



Memphis Transitional Grant Area (TGA)

# **2009 RYAN WHITE HIV/AIDS SERVICES COMPREHENSIVE PLAN**

Through December 31, 2011

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As Submitted to the Federal Health Resources Services Administration (HRSA) by the Memphis TGA Planning Council and the Memphis TGA Ryan White Part A Program Office in compliance with the Ryan White Treatment Modernization Act of 2006

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A C Wharton, Jr.  
Mayor

## Shelby County Government



December 2008

I am pleased to pledge my support for this 2009 Comprehensive HIV Services Plan, developed by the Memphis TGA Ryan White Planning Council in partnership with the Ryan White Part A Program Office. All eight counties of the Memphis TGA, including Shelby, Tipton and Fayette counties in Tennessee; Desoto, Marshall, Tate and Tunica counties in Mississippi and Crittenden County in Arkansas, benefit from the hard work and dedication reflected in this document.

This Comprehensive Plan guides our community in addressing the needs of people who are living with and those affected by HIV/AIDS. The Plan provides the format for assuring a comprehensive continuum of care for quality services that draws upon the rich existing resources

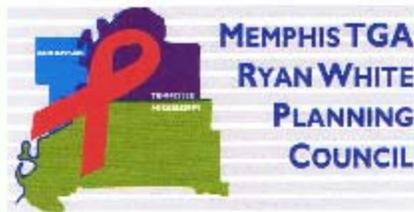
of medical institutions and community based organizations already serving those who are living with HIV/AIDS, as well as the creation of opportunities for new providers to be included in this network. It also allows for the full involvement of the community, in particular those who are clients of HIV services, in the continuous development towards a seamless, quality system of care.

Our area has the unique challenge and opportunity of providing HIV services to citizens across a multi-state region. I am proud that the spirit of coordination and collaboration necessary to do this effectively resonates throughout this plan. In this same spirit, I encourage all elected officials, service providers, clients, and concerned citizens to lend their support to this plan and continue to work to ensure access to quality HIV care for all who need it throughout the Memphis TGA.

Sincerely,



A C Wharton, Jr.  
Mayor



December 2008

Dear Friends and Colleagues,

As Co-Chairs of the Memphis TGA Planning Council, we are pleased to offer our support to the 2009 Ryan White Comprehensive Plan. The development of this plan was due to the input and hard work of a number consumers, service providers and community partners throughout the region.

We are proud of this effort as it is the very first Comprehensive Plan for HIV services submitted to HRSA on behalf of the Memphis TGA. We are confident that this document proves the commitment to increasing access to services to those who need them most not only by the Planning Council and Part A Program, but the entire community. There is a great excitement about the opportunities that exist for this region, and we firmly believe that the plans set forth in this document will provide a guide for ensuring quality, seamless care across the HIV delivery system. We look forward to continued work with all of our partners in meeting this goal.

Edward Gardner  
Co-Chair

James Sdoia  
Co-Chair



# Shelby County Government

A C Wharton, Jr.  
Mayor

December 29, 2008

Dear Colleagues and Community Partners,

It is with great pleasure that the Memphis TGA Ryan White Part A Program lends its full support to the 2009 Ryan White Comprehensive Plan. An incredible level of collaboration and cooperation between the Ryan White Part A Program and the Planning Council facilitated the development of The Comprehensive Plan. This fact is evident in the resulting document.

I look forward to working with the Council and all community partners as we work to meet the goals and objectives set forth in this Plan. It is my hope that this document will serve not only to guide the Part A program in its activities, but will be useful to other Ryan White and non Ryan White providers as we all work to create a seamless continuum of quality care for all citizens infected and affected by HIV in our region.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ricci Hellman", is written over a light blue horizontal line.

Dr. Ricci Hellman  
Memphis TGA Ryan White Part A Program Manager



United Way  
of the Mid-South

December 29, 2008

Memphis TGA Planning Council  
Darcas Young, Public Health Coordinator  
1075 Mullins Station Road Room 274  
Memphis, Tennessee 38134

Dear Ms Young:

The Mid-South Coalition on HIV/AIDS is pleased to submit its letter of support for the Memphis TGA Planning Council's 2009 Ryan White HIV/AIDS Services Comprehensive Plan. This letter is for inclusion in the submission of your plan to the Health Resources and Services Administration (HRSA) and has been administratively approved by the full membership of the Mid-South Coalition on HIV/AIDS. Full support is granted and MCHA looks forward to having a collaborative role in pertinent aspects of the comprehensive planning process.

Sincerely,

A handwritten signature in black ink that reads "Orisha Henry-Bowers". The signature is fluid and cursive, with the first name being the most prominent.

Orisha Henry-Bowers, M.Ed.

Mid-South Coalition on HIV/AIDS, Lead Agent



STATE OF TENNESSEE  
BUREAU OF HEALTH SERVICES  
DEPARTMENT OF HEALTH  
CORDELL HULL BUILDING  
425 5<sup>th</sup> AVENUE NORTH  
NASHVILLE, TENNESSEE 37243

December 29, 2008

Dr. Ricci A. Hellman  
Program Coordinator - Ryan White  
Shelby County Government  
1075 Mullins Station Rd. -- Rm W277  
Memphis, TN 38134

Dear Dr. Hellman:

This letter is written in support of the Comprehensive Plan developed by the Memphis Part A Transitional Grant Area. The plan was developed to work in conjunction with the Part B services that are provided in the TGA. Both Part A and Part B staff worked with Planning Council and the community to assure that the plan is comprehensive and is representative of the needs identified.

I look forward to working with the Planning Council and the staff of the Memphis TGA in the coming year as we direct our efforts toward the goals and objectives set forth in the plan.

Sincerely,

A handwritten signature in cursive script that reads "Jeanece Seals".

Jeanece Seals  
Director  
HIV/AIDS/STD Section



## Arkansas Department of Health

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4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000

**Governor Mike Beebe**

**Paul K. Halverson, DrPH, FACHE, Director and State Health Officer**

December 16, 2008

To Whom It May Concern:

The Arkansas Department of Health HIV Services Program is pleased to work with the Memphis TGA to enhance and expand services to those affected with HIV/AIDS. We support the Memphis TGA in their endeavors to address the challenges and opportunities that exist for HIV service delivery.

The Arkansas Department of Health HIV Services Program further supports the goals and objectives established by the Co-Chairs of the Planning Council outlined in the 2009 Memphis TGA Comprehensive Plan.

If you have any questions, please do not hesitate to contact me at (501) 661-2433 or via email at [Tiyanika.Keller@arkansas.gov](mailto:Tiyanika.Keller@arkansas.gov).

Sincerely,

Tiyanika N. Keller, M.P.A.

Ryan White Part B

Program Services Manager

Regional Medical Center at Memphis



Date: December 19, 2008

Ricci Hellman, Program Coordinator  
Ryan White Part A Program  
Shelby County Government  
1075 Mullins Station Rd., Room W277  
Memphis, TN 38134

Dear Ricci:

It is a pleasure to provide my support to the Comprehensive Plan for the Memphis TGA. These goals and objectives will focus the important work that Ryan White Part A funds contribute to the Memphis community.

More than ever, resources are limited due to recent drastic cuts in the state budget, which makes it even more important to focus Part A funds toward coordinated and collaborative service delivery for PLWHA's in the Memphis TGA. As a Ryan White Part C grantee, we are most appreciative of what you continue to do for HIV/AIDS patients in our community.

Sincerely,

A handwritten signature in blue ink that reads 'Becky Bayless'.

Becky Bayless, LCSW  
Manager, Grant Programs  
Regional Medical Center at Memphis  
880 Madison Ave.  
Memphis, TN 38103



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December 10, 2008

Dear Colleagues:

As the HIV/AIDS Program Manager for East Arkansas Family Health Center, I am pleased to submit a letter of support for the 2009-12 Comprehensive Plan. At our agency, we recognize the importance of the comprehensive plan in directing service delivery to individuals living with HIV and AIDS. We look forward to working closely with the service providers of the Memphis TGA as we continue to improve the quality of services offered to those in need.

Sincerely,

Cherry Whitehead-Thompson, MSSW  
EAFHC HIV/AIDS Program Manager



December 18, 2008

To Whom It May Concern:

I am writing to support the Memphis TGA Planning Council's Comprehensive Plan. I serve on the Priorities and Resource Allocation Committee as the Ryan White Part D representative. Creating this plan has been a great opportunity to assess services and initiatives across all Parts of the Ryan White Program. In addition, allocating responsibility across the Parts will help us to work on a common goal as we move forward.

The Part A grant has provided a unique opportunity to bring our community together and I look forward to being a productive part of that process. The additional services that are now available as a result of this funding are offering an opportunity to provide a comprehensive continuum of care to our consumers. Collaborating on projects such as this is necessary to make our efforts a success.

We have received a lot of support from HRSA, and Harold Phillips in this endeavor. I am thankful for that resource and for the wisdom that Harold brought to the process.

Sincerely,

A handwritten signature in blue ink that reads "Tiffany Ford, MSSW".

Tiffany Ford, MSSW  
Manager, Le Bonheur Community Outreach  
Ryan White Part D Programs



December 29, 2008

To Whom It May Concern:

As a funded Local Performance Site through the Southeast AIDS Training and Education Center (via the Community HIV Network), we are pleased to support Memphis' Ryan White Part A Comprehensive Plan. Our commitment is to support Part A funded agencies, especially clinical staff, with technical assistance and training as funds are available throughout the Comprehensive Planning cycle.

This partnership will benefit the entire Memphis Transitional Grant Area, and we are pleased to be the training arm of the Ryan White Program. If you have further questions, please don't hesitate to contact me at 901-287-4779 or [russelja@lebonheur.org](mailto:russelja@lebonheur.org)

Sincerely,

Jamie Russell, MA  
Southeast AIDS Training and Education Center  
Local Performance Site Coordinator  
Le Bonheur Community Outreach  
Community HIV Network  
2400 Poplar Avenue  
Memphis, TN 38111

## **Contributors**

The development of the 2009 Comprehensive Plan was the result of countless hours of work by a number of people living with HIV/AIDS, community volunteers and service providers. Over 80 individuals, including 55 PLWHA provided input especially for this Comprehensive Plan in special community forums held throughout the TGA. Both Ryan White and Non Ryan White Service providers have met together with renewed efforts to coordinate activities and offer insight into the current and ideal HIV service delivery system. A very special thanks is given to the Memphis TGA Planning Council, in particular the Priorities and Comprehensive Planning Committee, which serves as the work group for the plan and has the responsibility of setting goals and objectives that are reflective of a system that strives for quality care for all PLWHA in the TGA. The Memphis TGA Part A Program Office staff have also provided unyielding support in the actual composition and submission of the document to HRSA in coordination with the Council.

The development of the entire Comprehensive Plan and all of the processes associated with it would have not been possible without the tremendous support of Emily Gantz McKay and Harold Phillips, who have served as consultants for the Memphis TGA and the Planning Council since its beginning in 2008. They have provide countless hours of time and resources to guide the Council in the efforts to produce a document that the group developed on its own and can be used as a living map for the future of the Memphis Part A program.

Every contributor, whether listed below or not, has been essential to this process, and their input is greatly appreciated.

### *Priorities and Comprehensive Planning Committee*

Dr. Kathy Knapp, Committee Chair

Robert Adams

Alona Burnett

Tiffany Ford

Kathy Fox

Chuck Parr

Jimmie Samuels

Jeanece Seals

Robert Wilkins

Kimberly Newsom

Theresa Williams

*Memphis TGA Planning Council Members and Alternates (as of December 10, 2008)*

Edward Gardner, Co-Chair

David Case

James Sdoia, Co-Chair

Dr. David Collier

Alona Burnett, Secretary

Tiffany Ford

Robert Adams

Katherine Fox

Linda Barnes

John Gilmore

Becky Bayless

Joseph Girouard

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Craig Johnson

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Mary Jones

Dwight Bowen

James Kilderry

Arletta Braden

Dr. Katherine Knapp

Anita Bradley

Curtis Lopez

Ronald Neal

Tarsha Taylor

Kimberly Newsom

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Charles Parr

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Jamie Russell

Robert Wilkins

Jimmie Samuels

Andrea Williams

James Sanderson

David Williams

Jeanee Seals

Theresa Williams

Christine Sinnock

Toni Woodson

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Shanell McGoy

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Sylvia Hobbs

Dorcas Young

Cynthia Lawrence

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Dottie Jones

Lisa Krull

Darrell Lowe

Mary-Knox Lanier

Cathy Marcincko

Dr. Tom McGowan

# **Introduction**

One of the central focuses of the Ryan White HIV/AIDS Program is the use of comprehensive planning in the development of a system of care within the Memphis Transitional Grant Area (TGA). While the Planning Council must set service and resource allocation priorities each grant year, the Comprehensive Plan goes beyond this annual process and serves as a “roadmap” to ensuring a system of quality care over a longer period of time.

The key focus of comprehensive planning is to strengthen the continuum of care to address disparities and bring people into care. The Memphis TGA has developed its own Comprehensive Plan while paying careful attention to keep in line with the following HRSA expectations:

1. Ensures the availability and quality of all core medical services within the EMA/TGA (13 core medical services listed in the Ryan White HIV/AIDS program legislation);
2. Eliminates disparities in access to core medical services and support services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities;
3. Specifies strategies for identifying individuals who know their HIV status but, are not in care, informing them about available treatment and services, and assisting them in the use of those services;
4. Includes a discussion of clinical quality measures;
5. Includes strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system;
6. Provides goals, objectives, timelines, and appropriate allocation of funds (as determined by the needs assessment);
7. Includes strategies to coordinate the provision of service programs for HIV prevention, including outreach and early intervention services; and,
8. Includes strategies for the prevention and treatment of substance abuse.

It is of great importance to recognize that in light of the rapidly changing environment of HIV services delivery and funding, that this Comprehensive Plan and any other planning is a dynamic process. This fact is of greater magnitude as the Ryan White Treatment Modernization Act of 2006 is positioned to sunset in 2009, and the potential for new

directives and mandates is high. For this reason, the Memphis TGA Comprehensive Plan is one that will continually reviewed and updated to reflect any shifts in focus as they relate to the development of a high quality continuum of care.

# **Executive Summary**

The 2009 Comprehensive HIV Services Plan has been developed as a guide for the Planning Council and other HIV service planners and providers in the Memphis TGA region in planning and service decisions over the next three years. The Plan strives to set goals that will result in an improved, more efficient and effective HIV service delivery system that is highly collaborative and well coordinated among all stakeholders. This Plan outlines the following vision for the HIV service delivery system:

*The Memphis TGA is committed to the development of an ideal continuum of care for HIV services that ensures a flexible system with open access to all persons who need it, has multiple points of entry across both the geographic region and service categories, and includes a network of well qualified, trained providers to best meet the needs of those persons both out of care and in care within entire TGA. This system will be distinguished by strong communication, coordination and collaboration between funders, providers, and clients in efforts to best maximize resources for provision of client centered services.*

In order to move towards this vision, all stakeholders must familiarize themselves with the state of the epidemic in the TGA, characteristics of those living with HIV/AIDS, needs of PLWHA, barriers to services, and the availability of resources. This Comprehensive Plan outlines all of these points, and provides goals and objectives that take all related issues into consideration.

This region was first awarded Part A funds with the Ryan White Treatment Modernization Act of 2006, and the development of a local Comprehensive Plan for direct submission to HRSA was mandated for the first time for this region. The goals set forth in this plan directly reflect the expectations that HRSA has of all Grantees in the development of the Comprehensive Plan. The six goals of the Plan are as follows:

**GOAL #1: Ensure the availability and quality of all core medical services within the Memphis TGA.**

**GOAL #2: Eliminate disparities in access to core medical services and support services among disproportionately affected sub-populations and historically underserved communities.**

**GOAL #3: Specify strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in the use of those services.**

**GOAL #4: Include strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system.**

**GOAL #5: Include strategies to coordinate the provision of services for HIV prevention, including outreach and early intervention services.**

**GOAL #6: Create a system that reflects strategies for the provision and treatment of Substance Abuse and Mental Health services.**

The Priorities and Comprehensive Planning Committee of the Planning Council developed objectives and action steps to attain these goals based on information gathered from sources including the 2008 Needs Assessment, Community Forums, HIV resource and funding inventory, and provider data reports. In addition to these goals and objectives, the Comprehensive Plan includes information about how the plan will be monitored and evaluated for effectiveness. Additionally, there is discussion present about the Plan's connection to the 2009 HRSA mandates for collection of client level data, as well as the association of the plan to the Quality Management Plan for the TGA.

# SECTION I:

WHERE ARE WE NOW?



## Chapter 1: Description of the Part A Program

In December 2006, the Memphis Metropolitan Area was determined to be eligible for funds as a Transitional Grant Area (TGA) under the Ryan White Treatment and Modernization Act of 2006. The Memphis TGA covers eight counties over a three state region. The City of Memphis, the urban hub of the region, is located in Shelby County, Tennessee. The remaining counties in the TGA include: Tipton and Fayette counties in Tennessee; Desoto, Marshall, Tate and Tunica counties in Mississippi; and Crittenden County in Arkansas.



In April and August 2007, Shelby County Government was awarded a total of approximately \$5.5 million in both Part A and Minority AIDS Initiative funds from the Federal Health Resources Services Administration (HRSA). These Part A and MAI funds were made available for the first time in order to provide medical and support service to low income, uninsured or underinsured people living with and those affected by HIV/AIDS in this community.

Ryan White Part A services by definition are categorized into two types, core medical services and medical support services. The legislation requires that Grantees of Part A funds spend at least 75% of their awarded funds in services categorized as Core Medical, and no more than 25% on Support Services (less 10% Administrative Costs and 5% Quality Management funds). Eligible Ryan White services include the following:

### **Core Medical Services**

- Outpatient and Ambulatory Health Services
- AIDS Drug Assistance Program (ADAP)
- AIDS Pharmaceutical Assistance (local)
- Early Intervention Services
- Oral Health Care
- Health Insurance Premium and Cost Sharing Assistance
- Home Health Care
- Medical Nutrition Therapy
- Hospice Services
- Home and Community Based Health Services
- Mental Health Services
- Substance Abuse Outpatient Services
- Medical Case Management (including Treatment Adherence Services)

### **Support Services**

- Case Management (Non-medical)
- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation
- Psychosocial Support Services
- Referral for Health Care/Supportive Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Residential Services
- Treatment Adherence Counseling

## Chapter 2: Epidemiological Profile

In 2007, with a population of 1,280,553 people, the Memphis Metropolitan Statistical Area (MSA) ranked as the 41st largest MSA in the nation and as the second largest MSA in Tennessee. The population of the MSA has grown by 6.25 percent since 2000, and if current demographic trends continue, within a few years, it is expected to be the first major MSA in the nation to have a majority African American population (*Memphis Commercial Appeal*, Metro going majority African American, 12/31/06). The MSA is characterized by a high rate of poverty (20.4 percent, compared to a national rate of 13 percent). However, poverty among African Americans, estimated at 31.1 percent by the 2007 Census, is significantly higher than in the general population, and is directly related to lower education levels, underemployment, and low wage service jobs. The poverty level within the MSA has grown by approximately two percentage points since 2005. The table below gives a demographic snapshot of the region by its eight counties.

**Memphis TGA 2007 Demographic Profile (Table 1)**

County/State	2005 or 2007 * Est. Population	% African American	% White	% Other	Below Federal Poverty Line
Shelby County, TN*	889,748	50.9%	43.5%	5.6%	20.4%
Tipton County, TN	57,380	19.1%	79.1%	1.8%	12.9%
Fayette County, TN	36,102	28.2%	69.6%	2.2%	12.9%
Desoto County, MS	148,699	21.5%	76.3%	2.2%	7.5%
Tunica County, MS	10,419	73.4%	25.8%	0.8%	23.9%
Marshall County, MS	35,853	49.6%	49.6%	0.8%	19.9%
Tate County, MS	26,723	30.5%	68.8%	0.7%	15.6%
Crittenden County, AR	52,083	49.4%	49.2%	1.4%	21.9%
<b>TGA Counties (MSA)</b>	<b>1,280,553</b>	<b>45.1%</b>	<b>50.4%</b>	<b>4.5%</b>	<b>18.8%</b>

Source: \*U.S. Census estimates for MSA, Shelby and DeSoto Counties from 2007 American Community Survey; all others are 2005 U.S. Census County Quick Facts.

### *Epidemiology for the Eight-County TGA*

Data from the three states' departments of health were combined to create the figures for this section. The eight counties included in the Memphis TGA make up approximately 11

percent of the combined populations of Tennessee, Mississippi and Arkansas, but have approximately 22 percent of their PLWH/A. According to the epidemiological data reported for the Memphis TGA for the last two years, the total number of people living with HIV/AIDS (PLWH/A) increased from 6,218 in 2006 to **6,359** in 2007, or by 141 PLWH/A (2.26%). Of the total number of PLWH/A, 3,552 (55.8%) were reported to be living with HIV (not AIDS) and 2,807 (44.2%) were living with AIDS. The number of new AIDS diagnoses for the past two years (2006-2007) was 504, a 25 percent decline from the 675 reported for 2005-2006. The two-year AIDS incidence for 2006-2007, AIDS prevalence and HIV (not AIDS) prevalence by race, gender age and exposure category are provided in Attachment 3. Of the 504 new AIDS cases diagnosed in 2006-2007, 89.1 percent were African American, 60.1 percent were men, 67.6 percent were in the 20-44 year-old age category and 33.1 percent were Men who have Sex with Men (MSM) Of the 2,772 reported living cases of AIDS, 77.1 percent were African American, 74 percent were men and 47.5 percent were MSM. The number of diagnosed people living with HIV (not AIDS) was 3,552, and of these cases, 79.4 percent were African American, 65.1 percent were men, 68.4 percent were in the 20-44 year-old age category, and 37.6 percent were MSM. The percentage of AIDS and HIV disease among these groups has not changed significantly since 2005/2006 with two exceptions: the two-year AIDS incidence among women increased by seven percent (with a concurrent decline of seven percent for men), and there was a four percent increase in two-year AIDS incidence among African Americans.

#### *Epidemiology for Three Counties in Tennessee:*

As of December 31, 2007, there were 5,789 PLWH/A in Shelby, Fayette and Tipton Counties, a figure which represents an increase of 108 additional living cases of HIV/AIDS since December 31, 2006 (Tennessee Department of Health, hereafter TDH). This is a 1.8 percent increase, which is significantly less than the reported 7.9 percent increase in Mississippi counties and the reported 3.6 percent increase in Crittenden County Arkansas for the same year. (This may be due to errors in reporting the previous or current year, or differences in methodology.) Of the total PLWH/A reported for 2007, there were 2,581 (45%) people living with AIDS, and 3,208 were people living with HIV (not AIDS). In the two-year period 2006/2007, there were 462 new AIDS cases in the three Tennessee counties of the Memphis TGA. After increasing dramatically in 2005-2006 to 642 cases, the number of new AIDS cases in 2006-2007 has decreased to levels below that recorded in 2004. This decline in new AIDS cases is seen both among men and women, African Americans and whites.

#### *Epidemiology for Four Counties in Mississippi:*

At the end of 2007, there were 341 PLWH/A reported in the four northwest Mississippi counties of the TGA, including DeSoto (203), Marshall (63), Tunica (51) and Tate (24) counties (Mississippi Dept. of Health, Bureau of STD/HIV, or MDH). This figure represented a 7.9 percent increase in PLWH/A over the previous year. Of this total number, 134 (39%) were people living with AIDS only. During 2006 and 2007, there were 18 new AIDS cases

reported in the four counties, or 3.6 percent of all AIDS cases in the TGA compared to 2.8 percent last year.

*Epidemiology for Crittenden County, Arkansas:*

There were 229 PLWH/A reported in Crittenden County at the end of 2007, compared to 221 PLWH/A at the end of 2006, an increase of 3.6 percent (Arkansas Dept. of Health). In Crittenden County, 14 new AIDS cases were diagnosed during 2006 and 2007, the same as the previous two years. The reported number of people living with AIDS as of December 31, 2007, was 92 and the number of people living with HIV (non-AIDS) was 137. According to the *2006 Arkansas Statewide Coordinated Statement of Need*, the most recently available statewide assessment, Crittenden County has the highest HIV/AIDS prevalence of any county in the state.

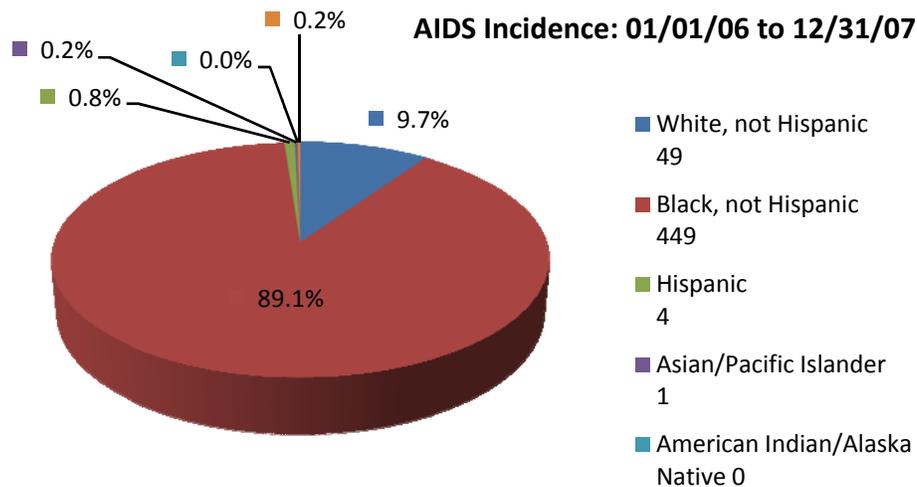
All of the above information is summarized in the table (Table 2) below:

Cases in TGA counties (8) by State	New AIDS Cases 2006 & 2007	AIDS Prevalence	HIV (not AIDS) Prevalence	Total HIV/AIDS Prevalence	% AIDS of HIV/AIDS Prevalence	% of TGA's HIV/AIDS Prevalence
Tennessee (3)	472	2,581	3,208	5,789	44.6%	91.0%
Mississippi (4)	18	134	207	341	39.3%	5.4%
Arkansas (1)	14	92	137	229	40.1%	3.6%
<b>Total TGA</b>	<b>504</b>	<b>2,807</b>	<b>3,552</b>	<b>6,359</b>		

**Memphis TGA Total AIDS Incidence, AIDS Prevalence, and HIV (Not AIDS) Prevalence by Demographic and Exposure Risk Category**

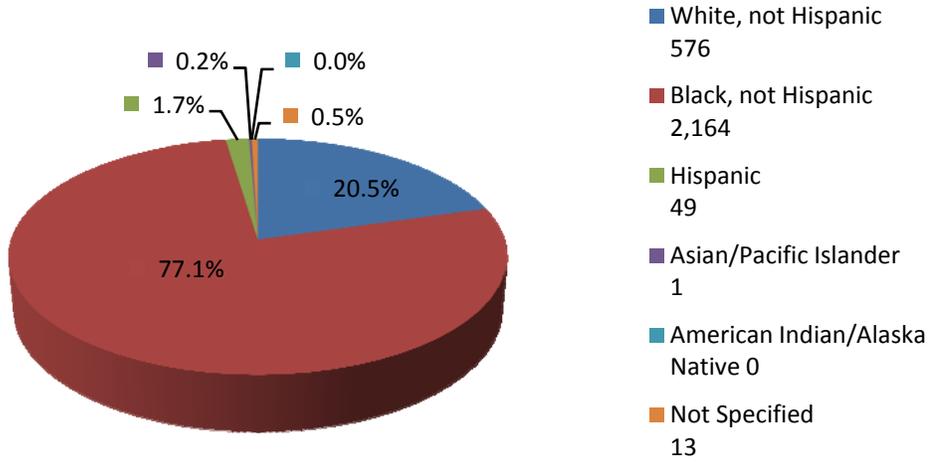
*By Race/Ethnicity*

**Table 3**



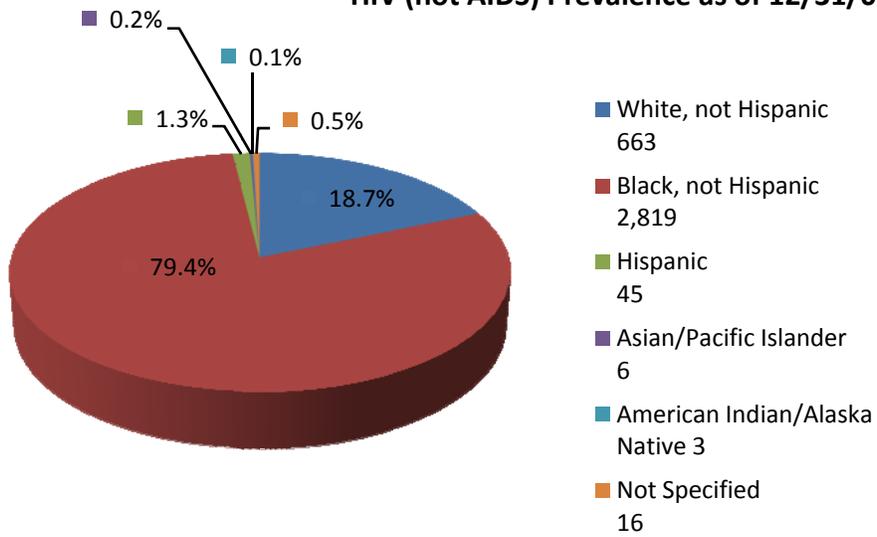
**Table 4**

**AIDS Prevalence as of 12/31/07**



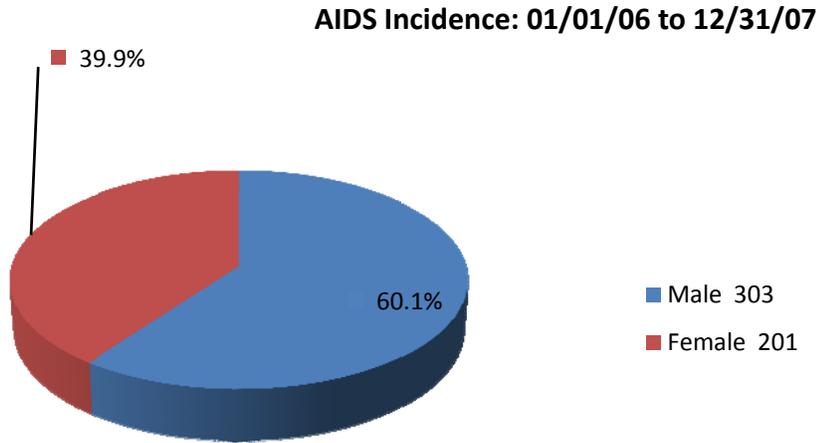
**Table 5**

**HIV (not AIDS) Prevalence as of 12/31/07**

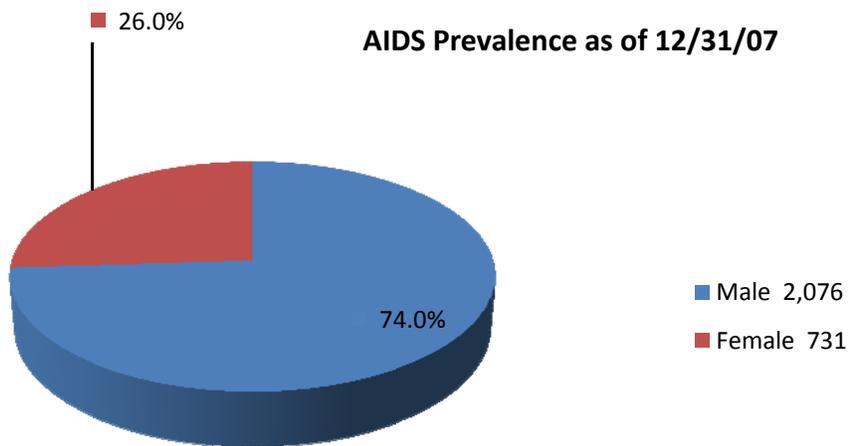


*By Gender*

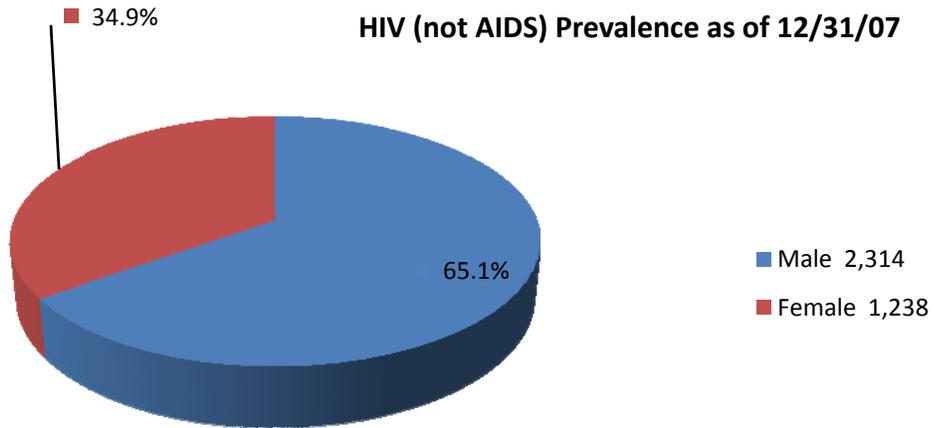
**Table 6**



**Table 7**



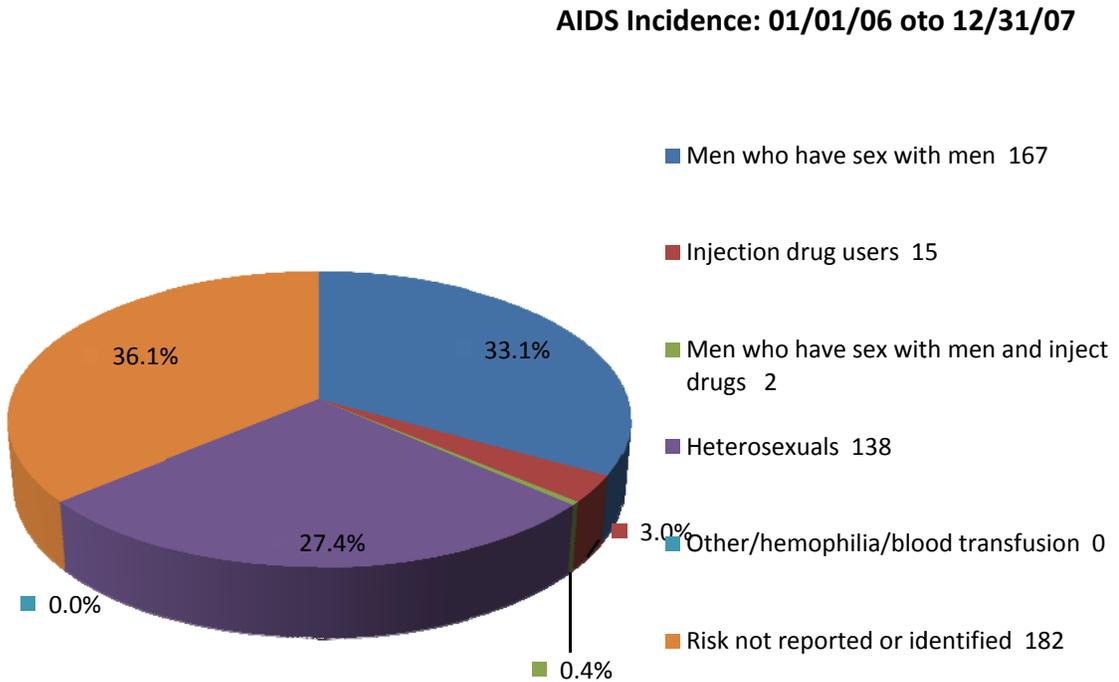
**Table 8**



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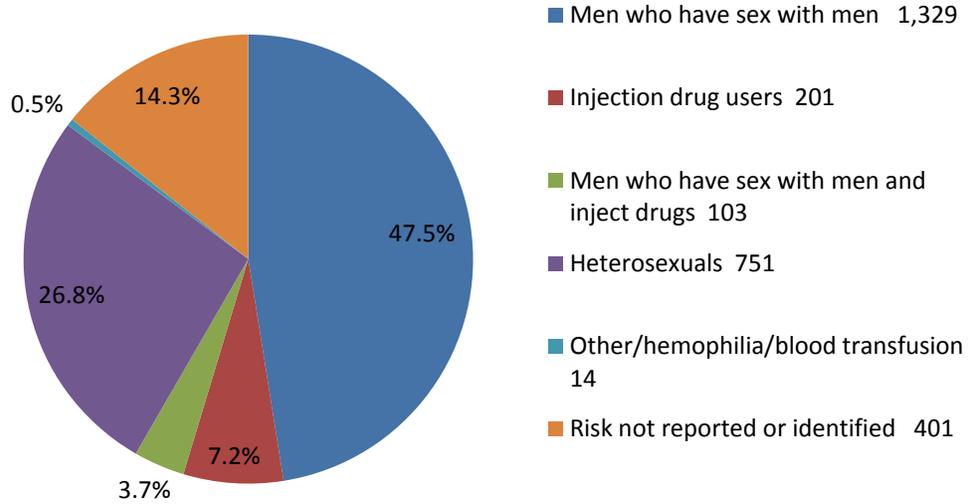
*By Exposure/Risk Category*

**Table 9**



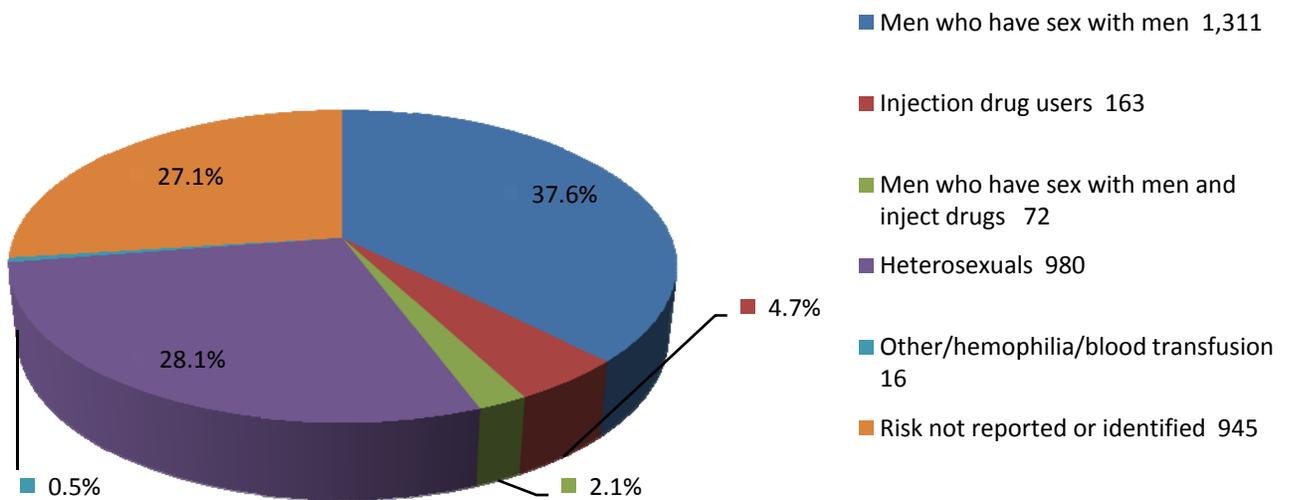
**Table 10**

**AIDS Prevalence as of 12/31/07**



**Table 11**

**HIV (not AIDS) Prevalence as of 12/31/07**



### *Disproportionate impact on certain populations*

In this section, the disproportionate impact of HIV/AIDS on certain populations is discussed for the Memphis TGA as a whole. The populations which show a disproportionate impact relative to the general population in 2007 are:

- *Non-Hispanic African Americans*
- *Men who have Sex with Men (primarily African American)*
- *African American Women*
- *Homeless Populations*
- *Incarcerated Populations (male and female)*

*Non-Hispanic African Americans:* Data presented in Table 3 show that Non-Hispanic African Americans in the Memphis TGA are disproportionately affected by the HIV epidemic. In 2007, non-Hispanic African Americans represented 78.4 percent of PLWH/A while comprising 45 percent of the TGA population. The number of non-Hispanic African Americans living with HIV/AIDS in the Memphis TGA in 2007, 4,983, was more than four times the number of non-Hispanic whites (1,239). In 2007, there were 449 new AIDS cases diagnosed among African Americans in the TGA, equivalent to 89.1 percent of all new cases. This disparity is less pronounced in the four north Mississippi counties, where 57 percent of the reported 341 PLWH/A, and 61 percent of the reported new AIDS cases for 2006-2007 were African Americans. However, the disparity is much greater in Tunica County, Mississippi, where 90 percent of all HIV/AIDS cases are among African Americans. Likewise, in Crittenden County, Arkansas, 82 percent of the reported 229 PLWH/A, and 93 percent of the reported new AIDS cases in 2006-2007 were African Americans.

*Men Who Have Sex With Men (primarily African American):* A total of 1,329 MSM were reported to be living with AIDS and 1,311 MSM were reported to have HIV (not AIDS) in the Memphis TGA in 2007, making it the single largest exposure group for PLWH/A (42%). MSM/Intravenous Drug Users (IDU) represented less than 2.5 percent of PLWH/A, and was the second smallest reported risk group after other/hemophilia/blood transfusion. For the two years 2006-2007, a total of 167 new AIDS cases were reported in the Memphis TGA for MSM, accounting for 33.1 percent of new AIDS diagnoses, while “risk not reported” became the largest reported exposure category with 34 percent. (Heterosexual contact was third largest category, at 27.4 percent of all reported cases.) Just as the majority of HIV/AIDS cases in the TGA are among African Americans, the majority of affected MSM in the TGA are African American. Although data by race for MSM were not available for the TGA, 2006 data for Memphis/Shelby County showed that 90.9 percent of all MSM were non-Hispanic African Americans (TDH, 2007). In 2007, the MSM exposure category reported for the four north Mississippi counties was 37 percent of all PLWH/A, and in Crittenden County, Arkansas, MSM were reported to be 30 percent of all PLWH/A. For AIDS incidence 2006-2007, this exposure category represented 16.6 percent of AIDS cases in the four Mississippi TGA counties and was 35.7 percent of cases in Crittenden County.

*African American Women:* HIV/AIDS reported prevalence for women in the TGA in 2007 was 1,969 cases, or 30.9 percent of all PLWH/A. Two-year data for 2006-2007 show that

women were 39.9 percent of all new AIDS cases, up from 32.9% the previous two years. There was a total decrease in AIDS cases among women for the 2006-2007 period from the previous two years (222 to 201 cases), but for men there was a much sharper decrease of 453 to 303 cases. Although the percentage of these HIV/AIDS cases that were among African American women is not available for the entire TGA, it is probably greater than 90 percent of cases among women based on available 2006 race/gender data from Shelby County. Overall, within the Memphis TGA, African American women are the second most HIV-affected population after African American males.

*Homeless Population:* In 2006, 7,607 people received services from homeless service providers in Memphis and Shelby County. The January 28, 2007 annual point-in-time street and shelter homeless count identified 1,841 persons in homeless facilities or on the street. This number included 88 individuals being housed by HIV providers, and five other unsheltered PLWH/A, giving a total of 93 PLWH/A, equal to approximately five percent of the total homeless persons count. (City of Memphis Consolidated Plan FY 2008 Action Plan, 17). Within the 2007 Ryan White Program Data Reports (RDR), medical providers in the TGA reported that 5.7 percent of PLWH/A consumers receiving care lacked permanent housing, while social service providers reported on average that 13.8 percent of their PLWH/A consumers were non-permanently housed. These figures are fairly consistent with those reported the previous year by providers. Findings in the *2008 Needs Assessment* also show the potential for unstable housing among PLWH/A, one being that 28 percent of respondents had moved two or more times from their place of residence in the last 12 months. Further, 39 percent of respondents reported that their income was \$500 or less per month—which would also put them at risk for homelessness. The consumer survey conducted as part of the *2008 Needs Assessment* found that PLWH/A were living in a variety of potentially unstable or temporary quarters, including halfway or treatment programs (2%), housing for PLWH/A (4%), shelters (3%) and church apartments (1%). Many PLWH/A were living with friends (9%), family (17%) and other (5%). Based on the 2007 point-in-time homeless count, utilization of homeless shelters by PLWH/A, the consumer survey and provider reports, it is estimated that approximately 8.5 percent or 540 PLWH/A were homeless at some point during 2007.

*Incarcerated Populations:* According to the Shelby County Sheriff's Office, in calendar year 2007, the Shelby County Jail had an average daily population of 2,690 inmates of which 91 percent were male. The jail logged 16,471 bookings in 2007, an average of 45 bookings per day. The jail is a "revolving door" for repeat offenders. In 2007, 85 percent of those booked had had a prior incarceration and 55 percent had had six or more prior incarcerations. (Shelby County Sheriff's Office August 2007 Jail Report). In 2007, 7,946 male detainees, or 20 percent of those booked, were tested for HIV by MSCHD through a CDC-funded program. This testing effort resulted in identification of 141 HIV-positive men, roughly two percent of those tested. At the Jail East, 5,258 female detainees or 52 percent were tested, resulting in identifying 103 HIV positive women, two percent of those tested. This is a prevalence rate that is three to four times higher than in the general population. Through a separate rapid HIV testing program funded by the Tennessee Department of Health from April 1 to August 30, 2008, 89 HIV positive cases or 2.1 percent of males tested at the Shelby County

Criminal Justice Center, and 66 cases or 2.4 percent of females tested at the Jail East were HIV positive. According to the Shelby County Jail Report Card, in 2007, a total of 74 inmates received HIV medications and 409 were on TB medications. A Health Investigator is assigned to any inmate with positive HIV test results, and meets with the inmate in the medical unit if they are still incarcerated, or conducts a field investigation if they have been released. The Health Investigator informs the individual of the importance of obtaining medical care, and provides a referral to an HIV Care Manager at MSCHD. HIV-positive detainees in jail for an extended stay receive care from providers at the Regional Medical Center's Adult Special Care Clinic (ASCC). The cost of care for detainees could not be determined since this is provided under a contract with Shelby County and ASCC does not track the cost of care. With respect to co-morbidities, there is no available information. The Jail Report Card indicated that 334 inmates received tuberculosis medications in 2006, which increased to 409 in 2007. In 2007, 8,027 (20.5%) men tested for syphilis of which 3.6% (286) were positive for syphilis. In 2007, 5,321 (52.7%) females tested for syphilis of which 9.4% (500) were positive for syphilis (MSCHD, 2007). Of those who tested positive, approximately 3.6 percent were confirmed as "active" positive cases. A significant number of inmates also have diabetes and other chronic conditions. The majority of detainees are poor, unemployed, uneducated, and uninsured, and many have alcohol and drug, mental health or other chronic health problems that make it more difficult and costly to provide HIV services. Many female inmates are sex workers and/or drug addicts. Cultural barriers due to race, poverty, and the fact that most of these individuals mistrust and/or have chosen to live "outside the system" make outreach and treatment for this population particularly difficult. Inmates also often give false names, permanent addresses, or contact information which makes it challenging to find them once they are released.

### *Impact of Co-Morbidities on HIV/AIDS Epidemic*

The impact of the co-morbidities of HIV and other diseases cannot be overstated in the context of the Memphis TGA. One local HIV provider estimated that the annual cost for treating HIV over the course of one year with few complications, was \$18,202. This amount included vaccines, laboratory costs and doctor fees totaling \$1,793, and HART medications (Truvada and Sustiva) totaling \$16,409. The Ryan White Part A 2007 Service Utilization Report reported an average cost per client of \$1,407 for outpatient health services, \$2,969 for ADAP treatments, and \$177 for AIDS Pharmaceutical assistance, totaling \$4,553. However, this does not account for patients partly covered by or transferred to other programs. Ultimately, there is no such thing as an "average" HIV patient, and likewise, costs for treating co-morbidities are difficult to track and compare, and may have little meaning when applied individually.

### TGA Data on Co-Morbidities for STDs:

According to the Centers for Disease Control (CDC), in both 2005 and 2006, the Memphis TGA ranked first in the country among the 50 largest Metropolitan Statistical Areas (MSAs)

for its incidence rates for both Chlamydia and Gonorrhea, and was second in the nation for its rate of primary and secondary syphilis.(2007 CDC data was unavailable.) The numbers of reported cases for men and women, and comparative rates for the three states and average rates for all other MSAs for these diseases are shown in the following table.

A comparison of 2005 and 2006 rates per 100,000 population as reported by the CDC, shows that Chlamydia increased by seven percent, Gonorrhea by 22.5 percent and Syphilis by 4.5 percent in the Memphis TGA. The average rate for these three STDs declined for other MSAs in the United States. In 2006, Shelby County had 53 percent of all reported syphilis cases in Tennessee; statewide, 71 percent of all cases were among African Americans (Source: NETSS Reporting System, TDH). High rates of STDs are a concern because of the epidemiologic synergy that is believed to exist between HIV/AIDS and other sexually-transmitted diseases (STDs). The presence of other STDs is believed by some experts to increase the likelihood of both transmitting and acquiring HIV (Fleming, Wasserheit, 1999). Within the Memphis TGA, factors such as poverty, mistrust of the health system and providers, and low educational levels present additional barriers to outreach, treatment and prevention of STDs. STDs are also more likely to affect difficult-to-reach populations such as the homeless, mentally ill, and those who lack access to medical care. It is the combined impact of these extraordinarily high rates of STDs that adds a cost burden and increases the risk of HIV infection within the community. A discussion of each disease, prevalence among subpopulations, challenges and estimated costs of treatment follows.

**Syphilis:** The CDC reports that within the past five years, the syphilis rate in the United States has been increasing among men, MSM and African American women. Although racial disparities in syphilis are narrowing, they continue to persist. Rates among women have also increased, mainly among African American and Hispanic women. Nationally, the greatest increases in syphilis have occurred among MSM, who are also characterized by high rates of HIV co-infection and high-risk sexual behavior (<http://www.cdc.gov/std/stats/syphilis.htm>). Risk factors for syphilis and HIV are the same (Fleming, 1999 and Vernazz, 1999). Thus, the high incidence and prevalence of syphilis infection among African American men, MSM and African American women in the Memphis TGA establishes epidemiological conditions where the risks of HIV infection and transmission are magnified within an already vulnerable population. It also increases the chance that HIV will continue to affect greater numbers of women and young people unless effective early intervention strategies can be implemented.

There were 82 co-morbid cases of HIV/syphilis reported for the TGA counties to the CDC in 2007. (See Attachment 4). According to 2007 RDR reports, Ryan White medical providers in the Memphis TGA treated 74 cases of co-morbid syphilis among PLWH/A. Sex workers are particularly at high risk for STDs. In 2007, at the Shelby County Jail East, the detention center for women, 5,321 female inmates were tested by MSCHD for syphilis. Of these, 500 or 8.6 percent had positive results, a percentage that was similar to that of the previous year. Of these, approximately 3.6% were confirmed as having active cases. Areas in the TGA which have large numbers of sex workers include sections of Memphis, West Memphis, AR

(large concentration of truck stops), and Tunica, MS (casino gambling). In 2006, Crittenden County was reported to have the highest number of STD cases among the 17 counties in the northeast region of Arkansas in 2006. This included one case of congenital syphilis and eight cases of early syphilis (Source: Arkansas Dept. of Health). A CDC study published in June 2007 emphasized the need to carefully monitor HIV positive individuals who test positive for syphilis. This study, which looked at medical records of male PLWH/A in four cities, found that among HIV-positive MSM with early syphilis, the estimated risk for having symptomatic early neurosyphilis was 1.7 percent, and the risk for having early neurosyphilis with persistent symptoms six months after treatment was 0.5 percent. Most of the patients were admitted to a hospital, received 10 to 14 days of treatment with IV penicillin, and likely had numerous office visits, expenses, and loss of work time. At six-month follow-up, 30 percent of patients had persistence of their principal neurosyphilis symptom (6). (Source: CDC, *Symptomatic Early Neurosyphilis Among HIV-Positive Men Who Have Sex With Men, Four Cities, United State, June 2002-June 2004*, MMWH Weekly, 56(25);625-628 retrieved 9/21/08, [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5625a1.htm?s\\_cid=mm5625a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5625a1.htm?s_cid=mm5625a1_e))

Because early syphilis is easily treatable with antibiotics, the cost of care is frequently discounted. A positive test can simply mean that the individual has been previously exposed to syphilis and therefore results must be confirmed to determine active infections. Those who are treated should be re-tested and it can take up to a year after treatment for tests to be negative. However, in HIV/syphilis co-infection, epidemiologic follow-up can be more difficult and costly. Patients with HIV may have atypical results, resulting in the need for repeated testing and follow-up. Also, when a PLWH/A is allergic to penicillin, the treatment is more time-consuming and costly. Generally, treatment for early stage (primary or secondary) syphilis is less expensive than treatment for later stage disease. Because of the larger number of early-stage syphilis cases identified in Shelby County, the estimate for treating syphilis/HIV co-infection is \$2,000.

**Chlamydia:** In 2007, there were only 36 co-morbid cases of HIV/Chlamydia reported in the TGA, which is most certainly under-reported as there were 8,651 cases in the general population (See Attachment 4). In 2006, the Memphis TGA had the highest rate of Chlamydia infection of any major MSA in the county according to the CDC, with 10,224 reported cases. The Memphis TGA had a rate of 810.8 cases per 100,000 population, compared to a rate of 424.6 per 100,000 for the state of Tennessee and an average rate of 347.8 per 100,000 for major MSAs nationally. The rate for the TGA was closest to that of the state of Mississippi, which was 650/100,000. However, the Mississippi rate fell by 11 percent between 2005 and 2006, while the rate in the TGA increased by seven percent. Chlamydia is believed to increase the risk of acquiring HIV infection by two to five times. It can be treated with azithromycin (an antibiotic), which for one month's treatment costs \$90. HIV patients should be screened annually for both Chlamydia and Gonorrhea, which costs approximately \$180 (both diseases are screened with the same test). Both sexual partners should be treated if possible, otherwise re-infection may occur. Many of the same cultural and medical barriers exist in the treatment of Chlamydia as with other STDs, but are compounded by the fact that the infection is asymptomatic and unlikely to be recognized unless testing occurs. (Cost data source: Christ Community Health Services.)

**Gonorrhea:** In 2007, there were 42 cases of co-morbid gonorrhea and HIV compared to 3,500 cases in the general population for the three-state TGA (See Attachment 4.). As with Chlamydia, the reported number of co-morbid cases seems low. The previous year, with a 2006 overall case rate of 370 per 100,000, the Memphis TGA ranked first nationally in the rate of gonorrhea cases among all the major MSAs in the county according to the CDC. The gonorrhea rate in the Memphis TGA was three times the average national rate for major metropolitan areas. In 2006, there were 4,207 cases of gonorrhea reported in Shelby, Tipton and Fayette counties, with 98 percent of those cases in Shelby County. Rates appear to have declined in 2007 by approximately 17 percent following a 26 percent increase from 2005. Overall, statewide, cases of gonorrhea have increased since 2003. A majority of cases in Tennessee are found among African Americans, as is true with Chlamydia and syphilis. The CDC has estimated the average total cost of care for uncomplicated gonorrhea to be \$156 per case. One Memphis medical provider gave the figure of \$23 for treating Gonorrhea with azithromycin in an HIV patient without any complications. However, the increased resistance to fluoroquinolone antibiotics in some PLWH/A since 2004 has made it necessary to use more expensive treatments (usually ceftriaxone, an injectable antibiotic), particularly in MSM who more often have the resistant variety. A CDC monitoring project has shown resistance in men who have sex with men (MSM), to be nearly eight times higher than among heterosexuals (29% vs. 3.8%). Thus, in April 2004, CDC recommended that fluoroquinolones no longer be used as treatment for gonorrhea among MSM.

**Hepatitis C (HCV)** is a lifelong infection for the vast majority who acquires it, and may take decades to cause serious liver damage if it progresses to cirrhosis or liver cancer. HCV is the leading cause of liver transplantation in the U.S. The CDC reports that one-quarter of HIV-infected persons are also infected with HCV and an estimated 50 to 90 percent of persons infected with HIV through Injection Drug Use (IDU) are also infected with HCV ([www.cdc.gov/hiv/pubs/facts/HIVHCV\\_Coinfection.htm](http://www.cdc.gov/hiv/pubs/facts/HIVHCV_Coinfection.htm)). HCV is transmissible through bloodborne exposure and studies funded by the National Institute of Drug Abuse (NIDA) have found that, within three years of beginning injection drug use, most IDUs contract HCV and that up to 90 percent of HIV-infected IDUs may also be infected with HCV. HCV and HIV co-infection results in an accelerated progression to end-stage liver disease when compared with individuals infected with HCV alone. While treatment of co-occurring HIV and HCV presents challenges, treatment during the acute phase of HCV infection (within 6 to 12 months of detection) can be effective in controlling the virus. (Source: <http://www.nida.nih.gov/Infofacts/drugabuse.html>) In people who have HIV and HCV costs per patient per year for those under treatment range from \$12,000 to \$25,000, unless liver transplantation is required, which can cost in excess of \$250,000 (Nerenberg, R, et al. Hepatitis C Virus in Corrections: Frontline or Backwater? *HEPP News*, April 2002). Given the extra expenses of medication adjustments and monitoring for those co-infected with HIV and HCV, a conservative figure of \$20,000 per case per year is estimated. The federal government does not provide any funds to state and local health departments specifically for treating HCV, but individuals who are co-infected with HIV and hepatitis can be treated

under the CARE Act, as long as they meet the eligibility requirements, which vary from state to state. (Source: NASTAD, *Viral Hepatitis and HIV/AIDS Integration: A Resource Guide for HIV/AIDS Programs*, p. 208). Fortunately, people who are HIV-positive can prevent hepatitis A and B by getting vaccinated.

According to the 2007 Ryan White Data Reports (RDR), injection drug users (IDU) in the Memphis TGA numbered 72, and were 2.4 percent of the HIV/AIDS patients receiving care from Ryan White providers. According to the TGA epidemiological data, 539 PLWH/A were exposed to HIV through IDU at the end of 2007. Altogether, there were only five cases of reported co-morbid Acute Hepatitis A, B or C and HIV, and 44 cases of Acute Hepatitis in the general population in 2007. However, local providers anecdotally have reported that HBV and HCV are common conditions which affect up to 20 percent of all HIV/AIDS patients, but that because it is not reportable to the state, there are no reliable figures.

**Tuberculosis (TB):** According to the CDC, the Memphis MSA had 83 cases of reported TB in 2007 and 12 cases of co-morbid TB/HIV. In 2006, the Memphis MSA's TB case rate was 9.5 cases per 100,000 population, more than double the 2006 TB case rate for Tennessee and the United States (both of which had a 2006 TB case rate of 4.6 per 100,000). Among metro areas with populations equal to or greater than 500,000, the Memphis MSA ranked eighth in 2006 TB case rates behind cities such as San Jose, San Diego, and San Francisco, CA; Honolulu, and El Paso and McAllen, TX. The five year TB incidence for the Memphis TGA was 493 cases, with 68 reported cases of HIV and TB co-morbidity. (Source: *Reported Tuberculosis in the United States, 2006*, CDC, and Online Tuberculosis Information System (OTIS), National Tuberculosis Surveillance System, United States, 1993-2006. U.S. Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), Division of TB Elimination, CDC WONDER On-line Database, December 2007. Accessed at <http://wonder.cdc.gov/tbv2006.html> on Sep 10, 2008 7:23:01 PM). It is estimated that 10 to 15 million Americans are infected with TB but have no symptoms. Over a lifetime, only 10 percent of people with such latent TB infection and who have normal immune systems will progress to develop active disease. For persons with HIV, however, that risk is closer to 10 percent of identified cases per year, thus, TB screening for PLWH/A is particularly important. Research conducted by the National Institute on Drug Abuse (NIDA) has shown that Intravenous Drug Users have especially high rates of latent TB infection. TB requires special handling in the context of HIV-infection. The treatment cost for uncomplicated disease can be as low as \$2,000 per case. However, treatment of multi-drug resistant TB can easily exceed a cost of \$250,000, and in multiple reviews, a total average cost in excess of \$20,000 is common. Until more exact cost figures can be obtained for treating TB as a co-morbid condition with HIV, MSCHD will use \$2,000 in estimating the cost of treating TB in PLWH/A.

**Renal Disease:** According to the Regional Medical Center's Adult Special Care Clinic (ASCC), which provides HIV medical care to more than 1,800 PLWH/A on an annual basis, renal disease is the largest co-morbidity among its patients. ASCC administrators report that 40 to 50 percent of new and existing patients have renal disease or proteinuria, a condition in which urine contains an abnormal amount of protein. At the dialysis center in

The Regional Medical Center at Memphis (The MED), a reported 15 percent of all patients are HIV-positive. People with diabetes, hypertension, or a family history of this disease are at much higher risk for proteinuria. A 1996 study sponsored by the National Institutes of Health determined that proteinuria is the best predictor of progressive kidney failure in people with type 2 diabetes. African Americans are six times more likely than whites to develop hypertension-related kidney failure, and nationally, they are one-third of the dialysis and transplant population (National Kidney & Urologic Diseases Information Clearinghouse). For those who qualify, Medicare pays 80 percent of all dialysis costs, and private health insurance or state medical assistance pays almost everything else (National Kidney Foundation of East Tennessee). However, the cost of treating HIV patients so that they do not progress to dialysis requires that HIV medications be adjusted to the least renal-toxic regime possible, and this necessitates the services of a nephrologist.

**Number and Percent of Persons Without Insurance Coverage:** The Urban Institute and Kaiser Commission on Medicaid and the Uninsured provide the following uninsured estimates for the general adult population and for adults that fell below 100 percent of Federal Poverty Level (FPL) for Tennessee, Mississippi and Arkansas:

TGA States	Uninsured Adult Population	Uninsured Adults 18-64 w/Incomes <100% FPL
Tennessee	14%	40%
Mississippi	19%	50%
Arkansas	18%	54%

Source: Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements), Kaiser Statehealthfacts.org, <http://www.statehealthfacts.org>

Early release of estimates for The Centers for Disease Control (CDC) 2007 National Health Interview Survey, which includes Tennessee among the 20 largest states, reported an uninsured rate for all age groups of the state's population of 13.8 percent. For 18 to 64 year-olds only, however the rate was 17.3 percent uninsured, with 14.5 percent reported as being on some form of public insurance and 67.1 percent as privately insured. (Source: CDC Web site <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200806.htm#T1>) In 2005, enrollment in Tennessee's state Medicaid program, TennCare, was reduced by 170,000 persons as a result of state budget cuts. This impacted PLWH/A, as well as other citizens. As a result, by 2006, the Adult Special Care Clinic (ASCC) at the Memphis Regional Medical Center saw the percentage of HIV patients with TennCare coverage fall from 55 percent to 34 percent. In 2007, the percentage of PLWH/A covered by TennCare at ASCC was at 36 percent, while 34 percent of patients were uninsured. Overall, Ryan White providers in the Memphis TGA documented 975 persons or 32.7 percent of all patients as without insurance coverage. (Source: 2007 RDRs for Memphis TGA Ryan White providers, patients uninsured). East Arkansas Family Health Center (EAFHC), the Ryan White service provider in Crittenden County, reported in its 2007 RDR that 45 percent of its consumers had Medicare or Medicaid coverage, with 36 percent being uninsured, compared to a statewide estimate of 18 percent uninsured (see table above). According to this medical

provider, it can take up to six months to determine if new clients are Medicare or Medicaid eligible, which creates a gap in funding for services. In North Mississippi, case managers for the four-county area also report that very few HIV clients qualify for state Medicaid benefits. Sacred Heart Southern Missions, a supportive service provider in North Mississippi reported in its 2007 RDR that 12 or 41 percent of its 29 clients had no insurance, while nine (31%) were on Medicaid. In Mississippi, qualifying for Medicaid for adults is more difficult: 16.4 percent of Mississippi Medicaid recipients are adults, while in Tennessee, 25.6 percent and in Arkansas 23.8 percent are adults. (Source: State Medicaid Fact Sheets, <http://www.statehealthfacts.org/mfs>).

According to last year's *2007 Needs Assessment*, the changes in TennCare coverage also created a gap in mental health care. The state imposed new prescription limits, which many mentally ill consumers exceeded. In such cases, mental health medication treatment has been interrupted, undermining consumers' ability to remain adherent to HIV regimens.

**Number and Percent Below 300 Percent Poverty Level:** The Census Bureau's 2007 American Community Survey (ACS) reports 660,769 people living below 300 percent of the federal poverty level in the Memphis TGA. This equates to 53 percent of the population. By comparison, 48 percent of the United States and 64 percent of the population of the City of Memphis live below 300 percent of poverty level. (Source: ACS Table B17002, selected geographies). Based on compiled 2007 RDR reports of HIV medical providers in the Memphis TGA, 91 percent of the PLWH/A are living at or below 300 percent of federal poverty level (FPL). An estimated 70 percent of PLWH/A are at or below 100 percent of the poverty level compared to FPL figures of 18.8 percent for the general population and 26 percent for the City of Memphis. In the *2008 Needs Assessment*, 83 percent of PLWH/A survey respondents had net monthly incomes of \$1,000 or below (p. 39). Census figures show that poverty has increased within Shelby County since 2005. Although the 2007 estimate for persons living below federal poverty level in the Memphis TGA is 18.8 percent, poverty is higher in Shelby (20.1%), Crittenden (21.9%), and in two rural Mississippi counties of Marshall (19.9%) and Tunica (23.9%). Poverty is concentrated in the African American community, and 31.1 percent of all African American TGA households were estimated to be below the poverty level in 2007 compared to 7.7 percent of whites. Poverty has a direct effect on the cost and outcomes of HIV health services simply because people who cannot afford healthcare tend to defer it until their condition becomes acute or chronic, at which point care becomes astronomically more expensive.

**Impact on Service Delivery System of Individuals formerly Federal, State or Local Prisoners:** According to the U. S. Department of Justice, Shelby County is the 11th largest local jail jurisdiction in the country based upon the number of inmates held in local, state and federal correctional institutions. Shelby County housed 5,741 inmates in 2007, which included an average daily population of 2,690 inmates at the Shelby County jail alone. In addition, approximately 400 prisoners are housed by the state, approximately 240 by the federal government, and more than 1,000 at other correctional (including private) facilities

in the county. Nationally, more than 11 percent of African American males, ages 25 to 34, were incarcerated; this figure is likely even higher in Shelby County given the demographics of the community. (Source: Bureau of Justice Statistics, *Prison and Jail Inmates at Midyear 2007*, June 2008.) The large number of incarcerated individuals in Shelby County has a significant impact on the HIV/AIDS service delivery system for several reasons. First, HIV rates among the prison population are three to four times higher than in the general population, and these individuals, once identified, must be cared for in jail, placing a burden on tax payers. Second, released former inmates need to be linked to care in order to ensure their future health as well as to prevent HIV disease from spreading. Most former inmates require intensive case management in order to keep them in care, and this is costly. Third, many former inmates are unemployed, and have limited literacy and have low incomes, and therefore depend on Ryan White services. Many inmates have led impoverished and transient lives, and require costly health, dental, substance abuse and mental health services to stabilize their condition and achieve adherence. The challenges presented in serving former inmates impacts all levels of the service delivery system and increases costs for providers and the local jurisdiction.

## Chapter 3: Local Response to the Epidemic

Planning efforts since May 2008 by MSCHD and the TGA Planning Council have been aimed at developing a more comprehensive understanding of the multiple Ryan White funding streams in the TGA region, the populations those funding sources currently serve, and of how services gaps can be addressed to meet the needs of those who know their status but are not in care, the underserved, and current Ryan White consumers. MSCHD committed a portion of its TGA administrative funding (\$42,000) to support a needs assessment in 2008, which was undertaken in collaboration with the TGA Planning Council, Le Bonheur Community Outreach, and the Mid-South Coalition on HIV/AIDS (the regional HIV/AIDS provider organization, which serves as the Part B planning body). The *2008 Needs Assessment* included an expanded consumer survey, as well as a survey of nine PLWH/A who were not in care. In addition, MSCHD has started to utilize its position as TGA administrator for Shelby County government to bring other county and state government agencies into the planning process. To date, this has resulted in communication among the three state health departments in compiling TGA epidemiological data, in obtaining ADAP service and funding information, and beginning discussions about how to meet medical and social service needs in adjoining states. This effort has also focused on ensuring that Ryan White funds are the payer of last resort, on maximizing access to services to create greater geographic parity, on targeting emerging subpopulations, and on reducing duplication of services. The prioritization and allocation of FY2009 Part A funding, as well as 2008-2009 MAI funding, were established by the collaborative planning efforts of the TGA Planning Council. The Council was established by MSCHD in the spring of 2008. The funding priorities for Part B were established by Mid-South HIV and AIDS Coalition, of which MSCHD is a member. The Planning Council coordinated its needs assessment with the Mid-South Coalition on HIV/AIDS by having joint committee meetings throughout the process. The combined committee meetings are intended to ensure a more comprehensive and representative process while at the same time allowing the Coalition and Council to retain autonomy.

In its role administering TGA funds, the Planning Council Coordinator provides information, support and access to technical assistance for the Planning Council. The Planning Council Coordinator has also helped the Council and its committees identify the presence and use of other Ryan White and HIV public funding resources as one step in identifying service gaps and needs. A description of the amounts and anticipated uses of 2009 Ryan White funding from all parts is provided below.

Ryan White Funding for FY2009: Populations from pre-natal and infants to older adults are served by Ryan White funding in the Memphis TGA. Expected FY 2009 funding from all Care Act sources and the relative percentage of funding each part provides is shown below.

Care Act Funding Source	Est. FY2009 Funding	%
Part A Memphis TGA (All uses)	\$ 4,493,412	31%
Part B (TN Counties)	\$ 1,261,762	9%
Part B Insurance Assistance Program (TN Counties)	\$ 1,410,692	10%
Part B Oral Health (TN Counties)	\$ 201,600	1%
Part B Tennessee ADAP	\$ 4,771,069	32%
Part B Mississippi ADAP	\$ 248,088	1.5%
Part C (Adult Special Care Clinic)	\$ 624,696	4%
Part C East Arkansas Family Health Center	\$ 186,155	1%
Part D Family Care Program, Le Bonheur	\$ 727,888	4%
Part D Memphis Young Adult HIV Program	\$ 353,153	2%
Part F: ATEC	\$ 30,000	< 1%
Minority AIDS Initiative (2007 & 2008)	\$ 960,267	6%

**Part A and Part E (Minority AIDS Initiative)** make up approximately 37 percent of available Ryan White funding within the TGA. **Part B funding** administered by United Way of the Mid-South (estimated FY2009 pass through funding from the state is \$295,700) will be used primarily to fund community-based ambulatory medical and non-medical case management services through subcontracts with medical service providers that serve the general PLWH/A population. Nashville Cares administers the Part B Insurance Assistance Program (\$1,410,692) and Part B Oral Health funding (\$201,600). The State of Tennessee Department of Health administers state ADAP and Medical provider Fee for Service funding. **Part C funding**, granted to the Adult Special Care Clinic (ASCC) at the Regional Medical Center, will mainly be used for core medical services for African Americans who make up 85 percent of the consumers at ASCC. Achieving geographic parity of services in underserved areas is a primary goal of the Planning Council in setting priorities, and of the Ryan White Part A Program Office in allocating funds to subcontractors.

*Tennessee ADAP:*

The Tennessee Department of Health (TDH) operates the AIDS Drug Assistance Program (ADAP) through a mail-order pharmacy services contract with BioScrip, Inc. BioScrip dispenses prescriptions via mail-order, or through their retail pharmacy in Memphis. Providers fax prescriptions to BioScrip and the medications are sent to ADAP clients by Priority Mail or Federal Express. Eligibility for Tennessee’s ADAP requires an income at or below 300 percent of Federal Poverty Level. Medical eligibility includes a confirmed positive HIV antibody or detectable HIV RNA test results. According to the National Association of State and Territorial AIDS Directors (NASTAD), the Tennessee ADAP formulary includes all antiretrovirals in all drug classes (NRTIs, NNRTIs, Protease Inhibitors, Fusion Inhibitors, CCR5 Antagonists, and Integrase Inhibitors, as well as Multi-Class Combination Products). As of July 2008, NASTAD reported that there were no waiting lists or cost containment measures in any of the three TGA state ADAP programs. (*The ADAP Watch*, July 10, 2008.) According to the FY2007 service utilization report, in addition to state of Tennessee Part B funding for ADAP, \$1.75 million in Part A funding was allocated to the state and expended for ADAP assistance. In FY2008, the amount of Memphis TGA

funding allocated for ADAP was significantly reduced by the TGA Planning Council to \$443,997. According to state officials, the three southwest Tennessee counties were projected to receive approximately \$4.7 million in state ADAP assistance in FY 2009.

*Arkansas ADAP:*

Eligibility for ADAP in Arkansas requires an income at or below 500 percent of Federal Poverty Level, meeting specific medical eligibility requirements established by the state, and proof of ineligibility for Medicaid and other third party payer insurance. The federal ADAP funding in Arkansas was \$4.2 million with 305 clients served statewide at a per capita expenditure of \$2,392. Medications are only covered if included on the ADAP Formulary, and must be dispensed through Arkansas' ADAP-approved pharmacy, Healthcare Pharmacy.

Arkansas also has an Arkansas Comprehensive Health Insurance Pool (CHIP), established in 1995 to provide insurance coverage for Arkansas residents with high-risk conditions who could not obtain coverage through the individual health insurance market and who do not qualify for Medicaid due to the income limits. (Source: The AIDS Treatment Data Network, <http://www.atdn.org/access/states/ar/ar.html>.)

*Mississippi ADAP:*

In FY2008, the state of Mississippi had approximately \$8 million in federal ADAP funding, and served 690 PLWH/A at an average cost of \$2,380. To qualify, patients must have a total household income of less than 400 percent of the Federal Poverty Level, a CD4 count < 350 or Viral Load >100,000. In Mississippi, physicians must submit the ADAP application to the state (including a copy of most recent, actual qualifying laboratory results) along with the patient's prescription(s). The state ADAP staff forwards the prescription to State Pharmacy and medications are sent by courier to a local health department selected by the patient for pick-up. (According to local service providers, this process can take up to two weeks.) As of June 2007, NASTAD reports that the state formulary does not cover all antiretrovirals in all drug classes. (Sources: <http://www.atdn.org/access/states/ms/ms.html>; and NASTAD, *National ADAP Monitoring Project Annual Report*, April 2008.)

## Chapter 4: Assessment of Need

According to HRSA, service gaps are defined as “all service needs not currently being met for all PLWH/A except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care (in care).” (*Ryan White CARE Act Title I Manual*). This definition also includes identification of particular service needs for specific PLWH/A populations. The *2008 Needs Assessment* included a summary of key core medical as well as supportive service needs and gaps (see Tables 16 and 17, p. 73-74 of *Needs Assessment*). Documentation used to support the level of need assigned to each individual category included responses from the consumer survey, as well as responses from the provider survey. Four levels of need were assigned to each category: “high documented need,” “considerable documented need,” “low documented need,” and “unclear need.” The service gaps were characterized as “evident” or “suggested” based upon the available data from the consumer and provider surveys.

- *HIV Medical Care*: Outpatient Medical Care was identified as an “evident” gap in core services in all of the TGA counties except Crittenden County in the *2008 Needs Assessment* (p. 75). The estimated service gap for approximately 1,100 PLWH/A was calculated based upon the overall percentage of in-care PLWH/A who are currently served by Ryan White. In 2007, 33 percent of the 2,957 PLWH/A served by Care Act medical providers, or 975 PLWH/A, were determined to be uninsured, and received Ryan White services. (This reflects an increase of 162 additional patients from 2006, when 30 percent of patients were reported as uninsured.) If it is assumed that 33 percent of all identified PLWH/A in the TGA are similarly uninsurable and eligible for “payer of last resort” Ryan White services, then the total number is  $6,359 \times 33\% = 2,098$ . Of this number, 975 received Ryan White services in 2007, leaving a remainder of 1,123 out-of-care PLWH/A who would be eligible for Ryan White services. For the purposes of further discussion, this number has been rounded to 1,100. The estimated service gap for medical care among PLWH/A in the Memphis TGA is based upon an expected average of 4.0 medical visits per year. For 1,100 persons this would equal 4,400 units of service annually. The cost for meeting 4,400 units of service at an average cost of \$83.50 per service unit (per the FY2009 Implementation Plan, Attachment 7) = \$334,000.

- *Medical Case Management Services*: Medical case management was identified as an “evident” gap in core services in all of the TGA counties except Crittenden County in the *2008 Needs Assessment* (p. 75). The *2008 Needs Assessment* consumer survey reported that 10 percent of consumers reported that they needed but did not receive case management services, compared to 24 percent the previous year. Altogether 84 percent of surveyed consumers reported a need for case management, compared to 79 percent the previous year. Virtually all Ryan White providers currently offer case management, so for the purposes of this service gap analysis, the number of PLWH/A who need but are not receiving case management will be assumed to be the same as for medical care, or 1,100 PLWH/A. The established level of case management services defined by the TGA for new

patients, including initial assessments, carried a total annual cost of \$256/client in FY07 (Source: RW Part A 2007 Service Utilization Report). If it is assumed that PLWH/A who are in-need will receive this standard of service in the same proportion as those who are actively in care, the cost of meeting the service gap for 1,100 PLWH/A may be estimated at \$281,600.

- *ADAP/Pharmaceutical Assistance:* With respect to pharmaceutical assistance, four percent of consumers surveyed for the *2008 Needs Assessment* reported that they need but do not receive prescription drug assistance (down from 14 percent of consumers in 2007). Pharmaceutical assistance was classified as having a “suggested” gap in Shelby County, and an “evident” gap in the two other Tennessee and four North Mississippi counties. There was no observed gap in Crittenden County. Altogether, 88 percent of the surveyed consumers indicated that they needed this service, making it the third ranked service behind Primary/HIV doctor care and food pantry. (Note: Only 68 percent “not-in-care” PLWH/A saw pharmaceutical assistance as a need, but it is assumed that it is, in fact, needed by a majority of these individuals.) If we assume that at minimum the individuals needing ADAP/pharmaceutical assistance are equivalent to the out-of-care individuals previously calculated for medical care, the service gap will be 1,100 PLWH/A times the estimated annual cost of providing HIV/AIDS drugs per individual. In Shelby County, the average cost is reported as \$6,144. Therefore, the total cost to meet the unmet need service gap is  $1,100 \times \$6,144 = \$6,758,400$

- *Oral Health Care:* According to the 2007 Service Utilization Report, the average cost of providing dental care to Ryan White patients was \$1,578 (\$1,750 is the maximum benefit). In the *2008 Needs Assessment*, 81 percent of surveyed consumers report a need for dental care. In the *2008 Needs Assessment*, consumers from Crittenden County that participated in the focus group report the lowest percentage of unmet need for medical transportation services (none reporting this as a barrier) throughout the eight-county area. However, 49 percent of these reported that they need but do not receive dental care. The total number of PLWH/A in the TGA needing oral health care is based on an estimated 4,000 in-care (2,900) and out-of care (1,100) low-income PLWH/A times a 49 percent reported unmet need in the consumer survey = 1,960. At \$1,578 per person, the estimated cost of meeting this care would be approximately \$3 million. At the current Ryan White Part A allocation of approximately \$340,000 per year, it will take at least ten years to meet the current need. In Arkansas, in-care consumers at East Arkansas Family Health Center (EAFHC) can access dental care, but low-income Mississippi PLWH/A lack access to dental care according to social service providers. This is a critical health care need for many PLWH/A, because HIV/AIDS medications make dental problems much worse, which can lead to deterioration of nutritional status. Oral health care is often restricted under public and private insurance, thus many otherwise covered individuals have a service gap for dental care.

- *Medical Transportation:* The *2008 Needs Assessment* survey reported that 23 percent of all consumers had an unmet need for medical transportation (*2008 Needs Assessment*, Table 4, p. 48) and that medical transportation was an “evident” service gap in all TGA counties except Crittenden. If all in-care and out-of-care consumers are used as a basis for

calculating the gap in medical transportation, this equates to approximately 4,000 PLWH/A X 23 percent who have an unmet need = 920. If this figure is multiplied by the average cost of providing transportation to clients according to the 2007 RW Utilization Report, or \$11, this cost comes to \$10,120. sample of consumers responding to the survey may not have included rural PLWH/A. In Mississippi, transportation was reported as the third top barrier to accessing needed services after “lack of information” and waiting periods. PLWH/A lack reliable transportation to medical providers, most of whom are up to two hours distant. Because of fear of disclosure and stigma, they resist riding in a van with other consumers. Sacred Heart Southern Missions (SHSM) in North Mississippi provides transportation via a SHSM case manager, who drives consumers to medical appointments in Memphis or Jackson. Programmatic barriers in Tennessee to providing medical transportation services were encountered in 2007 and are expected again in 2008 due to the fact that TennCare has recently contracted with a new, out-of-state transportation provider.

- *Food Bank/Home Delivered Meals Services:* In the *2008 Needs Assessment*, 91 percent of PLWH/A surveyed reported a need for Food Bank Services, with 11 percent reporting that they need but do not receive this service. It can be assumed that most out-of-care PLWH/A will need Food Bank Services in addition to the reported 11 percent of in-care consumers who said they needed but did not receive this service. This equals approximately 1,400 PLWH/A. Based on the 2007 cost per client of \$212 for food pantry/home delivered meals services, this estimated service gap would cost approximately \$296,800 to meet. However, as food costs have risen by at least 11 percent within the last year, this figure could be as high as \$330,000. (Source: Bureau of Labor Statistics, <http://www.bls.gov/news.release/cpi.nr0.htm>).

- *Early Intervention Services:* The *2008 Needs Assessment* found that data supporting the need for early intervention services was unclear, though the assessment notes that a lack of data or evidence did not necessarily mean that a gap for that service does not exist (p. 72). The TGA Planning Council ranked this category 18th among 19 priority categories and provided the 10<sup>th</sup> highest funding of any category (\$150,475). A reported 28 percent of consumers surveyed for the 2007 Needs Assessment did not access care within six months of their diagnosis, and eight percent report never receiving care or only seeking care when they became sick. Based on this, it is not unreasonable to assume that as many as 30 percent of all newly-diagnosed PLWH/A fails to access care in the first six months.

- *Medical Nutritional Therapy:* Slightly more than half of consumers surveyed reported a need for nutritional supplements and counseling, and 47 percent of those reporting a need for supplements do not receive them and 40 percent of those who need nutritional counseling do not receive counseling. This core service was identified as an “evident” gap in the *2008 Needs Assessment* (Table 16, p. 72). The estimated level of service gap for medical nutritional therapy for RW-eligible PLWH/A will be assumed at minimum to be 47 percent of the 1,100 out-of-care low-income PLWH/A, or 517 persons. The annual cost per client for medical nutritional therapy according to the TGA’s 2007 Utilization Report was \$498, which would indicate a funding gap of 517 X \$498 = \$257,466.

- *Substance Abuse and Mental Health Services:* The *2008 Needs Assessment* identified a suggested gap in substance abuse outpatient services based upon the consumer survey, which showed that 14 percent of responding PLWH/A felt they had a need for this service, and that more than half (57%) did not receive such services. Substance abuse outpatient services are available from a limited number of providers in Memphis, including St. Jude, Grace House and New Directions. In Crittenden County, substance abuse treatment is not available, and a similar situation exists in north Mississippi. (*2006 Arkansas Statewide Coordinated Statement of Need*). According to the *2008 Needs Assessment*, a somewhat larger percentage of consumers (36-39%) reported a need for mental health care, support group or individual counseling, and 36 percent report that they did not receive such services (p. 73). This “evident” gap may best be met through co-location and coordination of primary care, substance abuse and mental health services, particularly for consumers in rural areas. Co-location of services was one directive of the 2007 TGA Planning Council. Telemedicine could also offer potential cost savings and other benefits including greater confidentiality and access to multiple services from a single location.

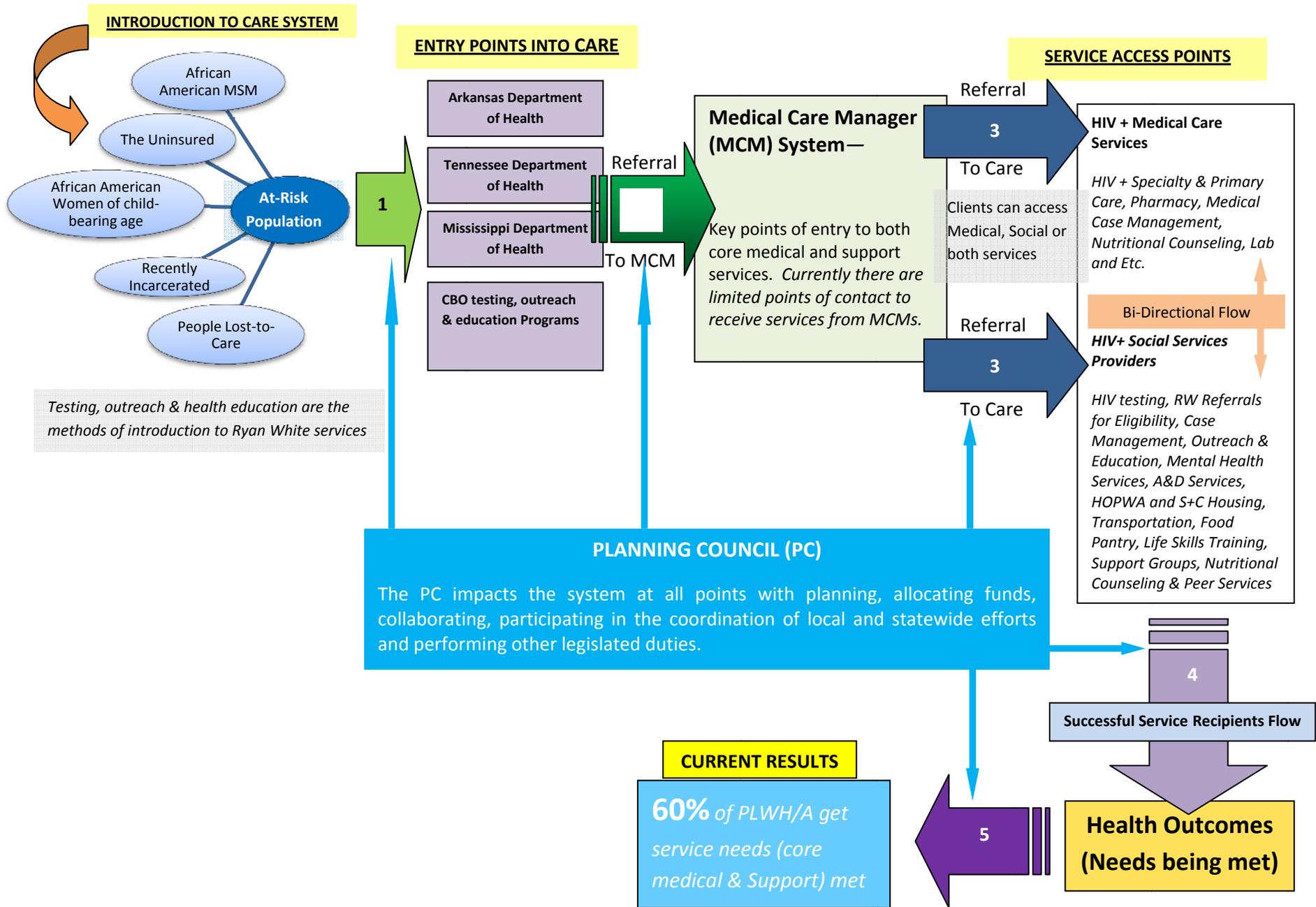
- *Other Services:* The need and apparent gap in home health care, hospice services and home and community based services are either relatively low (less than 10% of consumers reporting a need) or unclear according to the *2008 Needs Assessment*. This does not mean that the need is not acute for some individuals. However, the assessment points out a considerable need for **treatment adherence services**, for which there is documentation. The need for such services is evident in the percentage of consumers who report missed HIV medication doses (24%), the low knowledge consumers have of their own CD4 T-cell and viral loads, and the reported 31 percent gap in consumers who say they need but do not receive treatment adherence services.

## Chapter 5: Current Continuum of Care

The current continuum of care for HIV services in the Memphis TGA is highly reliant on the work of medical case managers to enroll people into care no matter where they might enter the system. This system has worked well in terms of ensuring that all clients who have been enrolled for Part A services are also screened for the State AIDS Drug Assistance Programs for Tennessee and Arkansas, but has left an admitted gap in the system for those residents of Mississippi who have limited to no access to medical case management by providers within their own state. Also, those social service providers who do not have medical case management as a part of their programs have a limited realm of authority of determining the eligibility of a client for Ryan White services, which may serve as a barrier for clients who may only need or be eligible for supportive services.

One of the obvious challenges of the system for the Memphis TGA is the fact that clients are served across an eight county, multi-state jurisdiction. There is limited coordination between the State entities which have the responsibility of providing clients with coverage for drug assistance, Medicaid, and other forms of services related to Ryan White care. There is also a disconnection between the efforts of prevention at both State and local levels with the Ryan White service system. As illustrated in the following diagram, even with an estimated unmet need of 41% for the entire TGA, the current system does not include targeted Early Intervention Services with those at risk populations at the onset of introduction into the Ryan White system.

# MEMPHIS TGA CURRENT HIV/AIDS CARE CONTINUUM



## Chapter 6: Resource Inventory

Following is a summary, by service category, of community resources providing services to PLWHA in the Memphis TGA, based on information contained in the *Mid-South Coalition on HIV/AIDS Community Resource Directory*. A comprehensive, detailed listing of HIV/AIDS services within the TGA will be available on the Memphis TGA Planning Council website to be rolled out in January 2009 ([www.hivmemphis.org](http://www.hivmemphis.org))

### ALCOHOL AND DRUG COMMUNITY SUPPORT SERVICES

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
8 <sup>th</sup> Street Mission	Crittendon	West Memphis, AR	(870)735-6010
Alcoholics Anonymous	Shelby	Memphis, TN	(901)726-6750
CAAP, Inc.,	Shelby	Memphis, TN	(901)367-7550
Charles McKinnon Center	Tipton	South Brighton, TN	(901)476-8967
Christian Counseling Ministries	Desoto	Southaven, MS	(662)342-0155
Communicare	Desoto	Hernando, MS	(662)429-7875
Counseling Alternatives	Tipton	Covington, TN	(901)476-8999
Counseling Services of Eastern Arkansas	Crittendon	West Memphis, AR	(870)735-5118
DeSoto Behavioral Health	Desoto	Southaven, MS	(662)349-6658
DeSoto Family Counseling Center	Desoto	Southaven, MS	(662)342-2700
Family Counseling Services of Millington	Shelby	Millington, TN	(901)872-3525
Family Services of the Mid-South	Shelby	Memphis, TN	(901)324-3637
Frayser Family Counseling Center	Shelby	Memphis, TN	(901)353-5440
JB Summers Center	Fayette	Somerville, TN	(901)465-9831
Lakeside	Shelby	Memphis, TN	(901)377-4700
Life Strategies	Crittendon	West Memphis, AR	(870)702-7563
Memphis Alcohol and Drug Council	Shelby	Memphis, TN	(901)274-0056
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Memphis Gay and Lesbian Community Center	Shelby	Memphis, TN	(901)278-4297
Memphis Recovery Center	Shelby	Memphis, TN	(901)272-7751
Midtown Mental Health Center	Shelby	Memphis, TN	(901)577-0221
Millington Professional Counseling	Shelby	Millington, TN	(901)476-8967
Narcotics Anonymous	Shelby	Memphis, TN	(901)276-5483
New Directions	Shelby	Memphis, TN	(901)346-5497
Pyramid Recovery	Shelby	Memphis, TN	(901)948-4862
Southeast Mental Health Center	Shelby	Memphis, TN	(901)369-1400
Victory Center	Shelby	Memphis, TN	(901)794-5683
Whitehaven Southwest Mental Health Center	Shelby	Memphis, TN	(901)259-1920

### ALCOHOL AND DRUG RESIDENTIAL PROGRAMS

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Baby Love	Shelby	Memphis, TN	(901)577-0256
Dozier House	Shelby	Memphis, TN	(901)722-4719
East Arkansas Substance Abuse Program	Crittendon	West Memphis, AR	(870)739-5676
Genesis House	Shelby	Memphis, TN	(901)726-9786
Grace House	Shelby	Memphis, TN	(901)722-8460
Harbor House	Shelby	Memphis, TN	(901)743-1836

Lakeside	Shelby	Memphis, TN	(901)377-4700
Memphis Recovery Center	Shelby	Memphis, TN	(901)272-7751
Moriah House	Shelby	Memphis, TN	(901)522-8819
New Directions, Inc.,	Shelby	Memphis, TN	(901)346-5497
Renewal Place	Shelby	Memphis, TN	(901)543-8586
Serenity Recovery Center	Shelby	Memphis, TN	(901)521-1131
Synergy Foundation	Shelby	Memphis, TN	(901)332-2227

### **CASE MANAGEMENT SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Case Management, Inc.,	Shelby	Memphis, TN	(901)821-5600
Community HIV Network	Shelby	Memphis, TN	(901)545-6577
East Arkansas Family Health Center	Crittendon	West Memphis, AR	(870)735-3291
Family Services of the Mid-South	Shelby	Memphis, TN	(901)324-3637
Frayser Family Counseling Center	Shelby	Memphis, TN	(901)353-5440
Friends for Life	Shelby	Memphis, TN	(901)272-0855
Jefferson Comprehensive Care System	Jefferson	Pine Bluff, AR	(870)543-2380
LeBonheur Children's Medical Center	Shelby	Memphis, TN	(901)572-5225
Magnolia Medical Clinic	Leflore	Greenwood, MS	(601)459-1277
Memphis Health Center, Inc.,	Shelby	Memphis, TN	(901)775-2000
Mid-State Opportunities	Desoto	Olive Branch, MS	(662)895-4153
Midtown Mental Health Center	Shelby	Memphis, TN	(901)577-0221
Porter Leath Children Services	Shelby	Memphis, TN	(901)577-2500 (901)577-2506
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481
Southeast Mental Health Center	Shelby	Memphis, TN	(901)369-1400
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
University of Tennessee, OB/GYN Clinic	Shelby	Memphis, TN	(901)545-6369
Whitehaven Southwest Mental Health Center	Shelby	Memphis, TN	(901)259-1920
Youth Villages	Shelby	Memphis, TN	(901)251-5000

### **CHURCH SPONSORED SUPPORTS**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
8 <sup>th</sup> Street Mission	Crittendon	West Memphis, AR	(870)735-6010
African American Pastors Consortium (AAPC)	Shelby	Memphis, TN	(901)543-9600
African American Pastors Spouses	Shelby	Memphis, TN	(901)786-0414
Calvary Episcopal Church	Shelby	Memphis, TN	(901)525-6602
Cathedral of the Immaculate Conception	Shelby	Memphis, TN	(901)725-2702
Christian Counseling Ministries	Desoto	Southaven, MS	(662)342-0155
Counseling Center of First Baptist Church	Tipton	Covington, TN	(901)476-2489
Ecumenical Village	Crittendon	West Memphis, AR	(870)735-1115
First Baptist	Crittendon	West Memphis, AR	(870)735-5241
First Congregational Church (First Congo)	Shelby	Memphis, TN	(901)278-6786
First United Methodist	Tipton	Covington, TN	(901)476-9694

Heart to Heart	Tipton	Covington, TN	(901)476-6528
Holy Trinity Community Church	Shelby	Memphis, TN	(901)320-9376
Interfaith Council on Poverty in Hernando	Desoto	Hernando, MS	(662)429-6646
Mississippi Boulevard Christian Church	Shelby	Memphis, TN	(901)729-6222
Neighborhood Christian Center	Shelby	Memphis, TN	(901)452-6701
			(901)881-6013
Open Heart Spiritual Center	Shelby	Memphis, TN	(901)323-3514
Prescott Memorial Baptist Church	Shelby	Memphis, TN	(901)327-8479
Ray of Hope Christian Counseling Center	Shelby	Millington, TN	(901)873-4673
Sacred Heart Southern Mission AIDS Ministry	Desoto	Walls, MS	(662)626-6654
St. Andrew A.M.E. Church/Project CHARM	Shelby	Memphis, TN	(901)775-2968
St. Andrew A.M.E. Church/Project HOPE	Shelby	Memphis, TN	(901)775-2968
Wonder City Ministries	Crittendon	West Memphis, AR	(870)735-3394

### **DAYCARE SERVICES AND EMERGENCY RESPITE CARE**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Hope House Day Care Center	Shelby	Memphis, TN	(901)272-2702

### **DENTAL SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Bill Castle, DDS	Shelby	Memphis, TN	(901)685-5008
Church Health Center	Shelby	Memphis, TN	(901)272-0003
Magnolia Medical Clinic	Leflore	Greenwood, MS	(601)459-1277
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Memphis Health Center, Inc.	Shelby	Memphis, TN	(901)775-2000
Joe O'Neal, DDS	Shelby	Memphis, TN	(901)276-7314
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481
University of Tennessee College of Dentistry	Shelby	Memphis, TN	(901)448-6220

### **EDUCATIONAL RESOURCES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
American Red Cross	Shelby	Memphis, TN	(901)726-1690
Area Health Education Centers	Fayette	Somerville, TN	(901)465-6183
Arkansas Managed Care	Crittendon	West Memphis, AR	(870)735-3291
Association of Nurses in AIDS Care (ANAC)	Shelby	Memphis, TN	(901)495-3240
Children and Family Services Wellness Center	Tipton	Covington, TN	(901)476-2364
Community HIV Network	Shelby	Memphis, TN	(901)545-6577
Comprehensive School Health Program	Shelby	Memphis, TN	(901)729-3779

Delta Area Health Education Centers	Crittendon	West Memphis, AR	(870)735-5527
DeSoto County Health Department	Desoto	Hernando, MS	(662)429-9814
Fayette County Health Department	Fayette	Somerville, TN	(901)465-5243
Friends For Life	Shelby	Memphis, TN	(901)272-0855
Girls, Inc.	Shelby	Memphis, TN	(901)523-0217
Heart to Heart	Shelby	Memphis, TN	(901)476-6528
Hemophilia Foundation	Shelby	Memphis, TN	(901)458-6727
Latino Memphis	Shelby	Memphis, TN	(901)366-5882
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Memphis Center for Reproductive Health	Shelby	Memphis, TN	(901)274-3550
Memphis Gay and Lesbian Community Center	Shelby	Memphis, TN	(901)278-4297
Memphis Health Center, Inc	Shelby	Memphis, TN	(901)775-2000
Memphis Regional Planned Parenthood	Shelby	Memphis, TN	(901)725-1717
New Directions, Inc.	Shelby	Memphis, TN	(901)346-5497
Parents, Family and Friends of Lesbians and Gays (PFLAG)	Shelby	Memphis, TN	(901)268-2511
Pfizer Pharmaceuticals/Agouron Division	Shelby	Memphis, TN	(901)487-7412
Positive Living Center	Shelby	Memphis, TN	(901)247-8321
Positive Voices	Shelby	Memphis, TN	(901)247-8321
Pyramid Recovery Center	Shelby	Memphis, TN	(901)948-4862
South Memphis Alliance (SMA)	Shelby	Memphis, TN	(901)946-9582
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
Tennessee Department of Health	Davidson	Nashville, TN	(800)525-2437
Tipton County Health Department	Tipton	Covington, TN	(901)476-0235
University of Arkansas Cooperative Extension Services	Crittenden	Marion, AR	(870)739-3239

## **FINANCIAL ASSISTANCE**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
8 <sup>th</sup> Street Mission	Crittenden	West Memphis, AR	(870)735-6010
AIDS Virus Awareness	Shelby	Memphis, TN	(901)789-7123
Community Service Agency	Shelby	Memphis, TN	(901)523-7551
Crowley Ridge Development Corporation	Crittenden	Marion, AR	(870)739-6019
Delta Human Resources Agency	Fayette	Somerville, TN	(901)465-3201
Family Services of the Mid-South	Shelby	Memphis, TN	(901)324-3637
Fayette Cares	Fayette	Somerville, TN	(901)465-3805
First United Methodist	Shelby	Memphis, TN	(901)476-9694
Good Neighbor Center	Crittenden	West Memphis, AR	(870)735-0870
Helping People with AIDS	Pulaski	Little Rock, AR	(501)666-6900
Memphis Light Gas and Water (MLGW)	Shelby	Memphis, TN	(901)528-4788
Mid-State Opportunities	Desoto	Olive Branch, MS	(662)895-4153

MIFA (Metropolitan Inter-Faith Association)	Shelby	Memphis, TN	(901)527-0226
Mississippi Boulevard Christian Church	Shelby	Memphis, TN	(901)729-6222
Partners for the Homeless	Shelby	Memphis, TN	(901)526-9411 (901)526-9413
South Memphis Alliance (SMA)	Shelby	Memphis, TN	(901)946-9582
Southaven Samaritans	Desoto	Southaven, MS	(662)393-6439
Whitehaven Southwest Mental Health Center	Shelby	Memphis, TN	(901)259-1920
Wonder City Ministries	Crittenden	West Memphis, AR	(870)735-3394

### **FOOD AND NUTRITION SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
8 <sup>th</sup> Street Mission	Crittenden	West Memphis, AR	(870)735-6010
AIDS Virus Awareness	Shelby	Memphis, TN	(901)789-7123
Commodity Supplemental Food Program	Shelby	Memphis, TN	(901)528-0461
Crowley Ridge Development Corporation	Crittenden	Marion, AR	(870)739-6019
Fayette Cares	Fayette	Somerville, TN	(901)465-3805
Feast for Friends	Shelby	Memphis, TN	(901)272-0855
First Baptist	Crittenden	West Memphis, AR	(870)735-5241
First United Methodist	Shelby	Memphis, TN	(901)476-9694
Friends for Life	Shelby	Memphis, TN	(901)272-0855
Good Neighbor Center	Crittenden	West Memphis, AR	(870)735-0870
Interfaith Council on Poverty in Hernando	Desoto	Hernando, MS	(662)429-7851
Jefferson Comprehensive Care System	Jefferson	Pine Bluff, AR	(870)543-2380
Magnolia Medical Clinic	Leflore	Greenwood, MS	(601)459-1277
Manna House	Shelby	Memphis, TN	(901)726-1142
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Memphis Health Center, Inc.	Shelby	Memphis, TN	(901)775-2000
MIFA (Memphis Inter-Faith Association)	Shelby	Memphis, TN	(901)527-0226
Olive Branch Food Pantry	Desoto	Olive Branch, MS	(662)895-2913
Positive Living Center	Shelby	Memphis, TN	(901)247-8321
Sacred Heart Southern Missions AIDS Ministry	Desoto	Walls, MS	(662)626-6654
Southaven Samaritans	Desoto	Southaven, MS	(662)393-6439
Tennessee Department of Health (food stamps)	Davidson	Nashville, TN	(800)525-2437
Tipton Cares	Tipton	Munford, TN	(901)837-1777
University of Arkansas Cooperative Extension Services		Marion, AR	(870)376-6299
WIC (Women Infants and Children)	Shelby	Memphis, TN	(901)544-1341
Wonder City Mission	Crittenden	West Memphis, AR	(870)735-3394

### **FUNDING AND FUNDRAISING**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone #</b>
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Aphrodite	Shelby	Memphis, TN	
Mid-South AIDS Fund	Shelby	Memphis, TN	(901)722-0054
Pfizer Pharmaceuticals/Agouron Division	Shelby	Memphis, TN	(901)487-7412
Southwest Tennessee HIV/AIDS Care Consortium	Shelby	Memphis, TN	(901)433-4300

### **HEALTH DEPARTMENTS**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Arkansas Department of Health	Crittenden	West Memphis, AR	(870)735-4334
DeSoto County Health Department	Desoto	Hernando, MS	(662)429-9814
Fayette County Health Department	Fayette	Somerville, TN	(901)465-5243
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Tennessee Department of Health	Davidson	Nashville, TN	(800)525-2437
Tipton County Health Department	Tipton	Covington, TN	(901)476-0235

### **HOME HEALTH SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>	<b>Page</b>
Crossroads Hospice	Shelby	Memphis, TN	(901)382-9292	
Hospice South	Shelby	Bartlett, TN	(901)385-2221	
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552	
Methodist Alliance Hospice	Shelby	Memphis, TN	(901)680-0169	
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481 (901)545-7177	
Trinity Home Health and Hospice	Shelby	Memphis, TN	(901)762-6767	
Visiting Nurses Association	Shelby	Memphis, TN	(901)385-7787	

### **HOTLINES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
American Social Health Association			(800)227-8922
Alcoholics Anonymous	Shelby	Memphis, TN	(901)726-6750
Family Services. of the Mid-South Crisis Center Hotline	Shelby	Memphis, TN	(901)274-7477
LINC - Memphis Library Community Resource Database	Shelby	Memphis, TN	(901)415-2790 (or) 211
Memphis and Shelby County AIDS Hotline	Shelby	Memphis, TN	(901)544-7575
Memphis Area Gay Youth (MAGY)	Shelby	Memphis, TN	(901)335-6249
Memphis Gay and Lesbian Switchboard	Shelby	Memphis, TN	(901)324-4297
Memphis Sexual Assault Resource Center	Shelby	Memphis, TN	(901)272-2020

Narcotics Anonymous	Shelby	Memphis, TN	(901)276-5483
Spanish Information Hotline (SIDA)			(800)344-7432
Suicide and Crisis Intervention	Shelby	Memphis, TN	(901)274-7477
Teen AIDS Hotline			(800)234-8336

### **HOUSING SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Crowley Ridge Development Corporation	Crittendon	Marion, AR	(870)739-6019
Ecumenical Village	Crittendon	West Memphis, AR	(870)735-1115
First United Methodist	Tipton	Covington, TN	(901)476-9694
Friends for Life/Shelter Plus Care	Shelby	Memphis, TN	(901)272-0855
Memphis Housing Authority	Shelby	Memphis, TN	(901)544-1100
Memphis Inter-Faith Hospitality Network (MIHN)	Shelby	Memphis, TN	(901)529-4536
Metropolitan Inter-Faith Association (MIFA)	Shelby	Memphis, TN	(901)529-4515
Partners for the Homeless	Shelby	Memphis, TN	(901)526-9411 (901)526-9413
Peabody House	Shelby	Memphis, TN	(901)527-3863
Project Safe Place	Shelby	Memphis, TN	(901)725-6911
Salvation Army	Shelby	Memphis, TN	(901)543-8586
Shelby County Housing Authority	Shelby	Memphis, TN	(901)353-0590
Sisters of Charity	Shelby	Memphis, TN	(901)276-7386
Southeast Community Mental Health Center - Housing Developer	Shelby	Memphis, TN	(901)452-6941
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
Whitehaven Southwest Mental Health Center	Shelby	Memphis, TN	(901)259-1920
YWCA of Greater Memphis, Crisis Shelter	Shelby	Memphis, TN	(901)323-2211

### **LEGAL SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Community Legal Center	Shelby	Memphis, TN	(901)543-3395
East Arkansas Legal Services	Crittendon	West Memphis, AR	(870)732-6370
Memphis Area Legal Services	Shelby	Memphis, TN	(901)523-8822
Memphis Lesbian and Gay Coalition for Justice	Shelby	Memphis, TN	(901)327-2677
Positive Living Center	Shelby	Memphis, TN	(901)247-8321
Shelby County Relative Caregiver Program	Shelby	Memphis, TN	(901)448-7097

### **MEDICAL CARE SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Church Health Center	Shelby	Memphis, TN	(901)272-0003

Christ Community Health Services	Shelby	Memphis, TN	
East Arkansas Family Health Center	Crittendon	West Memphis, AR	(870)735-3291
Health Loop	Shelby	Memphis, TN	(901)525-6761
Infectious Disease Associates	Shelby	Memphis, TN	(901)685-3490
Jefferson Comprehensive Care System	Jefferson	Pine Bluff, AR	(870)543-2380
LeBonheur Children's Medical Center	Shelby	Memphis, TN	(901)572-5225
Magnolia Medical Clinic	Leflore	Greenwood, MS	(601)459-1277
Memphis Center for Reproductive Health	Shelby	Memphis, TN	(901)274-3550
Memphis Health Center, Inc.	Shelby	Memphis, TN	(901)775-2000
Methodist Teaching Practice	Shelby	Memphis, TN	(901)726-8785
Mid-South Center for Natural Medicine	Shelby	Memphis, TN	(901)766-9355
Peabody Healthcare Group	Shelby	Memphis, TN	(901)725-0648
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
The Birthplace at the Regional Medical Center	Shelby	Memphis, TN	(901)545-6100
University of Tennessee, OB/GYN Clinic	Shelby	Memphis, TN	(901)545-6369

### **MEDICATION SUPPORT**

Bioscrip Pharmacy	Shelby	Memphis, TN	(901)725-7828
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### **PSYCHIATRIC/MENTAL HEALTH SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Charles McKennon Center	Tipton	South Brighton, TN	(901)476-8967
Christian Counseling Ministries	Desoto	Southaven, MS	(662)342-0155
Communicare	Desoto	Hernando, MS	(662)429-7875
Community HIV Network	Shelby	Memphis, TN	(901)545-6577
Counseling Alternatives	Tipton	Covington, TN	(901)476-8999
Counseling Center of First Baptist Church	Tipton	Covington, TN	(901)476-2489
Counseling Services of Eastern Arkansas	Crittendon	West Memphis, AR	(870)735-5118
DeSoto Behavioral Health	DeSoto	Southaven, MS	(662)349-6658
DeSoto Family Counseling Center	DeSoto	Southaven, MS	(662)342-2700
Family Counseling Services of Millington	Shelby	Millington, TN	(901)872-3525
Frayser Family Counseling Center	Shelby	Memphis, TN	(901)353-5440
JB Summers Center	Fayette	Somerville, TN	(901)465-9831
Lakeside	Shelby	Memphis, TN	(901)377-4700
Life Strategies	Crittendon	West Memphis, AR	(870)702-7563
Lowenstein House	Shelby	Memphis, TN	(901)274-5486
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Midtown Mental Health Center	Shelby	Memphis, TN	(901)577-0221
Millington Professional Counseling	Shelby	Millington, TN	(901)476-8967
Porter Leath Children Services	Shelby	Memphis, TN	(901)577-2500
Professional Care Services	Fayette	Somerville, TN	(901)465-9831

Professional Counseling	Shelby	Millington, TN	(901)873-0305
Ray of Hope Christian Counseling Center	Shelby	Millington, TN	(901)873-4673
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481 (901)545-7177
Sacred Heart Southern Missions AIDS Ministry	Desoto	Walls, MS	(662)253-1035
Southeast Mental Health Center	Shelby	Memphis, TN	(901)369-1400
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
Whitehaven Southwest Mental Health Center	Shelby	Memphis, TN	(901)259-1920
Youth Diagnostic Assessment Center (YDAC)	Shelby	Memphis, TN	(901)577-0200
Youth Villages	Shelby	Memphis, TN	(901)251-5000

### **SUPPORT SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
African-American Pastors Consortium	Shelby	Memphis, TN	(901)543-9600
Alcoholics Anonymous	Shelby	Memphis, TN	(901)726-6750
Arkansas Delta AIDS Consortia (ADAC)	Crittendon	West Memphis, AR	(870)735-3291
Caregivers Inc.	Shelby	Memphis, TN	(901)794-2060
Children and Family Services	Tipton	Covington, TN	(901)476-2364
Community HIV Network	Shelby	Memphis, TN	(901)545-6577
DePorres Health Center	Quitman	Marks, MS	(662)326-9232
East Arkansas Family Health Center	Crittendon	West Memphis, AR	(870)735-3291
Exodus Empowerment Project	Shelby	Memphis, TN	(901)274-1024
Family Services of the Mid-South	Shelby	Memphis, TN	(901)324-3637
Feast for Friends	Shelby	Memphis, TN	(901)272-0855
Friends for Life	Shelby	Memphis, TN	(901)272-0855
Healing Arms Support Group	Shelby	Memphis, TN	(901)276-4726
Holy Trinity Community Church	Shelby	Memphis, TN	(901)320-9376
Hope House	Shelby	Memphis, TN	(901)272-2702
Hospitality HUB	Shelby	Memphis, TN	(901)522-1808
Jefferson Comprehensive Care System	Jefferson	Pine Bluff, AR	(870)543-2380
LeBonheur Center for Children and Parents	Shelby	Memphis, TN	(901)327-4766
Manna House	Shelby	Memphis, TN	(901)726-1142
Memphis Area Gay Youth (MAGY)	Shelby	Memphis, TN	(901)335-6249
Memphis Gay and Lesbian Community Center	Shelby	Memphis, TN	(901)278-4297
Memphis Health Center, Inc.	Shelby	Memphis, TN	(901)775-2000
Narcotics Anonymous	Shelby	Memphis, TN	(901)276-5483
Northeast Arkansas Regional AIDS Network	Crittendon	West Memphis, AR	(870)400-0072
Partners for the Homeless	Shelby	Memphis, TN	(901)526-9411 (901)526-9413
Porter Leath Children Services	Shelby	Memphis, TN	(901)577-2500 (901)577-2506
Positive Living Center	Shelby	Memphis, TN	(901)247-8321
Regional Medical Center at Memphis (Adult Special Care Clinic)	Shelby	Memphis, TN	(901)545-8481 (901)545-7177
Shelby County Relative Caregiver Program	Shelby	Memphis, TN	(901)448-7097
St. Andrew A.M.E. Church/Project CHARM	Shelby	Memphis, TN	(901)775-2968

Urban Youth Initiative	Shelby	Memphis, TN	(901)729-3988
Victims Assistance Center of Shelby County	Shelby	Memphis, TN	(901)545-4357
West Memphis Junior Auxiliary	Crittendon	West Memphis, AR	(870)732-2488
Women in Community Services	Shelby	Memphis, TN	(901)544-1341
YWCA of Greater Memphis, Crisis Shelter	Shelby	Memphis, TN	(901)323-2211

### **TESTING SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Arkansas Department of Health	Crittendon	West Memphis, AR	(870)735-4334
DeSoto County Health Department	Desoto	Hernando, MS	(662)429-9814
Fayette County Health Department	Fayette	Somerville, TN	(901)465-5243
Life Blood	Shelby	Memphis, TN	(901)522-8585
Memphis and Shelby County Health Department	Shelby	Memphis, TN	(901)544-7552
Memphis Center for Reproductive Health	Shelby	Memphis, TN	(901)274-3550
Memphis Health Center, Inc	Shelby	Memphis, TN	(901)775-2000
Memphis Regional Planned Parenthood	Shelby	Memphis, TN	(901)725-1717
Memphis Sexual Assault Resource Center	Shelby	Memphis, TN	(901)272-2020
New Directions Outreach Office	Shelby	Memphis, TN	(901)346-5497
Positive Voices	Shelby	Memphis, TN	(901)247-8321
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029

### **TRANSPORTATION SERVICES**

<b>Agency</b>	<b>County</b>	<b>City, State</b>	<b>Phone#</b>
Arkansas Medicaid Transportation			(800)482-1141
Delta Area Rural Transportation Services (DART)	Fayette	Somerville, TN	(901)465-9602
Delta Human Resource Agency	Fayette	Somerville, TN	(901)465-3201
Delta Transportation	Tipton	Covington, TN	(901)475-1269
DePorres Health Center	Quitman	Marks, MS	(662)326-9232
Family Services of the Mid-South	Shelby	Memphis, TN	(901)324-3637
Friends for Life	Shelby	Memphis, TN	(901)272-0855
Jefferson Comprehensive Care System	Jefferson	Pine Bluff, AR	(870)543-2380
Magnolia Medical Clinic	Leflore	Greenwood, MS	(601)459-1277
Sacred Heart Southern Missions AIDS Ministry	Desoto	Walls, MS	(662)253-1035
St. Jude Children's Research Hospital	Shelby	Memphis, TN	(901)495-5029
TennCare Transportation	Shelby	Memphis, TN	(901)385-0025

## Chapter 7: Ryan White Provider Profiles

<u>Provider</u>	<u>Narrative</u>	<u>Funded Ryan White Service</u>
<p><b>Adult Special Care The Regional Medical Center</b></p> <p>877 Jefferson Ave. Memphis, TN 38109</p> <p>(901)545-7446</p>	<p>Through the Adult Special Care Center at The Regional Medical Center at Memphis (The MED), HIV-positive patients seek treatment knowing they will receive the highest standard of care. Individualized treatment is available for the whole person, addressing medical, psychosocial, nutritional and financial needs. Patients are provided guidance on how best to access information about the latest HIV-related research, as well as information about HIV-related community events, social activities, support groups, and networking opportunities.</p>	<ul style="list-style-type: none"> <li>• Outpatient/Ambulatory Health Services</li> <li>• ADAP – local</li> <li>• Medical Case Management (including Treatment Adherence)</li> <li>• Medical Transportation Services</li> </ul>
<p><b>Christ Community Health Services</b></p> <p>2953 Broad Ave. Memphis, TN 38112</p> <p>(901)260-8486</p>	<p>Christ Community Health Services is a Christian non-profit organization focused on fulfilling the physical, spiritual, and emotional needs of the underserved through health centers and outreach programs.</p> <p>Since our founding in 1995, Christ Community has provided high-quality healthcare and services to thousands of patients, caregivers, students, and families in designated geographical areas in Memphis where the needs are greatest.</p>	<ul style="list-style-type: none"> <li>• Outpatient/Ambulatory Health Services</li> <li>• Medical Case Management (including Treatment Adherence)</li> <li>• Medical Transportation Services</li> <li>• Mental Health Services</li> </ul>
<p><b>Cocaine Alcohol Awareness Program</b></p> <p>4041 Knight Arnold Memphis, TN 38118</p>	<p>CAAP, Inc., an organization offering a wide variety of programs serving a diverse client base, is truly a unique and diverse treatment provider. It is one of the largest behavioral health providers in the State of Tennessee and the only one that has such a diversity in funding revenue. Also, CAAP, Inc. is one of the largest Community Based Organizations (CBO) in Tennessee, serving the needs of the community and has relationships with other community based organizations</p>	<ul style="list-style-type: none"> <li>• Substance Abuse Outpatient</li> <li>• Outpatient/Ambulatory Health Services</li> </ul>

(901)360-0442

<b>East Arkansas Family Health Center</b>	East Arkansas Family Health Center's mission is to provide accessible, comprehensive, and quality healthcare to the community with emphasis toward the traditionally underserved. Provide comprehensive primary healthcare services to the entire family. Services include primary medical, dental, mental health and preventive health services. Services may vary at health center locations. A representative from each health center location can provide additional information regarding local services.	<ul style="list-style-type: none"><li>• Outpatient/Ambulatory Health Services</li><li>• ADAP – local</li><li>• Medical Case Management (including Treatment Adherence)</li><li>• Oral Health Care</li><li>• Food Bank/Home Delivered Meals</li><li>• Emergency Financial Assistance-Utilities</li></ul>
215 East Bond Street		
West Memphis, AR 72301		
(870)735-3291		

**Provider**

**Narrative**

**Funded Ryan White Service**

<b>Family Services of the Mid-South</b>	The mission of Family Services of the Mid-South is to develop and provide community resource, programs and services to respond to the changing needs of families. Founded in 1893, Family Services of the Mid-South began as an agency dedicated to addressing the health problems of the indigent. Although, a secular and nonprofit social services agency, Family Services of the Mid-South was founded by clergy representing all major religious affiliations in Memphis.	<ul style="list-style-type: none"><li>• Case Management (non-medical)</li><li>• Pyschosocial Support Services</li></ul>
2430 Poplar Ave.		
Memphis, TN 38112		
(901)271-5482		

<b>Friends for Life Corp.</b>	The mission of Friends For Life Corporation is to help persons affected by HIV/AIDS live well. Our comprehensive, client-centered approach includes education, housing, food, transportation, healthcare and healthy life skills training. We strive to enlighten the Mid-South community in a manner that heightens awareness, facilitates acceptance and promotes prevention.	<ul style="list-style-type: none"><li>• Food Bank / Home Delivered Meals</li><li>• Case Management (non-medical)</li></ul>
43 North Cleveland Ave.		
Memphis, TN 38104		
901-272-0855		

<b>Memphis Health Center</b>	<p>The Memphis Health Center, Inc. (MHC, Inc.) was incorporated in 1973 as a 501(c) federally qualified health center with the goal of increasing access to comprehensive primary and preventive healthcare and reducing health disparities in medically underserved areas. MHC initially opened in a storefront in the Metro Shopping Plaza at Crump and Danny Thomas Boulevards. The initial focus of the Center was on preventive medical and dental care.</p>	<ul style="list-style-type: none"> <li>• Outpatient/Ambulatory Health Services</li> <li>• ADAP – local</li> <li>• Medical Case Management (including Treatment Adherence)</li> <li>• Oral Health Care</li> <li>• Substance Abuse Outpatient</li> <li>• Mental Health Services</li> <li>• Medical Nutrition Therapy</li> <li>• Medical Transportation Services</li> </ul>
<p>360 E H Crump Blvd. Memphis, TN 38126</p>	<p><b>Services</b> Services include primary care, dental services, and substance abuse/mental health services, which are available directly or via subcontractors. A team at the main site provides primary care.</p>	
<p>(901)261-2072</p>		

<b>Memphis-Shelby County Health Dept</b>	<ul style="list-style-type: none"> <li>• Medical Case Management (including Treatment Adherence)</li> <li>• Medical Nutrition Therapy</li> <li>• Early Intervention Services (EIS)</li> </ul>
<p>814 Jefferson Memphis, TN 38105</p>	
<p>(901)544-7796 or (901)544-7344</p>	

<u>Provider</u>	<u>Narrative</u>	<u>Funded Ryan White Service</u>
<p><b>Nashville CARES</b>  501 Brick Church Park Dr. Nashville, TN 37207  (615)259-4866  (615) 532-2392</p>	<p>Nashville CARES is Tennessee's leading community-based AIDS service organization. Our mission is to promote and participate in a comprehensive and compassionate response to HIV and AIDS through education, advocacy, and supportive services. The doors of CARES are open to anyone affected by HIV and AIDS in need of comfort.</p>	<ul style="list-style-type: none"> <li>• Oral Health Care</li> </ul>

**Sacred Heart Southern Missions**

Assists the economically disadvantaged through advocacy, social services, affordable low-income housing and educational opportunities in its school and learning centers.

- Non-Medical Case Management
- Food Bank / Home Delivered Meals
- EFA - Utility Assistance

6050 Highway 161  
North

P.O. Box 190

Walls, MS 38680

(662)342-3176

**St. Jude Children's Research Hospital**

St. Jude is unlike any other pediatric treatment and research facility. Discoveries made here have completely changed how the world treats children with cancer and other catastrophic diseases. With research and patient care under one roof, St. Jude is where some of today's most gifted researchers are able to do science more quickly.

- Outpatient/Ambulatory Health Services
- Medical Case Management (including Treatment Adherence)
- Mental Health Services
- Psychosocial Support Services

262 Danny Thomas  
Place

Mail Stop # 600

Memphis, TN 38105

(901)595-4645 or  
(901)595-5067

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- ADAP – State

425 5th Ave. North

Nashville, TN

## Chapter 8 Barriers To Care

### *Community Forums for Comprehensive Planning*

During the Comprehensive Planning process, the Priorities and Comprehensive Planning Committee of the Memphis TGA Planning Council hosted three community forums across the region to gather input from consumers, Ryan White and Non Ryan White providers and the community at large. The participants were asked to share their perspectives of the current continuum of care, barriers to care and gaps in services, and potential measures to improve the system towards a seamless continuum of quality care. Over the course of the three forums (two were held in Memphis; one was held in Northern Mississippi), total of 75 individuals, including 50 consumers of Ryan White services, participated.

During each of forums, there were consistent ideas between both Providers and Consumers about barriers to receiving services. Those top barriers that were stated are listed below:

- ❖ **Transportation:** The issue of transportation was the most cited need by both consumers of HIV services as well as providers. One of the most obvious challenges in terms of transportation is present due to the large rural areas that exist in 7 of the 8 counties served by the TGA. Particularly within Mississippi counties where there are limited providers and the distances to reach what care exists are long. There are no public transportation resources in the rural parts of the TGA, and even taxi cab services are limited. Many clients stated that transportation resources through State Medicaid agencies were unreliable and may take extreme amounts of time to transport to care. One example to illustrate this point was given of a client spending an entire 12 hours on a van in order to get to an hour visit.

Although within the Memphis city limits, there is accessible public transportation, many individuals stated that the services are limited by hours of operation, and some limitations in terms of ease of access to transportation stops where they live. Even for those persons who do have access to private cars, the rising costs of gas make it far more costly to get around to access necessary services.

- ❖ **Lack of Awareness of Services (both providers and clients):** Many individuals stated that one of the main reasons that they may not access or refer individuals to Ryan White services is because they do not know that they are available.
- ❖ **Low Education Levels:** The entire TGA region has historically low levels of education and high levels of poverty. It is a challenge for those PLWHA who may fall into these categories to access care and subsequently stay in care because in some cases individuals do not completely understand

- ❖ **Housing:** Many individuals stated that regardless of how much care is available and accessible, it is moot without stable housing. Clients stated that it was virtually impossible to stay adherent to any regimen without access to the necessities of housing, such as clean water, proper heating/cooling, and access to a place to rest.
  
- ❖ **Substance Abuse:** Both clients and providers noted that there is a lack of availability for substance abuse treatment. While there are at least some agencies within urban hub of Memphis, there are no available resources, particularly in the Mississippi and Arkansas counties. Also, PLWHA who have substance abuse issues are far less likely to access medical care and/or to stay in care.
  
- ❖ **Mental Health Issues:** There is a great level of stigma that exists around mental health issues, and that combined with a diagnosis of HIV makes it more of a challenge for individuals to access and stay in care.
  
- ❖ **Language Barriers:** There is an increase in the populations of non English speaking, particularly Spanish speaking, PLWHA in the Memphis TGA. There are limited resources for appropriate translation services available for people who need them.
  
- ❖ **Lack of coordination and collaboration within Ryan White system and between Ryan White providers and Non Ryan White Providers:** Many providers stated that they is a lack of coordination between the Ryan White parts in the TGA. There is limited coordination of planning for resources available to meet the needs of PLWHA in the TGA. There is even less understanding of the services and resources available through Ryan White funding by non Ryan White providers.
  
- ❖ **Limited Access to health insurance:** Just as it is nationally, there is a growing number of uninsured individuals in the Memphis TGA. As economic conditions continue to decline, even more individuals are losing jobs which covered their health insurance benefits. The price of health insurance premiums is too costly for most individuals covered by Ryan White, and only the State of Tennessee currently administers a Insurance Assistance/ Cost Sharing Program for its citizens.
  
- ❖ **Limited Number of Providers (distances to care):** There is a well documented lack of service providers, especially in the Mississippi region. In some cases, there are extreme distances (two hours) that must be traveled to get to the nearest service provider.

- ❖ Lack of Child Care: Both female and male parents cite the need for more resources for child care during medical care and social service visits.
- ❖ Lack of Employment/ Economic Opportunities: Without opportunities to improve economic conditions, many PLWHA feel that they remain in a cycle of poverty and ultimately decreased health status. The circumstances surrounding current economic conditions mean that there are even less opportunities for PLWHA in an already tight job market.
- ❖ Isolation (both physical and internal): A great deal of stigma persists for those individuals who are living with HIV/AIDS in the Memphis TGA. In a region commonly known as the Bible Belt, many PLWHA feel a sense of shame associated with their diagnosis. There is also still a basic lack of understanding among the general population about HIV/ADS which perpetuates an increased feeling of isolation of PLWHA from their family, friends and community at large.
- ❖ Documentation requirements for services: many clients stated that it is many times a challenge to provide the countless pieces of documentation required to be deemed eligible for services. One specific example was that of documentation needed to prove residency when a client is homeless. Many individuals stated that the “hassle” of providing certain information may keep them from accessing services.
- ❖ Limited Hours for Provider Services: Many of the providers currently within the system have hours that are limited to standard business hours. Clients stated the difficulty in being able to schedule appointments if they are working or even seeking work. There are currently little to no providers available to see clients during evening and/or weekend hours.
- ❖ Medications (access, costs): While each State administers and AIDS Drug Assistance Program (ADAP), many clients still find that it is a challenge to access medications. For those individuals who do not meet the income requirements to qualify for ADAP, medications costs make it an obstacle to stay adherent.
- ❖ Lack of case management: There is a persistent need for more case management services widely distributed across the TGA to guide PLWHA to appropriate medical and support services.

### *Provider Survey*

The Memphis TGA Part A Program Office conducted twenty surveys of Non-Ryan White agencies that provide various services throughout our region. Because of the relatively short time that Ryan White Part A services have been available in this expanded TGA region, special attention given to the questions concerning knowledge of services available to clients that these providers encounter that are infected and/or affected by HIV/AIDS and the systems that are in place to get these individuals the access that they need.

One point that heavily supports information gathered throughout the planning process is the fact that 65% of respondents had no knowledge of the Ryan White Act or the services that exist for PLWHA in our community. Many agencies did not have formal way to refer PLWHA that they may serve to services they may be eligible for because they were unsure of where to start in the process. Astoundingly, a number of providers were not aware of some of the most prominent AIDS Service Organizations and Medical Care Providers that currently exist in the region regardless of funding stream. This survey provides further evidence of the barriers of lack of awareness of services as well as a lack of coordination between service providers across the TGA.

# SECTION II:

WHERE DO WE NEED TO GO?



## **Chapter 9: Shared Vision and Values for an Ideal Continuum of Care**

The mission of the Memphis TGA Ryan White Part A Planning Council is to determine priorities for how Ryan White Part A funds are allocated based on the documented needs of the HIV/AIDS communities within the TGA. It is the responsibility of the Council to assure that all affected and infected communities and populations within the TGA are represented on the Planning Council.

The goal of the Memphis TGA Ryan White Part A Planning Council is, through its needs assessment and planning processes and through the allocation of funding, to create a seamless continuum of care that addresses the unmet needs of the infected and affected populations of the eight counties it is charged to serve.

In meeting its mission and goals, the Planning Council's decision making process shall be governed by the following guiding principles:

1. **Epidemiology:** the percentage of cases in specific population categories or geographic area will be the major influence on the selection of services and the allocation of funds;
2. **Major Gaps in Service:** efforts will be made to fill the service gaps identified from the needs assessment
3. **Equity:** every attempt will be made to allocate funds so that all infected and affected groups receive necessary services based on demonstrated need;
4. **Unmet Needs:** every attempt will be made to address emerging needs and developing issues by allocating the appropriate level of funding that will maximize opportunities to acquire and retain clients into care.

### **VISION STATEMENT**

The Memphis TGA is committed to the development of an ideal continuum of care for HIV services that ensures a flexible system with open access to all persons who need it, has multiple points of entry across both the geographic region and service categories, and includes a network of well qualified, trained providers to best meet the needs of those persons both out of care and in care within entire TGA. This system will be distinguished by strong communication, coordination and collaboration between funders, providers, and clients in efforts to best maximize resources for provision of client centered services.

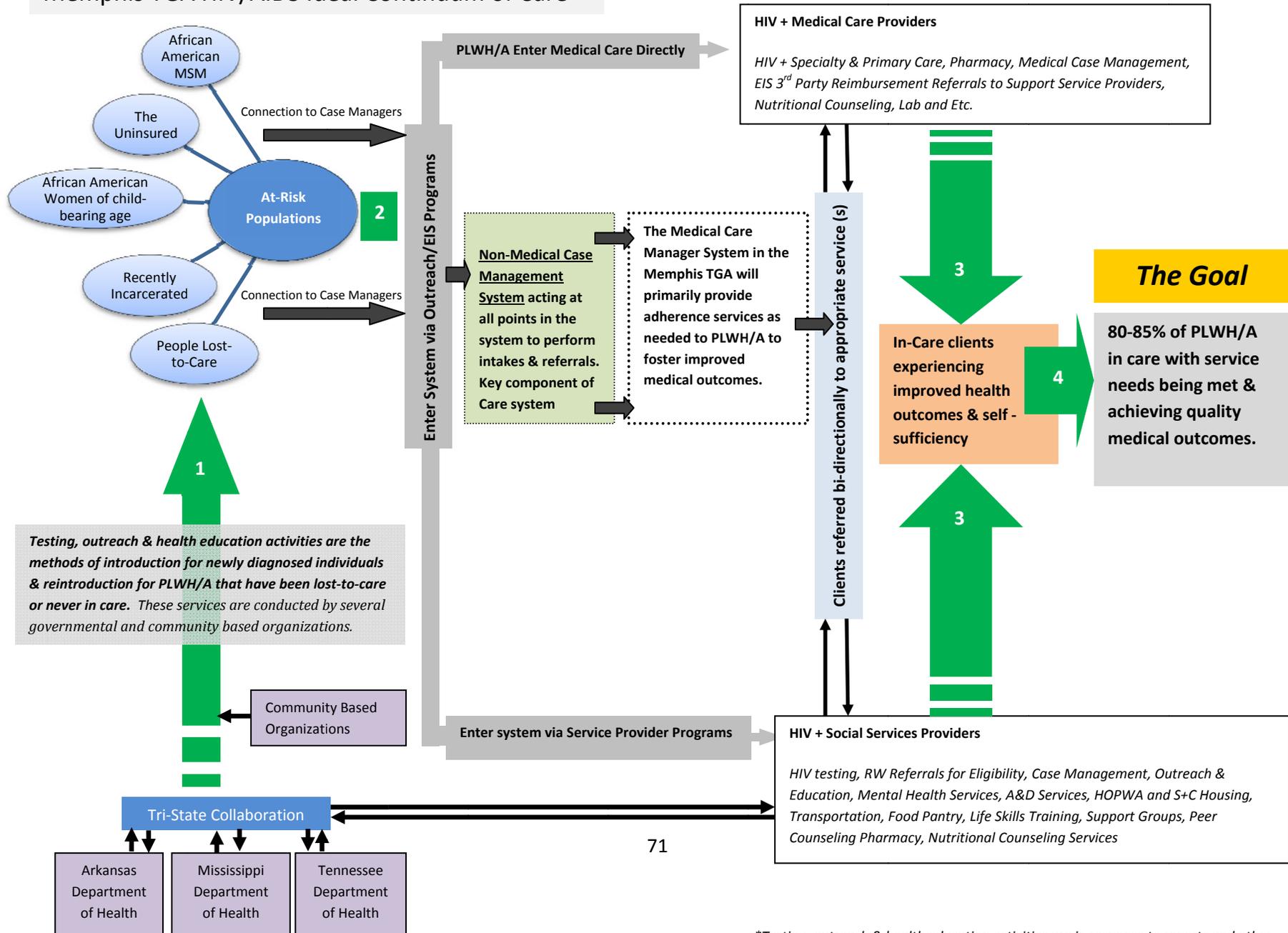
### **GUIDING PRINCIPLES**

The continuum of care for HIV services in the Memphis TGA will be characterized by the following principles:

- Treat all people with compassion and respect;
- Ensure equity of access to services for all residents of all counties within the TGA;

- Deliver services in a culturally competent manner;
- Promote creative approaches, and coordination and collaboration among individuals, agencies, and communities;
- Actively seek the input of those out-of-care as a means to broaden access to services; and
- Ensure integration of HIV prevention strategies, as well as strategies addressing substance abuse and mental health treatment into the continuum of care.

# Memphis TGA HIV/AIDS Ideal Continuum of Care



\*Testing, outreach & health education activities are in response to reports and other assessments conducted throughout The Memphis TGA Care System.

# SECTION III:

HOW WILL WE GET THERE?



## Chapter 10 Comprehensive Plan Goals and Objectives

The following goals and objectives were developed according to the unique challenges and opportunities that exist for HIV service delivery the Memphis TGA, as well as expectations that HRSA has for all EMA/TGAs completing a comprehensive plan. The goals and objectives here were developed by the Comprehensive Planning work group and will be used to move the Memphis TGA toward the ideal continuum of care for HIV services. The Memphis TGA Planning Council accepted and approved these goals and objectives during its December 10, 2008 meeting.

### **GOAL #1: Ensure the availability and quality of all core medical services within the Memphis TGA.**

Objective 1.1: Identify qualified providers for each of the 13 core medical services as designated by HRSA, and where there are no identifiable or qualified providers available, provide capacity development for new ones.

<i><b>Action Steps</b></i>	<i><b>Timeline</b></i>	<i><b>Responsibility</b></i>	<i><b>Evaluation Method/ Indicator</b></i>
a) Develop a comprehensive Resource Inventory of all services available in the rural counties within the TGA	January – June 2009	Part A Grantee, Part D Grantee, Southeast AIDS Education Training Center (Part F AETC), other community partners	Resource Inventory Document updated quarterly and available on website
b) Coordinate efforts of increasing access in rural areas with any State Rural Health Office plans	Ongoing	Part A Grantee, Planning Council	Attendance at Rural Health Council meetings quarterly
c) Train current Ryan White providers on subjects including, but not limited to: <ul style="list-style-type: none"> <li>• Working effectively with HIV positive clients and their families</li> </ul>	During monthly provider meetings	Part A Grantee, Service Providers and Part F AETC as appropriate	Documentation of trainings Training evaluations

<ul style="list-style-type: none"> <li>• Cultural competency</li> <li>• Decreasing stigma</li> <li>• Basic HIV knowledge</li> </ul>			
<p>d) Train current non Ryan White providers through community forums on subjects including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Working effectively with HIV positive clients and their families</li> <li>• Cultural competency</li> <li>• Decreasing stigma</li> <li>• Basic HIV knowledge</li> </ul>	Quarterly opportunities	Part A Grantee, Planning Council and other Ryan White Parts as appropriate	Documentation of trainings  Training evaluations
<p>f) Develop strategies to encourage the participation of new providers, ensuring limited barriers and wide access to information and capacity building efforts where needed</p>	January 2009-Ongoing	Part A Grantee	Evidence of outreach to Non-Ryan White providers  Documentation of new Ryan White providers added to the current network
<p>e) Provide regular technical assistance and capacity development to existing providers and, when requested by a provider or deemed necessary, provide additional technical assistance in a timely manner</p>	Ongoing, as needed	Part A Grantee, Service Providers	Documentation of assistance requested by provider and action taken by Grantee
<p><b>Objective 1.2: Continue the development of a Quality Management program using HRSA designated clinical indicators and expected outcomes.</b></p>			
<b>Action Steps</b>	<b>Timeline</b>	<b>Responsibility</b>	<b>Evaluation Method/ Indicator</b>
a) Utilize quarterly aggregate outcomes reports for future	Ongoing	Evaluation and Assessment	Outcome Reports

planning purposes		Committee, Quality Management staff	
b) Develop Standards of Care for each core medical service and support service, and update as necessary based on changes in Federal, State or Local mandates and results of outcomes reporting	Ongoing	Evaluation and Assessment Committee, Quality Management staff	Documentation of Standards of Care
<b>Objective 1.3: Develop a model of care that includes a local pharmaceutical assistance program that addresses various gaps in the State ADAP programs covering clients in the TGA.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Create a local pharmaceutical formulary for drugs available to PLWHA within entire TGA.	December 2009	Part A Grantee, Planning Council, HRSA Technical Assistance	Dissemination of formulary to providers and prescribers (formulary may be found on the website)
b) Develop a mechanism for adding drugs to formulary as needed	December 2009	Part A Grantee, Planning Council,	Documentation of policy and procedure
c) Review formulary to determine if any changes are necessary	Annually	Part A Grantee	Documentation of annual formulary review session
<b>Objective 1.4: Develop systems that assure the wide distribution of any RFP for Part A and/or MAI services, as well as timely contracting and reimbursement of service providers.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Ensure Fiscal Agent has proper systems in place for distribution and accessibility of RFP	Ongoing	Part A Grantee, Fiscal Agent	Grantee's Review of Fiscal Agent's Process Progress reports
b) Assess the administrative	Annually	Evaluation and	Assessment of the

mechanisms in place for contracting and rapid disbursement of funding to service providers		Assessment Committee	Administrative Mechanism Report
<b>GOAL #2: Eliminate disparities in access to core medical services and support services among disproportionately affected sub-populations and historically underserved communities.</b>			
Objective 2.1: Develop a system that specifically addresses the challenges of transportation within the TGA.			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Identify transportation service providers available to serve in rural counties	Ongoing	Part A Grantee, Needs Assessment Committee	Documentation of transportation providers
b) Conduct a special study researching barriers to transportation in the rural areas of the TGA	May 2010	Part A Grantee, Joint (Parts A and B) Needs Assessment Committee	Documentation of special study
Objective 2.2: Continue to utilize Minority AIDS Initiative (MAI) funds to develop unique ways to get communities of color to access and stay in the system of care.			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Increase number of bilingual (Spanish speaking) staff and resources available for services for PLWHA and their families	Ongoing	Part A Grantee, Service Providers, community partners	Documentation of bilingual staff and/or resources
b) Ensure culturally competent service delivery and provide cultural competence training for all providers of HIV services	Ongoing	Part A Grantee	Documentation of training

**Objective 2.3: Ensure that the services provided and allocations of funding adequately address the emergent support service needs of individuals living with HIV/AIDS.**

<i><b>Action Steps</b></i>	<i><b>Timeline</b></i>	<i><b>Responsibility</b></i>	<i><b>Evaluation Method/ Indicator</b></i>
a) Conduct at least two forums each grant year where PLWHA discuss emerging needs and barriers to care	Ongoing	Consumer and Affected Communities Committee	Documentation of forums
b) Conduct a special study researching emergency assistance resources and barriers in the TGA	May 2010	Needs Assessment Committee	Completion of special study

**Objective 2.4: Ensure a system that adequately addresses the housing needs of PLWHA in the Memphis TGA.**

<i><b>Action Steps</b></i>	<i><b>Timeline</b></i>	<i><b>Responsibility</b></i>	<i><b>Evaluation Method/ Indicator</b></i>
a) Increase coordination and collaboration with HOPWA program and other social service providers addressing housing and/or homelessness	Ongoing	Ryan White Grantees, HOPWA Grantee, other community partners	Evidence of communication
b) Review current and future studies concerning housing resources and barriers in the TGA	May 2009 and ongoing	Needs Assessment Committee	Documentation of review within Needs Assessment document

**Objective 2.5: Ensure funding levels to Women, Infants, Children and Youth in the Memphis TGA are consistent with HRSA requirements.**

<i><b>Action Steps</b></i>	<i><b>Timeline</b></i>	<i><b>Responsibility</b></i>	<i><b>Evaluation Method/ Indicator</b></i>
a) Increase coordination and collaboration with all Ryan White parts to develop service priorities, resource allocation	Ongoing	Part A Grantee, Part B , C, D and F Grantees, Priorities and	Comprehensive Community Funding Plan

decisions, and models of care for women. Infants, children and youth in the TGA		Comprehensive Planning Committee, All Parts Collaborative	
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**GOAL #3: Specify strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in the use of those services.**

Objective 3.1: Develop a strategy for increasing awareness among clients and the community at large of the availability of Ryan White services.

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
a) Develop a website ( <a href="http://www.hivmemphis.org">www.hivmemphis.org</a> ) which will direct PLWHA to available resources in the TGA	January 2009-Ongoing	Communications Committee	Website
b) Develop a public service announcement strategy that includes multiple forms of mass communication	March-December 2009	Part A Grantee, Community Partners, Communications Committee	Public Service Announcement
c) Ensure all information that is disseminated is appropriately translated into Spanish and other languages as necessary	Ongoing	Part A Grantee, Planning Council, Community Partners	Evidence of program materials in appropriate translation(s)

Objective 3.2: Develop models of care that focus on the use of peer advocates to assist in getting clients to access and keeping them in care.

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
a) Fully implement the directives for MAI FY08-09 given by the Planning Council concerning use of Early Intervention Services funds	Ongoing	Part A Grantee, Planning Council	Progress Reports Site Monitoring Visits

b) Encourage the use of clients in assessment of consumer needs	Ongoing	Needs Assessment Committee	Needs Assessment Document Evidence of Consumer Training
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**Objective 3.3: Utilize client satisfaction survey information in assessment of needs for services and models of services to be provided as well as the effectiveness of Ryan White services currently provided.**

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
a) Develop client satisfaction surveys to be administered to a representative sample of clients receiving services	Ongoing	Quality Management Staff, Providers	Evidence and results of client satisfaction surveys
b) Use data to refine plans for service delivery as necessary	Ongoing	Planning Council	Evidence of survey data in decision making processes

**GOAL #4: Include strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system.**

**Objective 4.1: Develop an enrollment/ eligibility determination process that ensures access to services and reduced barriers.**

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
a) Create a streamlined eligibility process with multiple opportunities for flexible documentation	April 2009	Part A Grantee, Providers	Documentation of procedure of eligibility process
b) Use a centralized CAREWARE system to aid intra-provider knowledge of client eligibility information for services	June 2009	Part A Grantee	Evidence of CAREWARE centralization among Ryan White providers

**Objective 4.2: Implement a mechanism by which PLWHA (in care, seeking care, or out of care) and the community at large can provide input concerning the medical and support service needs of PLWHA.**

<b>Action Steps</b>	<b>Timeline</b>	<b>Responsibility</b>	<b>Evaluation Method/ Indicator</b>
a) Host Wellness Forums for consumers (both in care and out care ) that focus on topics related to Ryan White service access and provision	Ongoing	Consumer and Affected Communities Committee	Evidence of Wellness Forums
b) Develop a mechanism for submission of comments through <a href="http://www.hivmemphis.org">www.hivmemphis.org</a>	Ongoing	Communications Committee Planning Council	Evidence of consumer comments/concerns use in various planning activities
c) Utilize surveys and interviews to assess the needs of people out of care	Ongoing	Needs Assessment Committee Planning Council	Needs Assessment document Evidence of info use in planning activities

**Objective 4.3: Address the impact of low educational levels and poverty on those living with HIV/AIDS and those at risk throughout the TGA.**

<b>Action Steps</b>	<b>Timeline</b>	<b>Responsibility</b>	<b>Evaluation Method/ Indicator</b>
a) Coordinate with existing prevention efforts in the TGA	Ongoing	Part A Grantee, Planning Council, Community Partners	Evidence of coordination with prevention plans
b) Ensure that campaigns will effectively reach those with low literacy levels	Ongoing	Part A Grantee, Planning Council, Providers, Community Partners	Evidence of easy to read, program materials
c) Collaborate with community vocational rehabilitation services	Ongoing	Part A Grantee, Planning Council, Providers,	Evidence of coordination and collaboration with

		Community Partners	existing plans/services concerning vocational rehabilitation services
d) Provide opportunities for employment of peer advocates	Ongoing	Part A Grantee, Planning Council, Providers, Community Partners	Evidence of increased peer advocate job opportunities and programs
<b>Objective 4.4: Support existing programs and establish new program(s) to facilitate PLWHA entry into the medical care system upon release from jail/prison. Ensure that such programs address disclosure concerns for soon-to-be released and recently released PLWHA.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/Indicator</i></b>
a) Create a referral system that at a minimum connects those recently released clients to a primary health care provider and state ADAP programs	Ongoing	Part A Grantee, Providers	Evidence of increased numbers of recently incarcerated PLWHA accessing medical care and medications
<b>GOAL #5: Include strategies to coordinate the provision of services for HIV prevention, including outreach and early intervention services.</b>			
<b>Objective 5.1: Support current initiatives seeking to increase prevention and outreach efforts within the faith community.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/Indicator</i></b>
a) Ensure that Planning Council is fully aware of all prevention and outreach initiatives of each State within the TGA	Ongoing	Priorities and Comprehensive Planning Committee	Evidence of coordination of various planning activities with State prevention plans
<b>Objective 5.2: Increase coordination with other Ryan White programs, other federally-funded HIV service grantees, and other community partners.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/Indicator</i></b>

a) Ensure that the Planning Council includes all mandated membership categories	Ongoing	Membership Committee	Assessment of Membership during monthly meetings
b) Encourage participation of community partners including the Mid-South Coalition on HIV/AIDS Planning Council activities	Ongoing	Planning Council	Increased coordination of planning between planning groups
c) Identify the availability of alternate funding sources and develop a plan that leverages those resources to support the core continuum	Annually and ongoing	Priorities and Comprehensive Planning Committee, Part A Grantee, Other RW programs and Non-RW programs	Evidence of review funding streams throughout priority setting and resource allocation process

**Objective 5.3: Develop models that combine targeted early intervention services, outreach and medical care for PLWHA who are newly diagnosed or out-of-care.**

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
a) Integrate special Early Intervention and outreach strategies into plans for services for newly diagnosed and out of care PLWHA	Ongoing	Part A Grantee, Planning Council	Evidence of increased retention in care for out of care and newly diagnosed PLWHA
b) Increase efforts of Early Intervention Services within key points of entry for PLWHA newly diagnosed or out of care	Ongoing	Part A Grantee, Planning Council	Evidence of increased EIS activities within key points of entry

**GOAL #6: Create a system that reflects strategies for the provision and treatment of Substance Abuse and Mental Health services.**

**Objective 6.1: Reduce the stigma associated with substance abuse and mental health issues.**

<i>Action Steps</i>	<i>Timeline</i>	<i>Responsibility</i>	<i>Evaluation Method/ Indicator</i>
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a) Continue to provide community education to educate non-Ryan White Substance Abuse and Mental Health providers about effective treatment of HIV positive clients	Ongoing	Part A Grantee, Planning Council and other Ryan White Parts as appropriate	Evidence of outreach to non -Ryan White providers
<b>Objective 6.2: Increase collaboration with local SAMHSA grantees to ensure comprehensive care for PLWHA whose needs may be covered by both funding streams.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Assess the availability and use of SAMHSA funding throughout the TGA	Ongoing	Priorities and Comprehensive Planning Committee	Documentation of SAMSHA funding inventory in the TGA
b) Ensure that SAMSHA Grantees are included in the planning activities related to HIV service delivery	Ongoing	Part A Grantee, Planning Council, Other Community Partners	Evidence of SAMSHA representation/ input in planning meetings and processes
<b>Objective 6.3: Assess the capacity of available substance abuse and mental health services for PLWHA within the TGA and ensure that funding resources are maximized.</b>			
<b><i>Action Steps</i></b>	<b><i>Timeline</i></b>	<b><i>Responsibility</i></b>	<b><i>Evaluation Method/ Indicator</i></b>
a) Create a detailed resource inventory, including capacity to serve PLWHA, for substance abuse and mental health services within the TGA	June 2008- Ongoing	Part A Grantee	Documentation of resource inventory
b) Create capacity development opportunities for Ryan White and Non-Ryan White substance abuse and mental health providers to serve PLWHA	Ongoing	Part A Grantee	Evidence of capacity development activities by Grantee

**Objective 6.4: Develop a case management model that ensures adequate assessment and appropriate referrals for substance abuse and mental health treatment.**

<i><b>Action Steps</b></i>	<i><b>Timeline</b></i>	<i><b>Responsibility</b></i>	<i><b>Evaluation Method/ Indicator</b></i>
a) Ensure that all providers have mechanisms in place for referrals to substance abuse and mental health agencies as necessary	Ongoing	Part A Grantee, Service Providers	Evidence of policies and procedures for referrals  Evidence of increased access to substance abuse and mental health services  Inclusion in Standards of Care

# SECTION IV:

HOW WILL WE MONITOR OUR  
PROGRESS?



## **Chapter 11: Improving Client Level Data**

Beginning January 1, 2009, Ryan White Program grantees and service providers will use a new semiannual data collection and reporting system to report information on their programs and the clients they serve to the HIV/AIDS Bureau (HAB) of HRSA. The Memphis TGA currently is assessing the readiness of its systems to gather the data needed for completion of the Ryan White Services Report (RSR) which will provide information about each Ryan White service as they are provided to individuals and their families.

One of the most immediate undertakings of the Memphis TGA program is the implementation of a centralized CareWare system which will provide providers access to limited, but helpful information about a client's use of Ryan White services. Additionally, it will provide all Parts within the HIV service delivery system a way of determining the number of unduplicated clients being served by any of the Ryan White services offered by the TGA as a whole.

## Chapter 12: Using Data for Evaluation

Both the Grantee's Office and Planning Council will utilize information gathered through various monitoring and quality assurance visits in making plans for HIV services. The types of data that will be collected include, but are not limited to:

- ✓ Provider Progress Reports
- ✓ Site Visit Reports
- ✓ Service Utilization and Cost Data
- ✓ Client Satisfaction Survey Data
- ✓ Survey Information from Out-of- Care PLWHA
- ✓ Quality Improvement Data

Additionally, the Quality Management team will continue to work closely with the Evaluation and Assessment Committee in the development of Standards of Care for all Ryan White services funded by the Part A program. These Standards will be the baseline for expectations of service provision for any organization that receives Ryan White funding. The Standards of Care play a fundamental role in the creation of a strong quality management plan for the TGA as well.

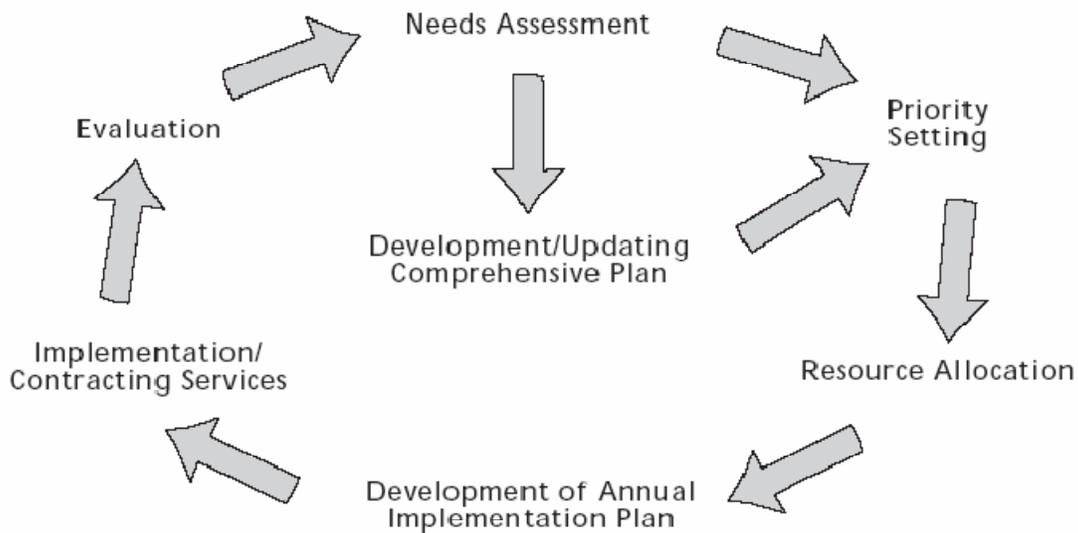
## Chapter 13 Measuring Clinical Outcomes

HRSA/HAB defines outcomes evaluation as the assessment of the effectiveness of a service or program in achieving its intended results. Conducting outcomes evaluation is important for Ryan White programs because it can highlight results achieved by a program. Documentation of program outcomes can be used in multiple ways, including: ensuring and improving service quality; helping to guide program planning, priority setting, and resource allocation efforts; and securing funding from public and private resources. (*TA Call Report, HRSA HIV/AIDS Bureau, Division of Training and Technical Assistance*)

In the summer of 2008, HRSA/HAB began a rollout of Core Clinical Performance Measures for Adults and Adolescents for integration into the quality management plans for EMA/TGAs around the country. As a new TGA, the Part A program has a brief history with the implementation of its own quality management plan. The Group 1 performance measures serve as a foundation to build outcome measures into clinical services. The Quality Management staff will continue to work with its Quality Management Work Group as well as other Ryan White Parts to work to gradually incorporate these measures into a quality management plan that unites the entire HIV delivery system.

## Chapter 14: Implementation, Monitoring and Evaluation of the Plan

The Comprehensive Plan is one part of the cycle of continuous planning that is fundamental to the success of all Ryan White programs. HRSA/HAB expects that Comprehensive Planning feed into the mandated Planning Council activities of Needs Assessment and Priority Setting and Resource Allocation (PSRA), as well as direct the actual implementation and contracting of services handled by the Grantee. As depicted in the figure below, the evaluation of activities stated in the Comprehensive Plan feeds into that plan's update and development. This process must be conducted as least annually to launch the PSRA process and support the development of an annual implementation plan.



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HRSA. HAB. *Ryan White CARE Act Title I Manual - Section VII Program Guidance*. 2001. Page 4

Implementation of the Comprehensive Plan is a coordinated effort through the Planning Council and the Memphis TGA Ryan White Part A Office within the Shelby County Government. The Priorities and Comprehensive Planning Committee of the Planning Council along with the Grantee's Office will do quarterly assessments of the program's progress toward meeting each of the goals and objectives set forth in the plan.

Evaluation comprises a significant component of the Comprehensive Plan. Every objective includes an evaluation component to measure its outcome and success. Evaluation includes not only whether an objective was completed but also whether it achieved its stated outcome by the stated deadline.

Success of the Memphis TGA Comprehensive Plan will be measured by the following outcomes:

- Ability to implement stated action steps within the projected timeframe;
- Achievement of the various objectives;
- Documented system improvements that support the six goals.

Progress in achieving a high quality, comprehensive ideal continuum of care will be measured by the following outcomes:

- Clients reporting an increased ability to navigate the service system;
- Clients reporting greater access to care and services;
- Increased number of clients who enter and remain in medical care;
- Positive client clinical outcomes;
- Positive system outcomes through continuous quality improvement;
- Increased collaborative agreements between Ryan White Grantees and providers, as well as non Ryan White providers

An evaluation of the Plan and its effectiveness as defined by the above-stated outcomes will be undertaken annually by the Planning Council. Data will be collected to measure the outcomes. Analysis and results will be reported to the Evaluation and Assessment Committee for consideration. This information will be used to determine the effectiveness of the Plan, the extent to which system change has been accomplished and future directions for policy decisions.