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

May, 2012

PHOENIX EMA
RYAN WHITE
PLANNING COUNCIL

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May, 2012

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The completion of this 3-Year Comprehensive HIV Services Plan is the culmination of a year-long effort by many caring people in our HIV community.

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Caring for our HIV Community

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May 14, 2012

Deborah Parham Hopson
Associate Administrator
HIV/AIDS Bureau, HRSA
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Dear Ms. Parham Hopson:

Please accept this letter of assurance that the Phoenix EMA Ryan White Planning Council has developed and approved this 3-Year Comprehensive Plan for the Delivery of Ryan White Part A Services in the Phoenix Eligible Metropolitan Area (EMA). The goals and activities detailed in the Plan were approved at the Council's March 8, 2012 meeting.

Development of this Comprehensive Plan was a collaborative effort guided by the Council's Community Health Planning & Strategies Committee, with input from consumers, representatives of local HIV service organizations, the Maricopa County Department of Public Health, the Arizona Department of Health Services, Maricopa Integrated Health Services, the Arizona Medicaid program, and Ryan White Parts B, C and D.

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

Sincerely,

Randall Furrow
Chair
Phoenix EMA Ryan White Planning Council

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EXECUTIVE SUMMARY:
COMPREHENSIVE PLAN GOALS AND OBJECTIVES

As approved by the Phoenix EMA Ryan White Part A Planning Council on March 8, 2012.

Goal 1: **Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.**

Objective 1: ***Develop and Implement dynamic activities for Early Intervention Services and Outreach services.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
1.1.1	Evaluate other EMA's EIS/Outreach activities to engage out-of-care individuals to return to care.	x			Community Health Planning & Strategies (CHPS), Standards Committees
1.1.2	Pilot best practices.		x		CHPS, Standards Committees
1.1.3	Evaluate pilot program, determine whether to permanently implement activities.			x	CHPS, Standards Committees

Objective 2: ***Based on 2012 Pathways to Care analysis (see 3.1.1), develop and implement strategies to ensure newly diagnosed individuals are appropriately connected to care from testing venues.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
1.2.1	Implementation/evaluation of Year 1 activities.	x			Pathways to Care Work Group
1.2.2	Implementation/evaluation of Year 2 activities.		x		Pathways to Care Work Group
1.2.3	Implementation/evaluation of Year 3 activities.			x	Pathways to Care Work Group

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

Objective 1: ***Collaborate with Arizona Department of Health Services (ADHS), Maricopa Integrated Health System (MIHS), and/or other hospital/clinic/urgent care entities to expand HIV testing/care coordination activities with one new partner each year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.1.1	Continue collaborative Opt-Out Jail testing pilot and Opt-Out Emergency Room testing pilot.	x			Community Health Planning & Strategies (CHPS) Committee, Part A Program
2.1.2	Implementation/evaluation of Year 2 activities.		x		CHPS Committee, Part A Program
2.1.3	Implementation/evaluation of Year 3 activities.			x	CHPS Committee, Part A Program

Objective 2: ***Participate in regional symposium to present current ED/jail testing initiatives to encourage implementation in state/regional locales.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.2.1	Create presentation and training module for regional symposium.	x			Part A Program
2.2.2	Present at regional symposium, adapt presentation for possible Ryan White Grantee Conference session.	x			Part A Program
2.2.3	Assist other entities with the implementation of a jail testing program, as requested.		x	x	Part A Program

Objective 3: ***Expand non-traditional testing activities, in collaboration with the Arizona Department of Health Services' HIV Prevention Program.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.3.1	Evaluate/continue County Jail testing program and identify additional partners.	x			Community Health Planning & Strategies (CHPS) Committee, Part A Program
2.3.2	Evaluate/report on Jail testing activities and implement testing activities with at least one new partner.		x		CHPS Committee, Part A Program
2.3.3	Evaluate/report on Year 2 activities and implement testing activities with at least one additional partner.			x	CHPS Committee, Part A Program

Objective 4: ***Collaborate with ADHS, MIHS, and other community partners to implement HIV awareness/testing/entry to care activities targeting individuals aged 45 and older, youth, Hispanics and African Americans.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.4.1	Collaborate with Ryan White Parts C and D to engage African American faith-based organizations to initiate awareness and testing activities.	x			Communities of Color Work Group, Part A Program
2.4.2	Determine special populations to focus additional activities on for GY 2013 and GY 2014, and develop evaluation tools.	x			Communities of Color Work Group, Part A Program
2.4.3	Implement and evaluate at least one activity to engage special populations to access HIV testing/enter in care.		x		Communities of Color Work Group, Part A Program
2.4.4	Implement and evaluate at least one activity to engage special populations to access HIV testing/enter in care.			x	Communities of Color Work Group, Part A Program

Goal 3: Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.

Objective 1: ***Align the Planning Council committee structure to better align tasks/responsibilities with Council and community goals/activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.1.1	Analyze and revise the existing Planning Council committee structure to better align committee activities with comprehensive plan goals and future community collaboration needs.	x	x		Executive Committee

Objective 2: ***Complete at least one needs assessment/service delivery assessment each grant year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.2.1	Pathways to Care analysis: How do Ryan White and non-Ryan White testing sites engage clients into medical care, what follow up occurs, etc.	x			Community Health Planning & Strategies (CHPS) Committee
3.2.2	Resource inventory: All HIV testing sites and providers, both Ryan White and non-Ryan White.	x			Planning Council Support
3.2.3	Transition assessment: Disenrolled Medicaid clients to Part A services, Part A/ADAP clients to ADAP Assist (PCIP).		x		CHPS Committee, Part A Program
3.2.4	Develop a strategic plan to transition clients to Health Exchanges/Affordable Care programs.			x	Transition Planning Work Group, Part A Program

Objective 3: ***Analyze the delivery of Part A Oral Health Services and implement revisions to this service (if any).***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.3.1	Implement combined Dental Insurance/Direct Dental Services and evaluate success of dual gateways to oral health services.	x			Oral Health Work Group, Part A Program
3.3.2	Evaluate and implement service delivery changes (if any).		x	x	Oral Health Work Group, Part A Program

Objective 4: ***Initiate expanded cultural competency activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.4.1	Cultural competency training for Part A Program staff/Planning Council members.	x			Part A Program, Planning Council Support
3.4.2	Provision of cultural competency training for Part A providers, and the establishment of approved training activities for new staff/ongoing training for existing staff.	x			Part A Program
3.4.3	Ongoing cultural competency training for all entities, as needed.		x	x	Part A Program

Objective 5: ***Address the needs of Refugee populations.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.5.1	Implement Refugee peer navigator program approved by the Planning Council.	x			Part A Program
3.5.2	Assessment and evaluation of needs, potential additional activities.		x		Community Health Planning & Strategies (CHPS) Committee, Part A Program staff
3.5.3	Implement additional/revised activities.			x	CHPS Committee, Part A Program staff

Goal 4: Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).

Objective 1: ***Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
4.1.1	Evaluate and report on what overlaps in care exist (if any).	x			Part A Program
4.1.2	Implementation of activities to eliminate overlaps (if any).		x		Part A Program
4.1.3	Evaluate and report on any activities that are implemented.			x	Part A Program

Goal 5: Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.

Objective 1: ***Maintain collaborative relationships with other Ryan White programs and community stakeholders.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
5.1.1	Continue established All Parts work group to develop efficiencies among all Ryan White programs.	x	x	x	Part A Program
5.1.2	Continue to assess the delivery of mental health and substance abuse services within the EMA.	x	x	x	Part A Program
5.1.3	Based on assessment analysis, implement collaborative activities to increase the number of clients engaged into substance abuse services.	x	x	x	Part A Program

Goal 6: Develop and implement strategies to strengthen retention in care.

Objective 1: ***Implement consumer health literacy activities, including peer-led programs designed to engage new-to-care clients into medical care.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.1.1	Pilot revised Health Journal and Care Planner wellness management tools.	x			Training, Education And Membership (TEAM) Committee
6.1.2	Evaluate Health Journal/Care Planner pilot, determine future implementation.		x		TEAM Committee
6.1.3	In conjunction with the University of Arizona, develop and pilot health literacy programming for new-to-care individuals with one Part A provider.	x			TEAM Committee, University of Arizona students, Planning Council Support, Part A Program
6.1.4	Evaluate health literacy pilot programming, determine whether to continue implementation.		x		TEAM Committee, University of Arizona students, Planning Council Support, Part A Program
6.1.5	Monitor and evaluate program implementation (if any).			x	Part A Program

Objective 2: ***TEAM committee to present or participate in at least one consumer education event each year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.2.1	Presentation of Year 1 event(s).	x			Training, Education And Membership (TEAM) Committee
6.2.2	Presentation of Year 2 event(s).		x		TEAM Committee
6.2.3	Presentation of Year 3 event(s).			x	TEAM Committee

Objective 3: ***Part A program to partner with the National Quality Center (NQC), other Ryan white programs and community stakeholders to implement quality improvement activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.3.1	Part A program to host a regional quality training program, in collaboration with the National Quality Center.	x			Standards Committee, Part A Program
6.3.2	Establish at least one measureable health outcome for each service category.	x			Standards Committee, Part A Program
6.3.3	Collaborate with community stakeholders to establish community viral load monitoring.		x		Standards Committee, Part A Program

6.3.4	Participate in NQC Quality Improvement and in+care initiatives.	x	x	x	Standards Committee, Part A Program

Objective 4: ***Collaborate with other Ryan White programs and community stakeholders to ensure that clients who transition between programs do not lose continuity of care.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.4.1	Collaborate with the state's Medicaid program (AHCCCS) to efficiently transition HIV positive clients who have been disenrolled from the program to Ryan White services, and monitor the engagement of these clients into care.	x	x	x	Transition Planning Work Group, Part A Program
6.4.2	Collaborate with the state's ADAP Assist program to efficiently transition eligible clients from Ryan White Part A services to the Pre-Existing Condition Insurance Program (PCIP), and monitor the engagement of these clients into care.	x	x	x	Transition Planning Work Group, Part A Program
6.4.3	Collaborate with ADHS, Ryan White Parts C and D to develop plan to transition clients to Affordable Care Act health care programs.	x	x		Transition Planning Work Group, Part A Program
6.4.4	Develop and implement training program for clients and providers regarding transitioning clients to Affordable Care Act health care programs.			x	Transition Planning Work Group, Part A Program

INTRODUCTION

ABOUT THE PHOENIX EMA RYAN WHITE PLANNING COUNCIL

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

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

OUR MISSION

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

OUR VISION

All people living with HIV/AIDS in Maricopa and Pinal Counties will have access to high quality health care and social services.

GUIDING PRINCIPLES

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

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

The Phoenix EMA may face, at some future time, issues which place powerful stresses on the HIV continuum of care, including funding changes, increased demand for services and/or increased costs to provide high quality care. Addressing these issues may necessitate changes to the mix and variety of services available through the Ryan White program. To best make decisions and maintain funding levels that align with the principals of HRSA/HAB and the Ryan White legislation, the Council commits itself to the following principles:

- No eligible PLWHA should be denied access to Ryan White primary health care.
- It is a valid practice to rank service categories in order of importance.

- Funding for higher ranked categories should be preserved before lower ranked ones.
- Funding for service categories will be reduced/ eliminated by priority from the bottom up.

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

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

DECISION MAKING

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

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

SERVICE DELIVERY

The Council is committed to uphold the following principles when developing directives to guide service delivery:

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

- Services should be culturally and linguistically appropriate for all PLWHA in the EMA

THE FEDERAL RYAN WHITE LEGISLATION

Ryan White was enacted by Congress in 1990 to provide emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic, to provide a continuum of care for persons living with HIV disease. Seventy five percent of each year's grant award must be used for core medical services and no more than 25 percent may be used for support services. Core services may include outpatient/ambulatory medical care services; pharmaceuticals; oral health services; health insurance premium and cost-sharing assistance for low income individuals; medical nutrition therapy; mental health services; substance abuse outpatient care; and medical case management. Support services must be linked to medical outcomes and may include outreach, medical transportation, food boxes/home-delivered meals, and non-medical case management.

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

The federal Ryan White legislation mandates that Planning Councils in every Eligible Metropolitan Area (EMA) and Transitional Grant Area (TGA) develop a comprehensive plan for the organization and delivery of HIV-related services. In fulfillment of this mandate, and to establish the strategic direction for the Phoenix EMA Part A program for the next three years, the Phoenix Ryan White Part A Planning Council (the Planning Council) has developed this Comprehensive Plan.

COMPREHENSIVE PLAN DEVELOPMENT METHODOLOGY

STEP 1: REVIEW OF THE 2009-2012 OBJECTIVES OF THE PART A PROGRAM

The Community Health Planning and Strategies (CHPS) Committee, the Planning Council Support Program Manager and staff from the Administrative Agency have made the following evaluation of the successes and challenges realized by the Part A Program from 2009 to 2012.

FIGURE 1: 2009-2012 Comprehensive Plan Goals and Objectives: Successes and Challenges

Goal 1:	**Improve the quality and delivery of Ryan White core services to increase retention of in care, facilitate the entry of newly diagnosed individuals into care, and eliminate disparities in care in communities of color.**
Objective 1:	***Ensure Ryan White Part A core services are available to all eligible Part A clients regardless of gender, age, race, ethnicity, sexual orientation, and geographic location, through targeted outreach and care models.***

Status	Objective	Activity	Comments
Achieved	1.1.1	Improve data sharing between service providers to improve coordination of care and identify people at risk of falling out of care.	

Achieved	1.1.2	Expand current initiatives that are focused on targeted outreach that ensures availability of services to all eligible Part A clients. This could include phased expansions of Ebony House outreach to African Americans, engagement of Hispanics through the family centered support and care model and targeted outreach to Women through the MIHS care system.	Two medical providers recruited for Part A services by the Part A Program One medical provider added culturally-appropriate patient navigators

Objective 2: ***Gather needs assessment and other epidemiological data from existing data systems to complete a comprehensive analysis of the gaps in services to include, quantification of specific gaps in services, studies on reasons for gaps in care for specific populations, and opportunities to address these gaps.***

Status	Objective	Activity	Comments
Achieved	1.2.1	Conduct assessment activities focused on population health status and health issues facing the HIV community.	Survey of Newly Diagnosed Population COBRA/ Health Insurance Continuation/Copay Assistance Evaluation EMA-wide Needs Assessment of 500 PLWHA Mental Health/Substance Abuse Services Analysis Out of Care Needs Assessment
Achieved	1.2.2	Each year, the Community Health Planning & Strategies Committee reviews data collected in Activity 1 to determine barriers and gaps to address, and then makes recommendations regarding general and MAI funding, capacity building, and directives for the delivery of Ryan White services. The recommendations will be tailored to populations at greater risk - African Americans, Hispanics and Women (For example, expansion of family centered support and care model for Hispanics at CPLC).	Directive for the provision of COBRA premium assistance Directive for the implementation of Oral Health service delivery guidelines Directive for revisions to Food Boxes/Homes Delivered Meals service delivery
Achieved	1.2.3	Review completed activities to evaluate effectiveness and determine revisions to activities, as needed.	

Objective 3: ***Ensure continuation of health care for people who are insured and not able to pay co-pays or other obligations needed to retain insurance coverage and/or access to medications.***

Status	Objective	Activity	Comments
Achieved	1.3.1	Complete data analysis using needs assessment and existing data sources to identify percentage of clients in various income brackets. Assess their risk for discontinuing medications or other care services based on greatest need.	
Achieved	1.3.2	Evaluation of data collected in Activity 1 to establish guidelines for financial assistance based on need and availability of funds.	
Achieved	1.3.3	Planning Council approval and implementation of any strategy/directive developed.	

Objective 4: ***Improve the timeliness of the transition of clients from positive HIV diagnosis to entry into Ryan White Part A core medical services.***

Status	Objective	Activity	Comments
Achieved	1.4.1	Collect data on newly diagnosed individuals to identify how clients access HIV testing, strengths and weaknesses of referral systems, and prevention strategies that were not effective	
Achieved	1.4.2	Analyze data to identify trends, quantify quality and operational improvements based on the interventions and identify opportunities for program expansion.	
Achieved	1.4.3	Collaborate with community stakeholders to develop and implement strategies to improve the transition of individuals newly diagnosed with HIV into care.	Recruitment of additional providers Development of Early Intervention Strategies Collaboration in pilot opt-out testing initiatives

Objective 5: ***Implement established Standards of Care to monitor and evaluate the quality and effectiveness of Ryan White Part A services.***

Status	Objective	Activity	Comments
Achieved	1.5.1	Ryan White Part A Standards of Care implemented in all service categories for one year. Quarterly reporting of evaluations is provided to the Standards Committee.	Standards of Care for all funded service categories completed and implemented.
Achieved	1.5.2	After one year of monitoring and evaluation, the Standards Committee reviews and revises each Standard of Care, as needed.	

Achieved	1.5.3	Administrative Agency Quality Management staff to provide ongoing training and technical assistance to the Standards Committee (i.e., quality management vs. quality assurance, cost effectiveness, etc.).	Part A Standards Committee members participated in local National Quality Center training hosted by Part A Program Ongoing training provided during Committee meetings

Objective 6: ***Provide health education and promotion activities that address consumer-identified health problems, improve knowledge of services and empower consumers to proactively manage their health and wellness.***

Status	Objective	Activity	Comments
Achieved	1.6.1	Present education events that provide clients with essential information, community resources, and useful tools to monitor and maintain their health.	Three English-language and two Spanish-language events presented
Not Achieved	1.6.2	Develop and maintain an open and efficient system to disseminate information about Part A services to providers and consumers both within and outside the Part A program.	Activity determined to be better implemented by non-Ryan White entity
Achieved	1.6.3	Develop and maintain Ryan White Part A web-based initiatives, and collaborate with other entities providing EMA-specific web-based information, to provide clients with information regarding Ryan White Part A services and services provided by other entities.	Part A program-specific communication system implemented Joint Planning Council and Part A website implemented

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

Objective1: ***Develop and implement methods to reduce administrative inefficiencies that challenge facilitating out-of-care individuals to enter into primary medical care.***

Status	Objective	Activity	Comments
Achieved	2.1.1	Improve data sharing linkages across local health departments and service providers (within legal boundaries) to increase efficiency and effectiveness of outreach efforts.	Data sharing agreement between most Ryan White Parts completed
Achieved	2.1.2	Complete an analysis of the additional administrative barriers that hinder the facilitation of out-of-care individuals into primary medical care.	Implementation of Centralized Eligibility for Part A Program
Achieved	2.1.3	Develop and implement strategies to overcome barriers identified in Activity 2.	

Achieved	2.1.4	Analyze data to identify trends, quantify quality and operational improvements and identify opportunities for program expansion.	

Objective 2: ***Successfully implement an Early Intervention Services service delivery model to facilitate an increased number of out-of-care individuals to enter or return to primary medical care.***

Status	Objective	Activity	Comments
Incomplete - Transitioned to new Plan	2.2.1	Train providers according to the revised Early Intervention Services service delivery model. Provide additional training to all Outreach Services providers regarding other medical systems (Medicaid, VA, etc.) providing services in the EMA.	HRSA guidelines for EIS revised before activity could occur Activity carried over to new Comprehensive Plan
Incomplete - Transitioned to new Plan	2.2.2	Implement the Early Intervention Services service delivery model, including the establishment of a data collection and monitoring system that will allow tracking of outcomes of the project.	HRSA guidelines for EIS revised before activity could occur Activity carried over to new Comprehensive Plan
Incomplete - Transitioned to new Plan	2.2.3	Analyze data to identify trends, quantify quality and operational improvements and identify opportunities for expansion.	HRSA guidelines for EIS revised before activity could occur Activity carried over to new Comprehensive Plan
Incomplete - Transitioned to new Plan	2.2.4	Development and implementation of Standards of Care for the Early Intervention Services service category.	HRSA guidelines for EIS revised before activity could occur Activity carried over to new Comprehensive Plan

Objective 3: ***Participate in Project Consumer LINC (Linking Individuals into Needed Care), a national initiative to identify, document, disseminate, and support the implementation of consumer-based strategies (e.g., outreach) as well as indirect models (e.g., consumer-led review of the system of care to remove access barriers) that involve Ryan White consumers in linking other PLWHA into primary medical care and other needed services.***

Status	Objective	Activity	Comments
Achieved	2.3.1	Participate in a national evaluation of promising models and strategies.	
Not Achieved	2.3.2	Identify and engage community stakeholders to collaborate on the project.	HRSA Cancelled Initiative

Not Achieved	2.3.3	Obtain training and technical assistance on the chosen program model.	HRSA Cancelled Initiative
Not Achieved	2.3.4	Implement the pilot program.	HRSA Cancelled Initiative
Not Achieved	2.3.5	Collect baseline and follow-up data and evaluate process and outcomes.	HRSA Cancelled Initiative

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

Objective 1: Identify the geographic distribution of Ryan White eligible clients.

Status	Objective	Activity	Comments
Achieved	3.1.1	Conduct an annual review of Ryan White client data by zip code.	
Achieved	3.1.2	Develop Geomaps and other profiles from the data.	
Achieved	3.1.3	Analysis of Geomap data.	
Achieved	3.1.4	Evaluation of implemented strategies/directives.	Outpatient Ambulatory Medical Care contract released based on geomapping initiative to identify target areas for services

Objective 2: Assess the utilization and satisfaction of Ryan White Part A services in particular areas.

Status	Objective	Activity	Comments
Achieved	3.2.1	Develop/identify method(s) to collect data on Part A service utilization and client satisfaction referencing geographic areas	Part A CAREWare data system revised to include geographic data
Achieved	3.2.2	Collect data on Part A service utilization/satisfaction referencing geographic areas.	
Achieved	3.2.3	Analysis of service utilization and satisfaction data referencing geographic areas.	

Objective 3: ***Advocate for hospital-based or ER HIV Testing for clients at risk for HIV/AIDS.***

Status	Objective	Activity	Comments
Achieved	3.3.1	Request Arizona Department of Health Services share results of feasibility study to implement routine HIV testing in hospitals and emergency rooms.	
Achieved	3.3.2	Evaluate research to determine potential projects/Ryan White Part A participation.	Part A Program and Planning Council participated in community planning activity to define pilot opt-out testing program
Achieved	3.3.3	Determine potential projects based on feasibility results.	Part A Program developed EIS strategy to partner with Maricopa Medical Center on pilot opt-out testing project

Objective 4: ***Research opportunities to implement a telemedicine care model to improve access to services.***

Status	Objective	Activity	Comments
Achieved	3.4.1	Research existing systems of telemedicine care models to gather an understanding of how they might apply to HIV communities in Maricopa and Pinal County.	Analysis revealed telemedicine system was extensively available throughout Arizona Providers identified the service was not needed to provide appropriate care

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

Objective 1: ***Determine the feasibility of transitioning to a centralized provider to offer seamless Ryan White Part A eligibility certification.***

Status	Objective	Activity	Comments
Achieved	4.1.1	Explore transitioning Ryan White Part A eligibility certification from the Ryan White Part A Administrative Agency to a centralized provider.	Centralized Eligibility implemented in the EMA

Objective 2: ***Create interagency collaboration between the Ryan White Parts, with input from other entities to create a single point of entry process for all programs and/or implement standardized eligibility certification documentation and procedures among multiple health care programs***

Status	Objective	Activity	Comments
Incomplete - Transitioned to new Plan	4.2.1	Establish stakeholder work group to ascertain the desire and ability of potential partners to implement standardized eligibility.	
Incomplete - Transitioned to new Plan	4.2.2	Work group meets to evaluate eligibility documents, policies and procedures from all collaborative partners.	
Incomplete - Transitioned to new Plan	4.2.3	Work group drafts common eligibility documents, policies and procedures for review by partner organizations.	
Incomplete - Transitioned to new Plan	4.2.4	Work group develops final eligibility documents, policies and procedures.	
Incomplete - Transitioned to new Plan	4.2.5	Final common eligibility documents, policies and procedures approved by all individual partner organizations. Implementation schedule established.	
Incomplete - Transitioned to new Plan	4.2.6	Clients and providers notified of changes to eligibility process.	
Incomplete - Transitioned to new Plan	4.2.7	Common eligibility certification process implemented among all collaborative partners.	

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

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

Status	Objective	Activity	Comments
Achieved	5.1.1	Review the Summary Report and develop activities and objectives for this Goal in Year 1, 2 and 3 of the Plan.	Review completed - other funding sources identified by providers No additional Part A funding required to meet need/address barriers and gaps

Objective 2: ***Develop a strategy for service improvements beyond those identified in the Substance Abuse report.***

Status	Objective	Activity	Comments
Achieved	5.2.1	Identify needed activities not necessarily present in the Substance Abuse Report.	No additional Part A funding required to meet need/ address barriers and gaps
Achieved	5.2.2	Develop specific objectives, activities and timelines for service improvement for each recommendation identified.	No additional Part A funding required to meet need/ address barriers and gaps

PART A PLANNING COUNCIL ACCOMPLISHMENTS 2009-2012

- Implementation of Centralized Eligibility for Part A services.
- An increase in the number/geographic diversity of Outpatient Ambulatory Medical Care providers.
- Completion of standards of care for all Part A services.
- Implementation of a mobile dietician program for Nutritional Services.
- Revisions to the Care Planner, a health journal and resource directory.
- Completion of needs assessments focusing on the Newly Diagnosed, Out of Care and an EMA-wide general assessment.
- Completion of service analyses for Mental Health, Substance Abuse and Oral Health Services.
- Presentation of health literacy events for 240 consumers.

- Implementation of Know Your Score and Are You Covered, two initiatives to engage consumers to understand the importance of remaining in medical care and renewing their eligibility for ADAP/Part A services in a timely manner.
- Implementation of Don't Get Dropped, an initiative to educate HIV positive Medicaid clients about changes to eligibility guidelines that would permanently disenroll clients who did not renew their eligibility on time.
- Provision of capacity building activities to transition Non-Medical Case Management providers to Medical Case Management providers.
- Revisions to service delivery guidelines for Oral Health services, including the implementation of Direct Dental Services.
- Members of the Planning Council, Part A Administrative Agency and Planning Council Support staff have become peer mentors for their counterparts in EMAs nationwide.
- Documents, policies/procedures, and activities/programs developed by the Phoenix EMA Planning Council have been shared with other EMAs/TGAs as models of best practices/innovations.
- Collaboration to pilot routine, opt-out HIV testing in MIHS emergency department. The Part A program provides linkage coordination.
- Collaborate with prevention and correctional services to implement an opt-out HIV testing pilot program in the Maricopa County jail system.
- Directives for COBRA assistance, food box distribution, AHCCCS copay assistance, direct dental services, capacity building for Medical Case Management.

PART A ADMINISTRATIVE AGENCY ACCOMPLISHMENTS 2009-2012

- Expanded Primary Care and Direct Dental Services. Primary Medical Care Services are now available in Eastern Maricopa and Pinal Counties, and Central Pinal County. Direct Dental Services are available in addition to the Dental Insurance Program to allow clients a choice in how they receive dental services.
- Expanded Medical Case Management Services. MAI Providers have contracts for Medical Case Management, completing the goal of having full case management services available in the EMA's MAI provider agencies.
- Developed multiple Early Intervention Strategies in response to HRSA's new requirements for Early Identification and Intervention Strategy requirements. New contracts have been awarded to increase testing, counseling, health literacy and linkage to care within the EMA.
- Received a HRSA Special Projects of National Significance grant to expand the capability of CAREWare to link clients to needed services by enhancing the referral system in CAREWare.
- Began Early Intervention Services and Transitional Case Management Services in the Maricopa County Jail System. These services include an OPT-OUT HIV testing program and discharge planning for clients being released into the community to ensure that clients are linked to community based services.

- Collaborated with the University of Arizona, College of Public Health to precept an Intern who will develop a research based Cultural Competency training program for HIV providers.
- Enhanced the financial and administrative functions of the RWPA Administrative Agency by implementing a Grants Management System to track all financial and billing data.
- Began the process to convert all paper systems in the RWPA Administrative Agency to a paperless system through the adoption of the ONBASE records management system.
- Provided technical assistance to providers to strengthen their ability to meet grant requirements
- Revised site visit data base to include all components of the HRSA Universal, Fiscal and Programmatic Monitoring Standards, and revised site visit protocols to meet all HRSA monitoring requirements.
- Hired a Special Populations Coordinator and a RN Health Data Analyst to strengthen the MAI and Quality Management programs in the EMA.
- Established the EMA's Quality Management Committee according to the EMA's Quality Management Plan, and met with the Committee semi-annually to review data and obtain the Committee's input into the Quality Management Plan's goals and objectives.
- Streamlined the EMA's contracting process, including Conditions of Award, Intergovernmental and Intradepartmental agreements.
- Worked closely with Ryan White Parts B and C to transition RWPA client to the new Pre-existing Insurance Program for medical care services.
- Worked closely with the Arizona Health Care Cost Containment System to minimize risk of clients being lost to care as they are disenrolled from AHCCCS in accordance to new AHCCCS requirements.

STEP 2: STAKEHOLDER INPUT

Key stakeholders, including HIV positive consumers, representatives from Ryan White Parts B, C and D, Ryan White-/non-Ryan White-funded service providers, Maricopa County HIV Testing and Partner Notification Services, the Prevention Planning Group of Arizona, and community members attended CHPS Committee meetings held over a six month period in 2011. Meeting participants reviewed the National HIV/AIDS Strategy, Healthy People 2020 goals, the goals of the regional Ryan White Quality Improvement Committee, needs assessment data, information on national/local trends in HIV care, the newly implemented HRSA Part A Program Standards, the Arizona Statewide Coordinated statement of Need, and other relevant information. As these discussions progressed, key themes were identified.

STEP 3: DEVELOPMENT OF GOALS AND ACTIVITIES

Based on the themes identified during the input process, Planning Council Support staff organized an initial draft of the Comprehensive Plan goals and activities. These were formatted into a chart that detailed each goal, the necessary objectives that needed to be completed, general timelines, collaborative partners needed, etc.

STEP 4: PUBLIC REVIEW AND COMMENT
The draft goals and activities were presented to the Planning Council in February 2012 and released to the public for comment immediately afterward.

STEP 5: FINAL APPROVAL OF GOALS AND ACTIVITIES
After comments were reviewed, the CHPS Committee finalized the proposed goals and activities. The Planning Council approved these goals and activities at their March 2012 meeting.

THE ROLE OF THE PART A ADMINISTRATIVE AGENCY IN PLANNING EFFORTS
The Planning Council and the Part A Administrative Agency enjoy an outstanding collaborative relationship. Members of the Administrative Agency staff were involved in the CHPS Committee activities discussed above, presenting data related to Part A health outcomes and client satisfaction. Additionally, the Part A Program hosted a work group session comprised of representatives of Ryan White Parts B, C and D, Maricopa County HIV Testing and Partner Notification Services, and the state AIDS Drug Assistance Program (ADAP) to identify common service delivery challenges and develop strategies to eliminate these issues.

STEP 6: FINAL GOALS

FIGURE 2: Final Phoenix EMA Comprehensive Plan Goals

Goal 1:	Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 2:	Identify individuals who are unaware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 3:	Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.
Goal 4:	Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).
Goal 5:	Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.
Goal 6:	Develop and implement strategies to strengthen retention in care.

PART 1: WHERE ARE WE NOW?

EPIDEMIOLOGICAL PROFILE OF THE PHOENIX EMA

The Phoenix EMA is comprised of Maricopa and Pinal Counties, located in central Arizona. The two counties have a combined land area of approximately 15,000 square miles, and a combined estimated population of 4,192,887 in 2010.[1] This represents 66 percent of the state's total population.

Source: US Census Bureau, 2010 Census of Population, Public Law 94-171 Redistricting Data File. http://factfinder2.census.gov

FIGURE 3: Arizona Counties

FIGURE 4: Phoenix EMA HIV Epidemiological Profile (Maricopa and Pinal Counties combined)

Source: Arizona Department of Health Services, HIV Epidemiology Program, 2011 Annual Report. http://www.azdhs.gov/phs/hiv/reporting/2011report.htm

2009 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
4,364,094	66.16	76.61	73.55

FIGURE 5: Phoenix EMA Current Estimated Prevalence

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	4358	41.5	197.34	4728	45.1	214.09	9086	86.6	411.43
Female	742	7.1	34.42	664	6.3	30.80	1406	13.4	65.22
TOTAL	**5100**	**48.6**	**116.86**	**5392**	**51.4**	**123.55**	**10492**	**100.0**	**240.42**
By Age									
Under 2	2	0.0	1.40	0	0.0	0.00	2	0.0	1.40
2-12	38	0.4	5.12	3	0.0	0.40	41	0.4	5.52
13-19	40	0.4	9.76	11	0.1	2.68	51	0.5	12.45
20-24	205	2.0	72.16	62	0.6	21.82	267	2.5	93.98
25-29	414	3.9	117.26	178	1.7	50.42	592	5.6	167.68
30-34	570	5.4	169.21	385	3.7	114.29	955	9.1	283.50
35-39	641	6.1	199.29	583	5.6	181.26	1224	11.7	380.55
40-44	859	8.2	290.66	1001	9.5	338.70	1860	17.7	629.36
45-49	942	9.0	318.65	1279	12.2	432.65	2221	21.2	751.30
50-54	686	6.5	261.23	883	8.4	336.25	1569	15.0	597.49
55-59	371	3.5	163.80	512	4.9	226.05	883	8.4	389.84
60-64	186	1.8	94.62	288	2.7	146.51	474	4.5	241.13
65 and Above	145	1.4	29.21	207	2.0	41.70	352	3.4	70.92
Age Unknown	1	0.0	N/A	0	0.0	N/A	1	0.0	N/A
TOTAL	**5100**	**48.6**	**116.86**	**5392**	**51.4**	**123.55**	**10492**	**100.0**	**240.42**
By Race/Ethnicity									
White Non-Hispanic	2886	27.5	113.44	3085	29.4	121.27	5971	56.9	234.71
Black Non-Hispanic	621	5.9	297.59	672	6.4	322.03	1293	12.3	619.63
Hispanic	1289	12.3	93.24	1389	13.2	100.48	2678	25.5	193.72
*A/PI/H Non-Hispanic	79	0.8	56.09	56	0.5	39.76	135	1.3	95.85
**AI/AN Non-Hispanic	118	1.1	133.82	153	1.5	173.51	271	2.6	307.33
***MR/O Non-Hispanic	107	1.0	N/A	37	0.4	N/A	144	1.4	N/A
TOTAL	**5100**	**48.6**	**116.86**	**5392**	**51.4**	**123.55**	**10492**	**100.0**	**240.42**
By Mode of Transmission									
+MSM	3069	29.3	N/A	3328	31.7	N/A	6397	61.0	N/A
++IDU	488	4.7	N/A	608	5.8	N/A	1096	10.4	N/A
MSM / IDU	337	3.2	N/A	550	5.2	N/A	887	8.5	N/A
Heterosexual	491	4.7	N/A	523	5.0	N/A	1014	9.7	N/A
+++O/H/TF/TPR	80	0.8	N/A	41	0.4	N/A	121	1.2	N/A
++++NRR/UR	635	6.1	N/A	342	3.3	N/A	977	9.3	N/A
TOTAL	**5100**	**48.6**	**116.86**	**5392**	**51.4**	**123.55**	**10492**	**100.0**	**240.42**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 6: Phoenix EMA Incidence 2005 to 2009

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	1741	61.3	16.61	726	25.5	6.93	2467	86.8	23.53
Female	278	9.8	2.71	97	3.4	0.94	375	13.2	3.65
TOTAL	**2019**	**71.0**	**9.73**	**823**	**29.0**	**3.97**	**2842**	**100.0**	**13.69**
By Age									
Under 2	8	0.3	1.14	0	0.0	0.00	8	0.3	1.14
2-12	11	0.4	0.32	0	0.0	0.00	11	0.4	0.32
13-19	83	2.9	4.21	9	0.3	0.46	92	3.2	4.67
20-24	312	11.0	22.86	39	1.4	2.86	351	12.4	25.72
25-29	347	12.2	20.96	105	3.7	6.34	452	15.9	27.30
30-34	307	10.8	19.59	110	3.9	7.02	417	14.7	26.61
35-39	337	11.9	22.03	138	4.9	9.02	475	16.7	31.06
40-44	289	10.2	19.79	163	5.7	11.16	452	15.9	30.95
45-49	164	5.8	11.61	112	3.9	7.93	276	9.7	19.53
50-54	83	2.9	6.72	74	2.6	5.99	157	5.5	12.71
55-59	49	1.7	4.44	33	1.2	2.99	82	2.9	7.42
60-64	15	0.5	1.65	25	0.9	2.75	40	1.4	4.41
65 and Above	14	0.5	0.59	15	0.5	0.64	29	1.0	1.23
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**2019**	**71.0**	**9.73**	**823**	**29.0**	**3.97**	**2842**	**100.0**	**13.69**
By Race/Ethnicity									
White Non-Hispanic	981	34.5	7.85	367	12.9	2.94	1348	47.4	10.79
Black Non-Hispanic	257	9.0	27.94	86	3.0	9.35	343	12.1	37.29
Hispanic	661	23.3	10.49	329	11.6	5.22	990	34.8	15.71
*A/PI/H Non-Hispanic	27	1.0	4.30	9	0.3	1.43	36	1.3	5.74
**AI/AN Non-Hispanic	57	2.0	13.83	25	0.9	6.07	82	2.9	19.89
***MR/O Non-Hispanic	36	1.3	N/A	7	0.2	N/A	43	1.5	N/A
TOTAL	**2019**	**71.0**	**9.73**	**823**	**29.0**	**3.97**	**2842**	**100.0**	**13.69**
By Mode of Transmission									
+MSM	1266	44.5	N/A	449	15.8	N/A	1715	60.3	N/A
++IDU	162	5.7	N/A	103	3.6	N/A	265	9.3	N/A
MSM / IDU	105	3.7	N/A	43	1.5	N/A	148	5.2	N/A
Heterosexual	153	5.4	N/A	63	2.2	N/A	216	7.6	N/A
+++O/H/TF/TPR	20	0.7	N/A	1	0.0	N/A	21	0.7	N/A
++++NRR/UR	313	11.0	N/A	164	5.8	N/A	477	16.8	N/A
TOTAL	**2019**	**71.0**	**9.73**	**823**	**29.0**	**3.97**	**2842**	**100.0**	**13.69**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

MARICOPA COUNTY

Maricopa County, Arizona, is the nation's fourth largest county in terms of population—nearly 3.9 million—and the 14th largest in the continental United States in land area, covering 9,203 square miles. The county was named in honor of the Maricopa Indians, who were known to have inhabited the area as early as 1775. Twenty-five cities and towns are located in the county; its largest city, Phoenix, is the capital of the state and the largest city in Arizona with an estimated 2010 population of 1,445,632. The remainder of the county is rural and includes the communities of Cave Creek, Goodyear, Buckeye, Wickenburg and Queen Creek. Maricopa County's economic base includes computer chip production, aerospace, advanced business services, transportation/distribution/wholesale trade, and tourism.

FIGURE 7: 2010 Maricopa County Population Percentages by Race

Source: U.S. Census Bureau http://quickfacts.census.gov/qfd/states/04/04013.html

White persons	73.0%
Black persons	5.0%
American Indian and Alaska Native persons	2.1%
Asian persons, percent	3.5%
Native Hawaiian and Other Pacific Islander	0.2%
Persons reporting two or more races	3.5%
Persons of Hispanic or Latino origin	29.6%
White persons not Hispanic, percent, 2010	58.7%

FIGURE 8: Maricopa County HIV Epidemiological Profile

Source: Arizona Department of Health Services, HIV Epidemiology Program, 2011 Annual Report. http://www.azdhs.gov/phs/hiv/reporting/2011report.htm

2009 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
4,023,132	61.00	69.27	68.52

FIGURE 9: Maricopa County Current Estimated Prevalence

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000
By Gender									
Male	4066	41.6	200.24	4378	44.8	215.61	8444	86.4	415.85
Female	700	7.2	35.13	630	6.4	31.62	1330	13.6	66.75
TOTAL	**4766**	**48.8**	**118.46**	**5008**	**51.2**	**124.48**	**9774**	**100.0**	**242.95**
By Age									
Under 2	2	0.0	0.29	0	0.0	0.00	2	0.0	0.29
2-12	35	0.4	5.10	3	0.0	0.44	38	0.4	5.53
13-19	37	0.4	9.75	11	0.1	2.90	48	0.5	12.65
20-24	194	2.0	73.58	56	0.6	21.24	250	2.6	94.82
25-29	387	4.0	118.55	162	1.7	49.63	549	5.6	168.18
30-34	519	5.3	167.05	346	3.5	111.37	865	8.9	278.41
35-39	577	5.9	194.19	524	5.4	176.35	1101	11.3	370.55
40-44	791	8.1	288.16	920	9.4	335.16	1711	17.5	623.32
45-49	889	9.1	323.49	1190	12.2	433.01	2079	21.3	756.50
50-54	659	6.7	270.70	831	8.5	341.35	1490	15.2	612.04
55-59	357	3.7	171.83	490	5.0	235.84	847	8.7	407.67
60-64	181	1.9	101.64	277	2.8	155.55	458	4.7	257.18
65 and Above	137	1.4	30.49	198	2.0	44.07	335	3.4	74.56
Age Unknown	1	0.0	N/A	0	0.0	N/A	1	0.0	N/A
TOTAL	**4766**	**48.8**	**118.46**	**5008**	**51.2**	**124.48**	**9774**	**100.0**	**242.95**
By Race/Ethnicity									
White Non-Hispanic	2793	28.6	119.18	2979	30.5	127.12	5772	59.1	246.30
Black Non-Hispanic	592	6.1	305.04	627	6.4	323.07	1219	12.5	628.10
Hispanic	1106	11.3	86.36	1177	12.0	91.91	2283	23.4	178.27
*A/PI/H Non-Hispanic	70	0.7	51.99	49	0.5	36.39	119	1.2	88.39
**AI/AN Non-Hispanic	104	1.1	148.05	142	1.5	202.14	246	2.5	350.19
***MR/O Non-Hispanic	101	1.0	N/A	34	0.3	N/A	135	1.4	N/A
TOTAL	**4766**	**48.8**	**118.46**	**5008**	**51.2**	**124.48**	**9774**	**100.0**	**242.95**
By Mode of Transmission									
+MSM	2944	30.1	N/A	3179	32.5	N/A	6123	62.6	N/A
++IDU	407	4.2	N/A	513	5.2	N/A	920	9.4	N/A
MSM / IDU	313	3.2	N/A	487	5.0	N/A	800	8.2	N/A
Heterosexual	457	4.7	N/A	481	4.9	N/A	938	9.6	N/A
+++O/H/TF/TPR	75	0.8	N/A	41	0.4	N/A	116	1.2	N/A
++++NRR/UR	570	5.8	N/A	307	3.1	N/A	877	9.0	N/A
TOTAL	**4766**	**48.8**	**118.46**	**5008**	**51.2**	**124.48**	**9774**	**100.0**	**242.95**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 10: Maricopa County Estimated Incidence 2005 to 2009

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000
By Gender									
Male	1595	61.4	16.42	647	24.9	6.66	2242	86.3	23.08
Female	265	10.2	2.77	90	3.5	0.94	355	13.7	3.71
TOTAL	**1860**	**71.6**	**9.65**	**737**	**28.4**	**3.82**	**2597**	**100.0**	**13.47**
By Age									
Under 2	8	0.3	1.22	0	0.0	0.00	8	0.3	1.22
2-12	10	0.4	0.31	0	0.0	0.00	10	0.4	0.31
13-19	79	3.0	4.30	9	0.3	0.49	88	3.4	4.79
20-24	292	11.2	23.19	35	1.3	2.78	327	12.6	25.97
25-29	325	12.5	21.32	91	3.5	5.97	416	16.0	27.29
30-34	265	10.2	18.17	96	3.7	6.58	361	13.9	24.75
35-39	306	11.8	21.40	127	4.9	8.88	433	16.7	30.28
40-44	275	10.6	20.09	150	5.8	10.96	425	16.4	31.05
45-49	152	5.9	11.48	96	3.7	7.25	248	9.5	18.72
50-54	76	2.9	6.58	65	2.5	5.63	141	5.4	12.22
55-59	46	1.8	4.48	32	1.2	3.12	78	3.0	7.60
60-64	14	0.5	1.68	23	0.9	2.76	37	1.4	4.43
65 and Above	12	0.5	0.56	13	0.5	0.60	25	1.0	1.16
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**1860**	**71.6**	**9.65**	**737**	**28.4**	**3.82**	**2597**	**100.0**	**13.47**
By Race/Ethnicity									
White Non-Hispanic	949	36.5	8.17	346	13.3	2.98	1295	49.9	11.14
Black Non-Hispanic	244	9.4	28.20	78	3.0	9.01	322	12.4	37.21
Hispanic	554	21.3	9.45	273	10.5	4.66	827	31.8	14.11
*A/PI/H Non-Hispanic	26	1.0	4.31	9	0.3	1.49	35	1.3	5.80
**AI/AN Non-Hispanic	51	2.0	15.45	24	0.9	7.27	75	2.9	22.71
***MR/O Non-Hispanic	36	1.4	N/A	7	0.3	N/A	43	1.7	N/A
TOTAL	**1860**	**71.6**	**9.65**	**737**	**28.4**	**3.82**	**2597**	**100.0**	**13.47**
By Mode of Transmission									
+MSM	1203	46.3	N/A	424	16.3	N/A	1627	62.6	N/A
++IDU	126	4.9	N/A	80	3.1	N/A	206	7.9	N/A
MSM / IDU	96	3.7	N/A	37	1.4	N/A	133	5.1	N/A
Heterosexual	135	5.2	N/A	51	2.0	N/A	186	7.2	N/A
+++O/H/TF/TPR	18	0.7	N/A	1	0.0	N/A	19	0.7	N/A
++++NRR/UR	282	10.9	N/A	144	5.5	N/A	426	16.4	N/A
TOTAL	**1860**	**71.6**	**9.65**	**737**	**28.4**	**3.82**	**2597**	**100.0**	**13.47**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

PINAL COUNTY

Rural Pinal County was formed from portions of Maricopa and Pima counties in 1875. Florence was designated the county seat and is home to both the Pinal County government complex and the Arizona State Prison. Pinal County is the third most populous county in Arizona. Pinal County is one of the largest counties in Arizona at 5,386 square miles, which is larger than the state of Connecticut (4,845 square miles). The County is comprised of two distinct regions: the eastern mountainous area and the low desert valleys of the west. Incorporated cities include Florence, Superior, Kearney, Coolidge, and Eloy. Pinal County contains parts of the Tohono O'odham Nation, the Gila River Indian Community and the San Carlos Apache Indian Reservation, as well as the entirety of the Ak-Chin Indian Community. Growth southward from the Phoenix metropolitan area has begun to spread into the northern parts of Pinal County.

FIGURE 11: 2010 Pinal County Population by Race

Source: U.S. Census Bureau http://quickfacts.census.gov/qfd/states/04/04021.html

White persons	72.4%
Black persons	4.6%
American Indian and Alaska Native persons	5.6%
Asian persons, percent	1.7%
Native Hawaiian and Other Pacific Islander	0.4%
Persons reporting two or more races	3.8%
Persons of Hispanic or Latino origin	28.5%
White persons not Hispanic	58.7%

FIGURE 12: Pinal County HIV Epidemiological Profile

Source: Arizona Department of Health Services, HIV Epidemiology Program, 2011 Annual Report.
http://www.azdhs.gov/phs/hiv/reporting/2011report.htm

2009 Population	% of State Population	% of State HIV/AIDS Incidence	% State HIV/AIDS Prevalence
340,962	5.17	7.34	5.03

FIGURE 13: Pinal County Current Estimated Prevalence

	Prevalent HIV			Prevalent AIDS			Prevalent HIV&AIDS		
	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000
By Gender									
Male	292	40.7	164.20	350	48.7	196.81	642	89.4	361.01
Female	42	5.8	25.75	34	4.7	20.84	76	10.6	46.59
TOTAL	**334**	**46.5**	**97.96**	**384**	**53.5**	**112.62**	**718**	**100.0**	**210.58**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	3	0.4	5.37	0	0.0	0.00	3	0.4	5.37
13-19	3	0.4	9.87	0	0.0	0.00	3	0.4	9.87
20-24	11	1.5	53.82	6	0.8	29.36	17	2.4	83.17
25-29	27	3.8	101.47	16	2.2	60.13	43	6.0	161.59
30-34	51	7.1	194.90	39	5.4	149.04	90	12.5	343.94
35-39	64	8.9	261.08	59	8.2	240.68	123	17.1	501.75
40-44	68	9.5	323.15	81	11.3	384.93	149	20.8	708.07
45-49	53	7.4	254.78	89	12.4	427.84	142	19.8	682.63
50-54	27	3.8	140.98	52	7.2	271.51	79	11.0	412.49
55-59	14	1.9	74.73	22	3.1	117.43	36	5.0	192.15
60-64	5	0.7	27.04	11	1.5	59.49	16	2.2	86.53
65 and Above	8	1.1	17.00	9	1.3	19.12	17	2.4	36.12
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**334**	**46.5**	**97.96**	**384**	**53.5**	**112.62**	**718**	**100.0**	**210.58**
By Race/Ethnicity									
White Non-Hispanic	93	13.0	46.40	106	14.8	52.88	199	27.7	99.28
Black Non-Hispanic	29	4.0	198.67	45	6.3	308.28	74	10.3	506.95
Hispanic	183	25.5	179.80	212	29.5	208.29	395	55.0	388.09
*A/PI/H Non-Hispanic	9	1.3	144.93	7	1.0	112.72	16	2.2	257.65
**AI/AN Non-Hispanic	14	1.9	78.08	11	1.5	61.35	25	3.5	139.43
***MR/O Non-Hispanic	6	0.8	N/A	3	0.4	N/A	9	1.3	N/A
TOTAL	**334**	**46.5**	**97.96**	**384**	**53.5**	**112.62**	**718**	**100.0**	**210.58**
By Mode of Transmission									
+MSM	125	17.4	N/A	149	20.8	N/A	274	38.2	N/A
++IDU	81	11.3	N/A	95	13.2	N/A	176	24.5	N/A
MSM / IDU	24	3.3	N/A	63	8.8	N/A	87	12.1	N/A
Heterosexual	34	4.7	N/A	42	5.8	N/A	76	10.6	N/A
+++O/H/TF/TPR	5	0.7	N/A	0	0.0	N/A	5	0.7	N/A
++++NRR/UR	65	9.1	N/A	35	4.9	N/A	100	13.9	N/A
TOTAL	**334**	**46.5**	**97.96**	**384**	**53.5**	**112.62**	**718**	**100.0**	**210.58**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 14: Pinal County Incidence 2005 to 2009

	Emergent HIV			Emergent AIDS			Emergent HIV&AIDS		
	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000	Cases	% County Total	Rate Per 100,000
By Gender									
Male	146	59.6	18.96	79	32.2	10.26	225	91.8	29.23
Female	13	5.3	1.85	7	2.9	1.00	20	8.2	2.84
TOTAL	**159**	**64.9**	**10.79**	**86**	**35.1**	**5.84**	**245**	**100.0**	**16.63**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	1	0.4	0.43	0	0.0	0.00	1	0.4	0.43
13-19	4	1.6	3.00	0	0.0	0.00	4	1.6	3.00
20-24	20	8.2	18.95	4	1.6	3.79	24	9.8	22.74
25-29	22	9.0	16.74	14	5.7	10.65	36	14.7	27.39
30-34	42	17.1	38.71	14	5.7	12.90	56	22.9	51.61
35-39	31	12.7	31.22	11	4.5	11.08	42	17.1	42.30
40-44	14	5.7	15.33	13	5.3	14.23	27	11.0	29.56
45-49	12	4.9	13.55	16	6.5	18.06	28	11.4	31.61
50-54	7	2.9	8.62	9	3.7	11.08	16	6.5	19.70
55-59	3	1.2	3.87	1	0.4	1.29	4	1.6	5.15
60-64	1	0.4	1.38	2	0.8	2.75	3	1.2	4.13
65 and Above	2	0.8	0.98	2	0.8	0.98	4	1.6	1.97
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**159**	**64.9**	**10.79**	**86**	**35.1**	**5.84**	**245**	**100.0**	**16.63**
By Race/Ethnicity									
White Non-Hispanic	32	13.1	3.66	21	8.6	2.40	53	21.6	6.06
Black Non-Hispanic	13	5.3	23.89	8	3.3	14.70	21	8.6	38.60
Hispanic	107	43.7	24.43	56	22.9	12.78	163	66.5	37.21
*A/PI/H Non-Hispanic	1	0.4	4.23	0	0.0	0.00	1	0.4	4.23
**AI/AN Non-Hispanic	6	2.4	7.32	1	0.4	1.22	7	2.9	8.54
***MR/O Non-Hispanic	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**159**	**64.9**	**10.79**	**86**	**35.1**	**5.84**	**245**	**100.0**	**16.63**
By Mode of Transmission									
+MSM	63	25.7	N/A	25	10.2	N/A	88	35.9	N/A
++IDU	36	14.7	N/A	23	9.4	N/A	59	24.1	N/A
MSM / IDU	9	3.7	N/A	6	2.4	N/A	15	6.1	N/A
Heterosexual	18	7.3	N/A	12	4.9	N/A	30	12.2	N/A
+++O/H/TF/TPR	2	0.8	N/A	0	0.0	N/A	2	0.8	N/A
++++NRR/UR	31	12.7	N/A	20	8.2	N/A	51	20.8	N/A
TOTAL	**159**	**64.9**	**10.79**	**86**	**35.1**	**5.84**	**245**	**100.0**	**16.63**

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

FIGURE 15: 2010 Unmet Need Estimate - Phoenix EMA

Source: http://www.azdhs.gov/phs/hiv/pdf/2011report/UnmetNeed2010.pdf

	Case Count	Unmet Need Relative Proportion	Relative Proportion EMA Population	Relative Proportion Prevalence
Total Persons with Unmet Need for HIV Primary Care	**4689**		44.09%	
Total Persons living with HIV/AIDS	**10636**			
Persons with an Unmet Need By Gender				
Males	4095	87.33%	50.64%	86.69%
Females	594	12.67%	49.36%	13.31%
Total	**4689**			
Persons with an Unmet Need By Age				
Age <2 Years	0	0.00%	3.25%	0.01%
Age 2-12	16	0.34%	17.09%	0.37%
Age 13-19	11	0.23%	9.36%	0.49%
Age 20-24	93	1.98%	6.40%	2.52%
Age 25-29	239	5.10%	8.15%	5.84%
Age 30-34	417	8.89%	7.70%	9.02%
Age 35-39	538	11.47%	7.39%	11.94%
Age 40-44	783	16.70%	6.64%	17.66%
Age 45-49	1005	21.43%	6.79%	21.30%
Age 50-54	754	16.08%	6.06%	14.86%
Age 55-59	424	9.04%	5.20%	8.35%
Age 60-64	223	4.76%	4.60%	4.32%
Age 65 and Above	186	3.97%	11.37%	3.30%
Unknown Age	0	0.00%	N/A	0.01%
Total	**4689**			
Persons with an Unmet Need By Race/Ethnicity				
White Non-Hispanic	2563	54.66%	57.36%	56.96%
Black Non-Hispanic	612	13.05%	4.93%	12.33%
Hispanic	1274	27.17%	32.35%	25.50%
Asian/Pacific Islander Non-Hispanic	52	1.11%	3.34%	1.25%
American Indian/Alaska Native Non-Hispanic	94	2.00%	2.02%	2.57%
Multi-Race/Other Race/Unknown	94	2.00%	N/A	1.38%
Total	**4689**			
Persons with an Unmet Need By Reported Risk				
MSM	2658	56.69%	N/A	61.06%
IDU	595	12.69%	N/A	10.47%
MSM/IDU	436	9.30%	N/A	8.43%
Heterosexual	400	8.53%	N/A	9.66%
Blood Exposure/Other	24	0.51%	N/A	0.37%
Maternal Vertical Transmission	26	0.55%	N/A	0.77%
No Reported Risk/ Unknown Risk	550	11.73%	N/A	9.24%
Total	**4689**			
Any MSM	3094	65.98%	N/A	69.49%
Any IDU	1031	21.99%	N/A	18.90%

PHOENIX EMA EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) STRATEGY

The Phoenix Eligible Metropolitan Area estimates approximately 2,785 individuals are unaware of their HIV-positive status. Based on the EMA's unaware estimate, the EMA's EIIHA strategies were developed in collaboration with the Unaware Ad-Hoc Committee composed of Planning Council, Part B, Part C, Part D, Maricopa County prevention services, State of Arizona prevention services; HIV focused non-profit agencies, community members and other key stakeholders. The Unaware Ad-Hoc Committee reviewed information about local activities, information from the National HIV/AIDS Strategy (NHAS) for the United States, July 2010 and data from the EMA 2009 Newly Diagnosed Needs Assessment.

In 2009, the Phoenix Planning Council commissioned a Newly Diagnosed Needs Assessment to: 1) Address the high incidence within the EMA which is directly related to the National HIV/AIDS Strategy (NHAS) and 2) to gather data to satisfy HRSA's Unaware mandate. The 2009 Newly Diagnosed Needs Assessment evaluated 70 newly diagnosed individuals and yielded information on needs of the newly diagnosed and insight into what prevents individuals in the EMA from getting tested and entering care earlier. Based on findings from the Newly Diagnosed Needs Assessment, the committee's discussions identified potential gaps for identifying unaware individuals and opportunities to reach more unaware people living with HIV/AIDS and bringing them into care. Highlights from the 2009 Needs Assessment can be found further in this report in the Central Region Community Surveys section.

The Phoenix EMA EIIHA strategy is focused on three components:

1. Strategically increasing testing based on a review of current program's seropositivity rates within the EMA;
2. Reaching the unaware in high need groups based on the EMA's EIIHA matrix; and
3. Enhancing referrals within the EMA's continuum of care all with the goal of reducing the EMA's unaware estimate.

The efforts of this strategy are focused on the following subgroups: 1) MSM White, 2) MSM Hispanic, 3) black women, 4) black refugees 5) black non-IDU substance users 6) Native American non-IDU substance users. Through an initial focus on the subpopulations and utilization of strong interagency partnerships the EMA is well positioned to identify, inform, refer and link unaware individuals living in the EMA to care. The EMA's robust CAREWare reporting requirements will aid the jurisdiction in capturing PLWHA who become Aware of their HIV status based on strategies developed by the Unaware Ad-Hoc Committee.

ACTIONS TO PROMOTE HIV TESTING

Through the use of new emergency department testing, expanded high risk testing, labor and delivery testing projects, more unaware individuals will have the opportunity to become aware of their status and enter into care. Based on the 2009 Newly Diagnosed Needs Assessment, 25% of survey respondents indicated they were diagnosed HIV+ at an Emergency Room when they were being treated for another reason. The Part A office has partnered with the Part C office to coordinate linkage to care through HIV+ clients found through routine emergency department testing. As of February 2012, the Emergency Department at Maricopa Integrated Health System had completed over 5,000 HIV tests and found 15 positives. Approximately half of the diagnoses are of acute infections.

In 2005, Maricopa Medical Center officially implemented Rapid HIV Testing in Labor and Delivery. The test is drawn when completing routine prenatal labs upon admission. Positive results are called to the charge nurse who then notifies the provider. Since 2005, Maricopa Medical Center has not had any children born with perinatal HIV due to this community effort of routine prenatal screening for HIV and Rapid Testing.

As shown in Figure 16, HIV Partner Services and risk-driven testing is the most successful method available for early diagnosis and increased awareness of HIV status. Phoenix EMA will continue to monitor testing and positivity rates to ascertain the effectiveness of the additional testing and to determine which strategies are successful and which require improvement.

FIGURE 16: Testing Strategies in Maricopa County, 2010-2011

Testing Strategy	Number of Tests	Number of New HIV Diagnoses	Positivity Rate	Positives per number of tests
Pregnant Women in Maricopa County, 2010	886	2	0.20%	1/443
Correctional Testing, Maricopa County, 2011	2000	4	0.20%	1/500
Emergency Department Testing, Maricopa County 2011	5000	15	0.30%	1/333
Partner Services, Maricopa County 2010	326	66	20.25%	1/6

IMPROVING CLIENT ACCESS AND RETENTION IN CARE

The goal to strengthen connections between HIV-focused agencies within the EMA to improve client access and retention in care relates to the Nation HIV/AIDS Strategy goals of increasing the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80% and to increase the proportion of newly diagnosed patients linked to clinical care from 65% to 85%. Through strengthened connections, testing staff will have the necessary relationships to facilitate transfer of a newly diagnosed client to medical care. A strong network of providers can emphasize the importance of staying in medical care so that clients receive consistent messages regardless of which provider they are seeing.

INFORMING UNAWARE INDIVIDUALS OF HIV STATUS

Stronger partnerships allow for increased collaboration not only in referring and linking clients to services but also for coordinated testing and identification of unaware individuals. Part A mandates that Business Associate Agreements regulate data sharing. Plans to create a shared community calendar will further break down silos by improving communication and collaboration between multiple agencies. Improved collaboration will ultimately benefit the unaware and aware individuals living with HIV/AIDS.

COORDINATING WITH KEY PARTNERS

The Part A program, in partnership with Part B, has proposed focusing EIIHA strategies in zip codes of high prevalence based on the EMA's epidemiology profile. The EMA will expand testing to more remote

locations throughout the EMA once initial EIIHA strategies have been evaluated. Discussions are in place regarding the roles of rural community health nurses and their assistance with data collection and reporting related to identifying HIV positive unaware individuals. The Part A program has a history of working closely with the Part B program to ensure that assistance is brought forth and that data is reported and exchanged as needed.

The Part A program utilizes partnerships with agencies to refer HIV positive individuals to care. For example, the Phoenix Indian Medical Center has regular communication with rural clinics and Indian Health Services locations throughout the state to encourage referrals of eligible individuals to the Phoenix located HIV Center of Excellence. Part A mirrors Part B in the use of case managers to build personal connections with urban and rural clinicians. Case Managers from both parts also arrange transportation, a service that 27% of the participants in the 2009 Newly Diagnosed/New to Care Needs Assessment identified as one which would help them with entry/retention in care.

Collaborative efforts also recently expanded to include the state refugee health services department, correctional health and refugee clinics. Some of the results of this collaboration are the increased HIV testing targeted towards Men who have Sex with Men (MSM), the highest risk factor for the unaware within the EMA, an opt-out testing pilot for inmates incarcerated in county jails for seven or more days, and an upcoming early intervention services project for refugee women.

ADDRESSING SPECIAL POPULATIONS

The populations targeted by the Phoenix EMA EIIHA strategy are historically underserved and/or have disparity issues. African Americans make up 4.5% of Arizona's general population but 11.8% of the new HIV cases, according to the Arizona Department of Health Services 2011 HIV/AIDS Annual Report. According to the same report, the rate of emergent cases of Black women with HIV is 21% higher than the statewide rate among men. Men who have sex with men (MSM) make up an unknown percentage of Arizona's population, yet account for 58% of emergent HIV/AIDS cases.

Through activities such as improving labor and delivery services in rural areas of the Phoenix EMA, underserved communities have improved access to testing and HIV related safety protocols which can lead to decreased transmission from mother to child. During the 2009 grant year, the EMA added two rural primary medical care sites located within the Phoenix EMA thereby increasing access to care in the underserved area. The rural clinics are now seeing approximately 50 HIV positive clients.

MAKING INDIVIDUALS AWARE OF HIV

State and local budgets for testing and partner services have been cut in recent years resulting in a decrease in testing and the ability of partner services to link positive individuals to care. Stigma also continues to be a challenge, particularly among the communities of color and rural areas. Legislative immigration reforms have created resistance to seeking government aid due to fear of deportation. This has led to a reported decrease in Hispanics seeking HIV testing. Data sharing between the governmental agencies is also a challenge. Not all agencies are collecting the same data points and data sharing polices have been legally difficult to navigate.

One of the ongoing challenges from Phoenix EMA partners that do testing is the procurement and retention of bilingual staff. With approximately 25% of the epidemic identifying as Hispanic, bilingual staff is an important need. Phoenix is the fifth largest reception site of refugees; therefore, languages

beyond Spanish are also needed. Agencies indicate that it is difficult to find bilingual staff in the social services sector. In designing routine HIV testing program in corrections, one of the challenges is determining the capacity needed to treat additional clients identified through routine testing. It is currently the practice of the local prison and jails to not conduct routine HIV testing for incarcerated individuals, so the positivity rate is unknown, making costs difficult to estimate.

The Ryan White Part A program launched a pilot program in November 2011 with Maricopa County Corrections to improve linkages for recently incarcerated individuals and to encourage routine testing within the jails. Inmates are HIV tested during their routine health physical which occurs 10-14 days after intake. The pilot will end after the first 20 new HIV diagnoses are identified. As of April 2011, more than 2,000 tests had been administered with a .2% positivity rate. Information collected during this pilot will allow corrections to conduct a more thorough cost benefit analysis which can be shared with the Part A office and also the local prison administration who will receive a portion of the newly diagnosed clients.

PART A COORDINATION WITH PART C
FOR PURPOSE OF MAKING HIV UNAWARE INDIVIDUALS AWARE OF THEIR HIV STATUS

EIS dollars are allocated for services that supplement Part C funded HIV testing in the emergency department through the provision of a patient navigator and to fund HIV testing at an agency that also receives Part C funding to conduct testing. Due to the complexity of testing and funder requirements, an EIS workgroup was established in October 2011 to standardize practices for the Ryan White Parts in Maricopa County (Parts A and C).

In addition to ensuring that EIS providers supplement and not supplant existing testing activities, this work group is charged with ensuring provider success in meeting federal and local rules around testing and early intervention services, decreasing administrative burden on providers and establishing standard practices that can be utilized by multiple Ryan White parts. All EIS workgroup activities have been aligned to goals from the National HIV/AIDS strategy.

EFFORTS TO ADDRESS LEGAL BARRIERS TO ROUTINE TESTING,
INCLUDING LOCAL AND STATE LAWS AND REGULATIONS

Arizona has undergone a transition to routine testing for HIV. There are no regulations regarding who may test and no regulations on how to offer counseling. However, the testing of pregnant women continues to be opt-in, which requires additional steps on the part of the tester and tested. The local Part D staff has worked with 15 of 21 hospitals throughout the EMA to establish protocols for testing of high risk pregnant women and treatment of any found positives. Maricopa Integrated Health Systems also lead a multi-part campaign to educate the community when HIV testing transitioned from opt-in to opt-out.

THE CURRENT CONTINUUM OF CARE

HRSA defines a comprehensive continuum of care as including primary medical care, HIV related medications, mental health, substance abuse treatment, oral health, and case management services that assist PLWHA in accessing treatment of HIV infection that is consistent with Public Health Services Treatment Guidelines. The Phoenix EMA has worked diligently to develop a responsive continuum of care for those living with or at risk for HIV/AIDS.

FIGURE 17: Grant Year 2012 Phoenix EMA Part A Services
Funded services are shown in order of priority. Shaded services are HRSA-defined core services.

Service Category
Outpatient/ Ambulatory Medical Care
Medical Case Management (including treatment adherence services)
Oral Health Care
Mental Health Services
Health Insurance Premium and Cost Sharing Assistance
Substance Abuse Services Outpatient
Medical Nutrition Therapy
Medical Transportation Services
Case Management Services - Non-Medical
Food Bank/ Home Delivered Meals
Early Intervention Services
Outreach Services

SNAPSHOT: GRANT YEAR 2011 RYAN WHITE PART A PROGRAM

FIGURE 18: GY 2010 Unduplicated Clients by County

County	Clients
Maricopa	3438
Pinal	121
Other	6
Total	**3565**

FIGURE 19: GY 2010 Unduplicated Clients by Gender Reporting Group

Gender	Clients
Female	575
Male	2950
Transgender	40
Total	**3565**

FIGURE 20: GY 2010 Unduplicated Clients by Age Group

Age Group	Clients
02 to 12	23
13 to 24	160
25 to 44	1587
45 to 64	1690
65+	105
Total	**3565**

FIGURE 21: GY 2010 Unduplicated Clients by Age/Gender Group and HIV Status

Group	HIV Status	Clients
Children	AIDS	3
	HIV Positive	20
Youth	AIDS	13
	HIV Positive	146
	HIV-/Unknown	1
Female >25	AIDS	140
	HIV Positive	392
Male >25	AIDS	941
	HIV Positive	1863
	HIV-/Unknown	6
Transgender >25	AIDS	13
	HIV Positive	27
Total		**3565**

FIGURE 22: GY 2010 Unduplicated Clients by Race/Ethnicity

Race/Ethnicity	Clients
American Indian/Alaska Native	125
Asian	41
Black or African American	518
Hispanic	1016
More Than One	116
Other/Unknown	20
Pacific Islander	11
White (non-Hispanic)	1718
Total	**3565**

FIGURE 23: GY 2010 Unduplicated Clients by Diagnosis

HIV Status	Clients
AIDS	1110
HIV Positive	2448
HIV-/Unknown	7
Total	**3565**

FIGURE 24: GY 2010 Unduplicated Clients by Transmission Factor

Transmission Factor	Clients
Hemophilia	5
Heterosexual	816
Injection Drug Use (IDU)	198
Men Who Have Sex With Men (MSM)	2151
MSM and IDU	216
Not Specified	75
Perinatal	46
Transfusion	27
Other	31
Total	**3565**

FIGURE 25: GY 2010 Unduplicated by Income Category

Percentage of Federal Poverty Level (FPL)	Clients
0% to 100%	2008
101% to 200%	1136
201% to 300%	361
301% to 400%	52
401% and above	8
Grand Total	**3565**

FIGURE 26: GY 2010 Unduplicated Clients by Client Type

Client Type	Clients
Continuing (served in GY 2010)	2741
New (first served in GY 2011)	522
Returning (served prior to, but not in GY 2010)	302
Grand Total	**3565**

FIGURE 27: GY 2010 Service Category Utilization Ranked by Number of Clients Served

Service Category	Clients Served
Medical Case Management	2727
Non-Medical Case Management	2617
Oral Health Care	2240
Outpatient Ambulatory Medical Care	1039
Medical Transportation Services	978
Food Bank/Home Delivered Meals	769
Medical Nutrition Therapy	768
Legal Services	413
Psychosocial Support	327
Mental Health Services	266
Health Insurance Premiums/Cost Sharing Assistance	105
Substance Abuse Services	67
Outreach Services	63
Early Intervention Services	62

RESOURCE INVENTORY HIV SERVICES OFFERED IN THE EMA
Please see Appendix A and B for Ryan White and non-Ryan White funded HIV services within the EMA.

HOW RYAN WHITE FUNDED CARE/SERVICES INTERACT WITH NON-RYAN WHITE SERVICES TO ENSURE CONTINUITY OF CARE
The local Ryan White community benefits from multiple years of positive working relationships between the Ryan White Parts, state and county health departments, for-profit and non-profit HIV providers, providers of the largest HIV clinic in the EMA, and community health centers. Through those partnerships, collaborative efforts recently expanded to include the state refugee health services department, correctional health and refugee clinics. Relationships have been formed to facilitate transitioning clients between programs as eligibility and/or other guidelines change. Additional collaboration has occurred to develop common data collection and sharing processes. The Part A Program's Administrative Office utilizes mandatory Business Associate Agreements with all providers in the EMA and annual reviews provider Memorandums of Understanding, Letters of Agreement and other referral relationship mechanisms to ensure communication/partnership between subcontractors and outside entities.

HOW THE SERVICE SYSTEM/CONTINUUM OF CARE HAS BEEN AFFECTED BY STATE AND LOCAL BUDGET CUTS
Arizona is facing a 17.5% funding gap in its general FY2012 state funds, totaling $1.5 billion dollars (compared to the US average state funding shortfall of 16%). *(Center on Budget and Policy Priorities, July 15, 2011)* Examples of reduced state, local and municipal funding decreases are widespread and include: a 10% reduction in AHCCCS reimbursement rates for providers for all clients in 2011, a freeze on AHCCCS enrollment of all childless adults and KidsCare, termination of AHCCCS Medical Emergency Spend Down category, decreased coverage for Seriously Mentally Ill clients, and decreased state contributions to health programs such as immunization programs. With the EMA's low rate of private health insurance, especially among certain populations, the group of PLWHA lacking insurance coverage yet ineligible for AHCCCS is proportionally larger than in other states and EMAs. The 10 clinic public health clinic system in Maricopa County is stretched with adding the necessary staffing and expanding hours of operation in order to meet the health care access needs of the 25% uninsured in the EMA. Compounding this issue is that the HIV/AIDS infection rates are occurring within communities with no health insurance coverage and such persons are increasingly reliant on Ryan White funded services for HIV primary medical and specialty care, making Ryan White funding essential to supporting the fragile health care system.

As a result, Ryan White Programs have realized unprecedented increases in the number of clients enrolling in services. While the state's ADAP program has been transitioning as many clients as possible to the Pre-Existing Condition Insurance Plan, the number of clients transferred has not been able to keep up with new Part A enrollments. In response, the Phoenix EMA Part A Planning Council has systematically reallocated funding to ensure that core medical services continue to be funded to meet identified need. Additionally, the Part A Program has collaborated with other Ryan White Parts to develop social marketing campaigns stressing the importance of remaining enrolled in Medicaid and other programs. While initially targeting HIV clients only, these campaigns have been adopted by several local and state consortia, resulting in an estimated 100,000 fewer individuals being disenrolled from Medicaid due to the lack of timely eligibility renewals.

CAPACITY DEVELOPMENT NEEDS RESULTING FROM DISPARITIES IN THE AVAILABILITY OF HIV-RELATED SERVICES IN HISTORICALLY UNDERSERVED COMMUNITIES AND RURAL COMMUNITIES

Through intense capacity building for minority funded providers of case management the goal of the Planning Council is to provide MAI funding in conjunction with Part A services to ensure a plan to support the needs of the communities of color and actively engage them earlier to ensure they remain adherent to treatment, and have advocacy for their needs.

During FY 2008, Case Management was split into Medical and Non-Medical, providing clear delineation for providers of overall Case management. The delineation of medical versus nonmedical Case Management and addition of new service providers has exponentially increased the need for capacity building and technical assistance. The revamping of the Case Management service provider base to target minority communities has become one of the most significant steps to increased awareness and adherence to the Phoenix continuum of care. Medical Case Management services now include:

- An active relationship with Primary Medical Care providers for regular case conferencing as part of the Standards of Care;
- Implementing a standard treatment adherence plan for consumers with clearly defined goals and objectives; and
- Increasing internal capacity to meet not only the supportive case management needs of clients, but the medical components as well.

The increase in clients receiving Medical Case Management services is a direct result of the EMA increasing the provider base and geographic locations. Case Management is one of the most critical points of contact for clients within the Phoenix EMA.

Recent data gathered by the Council has suggested that consumers receive varying levels of HIV-specific education upon their entry into care, based on their entry point, provider perceptions of the client, client willingness to engage in education opportunities, etc. The Training, Education And Empowerment (TEAM) Committee has been working with community stakeholders to establish an EMA-wide standardized opt-out orientation/education program for New-to-Care individuals, to empower them to be engaged in their health care, remain compliant with their medications, and lower the risk of HIV transmission. All new-to-care clients in the EMA, regardless of provider/payer source, would be encouraged to participate.

The burden of data collection and reporting has made increasing the number of medical providers within the EMA extremely challenging – only one entity responded to a 2011 bid request, and this organization later withdrew from evaluation after learning of increased programmatic standards released by HRSA. A single oral health provider responded to a second bid request for dental services, and was subsequently awarded a short-term contract. The organization has received technical assistance from the Part A Program, and began offering dental care in April 2012.

CARE NEEDS IN THE EMA

2010 EMA-WIDE NEEDS ASSESSMENT OF PLWHA CLIENT-IDENTIFIED NEED, USE, GAP, BARRIER RANKINGS (N=496)

Triennial Needs Assessments are conducted to determine the priority service needs, uses, barriers, and gaps in the continuum of care for People Living with HIV/AIDS (PLWHA). Results of this client centered activity are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity building, and help providers improve the accessibility, acceptability, and quality of services delivered, especially to the designated 'Severe Need Groups (SNGs)'.

FIGURE 28: 2010 Top Need, Use, Gap, Barrier Rankings – All Respondents

Rank	Need	Use	Gap	Barrier
1	Medication	Outpatient Ambulatory Medical Care	Housing Assistance	Emergency Financial Assistance
2	AOMC	Medication	Medication	Complementary/ Holistic Therapy
3	Medical Nutritional Therapy	Medical Nutritional Therapy	Oral Health Care/Dental	Medication
4	Housing Assistance	Medical Case Management	Medical Transportation	Health Insurance
5	Medical Transportation	Medical Transportation (tie) Health Insurance (tie)	Emergency Financial Assistance	Oral Health Care/Dental
6	Not Ranked	Not Ranked	Not Ranked	Housing Assistance

The 2010 Respondents ranked as both a Service Gap and Service Barrier the following key services:

- Housing Assistance
- Medication
- Oral Health Care
- Emergency Financial Assistance

These Gap/Barrier service rankings in the above service categories deserve special attention in the priority setting and resource allocation planning and decision making processes for the EMA.

SUMMARY OF NEED, USE, GAP, & BARRIER RANKINGS BY SNG

The Severe Need Groups also identify the same top ranking Service Needs as do the larger group of 2010 Respondents, although their rankings differ somewhat from one severe need group to another. Consistently, the #1 top ranking Service Need reported by the SNGs is Medication, with 4 of 7 SNGs ranking this service as their highest priority Service Need. The next highest ranking Service Needs include AOMC, Medical Nutrition Therapy, Housing among the Severe Need Groups of MSM, Hispanics, I/RR, Newly Diagnosed and American Indians.

FIGURE 29: 2010 Summary of Top Need Rankings by Severe Need Group

All	Need Rank	MSM	Hispanics	African Americans/ Blacks	Incarcerated/ Recently Released	Newly Diagnosed	American Indian	Youth
Medication	1	Medication	Medication	Medical Nutritional Therapy	Housing Assistance	Outpatient Ambulatory Medical Care	Medication	Medication
Outpatient Ambulatory Medical Care	2	Medical Nutritional Therapy	Outpatient Ambulatory Medical Care	Medication	Medication	Medication	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care
Medical Nutritional Therapy	3	AOMC	Medical Nutritional Therapy	Housing Assistance	Medical Nutritional Therapy	Medical Nutritional Therapy	Housing	Confidentiality
Housing Assistance	4	Housing Assistance	Housing Assistance	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Housing Assistance	Emergency Financial Assistance	Medical Nutritional Therapy
Medical Transportation	5	Mental Health	Mental Health	Medical Transportation	Mental Health	Mental Health	Mental Health	Medical Transportation

As evidenced by the "Use' Rankings table below, **ALL** of the Severe Need Groups unanimously ranked Ambulatory Outpatient Medical Care as their top ranking service Use.

FIGURE 30: 2010 Summary of Top Use Rankings by Severe Need Group

All	Need Rank	MSM	Hispanics	African Americans/ Blacks	Incarcerated/ Recently Released	Newly Diagnosed	American Indian	Youth
Outpatient Ambulatory Medical Care	**1**	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care	Outpatient Ambulatory Medical Care
Medication	**2**	Medical Nutritional Therapy	Medical Nutritional Therapy	Medication	Mental Health	Medication	Health Insurance	Medication
Medical Nutrition Therapy	**3**	Health Insurance	Medication	Medical Nutritional Therapy	Medical Nutritional Therapy	Medical Transportation	Medical Nutritional Therapy	Psychosocial Support Services
Medical Case Management	**4**	Medication	Mental Health	Medical Case Management	Medication	Health Insurance	Medical Case Manageme nt	Health Insurance Premium/Cost Sharing Assistance
Medical Transportation (tie) Health Insurance	**5**	Mental Health	Health Insurance	Medical Transportation	Housing Assistance	Medical Nutritional Therapy	Medication	Mental Health

There is considerable variation in the number of Service Gaps reported by SNG, although there is substantial similarity in the categories of services reported as "unavailable'. The most frequently reported Service Gaps include Housing Assistance, Medications, Oral Health Care, EFA and Medical Transportation. Although the numbers of Recently Released Respondents who participated in the needs assessment survey is relatively small, they report the greatest number of services perceived as unavailable, evidencing multiple Service Gaps, including Housing Assistance, Emergency Financial Assistance, Oral Health, Medical Transportation, Medical Nutrition Therapy, Mental Health Services, and Vision Care.

FIGURE 31: 2010 Summary of Top Gap Rankings by Severe Need Group

All	Need Rank	MSM	Hispanics	African Americans/ Blacks	Incarcerated/ Recently Released	Newly Diagnosed	American Indian	Youth
Housing Assistance	**1**	Housing Assistance	Health Insurance	Housing Assistance (4)	Housing Assistance	Support Groups	Medical Transportation (3)	Not Ranked
Medication	**2**	Oral Health Care/Dental	Compli-mentary/ Holistic Therapy	Medication	Emergency Financial Assistance (2) tied with Oral Health, Medical Transportation, Medications, Medical Nutritional Therapy, Mental Health, Vision Care	Medication	Employment (2) tied with Family Services (2)	Not Ranked
Oral Health Care/Dental	**3**	Complimentary/ Holistic Therapy	Mental Health	Medical Nutritional Therapy	Not Ranked	Medical Trans-portation	Mental Health (1) tied with Oral Health Care/ Dental (1), Health Insurance (1), Medical Nutritional Therapy (1), Case Management (1), Vision Care (1), Housing Assistance (1), Chiropractor	Not Ranked
Medical Trans-portation	**4**	Medication	Oral Health Care/ Dental	Medical Trans-portation	Not Ranked	Medical Nutritional Therapy	Not Ranked	Not Ranked
Emergency Financial Assistance	**5**	Mental Health	Medicine	Emergency Financial Assistance	Not Ranked	Not Ranked	Not Ranked	Not Ranked
Not Ranked	**6**	Medical Case Management	Emergency Financial Assistance	Not Ranked	Not Ranked	Not Ranked	Not Ranked	Not Ranked

SERVICE GAP REASONS

The reasons the 2010 PLWHA Respondents offer to explain why they perceive certain services are "unavailable" to them are multiple and varied and include:

- Lack of income or affordability;
- Funding budget cuts;

- Don't know where to go or who to ask;
- Service(s) not available in area;
- Do not qualify;
- Lack of insurance;
- Wait lists; and work schedules.

The top ranking Service Barriers reported by the 2010 Respondents include: Emergency Financial Assistance, Complementary/Holistic Therapy, Medications, Health Insurance Premium Assistance, Oral Health Care, and Housing Assistance. By SNG, the populations reporting the greatest number of Service Barriers include MSM, Hispanics, African Americans, and the Recently Released. Those SNGs reporting the fewest number of Service Barriers include Youth (who report none), followed by the Newly Diagnosed.

FIGURE 32: 2010 Summary of Top Barrier Rankings by Severe Need Group

All	Need Rank	MSM	Hispanics	African Americans/ Blacks	Incarcerated/ Recently Released	Newly Diagnosed	American Indian	Youth
Emergency Financial Assistance	**1**	Complimentary/ Holistic Therapy	Health Insurance	Emergency Financial Assistance	Housing Assistance (2)	Emergency Financial Assistance	Vision Care (1), tied with Health Insurance, Medical Transportation, Medical Nutritional Therapy, Chiropractor (1)	Not Ranked
Compli-mentary/ Holistic Therapy	**2**	Emergency Financial Assistance	Compli-mentary/ Holistic Therapy	Medication	Disability (1) tied with Medication, Vision Care, Emergency Financial Assistance, Employment, Education	Health insurance	Not Ranked	Not Ranked
Medication	**3**	Housing Assistance	Housing Assistance	Housing Assistance	Not Ranked	Not Ranked	Not Ranked	Not Ranked
Health Insurance	**4**	Medication	Oral Health Care/Dental	Mental Health	Not Ranked	Not Ranked	Not Ranked	Not Ranked
Oral Health Care/Dental	**5**	Health Insurance	Not Ranked	Oral Health Care/Dental	Not Ranked	Not Ranked	Not Ranked	Not Ranked
Housing Assistance	**6**	Vision Care	Not Ranked	Work/ Employment	Not Ranked	Not Ranked	Not Ranked	Not Ranked

SERVICE BARRIER REASONS

The reasons the 2010 PLWHA Respondents offer to explain why they perceive certain services as "hard to get" are multiple and varied and include:

- "Red tape"
- Illegal status
- Budget cuts
- Lack of income/inability to afford
- Lack of information regarding location of services and how to access them
- No Case Manager
- Can't qualify
- Lack of insurance
- Transportation too hard/far away
- Too few providers/services
- Wait list

SUMMARY HIGHLIGHTS OF 2010 SURVEY FINDINGS

Health Insurance Coverage: The majority of Youth report Medicaid coverage (73%); while 50% of the Recently Released relies on Medicaid for their health insurance coverage. The remaining SNGs report Medicaid/ ACCCHS coverage in the range of 26% (Hispanics) to 37% African Americans. Over 36% of the American Indian Respondents report Indian Health Service benefits. Youth Respondents report the highest frequency of private health insurance (18%), with the remaining SNG Respondents reporting private health insurance in the range of 4 to 7%.

Receipt of Antiretroviral Therapy: By SNG, the Respondent groups evidence slight variation in the proportion reporting active receipt of ART: 100% of the Youth Respondents report receiving ART; 91% American Indians; 84% MSM and African Americans; 78% Hispanics; 65% Recently Released; and 55% of the Newly Diagnosed report the receipt of antiretroviral therapy.

Mental Health and Substance Abuse: There is substantial variation by SNG in the proportionate reports of having been diagnosed with and/or treated for one or more mental health and substance abuse issues, as evidenced in the table below.

FIGURE 33: 2010 Reports of Mental Health/Substance Abuse Issues Among Special Needs Groups

	American Indian	African American/Black	Hispanic	MSM	Newly Diagnosed	Incarcerated/ Recently Released	Youth
Mental Health	42%	45%	51%	60%	43%	68%	19%
Substance Abuse	24%	18%	15%	22%	18%	41%	0%

Diagnosis and Treatment of Sexually Transmitted Diseases: Almost 44% of the 'In Care' PLWHA respondents report having been diagnosed and/or treated for an STD, with the most frequently reported STDs reported as Syphilis (20%); Gonorrhea (17%); and Chlamydia (11%). By Severe Need Group, both the Recently Released and MSM Respondent groups report high levels of STDs (at 58% and 53%, respectively). The Newly Diagnosed report 44% any STD, and 20% report a previous diagnosis of Syphilis. The SNG of American Indians report a 47% history of any STD; followed by 40% African Americans; 36% Hispanics; with only 9% of Youth reporting the diagnosis/treatment of an STD.

Current and Previous Homelessness: A substantial minority (over 32%) of the 2010 Respondents report a period of homelessness, with over 4% reporting current homelessness and an additional 28% reporting a period of previous homelessness, either during the past two years or over two years ago. This degree of housing instability represents a serious care coordination issue for the EMA and presents multiple challenges for providers who are striving to help PLWHA to access, engage with, and remain in HIV primary medical care and services.

Among the Severe Need Groups, each has experienced substantial homelessness, as evidenced in their survey responses. Of all the SNGs, I/RR report the highest current and previous homelessness (at 18.5% currently homeless and 53% ever homeless). African Americans report 34% ever homeless and 4% current homelessness. Hispanics report 31% ever homeless and over 7% identified they are currently homeless. MSM report 29% ever homeless and 4% are currently homeless. The Newly Diagnosed report 28% as ever homeless and 6% as currently homeless.

American Indian Respondents report 24% previous homelessness, and Youth report 18% previous homelessness, with no current homelessness.

Level of Annual Income: Almost 53% of all 2010 Respondents report exceptionally low incomes in the zero to $9,999 range. Fully 84% of the 2010 Respondents reports living at or below 200% FPL. By SNG, the most impoverished groups who report the greatest proportion of members living at or below $9,999 annual income include, in rank order: Recently Released (77%); Newly Diagnosed (67%); Hispanics (66%); American Indians (52%); and MSM and African Americans (47% respectively). None of the Youth respondents reports any income. This degree of impoverishment contributes to the escalating need for assistance with meeting basic needs for food, housing and emergency financial assistance. This level of overall poverty among the reporting PLWHA acts as a barrier to other practical assistance, such as transportation to doctor's appointments and affording co=pays for medical and dental care visits.

PHOENIX EMA-WIDE "IN-CARE PLWHA NEEDS ASSESSMENT OUTCOME: PRIORITY GOALS

- Develop strategies to increase the youth-friendly service environments within provider agencies, in order to attract and engage the increasing number of Youth, ages 13-19 years who are testing positive.
- Ensure strong linking mechanisms and co-locate to the extent possible increased levels of on-site Mental Health and Substance Abuse treatment services to address the high degree of these co-morbid conditions within the PLWHA population.
- Strengthen 'prevention with positives' programs and activities to reduce the high STD co-morbidities and reduce further HIV transmission.

- Ensure 'point of entry' agency and staff awareness of all available Ryan White and other resources to ensure timely referrals and linkages with care and services for newly diagnosed and relatively high proportions of the out of care PLWHA.
- Ensure Medical and non-Medical Case Management provider awareness and use of all Ryan White and other local funding sources available for meeting the comprehensive service needs expressed by PLWHA.
- Strengthen client linkages to care by assessing and addressing needs upon entry to care; targeting those deemed at high risk for erratic care use and/or disengagement from care; and strongly engaging them in care during the first year of primary medical care participation.
- Explore means of increasing Health Insurance Premium Assistance for those PLWHA who do not qualify for Medicaid or Medicare benefits.

  Expand/seek additional funding to support the unmet oral health care, housing assistance, medical nutrition, emergency financial assistance, and transportation needs reported by the surveyed PLWHA special populations.

2011 PHOENIX EMA MENTAL HEALTH AND SUBSTANCE ABUSE ASSESSMENT

During the November 2010 to February 2011 time period, the Phoenix EMA Ryan White Planning Council contracted with Collaborative Research, LLC, to conduct a survey assessment to determine if PLWHA were accessing mental health and substance abuse services from a different pay source than state provided Medicaid, also known as the Arizona Health Care Cost-Containment System (AHCCCS).

This survey was conducted in response to significant cuts to state behavioral health funding as well as legislative changes to AHCCCS eligibility resulting in the estimated elimination of health coverage for 250,000 to 310,000 Arizonans. Of the 56 respondents who participated, more than half (51.8%) indicated they were receiving services through AHCCCS, followed by 28.6% receiving services through Ryan White Part A. Findings from this assessment suggested a significant impact to the Ryan White Part A Care Continuum across all service categories based on AHCCCS cutbacks.

2011 PHOENIX EMA-WIDE PLWHA "OUT OF CARE" NEEDS ASSESSMENT

In the Spring/Summer of 2011, the Phoenix EMA Ryan White Planning Council contracted with Collaborative Research, LLC, to conduct a survey assessment of People Living with HIV/AIDS currently out of care with unmet need in the Phoenix EMA. Most persons living with HIV/AIDS in the EMA are centralized in the urban Greater Phoenix Metropolitan area: 95% of the EMA's total PLWHA resides in Maricopa County and 5% resides in Pinal County. A total of 55 respondents participated in the survey.

The results of the 2011 Out of Care Needs Assessment Survey reveal an overall highly impoverished PLWHA consumer group, who present to care with multiple co-morbidities, including high levels of mental health and substance abuse treatment needs, and substantial histories of STDs as well as numerous other chronic illnesses. Out of care groups tend to be MSM, IDU or MSM/IDU. The majority of the Phoenix out of care population includes Hispanic and White Males, whose risks include MSM and/or IDU, and are of ages 20-44 and 45-plus years. African Americans/Blacks are disproportionately impacted in terms of the out of care population. Aggressive efforts are underway to continue to improve data reporting by primary medical providers in order to ensure complete accuracy of the Ryan White Part A unduplicated client figure.

For those PLWHA who have **not** been engaged with primary HIV medical care for periods of time greater than one year, the services they identify as helpful to motivating their re-entry into care include in rank order:

1. More outreach services;
2. Acute illness;
3. Better trained doctors and nurses;
4. More government services; and
5. Free medical care.

According to the Needs Assessment report, many of these service expansions/changes are amenable to change and should be considered as high priorities for implementation, especially those recommendations pertaining to the expansion of outreach services, increased information about the services available and how to access them, and improved provision of referrals and advice.

PHOENIX EMA-WIDE "OUT-OF-CARE" PLWHA NEEDS ASSESSMENT OUTCOME: PRIORITY GOALS
Recommended priority strategies to optimize utilization and retention in care include:

- Improved links and system navigation between prevention and care for newly diagnosed PLWHA;
- Improved linkages between supportive and primary care services for PLWHA receiving partial services but not primary medical care;
- Improved provider-patient partnerships and collaborations with peers for PLWHA who have dropped out of care;
- Peer facilitated linkages between points-of-entry/testing/counseling and primary care for PLWHA never in care

The above listed Needs/Gaps/Barrier service rankings deserve special attention in the priority setting and resource allocation planning and decision making processes for the Phoenix EMA. The fact that Outpatient Ambulatory Medical Care is a top ranking Need, Gap and Barrier for PLWHA with unmet need is especially concerning and deserves particular attention so that the barriers to medical care may be reduced.

PREVENTION PRIORITIES IN THE EMA
The Phoenix EMA Planning Council has an excellent collaborative relationship with the Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease**,** the entity that oversees HIV prevention efforts within the state.

Effective prevention policy focuses upon groups most adversely impacted by HIV/ AIDS, or known to be at greater risk of transmitting HIV infection. ADHS has targeted the following special populations for HIV prevention activities:

1. HIV+ individuals statewide
2. MSM (men who have sex with men) in Phoenix and Tucson metro areas, Coconino and Mohave counties
3. IDU (injection drug users) in Phoenix and Tucson metro areas and Yavapai County
4. Black, non-Hispanic women in Phoenix and Tucson metro areas

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

PART 2: WHERE DO WE NEED TO GO?

THE IDEAL CONTINUUM OF CARE

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

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

The ideal continuum of care in the Phoenix EMA is focused on primary medical care coordinated with services which are recognized to facilitate positive medical outcomes: Integrated medical case management, oral health care, mental health services, and substance abuse treatment. A comprehensive range of supportive services, tightly related to promoting access to and engagement in primary medical care, completes the continuum and helps to improve retention in care. Emphasis is placed on ensuring that all services are sensitive to cultural issues and linguistically appropriate. Additionally, the continuum of care should continually evolve to address both the traditional and emerging needs of the community.

In an environment of resource constraints, the ideal continuum of care will also incorporate a strong element of inter-agency and cross-funding coordination, where Ryan White and non-Ryan White funded services are well integrated and coordinated with prevention and surveillance, as appropriate. A key component of this Plan is Medical Case Management. This core service will serve as a vital connection to primary medical care. Focusing on Medical Case Management in the Phoenix EMA will create a seamless continuum. An open dialogue between Medical and Support Case Managers and Primary Medical Care providers will actively promote engagement for each client with ongoing assessments and issue resolution. The goal of establishing relationships with Outreach/Case finding/Follow-up and Case Management will provide a reinforcing mechanism to successfully link clients who fail to show for several appointments to a trained Outreach staff to proactively re-engage with a client and promote reentry into Primary Medical Care.

SHARED VISION FOR SYSTEM CHANGE

As the Phoenix EMA and the Planning Council looks ahead to the next three years of the Part A program in Maricopa and Pinal Counties, The Council's guiding principles will be used to support the following core values defined as those that are most important to the organization:

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

- Geographic equity in access to services;
- All providers treat clients with a compassionate and professional approach to care;
- The system of care includes not only Ryan White providers, but is open and inviting to all service providers within our community; and
- PLWHA priorities and community input drive our planning processes.

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

Questions that shape the shared vision for system change:

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

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

2012 PHOENIX EMA COMPREHENSIVE PLAN GOALS

Goal 1:	Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 2:	Identify individuals who are unaware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 3:	Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.
Goal 4:	Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).
Goal 5:	Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.
Goal 6:	Develop and implement strategies to strengthen retention in care.

GOALS REGARDING INDIVIDUALS AWARE OF THEIR HIV STATUS

Goal 1:	Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 3:	Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.
Goal 5:	Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.
Goal 6:	Develop and implement strategies to strengthen retention in care.

GOALS REGARDING INDIVIDUALS UNAWARE OF THEIR HIV STATUS

Goal 2:	Identify individuals who are unaware of their HIV status and not in primary medical care, and facilitate their entry into care.
Goal 3:	Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.

Goal 5:	Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.
Goal 6:	Develop and implement strategies to strengthen retention in care.

CLOSING GAPS IN CARE, ENSURING OPTIMAL ACCESS TO CARE

Planning Council/Part A Program Responsibility	Activities to Close Gaps in Care/ Address Overlaps in Care	Coordination Activities	Collaborative Partners
Community Health Planning & Strategies Committee	Gather and evaluate needs assessment data Develop directives to eliminate service gaps/guide service delivery	Work with community stakeholders/service providers to obtain diverse feedback from consumers about service needs, barrier, use, gaps	Part A service providers Other Ryan White Programs Community partners (non-RW providers, testing sites, etc.)
Training, Education And Membership Committee	Educate consumers about the availability of services Educate consumers about changes to service delivery Solicit feedback from consumers about service needs/challenges	Collaborate with community stakeholders and providers to inform consumers of educational opportunities	Part A service providers Other Ryan White Programs Community partners (non-RW providers, testing sites, etc.) Peer networks/support groups Pharmaceutical representatives (for presenters)
Planning Council Members	Maintain memberships on Prevention Planning Group of Arizona, other community coalitions to ensure knowledge of emerging service gaps and trends Establish Committees and Work Groups to focus research of issues and development of strategies Assess the geographical need for services in the community	Participate on a diverse range of community advisory boards, community coalitions, provider networks to remain knowledgeable of community needs Identify partnerships to improve the number of providers/geographic diversity of providers	Other Ryan White Programs Community Coalitions Hospital Associations Private Providers Provider Networks Prevention Planning Group of Arizona Board of Health
Standards Committee	Evaluate quality data to establish/revise service category outcomes and performance measures	Collaborate with other Ryan White Parts to ensure continuity of standards of care among programs	Other Ryan White Programs National Quality Center

Part A Program	Identify service utilization patterns and expenditures Identify emerging issues in the community Maintain memberships on Prevention Planning Group of Arizona, other community coalitions to ensure knowledge of emerging service gaps and trends Follow directives approved by the Planning Council Monitor quality of the quality of Part A Services Provide Training and Capacity Establish common data systems and/or data sharing among entities	Maintain comprehensive evaluation of the Part A program Collaborate with community stakeholders to streamline service delivery, improve care coordination, and identify and eliminate duplication of services (if any)	Part A Providers Other Ryan White Programs Community Coalitions Hospital Associations Private Providers Provider Networks Prevention Planning Group of Arizona Board of Health

ADDRESSING GAPS IN CARE

Part A funding in the EMA is specifically designed to address service delivery gaps that result from varying entitlements and service descriptions in the Medicaid program. Regular Planning Council meetings include individuals representing State Medicaid, Arizona Department of Health, and Housing Opportunities for People with AIDS (HOPWA) along with other HIV servicing agencies. Discussions at these cross-title meetings center on coordination of services and funding streams. Representatives from the stakeholders ensure that Ryan White funds are indeed the payer of last resort. Information regarding funding sources is provided during the annual Planning Council's Needs Assessment process. Needs Assessment data is utilized for selection of services and allocation of funds during the annual Priority Setting and Resource Allocations process as decisions are made regarding the service categories that the EMA will fund based on community need and other available sources of funding. Specific amounts of Part A funding were determined based upon projections of need for increasing access to care and services by a growing Part A PLWHA population, as well as to meet the needs of those to be returned to care from among the targeted unmet need populations in the EMA. The overall goal of this service coordination process is to ensure that service needs are met and available funds are not duplicated.

COORDINATING EFFORTS AND ACTIVITIES WITH OTHER PROGRAMS IN THE EMA TO ENSURE OPTIMAL ACCESS TO CARE

The Planning Council has substantially strengthened its planning and evaluation efforts through the implementation of intensive gathering of needs assessment data (for all underserved, special and emerging populations, as well as unmet need study data) and the acquisition and analysis of timely, accurate and comprehensive program evaluation data. In response, the Administrative Agent has gathered and documented resources available throughout the EMA for all service categories and provides that information to the Planning Council in an annual report that enables the Council to better

coordinate their efforts with the amount of Part A resources received. Examples of the coordination include:

Centers for Disease Control and Prevention (CDC): HIV counseling and testing is fully coordinated at the local level by Maricopa County Department of Public Health (MCDPH) and the Maricopa Integrated Health System (MIHS). Funding is provided through the Arizona Department of Health Services (ADHS). CDC also directly funds MCDPH to provide HCV prevention and treatment education for the incarcerated. The Planning Council has been coordinating with MCDPH and ADHS to pilot opt-out testing and care coordination activities in the Maricopa Correction System and the Maricopa Medical Center emergency room. These activities have proven successful and planned for continuation.

Arizona Health Care Cost Containment System (AHCCCS - Arizona Medicaid): Of all payer sources and programs outside the Ryan White funded system, AHCCCS is the most significant. CARE Act funds are utilized to fill in significant gaps in the system. AHCCCS provides services through six contracted managed care plans. AHCCCS-covered services include primary medical care services, emergency dental care (extractions only), pharmaceuticals, limited home health services, in-patient services, and medically-related transportation. In February 2011, Health and Human Services Secretary Kathleen Sebelius granted Arizona's request for a Medicaid waiver by saying that no such waiver was ever needed. As a result, the State of Arizona has frozen eligibility for childless adults (which includes the majority of the EMA's HIV population) and established policies that do not allow clients to reenroll if they have failed to meet their eligibility renewal dates. About 30 HIV clients per month have lost their AHCCCS eligibility and moved to the Part A program. This number would be higher had the Planning Council not developed Don't Get Dropped, a marketing campaign designed to inform HIV consumers about AHCCCS eligibility changes and the importance of renewing on time. This successful initiative was adopted by statewide by several health care coalitions. It is estimated that over 100,000 fewer AHCCCS clients were disenrolled because of this campaign. The Planning Council receives monthly AHCCCS transition information and is partnering with all Ryan White entities to coordinate care for these clients.

State Child Health Insurance Program (SCHIP): Arizona's SCHIP program, KidsCare, is administered by AHCCCS. Enrollment in the KidsCare Program has been frozen since January 1, 2010 due to lack of funding for the program. Additionally, clients who have missed their eligibility renewal are not allowed back on the program. The Planning Council coordinates efforts with Ryan White Part D to monitor the transition of clients into Ryan White care as part of the over AHCCCS transition monitoring described above.

Veterans Affairs (VA): The VA Medical Center in Phoenix serves approximately 300 PLWHA through its outpatient primary care clinic, and provides limited dental services and some behavioral health services. Recent legislation permits veterans to select the VA or Ryan White for their health care. Initial data gathered as part of the Council's recent Pathways to Care study has demonstrated that many clients diagnosed in local VA health settings are not engaging in primary medical care. The Council and the Part A program are collaborating with the VA and other healthcare entities to develop partnerships with Part A Early Intervention Services providers.

Housing Opportunities for Persons with AIDS: The City of Phoenix Housing Department is the HOPWA Grantee for the EMA. HOPWA supports 10 different permanent and transitional housing programs through six different project sponsors. Over 1,050 PLWHA receive assistance. A HOPWA-funded housing coordinator collaborates with Ryan White case managers regarding housing issues. Care Directions, the largest Ryan White Part A funded case management provider, manages the EMA's HOPWA program and

provides regular reports to the Council. For many years, the Council has not had to fund Housing Services, but continues to partner with HOPWA to monitor utilization and need. The Council was recently involved in the development of the local HOPWA comprehensive plan.

Services for Women and Children: The Supplemental Food Program for Women, Infants and Children (WIC) is administered by MCDPH and provides WIC vouchers and nutritional services at 15 locations in Maricopa County, and 12 locations in Pinal County. According to the WICY report, the EMA met all of the target expenditures relative to the 2010 guidance for the expenditure of Ryan White Part A funding to serve women, infants, children and youth. The Council and all Ryan White Programs collaborate with the WIC program to promote the availability of services.

Medicare: An increasing number of PLWHA in the EMA are Medicare eligible, and many are choosing managed care programs through Medicare Advantage plans. An issue for PLWHA Medicare enrollees is coordination of pharmaceutical benefits. The average Medicare recipient receiving therapies consistent with Antiretroviral Therapy (ART) currently average approximately $12,000 in annual medication costs. A significant number (45%) of Part A pharmaceutical and ADAP clients are Medicare enrollees. The ADAP program is assisting clients with pharmaceutical expenses, and provides regular reporting to the Council regarding utilization and enrollment. The Part A Program and ADAP are strongly connected, and work collaboratively to address emerging issues related to access to pharmaceuticals.

Indian Health Service (IHS): Phoenix Indian Medical Center (PIMC) is also a provider of HIV services, serving over 122 active clients annually. Coordination of services across IHS and Ryan White has been documented to be consistent with HRSA/HAB Policy Notice 00-01. PIMC has successfully integrated HIV-related care and services within the facility and now includes specialized HIV Medical Case Management and Outreach Services, funded via Part A.

Substance Abuse/Mental Health Treatment Providers: Mental health and substance abuse providers in the EMA have been able to provide services funded by a variety of third-party entities, such that the Planning Council has only had to allocate a combined 5% of its entire grant award to these services. Despite relatively small utilization, these services remain highly prioritized in the Part A continuum of care. The Part A program monitors emerging need in this service category closely and is prepared to respond quickly.

Private Providers/Community Health Centers: Part A funded providers have strong relationships with private HIV medical providers and community health centers to facilitate referrals to Part A and other community services, assist with the enrollment of clients is various programs, and offer Early Intervention Services to New-to-Care clients. The Planning Council's 2012 Pathways to Care study has identified five medical providers to pilot EIS collaboration projects with. Additionally, the Training, Education And Membership Committee is collaborating with Part A medical providers and five non-Ryan White funded providers (three of which are the largest HIV providers in metropolitan Phoenix) to develop and pilot a standardized care orientation program for New-to-Care clients.

Partner Notification Services: Partner Notification Services are funded by the Arizona Department of Health Services and provided by Maricopa County Department of Public Health STD Testing. All New-to-Care individuals in the EMA are referred to Partner Services. The Part A program has established data sharing agreements with Partner Notification Services, to ensure Newly Diagnosed/New-To-Care Part A clients receive these services.

Prevention For Positives Initiatives: Several Part A funded service providers offer Prevention for Positives programming, funded by other sources. All New-to-Care Part A clients are referred to the programs upon confirmatory HIV testing. The Council's TEAM committee is collaborating with these providers in the development and piloting of a community-wide standardized care orientation program for New-to-Care individuals.

STD Programs: Maricopa County Department of Public Health and Pinal County Department of Public Health offer HIV/STD testing services. Several Part A providers offer STD testing as a component of their third-party funded HIV testing services. These entities are strongly linked to the Ryan White funded continuum of care.

CONCLUSION

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

PART 3: HOW WILL WE GET THERE?

FIGURE 34: COMPREHENSIVE PLAN GOALS AND OBJECTIVES
As approved by the Phoenix EMA Ryan White Part A Planning Council on March 8, 2012.

Goal 1: **Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.**

Objective 1: ***Develop and Implement dynamic activities for Early Intervention Services and Outreach services.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
1.1.1	Evaluate other EMA's EIS/Outreach activities to engage out-of-care individuals to return to care.	x			Community Health Planning & Strategies (CHPS), Standards Committees
1.1.2	Pilot best practices.		x		CHPS, Standards Committees
1.1.3	Evaluate pilot program, determine whether to permanently implement activities.			x	CHPS, Standards Committees

Objective 2: ***Based on 2012 Pathways to Care analysis (see 3.1.1), develop and implement strategies to ensure newly diagnosed individuals are appropriately connected to care from testing venues.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
1.2.1	Implementation/evaluation of Year 1 activities.	x			Pathways to Care Work Group
1.2.2	Implementation/evaluation of Year 2 activities.		x		Pathways to Care Work Group
1.2.3	Implementation/evaluation of Year 3 activities.			x	Pathways to Care Work Group

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

Objective 1: ***Collaborate with Arizona Department of Health Services (ADHS), Maricopa Integrated Health System (MIHS), and/or other hospital/clinic/urgent care entities to expand HIV testing/care coordination activities with one new partner each year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.1.1	Continue collaborative Opt-Out Jail testing pilot and Opt-Out Emergency Room testing pilot.	x			Community Health Planning & Strategies (CHPS) Committee, Part A Program
2.1.2	Implementation/evaluation of Year 2 activities.		x		CHPS Committee, Part A Program
2.1.3	Implementation/evaluation of Year 3 activities.			x	CHPS Committee, Part A Program

Objective 2: ***Participate in regional symposium to present current ED/jail testing initiatives to encourage implementation in state/regional locales.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.2.1	Create presentation and training module for regional symposium.	x			Part A Program
2.2.2	Present at regional symposium, adapt presentation for possible Ryan White Grantee Conference session.	x			Part A Program
2.2.3	Assist other entities with the implementation of a jail testing program, as requested.		x	x	Part A Program

Objective 3: ***Expand non-traditional testing activities, in collaboration with the Arizona Department of Health Services' HIV Prevention Program.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.3.1	Evaluate/continue County Jail testing program and identify additional partners.	x			Community Health Planning & Strategies (CHPS) Committee, Part A Program
2.3.2	Evaluate/report on Jail testing activities and implement testing activities with at least one new partner.		x		CHPS Committee, Part A Program
2.3.3	Evaluate/report on Year 2 activities and implement testing activities with at least one additional partner.			x	CHPS Committee, Part A Program

Objective 4: ***Collaborate with ADHS, MIHS, and other community partners to implement HIV awareness/testing/entry to care activities targeting individuals aged 45 and older, youth, Hispanics and African Americans.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
2.4.1	Collaborate with Ryan White Parts C and D to engage African American faith-based organizations to initiate awareness and testing activities.	x			Communities of Color Work Group, Part A Program
2.4.2	Determine special populations to focus additional activities on for GY 2013 and GY 2014, and develop evaluation tools.	x			Communities of Color Work Group, Part A Program
2.4.3	Implement and evaluate at least one activity to engage special populations to access HIV testing/enter in care.		x		Communities of Color Work Group, Part A Program
2.4.4	Implement and evaluate at least one activity to engage special populations to access HIV testing/enter in care.			x	Communities of Color Work Group, Part A Program

Goal 3: Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.

Objective 1: ***Align the Planning Council committee structure to better align tasks/responsibilities with Council and community goals/activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.1.1	Analyze and revise the existing Planning Council committee structure to better align committee activities with comprehensive plan goals and future community collaboration needs.	x	x		Executive Committee

Objective 2: ***Complete at least one needs assessment/service delivery assessment each grant year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.2.1	Pathways to Care analysis: How do Ryan White and non-Ryan White testing sites engage clients into medical care, what follow up occurs, etc.	x			Community Health Planning & Strategies (CHPS) Committee
3.2.2	Resource inventory: All HIV testing sites and providers, both Ryan White and non-Ryan White.	x			Planning Council Support
3.2.3	Transition assessment: Disenrolled Medicaid clients to Part A services, Part A/ADAP clients to ADAP Assist (PCIP).		x		CHPS Committee, Part A Program
3.2.4	Develop a strategic plan to transition clients to Health Exchanges/Affordable Care programs.			x	Transition Planning Work Group, Part A Program

Objective 3: ***Analyze the delivery of Part A Oral Health Services and implement revisions to this service (if any).***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.3.1	Implement combined Dental Insurance/Direct Dental Services and evaluate success of dual gateways to oral health services.	x			Oral Health Work Group, Part A Program
3.3.2	Evaluate and implement service delivery changes (if any).		x	x	Oral Health Work Group, Part A Program

Objective 4: ***Initiate expanded cultural competency activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.4.1	Cultural competency training for Part A Program staff/Planning Council members.	x			Part A Program, Planning Council Support
3.4.2	Provision of cultural competency training for Part A providers, and the establishment of approved training activities for new staff/ongoing training for existing staff.	x			Part A Program
3.4.3	Ongoing cultural competency training for all entities, as needed.		x	x	Part A Program

Objective 5: ***Address the needs of Refugee populations.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
3.5.1	Implement Refugee peer navigator program approved by the Planning Council.	x			Part A Program
3.5.2	Assessment and evaluation of needs, potential additional activities.		x		Community Health Planning & Strategies (CHPS) Committee, Part A Program staff
3.5.3	Implement additional/revised activities.			x	CHPS Committee, Part A Program staff

Goal 4: Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).

Objective 1: ***Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
4.1.1	Evaluate and report on what overlaps in care exist (if any).	x			Part A Program
4.1.2	Implementation of activities to eliminate overlaps (if any).		x		Part A Program
4.1.3	Evaluate and report on any activities that are implemented.			x	Part A Program

Goal 5: Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.

Objective 1: ***Maintain collaborative relationships with other Ryan White programs and community stakeholders.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
5.1.1	Continue established All Parts work group to develop efficiencies among all Ryan White programs.	x	x	x	Part A Program
5.1.2	Continue to assess the delivery of mental health and substance abuse services within the EMA.	x	x	x	Part A Program
5.1.3	Based on assessment analysis, implement collaborative activities to increase the number of clients engaged into substance abuse services.	x	x	x	Part A Program

Goal 6: Develop and implement strategies to strengthen retention in care.

Objective 1: ***Implement consumer health literacy activities, including peer-led programs designed to engage new-to-care clients into medical care.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.1.1	Pilot revised Health Journal and Care Planner wellness management tools.	x			Training, Education And Membership (TEAM) Committee
6.1.2	Evaluate Health Journal/Care Planner pilot, determine future implementation.		x		TEAM Committee
6.1.3	In conjunction with the University of Arizona, develop and pilot health literacy programming for new-to-care individuals with one Part A provider.	x			TEAM Committee, University of Arizona students, Planning Council Support, Part A Program
6.1.4	Evaluate health literacy pilot programming, determine whether to continue implementation.		x		TEAM Committee, University of Arizona students, Planning Council Support, Part A Program
6.1.5	Monitor and evaluate program implementation (if any).			x	Part A Program

Objective 2: ***TEAM committee to present or participate in at least one consumer education event each year.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.2.1	Presentation of Year 1 event(s).	x			Training, Education And Membership (TEAM) Committee
6.2.2	Presentation of Year 2 event(s).		x		TEAM Committee
6.2.3	Presentation of Year 3 event(s).			x	TEAM Committee

Objective 3: ***Part A program to partner with the National Quality Center (NQC), other Ryan white programs and community stakeholders to implement quality improvement activities.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.3.1	Part A program to host a regional quality training program, in collaboration with the National Quality Center.	x			Standards Committee, Part A Program
6.3.2	Establish at least one measureable health outcome for each service category.	x			Standards Committee, Part A Program
6.3.3	Collaborate with community stakeholders to establish community viral load monitoring.		x		Standards Committee, Part A Program

6.3.4	Participate in NQC Quality Improvement and in+care initiatives.	x	x	x	Standards Committee, Part A Program

Objective 4: ***Collaborate with other Ryan White programs and community stakeholders to ensure that clients who transition between programs do not lose continuity of care.***

Objective	Activity	Year 1	Year 2	Year 3	Oversight
6.4.1	Collaborate with the state's Medicaid program (AHCCCS) to efficiently transition HIV positive clients who have been disenrolled from the program to Ryan White services, and monitor the engagement of these clients into care.	x	x	x	Transition Planning Work Group, Part A Program
6.4.2	Collaborate with the state's ADAP Assist program to efficiently transition eligible clients from Ryan White Part A services to the Pre-Existing Condition Insurance Program (PCIP), and monitor the engagement of these clients into care.	x	x	x	Transition Planning Work Group, Part A Program
6.4.3	Collaborate with ADHS, Ryan White Parts C and D to develop plan to transition clients to Affordable Care Act health care programs.	x	x		Transition Planning Work Group, Part A Program
6.4.4	Develop and implement training program for clients and providers regarding transitioning clients to Affordable Care Act health care programs.			x	Transition Planning Work Group, Part A Program

ALIGNMENT OF THIS COMPREHENSIVE PLAN'S GOALS/OBJECTIVES WITH THOSE OF THE NATIONAL HIV/AIDS STRATEGY, HEALTHY PEOPLE 2020, THE RYAN WHITE PARTS A-D QUALITY IMPROVEMENT WORK GROUP, AND LOCAL QUALITY IMPROVEMENT AND PREVENTION PARTNERS

National AIDS Strategy Goals	Relevant Healthy People 2020 Goals	Ryan White Parts A-D Quality Improvement Work Group	Phoenix EMA Comprehensive Plan Goals/Objectives
Increase Access to Care and Improving Health Outcomes for People Living With HIV **Activity:** Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV **Activity:** Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV **Activity:** Support people living with HIV with co-curring health conditions and those who have challenges meeting their basic needs, such as housing	**HIV-9** Increase the proportion of new HIV infections diagnosed before progression to AIDS **HIV-10** Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards **HIV-11** Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS **HIV-12** Reduce deaths from HIV infection	Increase the number of entities providing opt-out testing programs Increase collaboration between Ryan White Parts and hospitals to engage additional providers of routine opt-out testing in Labor and Delivery departments Case managers collaborate with MDs to obtain lab reports, Increased collaboration between Ryan White case managers and non-Ryan White providers Implement activities to minimize challenges experienced by youth transitioning to adult HIV care settings Develop client skills/ prevention knowledge/ health literacy for improved self-management of HIV care, risk reduction, knowledge/ management of co-curring health conditions Improve Oral Health Care utilization Improve Patient scheduling, retention to facilitate care access, decrease missed appointments	**Goal 1: Identify individuals who are aware of their HIV status and not in primary medical care, and facilitate their entry into care.** Objective 1: Develop and Implement dynamic activities for Early Intervention Services and Outreach services. Objective 2: Based on 2012 Pathways to Care analysis (see 3.1.1), develop and implement strategies to ensure newly diagnosed individuals are appropriately connected to care from testing venues. **Goal 3: Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.** Objective 1: Complete at least one needs assessment/service delivery assessment each grant year. Objective 2: Analyze the delivery of Part A Oral Health Services and implement revisions to this service (if any). **Goal 4: Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any).** Objective 1: Identify overlaps in care, and develop and implement strategies for the elimination of overlaps that are identified (if any). **Goal 5: Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.** Objective 1: Maintain collaborative relationships with other Ryan White programs and community stakeholders.

		Goal 6: Develop and implement strategies to strengthen retention in care. Objective 3: Part A program to partner with the National Quality Center (NQC), other Ryan white programs and community stakeholders to implement quality improvement activities. Objective 4: Part A program to partner with other Ryan White programs and community stakeholders to ensure that clients who transition between programs do not lose continuity of care.

National AIDS Strategy Goals	Relevant Healthy People 2020 Goals	Prevention Planning Group of Arizona (PPGA) Goals	Phoenix EMA Comprehensive Plan Goals/Objectives
Reduce New HIV Infections **Activity:** Intensify HIV prevention efforts **Activity:** Expand targeted efforts to prevent HIV infection **Activity:** Educate all Americans about HIV	**HIV-1** Reduce the number of new HIV diagnoses among adolescents and adults **HIV-2** Reduce new HIV infections among adolescents and adults **HIV-3** Reduce the rate of HIV transmission among adolescents and adults **HIV-4** Reduce the number of new AIDS cases among adolescents and adults **HIV-5** Reduce the number of new AIDS cases among adolescent and adult heterosexuals **HIV-6** Reduce the number of new AIDS cases among adolescent and adult men who have sex with men **HIV-7** Reduce the number of new AIDS cases among adolescents and adults who inject drugs **HIV-8** Reduce the number of perinatally acquired HIV and AIDS cases	Free and anonymous HIV testing Availability of testing, outreach to diverse populations Improved funding for testing activities Improved public HIV education Central Arizona Target Populations: 1. HIV+ Persons (all ages, ethnicities, genders) in Maricopa and Pinal counties 2. MSM (all ages, ethnicities) in Maricopa and Pinal counties 3. IDU and/or Hep C+ persons (all ages, ethnicities, genders) in Maricopa and Pinal counties 4. Black, Non-Hispanic Women (all ages) in Maricopa and Pinal counties 5. Individuals with an STD diagnosis (all ages, ethnicities, genders) in Maricopa and Pinal counties 6. And/or the partners of individuals above Other recommendations: 1. Develop a system to track federal and state funding awarded to address HIV prevention	**Goal 2: Identify individuals who are unaware of their HIV status and not in primary medical care, and facilitate their entry into care.** Objective 1: Collaborate with Arizona Department of Health Services (ADHS), Maricopa Integrated Health System (MIHS), and/or other hospital/clinic/urgent care entities to expand HIV testing/care coordination activities with one new partner each year. Objective 2: Participate in regional symposium to present current ED/jail testing initiatives to encourage implementation in state/regional locales. Objective 3: Expand non-traditional testing activities, in collaboration with the Arizona Department of Health Services' HIV Prevention Program. Objective 4: Collaborate with ADHS, MIHS, and other community partners to implement HIV awareness/ testing/ entry to care activities targeting individuals aged 45 and older, youth, Hispanics and African Americans. **Goal 3: Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.** Objective 1: Complete at least one needs assessment/service delivery assessment each grant year. **Goal 5: Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.** Objective 1: Maintain collaborative relationships with other Ryan White programs and community stakeholders. **Goal 6: Develop and implement strategies to strengthen retention in care.**

	HIV-13 Increase the proportion of people living with HIV who know their serostatus **HIV-14** Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months (subpopulations of Adolescents and adults, MSM, pregnant women, adolescents and young adults) **HIV-15** Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV **HIV-16** Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support **HIV-17** Increase the proportion of sexually active persons who use condoms (unmarried females aged 15 to 44 years, unmarried males aged 15 to 44 years) **HIV-18** Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months	and/or care issues for Black non-Hispanic women and men in central region or the state 2. Better coordination of service providers to this population regardless of funding stream 3. Identify additional funding to address the continued rise in HIV infections in this population. Some of these funds should be allocated for research to better understand the specific HIV transmission vulnerabilities for this population Gather more data is needed for the following populations of concern: Homeless individuals Incarcerated persons Persons diagnosed with mental illnesses Special focus of HIV prevention activities to Black Communities in Arizona	Objective 1: Implement consumer health literacy activities, including peer-led programs designed to engage new-to-care clients into medical care. Objective 2: TEAM committee to present or participate in at least one consumer education event each year.

National AIDS Strategy	Relevant Healthy People 2020	Ryan White Parts A-D Quality Improvement Work Group Action Items	Phoenix EMA Comprehensive Plan Goals/Objectives
Reducing HIV-Related Health Disparities **Activity:** Reduce HIV-related mortality in communities at high risk for HIV infection **Activity:** Adopt Community-level approaches to reduce HIV infection in high-risk communities **Activity:** Reduce Stigma and discrimination against people living with HIV	**HIV-11** Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS **HIV-12** Reduce deaths from HIV infection	Case managers collaborate with MDs to obtain lab reports, Increased collaboration between Ryan White case managers and non-Ryan White providers Implement activities to minimize challenges experienced by youth transitioning to adult HIV care settings Develop client skills/ prevention knowledge/ health literacy for improved self-management of HIV care, risk reduction, knowledge/ management of co-curring health conditions Improve Oral Health Care utilization Improve Patient scheduling, retention to facilitate care access, decrease missed appointments	**Goal 3: Develop and implement strategies to increase access to care by eliminating barriers to care, and bridging gaps in care.** Objective 1: Complete at least one needs assessment/service delivery assessment each grant year. Objective 3: Initiate expanded cultural competency activities. Objective 4: Address the needs of Refugee populations. **Goal 5: Develop and implement strategies to strengthen the coordination of care services among Ryan White and non-Ryan White funded services.** Objective 1: Maintain collaborative relationships with other Ryan White programs and community stakeholders. Objective 3: Part A program to partner with the National Quality Center (NQC), other Ryan white programs and community stakeholders to implement quality improvement activities. Objective 4: Part A program to partner with other Ryan White programs and community stakeholders to ensure that clients who transition between programs do not lose continuity of care.

HOW THIS PLAN REFLECTS THE STATEWIDE COORDINATED STATEMENT OF NEED

The 2012-2014statewide Coordinated Statement of Need reveals various strengths of current HIV Care and Services available in Arizona. Some of these strengths are: no ADAP wait list, collaboration among HIV providers and Ryan White Programs, and leveraging of other resources. On the other hand, there were several barriers identified in accessing HIV care and services. These are: rural vastness, lack and cost of transportation, and stigma. Activities identified in this plan, and services prioritized by the Phoenix EMA Ryan white Part A Planning Council will closely reflect the prioritized areas identified in the SCSN and other regional needs assessments.

Because of the new emphasis upon Medical Case Management and testing as the platform for Early Identification of Persons with HIV/AIDS, including the integration of routine partner services within Medical Case Management, the central role of Medical Case Management to linkage to care will continue to strengthen. Linkages between delivery of Outpatient Ambulatory Medical services and Medical Case Management will be strengthened so that more effective benefits coordination can also take place as increasing numbers of ADAP and Ryan White Clients become enrolled in the new PCIP insurance plans. Effective benefits coordination through medical case management offers improved health system navigation for clients, improved retention in care, improved outreach to the undiagnosed unaware through partner services, and may help address the relatively high rate of unmet need in rural parts of the EMA.

HOW THIS PLAN WILL COORDINATE AND ADAPT TO CHANGES AS A RESULT OF THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT (ACA)

The Planning Council has been monitoring the implementation of the Affordable Care Act closely since the expansion of the Pre-Existing Condition Insurance Plan (PCIP) in 2010. At that time, the state's ADAP program has been evaluating the cost effectiveness of transferring clients to PCIP. Since late 2010, more than 400 ADAP clients have been transitioned to the PCIP. Members if the Part A Program and Planning Council Support staff, as well as many provider representatives on the Council, are active participants in the South and Central PCIP Coalition, the Arizona Community Health Coalition, and several local hospital associations and health care coalitions addressing broad community transition planning. The Council's Community Health Planning & Strategies Committee has been tasked to create a formal Transition Work Group to develop a specific strategy to transition Part A and ADAP clients to health care exchange programs.

The Part A Program participates in an All Parts Work Group with other Ryan White grantees, and has been collaborating to develop a comprehensive transition plan for providers. This has included identifying and communicating with non-Ryan White medical providers that clients may shift to when the Affordable Care Act is implemented, analyzing the effects of the transition on Part A providers, and developing communication strategies.

The Planning Council's TEAM Committee has been charged with developing consumer forums to educate clients and seek feedback regarding transition planning to Affordable Care Act programs.

STRATEGY TO RESPOND TO ANY ADDITIONAL OR UNANTICIPATED CHANGES IN THE CONTINUUM OF CARE AS A RESULT OF STATE OR LOCAL BUDGET CUTS

The Planning Council anticipates that the Phoenix EMA will have to address the impact of federal, state and local budget cuts that will place powerful stresses on the Part A HIV continuum of care. Addressing these issues may necessitate changes to the mix and variety of services available through the Ryan White program. The Council has established Guiding Principles, described earlier, to address funding needs in a systematic, logical manner to ensure core medical services are provided to all clients who need them. The Council's Allocations Committee and Community Planning & Strategies Committee work closely to determine service needs and directives/funding to guide service delivery.

In 2010 the state ADAP program began transitioning clients to the Pre-Existing Condition Insurance Plan (PCIP). More than 400 clients have been enrolled in PCIP, with many more in-process. Initially, the Part A Program realized decreased utilization in primary medical care services due to these transfers; however,

when Medicaid eligibility policies were changed in 2011, HIV clients that were disenrolled in the program became eligible for Part A services. Until mid-2012, the impact on the Part A Program had been manageable, as there was a somewhat equal transition between clients moving on to Part A and moving off to PCIP. There is now a disproportionate increase in clients transitioning from Medicaid to Part A, and a backlog of clients transitioning from ADAP to PCIP. The Council has prepared for reallocations too increase primary medical care funding to address this issue. ADAP has increased staffing to improve PCIP transition times.

Since 2010, the Planning Council has received regular updates from the Arizona Medicaid program, ADAP, prevention programs and other HIV-related care entities. Additionally, this Comprehensive Plan includes the establishment of work groups to develop strategies to proactively address emerging issues. Additionally, a work group will be formed to plan for the transition of Part A clients to programs established as part of federal health care reform.

PART 4: MONITORING OUR PROGRESS

IMPLEMENTATION AND MONITORING STRATEGY

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

IMPROVING CLIENT LEVEL DATA

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

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

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

USING DATA FOR EVALUATION

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

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

Planning Council Oversight: The Planning Council review the overall progress toward the objectives of the Comprehensive Plan quarterly. If objectives need to be adjusted based on activities and other

developments over the course of the year, the Planning Council will ask the CHPS Committee to develop and recommend changes.

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

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

MONITORING THE PLAN

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

Time Frame: Completing objectives listed in this plan require intense data collection and community collaboration, yearly timeframes. Because of many uncontrollable variables inherent to community-wide planning, yearly timeframes have been established.

Responsible Parties: The work plan delineates the Part A-specific committees, teams and individuals that have been charged with the implementation and monitoring of each objective.

OUTCOMES AND INDICATORS BY SERVICE CATEGORY

Service categories are prioritized and funded by the Planning Council each grant year, based on demonstrated need. As such, services categories listed below may not be funded in every grant year.

AIDS Drug Assistance Program (ADAP Treatments)

Outcome	Indicator
Decrease medication errors.	External medication error rate not to exceed **2 per 1,000** prescriptions filled.

AIDS Pharmaceutical Assistance (local)

Outcome	Indicator
Decrease medication errors.	External medication error rate not to exceed **2 per 1,000** prescriptions filled.

Emergency Financial Assistance

Outcome	Indicator
Improve adverse socioeconomic situations that negatively impact clients' ability to focus on receiving continued medical and dental care.	**80%** of charts reviewed will indicate that eligible clients received timely assistance with rent payments avoiding eviction. **80%** of charts reviewed will indicate that eligible client utility bills were processed within one week of contact with a case manager to ensure continuation of utility services.

Food Bank/Home Delivered Meals

Outcome	Indicator
Improve clients' health by increasing knowledge of appropriate dietary intake.	**75%** of clients will receive a medical nutritional therapy assessment by a registered dietitian to ensure appropriate dietary intake is monitored and appropriate nutritional information is dispensed.

Health Insurance Premium/Cost Sharing Assistance

Outcome	Indicator
Improve client's access to medical and dental care (Health Insurance Continuation/Cost Sharing Assistance services only).	**80%** of individual's charts submitting requests for financial assistance will indicate the requests had been processed and approved prior to the cancellation of health insurance benefits. **80%** of charts reviewed will indicate eligible clients had their medical and dental co-pays/prescription costs paid within one week of request.

Medical Case Management

Outcome	Indicator
Improve clients' health by increasing access to primary medical care and the support services necessary to reduce barriers to care, as shown by:	**90%** of clients have documentation of access to primary medical care within 3 months of initial assessment. **80%** of client charts have documentation that treatment adherence was discussed with the client. **100%** of client charts contain a comprehensive individualized care plan.

Medical Nutritional Therapy: Adult

Outcome	Indicator
Improve clients' health by increasing knowledge of appropriate Medical Nutrition Therapy and monitoring nutritional status.	**75%** of charts reviewed for monitored weight will indicate that clients maintained a body weight at 95 to 100% of usual body weight levels. **75%** of the charts document that client/family have been educated on the role of nutrition and HIV. **75%** of charts document that a review of oral intake was conducted and compared with calculated calorie requirement at initial visit.

Medical Nutritional Therapy: Pediatric

Outcome	Indicator
Improve clients' health by increasing knowledge of appropriate Medical Nutrition Therapy and monitoring nutritional status.	**75%** of client charts document normal growth and weight gain as defined by a BMI or weight/height greater than the 5th percentile, within six months of the implementation of the treatment plan. **75%** of the charts document that client/family have been educated on the role of nutrition and HIV.

Medical Transportation

Outcome	Indicator
Provide access to primary medical care and support services for eligible clients.	**80%** of eligible clients self-report decreased barriers to primary medical care due to availability of transportation services.

Mental Health Services

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

Non-Medical Case Management

Outcome	Indicator
Improve clients' health by increasing access to support services necessary to reduce barriers to care.	**100%** of non-medical case management charts will contain a care plan. **90%** of client charts document applicable service referrals.

Oral Health Care – Insurance Program

Outcome	Indicator
Service providers will demonstrate core competency in service delivery, monitoring and fiscal accountability.	**90%** of clients will be processed for enrollment into the program within 10 working days of the receipt of the application, once eligibility is determined. Less than **10%** of clients dis-enroll on a monthly basis.

Oral Health Care – Direct Dental Program

Outcome	Indicator
Improve and maintain oral health.	**75%** of clients receive an annual exam. **50%** of clients initiate their treatment plan. **25%** of clients are on track with their treatment plan.

Oral Health Services – All Programs

Outcome	Indicator
Address inflammatory periodontal disease.	**75%** of clients receive an initial periodontal exam, and follow-up exam as appropriate.

Outpatient Ambulatory Medical Care

Outcome	Indicator
Outcomes and target percentages will be reviewed annually to reflect EMA wide trends in achievable compliance and/or desired improvement.	**60%** of reviewed client records will document that viral loads have been measured at least every six months. **60%** of reviewed client records will document that the client's CD4 counts have been measured at least every six months. **60%** of reviewed client records of new clients who are women/sexually active adolescent females will document the client received a PAP smear annually. NOTE: Adolescent screenings are conducted per PHS guidelines. **60%** of reviewed client records for sexually active adult and adolescents will document the client received, at a minimum, an annual syphilis screening. **60%** of reviewed client records will document that the client was screened for tuberculosis at least annually if indicated.

Substance Abuse Services

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

Universal Standards of Care

Outcome	Indicator
Service providers will demonstrate core competency as delineated in these Universal Standards in service delivery, monitoring and fiscal accountability.	**90%** of client charts document that clients were appropriately screened for eligibility for services. **90%** of client charts contain a signed general release of information. **90%** of client charts have a signed acknowledgement of the receipt of a Client Rights and Responsibilities statement, or a provider notation of a clients' refusal to sign. **90%** of client charts have a signed acknowledgement of the receipt of a Grievance Procedure statement, or a provider notation of a clients' refusal to sign.

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

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

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

APPENDIX A:
RESOURCE INVENTORY OF RYAN WHITE PART A FUNDED HIV SERVICES

Ryan White Part A Program			
Ryan White Part A Program	401 W Jefferson Street	Phoenix, AZ 85003	602-506-5341
Phoenix EMA Ryan White Planning Council	4041 N Central Ave, 14th Floor	Phoenix, AZ 85012	602-506-6321
Case Management Services			
Care Directions	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-264-2273
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Centralized Eligibility Services			
Care Directions	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-212-3788
Food Services			
AGAPE Network	2425 E Thomas Rd	Phoenix, AZ 85016	602-234-6143
Compassion in Action	4225 S McClintock Dr	Tempe, AZ 85244	480-297-4389
Mental Health Services			
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Jewish Family and Children's Services (multiple locations)	4220 N 20th Ave	Phoenix, AZ 85015	602-279-7655 x248
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Phoenix Shanti Group	2345 W Glendale Ave	Phoenix, AZ 85021	602-279-0008
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330

Nutritional Services			
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Phoenix Children's Hospital Bill Holt Clinic	1919 E Thomas Rd	Phoenix, AZ 85016	602-546-0955
Oral Health Services			
Arizona School of Dentistry and Oral Health (multiple locations)	5850 E Still Circle	Mesa, AZ 85206	480-248-8100
Maricopa County Department of Public Health Office of Oral Health, Ryan White Part A Dental Insurance Program	4041 N Central Ave, 7th Floor	Phoenix, AZ 85012	602-506-6891
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Outreach Services			
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Outpatient Ambulatory Medical Care			
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Phoenix Children's Hospital Bill Holt Clinic	1919 E Thomas Rd	Phoenix, AZ 85016	602-546-0955
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Sun Life Family Health Center	865 N Arizola Rd	Casa Grande, AZ 85222	520-836-3446
Substance Abuse Services			
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Phoenix Shanti Group	2345 W Glendale Ave	Phoenix, AZ 85021	602-279-0008
Transportation Services			
Care Directions	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-264-2273

APPENDIX B:
RESOURCE INVENTORY OF ORGANIZATIONS OFFERING HIV-RELATED SERVICES

Case Management Services			
Care Directions	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-264-2273
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Complimentary/Wellness Services			
Peace Wellness Center	7600 N 15th St, STE 102	Phoenix, AZ 85020	602-439-0000
Restoration Bodywork & Massage Therapy	1640 E Thomas Rd, STE B	Phoenix, AZ 85016	602-695-0809
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Food Boxes/Congregate Meals			
AGAPE Network	2425 E Thomas Rd	Phoenix, AZ 85016	602-234-6143
Compassion in Action	4225 S McClintock Dr	Tempe, AZ 85244	480-297-4389
Joshua Tree Feeding Program	530 E McDowell Rd, #107-247	Phoenix, AZ 85004	602-264-0223
HIV Prevention and Education			
1n10 Youth Services Group	2700 N 3rd St, STE 2011	Phoenix, AZ 85004	602-475-7456
Aunt Rita's Foundation	2700 N 3rd St, STE 2011	Phoenix, AZ 85030	602-882-8675
Concilio Latino de Salud	546 E Osborn Rd, STE 22	Phoenix, AZ 85012	602-285-0970
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
HEAL International	1001 S McAllister	Tempe, AZ 85287	602-284-8895
Prevention Planning Group of Arizona	150 N 18th Ave, STE 110	Phoenix, AZ 85007	602-364-3883
Project Hard Hat	PO Box 39297	Phoenix, AZ 85069	602-357-4390
Southern Arizona AIDS Foundation	375 S Euclid Ave	Tucson, AZ 85719	520-628-7223

Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
UCAN	1320 E Bethany Home Rd, #31	Phoenix, AZ 85014	602-294-0214
HIV/STD Testing			
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Maricopa County Department of Public Health HIV Counseling and Testing	1645 E Roosevelt St	Phoenix, AZ 85006	602-506-2934
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Pinal County Division of Public Health	500 S Central	Florence, AZ 85232	866-960-0633
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
HIV Specialty Pharmacies			
Apothecary Shops of Phoenix	5040 N 15th Ave, STE 102	Phoenix, AZ 85015	800-330-2360
CarePlus Specialty Pharmacy	1002 E McDowell Rd	Phoenix, AZ 85006	800-351-5552
Melrose Pharmacy	704 W Montecito Ave	Phoenix, AZ 85013	602-277-4714
Sunwest Pharmacy	1300 N 12th St, STE 408	Phoenix, AZ 85006	602-595-3555
Walgreens HIV/AIDS Specialty Pharmacy at Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-307-5330 x2340
Walgreens HIV/AIDS Specialty Pharmacy	705 E McDowell Rd	Phoenix, AZ 85004	602-258-4865
Walgreens (24-hour) HIV/AIDS Specialty Pharmacy	3402 N Central Ave	Phoenix, AZ 85012	602-265-4781
Home Care/Hospice			
Banner Home Care and Hospice	1325 N Fiesta Blvd, STE 1	Gilbert, AZ 85233	480-497-5535
Pinal County Horizon Home Care	971 N Jason Lopez Circle, Bldg E	Florence, AZ 85232	520-866-4500
Community Information and Referral Services	2200 N Central Ave, STE 601	Phoenix, AZ 85004	602-263-8856, 800-352-3792

Housing Services			
Housing Opportunities for Persons With AIDS Coordinator (Care Directions)	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-264-2273
Pinal County Division of Housing	970 N Eleven Mile Corner Rd	Casa Grande, AZ 85294	520-866-7201
Interpreting Services			
Freelance Interpreting Services	PO Box 3296	Chandler, AZ 85244	480-595-9515
Valley Center of the Deaf	5025 E Washington St, STE 114	Phoenix, AZ 85034	602-267-1921
Legal Services			
Arizona Center for Disability Law	5025 E Washington St, STE 202	Phoenix, AZ 85034	602-274-6287
Arizona Department of Insurance	2910 N 44th St, STE 210	Phoenix, AZ 85018	602-364-2499
HIV/AIDS Law Project	305 S 2nd Ave, PO Box 21538	Phoenix, AZ 85036	602-258-3434 ext. 2820
Medical Care			
Arizona Department of Corrections Health Services Division	1110 W Washington St, STE 310	Phoenix, AZ 85007	602-364-2900
Arizona Health Care Cost Containment System (AHCCCS)	801 E Jefferson St	Phoenix, AZ 85034	602-417-4000
Clinica Adelante (multiple locations)	16551 N Dysart Rd, #104A	Surprise, AZ 85374	623-583-3001
Maricopa County Department of Public Health Healthcare for the Homeless Clinic	220 S 112th Ave	Phoenix, AZ 85007	602-258-2100
Mountain Park Community Health Centers (multiple locations)	635 E Baseline Rd	Phoenix, AZ 85042	602 243-7277
Phoenix Children's Hospital Bill Holt Clinic	1919 E Thomas Rd	Phoenix, AZ 85016	602-546-0955
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550

Sun Life Family Health Center	865 N Arizola Rd	Casa Grande, AZ 85222	520-836-3446
Mental Health Services/Support Groups			
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
For Positive Men (ForPM)	1029 E Turney Ave	Phoenix, AZ 85014	ForPM-owner@yahoogroups.com
Jewish Family and Children's Services (multiple locations)	4220 N 20th Ave	Phoenix, AZ 85015	602-279-7655 x248
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Phoenix Shanti Group	2345 W Glendale Ave	Phoenix, AZ 85021	602-279-0008
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Southwest Behavioral Health Services (multiple locations)	3450 N 3rd St	Phoenix, AZ 85012	602-285-4220
Valle del Sol	1209 S 1st Ave	Phoenix, AZ 85003	602-258-6797
Native American Services			
Native American Community Health Center	4520 N Central Ave	Phoenix, AZ 85012	602-279-5262
Native American Connections	4520 N Central Ave, STE 600	Phoenix, AZ 85012	602-254-3247
Phoenix Indian Medical Center	4212 N 16th St	Phoenix, AZ 85016	602-263-1200 x1835
Nutritional Services			
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Phoenix Children’s Hospital Bill Holt Clinic	1919 E Thomas Rd	Phoenix, AZ 85016	602-546-0955

Oral Health Services			
Arizona School of Dentistry and Oral Health (multiple locations)	5850 E Still Circle	Mesa, AZ 85206	480-248-8100
Da Vinci Dental Group	5336 N 7th Ave	Phoenix, AZ 85013	602-336-1111
Maricopa County Department of Public Health Healthcare for the Homeless Clinic	220 S 112th Ave	Phoenix, AZ 85007	602-258-2100
Maricopa County Department of Public Health Office of Oral Health, Ryan White Part A Dental Insurance Program	4041 N Central Ave, 7th Floor	Phoenix, AZ 85012	602-506-6891
Maricopa Integrated Health System (multiple locations)	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Maryland Avenue Periodontics	6520 N 7th Ave, STE 5	Phoenix, AZ 85013	602-242-2588
Open Wide Dental	6520 N 7th Ave, STE 1	Phoenix, AZ 85013	602-347-9999
Sundance Dental Care	2620 S 83rd Ave, STE 104	Phoenix, AZ 85043	623-939-6665
Other Services			
Aid to Adoption of Special Kids (AASK)	2320 N 20th St	Phoenix, AZ 85006	602-254-2275
Hemophilia Association	818 E Osborn Rd, STE 105	Phoenix, AZ 85014	602-955-3947
Outreach Services			
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Pet Care Assistance			
Agnes Fund – a program of Southwest Center for HIV/AIDS	1144 E McDowell Rd, STE 200	Phoenix, AZ 85006	602-307-5330
Ryan White Programs			
Ryan White Part A Program	401 W Jefferson Street	Phoenix, AZ 85003	602-506-5341
Phoenix EMA Ryan White Planning Council	4041 N Central Ave, 14th Floor	Phoenix, AZ 85012	602-506-6321

Ryan White Part B	150 N 18th Ave	Phoenix, AZ 85007	800-334-1540
Ryan White Part C Program	2601 E Roosevelt St	Phoenix, AZ 8500	602-344-2632
Ryan White Part D Program	2601 E Roosevelt St	Phoenix, AZ 85008	602-344-1710
Ryan White Part D Family Advocate	2601 E Roosevelt St	Phoenix, AZ 85008	602-344-6577
Arizona AIDS Education and Training Center	1501 N Campbell Ave, PO Box245143	Tucson, AZ 85724	520-626-0723
Substance Abuse Services			
Chicanos Por La Causa	4602 W Indian School Rd, C-3	Phoenix, AZ 85031	623-247-0464
Ebony House	39 E Jackson St	Phoenix, AZ 85004	602-254-6180
Maricopa Integrated Health System (multiple locations	1144 E McDowell Rd, STE 300	Phoenix, AZ 85006	602-344-6550
Phoenix Shanti Group	2345 W Glendale Ave	Phoenix, AZ 85021	602-279-0008
TERROS , Inc.	1029 N 1st St	Phoenix, AZ 85004	602-402-8362
Veterans Administration (Carl T. Hayden Medical Center) Immunodeficiency Clinic	650 E Indian School Rd	Phoenix, AZ 85012	602-277-5551 x7182
Transportation Services			
Care Directions	1366 E Thomas Rd, STE 200	Phoenix, AZ 85014	602-264-2273