PHOENIX EMA
RYAN WHITE
PLANNING COUNCIL

Moving Toward the Future

The 2009 to 2012 Comprehensive HIV Services Plan
of the Phoenix EMA Ryan White Planning Council

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Comprehensive HIV Services Plan of the
Phoenix EMA Ryan White Planning Council

For information contact:
Program Coordinator, Planning Council Support
Maricopa County Department of Public Health
4041 North Central Avenue, STE 1537
Phoenix, AZ 85012
602 506-6321 602 506-6896 fax
PlanningCouncil@mail.maricopa.gov
www.phoenixplanningcouncil.com

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Caring for our HIV Community

4041 North Central Avenue
Suite 1537 • Phoenix, AZ 85012-3330
(602) 506-6321 phone
(602) 506-6896 fax
PlanningCouncil@mail.maricopa.gov

March 13, 2009

Douglas Morgan, MPA
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7A-55
Rockville, MD 20857

Dear Mr. Morgan:

This letter serves as assurance that the Phoenix EMA Ryan White Planning Council has developed and approved this 2009-2012 Comprehensive Plan for the Delivery of Ryan White Part A Services in the Phoenix Eligible Metropolitan Area (EMA).

Led by the our Community Planning & Assessment Committee, the development of this Comprehensive Plan was a collaborative effort that included input from unaffiliated consumers, representatives from local HIV service organizations, the Maricopa County Department of Public Health, the Arizona Department of Health Services, Maricopa Integrated Health Services, the state Medicaid program, and Ryan White Parts B, C and D, among others.

The Phoenix EMA Ryan White Planning Council is committed to ensuring that people living with HIV have access to quality medical care and pharmaceuticals. We believe the goals and activities detailed in our Plan will enable us to improve our continuum of care, become more responsive to the changing epidemic of our community, and efficiently use limited resources to continue to provide quality care.

I am impressed with results of our efforts and am honored to have been involved in the creation of this document.

Please feel free to contact me for any additional information you may require.

Sincerely,

Mark Kezios
Chair
Phoenix EMA Ryan White Planning Council

Acknowledgements

Moving Toward the Future, the Phoenix EMA 2009 to 2012 Comprehensive HIV Services Plan is the culmination of the efforts of many individuals, including:

Larry Stähli, Chair, Community Planning & Assessment Committee
Mark Kezios, Chair, Phoenix EMA Ryan White Planning Council
Rose Conner, Program Manager, Ryan White Part A Program

Supervisor Mary Rose Wilcox, Maricopa County Board of Supervisors
Terri Leija, Chief of Staff, Office of Supervisor Mary Rose Wilcox

Bradley Allen	Corey Boyette	Michael Bryson
Dolores Ceballos	Debby Elliott	Erica Ferguson
Randall Furrow	Abdul Hasan	Jennifer Hawkins
Ron Hill	Fernando Kitcheyan	Patric Hernandez Kline
Regina Lechuga	Ken Leighton-Boster	Dan Lindell
Arcadio Madero	Jay Moman	Eric Moore
Philip Seeger	Seema Sewell	Colin Sheffield
Claire Sinay	Susan Smola	Erica TeKampe
Keith Thompson	Cheri Tomlinson	Don Welsh
Carol Williams		

John Sapero, Program Coordinator, Planning Council Support coordinated the development of this Plan. Staff members of Johnston, Villegas-Grubbs, Abraham and Associates facilitated community forums and contributed to the document. Additional information included in the Plan has been culled from documents prepared by the Phoenix EMA Part A Administrative Agency, Collaborative Research, Inc. and the Taylor-Wilkes Group.

Executive Summary

The Ryan White HIV/AIDS Treatment Modernization Act

The Ryan White HIV/AIDS Treatment Modernization Act (the Act) is a Federal program that provides HIV-related health services for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources. The program works with cities, states, and local community-based organizations to provide services to more than half a million people each year.

Part A of the Treatment Modernization Act provides Eligible Metropolitan Areas (EMAs) with funding for core medical services and essential support service. Core services include primary medical care, pharmaceutical assistance; oral health services; health insurance premium and cost-sharing assistance for low-income individuals; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services. Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, and non-medical case management.

A hallmark of this program is that each Eligible Metropolitan Area that receives Ryan White Part A funding must establish a community group, comprised of people infected and affected by HIV, to determine how to best provide services in their area. In the Phoenix EMA, this group is the Ryan White Planning Council.

The Phoenix EMA Ryan White Planning Council

The Council was established by the Maricopa County Board of Supervisors in 1993 to plan the organization and delivery of HIV services funded by Part A of the Ryan White HIV/AIDS Treatment Modernization Act. Each Council member is a caring, dedicated volunteer who has been carefully selected to reflect the diversity of our community. Members represent the general public, people living with HIV, Part A service providers, and other health and social service organizations.

SOLUTION
AHEAD
INCREASE
SPEED

Planning Council members work together to identify the care needs of people living with HIV. They then determine which services are of the highest priority, and how much Part A funding should be committed to each service. Council members also evaluate the cost effectiveness and the quality of the services provided.

Mission of the Planning Council

It is the mission of the Phoenix EMA Ryan White Planning Council to ensure an integrated, holistic, and comprehensive system of health care for people living with HIV that is culturally appropriate, multilingual, full-service, family-friendly and accessible to the entire community.

Comprehensive Planning

Every three years, Part A Planning Councils are required to develop a comprehensive plan for the provision of services in their area. This plan must include strategies to:

- Ensure the availability and quality of core services;
- Eliminate disparities in access to core medical and supportive services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities;
- Identify HIV-positive persons who are aware of their HIV status but not in care, inform them of the availability of services, and assist them with the use of these services; and
- Evaluate clinical quality measures.

Over the past six months, the Planning Council, in collaboration with a diverse group of stakeholders in our local HIV community, has worked diligently to develop a thoughtful, shared vision for the Phoenix EMA's future continuum of care. Moving Toward the Future, the document before you, is the result of these efforts.

The goals and objectives articulated in this plan are meant to improve the current system of care to meet the needs of the evolving epidemic in the Phoenix EMA, and to help bring into care those individuals who are aware of their HIV infection but are not in care. Activities and timelines have been specified under each goal to reach desired health outcomes.

Comprehensive Planning Methodology

The Planning Council used a rigorous, chronological methodology and a participatory process in the development of the Comprehensive Plan for 2009 to 2012. Work on the Plan began in early 2008, when the Community Planning & Assessment (CPA) Committee met regularly over a three month period to review the progress completed toward the eight goals and activities of the 2006 to 2009 Comprehensive Plan:

Goal 1: Improve delivery of core services and other services to populations with the greatest needs.

Goal 2: Improve entry into care by streamlining the eligibility process.

Goal 3: Identify individuals who are aware of their HIV status and are not in care, and facilitate their entry into care.

Goal 4: Improve access to services through multiple approaches.

Goal 5: Provide a continuum of HIV/AIDS services that is culturally and linguistically appropriate.

Goal 6: Improve operations of the Planning Council and increase consumer involvement.

Goal 7: Improve the integration and coordination among care services and between HIV care and prevention.

Goal 8: Develop standards of care for Ryan White Part A-funded service categories.

The committee determined that four of these goals (1, 2, 6, and 8*)* had been successfully addressed by guidance, directives, resource allocation or specific activities initiated by the Planning Council. Activities related to reaching the remaining Goals (3, 4, 5 and 7) had been completed, but the committee felt that further work was necessitated and these goals would become the basis for discussion when developing goals for the 2009 to 2012 Comprehensive Plan.

Also in 2008, the Health Care Strategies (HCS) work group was coordinating activities to address barriers to care that had been identified by clients in an exhaustive series of needs assessments completed over the previous three years. Consistent themes were the lack of awareness of services and challenges clients faced when documenting their eligibility at intake and recertification.

To address these issues, the HCS work group hosted Many Parts Make a Whole, a series of two half-day strategic planning sessions that focused on identifying common issues experienced by clients when accessing care services, regardless of provider. Participants included representatives from Ryan White Parts A, B, C and D, the state Medicaid program, the Arizona Department of Health Services, the Veterans Administration, Phoenix Indian Medical Center, HIV service organizations

and private physicians. The result of these meetings was the commitment from all participants to collaborate to develop a common eligibility screening process to maximize funding resources, and improve access and retention in care.

Information related to increasing client and provider knowledge of HIV-specific services available in the EMA was forwarded to the Education & Empowerment Committee. Activities developed by the committee to increase community awareness of services have been included in this Plan.

The Role of the Administrative Agency in Planning Efforts

The Planning Council and the Part A Administrative Agency enjoy an outstanding collaborative relationship. Members of the Administrative Agency staff were involved in the Council activities discussed above and also collaborated to collect and compile data related to Part A health outcomes and client satisfaction. Additionally, the Agency hosted a series of work group sessions comprised of representatives of Ryan White Parts B, C and D, Maricopa County HIV Testing and Partner Notification Services, and the state AIDS Drug Assistance Program (ADAP) to identify common service delivery challenges.

Comprehensive Plan Development Process

Once review activities, data collection/analysis, and work-group sessions had been completed, the Community Planning & Assessment Committee met frequently to synthesize all the gathered information. At this stage, Johnston, Villegas-Grubbs, Abraham and Associates (JVGA), a Phoenix-based public sector consulting firm, was contracted to assist with the facilitation of the Comprehensive Planning process and the development of the portions of the Plan document. As in previous years, the Phoenix EMA wanted a process that was inclusive (participation from a variety of stakeholders), interactive (building on existing work and progress that has been made through the years) and comprehensive (incorporating data from a range of sources).

Step 1: Review of Data and Information Already Gathered

The Community Planning & Assessment Committee, Planning Council Support Program Manager and representatives from the Administrative Agency met with JVGA staff to review the 2006 to 2009 Comprehensive HIV Services Plan for the Phoenix EMA along with additional data and information gathered as part of the current planning process. At this meeting, a representative group of stakeholders were identified to participate in the final stages of the planning process. The meeting also provided a forum for the review of progress to date and discussion of obstacles that were discovered in the course of implementing the current plan.

Step 2: Initial Stakeholder Forum
The initial Stakeholder Forum was held on January 7, 2009. A total of twenty individuals attended this forum. Participants included staff members, Council members, the Phoenix EMA Administrative Agent, representatives from Ryan White Parts B, C and D, service providers, HIV positive consumers and other key stakeholders. During this discussion, the group identified seven goal areas on which to develop further action plans:

- Improve quality of core services and other services to everyone
- Improve quality and delivery of services to populations with the greatest disparity and need
- Identify individuals who are aware of their HIV status, are not in care, and facilitate their entry into care
- Improve access to services through multiple approaches
- Improve the integration and coordination among care services and between HIV care and prevention
- Make the eligibility process easier among agencies
- Improve substance abuse service access and utilization

Step 3: Development of a Draft Plan from Ideas Generated at the Forum
JVGA gathered the input from the initial Forum and organized an initial draft of the Comprehensive Plan goals. These were formatted into a chart that detailed each goal, and the objectives, activities, people, outcomes and a timeline (to be identified in annual quarters) needed to reach the goal.

Step 4: Stakeholder Forum for Review and Revision of the Draft
The second Stakeholder Forum was held on January 21, 2009. The participants reviewed each goal and refined objectives and identified potential activities for each goal. Careful consideration was given to defining tangible and measurable outcomes for each activity. During the process the information was refined into the six distinctive goals that are reflected in the final Comprehensive Plan.

Step 5: Finalization of the Plan
JVGA collaborated with the Planning Council Support Program Manager to refine the goals and activities, committee responsibilities and timelines. The goals and objectives for inclusion in the Plan were approved by the full Planning Council on March 12, 2009.

After the goals and activities were approved by the Planning Council, additional community meetings were held to obtain targeted feedback on areas of relevance. The Planning Council Support Program Manager then compiled the final version of the document, which was approved by the Community Planning & Assessment Committee on March 18, 2009.

2009 to 2012 Goals

Goals are not listed in order of importance.

GOAL 1
Improve the quality and delivery of Ryan White core services to increase retention of in care, facilitate the entry of newly diagnosed individuals into care, and eliminate disparities in care in communities of color.

GOAL 2
Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.

GOAL 3
Develop and implement strategies to increase access to services throughout Maricopa and Pinal County through multiple approaches.

GOAL 4
Build on past success to create further administrative efficiencies and coordination of eligibility processes for all HIV clients in the EMA.

GOAL 5
Identify strategies and best practices for appropriate substance abuse service access and utilization.

Review of Secondary Data

Epidemiology

As of February, 2009, there were 9,791 PLWHA reported as living in the EMA, representing fewer than 73% of total cases reported throughout the state. Of the 9,791 PLWHA, 4,659 (48%) are PLWA and 5,132 are PLWH (52%). The majority of the PLWHA are Whites (59%), followed by Hispanics (24%), African American, non Hispanics (12%) and American Indians (2.6%). People of color as a group, including African Americans, Hispanics, American Indians and Asian/Pacific Islanders, represent 40% of PLWHA within the EMA. African Americans are disproportionably impacted by HIV in the Phoenix EMA, representing 3.8% of the EMA's population but accounting for 12% of PLWHA. MSM represent the largest proportion of emergent (62%) and prevalent (61% HIV and AIDS cases.

FIGURE 1: Phoenix EMA Profile (Maricopa and Pinal Counties combined)

2007 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
4,179,427	65.93	78.05	72.95

FIGURE 2: Phoenix EMA HIV/AIDS Current Estimated Prevalence *(AZDHS, 2008)*

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	4395	44.9	208.29	4102	41.9	194.40	8497	86.8	402.69
Female	737	7.5	35.61	557	5.7	26.92	1294	13.2	62.53
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	27	0.3	3.85	5	0.1	0.71	32	0.3	4.56
13-19	43	0.4	10.81	13	0.1	3.27	56	0.6	14.07
20-24	192	2.0	70.75	35	0.4	12.90	227	2.3	83.65
25-29	411	4.2	122.69	155	1.6	46.27	566	5.8	168.96
30-34	540	5.5	173.43	327	3.3	105.02	867	8.9	278.46
35-39	756	7.7	243.76	604	6.2	194.75	1360	13.9	438.51
40-44	994	10.2	339.69	1049	10.7	358.48	2043	20.9	698.17
45-49	976	10.0	340.92	1058	10.8	369.56	2034	20.8	710.49
50-54	601	6.1	241.36	670	6.8	269.07	1271	13.0	510.43
55-59	298	3.0	132.83	401	4.1	178.75	699	7.1	311.58
60-64	160	1.6	86.63	186	1.9	100.71	346	3.5	187.35
65 and Above	121	1.2	25.61	156	1.6	33.01	277	2.8	58.62
Age Unknown	13	0.1	N/A	0	0.0	N/A	13	0.1	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Race / Ethnicity									
White Non-Hispanic	3005	30.7	119.47	2742	28.0	109.02	5747	58.7	228.49
Black Non-Hispanic	637	6.5	346.52	561	5.7	305.18	1198	12.2	651.70
Hispanic	1193	12.2	93.84	1156	11.8	90.93	2349	24.0	184.77
*A/PI/H Non-Hispanic	66	0.7	51.84	43	0.4	33.78	109	1.1	85.62
**AI/AN Non-Hispanic	124	1.3	151.64	133	1.4	162.64	257	2.6	314.28
***MR/O Non-Hispanic	107	1.1	N/A	24	0.2	N/A	131	1.3	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Mode of Transmission									
+MSM	3074	31.4	N/A	2872	29.3	N/A	5946	60.7	N/A
++IDU	531	5.4	N/A	575	5.9	N/A	1106	11.3	N/A
MSM / IDU	322	3.3	N/A	497	5.1	N/A	819	8.4	N/A
Heterosexual	497	5.1	N/A	436	4.5	N/A	933	9.5	N/A
+++O/H/TF/TPR	75	0.8	N/A	43	0.4	N/A	118	1.2	N/A
++++NRR/UR	633	6.5	N/A	236	2.4	N/A	869	8.9	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 3: Phoenix EMA HIV/AIDS Incidence: 2003 to 2007 (AZDHS, 2008)

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	1734	58.6	17.46	809	27.3	8.12	2543	85.9	25.58
Female	299	10.1	3.09	119	4.0	1.22	418	14.1	4.31
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Age									
Under 2	5	0.2	0.81	1	0.0	0.16	6	0.2	0.97
2-12	11	0.4	0.33	0	0.0	0.00	11	0.4	0.33
13-19	50	1.7	2.76	10	0.3	0.52	60	2.0	3.28
20-24	283	9.6	21.19	52	1.8	3.77	335	11.3	24.97
25-29	333	11.2	21.80	114	3.9	7.34	447	15.1	29.14
30-34	335	11.3	21.47	142	4.8	9.13	477	16.1	30.60
35-39	381	12.9	25.83	167	5.6	11.43	548	18.5	37.26
40-44	317	10.7	22.45	181	6.1	12.50	498	16.8	34.94
45-49	156	5.3	11.32	121	4.1	8.89	277	9.4	20.21
50-54	81	2.7	6.95	68	2.3	5.91	149	5.0	12.86
55-59	41	1.4	4.10	35	1.2	3.57	76	2.6	7.67
60-64	25	0.8	3.09	19	0.6	2.42	44	1.5	5.50
65 and Above	15	0.5	0.69	18	0.6	0.84	33	1.1	1.53
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Race / Ethnicity									
White Non-Hispanic	1037	35.0	8.82	422	14.3	3.53	1459	49.3	12.35
Black Non-Hispanic	275	9.3	33.49	104	3.5	12.85	379	12.8	46.34
Hispanic	619	20.9	10.08	354	12.0	5.88	973	32.9	15.96
*A/PI/H Non-Hispanic	28	0.9	4.13	10	0.3	1.88	38	1.3	6.00
**AI/AN Non-Hispanic	57	1.9	16.96	31	1.0	8.80	88	3.0	25.76
***MR/O Non-Hispanic	17	0.6	N/A	7	0.2	N/A	24	0.8	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Mode of Transmission									
+MSM	1283	43.3	N/A	556	18.8	N/A	1839	62.1	N/A
++IDU	198	6.7	N/A	137	4.6	N/A	335	11.3	N/A
MSM / IDU	122	4.1	N/A	51	1.7	N/A	173	5.8	N/A
Heterosexual	206	7.0	N/A	97	3.3	N/A	303	10.2	N/A
+++O/H/TF/TPR	19	0.6	N/A	2	0.1	N/A	21	0.7	N/A
++++NRR/UR	205	6.9	N/A	85	2.9	N/A	290	9.8	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

Emerging Populations with Special Needs

In 2006, the EMA completed Special Studies for African American, Hispanic and Out of Care PLWHA, and Rural PLWHA, including PLWHA who were previously or currently incarcerated in state prisons. In 2007, a special Native American study, MSM-specific needs assessment study and an assessment of Aged PLWHA (45 years and older) were conducted. The Phoenix EMA Planning Council has used this data to create appropriate expansions in certain services to meet the reported needs of each special population and better inform the planning and allocation processes for the EMA overall. The key areas of need have been summarized in the following sections of this plan under the appropriate categories of need.

Needs among Hispanics

The 2006 Hispanic In-Care Needs Assessment surveyed 78 Hispanic PLWHA whose top five expressed Needs for HIV-related services evidence a strong mix of essential and supportive services:

- Medication
- Primary Medical Care
- Transportation
- Group Support
- Food

The demographics of this special population reveal high levels of poverty, substantial unemployment, and great housing instability, with 33 percent of the Hispanic In-Care survey respondents reporting current or recent homelessness. Previous EMA Consumer Surveys (2005) indicate that 17 percent of all Hispanic survey respondents list “Emergency Room” as their primary medical care site.

Needs among African American, non-Hispanics

According to the 2006 Phoenix EMA African American Needs Assessment, the “top 5” HIV service Needs reported by In-Care African Americans were:

- Primary Medical Care
- Housing
- Food
- Support
- Medications

The African American In-Care survey respondents identified service gaps in Dental Care services, Housing Assistance Support, Emergency Financial Assistance, Medications, Transportation, Legal Assistance, Rental Assistance, Eye Care, and Treatment Adherence/Medication reminders.

The primary reasons offered by African American In-Care survey respondents to explain the service gaps were resource-related reasons ("not available," "no resources," "wait list," and eligibility/income restrictions). Some services were perceived as unavailable because "no one cares."

This special population evidences a high rate of co-morbidities, with 55 percent of the respondents reporting diagnosis with and/or treatment for a substance abuse disorder. Additionally, 43 percent of needs assessment survey respondents indicate a diagnosis location other than the Phoenix EMA.

Needs among American Indians

According to the 2007 needs assessment study, the American Indian/Native American PLWHA respondents' reported service Gaps and Barriers evidence their difficulty and/or perceived inability to access some of the most basic services including housing, food and transportation. The reasons for gaps in services and barriers to access include financial limitations, lack of insurance and limitation in access to primary care clinics.

The causes of the health disparities among Native Americans are many and varied. Current research indicates that there are five primary contributors to disparities in health status and outcomes for Native Americans, including:

- Limited access (geographic) to appropriate health facilities
- Poor access to health insurance, including Medicaid, Medicare, and private insurance
- Insufficient federal funding
- Quality of care issues
- Disproportionate poverty and poor education. (Grim Statement, Briefing Transcript, 2003, pp.60-61)

Native Americans in the Phoenix EMA continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries, which is supported in the national literature.

Needs among Incarcerated/ Recently Released (I/RR) Populations

The Planning Council authorized a Needs Assessment survey of the incarcerated federal prisoners in 2006. The survey respondents were 100 percent male, 93 percent were in the 25-54 age group and 56 percent identified their transmission risk as heterosexual contact. 31 percent of respondents were White; 25 percent Hispanic; 38 percent African American; and 6 percent identified as American Indian. Key needs identified in the survey include:

- Seventy-five percent of all respondents reported living with HIV, while 25 percent reported an AIDS diagnosis
- Twenty-five percent of survey respondents report delaying entry into primary medical care more than one year after diagnosis
- Fifty-percent of I/RR respondents required dental care services in the past year, with 31 percent requiring extractions
- 100 percent of the I/RR In-Care population report a history of STIs
- Almost 30 percent of the survey respondents report multiple co-morbidities
- Forty-four percent of survey respondents admit to a history of IDU

Needs among Rural PLWHA (Pinal County)

Pinal County, considered a rural county, is the third largest county in Arizona. The population of Pinal County is 29.9 percent Hispanic, with a racial composition including: 70.4 percent White; 2.8 percent African American; 7.8 percent American Indian; 0.7 percent Asian/Pacific Islander; and 18.4 percent other/mixed race. Pinal County has the third highest number of prevalent cases (331) in the State, yielding an HIV/AIDS prevalence case rate of 162.14 per 100,000 persons. Pinal County's emergent case rate (15.38 per 100,000 persons) is the second highest in the State, with 145 emergent cases of HIV/AIDS reported from 1999 to 2003 (ADHS Integrated Epidemiologic Profile, 2005.)

In 2006, the Phoenix EMA undertook a comprehensive survey of rural PLWHA residing in Pinal County. The top five ranked Gaps (services needed but perceived as inaccessible) for ALL Pinal County respondents were:

- Specialty Medical Care
- Vision Care
- Food Bank
- Support Groups
- Dental Care services

The top three ranked service barriers perceived as hardest to access by ALL Pinal County respondents and prevent the In-Care from accessing needed services were:

- Transportation
- Rural access to services
- Emergency financial assistance

Barriers to HIV treatment and care for rural PLWHA, included:

- Geographic distances to be traversed to reach sources of HIV primary care and support
- Non-existent public transportation
- Stigma and PLWHA fear of breaches in confidentiality
- Absence of a cohesive supportive community for PLWHA
- Shortage of medical and dental specialists and mental health and substance abuse treatment resources
- Rural citizens are frequently less knowledgeable about HIV/AIDS and less tolerant of diversity

Needs among Men who have Sex with Men (MSM)

Based on information provided by AZDHS there are 5,946 MSM PLWHA residing in the EMA as of 08/2008. This represents 61 percent of the total PLWHA within the EMA and represent the highest AIDS Incidence (49 percent) and highest HIV Incidence (50 percent) of any severe need group. Fifteen percent MSM of respondents report having been in jail or prison over the past year. 83 percent are currently receiving ART. According to 2006 CAREWare data, the average primary medical costs for MSM is $1,885 per Ryan White Part A client.

As a group, the MSM survey respondents evidence a high level of co-morbidity. 38 percent report previous diagnosis and/or treatment of mental illness (including 35 percent who have been diagnosed with bipolar disease; 29 percent with major depression; 13 percent with affective disorder; 13 percent with paranoid schizophrenia; and 10 percent report post traumatic stress disorder.

Almost half of the survey respondents (48 percent) report diagnosis and/or treatment for a substance abuse disorder, which correlates with respondents' reported risks for transmission, with 19 percent reporting MSM/IDU and 9 percent reporting sex with IV drug user. Roughly 67 percent of the survey participants report having been treated for a sexually transmitted disease, and 56 percent report having been treated for diseases other than HIV.

The MSM In-Care survey respondents ranked the following service needs:

- Medication
- Primary Medical Care
- Housing
- Food Bank;
- Transportation

Survey respondents ranked the following service barriers:

- Housing
- Social Security / Insurance
- Quality Food - Meals and Food Boxes
- Financial Assistance
- Dentist; dental care

Needs among Aged PLWHA (45 Years or Older)

The 2007 Aged In Care Needs Assessment respondents expressed needs for a mix of essential and supportive services including:

- Medication
- Primary Medical Care
- Housing
- Counseling
- (Tie) Transportation and Alternative and Complementary Therapies

Service barriers evidence difficulty and/or perceived inability to access basic services including transportation and housing (#1 and 2), followed by more sophisticated clinical needs including specialty medical care and medications other than HIV meds that relate to the extensive co-morbidities reported by this subgroup. Service gaps reported were:

- Dental care
- Financial assistance
- Legal help and job counseling
- Housing
- Transportation

In addition to service needs, the isolation of older individuals, compounded by their HIV disease, concerns this group. Dominant issues are the ability to find companionship later in life and concerns about the stigma attached to their HIV disease. Provider disinclination to suspect HIV or even healthy sexual practice was perceived by all 30 individuals to play a role in late diagnosis, poorer health outcomes and in inability or unwillingness to discuss sex.

The Out of Care Population

Based on the 2007 AZDHS data the "Out of Care" (OOC) population in the Phoenix EMA is 87 percent male and 12 percent female. Based on the 2006 Out of Care Needs Assessment, the top five ranking service needs and gaps were:

- Housing
- Clothing
- Food
- Translation Services
- Transportation

A lack of awareness of exact service locations and/or how to access needed services and the lack of funding/insurance/underinsurance are cited by OOC respondents as reasons impeding access to care and services. The "motivators" most frequently cited by the OOC population which would prompt re-entry into care included substance abuse treatment, transportation, higher quality services and better trained physicians and nurses. A significant barrier to care is the fact that a majority of out of care survey respondents reported a history of incarceration. This issue alone makes many of the Out of Care survey respondents "un-house-able." This further complicates their re-entry to care.

55 percent of this population is likely to be homeless or temporarily housed at any given time. The majority of OOC PLWHA report "active substance abuse" as the main reason for their delay into primary medical care and/or their major reason for stopping HIV primary medical care. The crystal meth problem is recognized as a significant contributor to increased high risk sexual behaviors and higher rates of HIV and STI transmission among MSM. When continuously used by OOC MSM, the risk for the transmission of HIV disease to HIV-negative sexual and drug using partners is magnified. Additionally, the OOC survey group reported a high level (65 percent) of co-morbidity with STIs and other serious and chronic health conditions.

Unmet Need

ADHS calculations show that of the 10, 801 PLWHA in the EMA, 6,641 are In-Care and 4,160 are Out of Care or 38.5 percent. Out of Care groups tend to be MSM, IDU or MSM/IDU: 56 percent of all OOC PLWHA report MSM risk and more than 13 percent of all those with unmet need report IDU risk behavior. The majority of the

Phoenix out of care population includes Hispanic and White Males, whose risks include MSM and/or IDU, and are ages 35-54 years. African Americans/Blacks are disproportionately impacted in terms of living HIV/AIDS, new HIV cases, and the out of care. Aggressive efforts are underway to improve data reporting by primary medical providers in order to ensure complete accuracy of the Ryan White Part A unduplicated client figure. In addition, further examination of the private delivery system of care with exposure history, age group and HIV status is scheduled to occur as is review of the military/veterans system of care.

FIGURE 4: 2007 Unmet Need Estimate

Unmet Need	# Out of Care	Percent Out of Care	Percent of General EMA Population
Unmet Need by Race/Ethnicity			
White, non-Hispanic	2,396	58 percent	60 percent
Black	563	14 percent	4 percent
Hispanic	974	23 percent	31 percent
Asian/ Pacific Islander	36	1 percent	3 percent
American Indian/Native American	93	2 percent	2 percent
Multi-Racial/Unknown	98	2 percent	N/A
TOTAL	**4,160**	**100 percent**	
Unmet Need by Gender			
Male	3,623	87 percent	50.5 percent
Female	537	13 percent	49.5 percent
TOTAL	**4,160**	**100 percent**	
Unmet Need by Reported Risk			
MSM	2,342	56 percent	N/A
IDU	547	13 percent	N/A
MSM/IDU	363	9 percent	N/A
Heterosexual	371	9 percent	N/A
Blood Exposure/Other	19	0.6 percent	N/A
Maternal Vertical Transmission	17	0.4 percent	N/A
Not Reported Risk/Unknown Risk	501	12 percent	N/A
TOTAL	**4,160**	**100 percent**	

Conclusion

The Community Planning & Assessment Committee has worked diligently to develop this Comprehensive HIV Services Plan. They have spent substantial amounts of time developing, reviewing and approving the long- and short-term goals and objectives contained in the plan. This work was based upon summaries of evidence-based data sets including epidemiological data, consumer surveys, needs assessment data and an assessment of unmet need. The Plan is now the primary road map for the Phoenix EMA for 2009 to 2012.

Introduction

The Ryan White HIV/AIDS Treatment Modernization Act mandates that planning councils in each Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA) across the country develop a comprehensive plan for the organization and delivery of HIV-related services. In fulfillment of this mandate, and to establish the strategic direction for the Phoenix EMA Ryan White Part A program for the next three years, the Phoenix Ryan White Part A HIV Services Planning Council (the Planning Council) has developed this Comprehensive Plan.

Comprehensive Planning Methodology

The Planning Council used a rigorous, chronological methodology and a participatory process in the development of the Comprehensive Plan for 2009 to 2012. Work on the Plan began in early 2008, when the Community Planning & Assessment (CPA) Committee began a review the progress completed toward the eight goals and activities of the 2006 to 2009 Comprehensive Plan:

- **Goal 1:** Improve delivery of core services and other services to populations with the greatest needs.
- **Goal 2:** Improve entry into care by streamlining the eligibility process.
- **Goal 3:** Identify individuals who are aware of their HIV status and are not in care, and facilitate their entry into care.
- **Goal 4:** Improve access to services through multiple approaches.
- **Goal 5:** Provide a continuum of HIV/AIDS services that is culturally and linguistically appropriate.
- **Goal 6:** Improve operations of the Planning Council and increase consumer involvement.
- **Goal 7:** Improve the integration and coordination among care services and between HIV care and prevention.
- **Goal 8:** Develop standards of care for Ryan White Part A-funded service categories.

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IDEAS

The committee determined that four of these goals (1, 2, 6, and 8) had been successfully addressed by guidance, directives, resource allocation or specific activities initiated by the Planning Council. Activities related to reaching the remaining Goals (3, 4, 5 and 7) had been completed, but the committee felt further work was necessitated and these goals would become the basis for discussion when developing goals for the 2009 to 2012 Comprehensive Plan.

Also in 2008, the Health Care Strategies (HCS) work group was coordinating activities to address barriers to care that had been identified by clients in an exhaustive series of needs assessments completed over the previous three years. Consistent themes were the lack of awareness of services and challenges clients faced when documenting their eligibility at intake and recertification.

To address these issues, the HCS work group hosted Many Parts Make a Whole, a series of two half-day strategic planning sessions that focused on identifying common issues experienced by clients when accessing care services, regardless of provider. Participants included representatives from Ryan White Parts A, B, C and D, the state Medicaid program, the Arizona Department of Health Services, the Veterans Administration, Phoenix Indian Medical Center, HIV service organizations and private physicians. The result of these meetings was the commitment from all participants to collaborate to develop an improved (and ideally, common) eligibility screening process to maximize funding resources, and improve access and retention in care.

The Role of the Administrative Agency in Planning Efforts

The Planning Council and the Part A Administrative Agency enjoy an outstanding collaborative relationship. Members of the Administrative Agency staff were involved in the Council activities discussed above and also collaborated to collect and compile data related to Part A health outcomes and client satisfaction. Additionally, the Agency hosted a series of work group sessions comprised of representatives of Ryan White Parts B, C and D, Maricopa County HIV Testing and Partner Notification Services, and the state AIDS Drug Assistance Program (ADAP) to identify common service delivery challenges.

Comprehensive Plan Development Process

After the initial review activities, data collection/analysis, and work-group sessions had been completed, the Community Planning & Assessment Committee met frequently to synthesize all the gathered information. At this stage, Johnston, Villegas-Grubbs, Abraham and Associates (JVGA), a Phoenix-based public sector consulting firm, was contracted to assist with the facilitation of the Comprehensive Planning process and the development of the portions of the Plan document. As in previous years, the Phoenix EMA wanted a process that was participatory

(including a variety of stakeholders), interactive (building on existing work and progress that has been made through the years) and comprehensive (incorporating data from a range of sources).

Step 1: Review of Data and Information Gathered

The Community Planning & Assessment Committee, Planning Council Support Program Manager and representatives from the Administrative Agency met with JVGA staff to review the 2006-2009 Comprehensive HIV Services Plan for the Phoenix EMA along with additional data and information gathered as part of the current planning process. The meeting also provided a forum for the review of progress to date and discussion of obstacles that were discovered in the course of implementing the current plan. After this careful review, a Stakeholder Forum was developed to gather a representative group of stakeholders together for a thoughtful and thorough discussion of EMA-wide issues, potential solutions and the overall priorities of the HIV community.

Step 2: Initial Stakeholder Forum

The initial Stakeholder Forum was held on January 7, 2009. A total of twenty individuals attended this forum. Participants included staff members, Council members, the Phoenix EMA Administrative Agent, representatives from Ryan White Parts B, C and D, service providers, HIV positive consumers and other key stakeholders. The forum began with an review of the goals and objectives of the 2006-2009 Comprehensive Plan and the CPA Committee's evaluation of the Council's success at reaching the goals. While some of the goals remained relevant, this discussion revealed issues that the participants wanted to focus on during the planning process, including:

- Geographic equity in access to services: A major issue is the gap between how far one has to travel to get services; cultural competency is also important in geographic access to services.
- Data sharing among multiple sources needs to be improved: A large quantity of data is generated by providers and programs. However, data is often not shared across funding sources, or the same information is collected by multiple entities. Improving data sharing will result in more informed decision-making when the Planning Council and other entities attempt to improve the care delivery system.
- Compassionate and professional care: The discussion revealed a concern about what might be done to educate consumers about what to ask providers. Education of consumers on standards of care could increase expectations.
- The system of care is open and inviting: There is a need to make sure clients have a full array of services across a wider continuum that encompasses all providers, regardless of payer source.

After a careful review and adaptation of these issues, the forum participants then focused on the difficult work of creating goals for the new Comprehensive Plan. Through a facilitated discussion the group identified seven goal areas on which to develop further action plans:

- Improve quality of core services and other services to everyone
- Improve quality and delivery of services to populations with the greatest disparity and need
- Identify individuals who are aware of their HIV status, are not in care, and facilitate their entry into care
- Improve access to services through multiple approaches
- Improve the integration and coordination among care services and between HIV care and prevention
- Make the eligibility process easier among agencies
- Improve substance abuse service access and utilization

Step 3: Development of a Draft Plan from Ideas Generated at the Forum

JVGA gathered the input from the initial Forum and organized an initial draft of the Comprehensive Plan goals. Because the Forum had been successful in generating discussion and ideas, JVGA was able to begin the development of objectives to accompany the various issues/goals that were identified by the group. These were formatted into a chart that detailed each goal, and the objectives, activities, people, outcomes and a timeline (to be identified in annual quarters) needed to reach the goal.

Step 4: Stakeholder Forum for Review and Revision of the Draft

The second Stakeholder Forum was held on January 21, 2009. Approximately the same number of participants attended as in the initial forum. A presentation developed by JVGA allowed the group to see, in an organized manner, the work accomplished in the initial forum. The participants then spent time on each Goal and refined objectives and identified potential activities for each goal. Careful consideration was also given to defining tangible and measurable outcomes for each activity. During the process the information was refined into the six distinctive goals that are reflected in the final Comprehensive Plan.

Step 5: Finalization of the Plan

Upon the completion of the second Stakeholder Forum, JVGA collaborated with the Planning Council Support Program Manager to refine the goals and activities, committee responsibilities and timelines. The goals and objectives for inclusion in the Plan were approved by the full Planning Council on March 12, 2009.

After the goals and activities were approved by the Planning Council, additional community meetings were held to obtain targeted feedback on areas of relevance. The final version of the document was approved by the Community Planning & Assessment Committee on March 18, 2009.

The Phoenix EMA: Where We Are Now

The Ryan White HIV/AIDS Treatment Modernization Act

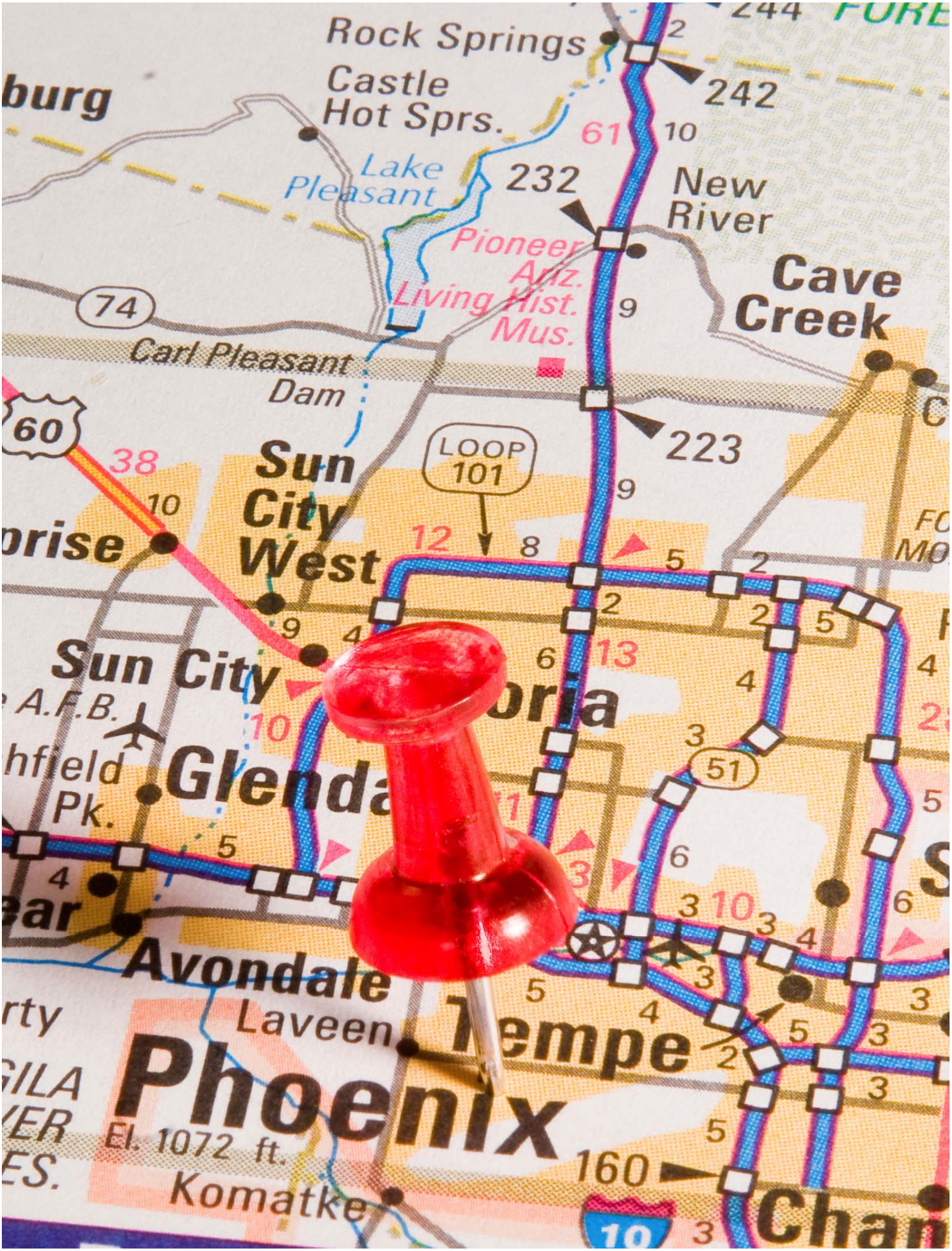
The Ryan White Treatment Modernization Act was enacted by Congress in 2006 as the third reauthorization of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act of 1990. Part A of the Act provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. Part A funds may be used to provide a continuum of care for persons living with HIV disease. Seventy five percent of the grant award must be used for core medical services and 25 percent must be used for support services.

Core services may include outpatient/ambulatory medical care services; pharmaceuticals; oral health services; health insurance premium and cost-sharing assistance for low income individuals; medical nutrition therapy; mental health services; substance abuse outpatient care; and medical case management.

Support services must be linked to medical outcomes and may include outreach, medical transportation, food boxes/home-delivered meals, and non-medical case management.

To learn more about the Ryan White HIV/AIDS Program, visit **http://hab.hrsa.gov/**

Since its inception, a hallmark of Ryan White legislation has been that each Part A EMA that receives Ryan White funding must establish a community group, comprised of people infected and affected by HIV, to determine how to best provide services in their area. In the Phoenix EMA, this group is the Ryan White Planning Council.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The Phoenix EMA Ryan White Planning Council

The Phoenix EMA Ryan White Planning Council is a community group appointed by the Maricopa County Board of Supervisors to plan the organization and delivery of HIV services funded by Part A of the Ryan White HIV/AIDS Treatment Modernization Act. Each council member is a caring, dedicated volunteer who has been carefully selected to reflect the diversity of our community. Members represent the general public, people living with HIV, Part A service providers, HIV/AIDS service organizations, and health and social service programs.

Planning Council members work together to identify the care needs of people living with HIV. The Council then determines which services are of the highest priority, and how much Part A funding should be committed to each service. Council members also evaluate the cost effectiveness and the quality of the services provided.

Mission of the Planning Council

It is the mission of the Phoenix EMA Ryan White Planning Council to ensure an integrated, holistic, and comprehensive system of health care for people living with HIV that is culturally appropriate, multilingual, full-service, family-friendly and accessible to the entire community.

Guiding Principles

In keeping with the guiding principles of the Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB), the paramount purpose of the Ryan White program is to address the health needs of persons living with HIV and AIDS (PLWHA) "by funding primary health care and support services that enhance access to and retention in care."

While recognizing that all services are inter-related, not all service categories are created equal. The ultimate goal is to provide an expansive continuum of care, containing an ideal mix of core and support services that assists PLWHA in the Phoenix EMA to achieve optimal health, well being, and self-determination.

The Phoenix EMA may face, at some future time, issues which place powerful stresses on the HIV continuum of care, including funding changes, increased demand for services and/or increased costs to provide high quality care.

To best make decisions and maintain funding levels that align with the principals of HRSA/HAB and the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the Phoenix EMA Ryan White Planning Council commits itself to the following guiding principles for priority setting and resource allocations:

Service Categories

The Council realizes that restricted funding may necessitate changes to the mix and variety of services available through the Ryan White program. As such, the Council commits itself to the following principles:

- No eligible PLWHA should be denied access to Ryan White primary health care.
- It is a valid practice to rank service categories in order of importance.
- Funding for higher ranked categories should be preserved before lower ranked ones.
- Funding for service categories will be reduced/ eliminated by priority from the bottom up.

Regardless of the amount of federal grants or the demands on services, certain service categories must be fully funded in order to preserve the health of PLWHA in the Phoenix EMA. Those categories include, but are not limited to:

- Primary medical care
- Pharmaceuticals
- Oral health
- Medical case management
- Mental health
- Outpatient substance abuse treatment
- Medical Transportation

Decision Making

The Council commits itself to making the wisest allocation decisions possible. In order to accomplish this goal, decisions will be grounded in reliable data that includes, but is not limited to, the following elements:

- Service utilization
- Epidemiology and demographics
- Population increases
- The cost of providing service
- Health care economics
- Inflationary forces
- The availability of other funding

Service Delivery
The Council has committed to uphold the following principles when developing directives to guide service delivery:

- The continuum of care should be responsive to the emerging needs of the community
- Services should be provided to all PLWHA based on their need for services, not their ability to pay
- Services should be geographically equitable throughout the EMA
- The provision of quality services should be cost effective and efficient
- Services should be culturally and linguistically appropriate for all PLWHA in the EMA

These principles have been the foundation for the decisions made by the Phoenix EMA Planning Council, particularly over the last 3 years. The Phoenix EMA also is committed to using these principles to guide all Planning Council activities in the future Achievements of the past three years will serve as stepping stones to further enhance the delivery of HIV/AIDS services within the EMA.

Summary of 2006 to 2009 Accomplishments

The Phoenix EMA Ryan White Planning Council has made significant strides in the last three years and will capitalize on this positive momentum to make further enhancements in the HIV care delivery system. Accomplishments of the last three years include:

Allocations Committee

- Established a data-driven Priority Setting and Resource Allocations process
- Developed Guiding Principles for Decision-Making to ensure that clients will have access core medical services

Community Planning & Assessment Committee

- Completed nine needs assessments of at-risk and emerging HIV populations within the EMA, including a large-scale (n=599) consumer survey and an assessment of the HIV population aged 45 years and older

Education & Empowerment Committee

- Presented English and Spanish language consumer education forums for nearly 500 PLWHA
- Piloted the Positive Self Management Program, which empowers consumers to coordinate and manage their health care
- Developed the Care Planner resource guide to health care and social services in the Phoenix EMA
- Collaborated with Ryan White Part D on a project funded by the National Library of Medicine to establish an interactive online version of the Care Planner (**www.mihs.org/careplanner)**

Membership Committee

- Increased the diversity of the Council membership, in terms of ethnicity, gender and knowledge/expertise
- Developed ongoing training and mentoring programs for new members
- Created a Leadership Academy to prepare members to take leadership positions on the Council and in the community
- Recruited two individuals to serve as the Planning Council's first Youth (18-24 years old) representatives

Rules Committee

- Revised the Council Bylaws to provide better governance to Council activities
- Guided the development of policies and procedures for Committee activities

Standards Committee

- Developed standards of care for all Part A-funded service categories
- Collaborated with the Part A Quality Management Program to implement quality assurance/improvement programs

Health Care Strategies Work Group

- Collaborated with service providers and community stakeholders to develop guidelines/directives to eliminate barriers to care and increase access to services
- Created the Direct Dental Program to provide immediate oral health services to those not enrolled in the Dental Insurance Program
- Collaborated with the Part A Administrative Agency to develop HIV Care, a marketing initiative to educate the community on the availability of Ryan White services
- Initiated community dialog and collaboration to identify and address common challenges to service provision among multiple entities (Ryan White Parts, VA, Medicaid, etc.)

Part A Administrative Agency

- Developed nationally recognized billing and reporting systems
- Created and piloted a centralized eligibility system for Part A clients
- Strengthened Part A collaboration and communication with Ryan White Parts B, C and D, state and county health departments, and private and non-profit HIV providers
- Implemented the HIV Care consumer education initiative to encourage out-of-care individuals to access services
- Increased the number of Ryan White Part A service providers

Not only has the work of the Planning Council benefited the care delivery system in and around the Phoenix metropolitan area, but members of the Planning Council, Part A Administrative Agency and Planning Council Support staff have become peer-mentors for their counterparts in EMAs nationwide. Documents, policies/ procedures, and activities/programs developed by the Phoenix EMA Planning Council and Administrative Agency have been shared with other EMAs/TGAs as models of best practices/innovations. Additionally, materials developed by the Council and Administrative Agent have been accepted for distribution on **www.careacttarget.org**, a Ryan White technical assistance website.

Milestones in the History of the Phoenix EMA

1983
- The first HIV/AIDS case is reported in the metro Phoenix area.

1984
- The first AIDS walk occurs in downtown Phoenix as a political demonstration organized by Chicanos por la Causa.

1985

1986
- Arizona AIDS Project, one of the first AIDS Service Organizations (ASOs) in Phoenix opens. The agency later becomes AIDS Project Arizona.
- AZT becomes the first medication approved to treat HIV disease.

1987
- TERROS begins HIV testing services.

1988
- Phoenix Shanti (substance abuse services) opens.
- AGAPE Network begins providing food boxes to PLWH.

1989
- The McDowell Healthcare Clinic (primary medical care) opens.
- Aunt Rita's Foundation is formed to raise funds for HIV care.

1990
- Arizona passes HIV confidentiality law.
- Body Positive opens, providing wellness services and complimentary therapies.
- The Ryan White CARE Act is approved by the federal government.

1991
- Ryan White Title III (Part C) funds are granted to the Phoenix area.

1992
- The Maricopa County AIDS Partnership (MCAP) is formed to address the growing HIV epidemic.
- Maricopa County receives Ryan White Title II (Part B) funds for case management and other services.

1993
- The Title I (Part A) Phoenix Eligible Metropolitan Area (EMA) is established.
- MCAP members become the first Ryan White Title I (Part A) Planning Council.

1994
- The McDowell Healthcare Clinic becomes a Ryan White provider.
- The Ryan White Part A Dental Insurance Program is initiated.

1995
- Protease inhibitors approved for use in the treatment of HIV.

1996

1997
- Management/coordination of the Title I (Part A) Planning Council transitions to the Maricopa County Department of Public Health.

1998
- Phoenix Children's Hospital/Bill Holt Clinic becomes a Ryan White pediatric provider.
- Maricopa County receives Ryan White Title IV (Part D) funds.

1999

2000
- Women-specific HIV clinic established at McDowell Healthcare Clinic.
- Camp Hakuna Matata, a summer camp for children with HIV, opens.

2001

2002

2003

2004
- Routine rapid testing in labor/delivery rooms begins in the EMA.
- The Care Planner resource/care management guide is published.
- AIDS Project Arizona/AIDS Walk Arizona close.

2005
- HIV/QUAL standards implemented in the Phoenix area.
- The Planning Council institutes a policy that 75% of its grant award must fund Core Services, one year before HRSA mandates this requirement nationwide.

2006
- The Planning Council approves its first directives to guide service delivery.
- The Planning Council pilots an Out of Care initiative and Direct Dental Program.

2007
- Phoenix Indian Medical Center becomes a Ryan White provider.
- The Part A Administrative Agency is nationally recognized for its innovative management.

2008
- AIDS Walk Phoenix is reintroduced .
- Consent laws are simplified to encourage routine HIV testing by all medical providers.

2009
- The Planning Council completes standards of care for all Part A services.
- The first phase of Part A centralized eligibility/enrollment is completed.

Profile: The Phoenix EMA

The Phoenix EMA's estimated 2007 population was 4,179,427, representing 66 percent of the state's population. Arizona is the second fastest growing state in the nation and Maricopa County is the fourth most populous county in the nation. Pinal County is the 7th fastest growing county in the nation among those counties with populations greater than 10,000 persons. The EMA has seen a 26 percent increase in population since the 2000 Census.

The EMA accounts for 73 percent of the prevalent cases of HIV/AIDS. Pinal County has the third highest HIV/AIDS prevalence rate next to Maricopa and Pima (Tucson) counties. Approximately 30 percent of the prevalent cases and 60 percent of the emergent cases of HIV/AIDS in Pinal County are attributable to the incarcerated persons housed there. The EMA's population is predominantly White with a significant and increasing Hispanic minority.

According to 2007 population estimates from the US Census Bureau, the EMA's demographics are 59 percent White, non-Hispanic, 4 percent African American, 29 percent Hispanic, 6 percent American Indian, 1.6 percent Asian/Pacific Islander, and approximately 1.5 percent other or multiple races. The Phoenix EMA has a combined HIV/AIDS prevalence of 9,791 persons. Of all cases, 87 percent are among males; 13 percent are among females. 59 percent are White; 12 percent are African American, 24 percent are Hispanic, 3 percent are American Indian and 1 percent are Asian/Pacific Islander (ADHS, 2008).

FIGURE 5: Map of Arizona Counties

Geography

The EMA's land area is approximately 15,000 square miles. Most PLWHA in the EMA are centralized in urban Greater Phoenix Metropolitan: 95 percent of the EMA's total PLWHA resides in Maricopa County and 5 percent reside in Pinal County.

Maricopa County

Maricopa County, Arizona, is the nation's fourth largest county in terms of population—nearly 3.9 million—and the 14th largest in the continental United States in land area, covering 9,203 square miles. The county was named in honor of the Maricopa Indians, who were known to have inhabited the area as early as 1775. Maricopa County continues to be one of the fastest growing regions in the United States. According to the U.S. Census Bureau, the county has grown from 2,122,100 residents in 1990 to 3,880,181 in 2007, representing a 77 percent increase in just 16 years.

Twenty-five cities and towns are located in the county; its largest city, Phoenix, is the capital of the state and the largest city in Arizona with an estimated 2006 population of 1,512,986. The remainder of the county is rural and includes the communities of Cave Creek, Goodyear, Buckeye, Wickenburg and Queen Creek.

Demographics

Maricopa County made up nearly 62 percent of the State's total population in 2007. About 90 percent of the population is represented by the White or Hispanic demographic categories.

The racial composition of the population is 59.5 percent white; 4.7 percent African American; 2.1 percent Native American; and 3 percent Asian/Pacific Islander. 30.5 percent of the population identifies as being of Hispanic origin. 1.7 percent of all persons reported being of two or more races. The gender of population is evenly distributed (50.4 percent male, 49.6 percent female). The median age is 33 years (2000 census), just under the median age for all of Arizona.

Socioeconomics

The economic base of Maricopa County includes computer chip production, aerospace, advanced business services, transportation/distribution/wholesale trade, tourism, and retirement and second home. While the military is responsible for over 13,000 jobs in Maricopa County, it represents less than 1.0 percent of the County's total non-agriculture employment. Compared to the U.S., educational attainment in Maricopa County in terms of both high school and college degrees is slightly above average.

Maricopa County is the most affluent county in Arizona, with a median income of $48,304 compared to $43,693 in the rest of the state. However, there is a large gap between affluent, near poor and poor households. Census statistics indicate that 13 percent of persons in Maricopa County live in poverty. Twenty percent of those living in poverty are under the age of 18 and 29 percent of these children are younger than five (Annie E. Casey Foundation KIDS Count! Databook). Forty percent of all Arizona children live in households at or below 200 percent of federal poverty level (FPL). Poverty is also high among young adults with 22 percent of Arizonans 18 to 24 living at or below FPL.

The 2005 Phoenix EMA Consumer Survey found that overall, 46 percent of PLWHA report incomes less than FPL, and 88 percent earn less than 300 percent FPL. Nearly 60 percent of Hispanic and African American PLWHA reported earning less than 100 percent FPL. The majority of IDU (94 percent) report incomes at or below 200 percent FPL. Asymptomatic PLWH reported the lowest income, suggesting that the newly infected are from the lowest socio-economic brackets and will display a high level of need for social and medical services.

For most of the past decade, Arizona's unemployment rate has remained below the national average. Maricopa County is now the fifth most populated county in the U.S. and until the national economic downturn in 2008 had seen unprecedented job growth in almost all sectors of the economy. In particular, the service, retail and construction industries absorbed a large number of unskilled workers. The decline in the area's housing market, along with nationwide economic pressures began rippling throughout the area's economy during 2008. The State's seasonal unemployment rate jumped to 6.5 percent in January 2009. Although minimum wage service and retail jobs remain available, many governmental employers have instituted hiring freezes and personnel cuts due to declining tax revenues.

Affected Community

Maricopa County, which includes the Phoenix metropolitan area, is home to 66 percent of Arizona's residents and 69 percent of Arizona's prevalent HIV and AIDS cases. In contrast to other parts of the U.S., the HIV/AIDS epidemic in Arizona continues to be predominantly composed of Whites and males. Females make up 12 percent to 13 percent of reported HIV/AIDS cases in the County and the State compared to the U.S. epidemic profile of 25 to 30 percent.

In 2007, there were approximately 1,525 women, children and youth living with HIV and AIDS in the County. Maricopa County has a higher HIV/AIDS prevalence rate among youth than found in the State, due to the concentration of the general population and PLWHA in the County.

Pinal County

Rural Pinal County was formed from portions of Maricopa and Pima counties in 1875. Florence was designated the county seat and is home to both the Pinal County government complex and the Arizona State Prison. Pinal County is the third most populous county in Arizona.

Pinal County encompasses 5,370 square miles and is made up of two distinct regions: the eastern mountainous portion and the western portion, comprising primarily low desert valleys. This mixed geography presents challenges in attempting to meet the varied and widespread health coverage issues of the HIV/AIDS population. Incorporated cities include Florence, Superior, Kearney, Coolidge, and Eloy.

Demographics

Pinal County experienced a population increase of 66.5 percent from April 1, 2000 to July 1, 2007, when the population was estimated at 299,246. Pinal County's racial composition is similar to that of Arizona as a whole, with approximately 91 percent of the population represented by White or Hispanic demographic categories. The population of Pinal County is composed of 29.6 percent persons of Hispanic ethnicity; with racial composition including: 59.1 percent white; 3.9 percent African American; 6.1 percent Native American; and .1 percent Asian/ Pacific Islander. Within these percentages, 1.4 percent identified as being of two or more races. The median age of the population is 37 years (2000 census). Females make up 47.9 percent of the population.

Socioeconomics

The current economic base of Pinal County includes mining, agriculture, government, tourism, retirement and second home. Pinal County had a 9.3 percent unemployment rate as of January 2009. 72.7 percent are high school graduates (below average when compared to Arizona), and 11.9 percent hold a college degree (2004).

The median household income (2007) is $49,909. 12.5 percent of the population is composed of persons living below the poverty level (compared to 13.9 percent for all of Arizona). The Pinal County per capita personal income rate has been on the decline since 1993. Possible reasons for this include: 1) a larger than average portion of the population is retired; and 2) the mix of jobs has shifted from high wage mining to typically lower paying State and local government-related, trade and services jobs. (Arizona Statewide Economic Study, 2002)

Affected Community

Pinal County has the third highest number of prevalent cases (600) in the State, yielding an HIV/AIDS prevalence case rate of 200.50 per 100,000 persons. Pinal County's emergent case rate (18.66 per 100,000 persons) is the second highest in the State, having 230 emergent cases of HIV/AIDS reported from 2003 to 2007. (2008 HIV Annual Report, Arizona Department of Health Services)

The prison population makes a significant impact on the HIV epidemic in Pinal County. Prisoners make up 5.2 percent of the total population of Pinal County, yet comprise almost 30 percent of the County's prevalent cases (99 of 331 persons) and almost 60 percent of the emergent cases in Pinal County (2005 ADHS).

HIV/AIDS Epidemiological Profile

As of February, 2009, there were 9,791 PLWHA reported as living in the EMA, representing fewer than 73% of total cases reported throughout the state. Of the 9,791 PLWHA, 4,659 (48%) are PLWA and 5,132 are PLWH (52%).

The 2009 AZDHS epidemiological profile notes:

- The majority of the PLWHA are Whites (59%), followed by Hispanics (24%), African American, non Hispanics (12%) and American Indians (2.6%).
- People of color as a group, including African Americans, Hispanics, American Indians and Asian/Pacific Islanders, represent 40% of PLWHA within the EMA.
- African Americans are disproportionably impacted by HIV/AIDS in the Phoenix EMA, representing 3.8% of the EMA's population but accounting for 12% of PLWHA.
- MSM represent the largest proportion of emergent (62%) and prevalent (61% HIV and AIDS cases.

FIGURE 6: Phoenix EMA Profile (Maricopa and Pinal Counties combined)

2007 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
4,179,427	65.93	78.05	72.95

FIGURE 7: Maricopa County Profile

2007 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
3,880,181	61.21	69.63	68.48

FIGURE 8: Pinal County Profile

2007 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
299,246	4.72	8.41	4.47

FIGURE 9: Phoenix EMA HIV/AIDS Current Estimated Prevalence (AZDHS, 2008)

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	4395	44.9	208.29	4102	41.9	194.40	8497	86.8	402.69
Female	737	7.5	35.61	557	5.7	26.92	1294	13.2	62.53
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	27	0.3	3.85	5	0.1	0.71	32	0.3	4.56
13-19	43	0.4	10.81	13	0.1	3.27	56	0.6	14.07
20-24	192	2.0	70.75	35	0.4	12.90	227	2.3	83.65
25-29	411	4.2	122.69	155	1.6	46.27	566	5.8	168.96
30-34	540	5.5	173.43	327	3.3	105.02	867	8.9	278.46
35-39	756	7.7	243.76	604	6.2	194.75	1360	13.9	438.51
40-44	994	10.2	339.69	1049	10.7	358.48	2043	20.9	698.17
45-49	976	10.0	340.92	1058	10.8	369.56	2034	20.8	710.49
50-54	601	6.1	241.36	670	6.8	269.07	1271	13.0	510.43
55-59	298	3.0	132.83	401	4.1	178.75	699	7.1	311.58
60-64	160	1.6	86.63	186	1.9	100.71	346	3.5	187.35
65 and Above	121	1.2	25.61	156	1.6	33.01	277	2.8	58.62
Age Unknown	13	0.1	N/A	0	0.0	N/A	13	0.1	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Race / Ethnicity									
White Non-Hispanic	3005	30.7	119.47	2742	28.0	109.02	5747	58.7	228.49
Black Non-Hispanic	637	6.5	346.52	561	5.7	305.18	1198	12.2	651.70
Hispanic	1193	12.2	93.84	1156	11.8	90.93	2349	24.0	184.77
*A/PI/H Non-Hispanic	66	0.7	51.84	43	0.4	33.78	109	1.1	85.62
**AI/AN Non-Hispanic	124	1.3	151.64	133	1.4	162.64	257	2.6	314.28
***MR/O Non-Hispanic	107	1.1	N/A	24	0.2	N/A	131	1.3	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**
By Mode of Transmission									
+MSM	3074	31.4	N/A	2872	29.3	N/A	5946	60.7	N/A
++IDU	531	5.4	N/A	575	5.9	N/A	1106	11.3	N/A
MSM / IDU	322	3.3	N/A	497	5.1	N/A	819	8.4	N/A
Heterosexual	497	5.1	N/A	436	4.5	N/A	933	9.5	N/A
+++O/H/TF/TPR	75	0.8	N/A	43	0.4	N/A	118	1.2	N/A
++++NRR/UR	633	6.5	N/A	236	2.4	N/A	869	8.9	N/A
TOTAL	**5132**	**52.4**	**122.79**	**4659**	**47.6**	**111.47**	**9791**	**100.0**	**234.27**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 10: Phoenix EMA HIV/AIDS Incidence: 2003 to 2007

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	1734	58.6	17.46	809	27.3	8.12	2543	85.9	25.58
Female	299	10.1	3.09	119	4.0	1.22	418	14.1	4.31
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Age									
Under 2	5	0.2	0.81	1	0.0	0.16	6	0.2	0.97
2-12	11	0.4	0.33	0	0.0	0.00	11	0.4	0.33
13-19	50	1.7	2.76	10	0.3	0.52	60	2.0	3.28
20-24	283	9.6	21.19	52	1.8	3.77	335	11.3	24.97
25-29	333	11.2	21.80	114	3.9	7.34	447	15.1	29.14
30-34	335	11.3	21.47	142	4.8	9.13	477	16.1	30.60
35-39	381	12.9	25.83	167	5.6	11.43	548	18.5	37.26
40-44	317	10.7	22.45	181	6.1	12.50	498	16.8	34.94
45-49	156	5.3	11.32	121	4.1	8.89	277	9.4	20.21
50-54	81	2.7	6.95	68	2.3	5.91	149	5.0	12.86
55-59	41	1.4	4.10	35	1.2	3.57	76	2.6	7.67
60-64	25	0.8	3.09	19	0.6	2.42	44	1.5	5.50
65 and Above	15	0.5	0.69	18	0.6	0.84	33	1.1	1.53
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Race / Ethnicity									
White Non-Hispanic	1037	35.0	8.82	422	14.3	3.53	1459	49.3	12.35
Black Non-Hispanic	275	9.3	33.49	104	3.5	12.85	379	12.8	46.34
Hispanic	619	20.9	10.08	354	12.0	5.88	973	32.9	15.96
*A/PI/H Non-Hispanic	28	0.9	4.13	10	0.3	1.88	38	1.3	6.00
**AI/AN Non-Hispanic	57	1.9	16.96	31	1.0	8.80	88	3.0	25.76
***MR/O Non-Hispanic	17	0.6	N/A	7	0.2	N/A	24	0.8	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**
By Mode of Transmission									
+MSM	1283	43.3	N/A	556	18.8	N/A	1839	62.1	N/A
++IDU	198	6.7	N/A	137	4.6	N/A	335	11.3	N/A
MSM / IDU	122	4.1	N/A	51	1.7	N/A	173	5.8	N/A
Heterosexual	206	7.0	N/A	97	3.3	N/A	303	10.2	N/A
+++O/H/TF/TPR	19	0.6	N/A	2	0.1	N/A	21	0.7	N/A
++++NRR/UR	205	6.9	N/A	85	2.9	N/A	290	9.8	N/A
TOTAL	**2033**	**68.7**	**10.32**	**928**	**31.3**	**4.69**	**2961**	**100.0**	**15.00**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 11: Maricopa County HIV/AIDS Current Estimated Prevalence (AZDHS, 2008)

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	4138	45.0	211.76	3826	41.6	195.80	7964	86.6	407.56
Female	695	7.6	36.08	532	5.8	27.62	1227	13.4	63.70
TOTAL	**4833**	**52.6**	**124.56**	**4358**	**47.4**	**112.31**	**9191**	**100.0**	**236.87**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	24	0.3	3.67	5	0.1	0.76	29	0.3	4.43
13-19	41	0.4	11.05	12	0.1	3.24	53	0.6	14.29
20-24	185	2.0	74.47	31	0.3	12.48	216	2.4	86.95
25-29	386	4.2	126.08	145	1.6	47.36	531	5.8	173.44
30-34	494	5.4	170.69	294	3.2	101.58	788	8.6	272.27
35-39	698	7.6	240.38	559	6.1	192.51	1257	13.7	432.89
40-44	935	10.2	340.76	978	10.6	356.44	1913	20.8	697.20
45-49	929	10.1	345.98	982	10.7	365.72	1911	20.8	711.69
50-54	572	6.2	245.79	636	6.9	273.30	1208	13.1	519.09
55-59	287	3.1	137.34	388	4.2	185.67	675	7.3	323.00
60-64	157	1.7	92.10	179	1.9	105.01	336	3.7	197.11
65 and Above	112	1.2	25.90	149	1.6	34.46	261	2.8	60.36
Age Unknown	13	0.1	N/A	0	0.0	N/A	13	0.1	N/A
TOTAL	**4833**	**52.6**	**124.56**	**4358**	**47.4**	**112.31**	**9191**	**100.0**	**236.87**
By Race / Ethnicity									
White Non-Hispanic	2916	31.7	124.78	2646	28.8	113.23	5562	60.5	238.01
Black Non-Hispanic	606	6.6	350.40	526	5.7	304.15	1132	12.3	654.55
Hispanic	1043	11.3	88.19	1005	10.9	84.98	2048	22.3	173.17
*A/PI/H Non-Hispanic	56	0.6	45.86	38	0.4	31.12	94	1.0	76.98
**AI/AN Non-Hispanic	111	1.2	169.24	120	1.3	182.96	231	2.5	352.20
***MR/O Non-Hispanic	101	1.1	N/A	23	0.3	N/A	124	1.3	N/A
TOTAL	**4833**	**52.6**	**124.56**	**4358**	**47.4**	**112.31**	**9191**	**100.0**	**236.87**
By Mode of Transmission									
+MSM	2962	32.2	N/A	2757	30.0	N/A	5719	62.2	N/A
++IDU	451	4.9	N/A	492	5.4	N/A	943	10.3	N/A
MSM / IDU	298	3.2	N/A	444	4.8	N/A	742	8.1	N/A
Heterosexual	466	5.1	N/A	406	4.4	N/A	872	9.5	N/A
+++O/H/TF/TPR	69	0.8	N/A	42	0.5	N/A	111	1.2	N/A
++++NRR/UR	587	6.4	N/A	217	2.4	N/A	804	8.7	N/A
TOTAL	**4833**	**52.6**	**124.56**	**4358**	**47.4**	**112.31**	**9191**	**100.0**	**236.87**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 12: Maricopa County HIV/AIDS Incidence: 2003 to 2007

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	1598	58.5	17.46	743	27.2	8.12	2341	85.7	25.58
Female	280	10.3	3.09	110	4.0	1.22	390	14.3	4.31
TOTAL	**1878**	**68.8**	**10.32**	**853**	**31.2**	**4.69**	**2731**	**100.0**	**15.00**
By Age									
Under 2	5	0.2	0.81	1	0.0	0.16	6	0.2	0.97
2-12	10	0.4	0.33	0	0.0	0.00	10	0.4	0.33
13-19	48	1.8	2.76	9	0.3	0.52	57	2.1	3.28
20-24	264	9.7	21.19	47	1.7	3.77	311	11.4	24.97
25-29	312	11.4	21.80	105	3.8	7.34	417	15.3	29.14
30-34	301	11.0	21.47	128	4.7	9.13	429	15.7	30.60
35-39	348	12.7	25.83	154	5.6	11.43	502	18.4	37.26
40-44	300	11.0	22.45	167	6.1	12.50	467	17.1	34.94
45-49	140	5.1	11.32	110	4.0	8.89	250	9.2	20.21
50-54	74	2.7	6.95	63	2.3	5.91	137	5.0	12.86
55-59	39	1.4	4.10	34	1.2	3.57	73	2.7	7.67
60-64	23	0.8	3.09	18	0.7	2.42	41	1.5	5.50
65 and Above	14	0.5	0.69	17	0.6	0.84	31	1.1	1.53
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**1878**	**68.8**	**10.32**	**853**	**31.2**	**4.69**	**2731**	**100.0**	**15.00**
By Race / Ethnicity									
White Non-Hispanic	998	36.5	8.82	400	14.6	3.53	1398	51.2	12.35
Black Non-Hispanic	258	9.4	33.49	99	3.6	12.85	357	13.1	46.34
Hispanic	532	19.5	10.08	310	11.4	5.88	842	30.8	15.96
*A/PI/H Non-Hispanic	22	0.8	4.13	10	0.4	1.88	32	1.2	6.00
**AI/AN Non-Hispanic	52	1.9	16.96	27	1.0	8.80	79	2.9	25.76
***MR/O Non-Hispanic	16	0.6	N/A	7	0.3	N/A	23	0.8	N/A
TOTAL	**1878**	**68.8**	**10.32**	**853**	**31.2**	**4.69**	**2731**	**100.0**	**15.00**
By Mode of Transmission									
+MSM	1214	44.5	N/A	527	19.3	N/A	1741	63.7	N/A
++IDU	153	5.6	N/A	121	4.4	N/A	274	10.0	N/A
MSM / IDU	111	4.1	N/A	44	1.6	N/A	155	5.7	N/A
Heterosexual	196	7.2	N/A	88	3.2	N/A	284	10.4	N/A
+++O/H/TF/TPR	17	0.6	N/A	2	0.1	N/A	19	0.7	N/A
++++NRR/UR	187	6.8	N/A	71	2.6	N/A	258	9.4	N/A
TOTAL	**1878**	**68.8**	**10.32**	**853**	**31.2**	**4.69**	**2731**	**100.0**	**15.00**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

Figure 13: Pinal County HIV/AIDS Current Estimated Prevalence (AZDHS, 2008)

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	257	42.8	164.76	276	46.0	176.94	533	88.8	341.70
Female	42	7.0	29.32	25	4.2	17.45	67	11.2	46.77
TOTAL	**299**	**49.8**	**99.92**	**301**	**50.2**	**100.59**	**600**	**100.0**	**200.50**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	3	0.5	6.33	0	0.0	0.00	3	0.5	6.33
13-19	2	0.3	7.42	1	0.2	3.71	3	0.5	11.14
20-24	7	1.2	30.51	4	0.7	17.43	11	1.8	47.94
25-29	25	4.2	86.70	10	1.7	34.68	35	5.8	121.38
30-34	46	7.7	209.64	33	5.5	150.40	79	13.2	360.04
35-39	58	9.7	293.39	45	7.5	227.63	103	17.2	521.02
40-44	59	9.8	323.50	71	11.8	389.30	130	21.7	712.80
45-49	47	7.8	264.52	76	12.7	427.74	123	20.5	692.26
50-54	29	4.8	178.01	34	5.7	208.70	63	10.5	386.72
55-59	11	1.8	71.60	13	2.2	84.62	24	4.0	156.22
60-64	3	0.5	21.09	7	1.2	49.21	10	1.7	70.30
65 and Above	9	1.5	22.41	7	1.2	17.43	16	2.7	39.83
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**299**	**49.8**	**99.92**	**301**	**50.2**	**100.59**	**600**	**100.0**	**200.50**
By Race / Ethnicity									
White Non-Hispanic	89	14.8	49.92	96	16.0	53.84	185	30.8	103.76
Black Non-Hispanic	31	5.2	284.82	35	5.8	321.57	66	11.0	606.39
Hispanic	150	25.0	169.16	151	25.2	170.29	301	50.2	339.45
*A/PI/H Non-Hispanic	10	1.7	192.23	5	0.8	96.12	15	2.5	288.35
**AI/AN Non-Hispanic	13	2.2	80.31	13	2.2	80.31	26	4.3	160.62
***MR/O Non-Hispanic	6	1.0	N/A	1	0.2	N/A	7	1.2	N/A
TOTAL	**299**	**49.8**	**99.92**	**301**	**50.2**	**100.59**	**600**	**100.0**	**200.50**
By Mode of Transmission									
+MSM	112	18.7	N/A	115	19.2	N/A	227	37.8	N/A
++IDU	80	13.3	N/A	83	13.8	N/A	163	27.2	N/A
MSM / IDU	24	4.0	N/A	53	8.8	N/A	77	12.8	N/A
Heterosexual	31	5.2	N/A	30	5.0	N/A	61	10.2	N/A
+++O/H/TF/TPR	6	1.0	N/A	1	0.2	N/A	7	1.2	N/A
++++NRR/UR	46	7.7	N/A	19	3.2	N/A	65	10.8	N/A
TOTAL	**299**	**49.8**	**99.92**	**301**	**50.2**	**100.59**	**600**	**100.0**	**200.50**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

Figure 14: Pinal County HIV/AIDS Incidence: 2003 to 2007

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	136	59.1	21.03	66	28.7	10.20	202	87.8	31.23
Female	19	8.3	3.24	9	3.9	1.54	28	12.2	4.78
TOTAL	**155**	**67.4**	**12.58**	**75**	**32.6**	**6.08**	**230**	**100.0**	**18.66**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	1	0.4	0.53	0	0.0	0.00	1	0.4	0.53
13-19	2	0.9	1.75	1	0.4	0.87	3	1.3	2.62
20-24	19	8.3	20.68	5	2.2	5.44	24	10.4	26.13
25-29	21	9.1	20.44	9	3.9	8.76	30	13.0	29.20
30-34	34	14.8	39.32	14	6.1	16.19	48	20.9	55.52
35-39	33	14.3	40.82	13	5.7	16.08	46	20.0	56.91
40-44	17	7.4	21.10	14	6.1	17.38	31	13.5	38.48
45-49	16	7.0	21.32	11	4.8	14.66	27	11.7	35.98
50-54	7	3.0	10.12	5	2.2	7.23	12	5.2	17.34
55-59	2	0.9	3.02	1	0.4	1.51	3	1.3	4.53
60-64	2	0.9	3.31	1	0.4	1.65	3	1.3	4.96
65 and Above	1	0.4	0.56	1	0.4	0.56	2	0.9	1.12
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**155**	**67.4**	**12.58**	**75**	**32.6**	**6.08**	**230**	**100.0**	**18.66**
By Race / Ethnicity									
White Non-Hispanic	39	17.0	5.30	22	9.6	2.99	61	26.5	8.29
Black Non-Hispanic	17	7.4	43.29	5	2.2	12.73	22	9.6	56.02
Hispanic	87	37.8	23.71	44	19.1	11.99	131	57.0	35.71
*A/PI/H Non-Hispanic	6	2.6	39.23	0	0.0	0.00	6	2.6	39.23
**AI/AN Non-Hispanic	5	2.2	6.67	4	1.7	5.34	9	3.9	12.01
***MR/O Non-Hispanic	1	0.4	N/A	0	0.0	N/A	1	0.4	N/A
TOTAL	**155**	**67.4**	**12.58**	**75**	**32.6**	**6.08**	**230**	**100.0**	**18.66**
By Mode of Transmission									
+MSM	69	30.0	N/A	29	12.6	N/A	98	42.6	N/A
++IDU	45	19.6	N/A	16	7.0	N/A	61	26.5	N/A
MSM / IDU	11	4.8	N/A	7	3.0	N/A	18	7.8	N/A
Heterosexual	10	4.3	N/A	9	3.9	N/A	19	8.3	N/A
+++O/H/TF/TPR	2	0.9	N/A	0	0.0	N/A	2	0.9	N/A
++++NRR/UR	18	7.8	N/A	14	6.1	N/A	32	13.9	N/A
TOTAL	**155**	**67.4**	**12.58**	**75**	**32.6**	**6.08**	**230**	**100.0**	**18.66**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

Disproportionate Impact on Emerging Populations

The HIV/AIDS epidemic is continuing to evolve and there is a disproportionate impact on emerging populations in the EMA. To better understand the needs of the EMA's at risk populations, the Planning Council initiated a three-year series of focused needs assessments. The Planning Council's 2005 Consumer Survey (n=599) was a broad-based comprehensive assessment that identified factors influencing HIV/AIDS service and need patterns within the Phoenix EMA. Highlights of this assessment include:

- The ethnic composition of women living with HIV and AIDS looks quite different from men living with HIV and AIDS. The plurality is White (48%) and one-quarter Hispanic. Although the absolute number of African American-non-Hispanics is small compared to Whites, women with HIV and AIDS are disproportionately African American, non-Hispanic (23%) given that only 3.8% of the general population includes African American non-Hispanic men and women.
- Roughly one-third of intravenous drug users (IDU) are women.
- Over 70% of those infected through heterosexual contact are women
- While the majority of IDU are White (54%), the African American, non-Hispanic IDU are disproportionately represented (20%).
- Transgender individuals represent 1% of all PLWHA, and are largely represented in communities of color, particularly among African American, non-Hispanic and Hispanic.
- Of the total undocumented population, 96% are Hispanic and 4% are Blacks from Africa.

African Americans

Trends of emergent HIV infection among all racial ethnic groups in Arizona are reflective of the state's broader population trends with the clear exception of African American, non-Hispanics. Non-Hispanic African Americans were only 3.4 percent of Arizona's population in 2006 (US Census Bureau, 2006) yet accounted for 11 percent in 2005, increasing to 15 percent of emergent HIV and AIDS cases in 2006.

In the Phoenix EMA, African American, non-Hispanics make up only 4 percent of the general population in the Phoenix EMA, but account for nearly 12 percent (n=1,198) of all PLWHA in the EMA. The rate of current HIV/AIDS in this population is 651 per 100,000 which is nearly three times that of the EMA overall. Based on 2007 Ryan White Primary Medical CAREWare utilization statistics, 88 or 13 percent African American, non-Hispanic PLWHA receive primary care services through Ryan White Part A. This represents a 65 percent increase from 2005.

Additionally, according to 2006 CAREWare reports, the average primary care cost for an African American Ryan White Part A client is $1,835.75. According to Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, there are 356 African American, non-Hispanics that receive primary care services through AHCCCS. The Veterans Administration in Phoenix reports a total client load of 300. Based on 2007 AZDHS estimates, there are 484 (13 percent) African American, non-Hispanic PLWHA Out-of-Care. Results of the 2006 African American Needs Assessment Study were utilized in the Planning Council's 2008 Priority Setting and Resource Allocation (PSRA) process.

African Refugees

According to the U.S. Bureau of Populations in 2001:

- Over 3,000 refugees arrive annually in Arizona, with 80% resettled in Phoenix.
- About 25 million refugees and immigrants account for 10% of the U.S. population
- 45% of African refugees resettled in the U.S. are of Somali origin;
- Roughly 13,000 Somali-Bantu refugees have been resettled in the U.S. since 2003
- Across all African-born immigrants, Somalis have the lowest English fluency and educational attainment, tend to be unemployed and are of lower socio-economic status
- Somali immigrants have been shown most likely to be uninsured, to lack a usual source of care, and the least likely to receive a routine health screening or well-woman exam in the past year

American Indian Population

Arizona has the seventh largest American Indian population in the United States. Roughly 6,400 American Indians/Alaska Natives were added to Arizona's population between July 1, 2003 and July 1, 2004. That is the largest numeric increase of any state in the nation. Maricopa County added roughly 3,000 people from this group during this same time frame. Maricopa County led all U.S. counties in this category (U.S. Census, August 2005).

While rural Arizona is thought of as the home of most tribal lands, the Phoenix EMA has two large tribal reservations, several smaller ones and a number of multi-tribal communities. More tribes and reservations are located within the Phoenix EMA than in any other Part A EMA/TGA. American Indians are increasingly urbanized and comprise the state's second largest minority group. Forty percent (47 percent) of Arizona's American Indians reside in the EMA. There are an estimated 267 American Indians are living with HIV/AIDS in the Phoenix EMA, representing 3.2 percent of total cases.

According to the Arizona Health Care Cost Containment System, there are 89 American Indians, who receive primary care services through AHCCCS. The average primary care cost for a Native American Ryan White Part A client is $890.48. While this average cost is significantly lower than other special need populations, American Indians have access to Indian Health Services, a significant primary care facility located within the Phoenix EMA. Based on 2007 AZDHS estimates, there are 90 American Indian PLWHA Out of Care (3 percent of the total OOC population).

Nationally, American Indians have the highest rates of co-morbidities including: diabetes, alcoholism, tuberculosis, pneumonia, and influenza among all racial and ethnic groups. One-third of all American Indians/Alaskan Natives who die before age 45 do so because of drug and alcohol abuse (HRSA/HAB, 2006).

Hispanics

In 2006, Hispanics of all races were 29.2 percent of the state population. For the reporting period 1/1/05 to 12/31/06, Hispanics represent 31.4 percent of the total emergent AIDS cases (n=217) and 30.8 percent (n=257) of emergent HIV cases. Hispanics represent 23 percent of living HIV/AIDS cases (n=1,882). From January-June 2006, 47 percent of new HIV infections (n=43) within the EMA are among Hispanic persons, mainly Hispanic males. (Maricopa County Department of Public Health Counseling and Testing Division, 2006).

According to 2006 Part A CAREWare data, the average primary medical costs for Hispanics are the highest, totaling $2,389.42 per Ryan White Part A client. AHCCCS, the state's Medicaid program, estimates there are 375 Hispanics that receive primary care services from AHCCCS providers. Based on 2007 AZDHS estimates, there are 835 (23 percent) Hispanic PLWHA who are Out of Care.

The Homeless

The Arizona Department of Economic Security (DES) estimates that there are between 12,000 and 15,000 homeless persons in Maricopa County (Maricopa Association of Governments 10- Year Regional Plan to End Homelessness). The DES 2002 HUD Housing Gaps Analysis concluded that unmet housing needs are dramatic. There are more than 500 PLWHA in immediate need of housing assistance, with many more individuals in danger of losing their housing in the near future. Locally, the major causes of homelessness include the lack of affordable housing for minimum wage and service industry workers, poor correctional facility pre-release planning, and low and declining levels of public assistance, including a woefully under-funded behavioral health system. Limited access to comprehensive healthcare delays the identification of HIV infection and accelerates the onset of AIDS. The 2005 Phoenix EMA Consumer Survey indicated intravenous drug users (IDUs) and Men Who Have Sex with Men (MSM)/IDU are much more likely to have been homeless. Intravenous drug use has historically been a greater contributor to HIV infection and AIDS diagnoses for women in the County as compared to men. Housing can be especially precarious for HIV-infected women with children who must balance the costs of childcare and medications. Maricopa County

Department of Public Health's Healthcare for the Homeless (HCH) clinic, the major provider of medical services to the Phoenix area's homeless population, estimates that 1 percent to 2 percent of clients are living with HIV/AIDS. This number has been increasing each year and in 2007, 36 clients (2 percent of all served through Ryan White programs) lacked permanent housing.

Incarcerated Populations

Current data suggest that HIV prevalence in the state's prison system among incarcerated individuals may be substantially higher than reported. Reported rates of HIV infection among prisoners are known to be more than four times the state average. Prisoners are 0.56 percent of the state population, but account for 2.4 percent of reported HIV/AIDS prevalence and 6.1 percent of 5-year HIV/AIDS emergence for Arizona. According to 2006 CAREWare data, the average primary medical costs for Incarcerated total $2,389.42 per Ryan White Part A client. Prisons experience high HIV/AIDS rates because demographic and behavioral factors among prison populations concur with prevailing HIV/AIDS demographic and behavioral factors (AZDHS, Executive Summary HIV/AIDS Annual Report, March 2006). In Arizona, all known prisoners diagnosed with HIV/AIDS are transferred to Arizona Department of Corrections (DOC) in Florence, Arizona (Pinal County). For this reason, the Phoenix EMA Planning Council commissioned a Needs Assessment for Pinal County, which included surveys with PLWHA incarcerated individuals to determine service needs, barriers and gaps they anticipate upon release.

Men who have Sex with Men (MSM)

Men who have Sex with Men constitute 61 percent of all living HIV/AIDS cases within the EMA. AZDHS estimates that 9 percent of MSMs in the EMA are living with HIV/AIDS. From 1/1/05 to 12/31/06, there were 437 new MSM AIDS cases (62 percent) and 545 new MSM HIV cases (65 percent) reported to CDC. Based on 2007 AZDHS estimates, there are 1,983 (55 percent) men who have sex with men who are Out-of-Care. According to 2006 CAREWare data, the average primary medical costs for MSM total $1,885 per Ryan White Part A client.

The Uninsured

Arizona has a greater percentage of uninsured residents (18 percent) compared to the U.S. average (15 percent) (US Census Bureau Income Poverty and Health Insurance Coverage in the U.S. 2006). Data from the 2006 US Census estimates the total rate of uninsured people in this community at 22 percent. The Phoenix EMA 2005 Consumer Survey revealed that only 20 percent of PLWHA have private insurance, COBRA, or other insurance sources. Whites and MSM are more likely to report private insurance. According to the recent Annie E. Casey Foundation Kids Count! Databook, nearly 90 percent of Arizona's children have health insurance coverage. Children are more likely than adults to have insurance coverage through Medicaid.

AHCCCS data show that 1,876 PLWHA in Maricopa County had AHCCCS coverage during 2006. Of PWLHA with AHCCCS coverage, 453 were women. Based on the number of women in Maricopa County identified with HIV or AIDS in 2006, it is estimated that 46 percent of female PLWHA had public insurance coverage. There were 311 women cared for at the McDowell Health Care Center during 2006, with a mix of payer sources. Combining the numbers of all women in the County receiving care in the County indicates that approximately 15 percent of female PLWHA lack health insurance coverage, increasing the likelihood that they will go without or delay seeking care.

Women, Children and Youth

Maricopa County is home to 93 percent of all Arizona females living with HIV/AIDS, and has a higher HIV/AIDS prevalence rate for females than for all females in the state. Females make up a smaller proportion of reported HIV infections and AIDS cases (12 percent to 13 percent) in the County and the State as compared to the U.S. epidemic profile (25 percent - 30 percent).

In 2006, there were approximately 1,250 women, children and youth living with HIV/AIDS in the County. Maricopa County has a higher HIV/AIDS prevalence rate among youth than found in the State due to the concentration of the general population and PLWHA in the County.

In 2007 there were 315 children and youth under 24 years in the Phoenix EMA living with HIV. By 2009, this number increased to 61. Most children are between the ages of 2 and 12. The number of children with HIV infection, not AIDS, has remained four times greater than the number with AIDS.

While Maricopa County has had less than 100 recorded cases of mother-to-infant HIV transmission, the potential for future maternal-child transmission is apparent given the dramatic increase of HIV incidence associated with increased age. Like adult PLWHA, most children and youth living with HIV/AIDS reside in Maricopa County. Accessible, continuous medical and behavioral health care that emphasizes ongoing treatment and support is needed for youth coming of age with HIV infection.

Assessment of Emerging Populations with Special Needs

Since 2004, the Part A Planning Council has completed needs assessments of special and emerging populations unique to the EMA: African Americans, Hispanic Out of Care PLWHA, Rural PLWHA, including PLWHA who were previously or currently incarcerated in state prisons. In 2007, a special Native American study, MSM-specific needs assessment study and an assessment of Aged PLWHA (45 years and older) were conducted. The Phoenix EMA Planning Council has used this data to create appropriate expansions in certain services to meet the reported needs of each special population and better inform the planning and allocation processes for the EMA overall. The key areas of need have been summarized in the following sections of this plan under the appropriate categories of need.

Needs among African American, non-Hispanics

Non-Hispanic African American PLWHA represent the fastest growing racially impacted special population in the EMA.

Similar to the Hispanic population, African American, non-Hispanics have a higher Part A cost per client ($2,430) than most other severe need groups.

In 2006, the Phoenix EMA conducted a needs assessment of the In-Care special population of African Americans to better understand the service needs, gaps and barriers of this disproportionately impacted population. This special population evidences high unemployment (58 percent); low income levels; a current homelessness rate of 34 percent, with a total current or previous homelessness rate of 53 percent; and a high rate of co-morbidities, with 55 percent of the respondents reporting diagnosis with and/or treatment for a substance abuse disorder. Additionally, 43 percent of needs assessment survey respondents indicate a diagnosis location other than the Phoenix EMA. Many respondents cited Eastern and Midwestern cities such as New York, Philadelphia, Boston, Minneapolis and Milwaukee as locations where they first learned of their HIV infection. While new infections continue to rise in the Phoenix EMA, the care system is furthered burdened by the relocation of individuals to the Phoenix EMA who were diagnosed in other jurisdictions.

The top five HIV service Needs reported by In-Care African Americans, include:

- Primary Medical Care
- Housing
- Food
- Support
- Medications

The African American In-Care respondents ranked the following service gaps:

- Dental Care services
- Housing Assistance Support
- Emergency Financial Assistance
- Alternative/Complimentary Therapies
- Medications

The primary reasons offered by African American In-Care survey respondents to explain the service gaps were resource-related reasons ("not available," "no resources," "wait list," and eligibility/income restrictions). Some services were perceived as unavailable because "no one cares."

Needs among Aged PLWHA (45 Years or Older)

The 2007 Aged In Care Needs Assessment surveyed PLWHA over 45 years of age in the Phoenix EMA whose top expressed needs for HIV-related services evidence a mix of essential and supportive services including:

- Medications
- Primary Medical Care
- Housing
- Counseling
- Transportation (tie)
- Alternative and Complementary Therapies (tie)

Service barriers evidence difficulty and/or perceived inability to access basic services including transportation and housing (#1 and 2), followed by more sophisticated clinical needs including specialty medical care and medications other than HIV meds that relate to the extensive co-morbidities reported by this subgroup.

Service gaps reported were:

- Dental care
- Financial assistance
- Legal help and job counseling
- Housing
- Transportation

These barriers to services create challenges in facilitating entry into and retention in HIV primary medical care for the growing numbers of Aged (45 years+) persons living with HIV/AIDS in the Phoenix EMA.

Today, this population continues to experience significant rates of other co morbidities, including diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Over half of the group (30 individuals) report more than three co morbid conditions, with half qualifying as disabled due to their HIV disease. Over a third are Anglo MSM, almost 30 percent are women of whom 2 are substance abusers and 6 are injection drug users (remainder high-risk heterosexual); 18 percent are Anglo heterosexual males, and 14 percent are African American Males.

Most respondents seemed satisfied with medical coverage and were vigilant about routine checks regarding their HIV status. Long-term survivors (over 15 years diagnosed with HIV or diagnosed before 1992) are a significant subset among the largest group, Anglo MSM. This subset consists of 22 individuals with 17 or 75 percent of the subgroup self-managing their care or 30 percent (17/56) of the entire respondent pool. They reported similar themes as the 8 African American MSM diagnosed later in their disease state—profound distrust of HIV medications, ability or perception of ability to self manage their care, and disdain for a 'dependence' system of HIV case management. Eighty percent of this largest subgroup have professional backgrounds and believe that they understand navigation of the care system as well or better than case managers currently working in the system.

Other service needs reported by the entire group relate to the needs of aging individuals—financial security; long-term care including legal, financial assistance and higher prioritization of 'other medications', and home health care and hospice as desired services to maintain 'in care' status.

Needs among American Indians

There are an estimated 267 American Indian PLWHA in the Phoenix EMA (3 percent of the total population of PLWHA). During the 2005-2006 time period, AZDHS reported 23 new AIDS cases and 26 new HIV cases. Costs associated with delivering services to this population increase for a variety of cultural and behavioral issues, particularly for those residing in rural areas (Pinal County) or on a reservation. Using cost estimates, service utilization data, and the recent consumer survey the cost of care ranges from $1,668 (low estimate) to $5,013 (high estimate) per person per year, largely dependent on the number and severity of co-morbid conditions.

According to the 2007 needs assessment study, the American Indian/Native American PLWHA respondents' reported service Gaps and Barriers evidence their difficulty and/or perceived inability to access some of the most basic services:

- Medications
- Food
- Housing
- Transportation
- Primary Medical Care

The reasons given for gaps in services and barriers to access include financial limitations, lack of insurance and limitation in access to primary care clinics.

Native Americans in the Phoenix EMA continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries, which is supported in the national literature. Native Americans are 770 percent more likely to die from alcoholism; 650 percent more likely to die from tuberculosis; 420 percent more likely to die from diabetes; 280 percent more likely to die from accidents; and 52 percent more likely to die from pneumonia or influenza than other Americans, including White and minority populations. (Director of Indian Health Services, Dr. Charles W. Grim, Statement in 108th Congress, 2003, regarding Indian Health Care Improvement Act Amendments of 2003) Dr. David Satcher stated, for example, that the Pima Native Americans of Arizona have one of the highest rates of diabetes in the world (HHS, "Satcher Testimony", 2000).

The causes of the health disparities among Native Americans are many and varied. Current research indicates that there are five primary contributors to disparities in health status and outcomes for Native Americans, including:

- Limited access (geographic) to appropriate health facilities
- Poor access to health insurance, including Medicaid, Medicare, and private insurance
- Insufficient federal funding
- Quality of care issues
- Disproportionate poverty and poor education. (Grim Statement, Briefing Transcript, 2003, pp.60-61)

Needs among Hispanics

The 2006 Hispanic In-Care Needs Assessment surveyed 78 Hispanic PLWHA whose top five expressed Needs for HIV-related services evidence a strong mix of essential and supportive services:

- Medication
- Primary Medical Care
- Transportation
- Group Support
- Food

The demographics of this special population reveal high levels of poverty, substantial unemployment, and great housing instability, with 33 percent of the Hispanic In-Care survey respondents reporting current or recent homelessness. The 2005 Consumer Survey discussed that 17 percent of all Hispanic survey respondents listed "Emergency Room" as their primary medical care site. Hispanic PLWHA reported ER utilization is the highest among all severe need group respondents. Combined with the latest epidemiological statistics showing 217 newly diagnosed AIDS cases among Hispanics (the second highest group), it would indicate Hispanic PLWHA are late to care; have higher service need level acuity than other severe need populations; lack health insurance; and require significant medical and supportive services.

Hispanic PLWHA have the highest Part A primary medical care cost per client of all severe need groups within the EMA at $2,639 per client.

Needs among Incarcerated/Recently Released (I/RR) Populations

The Incarcerate/Recently Released population exerts a huge impact on the HIV epidemic in the Phoenix EMA and particularly within Pinal County. Prisoners make up 5.2 percent of the total population of Pinal County, yet comprise almost 30 percent of the County's prevalent cases (99 of 331 persons) and almost 60 percent of the emergent HIV/AIDS cases in Pinal County (ADHS, 2005). In Arizona, since prison policy requires that inmates be screened for HIV upon intake or at discharge only on the inmate's request, the number of reported HIV infections that occur while in prison is significantly underreported (ADHS Integrated Epidemiologic Profile, 2005).

Despite this fact, prison-based HIV testing performed in 2004 yielded a 1.3 percent HIV positivity rate, which translates into 7 times the estimated rate of HIV infection in the general population. The prison system currently houses more than 148 HIV-

positive inmates and reports releasing approximately 120 HIV-positive inmates into the community each year. (AZ DOC). It must also be noted that according to the *Integrated Epidemiologic Profile, ADHS, 2005,* Hispanics account for the highest percentage of reported cases of HIV among incarcerated inmates (38.6 percent followed by White non-Hispanic inmates at 37.7 percent). Additionally, the most common risk behavior associated with HIV transmission among current inmates with HIV infection is intravenous drug use at 40.8 percent.

The Planning Council authorized a Needs Assessment survey of the incarcerated federal prisoners in 2006. The survey respondents were 100 percent male, 93 percent were in the 25-54 age group and 56 percent identified their transmission risk as heterosexual contact. In terms of racial background, 31 percent of respondents were White; 25 percent Hispanic; 38 percent African American; and 6 percent identified as American Indian.

Key needs identified in the survey include:

- 19 percent of inmates do not yet know where they will live upon release from the prison, evidencing a continuous state of homelessness and/or temporary and unstable housing.
- Twenty-five percent (25 percent) of survey respondents report delaying entry into primary medical care more than one year after diagnosis.
- Fifty-percent (50 percent) of I/RR respondents required dental care services in the past year, with 31 percent requiring extractions.
- 100 percent of the I/RR In-Care population report a history of sexually transmitted infections.
- Almost one-third (30 percent) of the survey respondents report multiple co-morbidities, including 38 percent reporting a history of hepatitis; 6 percent cardiac conditions; 44 percent mental health conditions; 12 percent hypertension; 12 percent Diabetes; and 25 percent report a history of tuberculosis. Additionally, survey respondents report a high level of mental health disorders: 31 percent report depression, a mood disorder, bipolar disorder, or schizophrenia.
- Forty-four percent (44 percent) of survey respondents admit to a history of IDU, including the intravenous use of cocaine, crystal methamphetamine and heroin; and 86 percent of the I/RR survey respondents who admit to history of IDU also admit to having shared needles and/or drug paraphernalia with others.

Needs among Men who have Sex with Men (MSM)

AZDHS estimates there are 5,946 MSM PLWHA residing in the EMA as of 08/2008. This represents 61 percent of the total PLWHA within the EMA and represent the highest AIDS Incidence (49 percent) and highest HIV Incidence (50 percent) of any severe need group. Fifteen percent MSM of respondents report having been in jail or prison over the past year. Sixty-seven or 83 percent are currently receiving ART. The average primary medical costs for MSM is $1,885 per Ryan White Part A client.

The highest priority HIV service needs reported by the MSM In-Care survey participants, in rank order, include:

- Medication
- Primary Medical Care
- Housing
- Food Bank;
- Transportation
- Family Support

As a group, the MSM survey respondents evidence a high level of co-morbidity. 38 percent report previous diagnosis and/or treatment of mental illness (including 35 percent have been diagnosed with bipolar disease; 29 percent with major depression; 13 percent with affective disorder; 13 percent with paranoid schizophrenia; and 10 percent report post traumatic stress disorder). Almost half of the survey respondents (48 percent) report diagnosis and/or treatment for a substance abuse disorder, which correlates with respondents' reported risks for transmission, with 19 percent reporting MSM/IDU and 9 percent reporting sex with IV drug user. Roughly 67 percent of the survey participants report having been treated for a sexually transmitted disease, and 56 percent report having been treated for diseases other than HIV.

The MSM survey group is characterized by a high degree of current and/or previous homelessness and housing instability. 15 percent report they are currently homeless; 22 percent report having been homeless within the past two years, but not now; and 21 percent report a previous period of homelessness longer than two years ago.

Needs among Rural PLWHA (Pinal County)

Rural Pinal County is the third largest county in Arizona. The mixed geography of the County presents challenges in attempting to meet the varied and widespread health coverage issues of the rural PLWHA residents. The population of Pinal County is 29.9 percent Hispanic, with a racial composition including: 70.4 percent White; 2.8 percent African American, non-Hispanic; 7.8 percent American Indian; 0.7 percent Asian/Pacific Islander; and 18.4 percent other/mixed race.

Pinal County has the third highest number of prevalent cases (331) in the State, yielding an HIV/AIDS prevalence case rate of 162.14 per 100,000 persons. Pinal County's emergent case rate (15.38 per 100,000 persons) is the second highest in the State, with 145 emergent cases of HIV/AIDS reported from 1999 to 2003 (ADHS Integrated Epidemiologic Profile, 2005.)

In 2006, the Phoenix EMA undertook a comprehensive survey of the Needs, Uses, Gaps and Barriers expressed by rural PLWHA residing in Pinal County. The results of this survey revealed that the top five ranked Gaps were:

- Specialty Medical Care
- Vision Care
- Food Bank
- Support Groups
- Dental Care services

Barrier reasons to HIV treatment and care for rural PLWHA, which must be bridged include:

- Geographic distances to be traversed to reach sources of HIV primary care and support
- Non-existent public transportation
- Stigma and PLWHA fear of breaches in confidentiality
- Absence of a cohesive supportive community for PLWHA
- Shortage of medical and dental specialists and mental health and substance abuse treatment resources
- Rural citizens are frequently less knowledgeable about HIV/AIDS and less tolerant of diversity

The Out of Care Population

The Arizona Department of Health Services estimates that the Out of Care (OOC) population in the Phoenix EMA at 4,160 individuals, or more than 38 percent of the EMA's total PLWHA population. Of this number, 87 percent are male and 12 percent female. Based on the findings of the Planning Council's 2006 Out of Care Needs Assessment, 55 percent of this population is likely to be homeless or temporarily housed at any given time.

The top five ranking service Needs and Gaps reported by the entire Out of Care respondent group include:

- Housing
- Clothing
- Food
- Translation Services
- Transportation

A lack of awareness of exact service locations and/or how to access needed services and the lack of funding/insurance/underinsurance are cited by Out of Care respondents as reasons impeding access to care and services. The motivators most frequently cited by the OOC population which would prompt re-entry into care included substance abuse treatment, transportation, higher quality services and better trained physicians and nurses. A significant barrier to care is the fact that a majority of out of care survey respondents reported a history of incarceration. This issue alone makes many of the Out of Care survey respondents ineligible for housing programs. This further complicates their re-entry to care.

Barriers to Care

The Phoenix EMA experiences many unique service delivery challenges that are associated with increasing costs and complexities in the provision of HIV/AIDS care. The EMA has experienced explosive growth that is mirrored in the expanding PLWHA population. Arizona is the second-fastest growing state in the country and the EMA represents over 65 percent of the state's population. Phoenix is the fifth largest city in the US and experienced the greatest increase in population during the last decade among all US metropolitan areas with populations greater than one million persons. According to the US Census Bureau, from July 1, 2005 to July 1, 2007, Maricopa County added 240,669 new residents, representing a 3.6 percent year-over year increase. Roughly, 40 percent of Maricopa County's population is comprised of persons of color.

- As of July 1st, 2007, Pinal County reported a total population of 293,312. From July 1, 2005 to July 1, 2007, Pinal County added 53,268 new residents, representing a 12.9 percent year-over-year increase. Roughly, 41 percent of Pinal County residents are minorities. Pinal County's population grew 19 percent between 2000 and 2004, ranking it the fastest growing county in Arizona. A burgeoning population growth, compounded by a lack of transportation and an inadequate service infrastructure have further compounded the barriers to care and strained available resources in the EMA.

- Health resources in the rural areas are scarce and the infrastructure has not caught up to the growing need. In Pinal County, one hospital and two community health centers are the only public healthcare facilities for the County's 293,312 residents within a 5,370 square mile radius. Public transportation in the rural areas is essentially nonexistent, so most PLWHA access primary and specialty care in Phoenix, up to a two hour drive each way.

- Many of the new persons presenting with HIV to the service system were diagnosed in a different locality. AIDS Service Organizations (ASOs) report a notable in-migration to the Phoenix EMA not only from other Arizona counties that do not have Part A services but also from other states. For these persons, the EMA is a magnet due to its urban nature and range of available services.

- The number of PLWHA is increasing at a rate higher than resources. Being a border state, Arizona's infrastructure is further strained with foreign immigration, which also contributes to cultural barriers unique to the Phoenix EMA.

- The EMA's moderate incidence, and increasing prevalence, coupled with reductions in unmet need all contribute to an expanding PLWHA population in service, which now threatens to maximally stretch and exceed all available Part A funds. From 2006 to 2007 the EMA experienced a 10.4 percent increase in HIV/AIDS prevalence and successfully reduced the level of unmet need in the service area from 39.31 percent to 38.51 percent of the total PLWHA. A total of 1,078 PLWHA were added to the 'In Care' fraction from 2006 to 2007, representing a 12 percent increase among all PLWHA.

- Co-morbidities of populations have a more significant impact on PLWHA because of the limited healthcare resources available to treat these co-morbidities. Ryan White resources must address these issues. Cocci co-infection is unique to the EMA. Quantitative data indicates that persons with substance abuse issues, TB, STI, co-morbidities, and homeless require more resources in comparison to those without these issues. To meet the diverse needs of PLWHA, the EMA's Ryan White programs must provide mental health and substance abuse services that are otherwise lacking due to the absence of state funds.

- According to the U.S. Census Bureau, Arizona ranked third in the nation for its high percentage of uninsured population (20.3 percent versus national average of 15.9 percent). Nearly one-half (48 percent) of Arizona residents are covered by government health care insurance programs, and greater than one in four (27.7 percent) Arizonians are uninsured. Hispanics, persons without a high school diploma, persons with incomes below the federal poverty level, and residents of central cities are uninsured at a rate higher than the general population Undocumented citizenship status further restricts many Hispanics' access to care.
- In 2000, the eligibility level for AHCCCS (Arizona Medicaid) was raised from 34 percent FPL to 100 percent FPL, resulting in an increase in enrollment. AHCCCS notes that the adult enrollees in this new category have a high level of unmet need for health care services and have proven to be a very expensive service group.
- With the EMA's low rate of private health insurance, especially among certain populations, the group of PLWHA lacking insurance coverage yet ineligible for AHCCCS is proportionally larger than in other states and EMAs. Compounding this issue is that the HIV/AIDS infection rates are occurring within communities with no health insurance coverage and such persons are increasingly reliant on Ryan White funded services for HIV primary medical and specialty care.

Unmet Need Estimate

AZDHS calculations show that of the 10,801 PLWHA in the EMA, 6,641 are In Care and 4,160 are Out of Care (38.5 percent).

FIGURE 15: PLWHA that are NOT in any Medical Care, Phoenix EMA, 2007

Unmet Need	# Out of Care	Percent Out of Care	Percent of General EMA Population
Unmet Need by Race/Ethnicity			
White, non-Hispanic	2,396	58 percent	60 percent
Black	563	14 percent	4 percent
Hispanic	974	23 percent	31 percent
Asian/ Pacific Islander	36	1 percent	3 percent
American Indian/Native American	93	2 percent	2 percent
Multi-Racial/Unknown	98	2 percent	N/A
TOTAL	**4,160**	**100 percent**	
Unmet Need by Gender			
Male	3,623	87 percent	50.5 percent
Female	537	13 percent	49.5 percent
TOTAL	**4,160**	**100 percent**	
Unmet Need by Reported Risk			
MSM	2,342	56 percent	N/A
IDU	547	13 percent	N/A
MSM/IDU	363	9 percent	N/A
Heterosexual	371	9 percent	N/A
Blood Exposure/Other	19	0.6 percent	N/A
Maternal Vertical Transmission	17	0.4 percent	N/A
Not Reported Risk/Unknown Risk	501	12 percent	N/A
TOTAL	4,160	100 percent	

(Source: AZDHS, 2008)

Out of Care groups tend to be MSM, IDU or MSM/IDU. 56 percent of all OOC PLWHA report MSM risk and more than13 percent of all those with unmet need report IDU risk behavior. The majority of the Phoenix EMA's Out of Care population are Hispanic and White Males, whose risks include MSM and/or IDU, and are ages 35-54 years. African Americans/Blacks are disproportionately impacted in terms of living HIV/AIDS, new HIV cases, and the Out of Care. Aggressive efforts are underway to improve data reporting by primary medical providers in order to ensure complete accuracy of the Ryan White Part A unduplicated client figure. In addition, further examination of the private delivery system of care with exposure history, age group and HIV status is scheduled to occur as is review of the military/veterans system of care.

Assessment of Unmet Need

Throughout the epidemic in Arizona, the majority of emergent HIV infections have been among men, who comprise 86 percent of both all confirmed emergent HIV infections and current HIV estimated prevalence. Arizona currently estimates that nearly 1 in 10 MSM statewide are infected with HIV. This figure rises to nearly 1 in 4 MSM who are between the ages of 35 and 49 years. Maricopa and Pinal counties together include 66 percent of the state's population, 74 percent of MSM HIV/AIDS prevalence, and 78 percent of MSM emergent HIV infection (2009 Integrated Epidemiologic Profile, ADHS).

MSM, and in particular, MSM of color (primarily African American MSM), have a disproportionate level of unmet need. In Maricopa County, for every 1.28 MSM in care there is one MSM out of care. In Pinal County, for every 0.96 MSM in care there is 1 MSM out of care.

Eighty-two percent (82 percent) of all prevalent and emergent infections among IDU are men and 58 percent of the prevalent IDU cases are White. The majority of IDU-related infections are found in the urban counties. However, Pinal County has twice the proportion of emergent IDU cases as its proportion of the state population. HIV-positive IDU are less likely to be in primary care and support services than HIV-positive non-IDU MSM. In Maricopa County, where 59 percent of all IDU HIV/AIDS cases are reported, there are 1.03 IDU persons in care for every 1 who is out of care. In Pinal County, for every 0.82 HIV-positive IDU who is in care, there is one who is out of care (2009 Integrated Epidemiologic Profile, ADHS). High Risk Heterosexuals (HRH) comprise 9.9 percent of prevalent HIV/AIDS cases and 10.9 percent of emergent infections in Arizona. Among HRH, women outnumber men by a ratio of nearly 2.5 to 1 among prevalent cases and 2 to 1 among emergent cases. The greatest number of HRH cases are White but, as with MSM racial and ethnic IDU, minorities are disproportionately affected (2005 Integrated Epidemiologic Profile, ADHS). For every 1.32 HRH who is in care in Maricopa County there is one HRH who is out of care. In Pinal County, for every 0.89 HIV-positive HRH who is in care, there is one HIV-positive one HRH who is out of care.

Prevention Needs

The Planning Council has an excellent collaborative relationship with the Arizona Department of Health Services, Office of HIV, STD and Hepatitis C Services, the entity responsible for leading the HIV prevention efforts within the State. Many of the services identified in this plan are linked to the priorities of preventive services within Arizona.

Effective prevention policy focuses upon groups most adversely impacted by HIV/AIDS, or known to be at greater risk of transmitting HIV infection. Certain special need populations have a much higher rate of identification of new cases of HIV/AIDS than others (Hispanics, African Americans and Incarcerated individuals) and this is a common concern for both the Planning Council and prevention programs.

In Arizona, there is a clear and alarming impact of HIV/AIDS in the African American community. African Americans in Arizona experience an epidemic of HIV/AIDS that is at least 3 times more severe than any other race/ethnic group. This disparity is more pronounced among African American women than among African American men. Among African American women, the rate of emergent HIV infection continues to rise. Although HIV has historically been a disease that predominantly affects males in Arizona, the 2003-2007 rate of emergent HIV among African American women is nearly 60% higher than the statewide rate among men.

Additionally, in the most recent Comprehensive HIV Prevention Plan completed by the Arizona Department of Health Services, key prevention priorities are identified, including:

- Efforts focused on persons who experience an STD diagnosis, particularly those who are also HIV infected. In recent years Syphilis outbreaks have been a significant problem and there is a well-established link between Sexually Transmitted Disease (STD) and increased likelihood of HIV transmission.
- Increased attention to STD prevention. Arizona is seeing a significant increase of early syphilis. The link between Sexually Transmitted Disease (STD) and increased likelihood of HIV transmission is well established. Since 2002, the number of men diagnosed with early Syphilis who report having sex with men (MSM) has risen by nearly 500%. The Maricopa County Department of Public Health (MCDPH) found 60% of 2007 syphilis diagnoses were among MSM with 57% of those co-infected with HIV. Conversely, 40% of those diagnosed with syphilis during 2007 were infected through HRH, making syphilis a strong surrogate marker for the potential for HIV infection among women. Overall, ADHS estimates that HRH accounts for approximately 10.3% of prevalent HIV/AIDS, and 13.1% of incident HIV infection (ADHS 2005 Epidemiological Profile). The ADHS Office of HIV/STD/ Hepatitis C services is working to expand prevention efforts in this area, including the delivery of priority Partner Services to HIV infected persons who experience an STD diagnosis.
- A focus on prevention efforts among those not receiving primary care services and Highly Active Anti-Retroviral Therapy (HAART). This has been shown to be extremely effective in decreasing the likelihood of HIV transmission by reducing viral loads. Current estimates are that nearly 40% of persons reported with HIV infection in Arizona are not receiving HIV primary care.

From a process standpoint, the most recent comprehensive prevention survey and assessment completed identified certain preventive service areas where improvement opportunities exist:

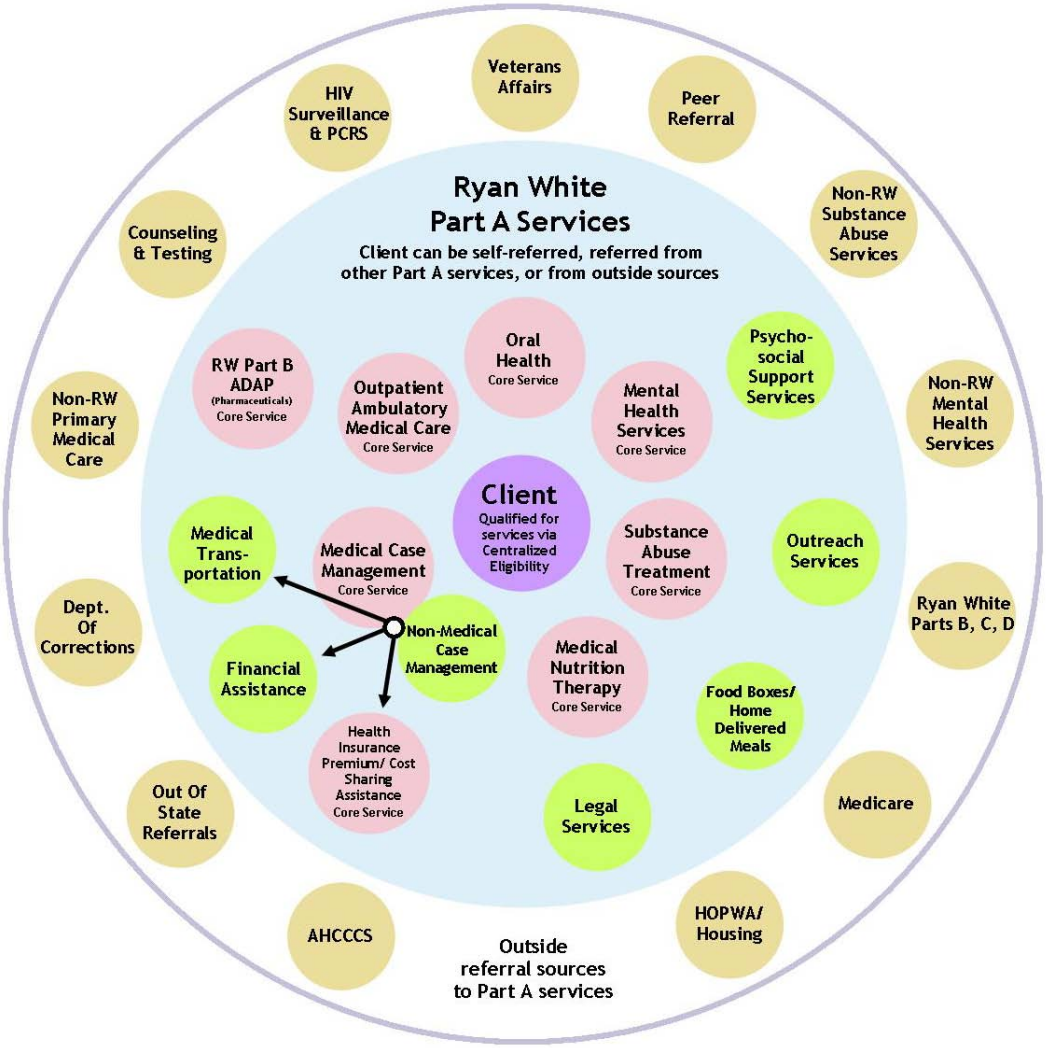
- Improve incentives for preventive service access and utilization
- Coordination of referral services within prevention and in between prevention and primary care services
- Comprehensive programs that include multiple strategies including involve needle exchange programs, more free condoms, more anonymous testing, more free testing, peer support groups and peer leader's certification, condoms for women, free testing in high schools, bleach kits, less paperwork and targeted testing
- More involvement partners/family members in prevention programs
- New approaches to outreach particularly targeted younger age groups

The Planning Council will continue to collaborate with prevention programs to ensure that any strategies that are designed and implemented for HIV services include a strong emphasis on creative strategies for prevention, particularly focused on the areas of opportunity identified above.

Description of Current Continuum of Care

"Continuum of care" is a term used to describe the range of services available to meet the full needs of individuals at any point of time for a particular condition. In the case of care for persons with HIV/AIDS, HRSA defines a "comprehensive continuum of care as including primary medical care, HIV related medications, mental health, substance abuse treatment, oral health, and case management services that assist PLWHA in accessing treatment of HIV infection that is consistent with Public Health Services Treatment Guidelines. The Phoenix EMA has worked diligently to develop a responsive continuum of care for those living with or at risk for HIV/AIDS. This continuum is a client centered model for service delivery and contains multiple entry points and multiple referral sources throughout the system. Access to Medical Transportation, Financial Assistance and Health Insurance Premium/Cost Sharing Assistance require specific referrals from a case management provider.

FIGURE 16: Phoenix EMA Part A Continuum of Care



In the Phoenix EMA, Part A-funded services include primary medical care, case management, legal services, medical transportation, emergency financial assistance, outreach, medical and non-medical case management, mental health services, food services, psychosocial support, oral health care, medical nutrition counseling, pharmaceutical assistance, and substance abuse services.

The Phoenix EMA continues to improve the continuum of care by focusing on access to, and retention in care for racial and ethnic minorities disproportionately impacted by HIV/AIDS. Early intervention services such as HIV Education and Outreach services were revised and new standards created to enhance linkage to care, primarily directed towards populations not in care and historically underserved. The EMA refined a targeted Outreach Campaign based on findings from the 2006 Out of Care Study; in 2008, 46 individuals were re-engaged into Primary Medical Care. Education Service Standards now emphasize educating consumers about services available and how to access them.

The Phoenix EMA Planning Council has created a Health Care Strategies Ad Hoc Committee to further analyze and enhance the EMA's Continuum of Care. The main goals of the Task Force are to: 1) ensure equal access and service parity for each special need population; 2) further reduce health care disparities; 3) link PLWHA to Primary Care; and 4) collaborate with providers to ensure PLWHA engagement and retention in care.

The Planning Council also considers the Minority AIDS Initiative funding to further enhance the quality of care to communities of color by complementing the services funded from Part A to ensure an adequate funding base targeted to these emerging populations. Recent shifts in the strategy for the Phoenix EMA have put more focus on early care and retention by engaging communities of color by funding supportive and medical case management. Through intense capacity building for minority funded providers of case management the goal of the Planning Council is to provide MAI funding in conjunction with Part A services to ensure a plan to support the needs of the communities of color and actively engage them earlier to ensure they remain adherent to treatment, and have advocacy for their needs.

The revamping of the Case Management service provider base in FY 2007 to target minority communities has become one of the most significant steps to increased awareness and adherence to the Phoenix continuum of care. The increase in clients receiving Case Management services is a direct result of the EMA increasing the provider base and geographic locations. Case Management is one of the most critical points of contact for clients within the Phoenix EMA. During FY 2008, Case Management was split into Medical and Non-Medical, providing clear delineation for providers of overall Case management. The delineation of medical versus non-medical Case Management and addition of new service providers has exponentially increased the need for capacity building and technical assistance. To date, some success in increasing the awareness and support to linking clients to care have been reported, but the newer providers continue to struggle in their internal capacity around integrating medical case management into their practices.

In FY 2007, the Planning Council approved a three-year plan for Minority AIDS Initiative (MAI) funding that supports intensive capacity building and technical assistance during the first year (FY 2007). The goal for year one, nearing completion at the time of printing, is to establish a standardized system of Medical Case Management, especially for the new minority-focused providers within the continuum. However, this plan was eventually reworked and funded through the Administrative Agent; initial benchmarks are set to be reviewed during FY 2008 to determine the effectiveness of these efforts. These benchmarks include establishing an active relationship with Primary Medical Care for regular case conferencing as part of the Standards of Care, implementing a standard treatment adherence plan for consumers with clearly defined goals and objectives, and building agencies' internal capacity to meet not only the supportive case management needs of clients, but the medical components as well.

Highlights and Accomplishments of the Continuum of Care

The EMA has strived to improve quality and levels of care for emerging populations. Outpatient/Ambulatory Medical Care is emphasizing more specialized care with a focus on improved clinical outcomes. Efforts under the Quality Management Program have helped to guide providers to set indicators and benchmarks. In FY 2009, Primary Medical Care service category was allocated $2,206,140, the largest percentage (34 percent) of the EMA's Ryan White funding to support increases in primary care in rural areas and develop telemedicine services.

To comply with HRSA mandates, the Administrative Agency has created medical and non-medical case management services. Standards of Care have been established and technical assistance has been provided to develop the competencies of community based programs wit established ties with special populations. With the expansion of contracts with service providers in 2007, more clients have received case management services, an increase of 41 percent (1,960 in FY 2006 to 2,766 in FY 2007). Hispanic clients increased 2 percent (426 in FY 2006 and 660 in FY 2007). African American clients increased 1 percent (263 in FY 2006 and 392 in FY 2007). Additionally, in 2007, the Ryan White Part A Porgram directly contracted case management services with Arizona Department of Corrections to ease the transition of I/RR into the EMA's Continuum of Care, serving 84 unduplicated clients.

There is a significant prevalence of mental health disorders within the Phoenix EMA's PWLHA population. There is increased emphasis on developing substance abuse/mental health treatment resources in the community. The Planning Council has been sensitive to gaps in service, particularly for individuals with severe chronic mental illnesses and those who need intensive long-term mental health care. Of particular importance is the expansion of mental health services to the monolingual Hispanic population and the African American community; both historically underrepresented minority populations in the EMA.

Starting in 2007, the EMA developed and began implementing a centralized eligibility process to reduce barriers to accessing and remaining in care. The FY 07 Client Survey indicated that recertification at multiple locations was a significant barriers to care. This was especially burdensome to immigrant and homeless clients where identity information is needed. Clients in the EMA have the ability to present eligibility documents at any one Part A Service Provider and this eligibility information can be updated for services across the EMA. This reduces the burden of clients having to present copies of the same information at multiple locations for multiple services. Effective March 2008, the system was fully implemented and has continued to evolve through a periodic Plan Do Study Act (PDSA) process where successes and challenges have been evaluated and the system modified accordingly. As of June 2008, compliance with the Central Eligibility system has risen from 48 percent in January 2007 to 92 percent in June 2008 indicating technical assistance is communicated to clients and providers in the EMA.

Part A Program Description

Since 1991, services within the EMA have been funded through Ryan White HIV/ AIDS Programs. The Part A program began as loose network of community organizations coming together as the initial response to the HIV/AIDS epidemic. The Program now provides care services to more than 8,000 PLWHA in Maricopa and Pinal Counties.

The Phoenix Eligible Metropolitan Area (EMA) has strived to continue its forward progress to provide all eligible clients living with HIV/AIDS in the community with access to quality care that they need to remain healthy while battling this disease.

During Fiscal Year 2007 (March 1, 2007 to February 29, 2008), the Ryan White Part A Program for the Phoenix Eligible Metropolitan Area (EMA) provided services to 3,725 unduplicated clients. Demography of the unduplicated clients represents 51% being from minority (non-white) populations of which 1,022 (27%) reported as being Hispanic and 496 (13%) reported as being black or African American. 515 (14%) of the unduplicated clients reported were females greater than 24 years of age. 2,001 clients (4%) were between the ages of 25 – 44. 134 clients (4%) reported Pinal County as their residence.

HIV Status

1,078 clients (29%) reported a diagnosis of CDC-defined AIDS in the Phoenix EMA. 1,995 (53%) reported a risk factor as Men who have Sex with Men (MSM), and 702 (19%) reported transmission via Heterosexual contact.

Income

Ryan White funds are intended for low income clients. During FY 2007 2,175 clients (59%) reported an income level of less than 201% of Federal Poverty Level (FPL). Among the minority populations 89 (55%) of American Indian clients reported an income of less than 201% of FPL, 306 (62%) of African American clients reported income less than 201% of FPL, and 592 (58%) of Hispanic clients reported income less than 201%. Clients reporting as More than One race also reported 135 (70%) were at or below 201% of FPL. 1,028 White (Non-Hispanic) clients (58%) reported income at or below 201%.

WICY

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires Part A grantees to use a proportionate amount of their grant dollars to provide services to women, infants, children and youth (WICY) living with HIV/AIDS. The Phoenix EMA has a reported demography of WICY of: 7,179 total clients – all funding sources - in the EMA: (15.32%: 12.12% Women, .07% Infants, .53% Children, and 2.60% Youth). During FY 2007 678 unduplicated Part A WICY clients (18%) were served: 515 (14%) Women, 41 (1%) Children, and 122 (3%) Youth. Total Part A funds utilized for WICY are reported at $1,039,579 (18%) for FY 2007.

Utilization

During FY 2007 the Phoenix EMA received $7,551,484 ($6,781,484 Part A and $770,000 Carry Over). The Part A award consisted of $4,970,250 Formula and $1,811,234 Supplemental. HRSA has mandated that 75% of the funds utilized in Direct Service Dollars (Award $7,551,484 less Administration $1,132,723 = $6,418,761) be spent on Core Services ($6,418,761 x 75% = $4,814,071). The Phoenix EMA spent $4,945,422 (77%) on Core Services during the FY 2007 grant year. HRSA has also mandated that not more than 2% of the formula award ($4,970,250) be unobligated at year end. During FY 2007, the Phoenix EMA utilized $4,961,586 (99.8%) of the formula award.

Average costs per service category during FY 2007 ranged from $115 (Legal Services) to $2,372 (Outpatient Primary Medical Care). During this time period American Indian clients averaged $1,124, African American clients an average cost of $1,275, Hispanic clients averaged $2,210 per client, More than One race averaged $1,697 per client, and White (Non-Hispanic) averaged $1,307 per client.

In FY 2007 the four highest utilized service categories were: Medical Case Management (2,514 unduplicated clients), Oral Health (1,535 unduplicated clients), Supportive Case Management (1,273 unduplicated clients), and Outpatient Primary Medical Care (836 unduplicated clients).

Service Utilization by Select Minority Populations

African Americans

Less than 8 percent (64) of all African American PLWHA served by Part A funds (496) accessed Part A Primary Medical Care services in 2007. The proportion of African American PLWHA in RWPA funded primary medical care dropped by almost half from 13 percent in 2006 to 7.65 percent in 2007. According to 2007 CAREWare data, African Americans have the third lowest relative income levels of all groups (only higher than multiracial PLWHA at 70 percent and WICY at 65 percent) with 62 percent reporting incomes below 200 percent FPL. African Americans have a higher cost per client in primary medical care than other severe need groups, as evidenced in the table below.

FIGURE 17: 2007 Part A Primary Medical Care Utilization Among African Americans

Race/Ethnicity- African American, non-Hispanic	Client Count	Percent of Total	Client Utilization	percent of Total	Cost/ client
Part A PMC	64	7.65 %	$155,508	7.8 %	$2,430
All Part A Services	496	13.3 %	$632,470	11 %	$1,275

Source: Phoenix EMA Ryan White Part A Program

From 2006 to 2007, the average annual cost for an African American PLWHA in the EMA's Part A primary care medical system increased from $1,835.75 to $2,430. According to the 2008 Unmet Need estimate, there are 563 out of care African American PLWHA. With a significant number of African Americans out of care, the EMA is researching minority outreach strategies to find and engage in care this population.

American Indians

The provision of HIV care for American Indians in the Phoenix EMA is very complex since this population tends to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Native Americans are 770 percent more likely to die from alcoholism; 650 percent more likely to die from tuberculosis; 420 percent more likely to die from diabetes; 280 percent more likely to die from accidents; and 52 percent more likely to die from pneumonia or influenza than other Americans, including White and minority populations. A total of 82 American Indian PLWHA (or 31 percent of AI PLWHA) accessed Part A funded primary care services in 2007. From 2006 to 2007, the average annual cost for an American Indian PLWHA in the EMA's Part A primary care medical system increased from $1,086 to $1,186. The costs for primary medical care are lower than for any other special population in the EMA, largely

FIGURE 18: 2007 Part A Primary Medical Care Utilization Among American Indians

Race/Ethnicity- American Indian	Client Count	percent of Total	Client Utilization	percent of Total	Cost/ client
Part A PMC	82	9.8 %	$97,258	4.9 %	$1,186
All Part A Services	165	4.4 %	$185,504	3.2 %	$1,124

Source: Phoenix EMA Ryan White Part A Program

owing to the coordinated access to IHS (Indian Health Services) funded primary medical care services.

American Indian PLWHA evidence the need for intensive medical case management services to ensure ongoing access to primary medical care and the acquisition of basic supportive service needs (food, housing, transportation), which will strengthen engagement and retention in primary care. Some 35 percent of all American Indian PLWHA (or 93) are Out of Care, according to the 2008 Unmet Need Estimate.

Hispanics

According to FY 2007 Primary Care CAREWare cost utilization data reported by the Grantee's office, 1,022 Hispanics received Part A funded services at an average client cost of $2,210. Some 427 Hispanics received Part A funded primary care services in 2007. Hispanics represent the largest proportion (51 percent) of the unduplicated client count within the EMA's Ryan White Part A funded primary medical care program and the group has the highest cost per client of all populations within the EMA.

FIGURE 19: 2007 Part A Primary Medical Care Utilization Among Hispanics

Race/Ethnicity- Hispanic	Client Count	Percent of Total	Client Utilization	Percent of Total	Cost/ client
Part A PMC	427	51 %	$1,126,902	57 %	$2,639
All Part A Services	1,022	27 %	$2,258,488	39 %	$2,210

Source: Phoenix EMA Ryan White Part A Program

From 2006 to 2007, the average annual cost for a Hispanic PLWHA in the EMA's Part A primary care medical system increased from $2,389.42 to $2,639. According to 2007 CAREWare data, Hispanics have the highest uninsured rates of all Phoenix EMA special populations (over 65 percent lack insurance). Of the $1,982,812 allocated to 2007 Ryan White Part A primary care service category, Hispanic PLWHA utilized $1,126,902 or 57 percent of the total primary care allocation. Based on 2007ADHS estimates, there are 934 (23.4 percent) Out-of-Care Hispanic

PLWHA despite the increasing numbers entering into primary care each year. The increasing number of new infections within the Hispanic population will continue to put a significant financial strain on the EMA's Ryan White funding.

Part A Service Providers (GY 2008)

Agape Network: Food Bank/Home-delivered Meals

Area Agency on Aging/Care Directions: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Medical Case Management; Supportive Case Management; Transportation Services

Arizona Department of Corrections: Supportive Case Management

Chicanos Por La Causa: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Mental Health Services; Outreach Services; Psychosocial Support; Substance Abuse Services; Supportive Case Management

Community Information & Referral: Outreach Services

Compassion in Action: Food Bank/Home-delivered Meals

Ebony House: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Mental Health Services; Outreach Services; Substance Abuse Services; Supportive Case Management

HIV/AIDS Law Project: Legal Services

Jewish Family & Children's Services: Mental Health Services

Joshua Tree Feeding Program: Food Bank/Home-delivered Meals

Maricopa Integrated Health Services: Mental Health Services; Oral Health; Primary Medical Care; Substance Abuse Services

Maricopa County Department of Public Health Office of Oral Health: Oral Health

Phoenix Children's Hospital: Mental Health Services; Nutrition Services

Phoenix Indian Medical Center: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Medical Case Management; Mental Health Services; Outreach Services; Primary Medical Care

Phoenix Shanti Group: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Medical Case Management; Mental Health Services; Substance Abuse Services; Supportive Case Management

Pinal Gila Long Term Care: Financial Assistance-General Emergency; Financial Assistance-Health Insurance Premiums; Financial Assistance-Medical Copays; Financial Assistance-Oral Health; Financial Assistance-Pharmaceutical Assistance; Medical Case Management; Supportive Case Management

Southwest Center for HIV/AIDS: Food Bank/Home-delivered Meals; Mental Health Services; Nutrition Services; Outreach Services; Psychosocial Support

Additional Service Coverage

Ryan White Part B

The Arizona Department of Health Services (AZDHS) is the administrator of Arizona's AIDS Drug Assistance Program (ADAP), funded by Part B. ADAP provides low-income individuals living with HIV/AIDS with access to medications used to treat HIV and prevent the onset of related opportunistic infections.

Ryan White Part C

Part C provides services including HIV counseling and testing (at various sites), primary care, mental health services, and oral health scare. Services are primarily offered at the McDowell Health Care Center located in central Phoenix. The Maricopa Integrated Health System (MIHS) McDowell Health Care Center is the largest provider of HIV primary care services within Maricopa County. The Center provides primary medical care, HIV-specialty care, laboratory services, mental health services, substance abuse services, oral health care, nutritional counseling, case management, treatment adherence, and financial counseling services.

Ryan White Part D

The Part D program focuses on providing coordinated, culturally competent, family-centered medical care for HIV positve women, children, and youth. Services are provided at the McDowell Health Care Center (MHCC) and several additional partners in Maricopa County. MHCC sponsors the only Women's HIV Clinic in Arizona, with Thursday dedicated to serving female clients. The Southwest Center for HIV/AIDS organizes a weekly women-only support group and educational luncheon in conjunction with the MHCC women's clinic. They also operate Logan's Playground, a child care center that allows parents to leave their children in a safe environment while attending health care appointments. The Bill Holt Clinic at

Phoenix Children's Hospital is dedicated to caring for HIV positive children by providing medical care and case management services to their families. The Clinic is the only comprehensive pediatric HIV clinic in the state of Arizona. In addition, Care Directions has a team of Medical Case Managers that assist Part D clients with referrals to services.

Arizona Health Care Cost Containment System (AHCCCS - Arizona Medicaid)

Of all payer sources and programs outside the Ryan White funded system, AHCCCS is the most significant. AHCCCS provides services through six contracted managed care plans. AHCCCS-covered services include primary medical care services, emergency dental care (extractions only), pharmaceuticals, limited home health services, in-patient services, and medically-related transportation. In addition to monthly capitation payments, additional payments are made to plans to help "defray" costs for members receiving approved medications and associated laboratory services related to their treatment for HIV/AIDS.

State Child Health Insurance Program (SCHIP)

Arizona's SCHIP program, KidsCare, is administered by AHCCCS. As 90 percent of PLWHA under the age of 19 in the EMA are AHCCCS eligible, the impact of the SCHIP program is less significant than it may be elsewhere.

Veterans Affairs (VA)

The VA Medical Center in Phoenix serves approximately 300 PLWHA through its outpatient primary care clinic, and provides limited dental care and behavioral health services. Recently passed legislation allows veterans to select the VA or Ryan White for their health care. The impact of this recent legislation on the continuum of care within the Phoenix EMA is yet to be realized.

Housing Opportunities for People with AIDS (HOPWA)

The City of Phoenix Housing Department is the HOPWA Grantee. HOPWA supports 10 different housing programs through six different project sponsors. Over 1,051 PLWHA receive assistance. A HOPWA-funded housing coordinator collaborates with Ryan White case managers regarding housing issues.

Services for Women, Infants and Children

The Supplemental Food Program for Women, Infants and Children (WIC) is administered by MCDPH and provides WIC vouchers and nutritional services at 15 locations in Maricopa County. A similar program in Pinal County serves eligible women and children at 12 locations. Both programs provide referrals for medical services, distribute HIV literature and provide one-on-one nutrition education services. According to the WICY report, the Phoenix EMA met all of the target expenditures relative to the 2008 guidance for the expenditure of Ryan White Part A funding to serve women, infants, children and youth.

Medicare

An increasing number of PLWHA in the EMA are Medicare eligible, and many are choosing managed care programs through Medicare Advantage plans. An issue for PLWHA Medicare enrollees is coordination of pharmaceutical benefits. Most HIV-specific medications are expensive. The average Medicare recipient receiving therapies consistent with Antiretroviral Therapy (ART) currently average approximately $18,000 in annual medication costs. A significant number (45 percent) of Part A pharmaceutical and ADAP clients are Medicare enrollees. Beginning on January 1, 2006, Medicare beneficiaries who qualified for the full low income subsidy assistance through Medicare Part D were dropped from the ADAP and Part A pharmaceutical rolls. Other Medicare beneficiaries were required to enroll in a Medicare Part D plan in order to maintain their ADAP eligibility.

Indian Health Service (IHS)

Phoenix Indian Medical Center (PIMC) serves over 105 active HIV clients annually. PIMC has successfully integrated HIV-related care and services within the facility.

Private Providers

Within the metropolitan Phoenix area, there are over 20 providers certified by the American Academy of HIV Medicine (AAHIVM). There are no AAHIVM-certified providers located in Pinal County.

Where Do We Need To Go?

The Ideal Continuum of Care

The Planning Council envisions an ideal system of care that, in collaboration with other funding streams, will achieve the following:

- Shorten the time between diagnosis and entry into care
- Reduce the transmission of the virus to others
- Lengthen the time between entry into care and the transition to an AIDS-defined status
- Reduce the number and severity of complications and episodes of illness
- Lengthen the time between diagnosis and death from the virus

The ideal continuum of care in the Phoenix EMA is consistent with HRSA's priority goals of increasing access to services while decreasing disparities among affected populations and historically underserved communities and continues to evolve to meet the needs of clients in emerging populations. The continuum of HIV/AIDS treatment and care services in the Phoenix EMA is focused on primary medical care coordinated with essential services, which are highly correlated with positive medical outcomes, including integrated medical case management, oral health, mental health, and substance abuse treatment. A comprehensive range of additional supportive services, tightly related to promoting access to and engagement in primary medical care completes the continuum and helps to improve retention in care. Emphasis is placed on ensuring that all services are sensitive to cultural issues and linguistically appropriate.

The EMA's ideal continuum of care will evolved to address both the traditional and emerging needs of the community. Resources allocated to the core services, in conjunction with other allocations to support services will be integral to the continuum of care and will maintain the strong ties to primary medical care and support for PLWHA in the EMA.

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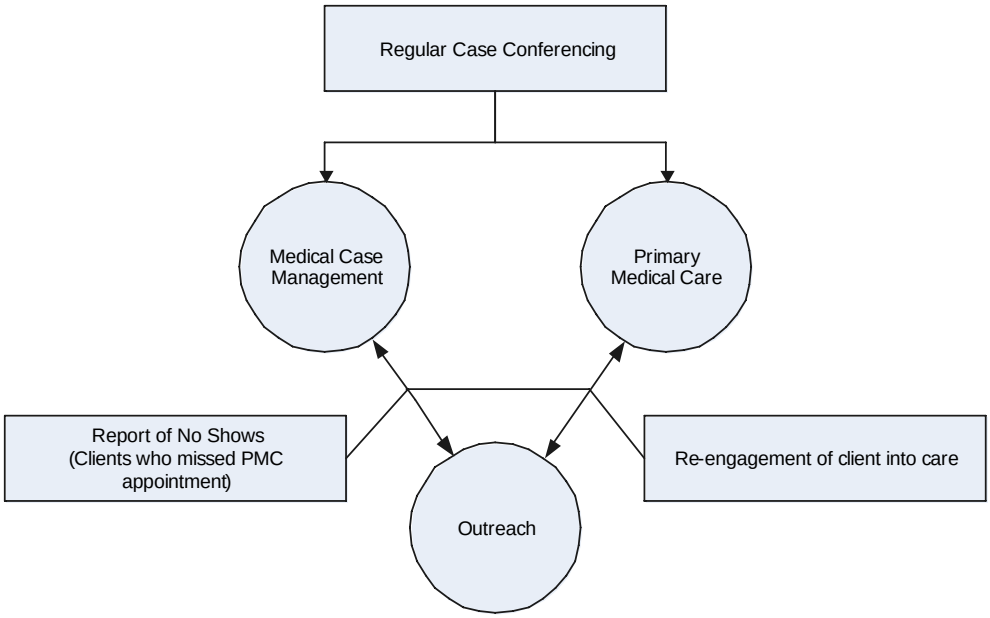
In an environment of resource constraints, the ideal continuum of care will also incorporate a strong element of inter-agency and cross-funding coordination, where Ryan White and non-Ryan White funded services are well integrated and coordinated with prevention and surveillance, as appropriate.

A key component of this Plan is Medical Case Management. This core service will serve as a vital connection to primary medical care. Focusing on Medical Case Management in the Phoenix EMA will create a seamless continuum. An open dialogue between Medical and Support Case Managers and Primary Medical Care providers will actively promote engagement for each client with ongoing assessments and issue resolution. The goal of establishing relationships with Outreach/Case finding/Follow-up and Case Management will provide a reinforcing mechanism to successfully link clients who fail to show for several appointments to a trained Outreach staff to proactively re-engage with a client and promote re-entry into Primary Medical Care.

The Administrative Agent's centralized data management and eligibility systems will further enhance this flow. Other service improvements will include the expansion of accessible hours for primary medical care. In support of providing core services to the rural and outlying areas of the Phoenix EMA, the Administrative Agent, Planning Council, and the Arizona Association of Community

FIGURE 20: Link between Medical Case Management, Medical Care and Outreach



Health Centers will have systems in place to incorporate telemedicine for convenient care in the rural communities, allowing clients to access core services without the barrier of inadequate transportation.

Shared Vision for System Change

As the Phoenix EMA and the Planning Council looks ahead to the next three years of the Part A program in Maricopa and Pinal Counties, a set of guiding principles will define its quest for continued enhancement of the HIV/AIDS care delivery system. These principles are:

- Geographic equity in access to services
- The system of care adopts a realistic approach that relies upon data to make hard choices and decisions about the availability of services
- All providers treat clients with a compassionate and professional approach to care
- The system of care includes not only Ryan White providers, but is open and inviting to all service providers within our community.

Furthermore, the Council seeks to adopt a collaborative framework for planning and oversight that takes into consideration urban, suburban and rural planning priorities to determine priority setting and resource allocation for the EMA. Minimum funding levels for service categories will be developed with community input that supplements data collected by the Council, the Administrative Agency, the Arizona Department of Health Services and other sources.

Questions that shape the shared vision for system change:

- What services are out there for use by our clients that are not Ryan White funded projects and where are they located?
- How do we capitalize on and use the entire continuum of care without crippling our system of care.
- What are the critical priorities (obtained by assessments and other tools)?
- What is our capacity to provide care?

The Council supports the following core values defined as those that are most important to the organization:

- The continuum of care should be responsive to the emerging needs of the community
- Services should be provided to all PLWHA based on their need for services, not their ability to pay
- Services should be geographically equitable throughout the EMA
- The provision of quality services should be cost effective and efficient
- Services should be culturally and linguistically appropriate for all PLWHA in the EMA
- Providers must be accountable for service access and quality
- PLWHA priorities and community input drive our planning processes

Throughout this process, the Planning Council is committed to making thoughtful decisions that are based on data derived from the various elements described above. Additionally, at every step, the Planning Council will define measurable indicators of clinical quality to evaluate the impact of decisions and programs on clinical outcomes for those living with HIV/AIDS.

Conclusion

As the Phoenix EMA moves forward, education, public awareness and other risk reduction activities are vital to prevent new infections in the EMA. HIV treatment includes not the provision of services designed to meet the needs of persons living with HIV but also strategies to close disparities in HIV care, access and services for underserved populations. The ideal system includes outreach and education activities targeted at those most at risk; linkages and coordination of services, particularly substance abuse and mental health; and early for linking into care those who know their status but are not in care.

Goals and Objectives

GOAL 1

Improve the quality and delivery of Ryan White core services to increase retention of in care, facilitate the entry of newly diagnosed individuals into care, and eliminate disparities in care in communities of color.

Statement of Need

The Planning Council has identified a critical need to ensure the delivery of consistent, high quality core medical services to all HIV positive clients in the EMA, regardless of where they live, what population group they represent or what language they speak. Needs assessments and other data reports indicate that African Americans, Hispanics and Women need to be the focus of these efforts.

Desired Health Outcomes

- 10% decrease in the number of clients who fall out of care (retention in care)
- Two client-identified barriers to care addressed by Planning Council directives/ funding each year
- MAI funding determinations targeting the needs of communities of color (consistent with 3-year MAI plan)

Objective 1

Ensure Ryan White Part A core services are available to all eligible Part A clients regardless of gender, age, race, ethnicity, sexual orientation, and geographic location, through targeted outreach and care models.

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Desired Health Outcomes

- All Part A clients have access medical care as defined by the Part A standards of care
- All Part A core services are funded according to the Planning Council's Guiding Principles for Allocations Decisions

Activity 1

Improve data sharing between service providers to improve coordination of care and identify people at risk of falling out of care.

Outcome

- Establishment of formal and informal data sharing agreements and arrangements with various agencies to allow for improved ability to track and correct gaps in care

Timeline: Quarter 4, 2009

Responsibility: Ryan White Part A Administrative Agency

Activity 2

Expand current initiatives that are focused on targeted outreach that ensures availability of services to all eligible Part A client. This could include phased expansions of Ebony House outreach to African Americans, engagement of Hispanics through the family centered support and care model and targeted outreach to Women through the MIHS care system.

Outcomes

- Successful and on-time implementation of at least 1 targeted outreach initiative for at risk populations
- 10% decrease in the number of clients who fall out of care
- 10% improvement in core clinical measures for clients engaged in the targeted outreach initiatives

Timeline: Quarter 1, 2010 to Quarter 4, 2011

Responsibility: Ryan White Part A Administrative Agency

Objective 2

Gather needs assessment and other epidemiological data from existing data systems to complete a comprehensive analysis of the gaps in services to include, quantification of specific gaps in services, studies on reasons for gaps in care for specific populations, and opportunities to address these gaps.

Activity 1

Conduct assessment activities focused on population health status and health issues facing the HIV community.

Desired Outcomes

- Collect and maintain reliable, comparable and valid data on the needs of people living with HIV and their health status
- Analyze data to identify trends, health problems, and social and economic risks that adversely affect their overall wellness and ability to access/stay in care
- Provide results of data analysis to the Health Care Strategies Committee to use to develop directives to guide service delivery and recommendations for Part A Program improvement

Timeline: 2009—Survey of Newly Diagnosed, COBRA/Health Insurance Continuation/Co-pay Assistance evaluation; 2010—Large Scale EMA- Needs Assessment (n=1000); 2011—Large Scale Communities of Color

Responsibility: Community Planning & Assessment Committee

Activity 2

Each year, the Health Care Strategies Committee reviews data collected in Activity 1 to determine barriers and gaps to address, and then makes recommendations regarding general and MAI funding, capacity building, and directives for the delivery of Ryan White services. The recommendations will be tailored to populations at greater risk - African Americans, Hispanics and Women (For example, expansion of family centered support and care model for Hispanics at CPLC).

Desired Outcome

- Two client-identified barriers to care addressed by Planning Council directives/funding each year

Timeline: July of each year

Responsibility: Health Care Strategies Committee

Activity 3
Review completed activities to evaluate effectiveness and determine revisions to activities, as needed.

Outcome

- Measurable improvement in client retention in care (10%)

Timeline: Yearly

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Objective 3

Ensure continuation of health care for people who are insured and not able to pay co-pays or other obligations needed to retain insurance coverage and/or access to medications.

Desired Health Outcome

- Clients are able to retain comprehensive health care so that these individuals do not enter Ryan White or State funded care, or fall out of care

Activity 1
Complete data analysis using needs assessment and existing data sources to identify percentage of clients in various income brackets. Assess their risk for discontinuing medications or other care services based on greatest need.

Outcomes

- Completion of analysis to identify risk of discontinuing care based on financial duress
- Presentation of findings to the Planning Council within defined activity timeframes

Timeline: Quarter 2, 2009 to Quarter 3, 2009

Responsibility: Community Planning & Assessment Committee, Ryan White Part A Administrative Agency

Activity 2
Evaluation of data collected in Activity 1 to establish guidelines for financial assistance based on need and availability of funds.

Outcome

- Development of strategy/directive to reduce the number of individuals who lose insurance benefits and enter into Ryan White or State-funded care, fall out of care, or become unable to maintain their pharmaceutical regimens

Timeline: Quarter 2, 2009 – Quarter 1, 2010

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency

Activity 3
Planning Council approval and implementation of any strategy/directive developed.

Outcomes

- Approval and implementation of strategy/directive
- Quarterly review of utilization/effectiveness

Ti**meline:** Quarter 3, 2009; Directive effective March, 2010

Responsibility: Health Care Strategies Committee

Objective 4

Improve the timeliness of the transition of clients from positive HIV diagnosis to entry into Ryan White Part A core medical services.

Activity 1
Collect data on newly diagnosed individuals to identify how clients access HIV testing, strengths and weaknesses of referral systems, and prevention strategies that were not effective

Outcome

- Collection and compilation of data from client surveys and existing data sources

Timeline: Quarter 1 and 2, 2009

Responsibility: Community Planning & Assessment Committee, Consultant

Activity 2
Analyze data to identify trends, quantify quality and operational improvements based on the interventions and identify opportunities for program expansion.

Outcome

- Evaluation of data and presentation of finding to the Planning Council

Timeline: Quarter 1, 2010

Responsibility: Community Planning & Assessment Committee, Consultant

Activity 3
Collaborate with community stakeholders to develop and implement strategies to improve the transition of individuals newly diagnosed with HIV into care.

Outcome

- Improvements to the linkages between HIV testing services and care providers that facilitate newly diagnosed individuals to access core medical services according to timeframes defined by Ryan White Part A standards of care.

Timeline: Quarter 1, 2010

Committee: Health Care Strategies Committee, Standards Committee, Ryan White Part A Administrative Agency

Objective 5

Implement established Standards of Care to monitor and evaluate the quality and effectiveness of Ryan White Part A services.

Desired Health Outcomes

- Clients realize health outcomes as defined by each service category's Standards of Care
- Service providers maintain quality standards as defined by each service category's Standards of Care
- The quality and effectiveness of Ryan White Part A services are evaluated and improved

Activity 1
Ryan White Part A Standards of Care are implemented in all service categories for one year. Quarterly reporting of evaluations is provided to the Standards Committee.

Outcomes

- Standards of Care are implemented in 100 % of service categories by the Ryan White Part A Program
- 100% of Ryan White Part A providers are trained regarding the Standards of Care

Timeline: Training and implementation to occur by Quarter 3, 2009

Responsibility: Ryan White Part A Administrative Agency Quality Management staff

Activity 2
After one year of monitoring and evaluation, the Standards Committee reviews and revises each Standard of Care, as needed.

Outcome

- Improved Standards of Care for all Ryan White Services

Timeline: March, 2010 through February, 2011

Responsibility: Standards Committee, Ryan White Part A Administrative Agency Quality Management staff

Activity 3
Administrative Agency Quality Management staff to provide ongoing training and technical assistance to the Standards Committee (i.e., quality management vs. quality assurance, cost effectiveness, etc.).

Outcome

- Standards Committee receives ongoing training and technical assistance

Timeline: Ongoing, beginning Quarter 2, 2009

Responsibility: Ryan White Part A Administrative Agency, Standards Committee

Objective 6

Provide health education and promotion activities that address consumer-identified health problems, improve knowledge of services and empower consumers to proactively manage their health and wellness.

Desired Health Outcomes

- Clients have increased knowledge and skills to better manage their HIV disease
- Clients are aware of the availability of HIV care and social services provided by the Ryan White Part A program and other service providers/programs
- Ryan White Part A clients are informed of changes to the Ryan White program in a timely manner to ensure their retention in current services and expedite access/enrollment in newly available services

Activity 1

Present education events that provide clients with essential information, community resources, and useful tools to monitor and maintain their health.

Outcomes

- Presentation of Learn+Link+Live English-language client education events
- Presentation of Aprende, Unite y Vive Spanish-language client education events

Timeline: Quarter 4, Annually

Responsibility: Education & Empowerment Committee

Activity 2

Develop and maintain an open and efficient system to disseminate information about Part A services to providers and consumers both within and outside the Part A program.

Outcome

- Established method/timeline of communication (newsletter, scheduled mailing, etc.) to providers and consumers regarding Ryan White Part A services

Timeline: Quarter 3, 2009

Responsibility: Ryan White Part A Administrative Agency

Activity 3
Develop and maintain Ryan White Part A web-based initiatives, and collaborate with other entities providing EMA-specific web-based information, to provide clients with information regarding Ryan White Part A services and services provided by other entities.

Outcome

- Establish web-based promotion of Ryan White services and changes in service delivery
- Establish collaboration with other web-based education initiatives to provide

Timeline: Quarter 3 and 4, 2009

Responsibility: Planning Council Support, Ryan White Part A Administrative Agency

GOAL 2

Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.

Statement of Need

Studies and surveys have shown that there are a significant number of clients who are aware of their HIV status and are not receiving the primary medical care services. This population is prone to deteriorating health status and poor clinical outcomes. When these individuals enter care, it is typically due to severe health complications. This creates a significant strain on the resources and infrastructure of the HIV service delivery system to care for them.

Desired Health Outcomes

- Facilitate the entry of 140 out-of-care individuals into primary medical care over a three-year period, targeting African American and Hispanic clients.
- Monitor these individuals to ensure they remain in care for at least one year.

Objective 1

Develop and implement methods to reduce administrative inefficiencies that challenge facilitating out-of-care individuals to enter into primary medical care.

Activity 1

Improve data sharing linkages across local health departments and service providers (within legal boundaries) to increase efficiency and effectiveness of outreach efforts.

Outcome

- Establish formal and informal data sharing agreements and arrangements with various departments and providers to allow for access to data on clients that will be used to maximize outreach and engagement success

Timeline: Quarter 1, 2009 - Quarter 1, 2010

Responsibility: Ryan White Part A Administrative Agency

Activity 2

Complete an analysis of the additional administrative barriers that hinder the facilitation of out-of-care individuals into primary medical care.

Outcome

- Report on findings presented to the Planning Council work group (PC and community stakeholders)

Timeline: Quarter 1, 2010 - Quarter 3, 2010

Responsibility: Part A Administrative Agency, Planning Council work group

Activity 3

Develop and implement strategies to overcome barriers identified in Activity 2.

Outcome

- Implementation of activities designed to remove administrative barriers that hinder the rapid transition of the newly diagnosed into primary medical care

Timeline: Quarter 1, 2011

Responsibility: Part A Administrative Agency, Planning Council work group

Activity 4
Analyze data to identify trends, quantify quality and operational improvements and identify opportunities for program expansion.

Outcomes

- Evaluation of strategies
- Development and implementation of an improvement plan within activity timeframe

Timeline: Quarter 1, 2012

Responsibility: Part A Administrative Agency, Planning Council work group

Objective 2

Successfully implement a revised Outreach Services service delivery model to facilitate an increased number of out-of-care individuals to enter or return to primary medical care.

Outcomes

- Individuals at-risk of going out of care are proactively engaged to remain in care
- Identify individuals who have never accessed care or who have been out of care one year or more, and facilitate their entry into care.

Activity 1
Train providers according to the revised Outreach Services service delivery model. Provide additional training to all Outreach Services providers regarding other medical systems (Medicaid, VA, etc.) providing services in the EMA.

Outcomes

- All Outreach Services providers trained to deliver services according to the new model
- All Outreach Services providers are knowledgeable of the non-Ryan White medical systems providing services in the EMA.

Timeline: Quarter 2, 2009 - Quarter 2, 2010

Responsibility: Part A Administrative Agency, Consultant

Activity 2
Implement the revised Outreach Services service delivery model, including the establishment of a data collection and monitoring system that will allow tracking of outcomes of the project.

Outcomes

- Implementation of the revised service delivery model by all providers of Outreach Services
- Creation of data elements and indicators to track the status and results of the implementation

Timeline: Quarter 2, 2009 - Quarter 1, 2010

Responsibility: Part A Administrative Agency, Consultant

Activity 3
Analyze data to identify trends, quantify quality and operational improvements and identify opportunities for expansion.

Outcomes

- Completion of evaluation
- Presentation of finding to the Planning Council
- Identification/implementation of improvements

Timeline: Quarter 1, 2010 - Quarter 1, 2010

Responsibility: Part A Administrative Agency, Consultant

Activity 4
Development and implementation of Standards of Care for the Outreach Services service category.

Outcomes

- Creation of Standards of Care for the Outreach Services service category
- Approval of Standards of Care by the Planning Council
- Successful implementation of the Standards of Care by the Part A Administrative Agency

Timeline: Quarter 2, 2010 - Quarter 3, 2010

Responsibility: Standards Committee**,** Ryan White Part A Administrative Agency

Objective 3

Participate in Project Consumer LINC (Linking Individuals into Needed Care), a national initiative to identify, document, disseminate, and support the implementation of consumer-based strategies (e.g., outreach) as well as *indirect* models (e.g., consumer-led review of the system of care to remove access barriers) that involve Ryan White consumers in linking other PLWHA into primary medical care and other needed services.

Outcome

- Implement and evaluate a peer-driven program to increase the retention in care of Ryan White clients and engage out-of-care individuals and facilitate their entry into care

Activity 1

Participate in a national evaluation of promising models and strategies.

Outcome

- Determine a program model to pilot in the Phoenix EMA

Timeline: Quarter 1, 2009 - Quarter 2, 2009

Responsibility: Planning Council Chair, Planning Council Support staff

Activity 2

Identify and engage community stakeholders to collaborate on the project.

Outcome

- Develop collaborative partnerships to implement the pilot program

Timeline: Quarter 2, 2009 - Quarter 3, 2009

Responsibility: Education & Empowerment Committee, Planning Council Chair, Planning Council Support staff

Activity 3

Obtain training and technical assistance on the chosen program model.

Outcome

- Collaborative partners trained according to the program model

Timeline: Quarter 4, 2009

Responsibility: Planning Council Support staff, Project LINC staff

Activity 4
Implement the pilot program.

Outcome

- Implementation of the pilot program

Timeline: Quarter 1, 2010 - Quarter 1, 2011

Responsibility: Planning Council Support staff, Project LINC staff, collaborative partners

Activity 5
Collect baseline and follow-up data and evaluate process and outcomes.

Outcomes

- Evaluation of the pilot program
- Determination of whether to continue implementation of the program

Timeline: Quarter 1, 2011 - Quarter 2, 2011

Responsibility: Planning Council Support staff, Project LINC staff, collaborative partners

GOAL 3

Develop and implement strategies to increase access to services throughout Maricopa and Pinal County through multiple approaches.

Statement of Need

The large geographic areas of Maricopa and Pinal Counties can challenge PLWHA to access care services. Nearly all Ryan White-funded service providers are located in central Phoenix, a large metropolitan area with a poor public transportation infrastructure. One-way travel times to primary medical services from towns in outlying areas of the EMA can be up to two-hours long. This goal focuses on diversifying the distribution of services by expanding the Part A provider base and implementing innovative methods to improve access to care.

Desired Health Outcomes

- Eliminate client-identified barriers to care related to the time and effort needed to access services
- Increase data collection to continue to increase access to services as determined necessary by data and research

Objective 1

Identify the geographic distribution of Ryan White eligible clients.

Activity 1
Conduct an annual review of Ryan White eligible clients data by zip code.

Outcome

- Summary of review of data presented to Planning Council

Timeline: Annually, Q2

Responsibility: Ryan White Part A Administrative Agency

Activity 2
Develop Geomaps and other profiles from the data.

Outcomes

- Geomap reports generated annually

Timeline: Annually, Quarter 2

Responsibility: Ryan White Part A Administrative Agency

Activity 3
Analysis of Geomap data.

Outcome

- Strategies/directives to increase access to care throughout Maricopa and Pinal County forwarded to the full Planning Council to approval

Timeline: Annually, Quarter 3

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Activity 4
Evaluation of implemented strategies/directives.

Outcome

- Analysis of the effectiveness of the implemented strategies/directives, revisions made as needed

Timeline: Annually, Quarter 3

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Objective 2

Assess the utilization and satisfaction of Ryan White Part A services in particular areas.

Activity 1
Develop/identify method(s) to collect data on Part A service utilization and client satisfaction referencing geographic areas

Outcome

- Method(s) identified which will provide needed data

Timeline: Utilization – Quarterly; Satisfaction – as scheduled by AA

Responsibility: Ryan White Part A Administrative Agency

Activity 2
Collect data on Part A service utilization/satisfaction referencing geographic areas.

Outcome

- Data available and summarized for analysis

Timeline: Utilization – Quarterly; Satisfaction – as scheduled by AA

Responsibility: Ryan White Part A Administrative Agency

Activity 3
Analysis of service utilization and satisfaction data referencing geographic areas.

Outcome

- Improvement in primary care utilization and satisfaction rates by 10% from baseline. Identification of services needed by geographic area, including reference to satisfaction of services

Timeline: Quarter 4
Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Objective 3

Advocate for hospital-based or ER HIV Testing for clients at risk for HIV/AIDS.

Activity 1
Request Arizona Department of Health Services share results of feasibility study to implement routine HIV testing in hospitals and emergency rooms.

Outcomes

- Obtain information to determine Part A collaboration

Timeline: Quarter 3, 2009

Responsibility: Health Care Strategies Committee, Planning Council Support

Activity 2
Evaluate research to determine potential projects/Ryan White Part A participation.

Outcome

- Analysis of information

Timeline: Quarters 1 and 2, 2010

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Activity 3
Determine potential projects based on feasibility results.

Outcome

- Determination of projects to develop for future implementation.

Timeline: Quarters 1 and 2, 2010

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Objective 4

Research opportunities to implement a telemedicine care model to improve access to services.

Activity 1
Research existing systems of telemedicine care models to gather an understanding of how they might apply to HIV communities in Maricopa and Pinal County.

Outcome

- Recommendations for the implementation of telemedicine care models for HIV communities in Maricopa and Pinal County, including potential costs.

Timeline: Quarter 2-4, 2009

Responsibility: Ryan White Part A Administrative Agency

GOAL 4

Build on past success to create further administrative efficiencies and coordination of eligibility processes for all HIV clients in the EMA.

Statement of Need

The Planning Council and Part A Administrative Agency collaborated to establish a centralized eligibility process for Ryan White Party A clients, including standardized forms, data entry requirements, data sharing among Part A providers and recertification capabilities with any provider. A 2008 evaluation of the centralized eligibility program has identified the need to address challenges across the continuum of care. Additionally, Part A needs to collaborate with other Ryan White Parts and State/local entities to improve and standardize eligibility processes to eliminate redundant data collection and enhance enrollment/retention in care.

Desired Health Outcomes

- Eliminate client-identified barriers to care related to the time/effort/ documentation required to enroll for services funded by different entities.
- Improved data sharing among Part A providers, other grantees and other governmental entities.
- Efficient monitoring of appointments and referrals to minimize lapses in care and identify clients at-risk of going out-of-care.
- Standardized enrollment/eligibility procedures among multiple entities/funding sources for greater efficiency and improved coordination of care.

Objective 1

Determine the feasibility of transitioning to a centralized provider to offer seamless Ryan White Part A eligibility certification.

Activity 1
Explore transitioning Ryan White Part A eligibility certification from the Ryan White Part A Administrative Agency to a centralized provider.

Outcome

- Develop recommendations regarding transitioning Ryan White Part A eligibility certification to a centralized provider.

Timeline: Quarter 4, 2009

Responsibility: Ryan White Part A Administrative Agency

Objective 2

Create interagency collaboration between the Ryan White Parts, with input from other entities to create a single point of entry process for all programs and/or implement standardized eligibility certification documentation and procedures among multiple health care programs

Activity 1
Establish stakeholder work group to ascertain the desire and ability of potential partners to implement standardized eligibility.

Outcomes

- Identify collaborative partners
- Identify issues faced by each partner
- Create action plan to reach objectives

Timeline: Quarter 4, 2009

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 2
Work group meets to evaluate eligibility documents, policies and procedures from all collaborative partners.

Outcomes

- Identify existing documentation needs, policies and procedures that are common among multiple partners
- Identify challenges with the elimination/inclusion of documentation, policies and procedures that are not common among multiple partners
- Work group members commit to research organizational procedures to revise documents, policies and procedures

Timeline: Quarter 1, 2010

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 3
Work group drafts common eligibility documents, policies and procedures for review by partner organizations.

Outcomes

- Standardized eligibility documentation, policies and procedures are drafted
- Partner organizations review draft documents, provide feedback

Timeline: Quarter 2, 2010

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 4
Work group develops final eligibility documents, policies and procedures.

Outcomes

- Identify existing documentation needs, policies and procedures that are common among multiple partners
- Identify challenges with the elimination/inclusion of documentation, policies and procedures that are not common among multiple partners

Timeline: November, 2010

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 5
Final common eligibility documents, policies and procedures approved by all individual partner organizations. Implementation schedule established.

Outcomes

- Agreements and other documentation for collaboration finalized
- Implementation schedule established

Timeline: Quarter 1, 2011

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 6
Clients and providers notified of changes to eligibility process.

Outcomes

- Information disseminated to clients and providers
- Implementation schedule established

Timeline: Quarter 2, 2011

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

Activity 7
Common eligibility certification process implemented among all collaborative partners.

Outcomes

- Program successfully implemented within activity timeframe

Timeline: Quarter 3, 2011

Responsibility: Health Care Strategies Committee, Ryan White Part A Administrative Agency, community stakeholders

GOAL 5

Identify strategies and best practices for appropriate substance abuse service access and utilization.

Statement of Need

The 2005 Phoenix EMA Consumer Survey found that 90 percent of PLWHA report ever using alcohol and 44 percent report using crystal meth. During 2006, 20 percent of MHCC clients received substance abuse counseling. According to 2003 data, at 114.8 deaths per 100,000 population, the Phoenix EMA ranked in the top third of all metropolitan areas for deaths by drug misuse.

Additionally, ADHS reports that the drug-related fatality rate in the Phoenix EMA is 10.9 per 100,000 as compared to the Healthy People 2010 target rate of 4.5 per 100,000. Documentation of services in the Phoenix EMA show a significant numbers of those individuals are not only dually diagnosed but are dealing with triple diagnosis (HIV positive clients needing Mental health and Substance Abuse Treatment).

This is a growing issue among women as well with Intravenous drug use (IDU) accounting for approximately 30 percent of HIV infection among women in Maricopa County (Arizona Department of Health Services Office of HIV/AIDS 2007 Epidemiology Report). The greatest service needs of IDUs (impacting their ability to remain in the service system and maintain adherence to drug and service regimens) are substance abuse treatment and behavioral health services.

Objective 1

Review Substance Abuse/Mental Health Project Summary Study Report to be completed in 1st Quarter of 2009 to develop specific recommendations for each year of the Comprehensive Plan.

Activity 1
Review the Summary Report and develop activities and objectives for this Goal in Year 1, 2 and 3 of the Plan.

Outcome

- Analysis of the Summary Report
- Objectives, activities and timelines regarding Substance Abuse – Mental Health are incorporated into Comprehensive Plan

Timeline: Quarter 2, 2009

Responsibility: Community Planning & Assessment Committee, Health Care Strategies Committee

Objective 2

Develop a strategy for service improvements beyond those identified in the Substance Abuse report.

Activity 1
Identify needed activities not necessarily present in the Substance Abuse Report.

Outcome

- After reviewing the Summary Report, the Council will identify any additional recommendations that they feel would be needed to improve services regarding Substance Abuse

Timeline: Quarter 4, 2009

Responsibility: Planning Council

Activity 2
Develop specific objectives, activities and timelines for service improvement for each recommendation identified.

Outcomes

- Specific objectives, activities and timelines are incorporated Comprehensive Plan

Timeline: Quarter 2, 2010

Responsibility: Community Planning and Assessment Committee

Monitoring Our Progress

Implementation and Monitoring Strategy

A critical part of any comprehensive plan is to ensure that a sound strategy is established and clearly documented for tracking and monitoring outcomes. This monitoring process helps the Planning Council, the Administrative Agency and other stakeholders to re-prioritize, adjust or revise strategies in a nimble manner in response to the evolving needs or changing profile of the HIV epidemic.

Improving Client Level Data

The Phoenix EMA implemented the use of the CAREWare client-level data reporting system in 2006, resulting in a dramatic change in the sophistication and comprehensiveness of the information that can be generated:

- Fiscal monitoring reports
- Programmatic monitoring reports
- Exception reporting
- Compliance monitoring reports
- Services Utilization Reports Across the Continuum of Care

The Council and the Administrative Agent have identified that the next phase of reporting efforts should focus on automated generation of clinical quality indicator reports, including the clinical measures developed by HAB. This enhancement will be a focus of the monitoring efforts in the 2009 to 2012 Comprehensive Plan.

Success

Using Data for Evaluation

The Planning Council and the Administrative Agency recognize the importance of data-driven decisions at every step of program implementation and monitoring. In order to ensure that this commitment is reflected in all the EMA activities, the following structural elements of the program will be emphasized.

Community Planning & Assessment (CPA) Committee: The Community Planning & Assessment Committee will continue to assume lead responsibility for monitoring the Comprehensive HIV Services Plan, but in the upcoming planning period, a greater emphasis will be placed on quantifiable data that demonstrates outcomes for each activity outlined in the Plan. It shall report back to the Planning Council on a quarterly basis on the progress associated with the various goals, objectives, and activities. Not only will the CPA Committee report on whether the activities under each objective have begun and provide updates on the status of the activity, but it will also take the lead role in evaluating outcomes and other data reports for the various activities being completed to determine how successful these efforts have been in achieving the goals defined by the Planning Council. The CPA Committee will then provide recommendations to the Planning Council on additional steps that need to be taken to address issues or to enhance results.

Planning Council Oversight: Annually, the Planning Council will review overall progress on the objectives of the Comprehensive Plan. If objectives need to be adjusted based on activities and other developments over the course of the year, the Planning Council will ask the CPA Committee to develop and recommend changes.

Plan Outcomes Tracking Reports: The Council will work with the Administrative Agency to define a set of reports that will allow tracking of some of the measurable outcomes defined for the activities within this comprehensive plan. As much as possible, the reports will rely on electronic data sources and data capture mechanisms that are already in place or that are planned for implementation. These reports will be generated quarterly and/or annually depending on the outcome being measured.

Satisfaction Surveys: The Phoenix EMA conducts regular client satisfaction surveys. These surveys will be another valuable tool for monitoring and tracking success of the various activities in the plan. Surveys are conducted annually and each year's results will enable the Planning Council to make adjustments and enhancements to their planned initiatives.

Implementation and Monitoring Work-Plan

The Planning Council will use a comprehensive work-plan tool to track and monitor results of the Plan's various activities on an ongoing basis. This tool will include the level of detail needed to accurately monitor all aspects of the plan in a simple, easy-to-follow format. The work-plan will contain the following key informational elements.

Time Frame: While specific dates for accomplishing each activity are not included in this plan, the Planning Council has recognized the need to hold the EMA accountable to clear expectations regarding approximate timeframes of initiation and completion of activities. For this reason, the work-plan specifies which quarters of the year activities will begin and be completed in. Specific individuals or committees that are responsible for each goal, objective, or activity are encouraged to define more precise times when possible.

Responsible Parties: Within the summary work-plan included in this report, only the lead agency or individuals identified for each activity are presented. However, the lead agency or individuals will be responsible for identifying the other members of the team that will be charged with the implementation and monitoring of each activity.

Outcomes: The third key element in the plan is the identification of clear, measurable, indicators of outcomes for each activity.

Measuring Clinical Outcomes

The Phoenix EMA has prioritized the task for formalizing the infrastructure needed to track and monitor clinical quality outcomes for the Part A program. This infrastructure includes the identification of existing data collection methods, aggregation of clinical data from various sources, particularly those sources that are electronic, and the creation of analytic tools that can use the data to identify clinical gaps in care and opportunities for improved outcomes. The basis for this infrastructure already exists in the form of the financial and operational monitoring data system that is already in widespread use. By incorporating the clinical data into this system, the data warehouse will truly be a comprehensive and holistic system monitoring all elements of HIV/AIDS program delivery.

Outcomes and Indicators by Service Category

AIDS Drug Assistance Program (ADAP Treatments)

Outcome: Decrease medication errors.

- External medication error rate not to exceed **2 per 1,000** prescriptions filled.

AIDS Pharmaceutical Assistance (local)

Outcome: Decrease medication errors.

- External medication error rate not to exceed **2 per 1,000** prescriptions filled.

Emergency Financial Assistance & Health Insurance Premium/Cost Sharing Assistance

Outcome: Improve adverse socioeconomic situations that negatively impact clients' ability to focus on receiving continued medical and dental care.

- **80%** of charts reviewed will indicate that eligible clients received timely assistance with rent payments avoiding eviction.
- **80%** of charts reviewed will indicate that eligible client utility bills were processed within one week of contact with a case manager to ensure continuation of utility services.

Outcome: Improve client's access to medical and dental care (Health Insurance Continuation/Cost Sharing Assistance services only).

- **80%** of individual's charts submitting requests for financial assistance will indicate the requests had been processed and approved prior to the cancellation of health insurance benefits.
- **80%** of charts reviewed will indicate eligible clients had their medical and dental copays/prescription costs paid within one week of request.

Food Bank/Home Delivered Meals

Outcome: Improve clients' health by increasing knowledge of appropriate dietary intake.

- **75%** of clients will receive a medical nutritional therapy assessment by a registered dietitian to ensure appropriate dietary intake is monitored and appropriate nutritional information is dispensed.

Legal Services

Outcome: Reduce clients' civil legal concerns by providing competent legal services.

- **100%** of charts are reviewed by a supervising attorney.
- **90%** of charts (that contain legal documents) reviewed by a supervising attorney indicate that legal documents were appropriately prepared by non-lawyer assistants.

Medical Case Management

Outcome: Improve clients' health by increasing access to primary medical care and the support services necessary to reduce barriers to care.

- **90%** of clients have documentation of access to primary medical care within 3 months of initial assessment.
- **80%** of client charts have documentation that treatment adherence was discussed with the client.
- **100%** of client charts contain a care plan.

Medical Nutritional Therapy: Adult

Outcome: Improve clients' health by increasing knowledge of appropriate Medical Nutrition Therapy and monitoring nutritional status.

- **75%** of charts reviewed for monitored weight will indicate that clients maintained a body weight at 95 to 100% of usual body weight levels.
- **75%** of the charts document that client/family have been educated on the role of nutrition and HIV.
- **75%** of charts document that a review of oral intake was conducted and compared with calculated calorie requirement at initial visit.

Medical Nutritional Therapy: Pediatric

Outcome: Improve clients' health by increasing knowledge of appropriate Medical Nutrition Therapy and monitoring nutritional status.

- **75%** of client charts document normal growth and weight gain as defined by a BMI or weight/height greater than the 5th percentile, within six months of the implementation of the treatment plan.
- **75%** of the charts document that client/family have been educated on the role of nutrition and HIV as not having a severely com-promised immune status based on current PHS guidelines.

Medical Transportation

Outcome: Provide access to primary medical care and support services for eligible clients.

- **80%** of eligible clients self-report decreased barriers to primary medical care due to availability of transportation services.

Mental Health Services

Outcome: Improve clients' health by decreasing symptoms of mental health disorder thereby reducing barriers to medical care.

- **90%** of treatment goals are addressed and **50%** are met, upon completion of mental health treatment.
- Clients' average GAF scores improve by **5%** within 6 months or upon discharge.
- **100%** of clients receive an assessment prior to implementing the treatment plan.
- **100%** of clients have a completed treatment plan within 90 days from the clients' first visit.
- **100%** of treatment plans address primary medical care needs and make appropriate referrals as needed.

Non-Medical Case Management

Outcome: Improve clients' health by increasing access to support services necessary to reduce barriers to care.

- **100%** of non-medical case management charts will contain a care plan.
- **90%** of client charts document applicable service referrals.

Oral Health Services

Outcome: Service providers will demonstrate core competency in service delivery, monitoring and fiscal accountability.

- **90%** of clients will be processed for enrollment into the program within 10 working days of the receipt of the application, once eligibility is determined.
- Less than **10%** of clients dis-enroll on a monthly basis.

Outpatient Ambulatory Medical Care

Outcome: Improve patient care outcomes.

- **50%** of clients tested will have viral loads below the level of detection.
- **75%** of clients tested will have CD4 counts that identify them as not having a severely compromised immune status based on current PHS guidelines.
- **80%** of women/sexually active adolescents will receive PAP smears annually.
- **80%** of clients will be screened for active viral hepatitis C and hepatitis B annually unless antibodies are present.
- **80%** of adult clients will be screened for syphilis at least annually.
- **80%** of clients will be screened for tuberculosis at least annually if indicated.

Psychosocial Support Services

Outcome: Improve client health by decreasing symptoms of psychosocial stressors thereby reducing barriers to medical care.

- **80%** of records (e.g., group logs) will demonstrate appropriate documentation of service delivery.

Client surveys will demonstrate:

- **80%** of respondents will reflect self-reported improvement of psychosocial issues discussed in support groups or one-on-one sessions.
- **80%** of respondents will rate support group or one-on-one sessions as "good" or "excellent" in discussing the importance of staying in medical care.

Substance Abuse Services

Outcome: Improve clients' health through reduction of barriers to medical care by decreasing substance abuse.

- **90%** of treatment goals are addressed and 50% are met upon completion of substance abuse treatment.
- Clients' average GAF scores improve by **5%** within 6 months or upon discharge.
- **50%** of clients report a reduction in substance use.
- **100%** of clients have a completed treatment plan within 90 days from the clients' first visit.
- **100%** of treatment plans address primary medical care needs and make appropriate referrals as needed.

Universal Standards of Care

Outcome: Service providers will demonstrate core competency as delineated in these Universal Standards in service delivery, monitoring and fiscal accountability.

- **90%** of client charts document that clients were appropriately screened for eligibility for services.
- **90%** of client charts contain a signed general release of information.
- **90%** of client charts have a signed acknowledgement of the receipt of a Client Rights and Responsibilities statement, or a provider notation of a clients' refusal to sign.
- **90%** of client charts have a signed acknowledgement of the receipt of a Client Rights and Responsibilities statement, or a provider notation of a clients' refusal to sign.
- **90%** of client charts have a signed acknowledgement of the receipt of a Grievance Procedure statement, or a provider notation of a clients' refusal to sign.
- **80%** of Client Survey respondents rate the provider as 'good' and/or 'excellent'.

Outcomes indicators will be measured across a wider range of areas of importance and a thoughtful approach will be used to determine which areas to measure and what indicators to use. For this purpose, three key criteria defined by the Institute of Medicine for clinical indicator selection and validity will be used.

Criteria	Defining Questions
Impact	How big is the problem? How prevalent is the problem? Can interventions improve mortality, morbidity, disability, or quality of life? Is the problem costly and can interventions be cost-effective?
Improvability	Are there significant gaps between best practice and usual care, and unwarranted variations in care? Is there evidence that existing quality gaps and variations in care can be narrowed or eliminated?
Inclusiveness	Will addressing the priority area improve quality of care for a broad spectrum of patients and health care settings? Will the priority area result in improved health and quality of life for persons who are otherwise at a disadvantage in health care?

The Planning Council recognizes that the process of selecting the right outcomes measures is critical to its monitoring and oversight efforts. For every planned activity, the Council will ensure that quality measures are appropriately selected, defined and measured so as to provide meaningful information for quality assurance and improvement purposes.

Notes