about the regional epidemic, as well as PLWHA service use, needs, availability, gaps and barriers to care.

This needs assessment combines data about the epidemic with information from consumers and providers of care in order to develop information for decision making. A goal of this needs assessment was to build on previously conducted studies that were largely quantitative by providing more qualitative data focusing on consumer perceptions, concerns and motivations. Therefore, focus groups and personal interviews were largely employed with a short quantitative survey. In addition, the number of participants was smaller than found in a large-scale quantitative study. Specifically, the following methods were employed:

1. Surveillance and sociodemographic data about the population of the region and status of the epidemic obtained from the Texas Department of State Health Services (DSHS).
2. Thirteen PLWHA focus group discussions that included 112 consumers (105 in-care and 7 out-of-care).
3. In depth interviews with out-of-care and rural PLWHA, including 23 of the former and six of the latter.
4. A short consumer survey of PLWHA that included 139 respondents.
5. Two focus groups and a survey of provider capacity and capability with Ryan White funded providers.
6. Eleven key informant interviews with providers, consumers, and community leaders.
7. Evaluation of Third Party Payers' (Medicaid and others) coverage of PLWHA health care costs including information on trends and enrollment benefits.
8. A Community Planning Group Prevention Assessment.

The 2006 Ryan White Reauthorization emphasized identifying PLWHA who know their status but are not receiving primary medical care, and engaging them in care. These consumers were a particular focus of this needs assessment. In addition, emerging populations and others that are disproportionately affected were priorities including:

Priority Populations			
In-Care	Out-of-Care	Closeted MSM	Injecting Drug Users
Late to Care	Monolingual Spanish Speakers	Older (55+) Men Who Have Sex With Men	Recently Diagnosed
Recently Released from Incarceration	Rural Residents	Transgendered Individuals	Women

This needs assessment was a team effort. Direct oversight of the needs assessment was provided by the Planning Council's Needs Assessment Committee, chaired by Roland Recio. In addition, the BC DCI Planner and other members of the administrative agency staff provided oversight and support of the needs assessment process.

EPIDEMIOLOGIC PROFILE

The San Antonio Transitional Grant Area (TGA), San Antonio HIV Service Delivery Area (HSDA), the Uvalde HSDA and the Victoria HSDA include nearly 2.5 million people and 4,750 PLWHA. Details on the region include:

- ⌘ The four-county San Antonio TGA, specifically Bexar County, is the most populous and the epicenter of the regional epidemic.
 - In 2007 there were 4,391 PLWHA in the San Antonio TGA.
 - Although 76% of the regional population resides in these four counties, they are home to 92% of the regional epidemic.
 - This is a majority minority region: Hispanics comprise 53% of the population, Whites 35%, and Blacks 7%. Considering PLWHA, 54% are Hispanic, 30% are White and 15% are Black.
- ⌘ The San Antonio HSDA is comprised of these four counties and eight others. With 10% of the regional population, the eight non-TGA counties include 2.5% of the regional epidemic.
 - In these eight non-TGA counties, Whites are the predominant population (59%) followed by Hispanics (38%).
- ⌘ The Uvalde HSDA is a very poor area, with 28% of the population living below the poverty level. The nine counties making up this HSDA are very rural. Hispanics make up 81% of residents while 78% of PLWHA are Hispanic.
- ⌘ The Victoria HSDA, while rural, is not as poor as the Uvalde HSDA, with 16% of residents living below the poverty level. The population is majority White (55%) followed by Hispanic (37%) and Black (7%). The epidemic is comprised of 151 PLWHA and both Whites and Hispanics are 38% of those infected while 23% are Black.

Specific trends to consider include:

- ⌘ The epidemic continues to increase.
 - Between 2003 and 2007, the number of PLWHA increased by 32% in the San Antonio HSDA (12 counties) and Uvalde HSDA.
 - PLWHA increased by 19% in the Victoria HSDA during this time.
 - New cases and deaths have been relatively stable with an average of 325 new cases annually between 2003 and 2007 and 79 average annual deaths.
- ⌘ Women are more than 15% of the PLWHA in the San Antonio TGA and HSDA. With women comprising 20% of new diagnoses in 2007, the overall percentage of female PLWHA can be expected to increase.
- ⌘ Although Blacks are 15% of the San Antonio TGA epidemic and Hispanics are 54%, the rate among Blacks is more than double that of Hispanics—541 per 100,000 for Blacks vs. 243 per 100,000 among Hispanics.

- Black women are infected at nearly five times the rate of Hispanic women.
- ⌘ Sixty percent of PLWHA have an AIDS diagnosis, compared to 58.4% throughout Texas.
- ⌘ Comparing the time from HIV diagnosis to conversion to AIDS provides an indication of the timeliness of diagnosis. Conversion within a year is considered a “late diagnosis” or “late to care.”
 - Between 2003 and 2007, 23% of PLWHA in the San Antonio TGA and HSDA converted from HIV to AIDS in one month and 35% in one year.
 - 33% of Uvalde PLWHA converted in one month and 43% in one year.
 - 30% of Victoria PLWHA converted in one month and 38% in one year.
- ⌘ Unmet need provides an estimate of the number of consumers who have not received medical care in the last year.
 - Thirty percent of PLWHA in the San Antonio TGA and HSDA have unmet need.
 - The unmet need in Uvalde HSDA is 31% and the Victoria HSDA is 33%.¹
- ⌘ Projections reveal significant increases in the epidemic over the five and ten years.
 - In 2014, the total population of people living with HIV and AIDS is expected to be 6,212; increasing to 7,517 in 2019.

EPIDEMIOLOGIC OVERVIEW--2007							
SAN ANTONIO TGA, and SAN ANTONIO, UVALDE, VICTORIA HSDAS							
	POPULATION	RACE/ETHNICITY	BELOW POVERTY	2007 PLWHA	2014 PLWHA	LATE TO CARE*	UNMET NEED
San Antonio TGA	1,851,721	Hispanic 53%	15.5%	4,391	6,212	23% and 35%	30%
San Antonio HSDA	2,093,242	Hispanic 52%	15.6%	4,510	6,391	23% and 35%	30%
Uvalde HSDA	162,008	Hispanic 81%	27.9%	89	126	33% and 43%	31%
Victoria HSDA	185,584	White 48%	16.3%	151	188	30% and 38%	33%

*Converted from HIV to AIDS in one month/one year.

NEEDS ASSESSMENT FINDINGS

The San Antonio region has a long-established and well-developed HIV service delivery system. Throughout this needs assessment consumers and providers identified strengths and challenges of this system. Strengths include:

- ⌘ Stable organizations with well-established leadership.
- ⌘ Many long term, dedicated staff.
- ⌘ A full range of Ryan White core services available.
- ⌘ A variety of funding sources in addition to Ryan White.
- ⌘ Increasing collaboration with non-Ryan White funded organizations.
- ⌘ New, innovative programs being supported by BC DCI in conjunction with providers.

¹ Note: DSHS unmet need estimates do not include data from Medicare, Veterans Administration and some private insurers.

Challenges include:

- ⌘ Established practices may result in barriers to care.
- ⌘ Historic competition between agencies limits collaboration.
- ⌘ Limited Ryan White funding for needed social services. Collaboration with non-Ryan White funded community agencies is needed, but difficult to accomplish.
- ⌘ Ongoing HIV stigma considered acute by providers and many consumers.

The following overarching recommendations are designed to build upon strengths, reduce consumer barriers to care, and limit system challenges.

1. Make the Care System as “Consumer-Friendly” as Possible

1.1. First Priority is Medical Care—Work with Ryan White Funded Medical Care Providers to Reduce Barriers

Collaborate with current medical care providers to develop short term and long term plans to increase efficiency and enhance patient satisfaction.

- ⌘ Opportunities exist to make immediate changes in clinic operations. Work closely with providers to begin this process.
- ⌘ The rapid cycle improvement process (Plan-Do-Study-Act)² may support monitoring the results of planned changes.
- ⌘ Evaluate future opportunities to fund a smaller medical care provider or a “clinic within a clinic” model for a targeted population, such as women.

1.2. Improve Efficiency Throughout the Ryan White System

Navigating the care system can be very time consuming, and the paperwork requirements discourage access. Evaluate all services from the consumer’s perspective and strive to make them as easy to use as possible. Overall system goals should:

- ⌘ Reduce waiting time for services.
- ⌘ Reduce paperwork requirements including duplicative paperwork.
- ⌘ Evaluate options to enhance services to accommodate consumers including uniform standards for allocating social services.

1.3. Expand Current Programs and/or Implement Additional Programs Targeting Out-of-Care Consumers

- ⌘ Build upon the success of the EIS program through program expansion to other locations or targeted populations.
- ⌘ Solicit proposals for other model programs targeting out-of-care consumers. Consider successful state or national models.
- ⌘ Evaluate opportunities to collaborate with HRSA-defined “key points of entry.”

² The rapid cycle quality improvement approach recommended by HRSA. Refer to <http://hab.hrsa.gov/tools/primarycareguide/PCGchap17.htm>.

1.4. Identify Innovative Approaches to Stretch Ryan White Funds in order to Increase the Availability of Important Social Services

- ⌘ Consumers need social services, but Ryan White funding is limited. Establish short term and long term targets, for each needed social service (food bank, housing, emergency financial assistance, etc.). Assign responsibility to members of the Administrative Agency staff to identify collaborative solutions to increase access to each needed service.
 - Support program development in conjunction with non-Ryan White funded providers for social services.
- ⌘ Network throughout the community to identify “nontraditional” partners.
- ⌘ Work with funded providers to identify national model programs that enhance collaboration and community linkages.

2. Evaluate and Enhance the Case Management Function

As the gateway to both medical and support services, case management is an essential service and is provided by almost all Ryan White funded agencies. Therefore, the service must be of very high quality and provided in a uniform manner. Implement best practices, including those identified through the DSHS evaluation.

- ⌘ Continue case management training and direct service provider networking.
- ⌘ Improve agencies’ compliance with required ARIES data collection system. Work with case management agencies to reduce case manager documentation burden.
- ⌘ Empower consumers to their level of ability.
 - Build on the case management acuity system to ensure adequate resources are available to those with the highest requirements.
- ⌘ Develop an easy to use resource directory for consumers and case managers. Consider making it available on-line.
- ⌘ Educate consumers about their roles and responsibilities in the case management system.

3. Increase Collaboration Between All Ryan White Funded Providers

Providers were asked to identify the single most important system-wide change that would improve services for all people living with or affected by HIV/AIDS. Responses focused on:

- ⌘ Improving access through collaboration among agencies.
- ⌘ Enhancing care coordination and the continuum of care.

Therefore, it is recommended to:

- ⌘ Develop incentives for Ryan White funded providers to collaborate, working together to optimize care and services for the consumer.
- ⌘ Implement systems to facilitate cross-referral among providers.
- ⌘ Resolve referral and payment issues between rural and urban providers.

4. Reduce Late Diagnoses

4.1. Collaborate with Prevention Outreach

The large number of “Late to Care” PLWHA has significant implications for HIV prevention, HIV care and the community overall.

- ⌘ HIV prevention and outreach is critical to curb the epidemic.
- ⌘ Collaborate with prevention providers to support prevention outreach and early counseling and testing.
- ⌘ Support community education related to HIV/AIDS prevention and early counseling and testing.

4.2. Reduce the Stigma

One reason for delayed testing is the stigma of HIV throughout the region. The continuing stigma of HIV was apparent in all populations. Focus group participants discussed the stigma’s impact on their lives, including being ostracized by family and friends.

- ⌘ Develop an integrated plan to reduce the stigma of HIV/AIDS throughout the region over the next three to five years. Include targeted community education with a specific emphasis on youth education.
- ⌘ Consider stigma reduction strategies put forward by HRSA.

PRIORITY POPULATIONS

In-Care Consumers

In-care consumers fall into three groups including: (1) those who have overcome barriers, understand the care system and have made it work for them, (2) those who enter and exit the system based on their personal situations, or (3) those who have recently begun care and need to be retained. The care system must recognize all of these consumers, and strive to retain them.

The most frequent reasons in-care consumers gave for dropping out-of-care included:

- ⌘ Financial concerns,
- ⌘ Waits for appointments,
- ⌘ Substance use/relapse,
- ⌘ Disclosure concerns/stigma,
- ⌘ Difficulty keeping appointments.

In-care consumers feel the care system could be significantly improved by increasing the focus on the patient/client. In addition, strategies to help consumers meet basic needs will support maintenance in care.

Out-of-Care Consumers

During this needs assessment, locating the out-of-care proved challenging. Although outreach workers, who served as recruiters, knew out-of-care individuals, these consumers would not

come forward for confidential interviews. Disclosure was a significant concern, as well as their unwillingness to face/discuss their HIV status.

Seventy percent of out-of-care consumers had received HIV medical care in the past. Therefore, maintenance in care is the first step to reducing the number of out-of-care PLWHA. The most frequent reasons for not receiving HIV medical care include:

- ⌘ The ongoing struggle to meet basic needs, particularly housing,
- ⌘ Dissatisfaction with the medical care system,
- ⌘ Feeling well,
- ⌘ Transportation,
- ⌘ Substance use,
- ⌘ Mental health issues including dual diagnosis,
- ⌘ Stigma.

In addition, out-of-care women discussed their obligations to take care of the family/other people as an important barrier to care.

Twenty percent of the out-of-care consumers interviewed are trying to get into medical care. They generally made the decision to start taking care of their health, often because they became symptomatic. The system should support entry/re-entry into care by making enrollment as easy as possible.

Monolingual Spanish Speakers

The San Antonio HSDA and the Uvalde HSDA are minority majority areas, with Hispanics comprising 53% of the former and 81% of the latter. They are also a significant minority (37%) in the Victoria HSDA.

Although many of these people were not foreign born or have lived in the United States for many years, they speak Spanish at home and consider Spanish their first language. They may have better comprehension of sensitive information in Spanish and may prefer to communicate in Spanish on health-related matters. However, providers may not realize this preference, resulting in confusion or limited understanding of information and education.

In addition to language issues, other barriers to medical care demonstrated by monolingual Spanish PLWHA include:

- ⌘ Poverty and financial concerns,
- ⌘ Immigration and legal status issues,
- ⌘ Depression and other mental health disorders,
- ⌘ Feelings of discrimination,
- ⌘ Stigma of HIV.

Strategies to address these in a culturally sensitive, linguistically appropriate manner must be developed. Specifically, providers must be aware of the importance of communicating in Spanish with this population to encourage adherence to treatment and retention in care. In

addition, Spanish language brochures and teaching tools must be available and appropriate. Mental health services, including counseling, must also be provided in Spanish.

As mentioned above, strategies to combat discrimination and stigma are critical in the Hispanic communities. Short and long term educational approaches that include community leaders are needed to combat these issues.

Older Men Who Have Sex with Men (MSM)

Many older MSM are “long term survivors” of the HIV epidemic, but some recently diagnosed older MSM were also identified in this needs assessment. The key issues include:

- ⌘ Mental health concerns associated with loneliness, loss, isolation,
- ⌘ Burnout due to long term HIV treatment,
- ⌘ Co-morbidities requiring both primary and specialty care,
- ⌘ Living on fixed incomes so they occasionally need financial and other support to meet basic needs.

Providers need to develop strategies to address these issues. In addition, many long term survivors are self-advocates and often case manage themselves. Some have significant experience and expertise with the care continuum. These men may serve as resources, providing a valuable service to the TGA/HSDA.

Recently Diagnosed

Recently diagnosed consumers discussed the shock and denial associated with learning of their HIV status. They all felt depressed and isolated after diagnosis, and many began binge drinking and/or drug use.

They recommended the following to help others successfully move into HIV medical care:

- ⌘ Counseling and support using peer counselors and/or professional counselors,
- ⌘ Health literacy to better understand the disease,
- ⌘ Easy access to medical care.

The new Early Intervention Services (EIS) program supports these interventions. Strategies to expand EIS and reach more of the newly diagnosed will facilitate entry into the care system.

Recently Released From Incarceration

Everyone returning to society from incarceration faces challenges and barriers, but PLWHA face compounding problems due to health care requirements and possible physical limitations. Over a quarter of consumer survey respondents report being in jail or prison for at least one month in the last two years.

The level and quality of HIV medical care varies between county jails and state and federal prisons.

- ⌘ Bexar County University Health System (UHS) provides HIV medical care to the Bexar County jail through telemedicine, creating an easy linkage upon release.
- ⌘ The Texas Department of Criminal Justice releases approximately 60 HIV positive inmates to the Bexar County area annually. These PLWHA receive a variable range of services and quality of medical care during incarceration. Release planning also varies, but all inmates receive a 10-day supply of medications upon release.

This limited supply of medication and limited information about community resources can make the transition to community medical care challenging. Priorities identified in this needs assessment include:

- ⌘ Access to medication,
- ⌘ Housing assistance,
- ⌘ The need for identification documentation including demonstration of HIV positivity in order to access the care system,
- ⌘ Substance abuse treatment and avoidance of past associates.

Upon release, PLWHA face additional issues associated with ineligibility for entitlements, difficulty finding employment, as well as the combined stigma of HIV and incarceration. The Planning Council and BC DCI should consider funding a model program for recently released incarcerated PLWHA building on established best practices. Program components may include: pre- and post- release service planning, intensive case management, medical care and other services to support transition back into the community.

Rural Residents

In the Victoria and Uvalde HSDA's, the HIV positive residents of these areas are diverse and complex and must confront significant barriers to care. Despite similarities in overall needs with non-rural populations, the regional differences impact the most appropriate responses.

Recommendations include:

- ⌘ Evaluate quality of care in the rural clinics to encourage local service use;
- ⌘ Improve coordination of care between rural and urban providers for patients who travel to San Antonio for HIV medical care and specialty care. Non-medical services may be provided in the rural area even if medical care is received in San Antonio. Consider telemedicine through UHS;
- ⌘ Transportation is important with the broad geographic area and must be maintained or expanded;
- ⌘ Health literacy programs must accommodate monolingual Spanish speakers and people with low literacy. Evaluate options to expand access to computers for communication and information;
- ⌘ Strive to reduce the stigma of HIV through outreach and education.

Transgendered

Transgendered consumers face a variety of barriers including substance use, survival sex work, domestic and other violence, and stigma. The result is high infection rates (25% in national studies) and incarceration rates ranging between 37% and 65%.³

The most frequent issues identified by the trans women⁴ focus group participants included:

- ⌘ The need for a transgendered mental health counselor or someone with a keen awareness and understanding of transgender concerns,
- ⌘ Support groups, possibly educational in nature for trans women, moderated by someone with appropriate expertise,
- ⌘ Housing, particularly due to issues associated with gender-specific homeless shelters,
- ⌘ Legal issues surrounding identification documentation, such as name, social security and passport,
- ⌘ A physician who understands the drug interactions between hormones, antiretroviral therapy and other medications,
- ⌘ Case managers knowledgeable in transgendered services,
- ⌘ Support in addressing the stigma of HIV.

Women

Although women are approximately 15% of PLWHA in the region, their HIV prevalence is increasing. This needs assessment identified distinct service needs and barriers to care.

Female PLWHA, often with single parent status, confront competing priorities for their time and attention. They require a system of care that is efficient and effective, and respects their competing priorities in taking care of their families, earning a living, and maintaining their health. Therefore, a supportive service system is critical including case management, medical care and essential social services.

To achieve this, consider the following recommendations:

- ⌘ Evaluate service eligibility requirements with specific consideration to the needs of women with children;
- ⌘ Make recommended changes to enhance medical care and case management services;
- ⌘ Consider developing a women's clinic that will focus on the complete health care needs of women in an efficient and effective manner;
- ⌘ Identify creative ways to fund social services to serve as a gateway to medical care for women.

³ National Training Exchange presentation "Transgender Health and HIV." June 5, 2009.

⁴ Trans women are individuals whose birth gender was male but who identify as female.

*For a copy of the
2009-2010 Comprehensive
Needs Assessment, please call
210-335-7056.*