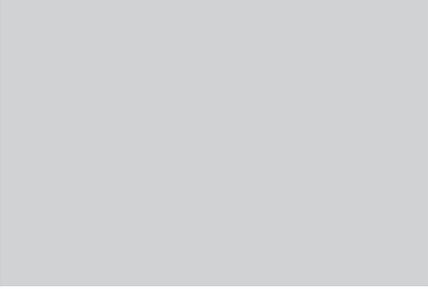


A photograph of the Phoenix skyline at sunset. The sky is a mix of orange, red, and purple, with dark clouds. The mountains are silhouetted against the bright orange horizon. The city lights are visible in the foreground, appearing as small white and yellow dots.

PHOENIX RISING

**The 2006-2009 Comprehensive HIV Services Plan
for Maricopa and Pinal Counties**



PHOENIX RISING



The 2006-2009 Comprehensive HIV Services Plan
for Maricopa and Pinal Counties

28 February 2006

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Letter of Concurrence



PHOENIX
EMA
RYAN
WHITE
PLANNING
COUNCIL

February 28, 2006

To all residents of Maricopa and Pinal Counties,

This document is the 2006-2009 Comprehensive HIV Services Plan for the Phoenix Eligible Metropolitan Area (EMA). This document represents the culmination of a process to understand and assess the needs of people living with HIV and AIDS and to develop a plan to better meet those needs. The assessment and the plan entailed many hours of time, much of which was volunteer time, in order to help provide a continuum of care services that are comprehensive and compassionate.

The epidemic in the Phoenix EMA (Maricopa and Pinal Counties) continues to grow. New treatments have slowed disease progression leading to more and more people alive with HIV or AIDS at the current time. Resources have not kept pace with the growth of prevalent cases requiring difficult choices in the delivery of services. We are committed to insuring that people living with HIV and AIDS continue to have access to life extending medical care and medications. This plan is intended to help us accomplish this goal over the next three-year period.

This plan was developed collaboratively and reflects a wide range of perspectives. The Community Planning and Assessment Committee used information collected through various needs assessments to develop priorities and allocations and then the goals and objectives in this plan. The final plan was submitted to and approved by the full Phoenix Title I HIV Services Planning Council on December 8, 2005. With authority granted by the Planning Council at its February meeting, the CPA approved the final Comprehensive Plan on February 27, 2006.

Sincerely,

Mark Kezios
Chair
Phoenix EMA
Ryan White Planning Council

Kevin McNeal
Administrative Agent
Maricopa County Department of Public Health
Ryan White Title I Services

Mark Kezios
Planning Council Chair

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Acknowledgements

The Comprehensive HIV Services Plan represents the efforts of many individuals. Thanks go to Mark Kezios, Chair of the Planning Council, for his overall leadership and guidance. Larry Stähli, Chair of the Community Planning and Assessment Committee (CPA), directed all of the meetings of the CPA where planning activities were discussed and determined. Thanks to Supervisor Mary Rose Wilcox, our representative on the Maricopa County Board of Supervisors for her support. Mr. John Sapero, Program Coordinator at the Maricopa County Department of Public Health, has provided connections to a great deal of the background information and documents that have helped inform this process.

Members of the CPA, Planning Council and other community members helped to develop and refine the long- and short-term goals and objectives that are the heart of this plan. They are Michelle Barker, Ana Maria Branham, Lorriane Brown, James Bryant, Michael Bryson, Laurie Buckles, Juan Carrasco, Rosie Casillas-Nuñez, Lee Cox, Debby Elliott, Randall Furrow, Fran Garrett, Sharyn Grayson, Alfredo Guardiola, Dennis Huff, Helen Lansche, Billy Leeth, Terri Leija, Dan Lindell, Mary Mauldin, Kevin McNeal, John Murray, MiAsia Pasha, Tara Geotas, Philip Seeger, RJ Shannon, Colin Sheffield, Claire Sinay, Bertha Sintillo, Keith Thompson, Dr. Elizabeth Valdez, Steven Varnadore, Carol Williams, Charlton Wilson, Maclovía Zepeda, and John Zielinski.

JSI staff who worked on this project included Jeremy Holman, Jessica Jiménez and Stewart Landers.

Executive Summary



The Phoenix Ryan White Title I HIV Services Planning Council (the “Planning Council”) and the Maricopa County Department of Public Health (MCDPH) have collaborated to develop this document entitled *Phoenix Rising: A Comprehensive HIV/AIDS Services Plan for 2006-2009* (the “Plan”).

The Plan was developed over a seven-month period from August 2005 through February, 2006, based upon guidance provided by the Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB) that oversees the administration of the Ryan White CARE Act. HRSA/HAB’s guidance states that:

“Comprehensive planning should result in a road map for the maintenance and improvement of a system of care that is responsive to the changing epidemic and the unmet health care needs of those not currently in care.”

The goals and objectives articulated in this plan are a road map to assist the Planning Council and MCDPH to improve the current system of care to meet the needs of the evolving epidemic and to help bring into care those individuals who are aware of their HIV infection but are not in care.

In addition, the Title I Manual states that:

“The comprehensive plan should drive development of goals and objectives in the annual implementation plan. In turn, the annual implementation plan is a tool to achieve goals and objectives in the comprehensive plan.”

The Plan establishes goals and objectives, and activities to achieve them that will become part of the EMA’s annual implementation plan. In general, the first objective for each Goal is intended to be addressed during the first year of the Plan (2006). Activities have been specified to help meet the first year objective. Subsequent objectives shall be addressed in the second and/or third year of the Plan, or sooner if the first objective is achieved more quickly.

The Planning Process

The Community Planning & Assessment Committee (CPA) of the Planning Council was responsible for the comprehensive planning process and worked closely with the staff at John Snow, Inc. (JSI), who facilitated the planning work. CPA held two extended meetings in September and October and invited additional participants including other Planning Council members, community members, and people living with HIV/AIDS not currently on the Planning Council. Prior to these meetings, JSI staff conducted key informant interviews with all of the individuals invited to participate in this process.

The first of these planning meetings included a review of HRSA/HAB's requirements for developing a comprehensive plan, a visioning process to establish a mission statement and guiding principles, and a process to establish the long-term goals for the plan. Small groups were established at the end of the first meeting to help develop objectives and activities to accomplish each of the long-term goals. The second meeting included the review and approval of both a draft mission statement and draft guiding principles and small group work towards completing goals, objectives and activities.

Based on these work group meetings, the key informant interviews, review of secondary data sources (including the previous comprehensive plan for the Phoenix EMA, the most recent consumer survey, HIV/AIDS epidemiological data, and other comprehensive plans), JSI staff developed a draft comprehensive plan for the Phoenix EMA. At the November CPA meeting, the group reviewed and discussed this plan and made additional recommendations for the final version.

The Plan presents the mission statement and guiding principles; goals, objectives and activities; and an implementation plan for the Phoenix EMA. It includes a description of the EMA, as well as summaries of the most recent HIV and AIDS epidemiological profile, the most recent consumer survey, available information on unmet need, and available resources in the EMA for HIV/AIDS care and services. A new Work Group on the continuum of care has held its first meeting and preliminary information regarding its work is presented in the section on "current and desired continuum of care."

Mission

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

Long-term Goals

These goals, objectives and activities were conceived to include both long-term and short-term goals and activities. Goals were designed to cover the three-year period from 2006-2009, however, some may be accomplished in a shorter or longer time frame. To implement this plan, the Planning Council is committed to using best practices for community planning bodies, HRSA guidance on the operation of Title I planning councils, and its own committee structure to develop processes and activities to fulfill its responsibility to ensure a high quality continuum of care that maximizes the quality of life for people living with HIV and AIDS.

Executive Summary

The goals are:

- 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 the 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 Title I-funded service categories.

The objectives for each goal are the “guideposts” for the Planning Council for achieving the goals over the next three years. In general, the first objective and all activities are intended to take place in year one and should be considered short-term goals and objectives.

Review of Secondary Data

A great deal of secondary data were reviewed and summarized to support the CPA in the development of the Plan and to provide evidence-based information for developing and achieving long-term and short-term goals and objectives.

Epidemiology

In spring 2005, there were an estimated 10,196 people living with HIV or AIDS (PLWHA) in the state of Arizona. Moreover, from 1999-2003, there were 3,503 newly diagnosed HIV and AIDS cases. The Phoenix EMA accounts for 71.3% of the combined estimated cases and 75.5% of the newly diagnosed cases.

There were 983 new AIDS cases reported in the Phoenix EMA from 1999-2003, representing about 73% of the emergent AIDS cases in Arizona. In both

Arizona and the Phoenix EMA, about 89% of emergent AIDS cases were among men and 11% among women.

From 1999-2003, 52% of the 983 newly reported AIDS cases in the Phoenix EMA were white (non-Hispanic), 31% were Hispanic, and 13% percent were black (non-Hispanic). The rate of new AIDS diagnoses was significantly higher among blacks (19/100,000) than among whites (4.6/100,000), Hispanics (6.8/100,000), and other racial/ethnic groups. Of all emergent AIDS cases among blacks in Arizona, over 77% were in the Phoenix EMA, a slightly higher proportion than most of the other racial/ethnic groups.

By mode of transmission, nearly two-thirds of newly reported AIDS cases in Phoenix EMA from 1999-2003 were attributable to male-to-male sexual (MSM) contact (63%). Other transmission modes account for smaller percentages of new AIDS cases, including injection drug use (15%), heterosexual contact (13%) and MSM /injection drug use (8%).

Needs Assessment

2005 Consumer Survey

In the spring and early summer of 2005, 599 people living with HIV and AIDS were surveyed. Among the top ten services by reported need, four were primary care-related including outpatient care (1st), oral health (2nd), HIV/AIDS medications (5th), and outpatient specialty care (8th); two were case management related, including case management (3rd) and client advocacy (9th); two are wellness services, including enzymes/herbs/vitamins (4th) and acupuncture and chiropractic (9th); and finally, two were food and nutritional services, including food boxes (6th) and nutritional supplements (7th). Less than 10% of all respondents reported a need for respite care (9%), residential and/or hospital-based substance abuse treatment (8%), translation/interpretation services (7%), detox and/or methadone maintenance (6%), and child day care (6%).

There were 15 services for which women reported a higher need than men. For 14 of these services, the differences were statistically significant, including case management; food box/bank; outpatient specialty care; transportation (taxi); transportation (bus); nutritional education; naturopathic physician; independent housing; emergency financial assistance (rent/utilities); peer support; emergency financial assistance (non-housing); spiritual counseling; respite; and child care.

The reported need for services also varied by race/ethnicity. For six services, these variations were statistically significant. A significantly higher proportion of Black PLWHA respondents than White or Latino/a respondents reported a need for case management, food boxes/food bank, bus passes, medical case management, and taxi services. A significantly lower proportion of Latino/a respondents than Whites or Blacks reported a need for oral health care.

Executive Summary

A high-to-low ranking of reported service needs by race/ethnicity is different than the overall rank for all respondents, reflecting different levels of need within these communities. For example, among Black respondents, case management was the second highest service need, and transportation (bus and taxi) was among the top five – two services that were ranked 12th and 15th among the entire survey sample. Planning for services to reach these underserved populations should consider these variations in developing strategies to increase access to care and meet service needs.

Unmet Need

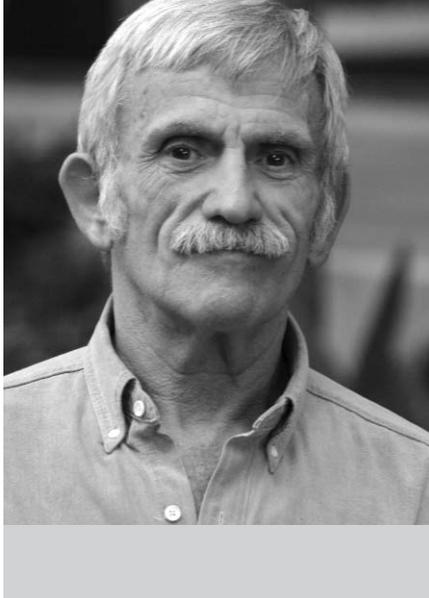
Estimates of unmet need conducted by the Arizona Department of Health Services (ADHS) have estimated a high level of unmet need among people living with HIV and AIDS in the Phoenix EMA. The overall level of unmet need is estimated to be 48.4%, although that varies among populations, with high-risk heterosexuals (43.6%) and men who have sex with men (44.1%) somewhat lower and injection drug users (49.7%) somewhat higher. It is believed that improving the matching algorithm used to match laboratory data with records of clients receiving services could result in a reduction of these numbers of between 5% and 10%.

Two efforts to interview individuals with unmet need (i.e. those matching HRSA/HAB's definition of "out of care") have identified 38 individuals not in care, 18 from the consumer survey and 20 from the rapid assessment. The results of these efforts indicated that individuals not in care were likely to be injection drug users or users of other illegal drugs and possibly more likely to be people of color or foreign born. Due to the small numbers identified to date, additional strategies to identify and bring into care individuals with unmet need must be pursued.

Conclusion

Members of the Phoenix EMA have 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, the consumer survey, other needs assessment data and a rapid assessment of unmet need. The Plan now serves as the primary road map for the Phoenix EMA for the period covering the years 2006-2009.

Introduction and Brief History of Phoenix EMA



Located in the state of Arizona, the Phoenix Eligible Metropolitan Area (EMA) is comprised of Maricopa and Pinal Counties – an area defined by the United States Census Bureau. Maricopa County measures 9,203 square miles and Pinal County measures 5,370 square miles.

The eligibility criteria for Title I Ryan White Comprehensive AIDS Resources Emergency (CARE) Acts funds is determined by the number of AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Since 1996, services within the EMA have been funded through Title I of the Ryan White CARE Act (RWCA). Specifically, the grantee (including the Maricopa County Board of Supervisors, the Administrative Agent and the Maricopa County Department of Public Health) is charged with distributing the funds for services within the EMA based upon the allocation decisions made by the Title I RWCA Planning Council. Determining allocations is a data driven process in which documents such as the EMA consumer survey and epidemiological profile are used to identify which services are most needed.

There are 3.3 million people in the Phoenix EMA, representing 63% of the state’s population of just over 5.1 million. Maricopa County includes some of the most populous cities in the state, including Phoenix, Mesa, Glendale, Scottsdale, Tempe, Chandler, Peoria and Gilbert. According to the 2000 US Census, Maricopa County was the 14th largest county by area in the country and also the 4th most populous. Table II illustrates that the EMA has a young population. For example, the median age for Maricopa County is 33.1 and Pinal County’s population is slightly older with a median age of 37. Please see Table II for more detailed age breakouts.

A 2004 survey conducted by the Arizona Department of Economic Security indicated that the population of the EMA is growing substantially; Maricopa County has grown by 15% since the 2000 Census and Pinal County by 22%.

Table III illustrates that the racial composition of the EMA is similar to that of the state. Maricopa County has a slightly higher percentage of people who identify as White, Black or African American, and Asian than the state and Pinal County. In contrast, Pinal County has a higher percentage of residents who identify as American Indian or Alaskan Natives and/or who report some other race. In terms of ethnicity, Pinal County has a higher percentage of

Table I: Gender

	Arizona	Maricopa	Pinal
Total population	5,130,632	3,072,149	179,727
Male	50.0%	50.0%	53.0%
Female	50.0%	50.0%	47.0%

Source: US Census 2000 Demographic Profile Highlights

Table II: Age

Age (years)	Arizona	Maricopa	Pinal
Under 18	26.6%	27.0%	25.1%
18 to 24	10.0%	10.2%	8.7%
25 to 44	29.5%	31.4%	27.3%
45 to 65	20.9%	19.8%	22.7%
65 and over	13.0%	11.7%	16.2%
Median Age	34.2	33.0	37.1

Source: US Census 2000 Demographic Profile Highlights

individuals of Hispanic origin than the state or Maricopa County (29.9% vs. 25.3% and 24.8% respectively). In addition, as Table IV illustrates, there is a higher percentage of foreign born individuals residing in Maricopa County than in Pinal County. In both the state and the EMA, about one-quarter of residents speak a language other than English in the home.

Table V demonstrates that in comparison to the state and Maricopa County, Pinal County has a higher percentage of people living below the poverty level and a lower percentage of individuals who graduated from high school. As Table V also illustrates, the median income in Maricopa County is higher than the median in Pinal County and in the state.

Table VI provides information on health insurance for residents in Arizona and in the US.¹ The largest percentage of Arizona residents has employer-sponsored health insurance coverage, a proportion slightly below the national percentage. The proportion of uninsured in Arizona is similar to proportion nationally; 17% the state's residents (or nearly 1 million) do not have insurance coverage of any type.

In summary, the Phoenix EMA experiences several unique service delivery challenges not previously discussed that are associated with increased costs and complexities of providing HIV/AIDS care.

Population growth

The EMA has experienced explosive growth that is mirrored in the PLWHA population. Arizona is the second-fastest growing state in the country, and the Phoenix metropolitan area had the greatest increase in population during the last decade among all US metropolitan areas with populations greater than one million. The city's population grew 66.7% between 1990 and 2004. As of July 1, 2002, Phoenix-Mesa-Scottsdale was ranked as the 14th largest metropolitan statistical area in the United States with a population of 3,500,151.

AIDS Service Organizations (ASO) serving this population report a notable in-migration to the Phoenix EMA from Arizona counties that do not have Title I services. For these persons, the EMA is a magnet due to its urban nature and range of available services. The number of PLWHA increases at a rate higher than resources. For example, the McDowell Healthcare Center, the primary care provider in the Phoenix EMA, has seen a 30%

Table III: Race and Ethnicity

	Arizona	Maricopa	Pinal
White	75.0%	77.4%	70.4%
Black or African American	3.1%	3.7%	2.8%
American Indian and Alaskan Native	5.0%	1.8%	7.8%
Asian	1.8%	2.2%	0.6%
Native Hawaiian and other Pacific Islander	0.1%	0.1%	0.1%
Persons reporting some other race	11.6%	11.9%	15.7%
Persons reporting two or more races	2.9%	2.9%	2.7%
Persons of Hispanic or Latino/a Origin	25.3%	24.8%	29.9%

Source: US Census 2000 Demographic Profile Highlights

Table IV: Foreign Born and Languages Spoken at Home

	Arizona	Maricopa	Pinal
Foreign Born Persons	12.8%	14.4%	9.0%
Language other than English spoken at home	25.9%	24.1%	25.2%

Source: US Census 2000 Demographic Profile Highlights

Table V: Poverty, Income and Education

	Arizona	Maricopa	Pinal
People below poverty	13.9%	11.7%	16.9%
Median household income	\$40,558	\$45,358	\$35,856
High School graduates, percent of people age 25+	81.0%	82.5%	72.7%

Source: US Census 2000 Demographic Profile Highlights

¹ Insurance data were not available at the county level.

Table VI: Health Insurance Coverage

	Arizona (N=5,642,340)	%	US (N=290,286,350)	%
Employer	2,697,590	48	1,555,778,670	54
Individual	342,130	6	13,968,130	5
Medicaid (AHCCCS)	809,440	14	37,242,750	13
Medicare	729,510	13	34,379,930	12
Other Public	93,820	2	3,096,400	1
Uninsured	969,850	17	45,820,480	16

Source: Kaiser Foundation, 2003-2004

increase in users since 2002.

The rural areas of the EMA have also experienced explosive growth that has further strained the resources available within the EMA. Pinal County’s population grew 19% from 2000 to 2004, ranking it the fastest growing county in Arizona. A lack of transportation and inadequate infrastructure has further compounded the barriers to care in the rural areas of the EMA.

Geographic Dispersion

The EMA is geographically very large at 14,573 square miles, with a low population density of 246.58 persons per square mile. The area is larger than 9 states including Maryland, Hawaii, Massachusetts, Vermont, New Hampshire, New Jersey, Connecticut, Delaware and Rhode Island. The Phoenix metropolitan area is largely urban and suburban: the rest of the EMA is predominantly rural and includes multiple Indian reservations. Health resources in the rural areas are scarce and the infrastructure has not caught up to the growing need.

Public transportation within the urban and suburban parts of the EMA has been limited up to now to buses. The system is a hub system which makes it difficult to access services not centrally located. If a client misses a bus connection, he or she must often wait 45 minutes for the next bus. A light rail system is now under construction in central Phoenix, and is scheduled for completion in December 2008, and will be limited in the neighborhoods it serves. However, six extensions are planned for completion between 2011 and 2026 reaching to Tempe, Mesa, Glendale, the I-10 corridor west and the SR 51 corridor north.

In Pinal County, one hospital and two community health centers are the only public healthcare facilities for the County’s 214,359 residents and 5,370 square miles. Public transportation in the rural areas is essentially nonexistent, with most persons receiving specialty care in Phoenix, a drive of as much as two hours each way.

The EMA is significantly transient and mobile, with most residents being relative newcomers. Foreign immigration, primarily from Mexico, has further strained the existing infrastructure and created language and cultural barriers unique to the EMA.

History of Ryan White Services in the Phoenix EMA

In 1992-1993 the Maricopa County AIDS Partnership (MCAP) was formed under the Arizona Community Foundation. MCAP's members included community-based providers and other stakeholders. MCAP had two functions, service coordination and resource development. Prior to that, there had been Title II money for case management and all other services in Maricopa County. Those moneys were shifted to other parts of the state after Title I funds came to the Phoenix EMA.

When Phoenix became a Ryan White Title I EMA in 1993, MCAP was designated as the Planning Council. It took on the functions of a RWCA Title I Planning Council and continued to do fundraising around HIV/AIDS in the Phoenix area with four staff persons. Around the same time, The Arizona AIDS Foundation was formed (under the Arizona Community Foundation) to conduct fundraising.

With the advent of RWCA Title I funds in Phoenix, the Maricopa Department of Public Health became the grant administrator. In 1997, the grant administrator pulled the Planning Council under the umbrella of the County Health Department.

In the period from 2000-2003 there were issues between the Planning Council and the County Health Department regarding who had ultimate authority over allocation of Ryan White funds. Several events in late 2004 and early 2005 (including a programmatic audit, conducted in April 2005) led to major changes in the local administration of the CARE Act including a new administrative agent and the provision of substantial technical assistance on most aspects of Administrative Agent and Planning Council functioning. That technical assistance continues to the present time with a range of new activities designed to meet the requirements of federal law and HRSA guidance.

The Comprehensive Planning Process



In August 2005, the Maricopa County Department of Public Health (MCDPH) in conjunction with the Phoenix EMA Ryan White Title I Planning Council (the Council) contracted with John Snow, Inc. (JSI) to develop and produce the 2006-2009 Comprehensive HIV Services Plan for the Phoenix EMA. The goal of the project was to develop a comprehensive plan for the EMA using a process that was participatory (including as many stakeholders as possible), iterative (building upon existing work and progress), and comprehensive (incorporating primary and secondary data from a range of relevant sources).

In the preliminary phase of the planning process, JSI planning team members worked with the Council support staff to develop a list of about 30 key stakeholders in the Phoenix EMA to contact for key informant interviews. JSI staff conducted interviews with approximately 25 of these individuals. The purpose of the interviews was to invite interviewees to participate in the planning process through a series of upcoming meetings of the Community Planning & Assessment Committee (CPA), and to gather information about current services, barriers to access, and some of the challenges to and successes of the HIV/AIDS service delivery system in the Phoenix EMA. The majority of the interviews were conducted by phone, with a few conducted by e-mail or in person. To ensure a broad range of perspectives were considered, the stakeholders were reflective of the epidemic in terms of race/ethnicity, gender, and age, and included people living with HIV/AIDS and providers of prevention, care, and support services. Several interviews were conducted in Spanish by a bilingual JSI team member.

As discussed later in this Plan, a comprehensive consumer survey was completed by the Phoenix EMA in 2005 prior to the commencement of the comprehensive planning process. JSI staff members attended the presentation of the results of the needs assessment at the August 2005 Council meeting, and summarized key findings for this Plan, including some additional data analyses. Because this planning component was complete, the comprehensive planning process focused primarily on implementing an inclusive and participatory process to develop goals and objectives, and collecting and summarizing relevant and complementary secondary data (e.g., epidemiologic data, resource inventories, other comprehensive plans, and stakeholder input).

The Council, CPA, Council support staff, and the JSI team worked collaboratively throughout the planning process. Between August and December 2005, the comprehensive plan was one of the primary focuses of the CPA. In September and October 2005, the regular CPA meetings were transformed into two three-hour planning sessions to develop the mission, guiding principles, goals, objectives, and activities for the Plan. The planning

portion of these meetings were facilitated by JSI staff members and included CPA members, other Council members, the Phoenix EMA Administrative Agent, key stakeholders from the community, and Council support staff. Planning materials, including agendas and other key documents and materials were provided in both English and Spanish. In addition, a draft outline of the plan was presented by JSI staff at the September meeting for input and review by CPA.

The first session, held on September 13, 2005, was attended by 20 people representing the various groups described above including providers and consumers from the Phoenix EMA. At that meeting, a presentation was given on the HRSA requirements of the comprehensive planning process and a “plan to plan” was outlined. The group deliberated on the development of a mission, guiding principles and long-term goals. Small groups were convened to work on objectives for each goal prior to the second meeting.

The second meeting, held on October 11, 2005, was attended by 14 people. About one-half of those who attended had not attended the September meeting. At this meeting, small groups worked on the goals and objectives to identify activities, or short-term goals and objectives, that could begin the implementation process.

After the two planning sessions, the draft mission, guiding principles, goals, objectives, and activities were circulated for comment. They were then revised to incorporate feedback from planning participants and to ensure that the plan would meet HRSA requirements. The revised goals, objectives, and activities were presented and discussed at the November 2005 CPAC meeting, providing a final opportunity for refinement before the development of the draft plan. At this meeting there was also a discussion of the implementation and monitoring activities for the Comprehensive Plan.

Based on the results of the planning sessions, the stakeholder interviews, and a review of secondary data sources (including the previous comprehensive plan for the Phoenix EMA, the most recent needs assessment, HIV/AIDS epidemiological data, and other comprehensive plans from other EMAs), JSI staff developed a draft comprehensive plan for the Phoenix EMA. The draft was distributed to planning session participants in mid-November 2005 for review. Comments and feedback on the draft were incorporated into a revised draft that was distributed to all Council members in advance of the December 2005 Council meeting. At the December 2005 Council meeting, JSI staff members presented the final draft of the comprehensive plan to the Council and answered questions about the content and development process.

Additional comments were received subsequent to the December 2005 Council meeting and additional sections of the plan were drafted and added in conjunction with the Community Planning & Assessment Committee. Recognizing the significant changes occurring in the epidemic and the EMA, the Planning Council established a Work Group to review the current continuum of care and develop an updated and improved continuum of care to improve access and retention in care for PLWHAs in all parts of the EMA. The initial session, held at the end of the comprehensive plan development

Chapter 2

process, included some 25 Planning Council members, consumers, and providers of HIV and supportive services in both counties. This session provided important clarity about the current continuum of care and its strengths and limitations. The Work Group is expected to play a similarly important role in implementing identified goals and objectives. Upon the approval of the final plan and its adoption by the Council, the document was published, translated from English to Spanish, and submitted to HRSA.

The CPA committee reviewed and discussed preliminary edits on February 7 and a final set of edits on February 27. With authority granted by the Planning Council at its February meeting, the CPA approved the final Comprehensive Plan on February 27, 2006.

Mission and Guiding Principles



Mission

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

Guiding Principles

- The system of care is comprehensive and responds to the full range of needs of people living with HIV and AIDS.
- There is geographic equity in access to services.
- The system of care adopts a “realist approach” to care systems that relies upon data to make hard choices.
- All providers treat clients with a compassionate and professional approach to care.
- Services are culturally and linguistically appropriate, respectful, and caring for all clients.
- The system of care includes not only Ryan White providers, but is open and inviting to all service providers within our community.
- Peer run services are incorporated while maintaining professional standards.

Current Continuum of Care



4.1 Current Continuum of Care

HRSA defines a continuum of care as “...a coordinated delivery system, encompassing a comprehensive range of services needed by individuals or families with HIV infection to meet their health care and psychological service needs throughout all stages of illness.” The Phoenix EMA has worked to create a continuum of care that is responsive to the needs of people living with and affected by HIV/AIDS in Maricopa and Pinal Counties.

In the EMA’s efforts to reduce barriers and provide high quality services to PLWHA, many of the services funded by Title I CARE Act funds have been centralized and consolidated, offering clients a range of highly-specialized services in one location. This model has provided many benefits to the community, including ease of access to care. Core services have been located centrally in the Phoenix metropolitan area, corresponding to the geographic location with the highest number of PLWHA.

However, as the population affected by HIV/AIDS has changed, gaps in service have become more evident in rural and minority populations. Clients have increasingly voiced concerns about the cultural appropriateness of existing services. As the EMA’s population grows and becomes more dispersed across both counties, clients have become increasingly dependent upon infrequent and long bus rides to access primary care and other services.

Client-Centered Continuum of Care

In its efforts to improve the Continuum of Care, the Administrative Agent has increased its focus on quality of care, with more emphasis on providing high quality and culturally appropriate services to minority populations typically underserved in the community. In addition, there is growing concern that “one-stop-shopping” may not meet the needs of specific communities. Lastly, the population of the EMA continues to experience rapid growth, especially in the more rural areas. The Planning Council has begun providing the Administrative Agent with new directives to ensure that culturally appropriate services are available throughout the EMA.

Core Services

Level funding for the Ryan White CARE Act has created new barriers and challenges to service provision in the EMA, requiring the Planning Council to balance the increasing need for services with the limited resources available. During the FY06 priority setting and allocation processes, the Council worked closely with the Administrative Agent to ensure adequate funding for core services, including primary medical care, pharmaceuticals, case management,

mental health, substance abuse services, and oral health; 76% of anticipated FY06 funds were allocated to these core services. Primary care remained the highest priority for the EMA and its allocation increased from 28% of funds in FY05 to 34% in FY06. Funding challenges have also forced the Planning Council to make difficult decisions about the range of services funded by Title I. For example, the FY06 allocation recommendation for alternative/complementary services represents a 58% reduction from FY05, and reflects the need to ensure adequate funding for core services.

Primary Care

Primary care in the Phoenix EMA is provided by a combination of hospital and community-based clinics and private medical practices. Individuals on Medicaid must select a plan which will determine the medical providers they can access. All Title I funds for primary care currently go to the McDowell Clinic, part of the Maricopa Integrated Health System. Currently, no primary care services are supported by Title I funds in Pinal County.

Pharmaceuticals

The local MCDPH-administered pharmaceutical assistance program is primarily Title I funded, and provides pharmaceuticals not available from the Title II ADAP. The Title I Pharmaceutical Assistance Program was established to provide a range of pharmaceuticals complementary to but not available through ADAP to help address the HIV-related medical needs of clients. The Title I Formulary encompasses several classes of medications for HIV/AIDS-associated conditions, including antibiotics, muscle relaxants, anti-psychotics, anti-convulsants, and others. The Planning Council has historically given high priority to the Title I pharmaceuticals as key to improving health outcomes.

Case Management

Case management facilitates access to the full Continuum of Care and assists clients with maintenance in care and adherence to treatment. The case management system is coordinated by four providers. Two agencies target Native Americans and homeless individuals. A third agency has one case manager to work with its clients who have histories of substance abuse. A fourth (and the largest case management provider) sees a range of clients within the EMA. This program currently has 14 case managers and 701 active clients. There are also 7,000 inactive clients reflecting the fact that not all clients need case management on an ongoing basis. Currently all clients receive the same services. If they no longer need services, they move to inactive status.

Some view the large case management agency as a strength of the Continuum of Care providing a central location for accessing this service. The agency has memoranda of understandings with seven private physicians and with Phoenix Children's Hospital. Due to the size of the agency, it has been

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able to hire and retain a diverse staff. Referrals to the program come from physician's offices, hospitals, counseling and testing sites, other clients, other AIDS service organizations, and other social services including the Department of Economic Security, social security, Medicaid, and home health agencies.

Efforts are underway to improve coordination of services to PLWHA who are leaving prison. This critical link will ensure that there is no gap in service when individuals leave the corrections system.

Mental Health and Substance Abuse Treatment

Mental health continues to be a priority of the Planning Council, with an increased emphasis on substance abuse treatment to address the emerging need in the community. The Planning Council has historically been sensitive to the gap in services, particularly for those with a severe chronic mental illness and those who need intensive long-term care. During FY05, services for mental health and substance abuse were separated by the Planning Council to more actively monitor the services provided and to emphasize the increasing need for substance abuse services for PLWHA in the EMA. The allocation to mental health in FY05 represented 2.1% of the award and the allocation to substance abuse 2.4%. Of the Minority AIDS Initiative (MAI) funds, \$70,000 has been targeted for the monolingual Hispanic population, a historically underrepresented minority population in the EMA. Non-licensed psychosocial support services have also been funded to help maintain PLWHA in care.

Oral Health

Oral Health is provided by Delta Dental and the Maricopa County Department of Public Health and receives approximately 10% of the Ryan White allocation. The Quality Management Team reviews dental insurance enrollment bi-annually and has made recommendations to the Maricopa County Office of Oral Health (OOH) to simplify the process of enrollment.

Services in Pinal County

Currently there is only one service agency in Pinal County contracted to provide services funded by Ryan White Title I through a subcontract with a Phoenix area provider. This agency provides case management, home health care, and transportation services.

Reducing Barriers

The Planning Council and the Title I Administrative Agent are committed to reducing barriers to care and ensuring that the Continuum of Care is adaptable and responsive to changes in the epidemic, the community, and the needs of PLWHA. One of primary goals for improving the Continuum of Care is to ensure access to culturally and linguistically appropriate services. Such services help reduce stigma and mistrust of the service system by some communities and improve the quality of care they receive.

Secondly, the Planning Council has renewed its efforts to bring into care hard to reach populations by emphasizing early intervention and outreach programs throughout the EMA. Funds have been utilized to build capacity and reevaluate the methods and models that the EMA uses to reach the minority populations.

The Planning Council has also begun to coordinate its processes more effectively with the Administrative Agent. Through intense technical assistance programs, the Planning Council has improved its relationship with the Administrative Agent and has begun using directives and information requests to ensure that its recommendations are implemented.

An example of this new collaborative relationship has been the directive from the Planning Council to expand primary care into rural areas of the EMA and to extend operating hours to increase the accessibility of services to those who need it.

Access to care

Several focus groups and needs assessments have been conducted to gather data to help the Administrative Agent and the Planning Council improve the Continuum of Care and better plan for the limited resources. A common barrier to care noted in these data collection activities has been the amount of “red-tape” that clients encounter when accessing care. The Comprehensive Plan includes a goal to evaluate the utility of creating a centralized eligibility database for all providers. This centralized database will allow providers to access client documentation no matter where they enter or navigate through the Continuum of Care. This will reduce the amount of paperwork clients and provider and promote more effective use of service funds. The centralized database will further assist the Administrative Agency by providing real-time data to analyze service utilization trends in the EMA.

Integrating Title I and other HIV Services for care

In addition to the increased cooperation among the Planning Council, the Administrative Agent, and the community, more effort is being made to increase the capacity of the overall HIV Continuum of Care. With expanded directives from the Planning Council, the Administrative Agent is focusing on building relationships with providers of HIV services outside of the Title I Continuum and to establish linkages to best meet the overall needs of the community affected by HIV. The Administrative Agency has also redeveloped its monitoring tool to focus on the referral relationships that providers use. Lastly, the Administrative Agent is establishing ongoing technical assistance to assist the community in strengthening collaborative relationships to enhance the Continuum of Care.

Link to Statewide Coordinated Statement of Need (SCSN)

The SCSN discusses the need to address the rising infection rates among women, minorities, injecting drug users, and persons with heterosexual risk. Data and trends presented in the document support the information gathered

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by the Planning Council or provided by other sources. The Planning Council's priorities and resource allocations have been determined to be supportive of the SCSN goals and address many findings identified in the SCSN, including:

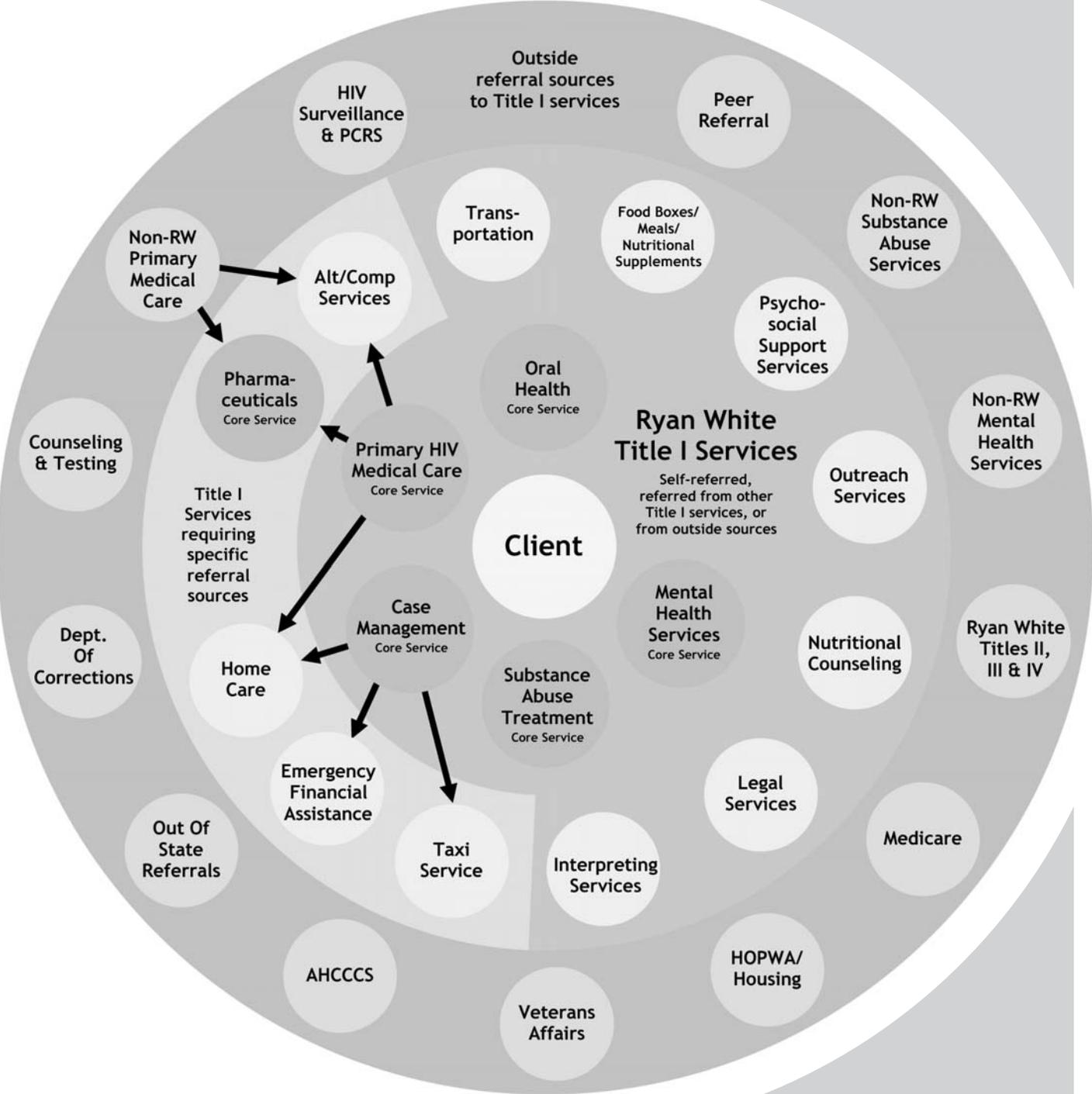
- Critical Gaps in Services (i.e., transportation and continuum of care linkages)
- Emergent Needs (i.e., behavioral health and substance abuse services)
- Barriers to Services (such as identification of clients not in services, and culturally specific services)

A revised SCSN was completed by the Title II Grantee in January 2006. The Planning Council will review the new document to ensure that the priorities and allocations remain compatible and supportive to the goals of the Statement.

Entry into Care

The range of places from which individuals may be referred into Title I services may include peer or self-referral; HIV surveillance and Partner Counseling and Referral Services (PCRS); counseling and testing; non-Ryan White primary medical care; non-Ryan White substance abuse and mental health services; Ryan White Titles II, III and IV; Medicare; AHCCCS (Medicaid); HOPWA and other housing for PLWHA; Veterans Affairs; Department of Corrections; and out-of-state referrals. The Work Group on Continuum of Care has developed a graphic representation of the current Continuum of Care that is depicted on the following page:

Continuum of Care



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4.2 Desired Continuum of Care

As the HIV epidemic, as well as care and treatment, continue to evolve, it is the responsibility of the Planning Council and Administrative Agent to adapt services to meet the needs of the community. During Grant Year 2005, the Planning Council and the Title I Administrative Agent restructured and began a paradigm shift to meet the changing needs of the EMA and HIV in general.

The Planning Council began focusing attention on improving access to care, with an increased emphasis on serving racial and ethnic minorities disproportionately impacted by HIV/AIDS. The Planning Council also began to focus on making data-driven decisions and devoted a large portion of time to gathering and studying the data available about the HIV epidemic in the EMA. As renewed efforts of coordination and cooperation have been established by the Planning Council, the Administrative Agent, and the community, the continuum of care in the Phoenix EMA has begun the shift to meet the changing needs of the community.

Within the comprehensive planning process, the mission and guiding principles help to establish the direction of the desired continuum of care. These principles specifically identify “geographic equity” in delivery of services and the principle that “services are culturally and linguistically appropriate” and “respectful.”

At the first meeting of the Work Group on the continuum of care, the following principles were articulated as components of the continuum of care:

- There should be a coordinated delivery system of care;
- it should be organized;
- it should be flexible and changeable to meet emerging needs;
- it should be seamless;
- it should be client centered;
- it should include both Ryan White and non-Ryan White service providers;
- there should be easy access/entry to care; and
- it should be easy for clients to enter the system, navigate from one service provider to another, and receive the services they need.

The Phoenix EMA has identified and funds six core services which are the same core services specified by HRSA: Primary Medical Care; Medications; Oral Health; Mental Health; Substance Abuse; and Case Management. These reflect the core needs of people living with HIV and AIDS. All other services are intended to provide access to and retention in primary care and other core services and should be viewed through that lens.

Additional Initiatives

The following sections describe several efforts underway to assess the current service delivery system and to help create the desired Continuum of Care:

Activities to promote parity of HIV services throughout the EMA

The Planning Council has identified a need to diversify its services by increasing the number of service providers, especially primary medical care. This service category will be bid competitively for the FY 2006 grant year. The Planning Council has developed directives for the Administrative Agent to review costs and logistics of decentralizing the Primary Care services to include expanded and weekend hours, as an indicated need in the communities of color; and to review the costs and logistics of expanding services into the rural areas of the large EMA.

Addressing disparities among racial and ethnic minorities in Phoenix EMA:

The Planning Council and Administrative Agent have issued a request for proposals (RFP) to conduct needs assessments among Latinos and African Americans living with HIV/AIDS in the Phoenix EMA. Building upon the information gathered in the 2005 consumer survey, these assessments would study in more detail the needs of both populations further. Further, the assessments will assess barriers to care, including those faced by Latinos and African-Americans who know their HIV status but are currently out-of-care. Lastly, the Comprehensive Plan includes a goal to develop and implement standards of care for culturally and linguistically appropriate services in an effort to respond to the needs of a diverse population.

Addressing disparities for residents of Pinal County: A recently funded study is under way to conduct an HIV needs assessment in Pinal County and to identify whether primary care services can be delivered effectively in the county, given concerns about confidentiality and quality of care. If the assessment indicates it is feasible, the upcoming competitive bid for primary care services will require that a portion of those services be delivered within Pinal County. The assessment will also identify individuals who are out-of-care in Pinal County and identify the barriers to accessing care and strategies for overcoming them.

Identifying and Linking Services to Those who are Out of Care

The most recent report on unmet need identified a reduction of approximately 7% in the proportion of people out of care. However, at an estimated 43%, the number of people out of care is still substantial. As a result, a number of activities are underway to identify and link to care PLWHA who know their status but are not in care. These include:

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1. Pinal County study (see above).
2. The development of a model for outreach focused on three groups:
 - the newly diagnosed;
 - individuals who are in care but are at risk for falling out of care;
 - individuals who have never been in care or have been out of care for more than two years;
3. New RFP to conduct a needs assessment of those out of care; and
4. New RFPs to conduct needs assessment of Latino/a and African-American communities including collecting information on those who are out-of-care (see above).

Developing a Model of Comprehensive Education

Information from the 2005 Consumer Survey and other sources indicated that many individuals are not accessing services because they do not know about them. Several activities will help the Phoenix EMA improve comprehensive HIV education for PLWHA. The Education & Empowerment Committee of the Council is working to revise the Resource Directory for the EMA. Further, a consultant has been engaged to develop a model for comprehensive HIV education that will help link PLWHA to services. While this process is not yet complete, preliminary recommendations include the resumption of a hotline and the development of an education program to build awareness among PLWHA about the functioning of the EMA, the Ryan White CARE Act, and the system of care in the EMA.

Ongoing Development of the Quality Management (QM) program

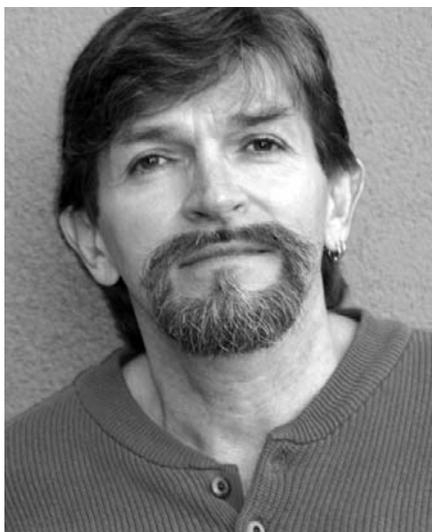
A consultant is working with the quality manager to make additional improvements to the Phoenix EMA QM program. The following activities have already been identified for strengthening the QM program:

1. The QM budget has been revised to better reflect functions performed by quality management. Funds were also added to the QM budget for educational and technical assistance on QM to all Title I providers.
2. The QM team composition is being reorganized to assure provider specific issues remain confidential. This is a major component of the technical assistance requested from the National Quality Center.
3. All QM data collection is being re-evaluated to assure objectivity and comprehensiveness. This will also be a major focus of the technical assistance scheduled from the National Quality Center.
4. The Standards Committee of the Planning Council is developing service specific standards of care. It has currently completed or nearly completed Universal Standards and standards for primary medical care, and pharmaceuticals. The QM data collection tools are being revised to conform to the newly-adopted standards of care.

Continue to Improve Planning Council Functioning

In the previous year, the Planning Council and its committees have received substantial technical assistance to improve its activities such as priority setting and resource allocation, needs assessment, comprehensive planning, assessment of the administrative mechanism, unmet need assessment and its governing rules and regulations. Among the current priorities are the continued development of the Membership Committee and additional recruitment of diverse Council members to represent the racial and ethnic minorities in the Phoenix EMA. A Leadership Institute is underway to train 12 Planning Council members on all aspects of the RWCA.

Goals and Objectives



Introduction

The Phoenix EMA Ryan White Title I Planning Council has developed goals and objectives through a process developed by its Community Planning & Assessment Committee (CPA) in conjunction with the Maricopa County Department of Public Health and consultants. These goals are evidence-based and rely upon information from the most recent epidemiologic profile, needs assessments, priority setting and resource allocation process, evaluation of unmet need, service utilization, and other sources.

To implement this plan, the Planning Council is committed to using best practices for community planning bodies, HRSA guidance on the operation of Title I planning councils, and its own committee structure to develop processes and activities to fulfill its responsibility to ensure a high quality continuum of care that maximizes the quality of life for people living with HIV and AIDS.

These goals, objectives, and activities were conceived to include both long-term and short-term goals and activities. Specifically, goals were designed to cover the three-year period from 2006-2009. In general, the first objective for each Goal is intended to be addressed during the first year of the Plan (2006). Activities have been specified to help meet the first year objective. Subsequent objectives shall be addressed in the 2nd and/or 3rd year of the Plan, or sooner if the first objective is achieved more quickly.

Responsible parties for goals, objectives and activities are identified where possible. The Council continues to assign responsibilities to individuals, committees and work groups and will notify HRSA of these assignments as they become available.

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

Statement of Need: Several sources, including the most recent consumer survey, identified higher needs for services among several populations including women, Blacks and Latinos. Specifically, women had significantly higher needs than men in 13 service areas. Blacks had significantly higher needs than Whites and Latinos for a range of services. Latinos had less pronounced differences in need than Blacks, but still had significantly higher needs than Whites for some services.

Objective 1: Based upon needs assessment and other data, conduct an analysis of how current service models can be adapted to ensure that those needing services are receiving them.

Activity 1: Compile current eligibility criteria for Ryan White services, as well as utilization and epidemiologic data.

People: Administrative Agent, Council committee or work group
Resources: Reports (epi, utilization, consumer survey)
Milestones: Assessment of current eligibility requirements

Activity 2: Document various “levels of need” based on needs assessment and other data and compare with utilization information to assess where those in greatest need are lacking access to services.

People: Council members, key stakeholders
Resources: Data collected in Activity 1
Milestones: Summary of deliberations/assessment

Activity 3: Develop recommendations for methods to ensure services are targeted to those in greatest need.

People: Council members, Administrative Agent
Resources: Methods used in other EMAs
Milestones: Regular presentation of process to Council, final recommendations.

Objective 2: Develop process within Standards Committee to recommend methods for improving services to those in greatest need (e.g., directing MAI funds or issuing directives to the Administrative Agent).

Objective 3: Monitor implementation of methods to target services to those with greatest need in all service categories.

Objective 4: Use utilization and needs assessment data to evaluate effectiveness of new strategies.

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

Statement of Need: Among the barriers identified in the most recent consumer survey, “too much red tape” and “too many rules and regulations” were identified by 48% and 52% of respondents respectively. In key informant interviews with providers and consumers, many noted the inconvenience of needing to demonstrate eligibility multiple times when seeking services.

Objective 1: Study, design and make recommendations for a consolidated eligibility system.

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Activity 1: Identify goals and benefits of a consolidated eligibility system.

Activity 2: Identify the needs and requirements of funding, including reporting requirements, HIPAA, and Arizona Revised Statutes.

Activity 3: Survey local providers to identify potential issues/barriers/obstacles to a consolidated eligibility system.

Activity 4: Recommend to Administrative Agent a process for implementation of consolidated eligibility system.

Activity 4.1: Support efforts of Administrative Agent to develop and implement training for providers.

Activity 4.2: Work with Administrative Agent to adopt/purchase/distribute necessary software/hardware systems.

Activity 5: Evaluate and refine the recommended consolidated eligibility system.

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

Statement of Need: The analysis of unmet need using the HRSA/UCSF formula identified that a substantial percentage of people living with HIV and AIDS in the Phoenix EMA know their status but are not in care. In consumer and provider key informant interviews in the EMA, nearly all stakeholders agreed that unmet need is a significant issue that needs to be addressed. The same stakeholder interviews identified problems with current outreach strategies. The Administrative Agent is contracting to obtain expert advice on the development of an outreach/early intervention model. A target should be established for identifying and bringing into care a specific number of new clients per month. This will be based on current studies of unmet need plus current challenges in bringing into care those individuals who are aware of their status but are not in care. The final number will be determined in conjunction with the model of outreach adopted.

Objective 1: Review and approve the proposed model to assist with the identification of people who are not in care in the Phoenix EMA by February 2007.

Activity 1: Use updated epidemiological information, the out-of-care study, and needs assessment data to identify who is not in care and why.

People: Community Planning & Assessment Committee, prevention providers

Resources: Needs assessment, out-of-care study

Milestones: Final documents, protocol

Activity 2: Review the proposed model of care presented by the Administrative Agent based on the criteria developed in Activity 1.

People: Professional societies, American Academy of HIV Medicine (AAHIVM)

Resources: Survey of service providers

Milestones: List of providers

Activity 3: Support activities of the grantee to educate providers on the use of the protocol and facilitate the implementation of the protocol.

People: AAHIVM, AETC, Planning Council, State Prevention ADHS, consultants

Resources: Conference, meeting, training resources

Milestones: List of all attendees and evaluation

Objective 2: With the Administrative Agent, implement and evaluate proposed activities under Targeted Outreach model.

Activity 1: The Appropriate Planning Council committee (CPA) reviews the Targeted Outreach pilot

Objective 3: Suggest refinements to the service model based on results of evaluation.

Goal 4: Improve access to services through multiple approaches.

Statement of Need: The 2005 consumer survey identifies several barriers to care, some of which are related to geography, including location and distribution of service providers, the concentration of points of service, and hours of operation.

Objective 1: Using epidemiological, needs assessment and service utilization data, identify barriers to access related to geography (the location, distribution, and concentration of service providers and points of access), as well as hours of operation and develop methods for addressing those barriers.

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Activity 1: Implement the directive to provide evening and weekend hours of operation.

Activity 2: Further develop strategies for studying issues related to geography, hours of operation, service locations, etc., that may limit access to care for populations of people living with HIV and AIDS.

Activity 3: Propose solutions to access issues based upon findings of study either through either allocations, directives, or MAI.

Objective 2: In collaboration with grantee, support implementation of solutions to reduce geographic and other logistical barriers to services.

Objective 3: Evaluate the effectiveness of implemented solutions using subsequent needs assessments, epidemiological data, and service utilization information.

Objective 4: Ensure that all Ryan White-funded service providers are aware of the broad spectrum of community-based services not limited to Title I, and include referrals to these services when possible.

Objective 5: Implement comprehensive education pilot and review initial findings.

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

Statement of Need: Information from current and previous needs assessments have indicated that people of color living with HIV and AIDS experience more barriers to care than other people living with HIV and AIDS in the Phoenix EMA. Through the first meeting of the Work Group on the continuum of care, the likely routes of entry to care and issues related to navigating the system were described. As the Work Group continues, there are likely to be recommendations regarding levels of case management or health navigation systems to insure access by different population groups living with HIV/AIDS. This goal is intended to ensure that services are culturally and linguistically appropriate.

Objective 1: Use the EMA's Universal Standards of Care for providing culturally and linguistically appropriate services to ensure that the specific needs of the diverse communities in the Phoenix EMA are met and monitor the implementation of the

Standards of Care as the communities affected by HIV and AIDS evolve over time.

Activity 1: Utilize the planned needs assessments of the African-American and Latino/a communities to test whether implemented objectives have been effective.

People: Planning Council Standards and Community Planning & Assessment Committees

Resources: Needs assessment results

Milestones: Report on effectiveness of universal standards.

Activity 2: Survey Title I-funded providers on populations served, languages, literacy levels, need for translation and cultural competency training for staff, as well as the feasibility of integrating standards for providing culturally and linguistically appropriate services into agency policies and practices.

Objective 2: Revise Universal Standards of Care for providing culturally and linguistically appropriate services in accordance with findings of study.

Activity 1: The Community Planning & Assessment Committee brings recommendations to the Standards Committee for use in revising Universal Standards of Care.

Activity 2: Revised standards are presented to the Phoenix EMA Planning Council for approval and then forwarded to the Administrative Agent for implementation.

Activity 3: Support Administrative Agent in provision of training to sites regarding the implementation of the standards and their importance in successful delivery of services.

Objective 3: Based upon findings from Work Group on continuum of care make develop directives related to health navigation systems or other strategies to insure seamless access to services by all population groups living with HIV/AIDS.

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

Statement of Need: A successful Planning Council, with effective and

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meaningful consumer participation, is necessary to ensure that the system of care for people living HIV and AIDS in the Phoenix EMA continues to meet the needs of communities affected by the epidemic.

Objective 1: Maintain the diversity of the Planning Council's membership so that it continues to reflect the changing epidemic in the Phoenix EMA.

Activity 1: Assess the extent to which the Planning Council's membership reflects the current epidemic in the Phoenix EMA and identify deficiencies in membership needs.

Activity 2: Using the revised Open Nominations Process recently adopted by the Planning Council, develop and implement targeted strategies to recruit members from diverse populations that are culturally and linguistically appropriate.

Objective 2: Increase the retention of consumers on the Planning Council and ensure effective participation in all activities and decisions.

Activity 1: Annually survey Planning Council members about training needs. Based upon the survey results, develop a specific training plan that includes a roles and responsibilities workshop for all new members.

People: Planning Council Support, Membership Committee

Activity 2: Conduct and evaluate trainings in the topic areas most frequently requested or suggested by members.

Activity 3: Conduct and evaluate 10-month Leadership Academy for membership development, retention and skills training.

Objective 3: Develop protocols to ensure that the activities of the Planning Council are culturally and linguistically appropriate.

Activity 1: Allot adequate resources (funding, training, materials, etc.) to ensure that Planning Council activities and documents are culturally and linguistically appropriate.

Activity 2: As needed, revise the Planning Council's materials, training programs, and meeting processes to comply with the established protocols for culturally and linguistically appropriate services.

Objective 4: Increase the general public’s knowledge of the Planning Council’s purpose and role in the local HIV continuum of care.

People: Education & Empowerment Committee with Administrative Agent

Activity 1: Develop outreach strategies to engage diverse participation from the community.

Objective 5: Work closely with HRSA to ensure that all Planning Council activities meet federal requirements.

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

Statement of Need: The linkage between HIV care services and HIV prevention is essential for identifying individuals who know their status but are not in care (see Goal 3) and for meeting the HIV prevention needs of people living with HIV and AIDS as part of their health care. The Work Group on the continuum of care is looking at how people get into care and how that can be approved. The Administrative Agent is in the process of assessing standards/ models for comprehensive education services. The Continuum of Care Workgroup is evaluating how people access care and how that might further be improved.

Objective 1: Review models developed by grantee to improve education services for individuals newly diagnosed with HIV and AIDS including peer education models.

Activity 1: Obtain and analyze standards and models of service delivery in collaborative process involving the Standards Committee, Planning Council, and Administrative Agent.

Activity 2: Implement and evaluate the model through procurement of services.

Objective 2: Examine the service “pathways” between prevention services, HIV counseling and testing and care services.

Objective 3: Maintain linkages with the Community Planning Group to insure coordination with its models for positive prevention and outreach.

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Goal 8: Develop standards of care for Ryan White Title I-funded service categories.

Statement of Need: An area of importance in the Phoenix EMA is the development of standards of care for core services and other service areas. These standards of care can improve access by identifying clear criteria for eligibility, explaining the components and parameters of each service, and establishing acuity measures where appropriate.

Objective 1: Establish and implement a process to develop standards of care for all service categories currently supported with Ryan White Title I funds.

Activity 1: Establish a meeting schedule to review and develop standards of care/best practices for all services beginning with core services.

People: Standards Committee, Planning Council Support
Resources: Meeting space, standards/best practices/models from other areas, objective review process
Milestones: Meetings, background materials on standards/best practices

Strategy for Monitoring and Implementation



A monitoring and implementation process helps to insure that the goals and objectives of the comprehensive plan are prioritized, implemented, adjusted, reviewed, and revised according to a realistic time frame. This section sets out that process.

Monitoring the Plan

It is agreed that the Community Planning & Assessment Committee (CPA) will assume responsibility generally for monitoring the Comprehensive HIV Services Plan. It shall report back to the Planning Council on a quarterly basis on the progress associated with the various goals, objectives, and activities. Specifically, CPA will report on whether the activities under each objective have begun and provide updates on the status of the activity. If an activity has not begun, CPA should make recommendations to the Planning Council regarding steps that may be taken to initiate the activity and the Planning Council shall vote on whether to authorize those steps.

Annually, the Planning Council should 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 should ask CPA to develop and recommend changes and bring them back to the Planning Council for approval.

Implementing the Plan

The responsibility for monitoring is not the same as the responsibility for implementing. For most of the goals and objectives, a responsible Planning Council committee or other responsible entity has been identified. In the case that such an entity has not been identified, the CPA shall recommend to the Planning Council what group(s) or individual(s) should assume responsibility for implementation. Thus, CPA coordinates, monitors, and reports back to the full Planning Council, but the broader implementation of the plan rests with those identified in the plan to undertake specific activities.

Time Frame

It is generally envisioned that each objectives put forth is to be addressed in a twelve-month period. Thus, Objective 1 is to be accomplished in 2006, Objective 2 in 2007, and Objective 3 in 2008. However, this may not be exactly the case for each goal, so CPA is advised to monitor the plan with this in mind. Committees responsible for each goal, objective, or activity are encouraged to develop a time frame for that goal, objective, or activity. In addition, the resources needed to accomplish a particular planning task must be identified at

the beginning of that process so that a commitment of resources may be obtained or the goal, objective, or activity reassessed.

Specific dates for accomplishing each activity are included in the chart on the following pages:

Timeframe for Phoenix EMA Long- and Short-term Goals and Objectives

Long-term Goals	Objectives and Short-Term Goals and Objectives/Activities	Year 1 March/ May 06	Year 1 June/ Aug 06	Year 1 Sept/ Nov 06	Year 1 Dec 06/ Feb 07	Year 2 (2007/ 2008)	Year 3 (2008/ 2009)
Goal 1: Improve delivery of core services and other services to populations with the greatest needs.	Analyze how current service models can be adapted to ensure that those needing services are receiving them.	■	■	■	■	■	■
	Compile current eligibility criteria for Ryan White services, as well as utilization and epidemiologic data.	■	■				
	Document various "levels of need" based on needs assessment and other data and compare with utilization information.	■	■				
	Develop recommendations for methods to ensure services are targeted to those in greatest need.			■			
	Develop process within Standards Committee to recommend methods for improving services to those in greatest need.				■		
	Monitor implementation of methods to target services to those with greatest need in all service categories.					■	
	Use utilization and needs assessment data to evaluate effectiveness of new strategies.						■
Goal 2: Improve entry into care by streamlining the eligibility process.	Study, design and make recommendations for a consolidated eligibility system.	■	■	■	■	■	■
	Identify goals and benefits of a consolidated eligibility system.	■					
	Identify the needs and requirements of funding, including reporting requirements, HIPAA, and Arizona Revised Statutes.	■	■				
	Survey local providers to identify potential issues/barriers/obstacles to a consolidated eligibility system.		■	■			

Chapter 6

Long-term Goals	Objectives and Short-Term Goals and Objectives/Activities	Year 1 March/ May 06	Year 1 June/ Aug 06	Year 1 Sept/ Nov 06	Year 1 Dec 06/ Feb 07	Year 2 (2007/ 2008)	Year 3 (2008/ 2009)
	Recommend to Administrative Agent a process for implementation of consolidated eligibility system.				■	■	
	Support efforts of Administrative Agent to develop and implement training for providers.					■	
	Work with Administrative Agent to adopt/purchase/distribute necessary software/hardware systems.					■	
	Evaluate and refine the consolidated eligibility system.						■
Goal 3: Identify individuals who are aware of their HIV status, are not in care, and facilitate their entry into care.		■	■	■	■	■	■
	Review and approve the proposed model to assist with the identification of people who are not in care in the Phoenix EMA by February 2006.	■ (Due Feb 06)					
	Use updated epidemiological information, the out-of-care study, and needs assessment data to identify who is not in care and why.	■	■				
	Review the proposed model of care presented by the Administrative Agent based on study of out-of-care.			■	■		
	Support activities of the grantee to educate providers on the use of the protocol and facilitate the implementation of the protocol.	■	■	■	■	■	
	With the Administrative Agent, implement and evaluate the proposed activities under the Targeted Outreach model Planning Council committee reviews findings from the Targeted Outreach pilot.	■	■	■			
	Suggest refinements to the service model based on results of evaluation.					■	
Goal 4: Improve access to services through multiple approaches.		■	■	■	■	■	■
	Using epidemiological, needs assessment and service utilization data, identify barriers to access related to geography and develop methods for addressing those barriers.	■	■				
	Implement the directive to provide evening and weekend hours of operation.	■	■				
	Develop additional strategies for overcoming barriers related to geography, hours of operation, service locations, etc., limit access to care for populations of PLWHA.		■	■			
	Propose solutions to access issues based upon findings of study either through allocations, directives, or MAI.				■	■	

Long-term Goals	Objectives and Short-Term Goals and Objectives/Activities	Year 1 March/ May 06	Year 1 June/ Aug 06	Year 1 Sept/ Nov 06	Year 1 Dec 06/ Feb 07	Year 2 (2007/ 2008)	Year 3 (2008/ 2009)
	In collaboration with grantee, support implementation of solutions to reduce geographic and other logistical barriers to services.				■	■	
	Evaluate the effectiveness of implemented solutions using subsequent needs assessments, epidemiological data, and service utilization information.					■	
	Ensure that all Ryan White-funded service providers are aware of the broad spectrum of community-based services not limited to Title I.			■	■	■	■
	Implement comprehensive education pilot and review initial findings.	■	■	■	■		
Goal 5: Provide a continuum of HIV/AIDS services that is culturally and linguistically appropriate.		■	■	■	■	■	■
	Use the EMA's Universal Standards of Care for providing culturally and linguistically appropriate services to ensure that the specific needs of the diverse communities in the Phoenix EMA are met and monitor the implementation of the Standards of Care as the communities affected by HIV and AIDS evolve over time.	■	■	■	■	■	■
	Utilize the planned needs assessments of the African-American and Latino/a communities to test whether implemented objectives have been effective.		■	■	■		
	Survey Title I-funded providers on populations served, languages, literacy levels, need for translation and cultural competency training for staff, and the feasibility of integrating standards for providing culturally and linguistically appropriate services into agency policies and practices.			■			
	Revise Universal Standards of Care for providing culturally and linguistically appropriate services in accordance with findings of study.				■	■	
	The Community Planning & Assessment Committee brings recommendations to the Standards Committee for use in revising Universal Standards of Care.					■	
	Revised standards are presented to the Phoenix EMA Planning Council for approval and then forwarded to the Administrative Agent for implementation.					■	
	Support Administrative Agent in provision of training to sites regarding the implementation of the standards and their importance in successful delivery of services.					■	

Chapter 6

Long-term Goals	Objectives and Short-Term Goals and Objectives/Activities	Year 1 March/ May 06	Year 1 June/ Aug 06	Year 1 Sept/ Nov 06	Year 1 Dec 06/ Feb 07	Year 2 (2007/ 2008)	Year 3 (2008/ 2009)
	Based upon findings from Work Group on continuum of care, develop directives related to health navigation systems or other strategies to insure seamless access to services.	■	■	■	■	■	
Goal 6: Improve the operations of the Planning Council and increase consumer involvement.		■	■	■	■	■	■
	Maintain the diversity of the Planning Council's membership so that it continues to reflect the changing epidemic in the Phoenix EMA.	■	■	■	■	■	■
	Assess the extent to which the Planning Council's membership reflects the current epidemic in the Phoenix EMA and identify deficiencies in membership needs.	■	■				
	Using the revised Open Nominations Process recently adopted by the Planning Council, develop and implement targeted strategies to recruit members from diverse populations that are culturally and linguistically appropriate.		■	■	■	■	■
	Increase the retention of consumers on the Planning Council and ensure effective participation in all activities and decisions.			■	■	■	■
	Annually survey Planning Council members about training needs. Based upon the survey results, develop a specific training plan that includes a roles and responsibilities workshop for all new members.				■	■	■
	Conduct and evaluate trainings in the topic areas most frequently requested or suggested by members. Continue 10-month Leadership Academy of on-going membership development.	■	■	■	■	■	■
	Conduct and evaluate 10-month Leadership Academy for membership development, retention and skills training.	■	■	■	■	■	
	Develop protocols to ensure that the activities of the Planning Council are culturally and linguistically appropriate.			■		■	■
	Allot adequate resources (funding, training, materials, etc.) to ensure that Planning Council activities and documents are culturally and linguistically appropriate.			■		■	■
	As needed, revise the Planning Council's materials, training programs, and meeting processes to comply with the established protocols for culturally and linguistically appropriate services.					■	■

Long-term Goals	Objectives and Short-Term Goals and Objectives/Activities	Year 1 March/ May 06	Year 1 June/ Aug 06	Year 1 Sept/ Nov 06	Year 1 Dec 06/ Feb 07	Year 2 (2007/ 2008)	Year 3 (2008/ 2009)
	Increase the general public’s knowledge of the Planning Council’s purpose and role in the local HIV continuum of care.			■		■	■
	Work closely with HRSA to ensure that all Planning Council activities meet federal requirements.	■	■	■	■	■	■
Goal 7: Improve the integration and coordination among care services and between HIV care and prevention.		■	■	■	■	■	■
	Review models developed by grantee to improve education services for individuals newly diagnosed with HIV and AIDS including peer education models.	■	■	■	■	■	■
	Obtain and analyze standards and models of service delivery in collaborative process involving the Standards Committee, Planning Council, and Administrative Agent.	■	■				
	Implement and evaluate the model through procurement of services.	■	■				
	Examine the service “pathways” between prevention services, HIV counseling and testing and care services.			■	■	■	
	Maintain linkages with the Community Planning Group to insure coordination with its models for positive prevention and outreach.			■		■	■
Goal 8: Develop standards of care for Ryan White Title I-funded service categories.	Establish and implement a process to develop standards of care for all service categories currently supported with Ryan White Title I funds (already underway).	■					
	Establish a meeting schedule to review and develop standards of care/best practices for all services beginning with core services (already underway).	■					

Evidence-Based Data



7.1 Epi Profile

As of March 2005, there were an estimated 10,196 people living with HIV and AIDS in Arizona. The Phoenix EMA is disproportionately affected by HIV/AIDS compared to other areas in the state, accounting for 71.3% of all estimated HIV/AIDS cases and 75.5% of newly diagnosed cases. Since nearly three-quarters of all cases are in the Phoenix EMA, trends in the statewide epidemic are similar to those in the EMA.

This section summarizes HIV/AIDS epidemiological data for the EMA and the state, highlighting key similarities and differences between the two geographic areas, and also identifying important variations and differences among groups within the EMA. These data have implications for comprehensive planning for services for PLWH. The two primary sources of the data in this section were the HIV/AIDS Annual Report (March 2005) and the Integrated Epidemic Profile (September 2005) as developed by the Arizona Department of Health Services, Office of HIV/AIDS.

HIV and AIDS Prevalence for 2005

HIV Prevalence

Prevalence is the estimated number of people living with HIV and AIDS at a given point in time. As of March 2005, there were an estimated 5,518 people living with HIV and 4,678 people living with AIDS in the state of Arizona. The Phoenix EMA accounts for 71% of the estimated HIV cases and 71.8% of the

AIDS cases in the state. According to the HIV/AIDS Annual Report (March 2005), prevalence rates for HIV and AIDS in Arizona are especially high in urban areas (defined as areas with a population density of 50 or more people per square mile). Maricopa County is predominately urban; Maricopa County alone accounts over 63% of the state's population.

As shown in Table I, there were more men than women living with HIV in the state (85.4% vs. 14.5%)

Table I: HIV Prevalence by Gender
The estimated total HIV cases

	Arizona			Phoenix EMA		
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000
Male	4714	85.4	168.87	3362	85.8	185.66
Female	804	14.5	28.82	554	14.1	31.08
Total	5518	—	98.87	3916	—	108.98

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

and in the EMA (85.8% vs. 14.1%). By age, the majority of estimated HIV cases were among people 35-49 years old in the state and in the EMA. Over 70% of the HIV cases in the Phoenix EMA are within these age categories (see Table II). The last column in Table II illustrates the percentage of all statewide cases in each age group that reside in the EMA. As shown, the EMA accounts for a higher proportion of younger HIV cases in the state than older cases — 77% to 78% of all cases among people age 20 to 39 are in the EMA, vs. 59% to 70% of the cohorts over age 39.

By race, 62% of the HIV cases in the EMA were White (non-Hispanic), 20.1% were Hispanic and 12.1% were Black (non-Hispanic) (see Table III). These percentages were similar to those for the state, but nonetheless highlight the disproportionate impact of HIV on Black communities when compared to the proportion of this group among the total state population (see Chapter 1). The HIV infection rates provided in Table III also illustrate the disproportionate impact of HIV by race, particularly on Black and American Indian communities. The rate of HIV infection among Blacks (314/100,000) was nearly quadrupled the rate among Hispanics (78/100,000), triple the rate among Whites (107/100,000), and double that among American Indians (160/100,000). Rates of HIV infection were similar in the state and the Phoenix EMA among all racial/ethnic groups, except among American Indians where the rate of infection in the EMA (160/100,000) was more than double the rate in the state (71/100,000).

Table II: HIV Prevalence by Age
The estimated total HIV cases

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ cases in EMA
Under 2	0	0.0%	0.00	0	0.0%	0.00	0%
2-12	33	0.5%	3.54	25	0.6%	4.03	75.8%
13-19	31	0.5%	5.23	17	0.4%	4.89	54.8%
20-24	133	2.4%	33.11	104	2.6%	39.94	78.2%
25-29	356	6.4%	89.40	279	7.1%	100.82	78.4%
30-34	630	11.4%	155.45	493	12.5%	171.98	78.3%
35-39	1,003	18.1%	260.43	769	19.6%	291.74	76.7%
40-44	1,294	23.4%	323.62	901	23.0%	341.38	69.6%
45-49	910	16.4%	247.46	608	15.5%	261.29	66.8%
50-54	539	9.7%	166.28	354	6.4%	176.49	65.7%
55-59	326	5.9%	115.84	200	3.6%	115.89	61.3%
60-64	130	2.3%	55.86	76	13.7%	55.35	58.5%
65 and Above	109	1.9%	15.26	72	1.3%	17.50	66.1%
Age Unknown	24	0.4%	NA	18	3.2%	N/A	75%
Total	5,518	100%*	98.87	3,916	100%*	108.98	71.0%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

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Table III: HIV Prevalence by Race/Ethnicity
The Total Number of HIV Cases Reported to CDC

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of Cases in EMA
White Non-Hispanic	3,446	62.4%	99.65	2430	62.0%	106.68	70.5%
Black Non-Hispanic	613	1.1%	342.91	475	12.1%	314.16	77.5%
Hispanic	1,123	20.3%	72.46	791	20.1%	78.33	70.4%
Asian Pacific Islander/ Hawaiian Native Non-Hispanic	43		34.52	29	0.7%	31.28	67.4%
American Indian/ Alaskan Native Non-Hispanic	190	3.4%	70.53	118	3.0%	159.88	62.1%
Multiple Race/ Other Race	103	1.8%	N/A	73	1.8%	N/A	70.9%
Total	5,518	100%	98.87	3,916	100%	108.98	71%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

The disparate impact of HIV on Black communities is particularly important for the Phoenix EMA because, as the final column in Table III illustrates, nearly 78% of all Blacks living with HIV in Arizona reside in the Phoenix EMA, a higher proportion than other racial/ethnic groups.

Table IV illustrates that of the estimated total of HIV cases in the Phoenix EMA, 56.3% were attributable to male-to-male sexual (MSM) contact, 12.2% to injection drug use, 10.4% to heterosexual contact and 7.4% to MSM /injection drug use. These percentages were similar to that of the state. For each transmission mode, approximately 70% of all HIV cases in the state were in the Phoenix EMA, except for IDU where the proportion was slightly lower (66%).

Table IV: HIV Prevalence by Mode of Transmission
The estimated total HIV cases

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of Cases in EMA
MSM	3,087	55.9	N/A	2,206	56.3	N/A	71.5%
IDU	727	13.1	N/A	480	12.2	N/A	66.0%
MSM/IDU	418	7.5	N/A	296	7.5	N/A	70.8%
Heterosexual	587	10.6	N/A	411	10.4	N/A	70.0%
Other	105	1.9	N/A	75	1.9	N/A	71.4%
No Reported Risk/ Unknown Risk	603	10.9	N/A	448	11.4	N/A	74.3%
Total	5,518	100%*	98.87	3,916	100%*	108.98	71%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

AIDS Prevalence

As of March 2005, there were 4,678 reported AIDS cases in Arizona. The Phoenix EMA represents 71.8% these cases. There were more men living with AIDS than women in both the state (88% vs. 12%) and in the EMA (89% vs. 11%).

For both the EMA and the state, the majority of the total estimated AIDS cases were among people ages 35-49 years, accounting for nearly 63% the total AIDS cases in the EMA. As with HIV cases, Table VI also shows that the Phoenix EMA accounts for a higher percentage of the state's AIDS cases among the younger age cohorts (age 20 to 39), except for the 60-64 age group where the EMA accounts for nearly 78% of the state's cases in that age group.

Of the total of estimated AIDS cases in the Phoenix EMA, 62.7% were White (non- Hispanic), 21.9% were Hispanic and 11.0% were Black (non-Hispanic). These percentages were similar to those for the state, and illustrate the disproportionate impact of HIV/AIDS among Blacks when compared to their overall percent of the state's population (3.1%). As with HIV rates, the AIDS prevalence rate was highest among Blacks (268/100,000), and was more than 3.5 times higher than the rate among Hispanics (73/100,000), nearly triple the rate among Whites, and nearly double the rate among American Indians/Alaska Natives. Nearly 80% of the Blacks living with AIDS in Arizona live in the Phoenix EMA, a proportion higher than that of other racial/ethnic groups (see Table VII, last column).

Table V: AIDS Prevalence by Gender
The estimated total AIDS cases

	Arizona			Phoenix EMA		
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000
Male	4,121	88.0%	147.63	2,986	88.8%	164.90
Female	557	11.9%	19.97	376	11.1%	21.09
Total	4,678	100%*	83.82	3,362	100%*-	93.56

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

Table VI: AIDS Prevalence by Age
The estimated total AIDS cases

Years	Arizona			Phoenix EMA			% of AZ cases in EMA
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	
Under 2	0	0.0%	0.00	0	0.0	0.00	0.0%
2-12	5	0.1%	0.54	3	0.0	0.48	60.0%
13-19	16	0.3%	2.86	11	0.3	3.17	68.8%
20-24	34	0.7%	8.46	25	0.7	9.60	73.5%
25-29	145	3.0%	36.41	109	3.2	39.39	75.2%
30-34	402	8.5%	99.19	316	9.3	110.24	78.6%
35-39	825	17.6%	214.22	627	18.6	237.87	76.0%
40-44	1,199	25.6%	299.86	858	25.5	325.08	71.6%
45-49	930	19.8%	252.90	633	18.8	272.04	68.1%
50-54	579	12.3%	178.62	399	11.8	198.93	68.9%
55-59	296	6.3%	105.18	201	5.9	116.47	67.9%
60-64	135	2.8%	58.00	105	3.1	76.47	77.8%
65 and Above	112	2.3%	15.68	75	2.2	18.23	67.0%
Age Unknown	0	0.0%	N/A	0	0.0	N/A	0.0%
Total	4,678	100%*	83.82	3362	100%*	93.56	71.9%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

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Table VII: AIDS Prevalence by Race
The estimated total AIDS cases

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ Cases in EMA
White Non-Hispanic	2,917	62.3	84.35	2,109	62.7	92.59	72.3%
Black Non-Hispanic	468	10.0	261.80	373	11.0	267.90	79.7%
Hispanic	1,070	22.8	69.04	737	21.9	72.98	68.9%
Asian Pacific Islander/Hawaiian Native Non-Hispanic	36	0.7	28.90	27	0.8	29.12	75.0%
American Indian/Alaskan Native Non-Hispanic	177	3.7	65.71	110	3.2	149.04	62.1%
Multiple Race/Other Race	10	0.2	N/A	6	0.1	N/A	60.0%
Total	4,678	100%*	83.82	3362	100%*	93.56	71.9%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

Of the total estimated AIDS cases in the Phoenix EMA, 62.4% were attributable to male-to-male sexual (MSM) contact, 13.1% to injection drug use, 10.8% to MSM /injection drug use and 9.8% to heterosexual contact. These percentages were similar to those for the state. For each transmission mode, approximately 70% of AIDS cases in the state reside in the Phoenix EMA.

Table VIII: AIDS Prevalence by Mode of Transmission
The estimated total AIDS cases

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of Total Cases in EMA
MSM	2,876	61.4	N/A	2,099	62.4	N/A	73.0
IDU	641	13.7	N/A	441	13.1	N/A	68.8
MSM/IDU	512	10.9	N/A	364	10.8	N/A	71.1
Heterosexual	464	9.9	N/A	330	9.8	N/A	71.1
Other	80	1.7	N/A	45	1.3	N/A	56.3
No Reported/Unknown Risk	105	2.2	N/A	83	2.4	N/A	79.0
Total	4,678	100%*	83.82	3,362	100%*	N/A	71.9

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

HIV and AIDS Incidence 1999-2003

Due to inconsistencies in data collection, incidence data are based upon the sum of new HIV cases and new AIDS cases that have not been previously diagnosed as HIV infections in any previous calendar year. These cases are referred to as “emergent cases” and are used to measure incidence (the number of newly diagnosed HIV and/or AIDS cases within a given time period).

From 1999-2003, there were 2,147 newly diagnosed HIV cases and 1,356 newly diagnosed AIDS cases in the state of Arizona. The Phoenix EMA accounted for 77.4 % of the newly diagnosed HIV cases and 72.4% of the newly diagnosed AIDS cases in the state.

Emergent HIV Cases from 1999-2003

From 1999-2003, there were 1,663 newly diagnosed HIV cases reported in the Phoenix EMA. Of those new cases, 85.2% were male and 14.7% were female (see Table IX).

The data in Table X demonstrate that for both the Phoenix EMA and the state, the majority of the emergent HIV cases were among people aged 25-39 years; nearly 55% of all new HIV cases were among these age groups. As the last column in Table X illustrates, a large proportion of new HIV cases in Arizona are within the Phoenix EMA, especially among younger cohorts where 80% or more of cases are in the EMA.

Of the 1,663 newly reported

**Table IX: Emergent HIV by Gender
Total new HIV Cases (1999-2003)**

	Arizona			Phoenix EMA		
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000
Male	1814	84.4	13.69	1417	85.2	16.64
Female	333	15.5	2.51	246	14.7	2.92
Total	2147	—	8.09	1663	—	9.82

Source: HIV/AIDS Annual Report- March 2005

**Table X: Emergent HIV by Age
Total new HIV Cases (1999-2003)**

	Arizona			Phoenix EMA			% of AZ Cases in EMA
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	
Under 2	7	0.3	0.84	6	0.3	1.08	85.7%
2-12	13	0.6	0.29	11	0.6	0.38	84.6%
13-19	45	2.0	1.69	38	2.2	2.31	84.4%
20-24	242	11.2	12.86	184	11.0	15.06	76.0%
25-29	341	15.8	17.99	274	16.4	20.82	80.4%
30-34	411	19.1	21.44	332	19.9	24.87	80.8%
35-39	411	19.1	21.16	310	18.6	23.75	75.4%
40-44	310	14.4	16.06	236	14.1	18.86	76.1%
45-49	187	8.7	10.81	133	7.9	12.30	71.1%
50-54	95	4.4	6.18	74	4.4	7.78	77.9%
55-59	41	1.9	3.23	28	1.6	3.63	68.3%
60-64	28	1.3	2.62	23	1.3	3.70	82.1%
65 and Above	16	0.7	0.47	14	0.8	0.70	87.5%
Age Unknown	0	0	N/A	0	0	N/A	0.00%
Total	2147	100%*	8.06	1663	100%*	9.82	77.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

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Table XI : Emergent HIV by Race and Ethnicity
Total new HIV cases (1999-2003)

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ Cases in the EMA
White Non-Hispanic	1,190	55.4%	7.05	944	56.7%	8.53	79.3%
Black Non-Hispanic	266	12.3%	31.33	216	12.9%	33.34	81.2%
Hispanic	569	26.5%	8.16	429	25.7%	9.61	75.4%
Asian Pacific Islander/ Hawaiian Native Non-Hispanic	18	0.8%	3.21	13	0.7%	3.13	72.2%
American Indian/ Alaskan Native Non-Hispanic	101	4.7%	7.91	59	3.5%	17.19	58.4%
Multiple Race/ Other Race	3	0.1%	N/A	2	0.1%	N/A	66.7%
Total	2,147	100%*	8.09	1,663	100%*	9.82	77.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

HIV cases in the Phoenix EMA, 56.7% were White (non-Hispanic), 25.7% were Hispanic and 12.9% were Black (non-Hispanic) (see Table XI). The rate of new HIV infections in the EMA was two to ten times higher among Blacks (33/100,000) than the other racial/ethnic groups. The proportion of new statewide HIV cases in American Indians/Alaska Natives who live in the EMA (58%) was lower than the other racial/ethnic groups and the overall total (77.5%).

By mode of transmission, the majority of newly reported HIV cases in Phoenix EMA were attributable to male-to-male sexual (MSM) contact (59.7%). Other transmission modes account for smaller percentages of new HIV cases, including injection drug use (12.6%), heterosexual contact (13.6%) and MSM /injection drug use (8.4%). The EMA has a lower percentage of transmission through injection drug use than the state (12.6% and 13.8% respectively). Of the statewide emergent HIV cases among IDU, the Phoenix EMA accounts for a lower proportion (71%) of cases than it does for other transmission categories.

Table XII: Emergent HIV by Mode of Transmission
Total new HIV cases (1999-2003)

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ Cases in the EMA
MSM	1,258	58.5%	N/A	993	59.7%	N/A	78.9%
IDU	297	13.8%	N/A	211	12.6%	N/A	71.0%
MSM/IDU	180	8.3%	N/A	141	8.4%	N/A	78.3%
Heterosexual	294	13.6%	N/A	222	13.3%	N/A	75.5%
Other	30	1.3%	N/A	26	1.5%	N/A	86.7%
No Reported Risk/ Unknown Risk	88	4.0%	N/A	70	4.2%	N/A	79.5%
Total	2,147	100%*	8.09	1,663	100%*	9.82	77.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

Emergent AIDS Cases from 1999-2003

From 1999-2003, there were 983 new AIDS cases reported in the Phoenix EMA, representing about 73% of the emergent AIDS cases in Arizona. In both Arizona and the Phoenix EMA, about 89% of emergent AIDS cases were among men and 11% among women.

By age, the majority of new AIDS cases in the state and the EMA were among people aged 30-44 years, representing nearly 61% of new cases in the EMA and 59% in the state. Of all new AIDS cases statewide, the Phoenix EMA accounts for a larger proportion of new cases among younger cohorts than it does among older cohorts (see Table XIV).

As shown in Table XV, 51.6% of the 983 newly reported AIDS cases in the Phoenix EMA were White (non-Hispanic), 30.6% were Hispanic, and 12.7% percent were Black (non-Hispanic). The rate of new AIDS diagnoses was significantly higher among Blacks (19/100,000) than among Whites (4.6/100,000), Hispanics (6.8/100,000), and other racial/ethnic groups. Of all emergent AIDS cases among Blacks in Arizona, over 77% were in the Phoenix EMA, a slightly higher proportion than most of the other racial/ethnic groups.

By mode of transmission, nearly two-thirds of newly reported AIDS cases in the Phoenix EMA were attributable to male-to-male sexual (MSM) contact (62.4%). Other transmission modes account for smaller percentages of new AIDS cases, including injection drug use (14.7%), heterosexual contact (12.8%) and MSM /injection drug use (8.1%).

Table XIII: Emergent AIDS by Gender
Total new AIDS cases (1999-2003)

	Arizona			Phoenix EMA		
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000
Male	1,203	88.%	9.08	874	88.9%	10.27
Female	153	11.2%	1.15	109	11.0%	1.29
Total	1,356	100%*	5.11	983	100%*	5.80

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

Table XIV: Emergent AIDS by Age
Total new AIDS cases (1999-2003)

Years	Arizona			Phoenix EMA			% of AZ Cases in EMA
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	
Under 2	5	0.3%	0.60	3	0.3%	0.54	60.0%
2-12	1	0.0%	0.02	1	0.1%	0.03	100%
13-19	7	0.5%	0.26	6	0.6%	0.36	85.7%
20-24	43	3.1%	2.29	34	3.4%	2.78	79.1%
25-29	128	9.4%	6.75	97	9.8%	7.37	75.8%
30-34	224	16.5%	11.69	182	18.5%	13.64	81.3%
35-39	306	22.5%	15.75	230	23.3%	17.62	75.2%
40-44	265	19.5%	13.73	184	18.7%	14.71	69.4%
45-49	167	12.3%	9.66	103	10.4%	9.52	61.7%
50-54	107	7.8%	6.96	78	7.9%	8.21	72.9%
55-59	56	4.1%	4.41	39	3.9%	5.06	69.6%
60-64	24	1.7%	2.25	12	1.2%	1.93	50.0%
65 and Above	23	1.6%	0.67	14	1.4%	0.70	60.9%
Age Unknown	0	0.0%	N/A	0	0.0%	N/A	0.00%
Total	1,356	100%*	5.11	983	100%*	5.80	72.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

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Table XV: Emergent AIDS by Race
Total new AIDS cases (1999-2003)

	Arizona			Phoenix EMA			
	Cases	% of Total cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ Cases in EMA
White Non-Hispanic	686	50.5%	4.07	508	51.6%	4.56	74.1%
Black Non-Hispanic	162	11.9%	19.08	125	12.7%	19.29	77.2%
Hispanic	418	30.8%	5.99	301	30.6%	6.75	72.0%
Asian Pacific Islander/ Hawaiian Native Non-Hispanic	9	0.6%	1.60	7	0.7%	1.69	77.8%
American Indian/ Alaskan Native Non-Hispanic	78	5.7%	6.11	40	4.0%	11.65	51.3%
Multiple Race/ Other Race	3	0.2%	N/A	2	0.2%	N/A	66.7%
Total	1356	100%*	5.11	983	100%*	5.08	72.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

Table XVI: Emergent AIDS by Mode of Transmission
Total new AIDS cases (1999-2003)

	Arizona			Phoenix EMA			
	Cases	% of Total Cases	Rate per 100,000	Cases	% of Total Cases	Rate per 100,000	% of AZ Cases in EMA
MSM	849	62.6%	N/A	614	62.4%	N/A	72.3%
IDU	206	15.1%	N/A	145	14.7%	N/A	70.4%
MSM/IDU	100	7.3%	N/A	80	8.1%	N/A	80.0%
Heterosexual	169	12.4%	N/A	126	12.8%	N/A	74.6%
Other	22	1.6%	N/A	12	1.2%	N/A	54.5%
No Reported Risk/ Unknown Risk	10	0.7%	N/A	6	0.6%	N/A	60.0%
Total	1,356	100%*	5.11	983	100%*	5.80	72.5%

*Columns may not sum to 100% due to rounding. Source: HIV/AIDS Annual Report- March 2005

AIDS Mortality

There are no currently available data on AIDS mortality for the Phoenix EMA, but there is information for the state of Arizona. According to the HIV/AIDS Annual Report-(March) 2005, the annual number of deaths among persons with AIDS in the state declined in the late 1990s. This is attributed to the introduction of multi-drug treatment. From 1999-2003, the number of deaths among persons with HIV and AIDS has remained level.

Trends in HIV Incidence

In Arizona, there are some important trends in HIV infections. Although men account for the vast majority of new HIV infections (87.2%) and all prevalent HIV cases (86.7%), the proportion among women is increasing. According to the HIV/AIDS Annual Report-(March 2005), between 1985 and 1987, 6.6% of new HIV cases were among women, but between 2001 and 2003, that proportion had nearly doubled to 12.4% of new HIV cases.

By race/ethnicity, Blacks in Arizona are disproportionately affected by HIV/AIDS in a number of measures of the HIV/AIDS epidemic. Blacks comprise 3.2% of Arizona's population, and account for 12% of new HIV and AIDS cases, 11% of prevalent HIV cases, and 10% of prevalent AIDS cases. Hispanics of all races, who comprise 28% of the state's population, are disproportionately represented among emergent AIDS cases, representing 31% of new AIDS cases.

Lastly, men who have sex with men (MSM) of all races are severely impacted by HIV/AIDS in the state, representing more HIV/AIDS cases than all other transmission modes combined. MSM account for 56% of prevalent HIV cases in Arizona, 61% of prevalent AIDS cases, 59% of emergent HIV cases, and 63% of emergent AIDS cases.

According to the HIV/AIDS Annual Report-(March 2005), the proportion of cases resulting from Intravenous Drug Uses (IDU), the second highest mode of transmission after MSM, has remained steady over the past 5 years.

Table 1: Gender, Race/Ethnicity, and Risk Factors among PLWHA in the Phoenix EMA and Respondents to the Consumer Survey

	PLWHA in Phoenix EMA (n=7,351)	Survey Sample (n=599)
Gender		
Male	87%	86%
Female	13%	13%
Transgender	n/a	1%
Race/Ethnicity		
White	63%	64%
Black/African American	12%	12%
Latino/a	21%	21%
Asian/Pacific Islander	1%	<1%
American Indian and other ethnic groups	3%	3%
Risk Factor		
MSM	65%	65%
IDU	14%	14%
MSM/IDU	10%	10%
Heterosexual	11%	11%

7.2 Needs Assessment

As part of the comprehensive planning process, HIV service providers and other stakeholders were interviewed in advance of the planning meetings. In 2005, the Maricopa County Department of Public Health contracted with Partnership for Community Health, Inc. to conduct an assessment of the service needs of people living with HIV/AIDS in the Phoenix EMA for the Ryan White Planning Council. This assessment is commonly known as the “2005 Consumer Survey.”

In the sections that follow, information from provider key informants and the consumer survey is summarized, with a focus on data that may be particularly useful for comprehensive HIV services planning.² In addition, some new data analyses were conducted using the data presented in the consumer survey and are provided in this section to help highlight important variations in service need for specific PLWHA populations.

Provider Key Informants

During the preliminary phase of the comprehensive planning process in late summer 2005, JSI staff conducted key informant interviews with key stakeholders in the Phoenix EMA. Working with Council members and the Council support staff, the JSI planning team developed a list of approximately 30 potential key informants. To ensure that a broad range of perspectives was considered, the stakeholders were reflective of the epidemic in terms of race/ethnicity, gender, and age, and included people living

with HIV/AIDS and providers of prevention, care, and support services. Of this group, interviews were conducted with 23 individuals. The majority of the interviews were conducted by phone, with a few conducted by e-mail or in person. Several interviews were conducted in Spanish by a bilingual JSI team member.

The purpose of the interviews was to invite stakeholders to participate in the comprehensive planning process and to gather information about current services, barriers to accessing care, and service delivery challenges in the Phoenix EMA. While much of the information gathered during the interviews helped inform the comprehensive planning process, including the development of the mission, guiding principles, goals and objectives, the interviews also yielded some qualitative information on the need for services and barriers to care.

The information below summarizes the barriers and needs identified by the subset of key informants who were HIV/AIDS care and prevention providers. While not statistically valid, this information provides some

² For the complete data analysis, please see the *2005 Consumer Survey*.

qualitative data from a “provider perspective” to complement the data collected from consumers in the recent consumer survey. Key informants identified the following:

- A need for increased coordination and linkages between and among HIV care and prevention services, as well as links to other state and federal funding streams (substance abuse, Indian Health Services, etc.) to ensure an effective, efficient, and comprehensive continuum in the Phoenix EMA.
- A need for culturally competent services, including but not limited to, services for African Americans, African refugees, Latinos, and Native Americans.
- A lack of a centralized client registration or intake system presents a burden to clients who must prove residency and status at each provider from which they seek to obtain services.
- The increase in the number of HIV positive clients, including the newly diagnosed, as well as immigrants from outside the US and from other states in the US, is straining resources and capacity.
- The lack of a comprehensive public transportation system, the location of services, and the size of the Phoenix EMA can pose barriers to service access.

2005 Consumer Survey

Between March and July 2005, 599 PLWHA were surveyed, most of whom were in care, to gather information about HIV/AIDS care and support service needs, co-morbidities, access to care, and other key demographic characteristics. The results of this comprehensive survey were presented to the Council in August 2005 and informed the FY06 priority setting and resource allocations process, as well as the development of this comprehensive plan.

Survey Respondents

Table 1 and Table 2 provide some demographic information on the PLWHA reached by the Consumer Survey. By race/ethnicity, gender, and HIV risk factor, the survey sample reflected the population of those known to be living with HIV and AIDS in the Phoenix EMA. Eighty-six percent of respondents were male, 13% were female, and 1% transgender. Nearly two-thirds of respondents were White (63%), 21% Latinos, 12% Blacks/African Americans (including Africans), 3%

Table 2: Income, Education, Employment, and Housing Status of Consumer Survey Respondents

% of respondents (n=599)	
Annual Income	
Less than \$9,300	46%
\$9,301 to \$18,600	35%
\$18,601 to \$28,000	8%
\$28,001 to \$35,000	5%
\$35,000+	7%
Education	
No high school/GED	16%
High school diploma or GED	26%
Some college or 2-year degree	38%
4 year degree or graduate school	20%
Employment Status*	
Disabled	52%
Employed full time	19%
Employed part time	9%
Seeking work	8%
Not working	6%
Retired	2%
Housing Status*	
Own house/apartment	24%
Rent house/apartment	54%
Living with family member	11%
Transitional housing	3%
Homeless	1%

*Column totals for each section may not equal 100% because all categories of responses are not included.

Table 3: Health Status Characteristics of Consumer Survey Respondents

% of respondents (n=599)	
HIV Disease Stage	
HIV asymptomatic	37%
HIV symptomatic	15%
AIDS asymptomatic	11%
AIDS symptomatic	38%
Length of Time Living with HIV/AIDS	
Less than 1 year	7%
1 to 3 years	14%
3 to 8 years	26%
More than 8 years	53%
Self Assessment of Physical Health	
Poor	11%
Fair	31%
Good	39%
Excellent	19%
Self Assessment of Emotional Health	
Poor	11%
Fair	35%
Good	40%
Excellent	15%
Last T-Cell (CD4) Count	
Below 200/μl	19%
200 - 350/μl	15%
Above 350/μl	66%
Medications	
Taking antiretrovirals	79%

³ As defined by HRSA, “out-of-care” refers to people living with HIV and AIDS who are aware of their HIV status, but are not receiving HIV medications and have had a viral load or CD4 test in the past year.

⁴ The Federal Poverty Level for an individual was \$9,310 in 2004 and \$9,570 for 2005. The income categories in Table 2 are those provided in the needs assessment and approximate the 2004 level.

American Indians, and 1% Asian and Pacific Islanders.

When considering race/ethnicity and gender, a higher proportion of women respondents were people of color than men. Among female respondents, 48% were White, 25% Latina, 17% black/African American, 6% African, and 4% American Indian. Among male respondents, 66% were White, 21% Latino/a, 9% Black/African American, 3% American Indian, and less than 1% African.

By risk factor, nearly two-thirds of those surveyed were men who have sex with men (MSM). This group was predominantly White (69%), with an additional 20% Latino/a, 7% Black/African American, and 3% American Indian. Among IDU respondents, Whites and people of color were closer to parity, with 54% White, 23% Latino/a, 20% Black/African American, and 3% American Indian. A majority of heterosexual respondents were people of color, including 30% Latino/a, 16% Black/African American, 7% African, and 4% American Indian; 43% of heterosexual respondents were White.

The consumer survey respondents also included some populations with special needs, including the recently incarcerated (9% of all respondents), youth aged 18-24 (2%), undocumented individuals (8%), and people who are out-of-care³ (3%).

Table 2 provides additional demographics of the needs assessment survey respondents. Forty-six percent (46%) of respondents reported income below the federal poverty level (FPL)⁴. Eighty-one percent (81%) earned less than 200% of the FPL, and 89% earned less than 300% of FPL (the maximum level for eligibility for the AIDS Drug Assistance Program). Among male respondents, 43% earn below the FPL, compared to 63% of females. By race/ethnicity, 60% of Black/African American respondents reported income below the FPL, as did 59% of Latino/a, 58% of American Indians and other ethnic groups, and 38% of Whites.

As shown in Table 2, a majority of survey respondents have completed high school (84%) and 58% have had some college education. Just over half of respondents were disabled and 28% were employed either part time or full time. In general, housing was not a major issue for survey respondents; 78% reported that they either own or rent their own house or apartment and 1% reported that they were homeless. In addition, 95% of respondents reported that their housing was “safe” and

89% reported that it was “stable.” However, when asked about housing status over the two years prior to the survey, over 10% reported that they had been homeless sometime during that period and 4% reported that they had lived in a shelter.

Health Status of Respondents

Table 3 provides data on the health status of survey respondents. As illustrated, just over one-half of respondents were living with HIV without an AIDS diagnosis, and 49% had been diagnosed with AIDS. Among those living with HIV, 37% were asymptomatic, compared to 11% of those with AIDS. A majority of respondents (53%) reported that they have been living with HIV or AIDS for more than 8 years and 7% were recently diagnosed (within the year prior to the survey). These data can be particularly helpful in comprehensive planning, as the need for a range of services can vary depending on the stage of HIV disease.

Overall, a majority of respondents reported relatively good health status, with 58% rating their physical health as “excellent” or “good” and 55% percent rating their emotional health as “excellent” or “good.” When stratified by disease status, a higher proportion of those who were either HIV or AIDS symptomatic reported that their physical and emotional health was “fair” or “poor.” 50% of HIV symptomatic and 69% of AIDS symptomatic respondents reported “fair” or “poor” physical health, and 50% of HIV symptomatic and 52% of AIDS symptomatic respondents reported “fair” or “poor” emotional health.

Table 3 also provides information on the most recent CD4/T-cell count of survey respondents. Antiretroviral therapy is recommended for individuals with a T-cell count below 200/ μ l whether or not they are symptomatic. Such individuals have reached a clinical AIDS diagnosis and are at increased risk for opportunistic infections and other AIDS-related complications. For respondents with T-cell counts between 201 and 350/ μ l, antiretroviral therapy should be offered or considered depending on viral load. For respondents with T-cell counts above 350/ μ l and low viral loads, anti-retroviral therapy should be deferred. Sixty-six percent of survey respondents reported that their most recent T-cell count was above 350/ μ l. In addition, 74% reported that their viral load was

Table 4: Substance Use and Hepatitis, STD, and Mental Health Diagnoses Among Consumer Survey Respondents

	% of all PLWHA respondents (n=599)
Substance Use (Recent*)	
Alcohol	92%
Marijuana	71%
Hallucinogens	39%
Poppers	31%
Crystal meth	28%
Opium/morphine	21%
Ecstasy	18%
Crack/cocaine	15%
Speedball	12%
PCP	11%
Heroin	11%
Special K	10%
GHB	10%
Hepatitis (diagnosis in year prior to survey)	
Hepatitis A/B	13%
Hepatitis C	15%
STDs (diagnosis in year prior to survey)	
Thrush/yeast infection	23%
Genital warts (HPV)	13%
Genital herpes (HSV)	12%
Syphilis	5%
Gonorrhea	5%
Chlamydia	3%
Mental Illness Diagnosis	
Depression	55%
Anxiety	37%
Bipolar	15%
Dementia	5%

* Frequent use was defined as using the substance once or more in the six months prior to survey, except for alcohol and marijuana which was defined as use in the week prior to the survey.

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Table 5: The Need for Services* among PLWHA in the Phoenix EMA

Services	Need for Services Among PLWHA Respondents (n=599)		
	Rank	% who expressed need	Council Priority FY06
Outpatient medical care	1	84%	1
Oral health (dental care)	2	69%	4
Case management	3	63%	3
Enzymes, herbs, vitamins	4	57%	9
HIV/AIDS medications	5	52%	2
Food boxes or food bank	6	51%	9
Nutritional supplements	7	50%	10
Outpatient medical care (specialist)	8	47%	1
Acupuncture and chiropractic care	9	47%	9
Client advocacy	10	45%	Not ranked
Mental or behavioral health counseling	11	44%	6 & 7
Bus passes for HIV/AIDS services	12	44%	8
Massage	13	41%	9
Medical case management	14	37%	Not ranked
Taxi rides to HIV/AIDS services	15	37%	8
Nutritional education	16	37%	Not ranked
Legal services	17	36%	18
Congregate meals	18	35%	10
Naturopathic physicians	19	35%	9
Prevention services from doctor	20	35%	Not ranked
Independent housing (subsidized)	21	34%	Not ranked

*Includes only the services for which more than 33% of all PLWHA respondents reported a need. Data on the complete list of 46 services can be found in the 2005 Consumer Survey.

undetectable. Nonetheless, 19% of respondents reported that their most recent T-cell count was below 200/ μ l, indicating advanced HIV disease. Among respondents with an AIDS diagnosis, 84% of those who were asymptomatic and 93% of those who were symptomatic reported that they were taking anti-retrovirals. These proportions were higher than the proportion of all respondents on antiretrovirals (79%).

Co-morbidities

Information on co-morbidities among people living with HIV and AIDS (PLWHA) is an important component of health service planning, as co-morbidities can affect the health status of PLWHA and increase the complexity of services needed improve and maintain health status. As shown in Table 4, 15% of respondents are co-infected with hepatitis C and between 3% and 23% of respondents had been diagnosed with an STD in the year prior to the survey. Mental health issues are also a significant co-morbidity among survey respondents, with 55% reporting a diagnosis of depression and 37% a diagnosis of anxiety.

Need for HIV Care and Support Services

Respondents to the Phoenix EMA care services assessment survey were asked to indicate whether they needed, in the year prior to the survey, any of 46 specific services within the broader categories of primary health care, case management, mental/behavioral health and substance abuse treatment, wellness services, food and nutrition, transportation, housing, and other services. Table 5 highlights the services for which more than one-third (>33%) of all respondents reported a need (21 of 46 services), ranked from high to low by the proportion of respondents that reported a need. Table 5 also includes the corresponding ranking of each service (where applicable) by the Council for FY06.

Among the top ten services by reported need, four were primary care-related including outpatient care (1st), oral health (2nd), HIV/AIDS medications (5th), and outpatient specialty care (8th); two were case management related, including case management (3rd) and client advocacy (9th); two are wellness services, including enzymes/herbs/vitamins (4th) and acupuncture and chiropractic (9th); and finally, two were food and nutritional services, including food boxes (6th) and nutritional supplements (7th). Fewer than 10% of all respondents reported a need for respite care (9.3%), residential and/or hospital-based substance abuse treatment (7.8%), translation/interpretation services (6.8%), detox and/or methadone maintenance (5.6%), and child day care (5.5%).

For some of the services in Table 5, the proportion of

Table 6: Comparison of the Reported Need for Services by Gender

Service	% of women who reported need	% of men who reported need	Significance of difference by gender*
Case management	78%	61%	p<.05
Food box/bank	67%	48%	p<.05
Outpatient specialty care	65%	44%	p<.001
Transportation: Taxi	57%	34%	p<.0001
Transportation: Bus	57%	43%	p<.05
Nutritional education	52%	34%	p =.06
Naturopathic physician	48%	33%	p<.05
Independent Housing	45%	33%	p<.05
Emergency financial assistance (rent/utilities)	41%	26%	p<.01
Peer support	35%	20%	p<.01
Emergency financial assistance (non-housing)	34%	23%	p<.05
Spiritual counseling	30%	15%	p<.005
HIV testing	28%	10%	NS
Respite	21%	8%	p<.001
Child day care	19%	4%	p<.00001

* This column represents the results of a chi-square test for independence. A p-value of less than 0.05 is generally considered statistically significant, meaning that the probability is less than 5% that the differences are the result of "chance." The lower the p-value, the lower the probability that the difference is the result of chance.

NS means that the difference was not statistically significant.

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Table 7: Comparison of the Reported Need for Services Among all Respondents and Among White, Black, and Latino/a Respondents

Services	All (rank)	All	White	Black	Latino/a	Significance* of difference by race
Outpatient medical care	1	85%	84%	90%	84%	NS
Oral health (dental care)	2	69%	71%	75%	60%	p<.05
Case management	3	63%	61%	80%	58%	p<.001
Enzymes, herbs, vitamins	4	57%	57%	56%	58%	NS
HIV/AIDS medications	5	52%	51%	58%	53%	NS
Food boxes/food bank	6	51%	45%	67%	56%	p<.005
Nutritional supplements	7	50%	50%	59%	47%	NS
Outpatient medical care (specialist)	8	47%	46%	51%	45%	NS
Acupuncture and chiropractic care	9	47%	47%	43%	49%	NS
Client advocacy	10	45%	46%	52%	38%	NS
Mental or behavioral health counseling	11	44%	45%	47%	41%	NS
Bus passes	12	44%	37%	77%	46%	p<.0001
Massage	13	41%	40%	48%	43%	NS
Medical case management	14	37%	32%	52%	38%	p<.05
Taxi	15	37%	30%	62%	44%	p=.0001
Nutritional education	16	37%	33%	49%	41%	NS
Legal services	17	36%	32%	52%	38%	p<.05
Congregate meals	18	35%	33%	42%	39%	NS
Naturopathic physician	19	35%	35%	34%	37%	NS
Prevention by doctor	20	35%	29%	51%	43%	p<.01
Independent housing	21	34%	28%	57%	41%	p<.0005

* This column represents the results of a chi-square test for independence. A p-value of less than 0.05 is generally considered statistically significant, meaning that the probability is less than 5% that the differences are the result of "chance." The lower the p-value, the lower the probability that the difference is the result of chance.

NS = not statistically significant, p value greater than 0.05.

Note – American Indians and other ethnic groups were not included in the analysis in this table owing to the small sample size.

respondents who reported a need varied by gender. Such information can be useful for comprehensive planning by highlighting higher or lower reported need among specific populations within the community – differences that are often hidden when examining data for the full group of survey respondents. The 2005 Consumer Survey provided data on 15 services⁵ where the proportion of women reporting a need exceeded the proportion of men reporting a need by over 10%. Using these data and information on the overall survey sample population, a statistical test was conducted for this Plan to determine whether the differences in the proportions were statistically significant. Statistical significance testing provides an assessment of how reasonable it would be to conclude that an observed difference is real, rather than the result of chance.

Table 6 compares the proportion of women and men who reported a need for 15 services. The fourth column in Table 6 provides the "p-value" of the statistical test. Generally, any p-value less than 0.05 is considered statistically significant, meaning there is only a 5% probability that the difference is the result of chance and a 95% probability that the difference is real. The lower the p-value, the higher the confidence that the difference is not the result of chance. As shown in Table 6, the proportion of women vs. men who reported a need for a service was significantly higher for nearly all of the services presented in the needs assessment.

Similarly, the need for services varied by the race/ethnicity of

⁵ Gender differences were provided for only 15 of 46 services. See Table entitled Top Service Needs by Gender in the 2005 Consumer Survey.

respondents, as shown in Table 7. As noted previously, this information is important for planning purposes, as it can point to specific populations within the survey group that have higher or lower needs for specific services. For six services, the variations in the reported need by race/ethnicity were statistically significant and are highlighted in bold in Table 7. A significantly higher proportion of Black PLWHA respondents than White or Latino/a respondents reported a need for case management, food boxes/food bank, bus passes, medical case management, and taxi services. A significantly lower proportion of Latino/a respondents than Whites or Blacks reported a need for oral health care (60% vs. 75% of Blacks, and 71% of Whites).

It is important to note that a high-to-low ranking of service needs by race/ethnicity would be different than the overall rank for all respondents, reflecting different levels of need within these communities. For example, among Black respondents, case management was the second highest service need, and transportation (bus and taxi) was among the top five—two services that were ranked 12th and 15th among the entire survey sample. Planning for services to reach these underserved populations should consider these variations in developing strategies to increase access to care and meet service needs.

Service Gaps

HRSA defines service gaps as “all needs not currently being met for all PLWHA except for the need for primary health care for individuals who know their status but are not in care.”⁶ Service gaps can include additional need for primary health care for those already receiving primary medical care (“in care”) as well as the need for supportive services for individuals not receiving primary care (“not in care”).

Data from the recent Phoenix EMA Consumer Survey can help assess potential service gaps in the Phoenix EMA. Survey respondents, in addition to being asked about whether they needed a service in the year prior to the survey (need) were also asked whether they had received that service during the same time period (utilization). The difference between those reporting a need and those who received the service (where need is greater than received) is a “service gap.” Table 8 highlights

Table 8: Service Gaps

Service	% who Received	% who Received	Service gap*
Massage	41%	10%	31%
Oral health/dental	69%	48%	21%
Acupuncture and chiropractic	47%	28%	19%
Emergency financial assist. (non-housing)	24%	6%	18%
Health insurance assistance	27%	10%	17%
Rent subsidies	25%	8%	17%
Emergency financial assistance (rent/utilities)	28%	14%	14%
Independent housing	34%	20%	14%
Advocacy	45%	31%	14%
Nutritional education	37%	23%	14%
Legal	36%	23%	13%
Nutritional supplements	50%	38%	12%
Individual mental health	45%	33%	12%
Outpatient medical care (specialist)	47%	36%	11%
Referral/directory	30%	19%	11%
Housing information (search)	32%	21%	11%
Transportation (taxi)	37%	26%	11%
Buddy	16%	5%	11%

* The difference between the percent of all PLWHA who reported that they needed a service and the percent who reported that they had received the service (both in the year prior to the survey).

Services in **bold** are among the top 21 overall needs of PLWHA as shown Table 5.

⁶ HRSA. 2003. *Needs assessment guide*.

Table 9: Barriers to Care among Respondents

Barrier	% with problem	Average rating*
Lack of or inadequate insurance coverage (medical services only)	34%	2.3
Too much paperwork or red tape	52%	2.1
Too many rules and regulations	48%	2.0
Denied or afraid to seek services owing to criminal justice matter	9%	2.0
Fear of my HIV status being discovered by others or lack of confidentiality	27%	2.0
Service provider was insensitive to my issues and concerns	31%	2.0
Service provider organization made me feel like a number	24%	2.0
Denial that I was HIV-positive prevented me from seeking services	15%	2.0

the services for which the reported “need” exceeded the reported “received” by more than 10%.⁷ The services highlighted in bold are services that were also among the top 21 overall needs of PLWHA, as shown in Table 5. Of note, oral health care was the second highest reported service need among all respondents, and was also the service with the second highest service gap, with 21% of those who said they needed the service reporting that they did not receive it.

Barriers to Care

An assessment of barriers to care can help identify particular issues or problems in the continuum of care or amongst PLWHA that affect access to needed services or the provision of services to meet those needs. Survey respondents were asked to rate, on a scale where 1 is “no problem at all” and 3 is “a big problem,” 25 different barriers to accessing or using HIV/AIDS care and services. Of the 25 barriers, nine had an average rating of 2.0 or higher (meaning they were moderate to big issues). Table 9 highlights these barriers and the percentage of respondents who reported that the issue was a problem.

The barrier with the highest average rating was a lack of insurance coverage (for medical services), and just over one-third of respondents reported that they experienced this barrier. With slightly lower average ratings, both “rules and regulations” and “paperwork or red tape” were barriers for a higher proportion of the survey respondents (48% and 52% respectively). This suggests a need to focus on reducing the bureaucratic “hurdles” that PLWHA confront when accessing services.

In the consumer survey report, the full list of barriers was grouped into categories of structural, organizational, and individual. As shown in Table 9, these barriers are difficult to place into discrete categories. For example, denial about HIV status may be an individual issue, but one that is linked to pervasive societal stigma around HIV. Rules and regulations, excess paperwork, or being made to feel like a number may reflect organizational procedures, staff capacity, burdens of funding requirements, broader systemic issues in health care, or any combination thereof.

⁷This method of calculating “service gaps” differs from that used in the most recent Phoenix EMA Consumer Survey, where service gaps were reported as the difference between “demand” for services (whether an individual asks for a service) and whether the service was received. The method used above more accurately reflects the HRSA definition of service gaps.

7.3 Unmet Need

Unmet need refers to the need for HIV-related health services by individuals with HIV disease who are aware of their HIV status but are not receiving HIV medications and who have not had a viral load or CD4 test in the past year. These are also individuals referred to as “out-of-care.”

An understanding of the extent of unmet need in the Phoenix EMA is an important component of comprehensive planning and requires careful review and consideration of several pieces of research and information, including the recent Integrated Epidemiological Profile (based upon research conducted using the UCSF model), the recently completed Consumer Survey for the Phoenix EMA, and a special study focused on those out-of-care.

Table 1: Distribution of ‘In-Care’ and ‘Unmet Need’ by County, Phoenix EMA

County	Total HIV/AIDS Cases In Care		Total HIV/AIDS Cases with Unmet Need		Total Cases	Unmet Need/ Total Cases (% Out of Care)
		%		%		
MARICOPA	3524	96.8	3242	95.0	6766	47.9
PINAL	115	3.4	170	5.0	285	60.0
TOTAL	3639	100	3412	100	7051	48.4

Estimates of Unmet Need Conducted by ADHS Using the UCSF Model

The following information summarizes the process used to develop the estimate of unmet need and is based on the report entitled the **Arizona Unmet Need Estimate Framework and Narrative for 2003**. The unmet need data, however, have been taken from updated work conducted by the Arizona Department of Health Services (ADHS) and recently released in the **Integrated Epidemic Profile** in September 2005.

The Unmet Need Framework was a cooperative effort among numerous state and private entities to measure the proportion of persons living with HIV and AIDS in Arizona who met a minimal standard of care during 2003. Using data from numerous sources and computer based cross-matching methods, patterns of care-related testing and treatment were compiled for calendar year 2003 for people who were reported to ADHS as living with HIV and AIDS in Arizona. Providers compiled information on whether or not each client has had a viral load, CD4 measurement or antiretroviral therapy in the past 12 months. People meeting one or more threshold criteria of care were classified as “in care,” while those failing to meet any threshold criteria were classified as having “unmet needs” (or “out-of-care.”) In this way both the relative proportions of persons “in care” or having “unmet need,” and their geographic distribution within the state could be studied and reported.

As a caveat, the designation of people as “out-of-care” may have been the result of an inability to accurately match case reports among various databases including HARS, client utilization, and laboratory reports. These issues, listed below, could affect the accuracy of the unmet need estimate:

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Table 2: Distribution of 'In-Care' and 'Unmet Need' Among Men Having Sex with Men (MSM) by County, Phoenix EMA, 2003

County	Total MSM Cases In Care		Total MSM Cases with Unmet Need		Total Cases	Unmet Need/ Total Cases (% Out of Care)
		%		%		
MARICOPA	2629	97.4	2054	96.6		43.9
PINAL	69	2.6	72	3.4		51.1
TOTAL	2698	100.0	2126	100.0		44.1

- 1) Discrepancies might exist between the name, date of birth and gender information in reporting (HARS) and laboratory data sets, although the person is actually the same person. However because of the discrepancy, different unique identifiers were generated and no match was found.
- 2) The person has, in fact been reported but not yet been entered into HARS.
- 3) The person has not yet been reported and, therefore, does not appear in HARS.

Given these possibilities, the team concluded that correction of problems causing these mismatches might increase the percentage of those in care by 5-10%⁸.

While work continues to improve the estimates of unmet need, the figures for the Phoenix EMA presented below comprise the most recently completed estimates.

Based on the estimates conducted using 2003 data, 48.4% of prevalent cases met HRSA's definition of unmet

need or out-of-care. The recent integrated epi report found no statistically significant correlation across Arizona between poverty rates by county and percent of cases meeting the definition of out-of-care.

Unmet need by population

Estimates of unmet need vary by population. For prevalent cases of HIV and AIDS among men who have sex with men (MSM) in 2003, the estimate of unmet need was somewhat lower than the overall rate of unmet need (44.1% compared to 48.4%). See Table 2 for estimates in the two counties comprising the Phoenix EMA.

Table 3 estimates the unmet need among injection drug users at 49.7% compared with 48.4% of all 2003 prevalent cases of HIV and AIDS in the Phoenix EMA.

Finally, the Integrated Epi Report includes information about high-risk heterosexuals. That information includes persons who themselves have no history of MSM or IDU behavior but who have had unprotected

Table 3: Distribution of 'In-Care' and 'Unmet Need' Among Injection Drug Users (IDU) by County, Phoenix EMA

County	Total IDU Cases In Care		Total IDU Cases with Unmet Need		Total Cases	Unmet Need/ Total Cases (% Out of Care)
		%		%		
MARICOPA	720	93.1	698	91.5	1418	49.2
PINAL	53	6.9	65	8.5	118	0.82
TOTAL	773	100.0	763	100.0	1536	49.7

⁸ Arizona Unmet Need Estimate Framework and Narrative for 2003

heterosexual sex with multiple sex partners, with any partner who reports MSM or IDU behavior, or with someone who is known to be HIV infected.

Thus looking at the estimates of unmet need conducted by the Arizona Department of Health Services, an overall rate of 48.4% of prevalent cases in 2003 were estimated to meet the definition of unmet need. Injection drug users had the highest rate of unmet need at 49.7% while both men who have sex with men (44.1%) and high-risk heterosexuals (43.6%) had lower rates of unmet need.

Table 4: Distribution of ‘In-Care’ and ‘Unmet Need’ Among High-Risk Heterosexuals (HRH) by County, Phoenix EMA, 2003

County	Total HRH Cases In Care		Total HRH Cases with Unmet Need		Total Cases	Unmet Need/ Total Cases (% Out of Care)
		%		%		
MARICOPA	369	95.6	279	93.6	648	43.1
PINAL	17	4.4	19	6.4	36	52.8
TOTAL	386	100.0	298	100.0	684	43.6

Information on “Out-of-Care” Provided by 2005 Consumer Survey

The recently completed consumer survey intended to identify and survey 100 individuals who were out-of-care and therefore met the HRSA definition of having unmet need. Ultimately, only 18 respondents who were out-of-care provided information for this consumer survey, making it unlikely that the data can be considered statistically representative of the group of individuals with unmet need. However, the data may be indicative of the population characteristics and when combined (or “triangulated”) with both the ADHS estimates of unmet need and the rapid study of people in the EMA who are out-of-care.

As reported in the 2005 Consumer Survey, the group that was out-of-care was somewhat more male (95% vs. 87%) and somewhat more likely to be people of color (48% vs. 37%) than the group of all consumers surveyed.

In addition to these demographic characteristics, the 2005 Consumer Survey reported the following characteristics of those out-of-care:

- Been newly diagnosed
- Asymptomatic
- Bisexual
- Homeless or crashing at a friend’s house
- Not working
- Been treated for substance abuse
- Been in jail in the past two years
- Don’t have insurance
- Diagnosed with a mental illness
- More likely to use recreational drugs
- Much more likely to have shared needles

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Further review of the data on those out-of-care identified one additional factor worth noting:

- Less likely to be born in the United States

As reported in the consumer survey report, those out-of-care were more likely than the sample as a whole to say they had the following service needs:

- Housing services
- Substance abuse program
- Treatment adherence
- Mental health treatments
- Nutritional education
- Translation
- Outreach

Further review of the data on those out-of-care identified these additional needs worth noting:

- Emergency Financial Assistance
- Legal Services
- Day care
- Buddy services
- HIV prevention information

With respect to barriers to care, individuals who were out-of-care were more likely to identify the following barriers to care than the respondents as a whole:

- Fear of others finding out I have AIDS
- Denial that I was HIV-positive
- The amount of time needed to wait for a doctor appointment
- Lack of insurance
- Lack of sensitivity on part of provider

Information from “Rapid Assessment of Persons Out-of-Care” study

In September and October of 2005, in response to the low number of individuals with unmet need surveyed in the consumer survey, an additional rapid assessment of people “out-of-care” was commissioned. This study was completed in a very short time frame and was meant to complement the information obtained in the consumer survey.

In this study, an additional 20 people living with HIV and AIDS who were “out-of-care” were identified and interviewed. Of these individuals 63% were White, 25% were Latino/a, 10% were Black and 2% were American Indian. 75% were male and 25% were female.

Of this cohort, 25% were diagnosed in an emergency room with “other symptoms” and 50% indicated they were not referred to services at the time of their positive test result.

Finally, the rapid assessment identified that several of the out-of-care individuals were using crystal meth, crack or other drugs on a frequent, if not daily basis. There was indication as well that those utilizing illegal drugs were likely to share needles.

Conclusions on Out-of-Care

Substantial effort has been expended through consultant services and the epidemiologists at the Arizona Department of Health Services to determine the number of individuals not in care and their characteristics. When comparing information from the three studies conducted to date, a few trends emerge. First, those individuals with unmet need appear more likely to be current users of illicit substances and more likely to use and share needles. There may be a greater concentration of out-of-care PLWHA in communities of color and among the non-U.S. born. It is possible as well that individuals with unmet need attach a greater sense of stigma to an HIV or AIDS diagnosis. Finally, it is likely that at the time of learning of their HIV test result, they were not referred directly into care services.

These estimates and characterizations of unmet need in the Phoenix EMA represent the best information currently available. Given the overall high number, there are significant numbers of out-of-care individuals among all special populations. Thus strategies to outreach to and bring into care those with unmet need must be both broad as well as targeted.

More information would provide greater insight into the population of individuals out-of-care in the Phoenix EMA. Currently, the Administrative Agent has contracted with a consultant to develop a new model for outreach/early intervention services to be implemented in Ryan White FY06. Using the current information to design the outreach model, and then evaluating the impact of that model, will provide additional information to the Planning Council as it directs resources to reduce unmet need in the EMA.

Updated Information on the Out-of-Care Population

Recently, a new estimate of those out of care was released by the Arizona Department of Health Services, Office of HIV/AIDS. According to that report, the total number of prevalent cases found in the HARS database was 10,000. The total number of clients “in” care in Arizona was 5668 (56.7%). This is up more than 7% over the 2003 estimate of unmet need. However, that result is entirely due to the use of named data to do this year’s cross match. The use of

Table 5: Arizona Unmet Need Estimate. Calendar Year 2004

Input	Value	Data Source
Population Sizes	Total=10,000	
A. # PLWA, recent time period	4,539	2004 HIV/AIDS Reporting System (HARS) Data
B. # PLWH (non-AIDS, aware) recent time period	5,461	2004 HARS Data
Care patterns	(56.7% Met Need)	
C. # PLWA, met need, 12 month period	3,327	2004 HARS, CD4 and VL Lab Data, ADAP Data
D. # PLWH (aware, non-AIDS, met need 12 month period	2,341	2004 HARS, CD4 and VL Lab Data ADAP Data
Calculated Results	Value	Calculation
E. # PLWA unmet need	1,212	(A-C)
F. # PLWH (non-AIDS, aware) unmet need	3,120	(B-D)
G. Total HIV+/aware, unmet need (quantified estimate of unmet need	4,332	(E+F) (G/(A=B)) or (43.3%) with unmet need

Title I

The following reflects the allocation of Ryan White Title I and Minority AIDS Initiative (MAI) resources among service categories in 2005:

Priority	Service Category	RW Title I	MAI
Core Services:			
1	Primary HIV Medical Care	\$1,424,771	\$175,229
2	Pharmaceuticals (Title I)	\$424,148	
3	Case Management	\$1,100,000	
4	Oral Health	\$555,000	
5	Pharmaceuticals (Title II)	\$0	
6	Mental Health Services	\$70,000	\$50,000
7	Substance Abuse Services	\$120,000	\$20,000
Supporting and Enabling Services:			
8	Transportation	\$150,000	
9	Alternative/Complementary Services	\$590,000	
10	Food Bank/Meals/Nutritional Supplements	\$175,000	
11	Psychosocial Support Services	\$85,000	
12	Outreach	\$0	\$145,000
13	Nutritional Counseling	\$200,000	
14	Emergency Financial Assistance	\$85,000	
15	Health Education/Risk Reduction	\$0	
16	Home Care	\$130,000	
17	Counseling and Testing	\$0	
18	Legal Services	\$45,000	
19	Early Intervention Services	\$0	
20	Interpreting Services	\$5,000	
21	Family Support Coordination	\$0	
22	Program Support	\$0	
23	Respite Care	\$0	
24	Emergency Housing Assistance	\$0	

⁹ Information on Titles II, III and IV comes from the Integrated Epidemiological Profile produced by the Arizona Department of Health Services, Office of HIV/AIDS, September, 2005

named data allowed for the capture of many more cases than were captured in 2003 simply by being able to resolve discrepancies between data sets regarding name, sex, or date of birth. The total number of clients who were identified as “out-of-care,” or having an unmet need, was 4,332 (43.3%). Of the 5,668 people in care, 2,341 (41.3%) were HIV cases, while 3,327 (58.7%) were AIDS cases. Of the 4,332 people with unmet need, 3,120 (72.0%) were HIV cases, while 1,212 (28.0%) were AIDS cases. Table 5 summarizes these findings.

7.4 Resource Inventory

This resource inventory attempts to document the current resource available in the Phoenix EMA to provide medical care and support services for people living with HIV and AIDS. Most of the information in this inventory comes from the integrated epi profile released by the Arizona Department of Health Services (ADHS) in September, 2005. It is supplemented with information from the Maricopa Department of Public Health, grantee for the Title I funds.

Title II⁹

Currently the only Title II resources for services in the Phoenix EMA are those for the AIDS Drug Assistance Program (pharmaceuticals) and for the Prevention for Positives Program. The State of Arizona received \$12,732,077 in FY05 for Title II services including ADAP.

Title III

The Ryan White Title III EIS program in Phoenix, Arizona, provides funding (\$695,000) to the Maricopa Integrated Health System (MIHS) to support its McDowell Healthcare Center (HCC). McDowell HCC is the largest provider of HIV primary care in Maricopa County and provides primary medical care, oral health services, behavioral health services, treatment adherence education and monitoring, and nutritional services on-site. The grant monies received through Title III funding sources provide salaries and benefits for 11.24 FTE’s of the

2005 Funded Agencies by Service Category:

Core Services:	Funded Agencies (sub-grantees):
Primary HIV Medical Care	Maricopa Integrated Health System (MIHS)
Pharmaceuticals (Title I)	Maricopa County Department of Public Health (MCDPH)
Case Management	Area Agency on Aging, Region I (Care Directions) Phoenix Shanti Group MIHS (Healthcare for the Homeless) Phoenix Indian Medical Center
Oral Health	Delta Dental MCDPH
Mental Health Services	Catholic Social Services Chicanos Por La Causa Jewish Family and Children's Service MIHS Phoenix Indian Medical Center Phoenix Shanti Group
Substance Abuse Services	Chicanos Por La Causa MIHS Phoenix Shanti Group
Supporting and Enabling Services:	
Transportation	Area Agency on Aging, Region I (Care Directions)
Alternative/Complementary Services	Body Positive
Food Bank/Meals/Nutritional Supplements	Body Positive
Psychosocial Support Services	Body Positive
Outreach	Arizona Opportunities Industrialization Center (African-Americans) Chicanos Por La Causa (Latinos) Body Positive (MSM) MCDPH (MSM) Phoenix Indian Medical Center (Native Americans)
Nutritional Counseling	Body Positive
Emergency Financial Assistance	MCDPH
Health Education/Risk Reduction	To be determined
Home Care	Area Agency on Aging, Region I (Care Directions)
Counseling and Testing	MCDPH (but \$0 in initial allocation)
Legal Services	Community Legal Services (HIV/AIDS Law Project)
Program Support	Various

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McDowell HCC clinical and support staff. Additionally, a total of 0.89 clinician FTE's are supported by this grant. Through the agreement with Maricopa County Department of Public Health, a 0.75 FTE is paid for out of the Title III monies.

Title IV

Maricopa Integrated Health System (MIHS) and the Title IV network of support service providers have been providing comprehensive, coordinated Title IV funded services to HIV infected women, infants, children, youth and their families in Maricopa County since 1998. MIHS has served as the healthcare safety net for county residents for over 125 years. MIHS is a comprehensive healthcare delivery system incorporating the Maricopa Medical Center (MMC), a 555-bed public teaching hospital with a Level I Trauma Center; Arizona Burn Center; Phoenix Cancer Center; a 92-bed psychiatric facility for inpatient, outpatient, and urgent psychiatric treatment; and 11 outpatient family health centers, including the comprehensive McDowell Healthcare Center (MHCC) with behavioral health and dental care on-site, serving persons living with HIV/AIDS (PLWHA) since 1989. MIHS is the grantee for Title III (since 1991) and the adult medical provider for Title I (since 1994).

This program builds on services provided through its four network agencies: Phoenix Children's Hospital Bill Holt Infectious Diseases Clinic (PCH), HIV Care Directions (CD), Phoenix Body Positive (BP), Maricopa County Department of Public Health (MCDPH). Title IV funds for FY2005 totaled \$627,980.

Housing Opportunities for Persons With AIDS

The City of Phoenix Housing Department is the HOPWA Grantee, with allocations in the 2005-06 fiscal year of \$895,000 for the Phoenix EMA. HOPWA supports 10 different housing activities through six different project sponsors. Over 1,051 PLWHA received assistance during FY2005. A HOPWA-funded housing coordinator provides services to homeless clients and those in need of affordable housing, with the goal of permanent, stabilized housing.

Conclusion



Members of the Phoenix EMA have 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, the consumer survey, other needs assessment data and a rapid assessment of unmet need. The Plan now serves as the primary road map for the Phoenix EMA for the period covering the years 2006-2009.

