The 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona

2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona

Arizona's audacious plan to end the local HIV epidemic

Developed by the HIV Statewide Advisory Group
and the Phoenix EMA Ryan White Planning Council

Submitted to the
Centers for Disease Control and Prevention and the
Health Resources and Services Administration on September 30, 2016

HIV Statewide Advisory Group
of the HIV Prevention Program and the
Ryan White Part B Care and Services Program
Arizona Department of Health Services
602-364-3599
AZDHS.gov

Phoenix EMA Ryan White Planning Council
of the Ryan White Part A Program
Maricopa County
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ARIZONA DEPARTMENT
OF HEALTH SERVICES

PREVENTION SERVICES

September 20, 2016

Kevin Ramos
Project Officer
Centers for Disease Control and Prevention
1600 Clifton Road, MS-E-58
Atlanta, GA 30333

RE: Letter of Concurrence
Arizona Jurisdiction 2017 to 2021 Integrated HIV Prevention and Care Plan

Dear Mr. Ramos:

The Arizona HIV Statewide Advisory Group ***concurs*** with the following submission by the Arizona Department of Health Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The HIV Statewide Advisory Group (SWAG) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The SWAG ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The 2017 to 2021 Integrated HIV Prevention and Care Plan was developed by the SWAG over the course of one and a half years of dialog with hundreds of HIV stakeholders statewide, extensive data review, thoughtful discussion among SWAG members, and extensive collaboration with the HIV Prevention Program, HIV Surveillance Program, Ryan White Part A Planning Council, Ryan White Programs, and STD Control and Hepatitis Programs, among others.

My signature below confirms the ***concurrence*** of the HIV Statewide Advisory Group with the Arizona Jurisdiction's 2017 to 2021 Integrated HIV Prevention and Care Plan.

Sincerely,

Chelsey Donohoo

Chelsey Donohoo
Chair
Arizona HIV Statewide Advisory Group

Phoenix EMA
RYAN WHITE
PLANNING COUNCIL

301 West Jefferson Street, Suite 3200, Phoenix, AZ 85003
(602) 506-6321 phone • (602) 506-6300 fax

September 23, 2016

LCDR Monique Richards
Public Health Analyst
HRSA/HAB/DMHAP
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Mail Stop 09W05B
Rockville, MD 20857

RE: Phoenix EMA Ryan White Planning Council
Letter of Concurrence for the 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona

Dear Ms. Richards:

Please accept this letter as confirmation that the Phoenix EMA Ryan Planning Council (Planning Council) ***concurs*** with the following submission by the Phoenix EMA Ryan White Part A Program, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council has reviewed the 2017 to 2021 Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council ***concurs*** that the 2017 to 2021 Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Ryan White HIV/AIDS Program legislation and program guidance, and the CDC's Funding Opportunity Announcement PS12-1201.

The Central Region section of the 2017 to 2021 Integrated HIV Prevention and Care Plan represents the integrated plan for the Phoenix EMA service area. This section was developed by the Planning Council's Community Health Planning and Strategies (CHPS) Committee, in collaboration with the HIV Statewide Advisory Group. The 67 prevention and care activities identified in the Central Region section were established after an extensive data collection and review process, and with direct input from people living with HIV, individuals at risk of acquiring HIV, community stakeholders, funded and non-funded providers, and collaboration with the HIV Prevention Program, HIV Surveillance Program, state STD Control and Hepatitis Programs, and other Ryan White Programs. The plan for the Central Region was approved at the September 22, 2016 Planning Council meeting.

I am tremendously proud of our efforts to gather community input to inform the development of this plan, and the commitment of the CHPS Committee members and our collaborative partners to create a thoughtful, comprehensive strategy to end the HIV epidemic in Arizona.

My signature below confirms the ***concurrence*** of the Phoenix EMA Ryan Planning Council with the 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona.

Sincerely,

John Sapero
Chair
Phoenix EMA Ryan White Planning Council

Acknowledgements

Community Health Planning & Strategies Committee
Phoenix EMA Ryan White Planning Council
Cheri Tomlinson, Chair

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Cynthia Trottier
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Guillermo (Gil) Velez
John Sapero
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About the Phoenix EMA Ryan White Planning Council

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

About the Community Health Planning & Strategies (CHPS) Committee

The CHPS Committee oversees the design and implementation of community needs assessments, establishes and monitors the Planning Council's comprehensive plan for the delivery of HIV/AIDS services, and establishes guidelines for the provision of Part A services.

Acknowledgements

Arizona HIV Statewide Advisory Group
Chelsey Donohoo, Chair

Members
Alyssa Guido
Calicia White
Cesar Egurrola
Deborah Reardon-Maynard
Felicia McLean
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Lynelle Brooks-Dorsey
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About the Arizona HIV Statewide Advisory Group
To better meet CDC/HRSA expectations for integrated HIV prevention and care planning, the HIV Prevention Program and Ryan White Part B Care and Services Program combined their respective planning bodies to form the HIV Statewide Advisory Group (SWAG).

The SWAG is charged with developing and monitoring Arizona's strategic plan to effectively end the state's HIV epidemic. The SWAG also guides the development and implementation of HIV services, social marketing activities, and quality improvement initiatives.

Membership includes representatives of people living with HIV, services providers, health departments, community leaders, and other stakeholders.

Acknowledgements

This plan has been developed in collaboration with:

Arizona AIDS Education and Training Center
University of Arizona

HIV Prevention Program
Arizona Department of Health Services

HIV Surveillance Program
Arizona Department of Health Services

Las Vegas TGA Ryan White Part A Program
Clark County, Nevada

Ryan White Part A Program
Maricopa County

Ryan White Part B Care and Services Program
Arizona Department of Health Services

Ryan White Part C Programs
El Rio Special Immunology Associates
Maricopa Integrated Health System
University of Arizona Petersen HIV Clinic

Ryan White Part D Program
Maricopa Integrated Health System

STD Control Program
Arizona Department of Health Services

Foreword

774

Ryan White clients and high-risk HIV negative individuals identified service needs, accessibility, barriers, and gaps across the care continuum

203

community partners participated in a survey of HIV prevention knowledge and perceptions among the target populations they serve

65

newly diagnosed individuals were surveyed about their HIV testing and linkage to care experiences

The Arizona HIV Statewide Advisory Group and the Phoenix EMA Ryan White Planning Council are pleased to submit this comprehensive plan for ending the HIV epidemic in Arizona.

When development of this plan began, people throughout the state were asked two simple questions: 1) What needs to happen in the next five years to end the HIV epidemic in Arizona? and 2) What are the barriers that might stop us from achieving this audacious goal?

Hundreds of people responded. People living with HIV shared their successes and struggles, their service needs, and the accessibility, barriers and gaps in care they experienced. High-risk HIV negative individuals, and people recently diagnosed with HIV provided thoughtful answers about their engagement in HIV prevention methods, their satisfaction with HIV testing and other prevention services, and what they wish they knew before becoming HIV positive. They also discussed their social media use, where they hang out, the impact of local prevention messages, and the HIV knowledge and perceptions of their friends and family.

Over the course of a year and a half, more than 200 representatives of people living with HIV, community-based organizations, medical providers, Ryan White and CDC funded programs, public health programs, community leaders, Tribal entities, and hospital systems contributed 1,483 man hours to strategic planning efforts. These individuals participated in two day-long training sessions focused on best-practices for linkage to care, retention in care, data-based quality improvement, innovations in prevention services, and client-centered care.

Participants then used the knowledge they gained from these sessions, along with their personal expertise, experience, and passion to inform the development of regional strategies. Teams studied continuums of care for clinics, regions, and the state. They discussed such issues as the challenge of abstinence only sex education, rural coalition development, and the needs for flexible funding and shared data systems. There were meaningful discussions barriers clients faced, going so far as to begin the work of problem solving where homeless clients can safely store their medications.

Participants tackled hard questions of how to step up the levels of cultural competency within our communities, the limits of government influence, and how we could expand our influence on behalf of the clients.

At times, the planning process was daunting. There were difficult discussions on realistic versus aspirational objective measures. Powerful conversations occurred about the impact of social justice issues on HIV prevention, and engagement/retention in care for people of color. There were months with multiple meetings scheduled each week, and a now-legendary series of grueling, four-hour web-based meetings that allowed for comprehensive public review and comment. Regardless of the amount or intensity of meetings, Arizona's Planning Body members showed up with passion, expertise and creative solutions. Every. Single. Time.

The integrated planning process has spurred some of the most inclusive and meaningful client-centric HIV discussions Arizona has ever had. This dialog is far from finished. But, thanks to the many outstanding contributions of our partners, it's off to an impressive start. On the following pages, you will learn of the great effort that has been expended to create this plan, and of the hard work our communities have ahead of them.

We are humbled by the dedication of our Planning Body members, and so very thankful for their commitment to ending the HIV epidemic in Arizona. Our programs have already begin preparing to implement the plan with great excitement. After you read the Plan, we believe you will become just as engaged.

Please join us as we begin to end the HIV epidemic in Arizona!

Respectfully,

225

representatives of people living with HIV, community-based organizations, medical providers, Ryan White and CDC funded programs, public health programs, community leaders, Tribal entities, and hospital systems contributed more than

1,483

man hours specifically to strategic planning for Arizona's regional communities

Carmen Batista
Program Manager
Ryan White Part B
Care and Services Program

Arizona Department
of Health Services

John Sapero
Office Chief
HIV Prevention Program

Arizona Department
of Health Services

Rose Conner
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Ryan White Part A Program

Maricopa County

Executive Summary

An Inclusive, Collaborative Planning Process

How People Involved in Planning Are Reflective of the Local Epidemic

The 2017 to 2021 Integrated HIV Prevention and Care Plan is the most inclusive planning effort ever undertaken by Arizona's HIV community. Participants in the planning process represent all target populations identified in each region, and a diverse array of program partners and key stakeholders.

The development of this Plan has been the most inclusive planning effort ever undertaken by Arizona's HIV community.

Participation of Planning Body Members

More than 60 Planning Body members and guests contributed 1,209 man hours to developing local activities and resources for the regional plans. Members from both Planning Bodies have attended each others' planning meetings. Multiple regional planning sessions occurred, with Planning Body members travelling to each region to meet with stakeholders.

How People Living with HIV Contributed to the Plan

People living with HIV participated in all four stages of planning. A statewide needs assessment was completed by 5% of all people living with HIV in Arizona. Foundational data was also collected from high risk negatives. People living with HIV were included in HIV Symposium and Planning Body activities over the past two years. The Phoenix EMA Ryan White Planning Council and HIV Statewide Advisory Group each meet the federal mandates for representation of people living with HIV and affected community members. Each Planning Body has regular stakeholder attendance at meetings.

Community Participation in HIV Symposium Planning Sessions

Arizona HIV Programs co-host 2-day HIV symposiums each year. The second day of these symposiums is been dedicated to planning. More than 225 unduplicated consumers, providers, stakeholders, Ryan White Program recipients and sub-recipients, and others contributed 1,483 man hours to HIV planning. In the first year, this group identified 1) What needs to happen in the next five years to end the HIV epidemic in Arizona? and 2) What are the barriers that might stop us from achieving this audacious goal? In the second year, the Symposium participants voted for regional goals and objectives, and worked in teams to identify strategies/activities.

The HIV Prevention and Ryan White Programs collaborate to present a 2-day HIV Symposium each year.

Community Participation in Prevention and Care Needs Assessments

Arizona's HIV Programs continue to identify and reach out to populations disproportionately impacted by HIV. Statewide assessments are completed every three years, along with yearly regional assessments of target populations. Additional input is gathered at Planning Body and community advisory board meetings, at community events, and from focus groups and client feedback surveys.

- 774 people living with HIV informed the 2014 statewide needs assessment on needs, gaps and barriers across the prevention and care continuum. This represents 5% of all people living with HIV in Arizona
- 203 community members participated in an HIV prevention assessment, sharing information about sexual habits, STD testing practices and knowledge of Pre-Exposure Prophylaxis
- 65 Newly Diagnosed individuals reflected on their experiences being tested for HIV, coping with receiving their diagnosis, and getting linked to medical care
- People at high risk for contracting HIV are engaged in yearly needs assessments conducted by the HIV Prevention Program

In 2015, the Phoenix EMA Ryan White Planning Council and HIV Statewide Advisory Group collaboratively presented a consumer-centric Leadership Academy.

The HIV Prevention Program has also established work groups to guide social marketing initiatives and service delivery. Participants of the work groups include representatives of people living with HIV, people at-risk for acquiring HIV, human equity groups, youth groups, English and Spanish-language media entities, non-elected community leaders, and non-federally funded partners.

Participation of Program Leadership

The development of the Integrated HIV Prevention and Care Plan was guided by the Program leads for the HIV Prevention Program, Arizona's Ryan White Programs, the Arizona AIDS Education and Train Center and the HIV Surveillance and STD Control Programs, in collaboration with the Planning Body Chairs. Many of these programs are lead by or employ people living with HIV.

How Impacted Communities Will Remain Engaged in Planning and Provide Critical Insight Into Developing Solutions

Arizona considers the integrated Plan a living document that will evolve with continued input from impacted communities. The HIV Statewide Advisory Group and the Phoenix EMA Ryan White Planning Council will be

implementing a variety of community engagement methods, above and beyond collection of needs assessment data and recruitment to Planning Bodies. Some of the methods include:

- Mobile town halls throughout Arizona (two to three per year)
- Client/Community member orientation sessions
- Graphic facilitation of community engagement sessions
- Use of internet-based feedback solutions, such as online surveys

Stakeholders and Partners Who Were Not Involved in the Planning Process, But Who are Needed

During the planning process, an additional 22 agencies and special interest groups were identified by participants for future inclusion in planning efforts. These entities include the Arizona Alliance of Community Health Centers, Black Chamber of Commerce, youth leadership from the Black Lives Matter – Tucson chapter, and Latino Clinic Amistades, among others.

Planning: A Regional Approach

For integrated planning purposes, Arizona has been delineated into three distinct geographically differentiated regions, each with specific public health concerns and HIV challenges.

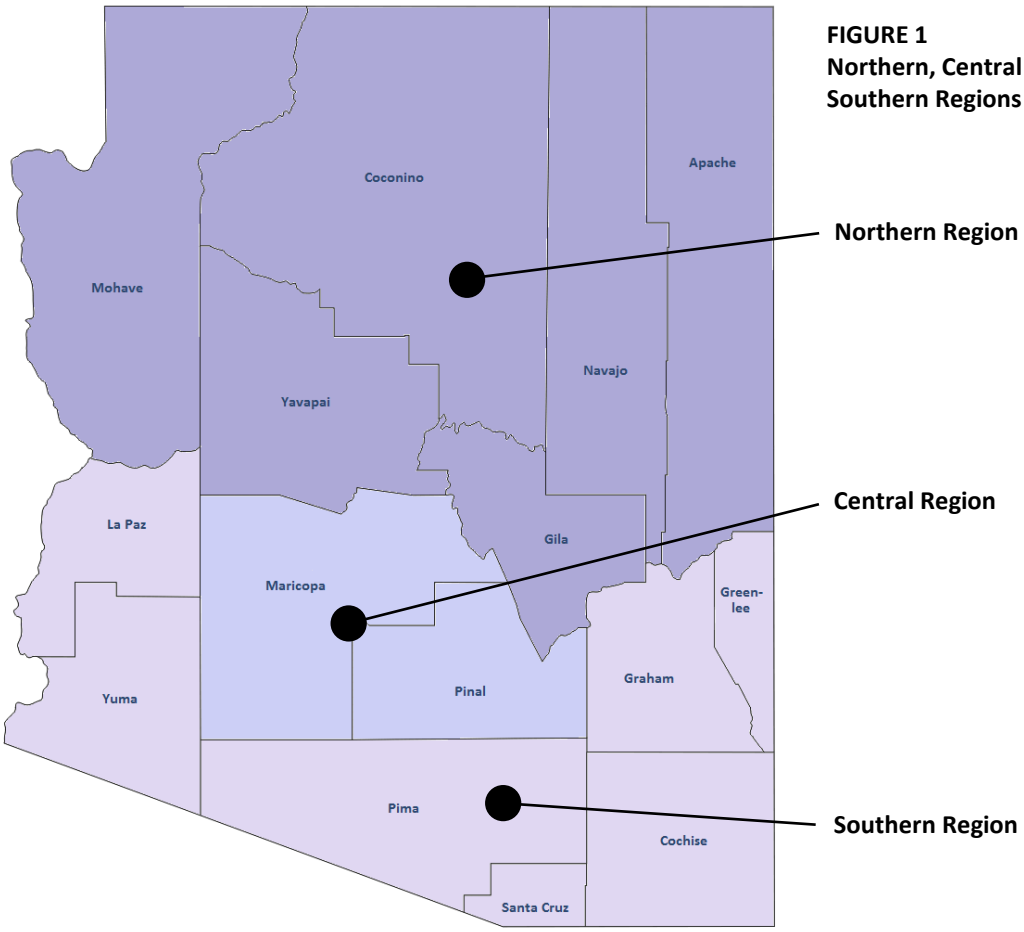


FIGURE 1
Northern, Central and Southern Regions

The Northern Region

The Northern Region includes Mohave, Coconino, Yavapai, Gila, Navajo, and Apache counties. This region is 47,890 square miles, with a population of 792,935 in 2014. Much of the Northern Region is tribal land and/or national forest, and is largely rural outside of the cities of Flagstaff, Prescott and Sedona. The sparse population density poses many challenges both for prevention and care of persons living with HIV. Major HIV issues in the Northern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, and access to resources. Federally-funded HIV care in Mohave county is provided by both the Las Vegas TGA Ryan White Part A Program and the Arizona Ryan White Part B Program. Arizona's HIV Prevention Program funds prevention services in Northern Arizona. The region utilizes an established telemedicine network.

Mohave county, in the Northern Region, was identified by the CDC as one of 221 counties nationwide at risk for an HIV/Hepatitis outbreak.

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- American Indians, regardless of gender
- Injection Drug Users

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased collaboration with mental health/substance abuse providers
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Strengthening of partnerships with providers, correctional facilities, and hospital systems to improve linkage to care timeframes
- Evaluation and implementation of innovative linkage to care/retention in care service models specific adapted to rural communities

The Central Region

The Central Region is comprised of Maricopa and Pinal counties, and had an estimated population of 4,489,109 in 2014. The Central Region includes Phoenix, the state's capital, which is the sixth most populated city in America. Phoenix' 2015 population was estimated to be more than 1,563,025. The Central Region accounts for more than 70% of the state's HIV incidence and prevalence. Major HIV issues affecting the Central Region include ethnic/racial disparities, especially within the African American/ Black community, stigma, lack of sexual health education in schools, and access to care issues.

More than 70% of Arizona's HIV incidence and prevalence occurs in Maricopa county, in the Central Region.

The Central Region defines the geographic service delivery area for the Phoenix EMA Ryan White Part A Program. Ryan White Parts B, C and D, and the HIV Prevention Program also provide services in the Region.

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- African Americans/Blacks, regardless of gender
- Transgender Individuals

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Form reduction and process improvements to reduce duplication of effort among funding sources
- Quality improvement initiatives designed to reduce linkage to care timeframes
- Consumer and provider training related to stigma reduction, cultural competency, and client empowerment
- Social marketing initiatives to increase HIV testing and awareness, PrEP engagement, and engagement in care

The Southern Region

Four counties in the Southern Region border Mexico.

The Southern Region includes Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee, and La Paz counties. The 2014 population for this region was 1,449,440. Pima County has the state's second highest prevalence (16%) and is home to Tucson, the state's second largest city. Four counties (Yuma, Pima, Santa Cruz, and Cochise) border Mexico. Hispanics account for a large percentage of the population of Southern Region counties, with the largest concentration being in counties along the international border. Major HIV prevention issues in the Southern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, access to resources, and border issues.

The HIV Prevention and Ryan White Part B and C Programs provide HIV prevention and care services in the Southern Region.

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- African Americans/Blacks regardless of gender
- Injection Drug Users

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Engagement of community stakeholders and policy makers in advocacy for expanded HIV education, increased local HIV funding, and other HIV-centric issues
- Strengthening partnerships with providers, correctional facilities, and community-based organizations to expand availability and accessibility of quality housing for people living with HIV
- Consumer and provider training related to stigma reduction, cultural competency, and client empowerment
- Social marketing initiatives to increase HIV testing and awareness, PrEP engagement, and engagement in care

Regional Objectives and Strategies to Achieve the National HIV/AIDS Strategy's Goal 1: Reduce New Infections.

Northern Region

Objective 1	Strategies
Increase the percentage of people living with HIV who know their serostatus to at least 90%.	• Community Engagement • Education • Prevention, Testing & Linkage to Care
Objective 2	**Strategies**
Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.	• Funding • Patient-Centered Care • Streamline Processes

Central Region

Objective 1	Strategies
Increase the percentage of people living with HIV who know their serostatus to at least 90%.	• Prevention, Testing & Linkage to Care • Education • Community Engagement • Stigma Reduction
Objective 2	**Strategies**
Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.	• Streamline Processes • Community Engagement • Patient-Centered Care

Southern Region

Objective 1	Strategies
Increase the percentage of people living with HIV who know their serostatus to at least 90%.	• Prevention, Testing & Linkage to Care • Education • Stigma Reduction
Objective 2	**Strategies**
Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.	• Patient-Centered Care • Streamline Processes • Incentives for Care • Stigma Reduction

Regional Objectives and Strategies to Achieve the National HIV/AIDS Strategy's Goal 2: Increase Access to Care and Improve Health Outcomes for People Living With HIV.

Northern Region

Objective 1

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies

- Prevention, Testing & Linkage to Care
- Streamline Processes
- Patient-Centered Care

Objective 2

Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategies

- Patient-Centered Care
- Funding
- Data Standardization

Central Region

Objective 1

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies

- Streamline Processes
- Education
- Patient-Centered Care

Objective 2

Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategies

- Patient-Centered Care
- Community Engagement
- Streamline Processes

Southern Region

Objective 1

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies

- Patient-Centered Care
- Community Engagement
- Stigma Reduction
- Prevention, Testing & Linkage to Care

Objective 2

Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategies

- Streamline Processes
- Patient-Centered Care
- Data Standardization
- Education

Regional Objectives and Strategies to Achieve the National HIV/AIDS Strategy's Goal 3: Reduce HIV-Related Health Disparities and Health Inequities.

Northern Region

Objective 1
Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategies
- Stigma Reduction
- Community Engagement
- Funding

Objective 2
Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies
- Patient-Centered Care
- Community Engagement
- Stigma Reduction

Central Region

Objective 1
Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategies
- Funding
- Patient-Centered Care
- Stigma Reduction
- Population-Specific Assessment & Strategy Development

Objective 2
Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategies
- Community Engagement
- Funding
- Patient-Centered Care

Southern Region

Objective 1
Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategies
- Funding
- Quality Housing
- Community Engagement

Objective 2
Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategies
- Community Engagement
- Education
- Stigma Reduction

Objective 3
Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategies
- Education
- Prevention, Testing & Linkage to Care
- Community Engagement

Regional Objectives and Strategies to Achieve the National HIV/AIDS Strategy's Goal 4: Achieve a More Coordinated Response to the HIV Epidemic.

Northern Region

Objective 1

Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategies

- Community Engagement
- Prevention, Testing & Linkage to Care
- Education

Objective 2

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies

- Prevention, Testing & Linkage to Care
- Streamline Processes
- Patient-Centered Care

Central Region

Objective 1

Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategies

- Coordinated Data Collection & Dissemination
- Patient-Centered Care

Objective 2

Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategies

- Community Engagement
- Funding
- Patient-Centered Care

Southern Region

Objective 1

Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategies

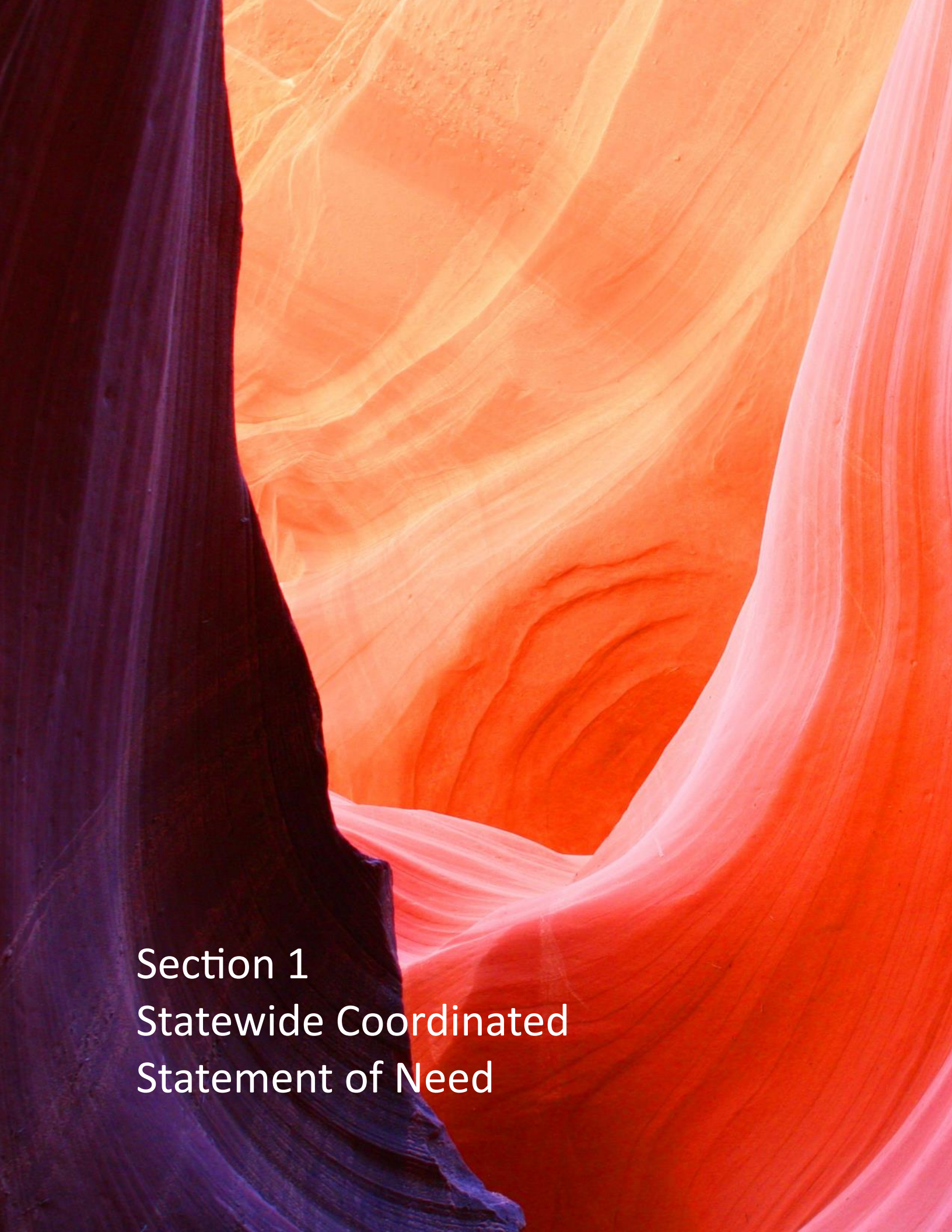
- Funding
- Community Engagement
- Policy Development
- Prevention, Testing & Linkage to Care

Objective 2

Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Strategies

- Patient-Centered Care
- Streamline Processes
- Funding



Section 1
Statewide Coordinated Statement of Need

Epidemiologic Overview of Arizona

Geographical Description

In 2015, Arizona's population was estimated at 6,828,065. The most populous counties experienced an increase in population whereas lesser populated counties remained relatively stable or decreased in size. The state's population grew by 435,758 (6.8%) between April 2010 to July 2015 according to the U.S. Census Bureau's estimates. The three most populous counties in Arizona, Maricopa (350,590), Pima (29,762), and Pinal (30,814) have the largest increases in terms of absolute numbers.

Arizona's least populated county, Greenlee (2015: 9,529), has the largest rate of increase, 12.9%. Maricopa, which is Arizona's most populous county, has the second highest rate of increase (9.2%). Five out of the twelve counties (Apache, Gila, La Paz, Santa Cruz, and Cochise) in Arizona that have a population of less than 320,000 have actually had decreases in population.

The state is 113,909 square miles in area, divided into fifteen counties. Fifty-seven percent is under state and federal jurisdiction, and sixteen percent is privately or corporately owned. Federally owned lands include six national forests: Kaibab, Coconino, Apache-Sitgreaves, Prescott, Tonto, and Coronado. There are 23 national parks, monuments, and historic sites in Arizona from Grand Canyon National Park and Monument to Canyon de Chelly with its Anasazi ruins.

More than a quarter of the area of the state is reservation land that is home to 22 federally recognized American Indian tribes. The largest tribal land areas include 25,000 acres of the Navajo Nation, the largest American Indian reservation in the US, and the entire Tohono O'odham Nation, the second largest reservation in the country. The smallest is the 85-acre Tonto Apache Reservation near Payson. Tribal lands are separate jurisdictions with their own tribal governments, laws and law enforcement units. Approximately 18% of tribal members reside on tribal lands, while 82% reside in urban settings. Some counties have high proportions of American Indians among their population. Seventy-seven

percent of Apache County, 48% of Navajo County, and 29% of Coconino County residents are American Indians.

Planning: A Regional Approach

The Epidemiologic Overview is focused on Arizona as a jurisdiction. For integrated planning purposes, Arizona has been delineated into three distinct geographically differentiated regions, each with specific public health concerns and HIV challenges. Section II of the plan will include abbreviated regional epi data and plans that were locally developed with support from the Planning Bodies and HIV leadership.

Northern Region

The Northern Region of the jurisdiction is comprised of Mohave, Yavapai, Coconino, Gila, Navajo, and Apache counties. The Northern Region combined population was estimated at 792,935 in 2014. The largest city, Flagstaff is located in Coconino county and had a 2015 estimated population of 70,320. Much of the Northern Region is tribal land and/or national forest, which contributes to its rural, or "frontier" vastness. The sparse population density poses many challenges both for prevention and care of persons living with HIV. Key HIV issues in the Northern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, and access to resources. Federally-funded HIV care in Mohave county is provided by both the Las Vegas TGA Ryan White Part A Program and the Arizona Ryan White Part B Program. Arizona's HIV Prevention Program funds prevention services in Northern Arizona.

Central Region

The Central Region of the jurisdiction is comprised of Maricopa and Pinal counties, and had an estimated population of 4,489,109 in 2014. The Central Region includes Phoenix, the state's capitol, which is the sixth most populated city in America. Phoenix' 2015 population was estimated to be more than 1,563,025. The Central Region accounts for more than 70% of the state's HIV incidence and prevalence. Major HIV issues affecting the Central Region include ethnic/racial disparities, especially within the African American/Black community, stigma, lack of sexual health education in schools, and access to care challenges. The Central Region defines the geographic service delivery area for the Phoenix EMA Ryan White Part A Program. Ryan White Parts B, C and D, and the HIV Prevention Program also provide services in the Region.

Southern Region

The Southern Region of the jurisdiction includes Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee, and La Paz counties. The 2014 population for this Region was 1,449,440. Pima County has the state's second highest prevalence (16%) and is home to Tucson, the state's second largest city. Four counties (Yuma, Pima, Santa Cruz, and Cochise) border Mexico. Hispanics account for a large percentage of the population of Southern Region counties, with the largest concentration being in counties along the international border.

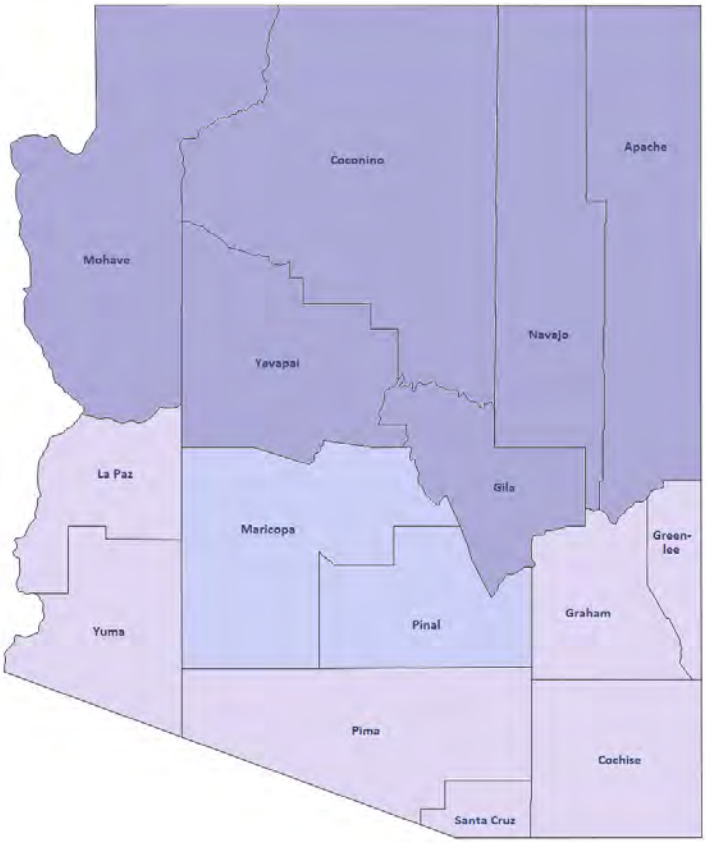


FIGURE 2
Northern, Central and Southern Regions

Key HIV prevention issues in the Southern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, access to resources, and border issues.

The HIV Prevention and Ryan White Part B and C Programs provides HIV prevention and care services in the Southern Region.

Socioeconomic, Demographic and Burden of HIV Data

The socio-demographic characteristics of newly diagnosed individuals, people living with HIV, and people at high-risk for acquiring HIV provides the basis for setting priorities, identifying appropriate interventions and services, and allocating resources.

Income

Arizona's 2014 median annual income is $49,928 with 18% of Arizonans living in poverty. High school graduates compose 86% of the population and bachelor's degree or higher composed 27% from the same year. Sixteen percent of the population has insurance. Nine percent have a disability and are under 65 years old. Among Ryan White clients. Arizona has 514,290 veterans. 13.5% of the Arizonans are foreign born.

Among Ryan White clients 79% earn 200% of the federal poverty level or less, with 51% being under 100% of the federal poverty level.

When evaluating healthcare coverage, 37% have Medicaid, 26% are Medicare, 19% have private insurance (or marketplace insurance), 1% have other insurance and 17% have no insurance. Among Arizona's Ryan White clients, 88% are stably housed, followed by 7% with unstable housing, 3% temporary housing, and 1% non-permanently housed.

Incidence and Prevalence

The State of Arizona experienced an 18% increase in new HIV cases from 2011 to 2012. However, the amount of AIDS cases decreased by 10% from 2011 to 2012. The result was a total HIV/AIDS case increase of 12% from 2011 to 2012, with the majority of new HIV cases among Whites (342 or 39%), Men who have Sex with Men (541 or 61%) and those ranging in age from 20 to 44 (644 or 74%). Correspondingly, the majority of new AIDS cases presented amongst Whites (141 or 43%), Men who have Sex with Men (163 or 50%) within the age ranges of 20 to 44 years of age (190 or 58%). In 2012,the combined HIV/AIDS prevalence of 15,288 represents a 4% or 583 person increase from 2011 and a 7% or 1,046 person increase from 2010. Race/ethnicity categories for people living with HIV are 57% White, 26% Hispanic, 11% African American/Black, 4% American Indian/ Alaska Native, 1% Asian/Pacific Islander and 1% Multi-racial. Gender ratios present at 87% male and 13% female. Additionally, the age categories for people living with HIV are: 1% under 19 years of age, 34% from 20 to 44 and 65% over age 45.

Regional data on incidence, prevalence and trends will be presented in Section II with the regional plans.

	2010	2011	2012	2013	2014
New HIV	406	403	488	526	605
New AIDS	225	174	155	204	157
Total New HIV/AIDS	631	577	643	730	762
Total HIV	6866	7142	7474	7759	8265
Total AIDS	7376	7563	7814	8039	8424
Total HIV/AIDS	**14242**	**14705**	**15288**	**15798**	**16689**

TABLE 1
HIV/AIDS Incidence and Prevalence Totals in Arizona 2010 to 2014

TABLE 2
2014 Arizona Incidence Among Males, by Mode of Transmission

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk
Vertical: Mother-to-Child Transmission

Mode of Transmission	Number of Cases	% Total
MSM	442	73
IDU	34	6
MSM/IDU	31	5
High-Risk Heterosexual Contact	23	4
Presumed Heterosexual Contact	58	9
Vertical	2	0.3
No Risk Reported	16	3

TABLE 3
2014 Arizona Incidence Among Females, by Mode of Transmission

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk
Vertical: Mother-to-Child Transmission

Mode of Transmission	Number of Cases	% Total
MSM	NA	NA
IDU	19	16
MSM/IDU	NA	NA
High-Risk Heterosexual Contact	49	40
Presumed Heterosexual Contact	45	37
Vertical	2	2
No Risk Reported	6	5

TABLE 4
Arizona Reported
Emergent Cases 2014

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	508	84	15.42	137	87.3	4.16	645	84.6	19.57
Female	97	16	2.91	20	12.7	0.6	117	15.4	3.51
TOTAL	**605**	**100**	**9.13**	**157**	**100**	**2.37**	**762**	**100**	**11.5**
By Age									
Under 2	0	0	0	0	0	0	0	0	0
2 to 12	2	0.3	0.2	1	0.6	0.1	3	0.4	0.3
13 to 19	41	6.8	6.46	0	0	0	41	5.4	6.46
20 to 24	118	19.5	24.35	9	5.7	1.86	127	16.7	26.2
25 to 29	123	20.3	27.87	17	10.8	3.85	140	18.4	31.72
30 to 34	88	14.5	19.98	21	13.4	4.77	109	14.3	24.75
35 to 39	73	12.1	17.87	19	12.1	4.65	92	12.1	22.51
40 to 44	61	10.1	14.48	19	12.1	4.51	80	10.5	19
45 to 49	33	5.5	8.11	30	19.1	7.37	63	8.3	15.48
50 to 54	30	5	6.99	17	10.8	3.96	47	6.2	10.95
55 to 59	16	2.6	3.94	11	7	2.71	27	3.5	6.65
60 to 64	11	1.8	2.97	8	5.1	2.16	19	2.5	5.12
65 and Above	9	1.5	0.88	5	3.2	0.49	14	1.8	1.37
Age Unknown	0	0	N/A	0	0	N/A	0	0	N/A
TOTAL	**605**	**100**	**9.13**	**157**	**100**	**2.37**	**762**	**100**	**11.5**
By Race/Ethnicity									
White Non-Hispanic	220	36.4	5.76	66	42	1.73	286	37.5	7.49
Black Non-Hispanic	117	19.3	39.49	15	9.6	5.06	132	17.3	44.55
Hispanic	210	34.7	10.47	57	36.3	2.84	267	35	13.32
***A/PI/H Non-Hispanic**	14	2.3	6.24	3	1.9	1.34	17	2.2	7.58
****AI/AN Non-Hispanic**	41	6.8	14.64	16	10.2	5.71	57	7.5	20.35
*****MR/O Non-Hispanic**	3	0.5	N/A	0	0	N/A	3	0.4	N/A
TOTAL	**605**	**100**	**9.13**	**157**	**100**	**2.37**	**762**	**100**	**11.5**
By Mode of Transmission									
+MSM	389	64.3	N/A	82	52.2	N/A	471	61.8	N/A
++IDU	42	6.9	N/A	16	10.2	N/A	58	7.6	N/A
MSM / IDU	28	4.6	N/A	5	3.2	N/A	33	4.3	N/A
Heterosexual	59	9.8	N/A	16	10.2	N/A	75	9.8	N/A
+++O/H/TF/TPR	4	0.7	N/A	1	0.6	N/A	5	0.7	N/A
++++NRR/UR	83	13.7	N/A	37	23.6	N/A	120	15.7	N/A
TOTAL	**605**	**100**	**9.13**	**157**	**100**	**2.37**	**762**	**100**	**11.5**

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

TABLE 5
Arizona Estimated Prevalence 2015

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	6956	41.7	211.1	7329	43.9	222.42	14285	85.6	433.52
Female	1309	7.8	39.29	1095	6.6	32.87	2404	14.4	72.16
TOTAL	**8265**	**49.5**	**124.72**	**8424**	**50.5**	**127.12**	**16689**	**100**	**251.85**
By Age									
Under 2	2	0	0	0	0	0	0	0	0
2 to 12	51	0.3	5.13	11	0.1	1.11	62	0.4	6.24
13 to 19	75	0.4	11.83	14	0.1	2.21	89	0.5	14.03
20 to 24	359	2.2	74.07	77	0.5	15.89	436	2.6	89.95
25 to 29	693	4.2	157.02	269	1.6	60.95	962	5.8	217.97
30 to 34	832	5	188.88	449	2.7	101.93	1281	7.7	290.82
35 to 39	876	5.2	214.38	698	4.2	170.82	1574	9.4	385.2
40 to 44	1066	6.4	253.11	1053	6.3	250.03	2119	12.7	503.14
45 to 49	1199	7.2	294.56	1590	9.5	390.62	2789	16.7	685.18
50 to 54	1321	7.9	307.8	1824	10.9	425.01	3145	18.8	732.81
55 to 59	844	5.1	207.94	1162	7	286.29	2006	12	494.24
60 to 64	484	2.9	130.47	721	4.3	194.35	1205	7.2	324.82
65 and Above	446	2.7	43.77	556	3.3	54.57	1002	4.5	71.54
Age Unknown	19	0.1	NA	0	0	NA	19	0.1	NA
TOTAL	**8265**	**49.5**	**124.72**	**8424**	**50.5**	**127.12**	**16689**	**100**	**251.85**
By Race/Ethnicity									
White Non-Hispanic	4366	26.2	114.27	4622	27.7	120.97	8988	53.9	235.24
Black Non-Hispanic	1113	6.7	375.67	1018	6.1	343.61	2131	12.8	719.28
Hispanic	2208	13.2	110.12	2254	13.5	112.41	4462	26.7	222.53
***A/PI/H Non-Hispanic**	135	0.8	60.18	107	0.6	47.7	242	1.5	107.88
****AI/AN Non-Hispanic**	279	1.7	99.61	336	2	119.96	615	3.7	219.57
*****MR/O Non-Hispanic**	164	1	N/A	87	0.5	N/A	251	1.5	N/A
TOTAL	**8265**	**49.5**	**124.72**	**8424**	**50.5**	**127.12**	**16689**	**100**	**251.85**
By Mode of Transmission									
+MSM	4977	29.8	N/A	5080	30.4	N/A	10057	60.3	N/A
++IDU	767	4.6	N/A	910	5.5	N/A	1677	10	N/A
MSM / IDU	535	3.2	N/A	856	5.1	N/A	1391	8.3	N/A
Heterosexual	921	5.5	N/A	910	5.5	N/A	1831	11	N/A
+++O/H/TF/TPR	121	0.7	N/A	96	0.6	N/A	217	1.3	N/A
++++NRR/UR	944	5.7	N/A	572	3.4	N/A	1516	9.1	N/A
TOTAL	**8265**	**49.5**	**124.72**	**8424**	**50.5**	**127.12**	**16689**	**100**	**251.85**

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

HIV Risk Factors

2015 Youth Risk Behavior Surveillance System (YRBSS) data for Arizona reports 39% of youth have had sex and among those who were sexually active 45% did not use a condom during last sexual intercourse. *Arizona does not use the YRBSS to survey youth about HIV, intravenous drug use, or partner violence through the YRBSS.*

In 2015, the Ryan White Part A and B Programs, with assistance from the HIV Prevention Program, conducted a survey of 65 newly diagnosed individuals to better understand risks and inform strategies. Participants were 71% male, 29% female, 35% aged 18 to 24, 39% 39 to 44, 17% 45 to 54, 9% 55+, 43% White, 35% African American/Black, 11% Native American, 2% Asian or Pacific Islander, 8% Other, 32% Hispanic/Latino, 49% Men who have Sex with Men (MSM), 34% Heterosexual, 6% Injection Drug User, 9% Other, and 1% Men who have Sex with Men and Injection Drug User. Of MSM respondents, 64% use web applications for sex. Of those, 52% are seeking sex 5+ days a week, 24% 3 to 4 days a week and 24% 1 to 2 days a week. Overwhelmingly, participants reported receiving their HIV information from their doctors and internet searches (Google, Bing, etc.) with limited use of school and social media resources.

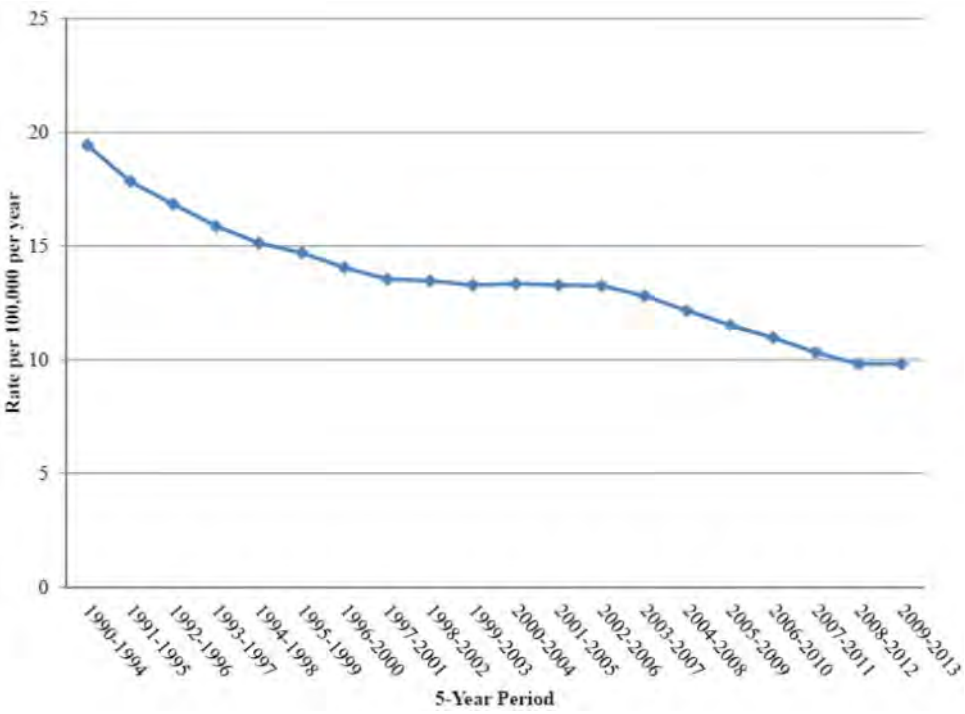


FIGURE 3
Arizona 5-Year Emergent HIV/AIDS Case Rate Trend

FIGURE 4
Arizona Emergent HIV/AIDS Case Trend by Single Year

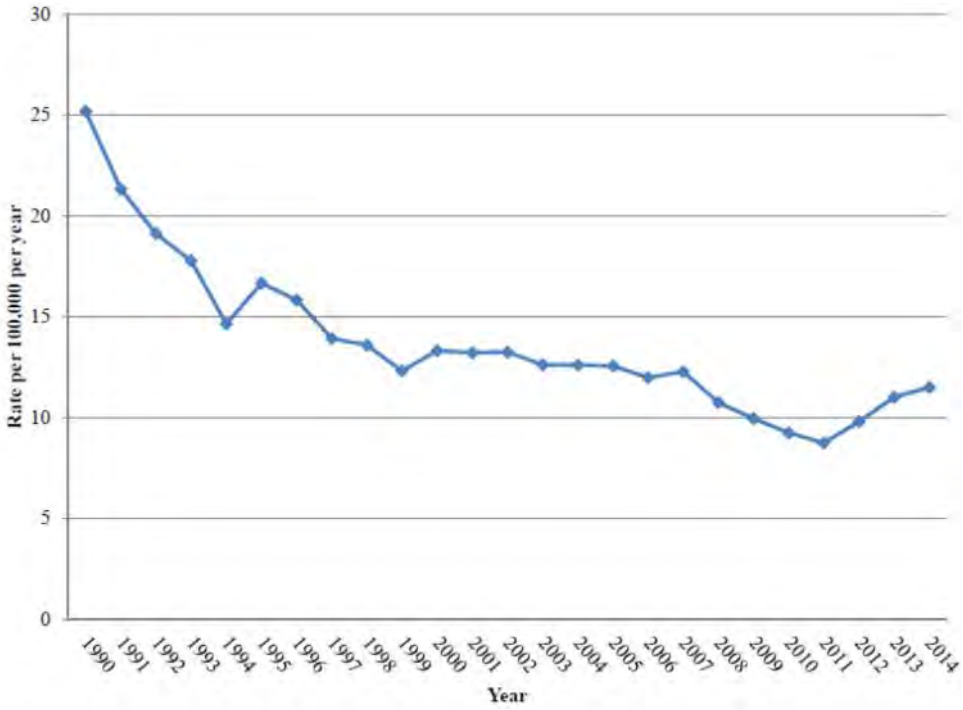


Figure 2 shows the five-year average rates, which have less year-on-year variance than the single-year rates. The five-year emergent HIV/AIDS case rate declined steadily throughout the 1990s, leveling off from the 1998-2002 time period and began to decline slightly again starting with the 2003 to 2007 time period. The five-year rates have had an overall decline for the past decade. The 2009 to 2013 five-year rates are 23% lower than the rate for 2003 to 2007.

The single-year rates have fluctuated more than the five-year rates, but a similar pattern is present (Figure 3). These rates also declined through the 1990's. The 2014 single-year rate is 13% lower than the rate for the year 2000, however, the rate for 2014 (11.5 per 100,000) is slightly higher than in 2013 (11.02 per 100,000). According to the most recent estimates of the Centers for Disease Control and Prevention, the 2011 estimated HIV/AIDS diagnosis rate for Arizona was under the national rate of 11.9 per 100,000 population (CDC Diagnoses of HIV Infection in the United States and Dependent Areas, 2014 (http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf).

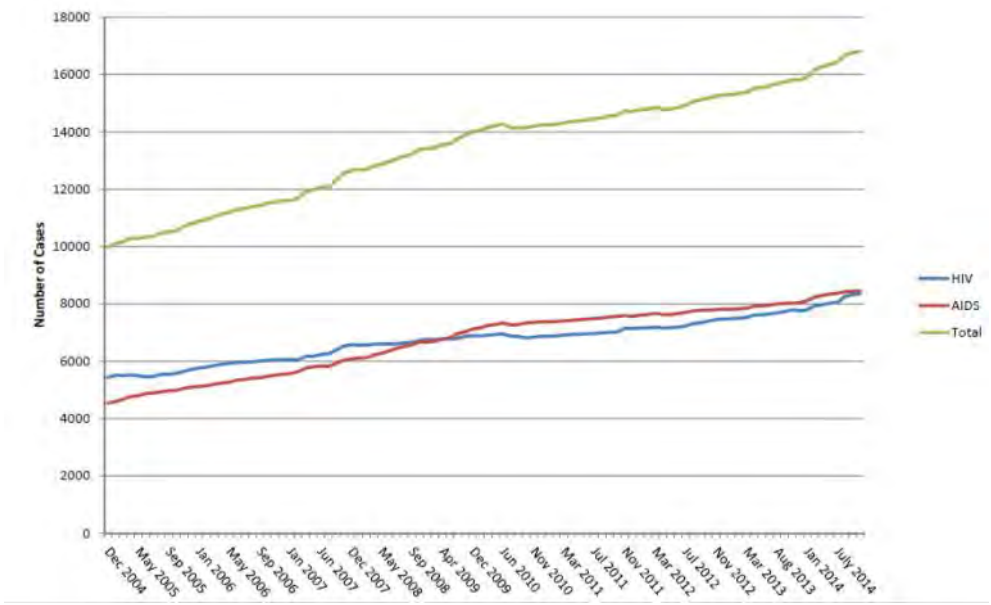


FIGURE 5
Arizona HIV/AIDS Prevalence Trend

Figure 4 shows the number of HIV/AIDS cases in Arizona. Arizona is currently considered a moderate morbidity state, with CDC-estimated prevalence in the middle rate category among states with well-established confidential name-based HIV reporting. Prevalence numbers have continued to rise in Arizona, but this is expected given the population of Arizona has been increasing every year for the past decade. As of December 2014, prevalence of reported HIV infection is 250.63 cases per 100,000 persons. Currently, there are 16,608 persons living with HIV/AIDS in Arizona, a rise of 23% in five years. The increase in prevalence rates may be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced the number of HIV-related deaths.

Of the 13,447 prevalent cases in the state five years ago, only 12.3% reported residing in another state, or had died in another state. Among prevalent cases, 25.5 % were diagnosed in another state.

In June 2009, the number of persons living with AIDS in Arizona surpassed the number of persons with HIV infection who have not been diagnosed with AIDS (Figure 3). Because the burden of HIV-related disease is greater among persons with AIDS, treatment, utilization, and continuity of care are an increasingly critical issues.

Among all the risk groups in Figure 6, Men who have Sex with Men (MSM) account for the largest proportion of emergent HIV/AIDS cases in Arizona. In 2014, the proportion of emergent cases that were MSM-related was

FIGURE 6
Arizona Percentage of Emergent Cases by Reported Risk Behavior, 1990 to 2014

Key
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk

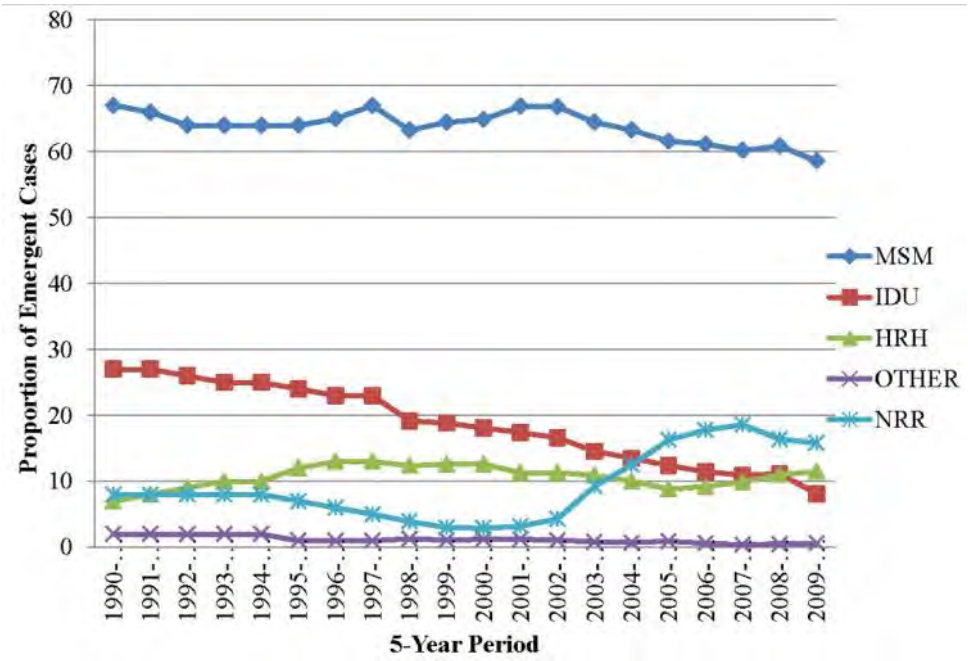
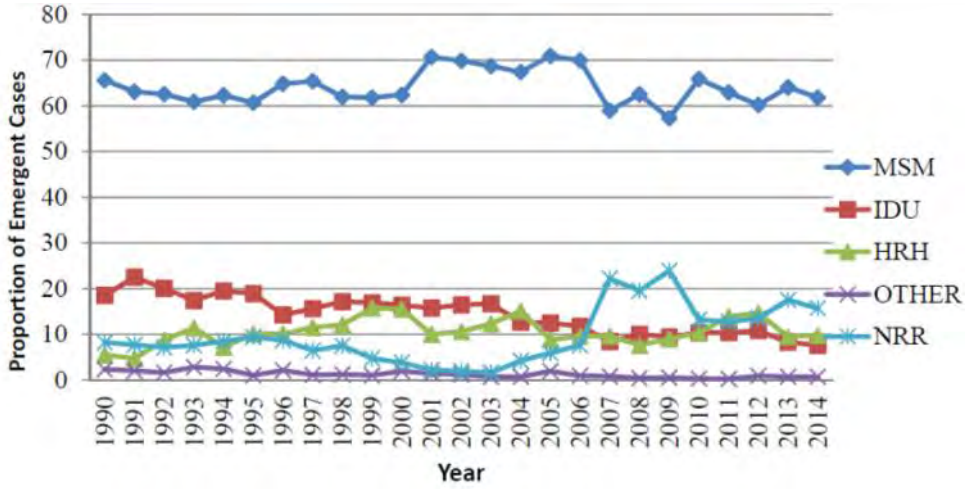


FIGURE 7
Estimated Single-Year Emergent HIV/AIDS Rates by Risk 1990 to 2014

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk



61.8%, the highest among all risk groups. The single-year MSM rate, however has declined from 64.5% in 2013 to 61.8% in 2014. The downward trend in rates among MSM has been mirrored by a similar upward trend among persons with No Reported Risk (NRR), which has decreased from 17.5% in 2013 to 15.7% in 2014.

Rates of HIV/AIDS prevalence and emergence differ sharply between Black Non-Hispanics and other racial/ethnic groups in Arizona. According to the 2014 single-year rates (Figure 6), the rate of HIV/AIDS emergence in Black Non-Hispanics have increased from 80% from 2010 to 2014. The 2014

emergent HIV/AIDS rate among Black Non-Hispanics in Arizona is 273% greater than the statewide average. These results are consistent with national data. The CDC estimates Black Non-Hispanics made up 46% of new 2011 HIV diagnoses despite composing only 12% of the overall population (CDC slide set, HIV Surveillance by race/ethnicity, through 2011 data http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.ht).

2015 Survey of Newly Diagnosed Clients for Ryan White Parts A and B

Since 2014, the HIV Prevention Program and Ryan White Part A and B Programs have collaborated on needs assessment activities. The 2015 Survey of Newly Diagnosed Clients was commissioned to gain a better understand 1) The experiences of individuals who have been recently diagnosed, and how organizational systems and processes enhanced or challenged their entry into care, 2) The client-centric issues (mindset, stigma, support systems, etc.) that enhanced or challenged entry-to-care for these individuals, 3) The knowledge/awareness/perceptions of HIV that these individuals had prior to being diagnosed, including a retrospective "hindsight" analysis of what changes in their knowledge, choices, actions, etc. might have minimized their risk of contracting HIV, and 4) How these individuals find, access and navigate systems of HIV care. Table 6 summarizes the results of this survey.

TABLE 6
2015 Survey of Newly Diagnosed Clients for Ryan White Parts A and B

	Received Prior HIV Prevention Messages	Knew an HIV+ Person Prior to Diagnosis	Never Tested Before Diagnosis	Diagnosis Location	Know of PrEP	Undetectable at Time of Survey
Gender						
Male	67%	37%	48%	52% Clinic or HIV testing site	30%	52%
Female	68%	11%	42%	42% Doctor's Office	0%	79%
Age Group						
18 to 24	78%	22%	43%	57% Clinic or HIV testing site	30%	57%
25 to 44	56%	68%	40%	56% Clinic or HIV testing site	28%	72%
45 to 54	64%	36%	63%	55% Emergency Department/Hospital	0%	73%
55+	83%	33%	50%	83% Doctor's Office	0%	83%
Race/Ethnicity						
White	64%	36%	29%	39% Clinic or HIV testing site	18%	64%
Hispanic/Latino	62%	14%	38%	48% Clinic or HIV testing site	29%	57%
African American or Black	65%	30%	39%	61% Clinic or HIV testing facility	30%	74%
Native American	86%	29%	100%	43% Emergency Department/Hospital	0%	57%
Asian/Pacific Islander	100%	0%	100%	100% Clinic or HIV testing site	0%	100%
Risk Factor						
MSM	75%	38%	41%	59% Clinic or HIV testing site	41%	53%
Heterosexual	68%	5%	50%	36% Clinic or HIV testing site	0%	82%
IDU	50%	50%	50%	50% Doctor's Office 50% Emergency Dept.	0%	50%

The Arizona HIV Care Continuum

The HIV Continuum of Care—sometimes also referred to as the HIV treatment cascade—is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care. The Arizona HIV Continuum of Care was created using data from eHARS (electronic HIV/AIDS Reporting System), an analysis of unmet needs, and ADAP (AIDS Drug Assistance Program) information. The definitions were agreed upon by the Arizona Regional Quality Group, composed of HIV Prevention, all Ryan White Parts in Arizona and HIV Surveillance.

As shown in Figure 8, in 2014 there were 16,769 HIV infected individuals in Arizona: an estimated 1,641 who are unaware of their HIV status, and 16,769 individuals who have been diagnosed as being HIV positive. Of the 16,769 who are aware of their status, 10,590 were linked to care. Of that number, 8,105 are retained in care. 8,270 HIV positive individuals are on Antiretroviral Therapy. Finally, only 8,003 HIV positive individuals have an undetectable viral load.

The percentages of HIV cases in Arizona, as shown in Figure 9, indicate just over half of all individuals diagnosed with HIV (aware of their HIV status) are linked to care (63%), but less than half (48%) are retained in care. 48% of individuals in Arizona who are aware of their HIV status have an undetectable viral load.

When 100% of HIV positive Arizonans are linked to and retained in care, a greater number of individuals will be on Antiretroviral Therapy, which will increase the percentage of individuals with an undetectable viral load. Data suggest that HIV positive individuals with an undetectable viral load are less infectious, and are less likely to transmit HIV via sexual contact.

Continuum of Care Definitions

HIV-Diagnosed: Prevalent cases that have been diagnosed

Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year

Incidence Linked to HIV Care: Incident cases for the year of the spectrum that were linked with a documented lab test, doctor visit or medication use within 90 days of their diagnosis, but not on the same day of the diagnosis. If a person has their first CD4, viral load or genotype on the same day as their diagnostic test the date of second CD4, viral load or genotype will be used as the linkage

Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or antiretroviral (ARV) use in the first and second six months of the year

On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable

Adherent/Suppressed: Prevalent cases whose last viral load of the calendar year was undetectable (<200 C/mL)

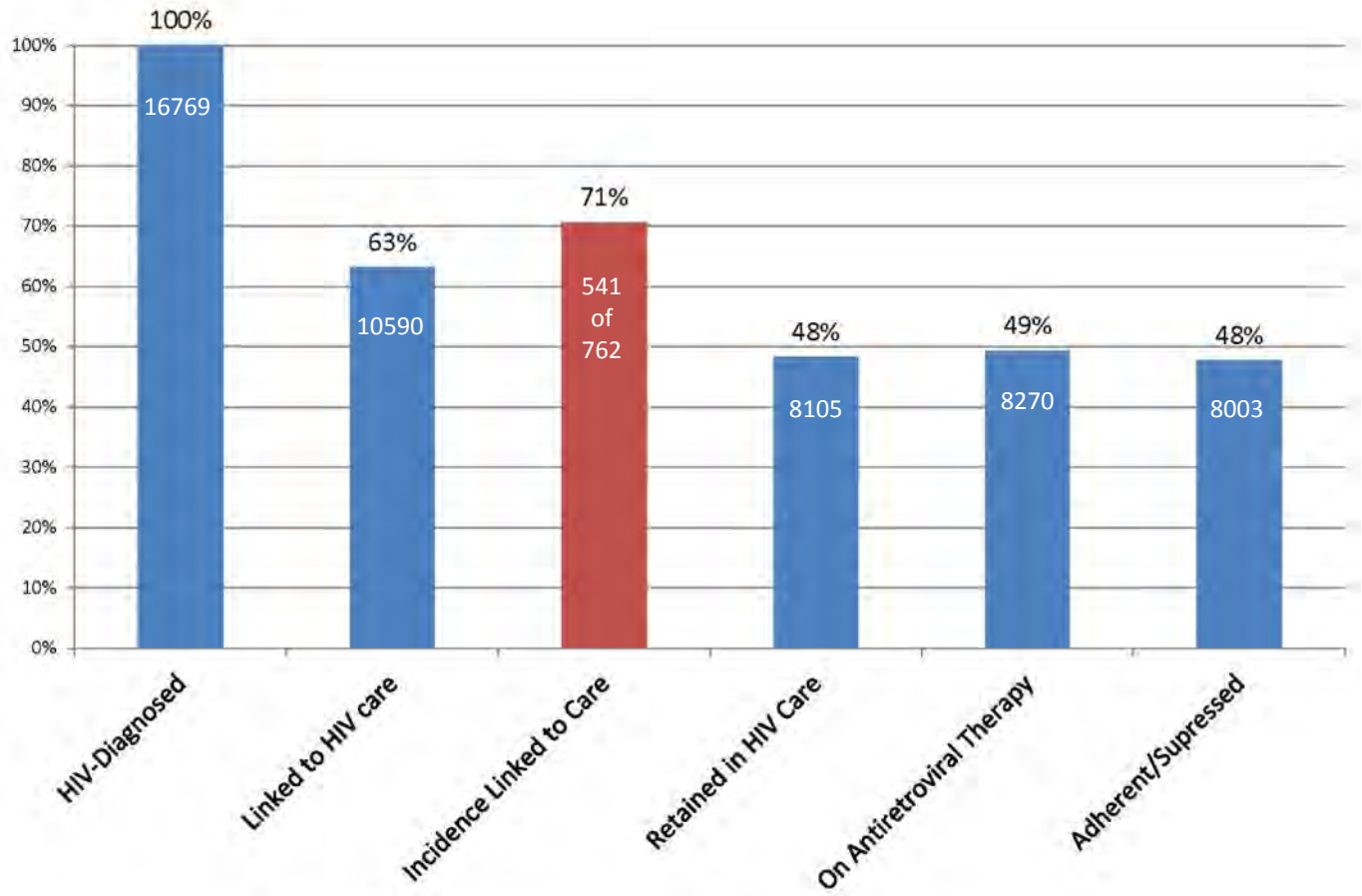


FIGURE 8
2014 Arizona HIV Continuum of Care

Continuum Disparities

Arizona utilizes a diagnosed based continuum. Continuum definitions can be found to the left. All columns were evaluated utilizing the 2014 calendar year data and with one exception, include a denominator of all the 2014 clients in the eHARs data system.

The HIV Surveillance Program has provided Arizona and regional continuum data dissected by race, gender, and risk. In evaluating the Arizona continuums, American Indians have some of the strongest outcomes with 85% of new cases linked and 60% virally suppressed. African American/Black and Hispanic populations report some of the lowest viral load suppression rates at 43% compared to 48% statewide. Men who have Sex with Men and Injection Drug User risk factors consistently scores the lowest with a linkage rate of 61%, retention rate of 45% and viral load suppression rate of 66%.The highest risk factor for viral load suppression is held by the Perinatal/Blood/Other group at 75%, followed by Men who have Sex with Men at 73%.

Ryan White Programs have supplemented Surveillance continuums with more frequent continuums developed by local CAREWare data. Currently, all Ryan White Programs in Arizona are collecting client lab values through Ryan White eligibility, or for Part C-hosted medical treatment. The Ryan White Programs have developed an Access database which translates CAREWare outcome reports to more easily graphed metrics. The Arizona Ryan White continuums are evaluated by race, gender, risk, housing, payer and service category. The continuums may be dissected by any of the Ryan White HIV/AIDS Program Services Report (RSR) data elements. Of interest are noted disparities among youth with 56% viral load suppression rates versus an 87% viral load suppression rate for adult males in RWPB/ADAP. Unstably housed report 67% viral load suppression rates compared to 92% among those stably housed. Among a review of race and ethnicity outcomes, viral load suppression rates range from 80% for African American/Black clients to 93% for Asian clients.

HIV Care Continuum Stages		
	Number	Percentage
Diagnosed	4,536	100%
Linked	4,103	90%
Retained	4,103	90%
Prescribed	3,979	88%
Suppressed	3,668	81%

Ryan White Part B
Arizona Department of Health Services
January 1, 2016 - December 31, 2016

Wednesday, May 25, 2016

		Retained in Care						Viral Suppression					
	Total Diagnosed	Retained	Not Retained	P Value	Odds Ratio	More Likely	Less Likely	Suppressed	Not Suppressed	P Value	Odds Ratio	More Likely	Less Likely
Entire Population	4,536	4,103	433					3,668	868				
Gender													
Female >24 years of age	691	634	57	0.1925	1.14	1.14	-----	552	139	0.1344	0.8911	-----	1.12
Male > 24 years of age	3,649	3,313	336	0.329	0.9383	-----	1.07	2,985	664	0.057562	1.173	1.17	-----
Transgender	34	28	6	0.0838	0.4647	-----	2.15	23	11	0.01936	0.4747	-----	2.11
Age Group													
Children	7	3	4	0.002075	0.07644	-----	13.08	3	4	0.02727	0.174	-----	5.75
Youth	147	125	22	0.008372	0.5711	-----	1.75	105	42	0.00115	0.57	-----	1.75
25+ years	4,340	3,947	393	0.0005133	2.04	2.04	-----	3,537	803	0.0001989	1.876	1.88	-----
Race/Ethnicity													
American Indian or Alaska Native	146	132	14	0.0003258	0.9949	-----	1.005	123	23	0.1462	1.275	1.28	-----
Asian or Pacific Islander	67	61	6	0.02747	1.074	1.074	-----	56	11	0.2844	1.208	1.21	-----
Black or African American	454	390	64	0.0002519	0.6056	-----	1.65	348	106	0.008084	0.7535	-----	1.33
Hispanic (any race)	1,492	1,396	96	0.000000297	1.81	1.81	-----	1,249	243	0.000319	1.328	1.33	-----
White/Caucasian	2,157	1,933	224	0.03356	0.8311	-----	1.20	1,727	430	0.09641	0.9063	-----	1.10
Unknown/Other	220	191	29	0.02995	0.6802	-----	1.47	165	55	0.0117	0.6963	-----	1.44
Primary Payer Category													
AHCCCS/Medicaid	1,138	1,028	110	0.4367	0.9817	-----	1.02	906	232	0.1078	0.8992	-----	1.11
Medicare	1,034	959	75	0.001703	1.47	1.47	-----	889	145	0.000000985	1.595	1.60	-----

FIGURE 9
Screenshot of Arizona Deep Dive Data Analysis Tool

To further understand health disparities, the Arizona Regional Quality Group developed a "deep dive" tool (figure 10) to evaluate health disparities along the continuum. This group is composed of leadership and quality staff from all the Ryan White Programs in Arizona, and the HIV Prevention and HIV Surveillance Programs. This "deep dive" tool evaluates the statistical significance of various factors and translates the likelihood of retention and viral load suppression into a statement such as, "Youth are 1.75 times less likely to be retained in care than the average Ryan White

client" or "Clients with Ryan White as a primary payer are 3.4 times more likely to be retained and two times more likely to be virally suppressed than the average Ryan White client." The tool identifies the p-value for each data element, and odds ratio. The Arizona Regional Quality Group has decided to focus on health outcomes for transgender (two times less likely to be retained, two times less likely to be virally suppressed) and youth (1.75 times less likely to be retained and 1.75 times less likely to be virally suppressed).

Prevention and Care Programs are receiving CDC-provided technical assistant to design a transgender provider training and a transgender needs assessment for use in 2017.

Continuum Planning

The HIV Care Continuum is one of Arizona's primary tools for measuring progress towards ending HIV through viral load suppression in Arizona. Recognizing the importance of comparable continuum data, the Arizona Regional Quality Group established statewide definitions and won a National Quality Award in 2015 for this collaborative regional quality group work. Continuum data has been heavily featured in both Annual HIV Symposiums. These Symposiums were attended by Planning Body members, staff from the HIV Prevention Program, Arizona Ryan White Programs, non-federally funded AIDS Service Organizations and community members. The HIV Prevention Program presented on the alignment of its activities across the care continuum, including promotion of routine HIV testing, and the use of evidence-based behavioral interventions to support treatment as prevention.

Within the Ryan White Programs, local continuums are used to drive change at the sub-recipient level. During quarterly monitoring calls, Ryan White Part A and B sub-recipients are given an agency-specific continuums that benchmarks outcomes to the regional and state average. Agency-specific continuums include evaluation by race/ethnicity, age, housing status, and a variety of factors. To further impact the continuum, the Ryan White Programs will be developing related, client named reports to distribute to sub-recipients, so they can follow up on individuals who are not virally suppressed or retained in care. Analysis of continuum data is leading to a transgender assessment and youth focused activities in 2017.

Due to the sharing of multiple sub-recipient agencies, the HIV Prevention Program and Ryan White Part B Program participate in joint quarterly monitoring calls for the 15 agencies funded outside of Maricopa and Pinal counties. The Ryan White Part A Quality Committee directs all sub-recipient quality improvement activities for linkage, retention or viral load suppression. The recently formed Ryan White Part B/HIV Prevention Program Quality Committee will soon guide similar quality initiatives.

Some continuum-focused successes include a workgroup of the HIV Prevention Program, Maricopa County Department of Public Health, and the Ryan White Part A Program that implemented activities that decreased linkage to care timeframes from an average of 58 days to 32 days. Related processes have evaluated and streamlined required paperwork, adjusted client scheduling approaches, and guided increased allocation of resources for newly diagnosed clients.

Continuum data is also being used to engage a larger, non-federally funded community. The Ryan White Part B Program is exploring opportunities to use rebate funds to help private HIV clinicians develop data reporting tools that would allow private clinicians to compare their practice to regional averages and Ryan White clinic performance. A group of private physicians have petitioned the Mayor of Phoenix to have the city designated as the 10th North American UNAIDS 90-90-90 Fast-Track City. The 90% aware, 90% retained, and 90% virally suppressed goals of the Fast-Track Cities Initiative is a variation of the continuum data that is being tweaked and integrated into the larger Integrated Plan framework. Due to the continuum's ability to show the story of how the community is moving closer or further from the end of the HIV epidemic, development of a community facing 'continuum report card' is currently in the works.

Financial and Human Resources Inventory

HIV Workforce Capacity and Impact on Prevention and Care Systems

The Arizona HIV Workforce Capacity was ascertained by surveying providers statewide to determine present capacity and identify gaps in capacity. The workforce was identified as follows: HIV Specialists, Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Practical Nurses, Medical Assistants, Nutritional Counselors, Psychiatrists, Psychologists, Licensed Clinical Social Workers, Medical Case Manager, Support Case Managers, Dentists, Dental Hygienists, and Administrative Support staff. The workforce impacts HIV prevention and care service delivery system by providing adequate availability of care and the quality of that care. Inadequate staffing could have a negative impact on services available to clients. Additional staff was identified as necessary and ways to address this issue are outlined in Table 8. Different funding sources interact via partnership between the Arizona Ryan White Programs, the HIV Prevention Program, local agencies and organizations, and providers working together to ensure services complement each other and are not duplicated.

HIV Resources Inventory

Arizona partners funded by the Health Services and Resources Administration, The Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, Housing Opportunities for Persons Living with AIDS, the National Institutes of Health, Indian Health Services, Arizona State Department of Health Service, and Arizona Medicaid, as well as those receiving from private sources, foundations, donations, and fees provided resource information via a comprehensive survey. Table 9 provides a high level summary of the $112,066,332 of HIV funding in Arizona. Table 10 identifies the services and correlation to phases of the continuum of care. Tables 11 to 16 detail the agency funding sources, Catalog of Federal Domestic Assistance numbers, dollar amounts per award or private funding source, and how the sources are being used. Detailed funding sources are located at the end of the Financial and Human Resources Inventory Section.

Funding Source Interaction

The Arizona Ryan White Programs and the HIV Prevention Programs grant participate in a monthly conference call to discuss collaborative issues, which include program updates, grant issues, and funding priorities. This regular meeting provides an opportunity for the recipients to share information on issues that may require assistance from the other Arizona programs. The Ryan White Part B program has availability of rebate funds

TABLE 7
2016 HIV Workforce Capacity

Identified Need	Number of Staff	Number Providing HIV Care	Additional Resources Identified by Participants
HIV Specialist	23	23	16
Physician (non-HIV specialist)	21	17	14
Nurse Practitioner	24	18	14
Physician Assistant	22	18	13
Registered Nurse	24	19	14
Licensed Practical Nurse	20	16	13
Medical Assistant	23	19	14
Nutritional Counselor	22	16	15
Psychiatrist	19	17	13
Psychologist	22	18	13
Licensed Clinical Social Worker	18	15	15
Medical Case Manager	23	19	17
Support Case Manager	21	19	16
Dentist	20	16	13
Dental Hygienist	20	16	13
Administrative Support	26	19	15

through the AIDS Drug Assistance Program, and has established mechanisms for the other Arizona recipients to request rebate funds for allowable HIV services that are needed, but not currently funded through grant funding. Several projects have been funded through rebate funds in 2015, including housing, medical services for newly diagnosed individuals, data system improvements, medical case management, trauma informed care training, and expanded core and support services.

All of the recipients participate in the Arizona Regional Quality Group, which analyzes statewide and regional data. This collaboration has resulted in identification of gaps in service that may be resolved through additional funding.

The Ryan White Part B, C and D Programs, the HIV Prevention Program, and Arizona's Medicaid Program have representation on the Phoenix EMA Ryan White Planning Council, and these representatives participate in the Council's annual Priority Setting and Resource Allocations process. Additionally, the Ryan White Part B and HIV Prevention Programs collaborate with the Las Vegas TGA Part A Program, which is responsible for funding HIV services in Mohave County, Arizona to ensure adequate funding is available for the needs of people living with HIV in this region.

Needed Resources

The Financial and HIV Workforce Capacity Inventories identified the following resources needed to meet the Statewide goal of ending the HIV epidemic by 2021.

The Arizona recipients and sub-recipients will evaluate progress on improvement in each of these identified need areas on an annual basis as part of the monitoring and evaluation process outlined in the Integrated HIV Prevention and Care Plan.

The Workforce Inventory Survey participants identified the following changes could assist in addressing workforce gaps: 53% improved reimbursement for clinical services, 48% additional state funding, 44% additional federal funding, and 20% other.

TABLE 8
2016 HIV Workforce Capacity Additional Staff Needed and Steps to Secure Resources

Identified Need	Steps to Secure Resources	Timeline
Additional HIV Medical Providers	Training and preceptorship by AETC	2017to 2021
Increased Federal Funding for HIV Prevention	Annual needs assessment to identify priorities	2017 to 2021
Increased Federal Funding for HIV Services	Annual Priority and Resource Setting Allocation process to identify priorities and funding levels	2017 to 2021
Improved Reimbursement Rate by Medicaid	Continued discussion with Medicaid on establishing rates specific for HIV care and services	2017 to 2021
HIV Prevention and Service Needs Assessment	Update needs assessment every two years	2017 to 2021
Increased Partner Services	HIV Prevention Program to identify resources that could be allocated to increase partner services	2017 to 2021
Increased Number of Test Sites	HIV Prevention Program in partnership with Ryan White Care Sites	2017 to 2021
Improved health literacy	Ryan White Parts A and B to fund health literacy initiatives	2017 to 2021
Improved Treatment Adherence	Ryan White Programs to evaluate as part of continuum focused activities	2017 to 2021
Increased Resources for Housing	Ryan White Part B to meet with partners and identify resources	2017 to 2021
Education/Awareness campaigns for Underserved Populations	HIV leadership to plan with community input	2017 to 2021
Provide Services in More Culturally Competent Manner	Planning Bodies to inform cultural competency training.	2017 to 2021

TABLE 9 2016 Aggregate Arizona HIV Resources

Funding Source	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
Total Funding	**112,066,332**	**100%**	x	x		x	x	x	x		x	x	x	x	x	x	x	x	x	x	x		x	x		x					x	x	x	x	x
Public Funding	**110,188,016**	**98.3%**	x	x		x	x	x	x		x	x	x	x	x	x		x	x		x		x	x		x					x	x	x	x	x
HRSA Subtotal	**34,160,389**	**30.5%**	x	x		x	x	x				x	x	x	x	x			x		x		x	x		x					x	x			x
CDC Subtotal	**6,138,957**	**5.5%**																														x	x		
SAMHSA Subtotal	**1,716,203**	**1.5%**										x			x																				
HOPWA Subtotal	**2,496,467**	**2.2%**																			x														
NIH Subtotal	**480,397**	**0.4%**																																x	
I H S Subtotal	**160,091**	**0.1%**																														x			
ADHS- State Appropriation	**1,000,000**	**0.9%**																															x		
AHCCCS- Arizona Medicaid (1)	**64,035,512**	**57.1%**	x	x		x			x		x	x												x											x
Private Funding	**1,878,316**	**1.7%**	x									x	x				x			x					x	x						x	x		x
Foundations/Donations/ Fees	**1,878,316**	**1.7%**	x									x	x				x			x					x	x						x	x		x

TABLE 10 HIV Care Continuum Steps Impacted by Services Provided

Continuum of Care Steps Impacted	Outpatient/Ambulatory Medical	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-	Home Health Care	Home & Community-based Health	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services –	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/	Rehabilitation Services	Respite Care	Substance Abuse Services –	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
Diagnosed	x				x																x		x		x					x	x	x	x
Linked to Care	x	x			x	x				x	x	x	x	x	x			x		x	x	x	x	x	x					x	x	x	x
Retained in Care	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x			x					x
ART	x	x				x	x	x	x	x	x	x	x	x		x	x		x		x			x	x			x	x				x
Virally Suppressed	x	x		x		x	x	x	x	x	x	x	x	x		x			x		x			x	x			x	x				x

TABLE 11 2016 HRSA Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	HIV Prevention and Surveillance	HIV Research	Other Services
HRSA Subtotal			**34,160,389**	**30.5%**	x	x		x	x	x				x	x	x	x	x			x		x		x	x		x					x	x			x
HIV Emergency Relief Project Grants- Part A	93.914	Maricopa County	8,722,962	7.8%	x			x	x	x				x	x	x	x	x			x		x			x		x					x				
HIV Care Formula Grants- Part B	93.917	Az Dept of Health Services	22,819,668	20.4%	x	x		x	x	x				x	x	x	x	x		x	x		x		x	x							x				
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease- Part C	93.918	Maricopa Integrated Health Systems	681,744	0.6%	x			x	x					x			x																	x			
		El Rio- Santa Cruz Neighbor hood Health Center	984,142	0.9%					x																												
		University of Az. College of Medicine	204,321	0.2%					x																												

TABLE 11 (Continued) 2016 HRSA Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	HIV Prevention and Surveillance	HIV Research	Other Services
HRSA Subtotal			**34,160,389**	**30.5%**	x	x		x	x	x				x	x	x	x	x			x		x		x	x		x					x	x			x
Coordinated Services and Access to Research for Women, Infants, Children, and Youth- Part D	93.153	Maricopa Integrated Health Systems	589,552	0.5%	x			x						x	x	x	x	x																			
AIDS Education and Training Centers Program-Part F	93.145	University of Az	158,000	0.1%																																	x

TABLE 12 2016 CDC Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
CDC Subtotal			**6,138,957**	**5.5%**																														**x**	**x**		
Cooperative Agreements to Promote Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance	93.079	Az Dept of Education	65,000	0.1%																															x		
HIV Prevention Activities Non-Governmental Organization Based	93.939	Native American Community Health Center	350,000	0.3%																															x		
		Ebony House	375,003	0.3%																															x		
		National Community Health Partners	870,000	0.8%																															x		

TABLE 12 (Continued) 2016 HRSA Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
CDC Subtotal			**6,138,957**	**5.5%**																														**x**	**x**		
HIV Prevention Activities Health Department Based	93.940	Az Dept of Health Services	3,523,958	3.1%																															x		
Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	93.944	Az Dept of Health Services	954,996	0.9%																															x		

TABLE 13 2016 SAMHSA Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	HIV Prevention and Surveillance	HIV Research	Other Services
SAMHSA Subtotal			**1,716,203**	**1.5%**										x			x																				
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	Native American Community Health Center	500,000	0.4%										x			x																				
Capacity Building Initiative for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults (HIV Capacity Building		Southern Az AIDS Foundation	283,888	0.3%													x																				

TABLE 13 (Continued) 2016 SAMHSA Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
SAMHSA Subtotal			**1,716,203**	**1.5%**										x			x																				
Initiative (HIV CBI))																																					
Targeted Capacity HIV/AIDS'		COPE Community Services Inc.	432,365	0.4%													x																				
MAI-COC Pilot		CODAC Behavioral Health Services Pima Co.	499,950	0.4%										x			x																				

TABLE 14 2016 HOPWA (Housing Opportunities for Persons with AIDS) and NIH (National Institute of Health) ARIZONA HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counselling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
HOPWA Subtotal			**2,496,467**	**2.2%**																			x														
HOPWA: Housing Opportunities for Persons With AIDS Program	14.241	City of Phoenix	$1,808,877.00	1.6%																			x														
		Pima County	$451,530.00	0.4%																			x														
		Az Dept of Housing	$236,060.00	0.2%																			x														
NIH Subtotal			**480,397**	**0.4%**																																x	
Drug Abuse and Addiction Research Programs	93.279	Az State University	325,074	0.3%																																x	
Child Health and Human Development Extramural Research	93.865	Az State University	155,323	0.1%																																x	

TABLE 15 2016 Indian Health Services (IHS), Arizona Department of Health Services and Arizona Medicaid HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
I H S Subtotal			**160,091**	**0.1%**																														**x**			
Demonstration Projects for Indian Health	93.933	Native American Community Health Center	90,000	0.1%																														x			
		Tohono O'odham Nation	61,000	0.1%																														x			
Urban Indian Health Services	93.193	Native Americans for Community Action	9,091	0.0%																														x			
ADHS- State Appropriation	N/A	Az Dept of Health Services.	**1,000,000**	**0.9%**																															x		
AHCCCS- Arizona Medicaid (1)	N/A	Az Health Care Cost Containment Services	**64,035,512**	**57.1%**	x	x		x			x		x	x												x											x

TABLE 16 2016 Non-Governmental Arizona HIV Resources

Funding Source	CFDA	Grantee Agencies	Anticipated 2016 Budget	% of Total	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**	**HIV Prevention and Surveillance**	**HIV Research**	**Other Services**
Private Funding			1,878,316	1.7%	x									x	x				x			x					x	x						x	x		x
Foundations/ Donations/Fees	N/A	Various	1,878,316	1.7%	x									x	x				x			x					x	x						x	x		x

Assessing Needs, Gaps, and Barriers

Process Description for Identifying HIV Prevention and Care Needs

Since 2014, HIV Prevention and Ryan White Parts A and B have collaborated on the development of needs assessments. This partnership has informed assessment design, timing, and cross promotion of assessments. Prevention and Care assessments are both presented to the Statewide Advisory Group and Phoenix EMA Planning Council.

The 2014 Arizona Statewide Needs Assessment for PWLHA was commissioned to provide consumer driven data with regard to needs, use, barriers, and gaps in care within the Phoenix, Arizona Eligible Metropolitan Area (Ryan White Part A) and the State (Ryan White Part B and HIV Prevention Programs). A total of 774 Arizona Ryan White clients responded to a survey as part of the assessment, representing 5% of the 2012 prevalence statistics for Arizona. In order to survey 5% of the population a framework was developed that defined the counts by region, gender, age, race/ethnicity, risk factor, and new diagnosis vs. ongoing diagnosis. All regions responded with surveys that met or exceeded their sample size. Findings were further detailed by six severe need groups: 1. Newly Diagnosed; 2. Men who have Sex with Men; 3. Hispanics; 4. African Americans/Blacks; 5: American Indians/Alaska Natives; and 6. Youth-Adolescence and Young Adults (age 13 to 24).

Specific topics studied included an analysis of client level data to show the client utilization/impact of the Affordable Care Act, a final report and database of the survey data as a PowerPoint presentation, and Needs Assessment document with an Executive Summary in English and Spanish. Also included is a comparison of the current findings to prior reports and a stratification of data and findings by regions.

The benefits of the needs assessment include:

1. Ability to integrate planning based on the findings of the 2014 Arizona Statewide Needs Assessment for people living with HIV (Barriers and Gaps in Care Continuum Completion)
2. Assessing the impact of Affordable Care Act implementation on people living with HIV receiving services in Arizona

3. Analyzing findings to inform Annual Priority Setting and Resource Allocation Process based on impact of Affordable Care Act
4. Creating a "Roadmap" for delivery of Ryan White services for Statewide HIV Care Continuum completion
5. Benchmarking Arizona to other states' HIV Care Continuum and impact of Affordable Care Act
6. Using statewide data for policy decision makers to identify the continued/new role for Ryan White services
7. Updating client data to inform the Ryan White Program's competitive grant applications, comprehensive plans and Statewide Coordinated Statement of Need; and
8. Utilizing data to inform HIV Prevention Program activities, based on information provided by Newly Diagnosed survey respondents.

The report can be accessed at: http://www.maricopa.gov/rwpc/docs/StatewideNeedsAssessment2014.pdf.

The HIV Prevention Program conducted a statewide health prevention survey with the goal of improving health outcomes for Arizonans. 203 community members completed the needs assessment. The data was used to help guide targeted prevention programs throughout the state to help Arizonans live healthier lives. The assessment included internet surveys during November and December of 2015. Multiple methods for deploying the survey to the general public were used including flyers, emails, listserv, palm cards, and multiple organizational websites linking to the survey. Key interest areas were libraries, colleges and universities, local bars and night clubs, gay and lesbian organizations, and multiple social media streams such as Facebook, Grindr, Jack'd and Craigslist.

The methodology for conducting this special study included the following areas: 1) documentation review; 2) data collection and analysis; and 3) the production of a final report. The data collection process utilized an online survey instrument that adhered to the topics determined and approved by the HIV Prevention Program. Also in this process, the partnering consultant created survey tools and scripts to evaluate the patterns of where newly HIV diagnosed clients might socialize and social media trends used to communicate and find sexual partners. The survey assessed sexual practices such as using alcohol during sexual encounters (46% responded often and sometimes). 25% reported using drugs during sexual

encounters, 28% never have protected sex, and 47% hadn't heard of Pre-Exposure Prophylaxis. These tools were closely linked to elements utilized by HIV Prevention Program staff as insights into the community's sexual habits. This information will further guide Arizona's strategies and will be used to develop targeted HIV prevention programs throughout the state.

Strategies for Including Stakeholders and Participants That Reflect the HIV Epidemic

The HIV Statewide Advisory Group (SWAG) and the Phoenix EMA Planning Council (Planning Council) have multiple members that represent people living with HIV and those at high risk for acquiring HIV. The Planning Council is composed of a diverse group of institutional, sub-recipient, and consumer members who provide guidance to the program on policy and priorities for all service categories and reflect the demographics of the local epidemic. The consumer members who serve on the Planning Council take an active role in identifying priorities on behalf of the community and participate in informing and educating the community on health issues. In 2015, the Planning Council and the SWAG hosted a Leadership Academy, designed to empower the community members of both Planning Bodies to take on expanded leadership roles in the community and among peers.

The HIV Statewide Advisory Group (SWAG) has diverse makeup but fewer community members. The SWAG has supported community engagement by 1) hosting mobile meetings throughout Arizona to make it easier for clients and community members to participate in the planning process and 2) engaging sub-recipients to help recruit community members for the planning process. During community planning sessions, 22 potential partnering agencies were identified. Some of the agencies include the Arizona Alliance of Communities, one•n•ten youth groups, and the National Association of Social Workers. As part of the plan development, recipients identified a framework to host regional meetings two to three times a year, and solicit partner invitations in advance. During the regional meetings, participants will review evidence-based prevention and care practices for mental health, substance abuse, and homelessness, and select practices that would work for their community to begin planning implementation of selected practices. The regional meetings will likely be paired with a mobile town hall or other opportunity for local community engagement.

The Arizona Ryan White Program collaborate to share information gathered through their Community Advisory Boards and consumer surveys and incorporates this input into the planning process. These Boards meet regularly to discuss clinic initiatives, aggregate client outcomes, and give input on strategies to improve health for people living with HIV.

Summary of Needs, Gaps and Barriers by Subpopulation

The following is a summary of the top three needs, gaps and barriers for selected populations. "1" is the most significant need, gap, or barrier and "3" reflects the third most significant need, gap or barrier. Subpopulations were informed by the Early Identification of Individuals with HIV/AIDS (EIIHA) subpopulations and Arizona's epidemiology reports. Additional analysis and subpopulations can be found in the full 2014 Needs Assessment Report at http://www.maricopa.gov/rwpc/docs/StatewideNeedsAssessment2014.pdf.

TABLE 17
HIV Prevention and Care Service Needs, Gaps and Barriers by Designated Populations

	Needs						Gaps						Barriers					
	Newly Diagnosed	MSM	Hispanics	African American	American Indian	Youth	Newly Diagnosed	MSM	Hispanics	African American	American Indian	Youth	Newly Diagnosed	MSM	Hispanics	African American	American Indian	Youth
Emergency Financial Assistance										1					3			
Exercise										3								
Health Educator/Peer Mentor								3				1						3
Holistic/Alternative Therapy										3								
Housing Assistance					3						3			1		3		
Insurance													2					
Internet/Phone																		2
Medical Case Manager						3				3								
Medication Assistance	2	2	1	2	1	2			2								3	
Mental Health							2											
Nutrition Assistance	3	3	3	3	3	2	2				2		2	3		2		
Oral Health							1		2									1
Outpatient/Ambulatory Care	1	1	2	1	1	1									2			
Specialty Doctors													2					
Support Groups													2					
Transportation								1	2	2	1	3		2	2	1	2	
Vision Care								2	1			2	1	3	1	3	1	

Prevention and Care Service Needs

Figure 11 illustrates the three highest ranking need service categories for the Northern, Central and Southern Regions of Arizona. The assessment also evaluated condom distribution with recommendations to expand efforts with a social marketing campaign. The assessment reported participants would feel comfortable accessing condoms from their doctor/clinic (72%), HIV Organization (60%), Case Manager (49%), and Pharmacy (49%). In 2014, the HIV Prevention Program used this information to inform a creative Pharmacy-based free condom distribution program.

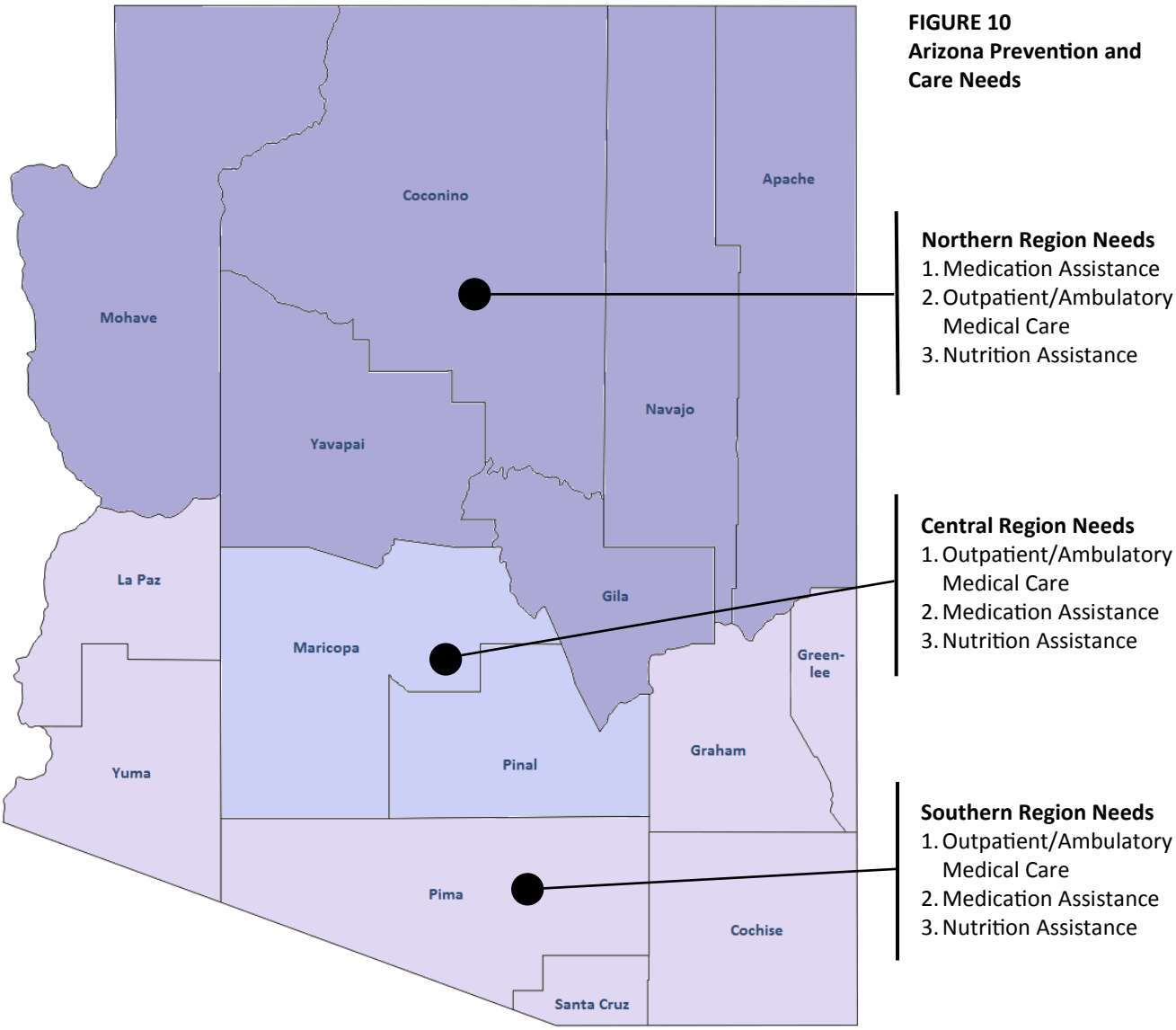
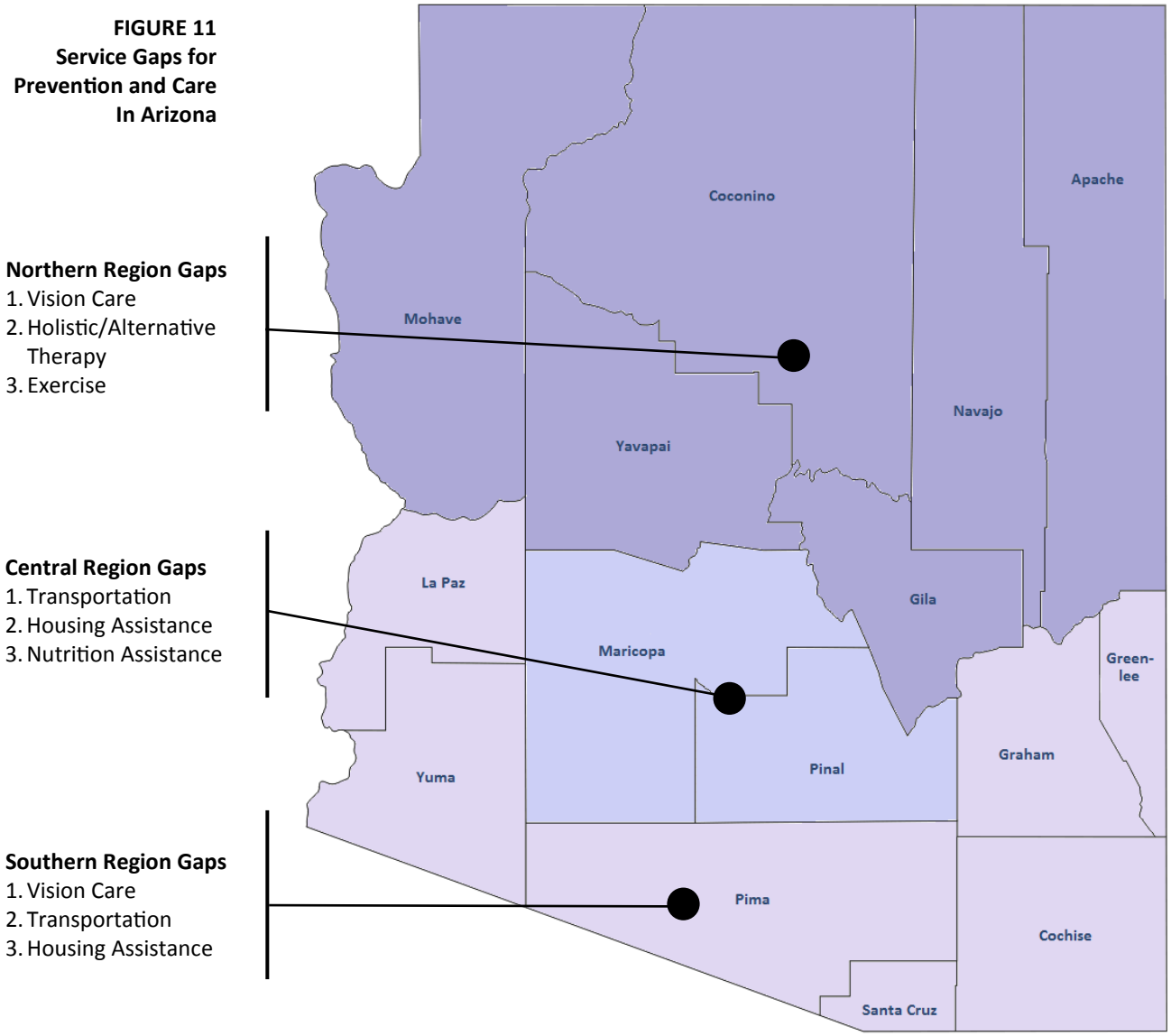


FIGURE 10
Arizona Prevention and Care Needs

FIGURE 11
Service Gaps for Prevention and Care In Arizona



Barriers to HIV Prevention

In 2015, HIV Prevention and the Ryan White program conducted a needs assessment of individuals that had been newly diagnosed within the past year. This survey followed the participant through the continuum and identified demographic data, where participants receive their HIV information, continuum outcomes, HIV testing practices and knowledge of Pre-Exposure Prophylaxis (PrEP). Highlighted results can be found in Section 1. Notably, only 41% of respondents who identified as Men who have Sex with Men knew about PrEP. Stigma continues to be high—71% of the newly diagnosed report that they did not know anyone with HIV.

The full report can be found at: http://www.maricopa.gov/rwpc/docs/PhoenixEMA_Newly_Dx_Survey20Results_FINALREPORT_02292016.pdf.

In a community assessment conducted by the HIV Prevention Program, which was predominantly completed by HIV negative individuals, 47% had not heard of PrEP in the past 12 months.

Social and Structural Barriers

Arizona experiences many of the common social and structural barriers as the census bureau reports that 18% of Arizonans are at or below 100% of the federal poverty level (FPL) and approximately 44% of Ryan White Part A and B clients are under 100% FPL. Arizona is 31% Latino, 5% African American/Black and 5% Native American. The Latino and African American communities face similar stigma and cultural challenges around homosexuality and HIV. The Latino population has faced challenges related to Arizona SB 1070 legislation, which was identified as one of the strictest anti-illegal immigration legislations of its time. Arizona's sex education is predominantly limited to abstinence-only programs, and Arizona one of eight states that has banned schools from portraying "homosexuality as a positive alternative life-style… suggests that some methods of sex are safe methods of homosexual sex" AZ Rev. Stat. § 15-716(c).

Homelessness

The prevalence of homelessness is 1% to 2% among people living with HIV in the Central Region, although 34% cited they have 'ever' been homeless in the 2014 Comprehensive Statewide Needs Assessment . Over 65% of the homeless respondents report mental, physical, and/or substance abuse disabilities (Homeless in Arizona – Annual Report 2014). A Point-In-Time study conducted for the Housing and Urban Development grant determined Maricopa County has 8,000 chronically homeless individuals. Homelessness has been shown to result in premature mortality, with lifespans typically shortened by 25 years. Challenges with discontinuous care, significant co-morbidities including cardiac, podiatric, respiratory, and infectious disease processes often result in the homeless individuals using emergency departments for medical care. This use of emergency services costs and average of $39,000 per person annually. A Healthcare for the Homeless Program in Boston, Massachusetts tracked chronically homeless individuals for five years and determined their average medical cost per year was $28,346. In the 2014 Comprehensive Statewide Needs Assessment, 9% (n=49) of respondents report being currently homeless,

9% (n=52) have been homeless in the past two years, but not now, and 16% (n=91) have been homeless over two years ago, but not now. It is noteworthy Phoenix is recognized as the first city in the nation to eradicate homelessness among veterans (HUD, 2014).

Previous Incarceration

Stigma associated with the formerly incarcerated often cloud individual's prioritization of HIV medical care. Barriers to housing access, employment, transportation, and other base subsistence needs result in the inability to function without significant case management to clear these obstacles. These are often complicated by custody issues, and either past or current substance use, which led to their incarceration. Legal support is often required to assist this group. A total of 110 incarcerated/recently released persons were served by Ryan White Part A medical programs in 2014. Of those 110, 10 were new, 84 continuing, and 16 returning to care. In the 2014 Comprehensive Statewide Needs Assessment, 28 recently released HIV positive prisoners responded. This group listed Housing Assistance as their priority need and service. This was followed by a tie of numerous services including emergency financial assistance, oral health, transportation, non-HIV medications, and vision care.

Backgrounder 2014 found 20% of inmates in jails and 15% of inmates in state prisons have serious mental illness. Social instability, depression, as well as other mental illnesses including anxiety disorders is associated with difficulty adhering to anti-retroviral therapy.

Serious Mental Illness

According to the 2014 Comprehensive Statewide Needs Assessment, 64% of clients surveyed stated that they had received mental or behavioral health services since HIV diagnosis. More than 50% of people with Major Depression, the most prevalent treatable mental illness, have not been clinically diagnosed. For people living with HIV who have been evaluated for Major Depressive Disorder, at least half are inadequately or not treated. This is particularly true for individuals with triple diagnoses (mental illness, substance use disorder, and HIV) who demonstrate poor clinical outcomes. Underlying mental illness among those with HIV is a significant barrier to entering drug treatment. Serious mental illness results in average costs of $14,000 per year. The Agency for Healthcare Research and Quality cites a cost of $57.5 billion in 2006 for mental health care in the US, equivalent to the cost of cancer care. Unlike cancer, much of the economic

burden of mental illness is not the cost of care, but the loss of income due to unemployment, expenses for social supports, and a range of indirect costs due to a chronic disability which begins early in life *(NIMH, 2011).*

Substance Abuse

Substance abuse, in particular IV-injection drugs, contributes to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors they might not engage in when sober. Mohave County, which has shared service delivery among the HIV Prevention Program, Arizona Ryan White Part B Program, and Las Vegas TGA Ryan White Part A Program was flagged by the Centers for Disease Control and Prevention as a potential place for an HIV and Hepatitis Outbreak, due to high injection drug use in the area. Two particular drugs of concern in the Central Region include use of crystal methamphetamine, particularly among Men who have Sex with Men, and growing dependence on illegal prescription drugs. The Central Region rate of 18% injection drug use among people living with HIV is lower than the 22% national rate in 2011 (Source: Center for Disease Control & Prevention, IDU Fact Sheet).

Hepatitis C

In the 2010 Needs Assessment 21% of the 500 survey respondents reported a history of, or treatment for Hepatitis C. In the 2014 Needs Assessment 15% of the 578 survey respondents reported a history of, or treatment for Hepatitis C. While Hepatitis C is now curable due to pharmaceutical advancements, the $100,000 average cost per client is extremely prohibitive. In July 2015, the Arizona AIDS Drug Assistance Program (ADAP) became the first ADAP in the nation to cover Hepatitis C treatment medications for all ADAP-eligible clients in Arizona.

Although Arizona does not have any legal barriers or regulations regarding who may test and how to offer counseling, the testing of pregnant women continues to be opt-in, which requires additional steps on the part of the tester and tested. Arizona's Ryan White Part D Program staff helped 18 of 21 hospitals throughout Maricopa and Pinal Counties establish protocols for testing of high-risk pregnant women and treatment for any found positives. The Ryan White Part C Program in Maricopa county conducted a multi-part campaign to educate the community when HIV testing in the Maricopa County Hospital's Emergency Room transitioned to an opt-out model. The Ryan White program has worked with ADHS's Border Health Office, the Arizona Mexico Commission, and the Maricopa County Sheriff's

Department to identify community needs around access to and retention in care of HIV positive undocumented individuals. An HIV indicator is integrated in the US-Mexico health plan.

Health Department Barriers

The Arizona Department of Health Services continues to operate under a hiring freeze for all non mission-critical staff. The hiring freeze is extended to employees and contract staff. The other Arizona Ryan White Programs do not have the same limitations. Infrastructure at the sub-recipient agencies is well established. Technical assistance is provided on an ongoing and as-needed basis.

Program Barriers

Arizona Department of Health Services shares data under the Arizona Public Health Law and does not consider the Ryan White Program a HIPAA covered entity. This has created some challenges with sharing of Ryan White data between the state and some of the HIV clinics. Data sharing agreements are being discussed.

Service Provider Barriers

The Integrated HIV Prevention and Care Plan identifies opportunities to further include private physicians, community groups, and additional stakeholders. Integrating planning into a large symposium model was successful in engaging 225 individuals in the planning process. Participating stakeholders include rural and urban clinicians, federally funded service providers, Planning Body members, and community members. With input from 1042 clients and a conservatively estimated 2,692 man-hours from key stakeholders, the 2017 to 2021 Integrated HIV Prevention and Care Plan is the most inclusive HIV-specific plan completed within Arizona. To further extend the reach, the HIV Statewide Advisory Group is developing 1) business cases and tools to communicate the value of HIV prevention and care programs, and 2) a call to action for our new partners which will move the community closer to the audacious goal of ending HIV in Arizona.

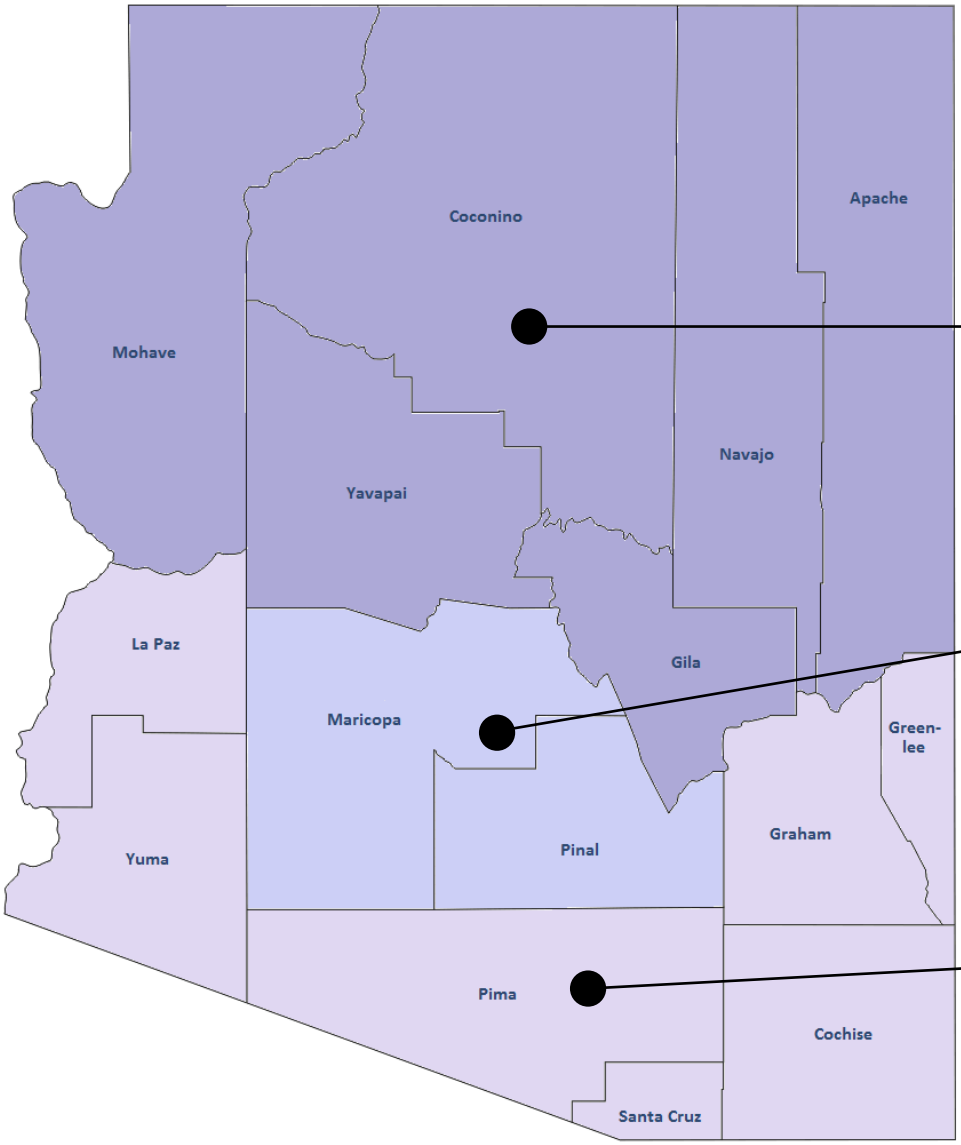


FIGURE 12
Client-Identified Barriers for HIV Prevention and Care Needs

Northern Region Barriers
1. Transportation
2. Support Groups (tie)
   Insurance (tie)
   Specialty Doctors (tie)
   Vision Care (tie)

Central Region Barriers
1. Vision Care
2. Housing Assistance
3. Medication Assistance

Southern Region Barriers
1. Transportation
2. Oral Health Care
3. Vision Care

Data: Access, Sources And Systems

Main Data Sources

Arizona continuum data is based on the eHARS data collected through lab feeds. Local Ryan White continuum data is collected through CAREWare. Ryan White Parts A and B have separate, parallel CAREWare systems and share the same CAREWare consultant. Both systems require viral load data as part of a client's six month eligibility renewal. The lab data is entered into CAREWare and can be accessed through CAREWare's Health Resources and Services Administration and HIV/AIDS Bureau performance reports, or custom reports. These reports are then manipulated through a separate access database that allows generation of continuum reports comparing regional and state averages. This data can also be bisected by data collected for Ryan White reporting needs or other CAREWare data.

Additional data is collected through:

- Patient Reporting Investigation Surveillance Manager (PRISM): PRISM provides a unique approach, and robust technical architecture to complete real-time monitoring of HIV/STD disease burden, identification of emerging outbreaks, monitoring and assurance of appropriate treatments, and quality of data for epidemiologic analysis and reporting. The Arizona HIV Prevention and STD Control Programs use PRISM to collect data related to disease investigation and partner services activities.
- CAREWare Data: The Ryan White Programs have a robust CAREWare system that allows for analysis beyond required Ryan White reporting, including costs per client service at aggregate and agency levels, multitude of custom reports, eligibility status, and communication
- Use of a Central Eligibility model and web application tools has been effective in supporting compliance to RSR data elements
- Qualitative Data from client feedback surveys and needs assessments
- Surveillance Data compiled by the HIV Surveillance Program

Data Policies that Facilitate/Serve as a Barrier

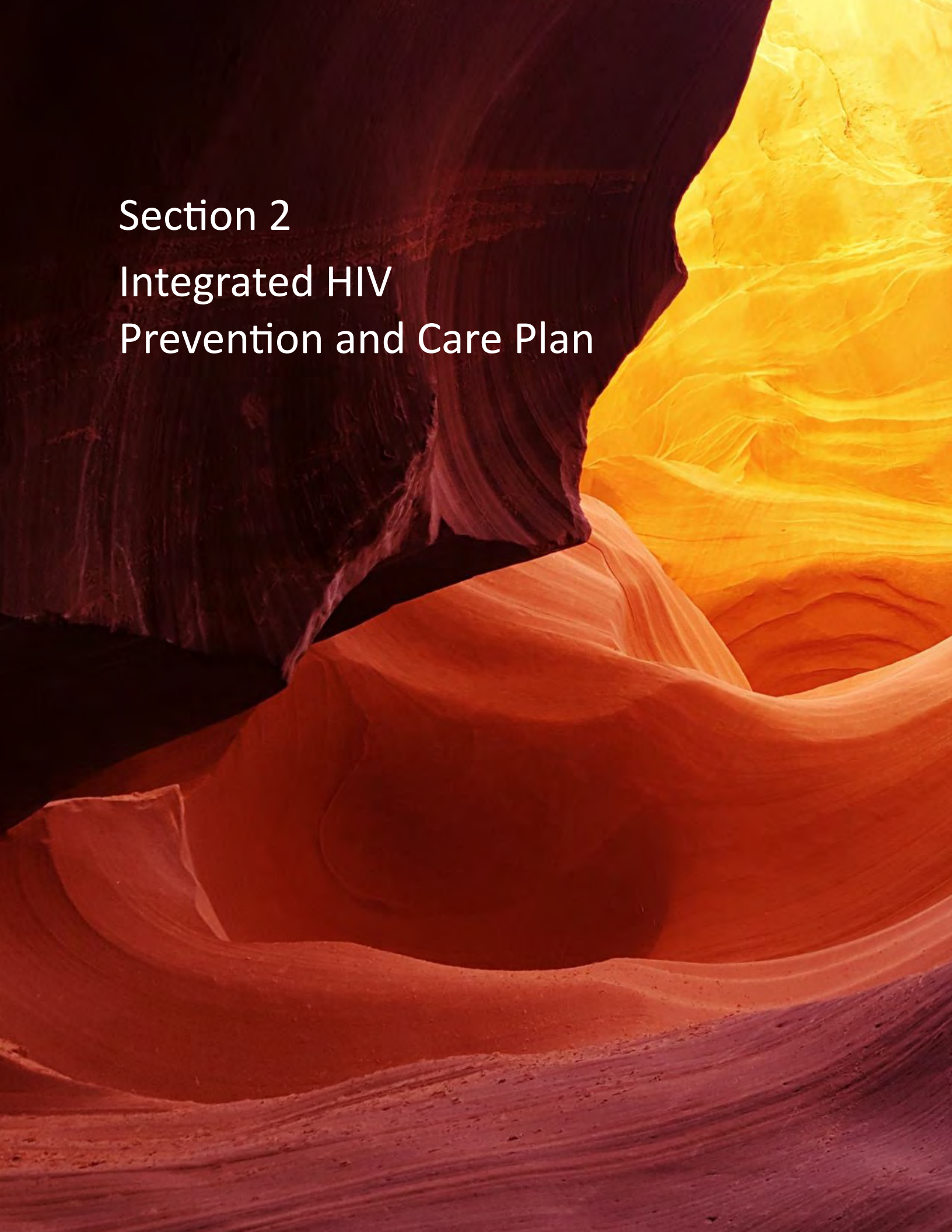
Arizona may be the last state in the country that does not legally mandate the reporting of virally suppressed HIV labs. The Arizona Surveillance program is working closely with the Rule-Writing Committee and anticipates a public comment period soon and implementation in 2017. The program currently receives almost all of the reports because an inclusive batch process has been preferred by the lab companies.

Arizona continues to work with its legal team to review Ryan White Part B's status as an uncovered entity and data sharing agreement opportunities with local partners. An established data sharing agreement will be fundamental to establishment of any integrated data systems to support linkage to care and service coordination for newly diagnosed individuals.

Data Desired by Planning Groups That Was Unavailable

The Prevention and Care programs have an overwhelming amount of data and data analysis available for discussion. During the process, an intentional effort was made to minimize the paperwork and data provided, while having all the data resources available on a thumb drive if any questions arose.

One debated data element was the use of aspirational versus realistic objective measures and the associated costs required to reach either measure. During the planning process, a detailed analysis identified it could cost $32 million for Arizona to reach the 90% awareness of positive HIV status goal set by the National HIV/AIDS Strategy. The mathematical modeling of the costs and potential impact was challenging to identify for all the goals and objectives. Ultimately the planning bodies decided to keep the national goals and targets with a local decision to either increase or decrease the impacted area by an undeclared amount.



Section 2

Integrated HIV Prevention and Care Plan

An Inclusive, Collaborative Planning Process

How People Involved in Planning Are Reflective the Local Epidemic

The 2017 to 2021 Integrated HIV Prevention and Care Plan is the most inclusive planning effort ever undertaken by Arizona's HIV community. Participants in the planning process represent all target populations identified in each region, and a diverse array of program partners and key stakeholders.

Participation of Planning Body Members

More than 60 Planning Body members and guests contributed 1,209 man hours to developing local activities and resources for the regional plans. Members from both Planning Bodies have attended each others' planning meetings. Multiple regional planning sessions occurred, with Planning Body members travelling to each region to meet with stakeholders.

How People Living with HIV Contributed to the Plan

People living with HIV participated in all four stages of planning. A statewide needs assessment was completed by 5% of all people living with HIV in Arizona. Foundational data was also collected from high risk negatives. People living with HIV were included in HIV Symposium and Planning Body activities over the past two years. The Phoenix EMA Ryan White Planning Council and HIV Statewide Advisory Group each meet the federal mandates for representation of people living with HIV and affected community members. Each Planning Body has regular stakeholder attendance at meetings.

Community Participation in HIV Symposium Planning Sessions

Arizona HIV Programs co-host 2-day HIV symposiums each year. The second day of these symposiums is been dedicated to planning. More than 225 unduplicated consumers, providers, stakeholders, Ryan White Program recipients and sub-recipients, and others contributed 1,483 man hours to HIV planning. In the first year, this group identified 1) What needs to happen in the next five years to end the HIV epidemic in Arizona? and

2) What are the barriers that might stop us from achieving this audacious goal? In the second year, the Symposium participants voted for regional goals and objectives, and then worked in teams to identify strategies and activities.

Community Participation in Prevention and Care Needs Assessments

Arizona's HIV Programs continue to identify and reach out to populations disproportionately impacted by HIV. Statewide assessments are completed every three years, along with yearly regional assessments of target populations. Additional input is gathered at Planning Body and community advisory board meetings, at community events, and from focus groups and client feedback surveys.

- 774 people living with HIV informed the 2014 statewide needs assessment on needs, gaps and barriers across the prevention and care continuum. This represents 5% of all people living with HIV in Arizona
- 203 community members participated in an HIV prevention assessment, sharing information about sexual habits, STD testing practices and knowledge of Pre-Exposure Prophylaxis
- 65 Newly Diagnosed individuals reflected on their experiences being tested for HIV, coping with receiving their diagnosis, and getting linked to medical care

People at high risk for contracting HIV are engaged in yearly needs assessments conducted by the HIV Prevention Program,

The HIV Prevention Program has also established work groups to guide social marketing initiatives and service delivery. Participants of the work groups include representatives of people living with HIV, people at-risk for acquiring HIV, human equity groups, youth groups, English and Spanish-language media entities, non-elected community leaders, and non-federally funded partners.

Participation of Program Leadership

The development of the Integrated HIV Prevention and Care Plan was guided by the Program leads for the HIV Prevention Program, Arizona's Ryan White Programs, the Arizona AIDS Education and Train Center and the HIV Surveillance and STD Control Programs, in collaboration with the Planning Body Chairs. Many of these programs are lead by or employ people living with HIV.

How Impacted Communities Will Remain Engaged in Planning and Provide Critical Insight Into Developing Solutions

Arizona considers the integrated Plan a living document that will evolve with continued input from impacted communities. The HIV Statewide Advisory Group and the Phoenix EMA Ryan White Planning Council will be implementing a variety of community engagement methods, above and beyond collection of needs assessment data and recruitment to Planning Bodies. Some of the methods include:

- Mobile town halls throughout Arizona (two to three per year)
- Client/Community member orientation sessions
- Graphic facilitation of community engagement sessions
- Use of internet-based feedback solutions, such as social media engagement, online surveys, webinars, etc.

Stakeholders and Partners Who Were Not Involved in the Planning Process, But Who are Needed

During the planning process, an additional 22 agencies and special interest groups were identified by participants for future inclusion in planning efforts. These entities include the Arizona Alliance of Community Health Centers, Black Chamber of Commerce, youth leadership from the Black Lives Matter – Tucson chapter, and Latino Clinic Amistades, among others.

The HIV Prevention and Ryan White Part B Programs are to develop Region -specific communication strategies utilizing new and traditional media to educate the public on HIV prevention and care initiatives and the progress of the Integrated HIV Prevention and Care Plan, and promote engagement of new individuals in planning efforts.

Contributions of Stakeholders and Key Partners

Stakeholder Group	Contributions to Plan Development
People Living with HIV	• 774 individuals (5% of all of Arizona's people living with HIV) participated in 2014 needs assessment identifying needs, gaps, and barriers • 65 newly diagnosed individuals were surveyed about their HIV testing and linkage to care experiences • Planning Bodies include people living with HIV as both members and public participants. These individuals contributed to all Planning Body activities related to Plan development • Government entities and community-based organizations hire people living with HIV, and many have HIV positive leadership • Participated in Symposium planning
Community Members	• 203 people participated in HIV Prevention-focused assessments • Multiple community members on both Planning Bodies
Non-traditional Partner Agencies	• Multiple non-government funded agencies participated in Symposium Planning • Human Equity Groups have informed HIV Prevention and Care Planning, and have facilitated relationship building with community leadership to begin planning and implementing initiatives to address HIV in communities of color • Cox and Univision, two large media entities, and print/radio/online media partners have promoted HIV initiatives to the public, and reported on HIV issues • Representatives of media companies, news and lifestyle magazines/newspapers, radio, and social media/marketing have participated in work groups to guide HIV-related social marketing initiatives
HIV Statewide Advisory Group	• Oversaw the completion of comprehensive statewide needs assessments • Participated in the planning and presentation of annual HIV Symposium planning sessions • Review, revise and finalize all strategies and activities for Arizona's Regional plans • Statewide Advisory Group leadership travelled to take part in planning sessions that occurred outside of metropolitan Phoenix
Phoenix EMA Ryan White Planning Council	• Oversaw the completion of comprehensive statewide needs assessment of people living with HIV and Ryan White clients, in collaboration with other HIV Prevention and Care Programs • Participated in both Symposium planning sessions • Responsible for the development of care-centric strategies and activities for the Central Region plan
HIV Prevention Program	• Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities • Co-wrote the Plan. Lead partner for integrating all community and planning body input into the Regional Plans • Co-hosted the HIV Symposiums • Contributed data for the Statewide Coordinated Statement of Need
Phoenix EMA Ryan White Part A Program	• Lead the small government leadership team for the Integrated Plan • Co-designed comprehensive statewide needs assessments of people living with HIV and high risk populations • Co-wrote the Plan. Lead for the Financial and Human Resources Inventory • Co-hosted the HIV Symposiums • Contributed data for the Statewide Coordinated Statement of Need

Stakeholder Group	Contributions to Plan Development
Arizona Ryan White Part B Care and Services Program	• Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities • Co-wrote the Plan. Lead program for the development of the Statewide Coordinated Statement of Need • Co-hosted the HIV Symposiums • Contributed data for the Statewide Coordinated Statement of Need • Supports allowable programs with rebate funds throughout Arizona
Arizona Ryan White Part C Programs	• Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities • Co-hosted the HIV Symposiums • Contributed data for the Statewide Coordinated Statement of Need • Supported Central and Southern Region activities to inform planning efforts
Arizona Ryan White Part D Program	• Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities • Co-hosted the HIV Symposiums • Contributed data for the Statewide Coordinated Statement of Need • Supported Central Region activities to inform planning efforts
Arizona AIDS Education and Training Center	• Provided HIV training to stakeholders engaged in the development of the Plan • Coordinated Southern Region stakeholder engagement and planning sessions • Participated in the Financial and HIV Workforce Capacity Survey • Membership on the HIV Statewide Advisory Group • Provided technical assistance during Plan development • Conducted a Pre-Exposure Prophylaxis readiness assessment of providers and consumers
Arizona Regional Quality Group	• Participated in HIV Symposiums • Participated in the regional plan writing • Approved the statewide definitions for use in the continuums developed by HIV Surveillance • Regularly monitor health outcomes for all Arizona Ryan White Programs
Last Vegas TGA Ryan White Part A Program	• Supported Northern Region Needs Assessment activities, and conducted regional focus groups to inform planning efforts • Participated in HIV Symposium planning sessions • Solicited feedback from Las Vegas medical providers and community-based organizations related to the medical care and supportive service needs of Mohave county clients accessing care in Las Vegas
HIV Surveillance Program	• Co-wrote the Plan. Lead program for conducting an epidemiology overview • Developed and continuum data for the Plan • Participated in HIV Symposium planning sessions • Assisted with cost analysis for achievement of outcomes
STD Control Program	• Participated in HIV Symposium planning sessions • Assisted with cost analysis for achievement of outcomes • Developed data capture and export methodologies, to provide data for planning

Stakeholder Group	Contributions to Plan Development
Community Health Centers	• Participated in the Financial and HIV Workforce Capacity Survey • Representatives have joined both Planning Bodies • Federally Qualified Health Center (FQHC) and FQHC look-a-like participation in HIV Symposiums • Southern Community Health Centers have hosted local community sessions for developing the integrated plan
Medicaid	• Membership on the Phoenix EMA Ryan White Planning Council • Provided data for the Statewide Coordinated Statement of Need • Participated in Financial and HIV Workforce Capacity Survey • Allocates resources for HIV medications for eligible clients in the community
Medicare	• Participated in Financial and HIV Workforce Capacity Survey • Allocates resources for HIV medications for eligible clients in the community
Veterans Health Administration	• Contributed to Statewide Coordinated Statement of Need • Allocates resources for HIV medications for eligible clients in the community
Housing and Urban Development	• Representation on the Planning Bodies • Actively participated in the development of the plans for the Central and Southern Regions • Participated in the Financial and HIV Workforce Capacity Survey • Allocates resources for HIV medications for eligible clients in the community

Northern Region Plan

The Northern Region

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- American Indians, regardless of gender
- Injection Drug Users

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased collaboration with mental health/substance abuse providers
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Strengthening of partnerships with providers, correctional facilities, and hospital systems to improve linkage to care timeframes
- Evaluation and implementation of innovative linkage to care/retention in care service models specific adapted to rural communities

The Northern Region includes Mohave, Coconino, Yavapai, Gila, Navajo, and Apache counties. This region is 47,890 square miles, with a population of 792,935 in 2014. Much of the Northern Region is tribal land and/or national forest, and is largely rural outside of the cities of Flagstaff, Prescott and Sedona. Major HIV issues in the Northern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, and access to resources. Federally-funded HIV prevention and care services in Mohave county are provided by both the HIV Prevention Program, the Arizona Ryan White Part B Program, and the Las Vegas TGA Ryan White Part A Program.

The 2015 Arizona Department of Health Services Epidemiology Report shows the Northern Region had 12% of the state population, 7% of the new HIV cases, and 6% of the ongoing HIV cases. 2015 census data for Northern Arizona reports a higher percentage of Native Americans than the other two Regions, particularly in Apache County (74%), Navajo County (45%), and Coconino County (27%).

CONTINUUM OF CARE DEFINITIONS

HIV-Diagnosed: Prevalent cases that have been diagnosed

Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year

Incidence Linked to HIV Care: Incident cases for the year of the spectrum that were linked with a documented lab test, doctor visit or medication use within 90 days of their diagnosis, but not on the same day of the diagnosis. If a person has their first CD4, viral load or genotype on the same day as their diagnostic test the date of second CD4, viral load or genotype will be used as the linkage

Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or antiretroviral (ARV) use in the first and second six months of the year

On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable

Adherent/Suppressed: Prevalent cases whose last viral load of the calendar year was undetectable (<200 C/mL)

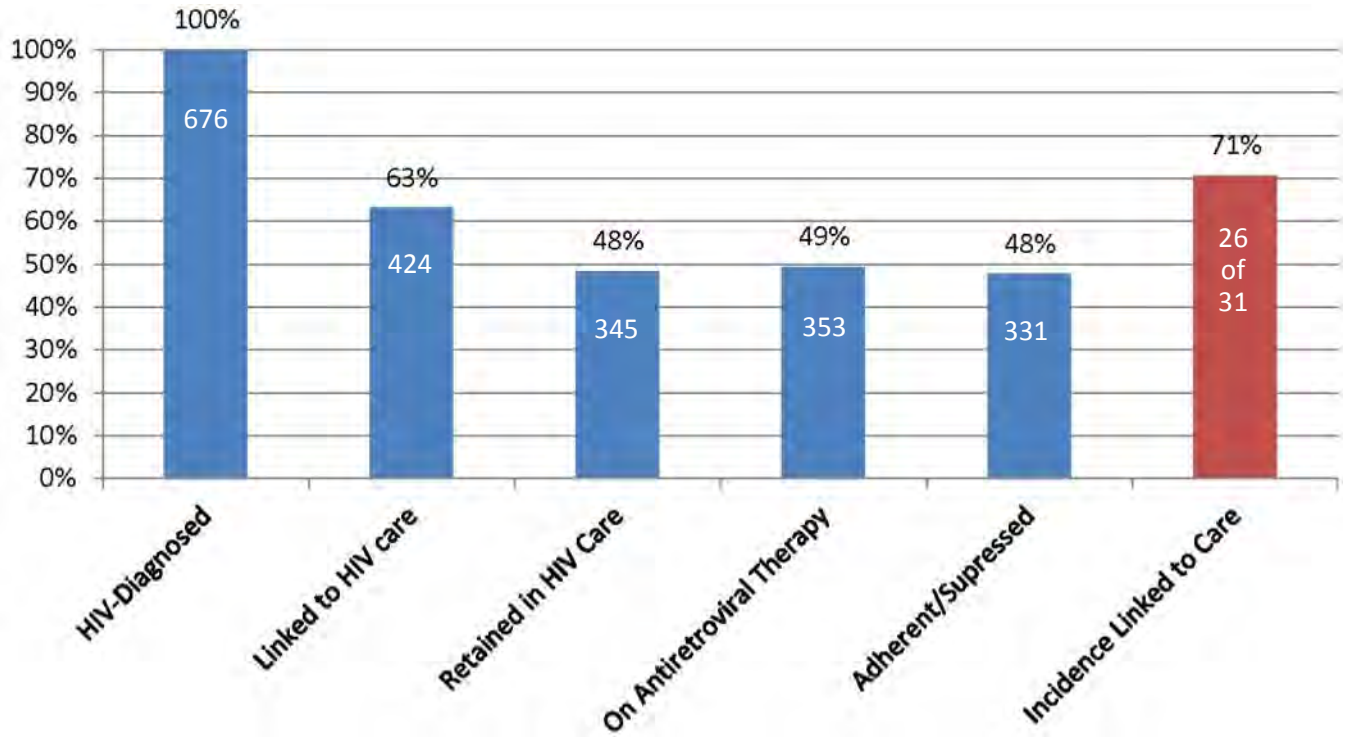
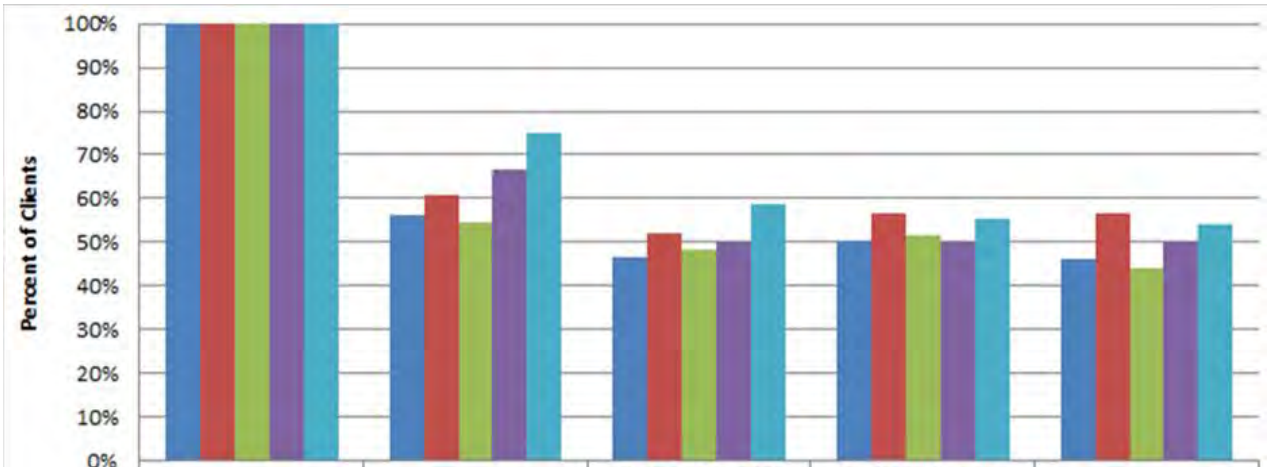


FIGURE 13
2014 Northern Arizona HIV Continuum of Care

In 2014, HIV incidence dropped to 39 (22 case reduction from previous year), while prevalence increased by 64, indicating that at least 25 HIV positive people who were not diagnosed in Northern Arizona moved into the region.

Review of continuum data in Figure 15 by race/ethnicity shows that African American/Black clients in Northern Arizona have the highest viral load suppression at 57%, followed by American Indians/Alaskan Natives at 54%. Latinos have the lowest rates of linkage (55%) and viral load suppression (44%).

In Figure 17, the most frequently reported risk factors for Northern Arizona are Men who have Sex with Men (319 people), Injection Drug Users (207 people), and Men who have Sex with Men who are Injection Drug Users (98 people).



	HIV-Diagnosed	Linked to HIV care	Retained in HIV Care	On Antiretroviral Therapy	Adherent/Sup.
White	100%	56%	47%	50%	46%
Black	100%	61%	52%	57%	57%
Hispanic	100%	55%	48%	52%	44%
Asian	100%	67%	50%	50%	50%
AI/AN	100%	75%	59%	56%	54%

FIGURE 14
2014 Northern Arizona HIV Continuum of Care by Race/Ethnicity

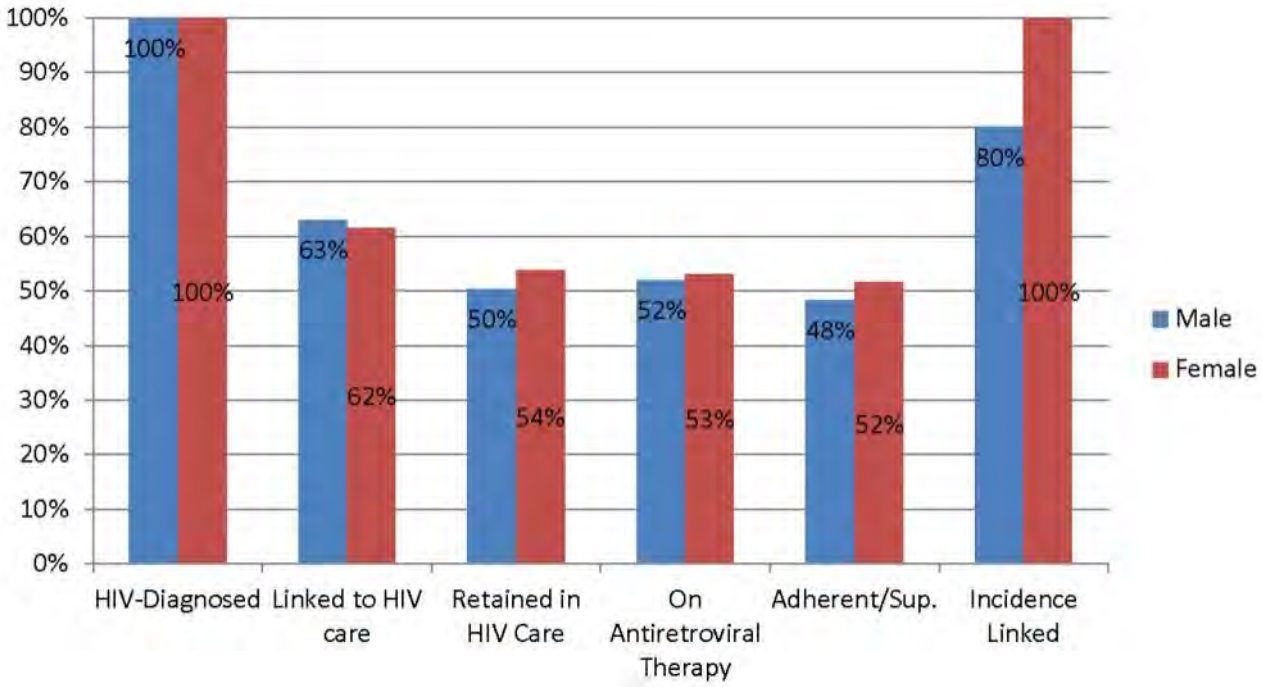


FIGURE 15
2014 Northern Arizona HIV Continuum of Care by Gender

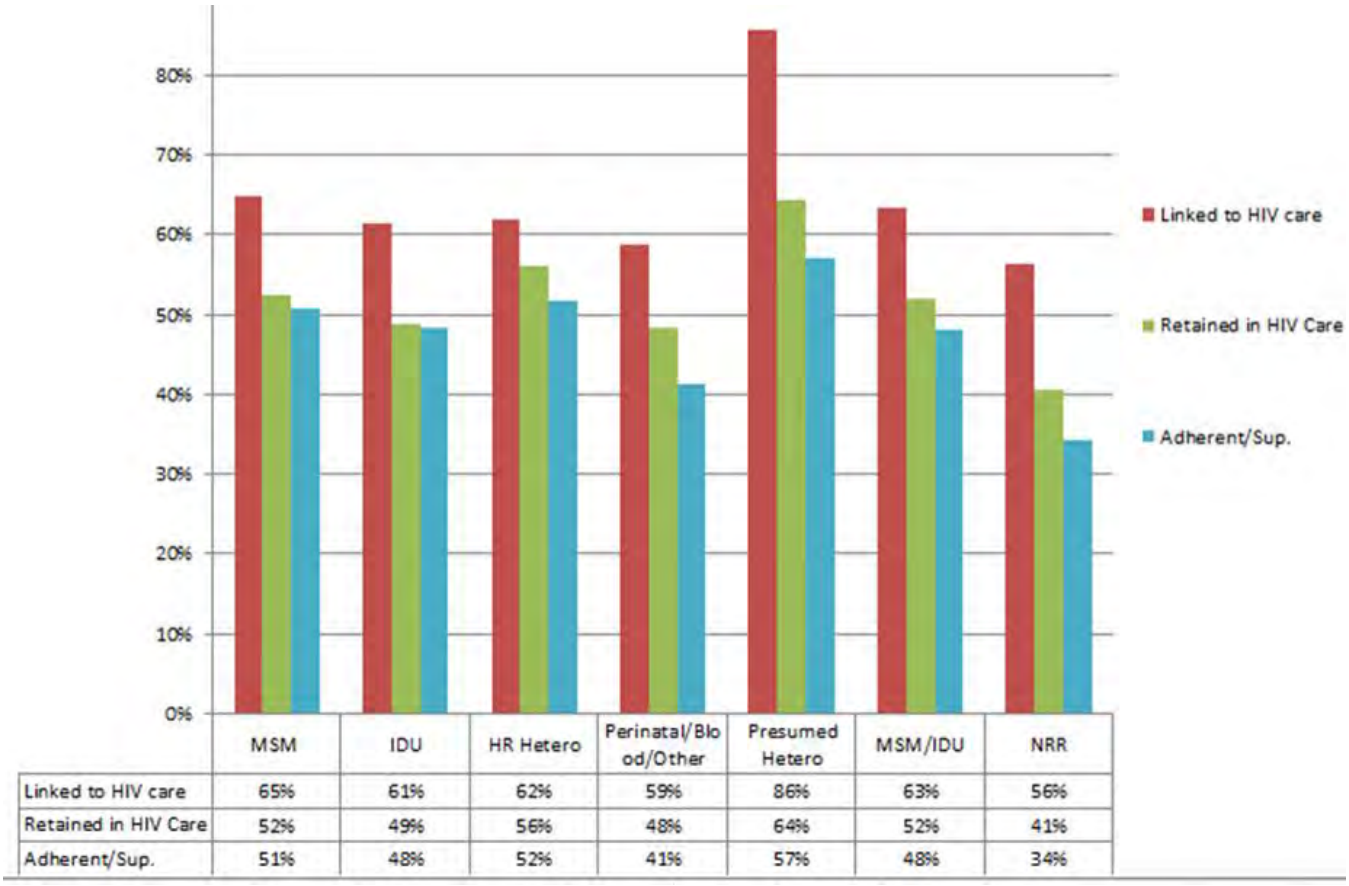


FIGURE 16
2014 Northern Arizona HIV Continuum of Care by Risk Category

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk

Year	Prevalence	Incidence
2005	562	44
2006	606	27
2007	652	42
2008	706	39
2009	740	40
2010	747	45
2011	795	36
2012	896	33
2013	939	61
2014	1003	39

TABLE 18
Comparison of Northern Region Incidence and Prevalence Totals by Year

TABLE 19
Northern Arizona Regional Incidence 2009 to 2013

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	100	46.5	5.16	82	38.1	4.23	182	84.7	9.40
Female	22	10.2	1.12	11	5.1	0.56	33	15.3	1.67
TOTAL	**122**	**56.7**	**3.12**	**93**	**43.3**	**2.38**	**215**	**100.0**	**5.50**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2 to 12	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
13 to 19	1	0.5	0.27	1	0.5	0.27	2	0.9	0.53
20 to 24	18	8.4	6.82	6	2.8	2.27	24	11.2	9.09
25 to 29	25	11.6	12.16	11	5.1	5.35	36	16.7	17.51
30 to 34	14	6.5	7.35	8	3.7	4.20	22	10.2	11.56
35 to 39	17	7.9	8.94	12	5.6	6.31	29	13.5	15.25
40 to 44	12	5.6	5.77	13	6.0	6.25	25	11.6	12.02
45 to 49	19	8.8	7.79	9	4.2	3.69	28	13.0	11.48
50 to 54	7	3.3	2.52	11	5.1	3.96	18	8.4	6.48
55 to 59	6	2.8	2.10	11	5.1	3.86	17	7.9	5.96
60 to 64	2	0.9	0.70	6	2.8	2.11	8	3.7	2.82
65 and Above	1	0.5	0.13	5	2.3	0.66	6	2.8	0.79
Age Unknown	0	0.0	NA	0	0.0	NA	0	0.0	NA
TOTAL	**122**	**56.7**	**3.12**	**93**	**43.3**	**2.38**	**215**	**100.0**	**5.50**
By Race/Ethnicity									
White Non-Hispanic	46	21.4	1.81	38	17.7	1.49	84	39.1	3.30
Black Non-Hispanic	3	1.4	6.61	4	1.9	8.81	7	3.3	15.42
Hispanic	11	5.1	2.13	8	3.7	1.55	19	8.8	3.68
***A/PI/H Non-Hispanic**	1	0.5	2.27	0	0.0	0.00	1	0.5	2.27
****AI/AN Non-Hispanic**	58	27.0	7.65	41	19.1	5.41	99	46.0	13.06
*****MR/O Non-Hispanic**	3	1.4	NA	2	0.9	NA	5	2.3	NA
TOTAL	**122**	**56.7**	**3.12**	**93**	**43.3**	**2.38**	**215**	**100.0**	**5.50**
By Mode of Transmission									
+MSM	52	24.2	NA	44	20.5	NA	96	44.7	NA
++IDU	26	12.1	NA	13	6.0	NA	39	18.1	NA
MSM / IDU	13	6.0	NA	14	6.5	NA	27	12.6	NA
Heterosexual	17	7.9	NA	4	1.9	NA	21	9.8	NA
+++O/H/TF/TPR	0	0.0	NA	0	0.0	NA	0	0.0	NA
++++NRR/UR	14	6.5	NA	18	8.4	NA	32	14.9	NA
TOTAL	**122**	**56.7**	**3.12**	**93**	**43.3**	**2.38**	**215**	**100.0**	**5.50**

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

TABLE 20
Northern Arizona
Prevalence 2014

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	346	34.5	88.62	473	47.2	121.5	819	81.7	209.77
Female	90	9.0	22.69	94	9.4	23.70	184	18.3	46.40
TOTAL	**436**	**43.5**	**55.40**	**567**	**56.5**	**72.04**	**1003**	**100.0**	**127.44**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2 to 12	1	0.1	0.97	1	0.1	0.97	2	0.2	1.93
13 to 19	6	0.6	8.32	2	0.2	2.77	8	0.8	11.09
20 to 24	17	1.7	31.17	5	0.5	9.17	22	2.2	40.34
25 to 29	27	2.7	64.08	14	1.4	33.23	41	4.1	97.31
30 to 34	35	3.5	87.33	26	2.6	64.87	61	6.1	152.20
35 to 39	36	3.6	96.54	39	3.9	104.58	75	7.5	201.12
40 to 44	66	6.6	163.28	62	6.2	153.38	128	12.8	316.66
45 to 49	62	6.2	139.40	107	10.7	240.58	169	16.8	379.98
50 to 54	81	8.1	149.99	111	11.1	205.55	192	19.1	355.54
55 to 59	53	5.3	91.13	101	10.1	173.66	154	15.4	264.80
60 to 64	25	2.5	42.77	58	5.8	99.23	83	8.3	141.99
65 and Above	27	2.7	16.39	41	4.1	24.89	68	6.8	41.29
Age Unknown	0	0.0	NA	0	0.0	NA	0	0.0	NA
TOTAL	**436**	**43.5**	**55.40**	**567**	**56.5**	**72.04**	**1003**	**100.0**	**127.44**
By Race/Ethnicity									
White Non-Hispanic	267	26.6	52.44	337	33.6	66.19	604	60.2	118.64
Black Non-Hispanic	16	1.6	161.68	18	1.8	181.89	34	3.4	343.57
Hispanic	46	4.6	43.19	57	5.7	53.51	103	10.3	96.70
***A/PI/H Non-Hispanic**	8	0.8	84.45	6	0.6	63.34	14	1.4	147.79
****AI/AN Non-Hispanic**	90	9.0	59.21	142	14.2	93.42	232	23.1	152.63
*****MR/O Non-Hispanic**	9	0.9	NA	7	0.7	NA	16	1.6	NA
TOTAL	**436**	**43.5**	**55.40**	**567**	**56.5**	**72.04**	**1003**	**100.0**	**127.44**
By Mode of Transmission									
+MSM	216	21.5	NA	284	28.3	NA	500	49.9	NA
++IDU	67	6.7	NA	86	8.6	NA	153	15.3	NA
MSM / IDU	46	4.6	NA	89	8.9	NA	135	13.5	NA
Heterosexual	57	5.7	NA	70	7.0	NA	127	12.7	NA
+++O/H/TF/TPR	6	0.6	NA	6	0.6	NA	12	1.2	NA
++++NRR/UR	44	4.4	NA	32	3.2	NA	76	7.6	NA
TOTAL	**436**	**43.5**	**55.40**	**567**	**56.5**	**72.04**	**1003**	**100.0**	**127.44**

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

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 1: **Community Engagement**

1.1.1.1 Establish a formalized processes to engage state, county and tribal entities, local providers and community stakeholders in ongoing dialog and collaboration to improve HIV services. Explore digital methods to conduct this activity.

Metric: Establishment of formalized processes

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

1.1.1.2 Annually present at least one consumer-centric, culturally responsible training designed to engage clients in medical care and supportive services. Activities should be offered using both traditional methods (support groups, peer mentoring, provider talks, etc.) and digital methods (online forums, video webinars, etc.).

Metric: At least one training is presented each year

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Indian Health Service, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2019

Strategy 1: Community Engagement *continued*

1.1.1.3 Engage additional community partners to promote HIV testing/medical care.

Metric: The number of additional community partners engaged each year

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Indian Health Service, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2019

1.1.1.4 Increase the number of medical providers offering HIV testing as a routine part of care for all clients.

Metric: The number of additional medical providers engaged in routine HIV testing each year

Lead Program: Ryan White Part B Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Indian Health Service, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 2: **Education**

1.1.2.1 Annually, develop and implement at least one social marketing initiative using new media (online ads, in-app ads, etc.) to reach target populations which are designed to engage individuals to be tested for HIV and/or enter medical care.

Metric: The implementation of at least one social marketing initiative each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Arizona AIDS Education and Training Center, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

1.1.2.2 Biannually, provide at least one regional training for primary medical providers that includes information on HIV, extra-genital STD screening, and retention in care.

Metric: At least one training completed every two years

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2020

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 3: **Prevention, Testing & Linkage to Care**

1.1.3.1 Engage Flagstaff Medical Center to implement semi-targeted opt-out HIV testing in their emergency department. (semi-targeted: patients at risk, have clinical indications).

Metric: Opt-out testing implemented at Flagstaff Medical Center; the number of tests conducted each year

Lead Program: Coconino County Health Department

Partners: HIV Prevention Program, Ryan White Part B Program, Flagstaff Medical Center, Medical Providers, Arizona AIDS Education and Training Center, Maricopa Integrated Health System

Start/End: 2018 to 2021

1.1.3.2 Conduct new, innovative initiatives to improve accessibility to free HIV testing, focusing on getting never-tested people tested. Initiatives might include home test kit delivery, expanded outreach testing, etc.

Metric: The number of initiatives implemented each year; the number of new HIV tests each year

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

1.1.3.3 Implement same-day supplemental/confirmatory testing among testing providers, to decrease the time from diagnosis-lab-first medical appointment.

Metric: Same-day supplemental/confirmatory testing implemented

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2020

1.1.3.4 Annually, develop and implement at least one PrEP-focused social marketing initiative focused on target populations, designed to engage individuals to become educated and engaged in PrEP.

Metric: The implementation of at least one social marketing initiative each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

1.1.3.5 Establish the provision of PrEP Evaluation Assistance services by at least two Northern Arizona community-based organizations. PrEP Evaluation Assistance is designed to educate and engage high-risk HIV negative people in the use of Pre-Exposure Prophylaxis as an HIV Prevention Method.

Metric: PrEP Evaluation Assistance offered by at least two organizations; utilization and engagement in PrEP monitored and evaluated

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

1.1.3.6 Increase the number of medical providers educated on HIV/PrEP, and ultimately prescribing PrEP, by one provider per year.

Metric: The number of providers educated about PrEP, and the prescribing PrEP each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities

Start/End: 2017 to 2021

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Funding**

1.2.1.1 Increase the availability of support services that assist clients to attend their first medical appointment and lab services.

Metric: Increased availability of support services

Lead Program: Ryan White Part B Program

Partners: Community-Based Organizations

Start/End: 2017 to 2021

1.2.1.2 Expand Affordable Care Act benefits navigation services.

Metric: Increase in the number of entities providing benefits navigation services

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

1.2.1.3 Provide community-based organizations with technical assistance regarding grant writing, sustainability, billing capacity, etc.

Metric: The number of technical assistance opportunities requested and provided

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center

Start/End: 2017 to 2021

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Patient-Centered Care**

1.2.2.1 Annually, provide at least one training for Ryan White sub-recipients, community-based organizations, and other service providers, focusing on such topics as cultural competency, health equity, disclosure of HIV diagnosis, and/or CLAS training. Explore opportunities to collaborate with other local training opportunities to increase participation. A self-appraisal should be implemented prior to each training.

Metric: Presentation of at least one training opportunity each year

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Providers

Start/End: 2017 to 2021

1.2.2.2 Annually, implement at least one social marketing initiative to educate clients about seeking HIV care from knowledgeable, culturally appropriate providers, and the ability to switch providers for more comprehensive care.

Metric: At least marketing initiative implemented each year

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Aunt Rita's Foundation, Community-Based Organizations

Start/End: 2017 to 2021

Strategy 2: Patient-Centered Care *continued*

1.2.2.3 Create and distribute resources for providers that define step-by-step processes to link HIV positive clients to care, focusing on clients being linked from private medical providers, correctional facilities, emergency departments, and behavioral health/recovery centers. Include promotion of HIVAZ.org as an educational and referral resource.

Metric: The step-by-step guide is published and available in traditional and electronic formats

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Providers, Behavioral Health/Substance Use Providers

Start/End: 2018to 2019

1.2.2.4 Increase the number of providers offering HIV services in Northern Arizona, including providers offering services via telemedicine.

Metric: The number of new providers offering services in Northern Arizona

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Providers

Start/End: 2018 to 2021

1.2.2.5 Develop and distribute client self-advocacy resources in traditional and electronic formats.

Metric: The resources are developed and distributed throughout the community

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Streamline Processes**

1.2.3.1 Develop methodologies to improve the delivery and success of Early Intervention Services.

Metric: Methodologies are defined, implemented and evaluated

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Northern Arizona Healthcare Providers

Start/End: 2018 to 2019

1.2.3.2 Establish a common enrollment application for Ryan White Programs, including an online enrollment portal.

Metric: Completion of the online enrollment portal and policies and procedures

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs

Start/End: 2017 to 2018

1.2.3.3 Develop reporting methodologies to accurately determine linkage to care timeframes.

Metric: The reporting methodologies are developed and utilized

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, HIV Surveillance Program, State/County Entities, Tribal Entities, Northern Arizona Healthcare Providers, Community-Based Organizations

Start/End: 2017 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Prevention, Testing & Linkage to Care**

2.1.1.1 Annually, present at least one HIV testing and linkage to care training, designed to increase dialog among providers to reduce linkage to care timeframes.

Metric: At least one training is presented each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, HIV Prevention Program, State/County Entities, Tribal Entities, Northern Arizona Healthcare Providers, Community-Based Organizations

Start/End: 2017 to 2021

2.1.1.2 Identify and evaluate HIV testing, linkage to care, and engagement in care models that have proven successful when implemented in rural areas..

Metric: Identification of service delivery models; evaluation of these models for implementation

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Medical Providers, Community-Based Organizations, Northern Arizona University

Start/End: 2018 to 2021

2.1.1.3 Increase collaboration with substance abuse agencies in northern Arizona to increase HIV testing and linkage to care, and referrals to/from HIV services and substance Abuse programs.

Metric: The number of collaborations established.

Lead Program: Coconino County Health Department

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Substance Abuse Providers

Start/End: 2017 to 2021

Strategy 1: Prevention, Testing & Linkage to Care *continued*

2.1.1.4	Develop and implement an annual community-based initiative to promote HIV awareness, testing/linkage to care, and engagement in care that is culturally and linguistically appropriate.
Metric:	At least one initiative implemented each year; yearly assessment data demonstrating improved knowledge of HIV awareness, use of HIV testing/linkage to care services, and increased engagement in care
Lead Program:	HIV Prevention Program
Partners:	Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders
Start/End:	2017 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Streamline Processes**

2.1.2.1 Develop and implement activities designed to improve communication between healthcare agencies serving American Indians, state/county entities, healthcare organizations, and community-based organizations.

Metric: Activities are developed and implemented, and evaluated annually

Lead Program: Ryan White Part B Program

Partners: County/State Entities, Tribal Entities, Indian Health Service, Northern Arizona Healthcare Providers, Community-Based Organizations

Start/End: 2017 to 2021

2.1.2.2 Clearly identified care navigation processes for all communities.

Metric: The navigation processes for each community in the region are defined; processes are distributed in traditional and electronic form

Lead Program: Ryan White Part B Program

Partners: County/State Entities, Tribal Entities, Indian Health Service, Northern Arizona Healthcare Providers, Community-Based Organizations

Start/End: 2018 to 2019

2.1.2.3 Integrate HIV case management services with services offered by mental health and substance abuse providers.

Metric: Successful integration of HIV case management services by mental health and substance abuse providers

Lead Program: Ryan White Part B Program

Partners: County/State Entities, Tribal Entities, Indian Health Service, Northern Arizona Healthcare Providers, Community-Based Organizations, NARBHA

Start/End: 2017 to 2019

Strategy 2: Streamline Processes *continued*

2.1.2.4 Identify substance abuse providers and engage them in collaborative efforts to implement an integrated care team approach (internal and external partnerships) to provide comprehensive services that promote access to care and retention in care.

Metric: The number of substance abuse providers that adapt an integrated care team approach

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, HIV Prevention Program, Substance Abuse/Behavioral Health Providers, Northland Cares

Start/End: 2017 to 2019

2.1.2.5 Beginning in 2018, and then annually, provide training for community health workers/ promotoras on HIV testing, prevention and linkage to care.

Metric: The number of trainings provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Patient-Centered Care**

2.1.3.1 Implement a standardized referral process that institutes culturally competent, "warm" referrals between service providers.

Metric: The implementation of a standardized referral process

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Substance Abuse/ Behavioral Health Providers, Correctional Facilities, Community-Based Organizations

Start/End: 2017 to 2021

2.1.3.2 Annually, provide at least one training for healthcare and community-based providers that addresses issues such as cultural competency, motivational interviewing, trauma-informed care, treatment adherence etc. Training may be provided in-person or online.

Metric: At least one competency training is provided each year.

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

2.1.3.3 Assess the needs of newly diagnosed clients that have co-occurring issues, such as homeless or substance abuse issues. Develop action items based on the evaluation of the assessment

Metric: The completion of the assessment; development of action items

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2019

2.1.3.4	Evaluate the capacity of service organizations to enable clients to receive medical and supportive service appointments at their home or other convenient location, when feasible. As an alternative, evaluate the need and ability to provide increased access to transportation services.
Metric:	Capacity to provide offsite medical and supportive service appointments is evaluated; the need and ability to provide increased transportation services is evaluated; action items developed
Lead Program:	Ryan White Part B Program
Partners:	State Entities, Tribal Entities, Community-Based Organizations
Start/End:	2018 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 1: **Patient-Centered Care**

2.2.1.1 Identify and evaluate health team models/strategies that would be effective in rural communities.

Metric: Models and/or strategies identified and evaluated; action items developed

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2019 to2020

2.2.1.2 Assess people living with HIV, at-risk individuals, in target populations, and providers to inform HIV planning, service delivery, and quality improvement initiatives.

Metric: The assessment is completed and evaluated; action items are developed

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 2: **Funding**

2.2.2.1 Evaluate retention-in-care service delivery and funding to include community outreach services.

Metric: Service delivery and funding evaluated

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2019

2.2.2.2 Conduct an assessment of the capacity building opportunities for community-based organizations and providers seeking to diversify their funding sources.

Metric: Completion of the assessment

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

2.2.2.3 Compile data from multiple sources, including continuums of care specific to each target population, to justify the need for funding, and disseminate this information to community partners.

Metric: Completion of needs assessment, Key informant interviews

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Indian Health Service, Arizona AIDS Education and Training Center

Start/End: 2017 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 3: **Data Standardization**

2.2.3.1 Reduce paperwork among community providers by establishing a universal enrollment and data-sharing process for non-Ryan White services.

Metric: Completion of the universal enrollment process

Lead Program: Ryan White Part B Program

Partners: Community-Based Organizations

Start/End: 2018 to 2019

2.2.3.2 Evaluate the feasibility of implementing a shared data system for prevention and care services, that includes linkage to care information.

Metric: An implementation evaluation is completed; action items are developed

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2020

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 1: **Stigma Reduction**

3.1.1.1 Conduct an assessment of the HIV knowledge, stigma, behaviors, education and service needs of local target populations most at-risk for contracting HIV, and people who are living with HIV.

Metric: Assessment completed

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

3.1.1.2 Establish partnerships with community stakeholders and entities that serve target populations to develop and implement strategies to address multiple types of stigma (individual, family, friends, providers, culture, etc.).

Metric: The establishment of partnerships

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 2: **Community Engagement**

3.1.2.1 Biannually, develop and implement at least one initiative to decrease negative perceptions of HIV and HIV testing.

Metric: At least one initiative implemented every two years

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, County/State Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2019

3.1.2.2 Collaborate with American Indian communities to develop culturally appropriate sexual health education and HIV messaging materials.

Metric: The development of materials

Lead Program: HIV Prevention Program

Partners: Arizona AIDS Education and Training Center, County/State Entities, Tribal Health Entities, Indian Health Service

Start/End: 2018 to 2020

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 3: **Funding**

3.1.3.1 Identify and evaluate methodologies for providers to modify the way they offer HIV/STD/Hepatitis prevention and care services to create opportunities for third-party billing.

Metric: Methodologies identified and evaluated for implementation; action items developed

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

3.1.3.2 Identify opportunities to combine programmatic resources to create efficiencies in contracting, improve service integration, and reduce duplication of effort and/or competition for funding.

Metric: Successful identification and implementation of new opportunities for efficiency

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

3.1.3.3 Assess opportunities to provide free/low cost services for people living with HIV who have co-infections that need to be addressed.

Metric: Assessment completed; action items developed

Lead Program: HIV Prevention Program

Partners: County/State Entities, Tribal Health Entities, Community-Based Organizations

Start/End: 2018 to 2019

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 1: **Community Engagement**

4.1.1.1 Recruit people living with HIV and other stakeholders to become to become leaders, advocates, planners and peer mentors for the local HIV community.

Metric: The number of people recruited for community leadership each year

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, County/State Entities, Tribal Entities, Youth Organizations, Community-Based Organizations

Start/End: 2017 to 2018

4.1.1.2 Annually, provide at least one leadership development, advocacy, and other training for HIV community leaders.

Metric: At least one training provided each year

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, County/State Entities, Tribal Entities, Youth Organizations, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 2: **Prevention, Testing & Linkage to Care**

4.1.2.1 Develop and implement activities that support the integration of comprehensive sexual health services as a routine part of care, including routine HIV/STD/Hepatitis testing.

Metric: The development and implementation of activities

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

4.1.2.2 Coordinate HIV/STD/Hepatitis testing services to ensure equity of service delivery among diverse providers, and appropriateness of services delivered to various age groups and target populations.

Metric: The number and types of collaborative activities

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, County/State Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 3: **Education**

4.1.3.1 Annually, provide at least one fact-based, culturally and linguistically appropriate HIV education opportunity to youth aged 13 to 19, and/or organizations serving youth.

Metric: The presentation of one education opportunity each year; the number of youth participants

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Northern Arizona Providers, County/State Entities, Tribal Entities, Youth Organizations, Community-Based Organizations

Start/End: 2017 to 2018

4.1.3.2 Establish a partnership with the Office of Women's and Children's Health reproductive health program to include HIV education and testing as a part of its programming.

Metric: Partnership established

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities

Start/End: 2017 to 2021

4.1.3.3 Establish a partnership with the Northern Arizona Regional Behavioral Health Authority to include HIV education and testing as a part of its programming.

Metric: Partnership established

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Northern Arizona Regional Behavioral Health Authority

Start/End: 2017 to 2021

Strategy 3: Education *continued*

4.1.3.4 Establish a partnership with the University/Colleges to include HIV education as a part of its educational programming.

Metric: Partnership established

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Prevention, Testing and Linkage to Care**

4.2.1.1 Increase referrals for HIV testing, prevention and linkage to care services from substance abuse providers.

Metric: An increase in the number of referrals

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Substance Abuse Service Providers, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Streamline Processes**

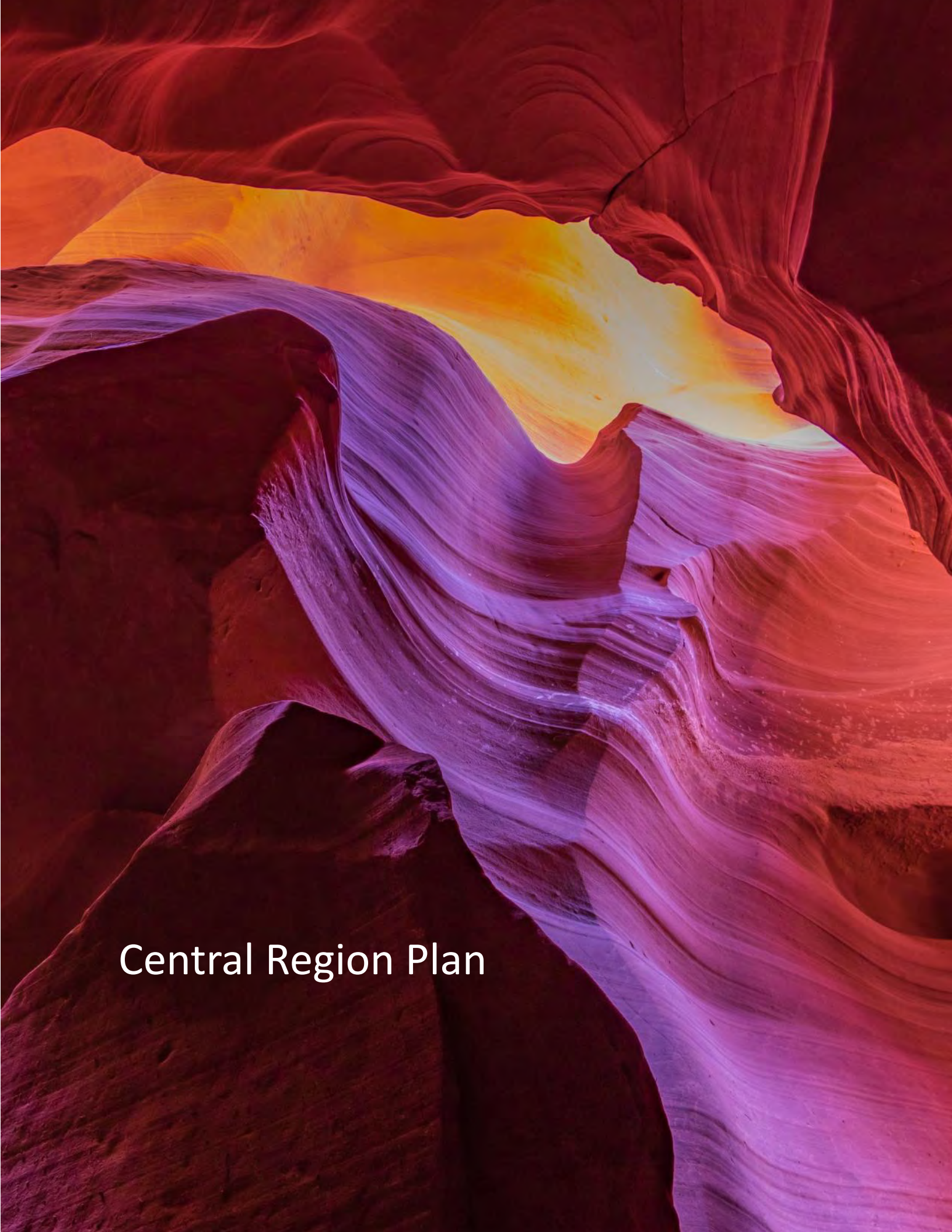
4.2.2.1 Develop capacity for substance abuse and behavioral health services to obtain SAMHSA funding assistance for HIV prevention and care services.

Metric: The provision of capacity building assistance

Lead Program: HIV Prevention Program

Partners: County/State entities, Tribal Health entities, Substance abuse/Behavioral Health Services Providers, Community-Based Organizations

Start/End: 2018 to 2020



Central Region Plan

The Central Region

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- African Americans/Blacks, regardless of gender
- Transgender Individuals

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Form reduction and process improvements to reduce duplication of effort among funding sources
- Quality improvement initiatives designed to reduce linkage to care timeframes
- Consumer and provider training related to stigma reduction, cultural competency, and client empowerment
- Social marketing initiatives to increase HIV testing and awareness, PrEP engagement, and engagement in care

The Central Region is comprised of Maricopa and Pinal counties, and had an estimated population of 4,489,109 in 2014. Federally-funded HIV prevention and care services in the Central Region are provided by the HIV Prevention Program, and Ryan White Part A, B, C and D Programs. The region is 14,566 square miles. The Central Region includes Phoenix, the state's capitol, which is the sixth most populated city in America at more than 1,563,025 people in 2015. Pinal County is mostly rural. The Central Region accounts for more than 70% of the state's HIV incidence and prevalence. Major HIV issues affecting the Central Region include ethnic/racial disparities, especially within the Black community, stigma, lack of sexual health education in schools, and access to care issues.

The Central Region defines the geographic service delivery area for the Phoenix EMA Ryan White Part A Program. Ryan White Parts B, C and D, and the HIV Prevention Program also provide services in the Region.

CONTINUUM OF CARE DEFINITIONS

HIV-Diagnosed: Prevalent cases that have been diagnosed

Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year

Incidence Linked to HIV Care: Incident cases for the year of the spectrum that were linked with a documented lab test, doctor visit or medication use within 90 days of their diagnosis, but not on the same day of the diagnosis.
If a person has their first CD4, viral load or genotype on the same day as their diagnostic test the date of second CD4, viral load or genotype will be used as the linkage

Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or antiretroviral (ARV) use in the first and second six months of the year

On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable

Adherent/Suppressed: Prevalent cases whose last viral load of the calendar year was undetectable (<200 C/mL)

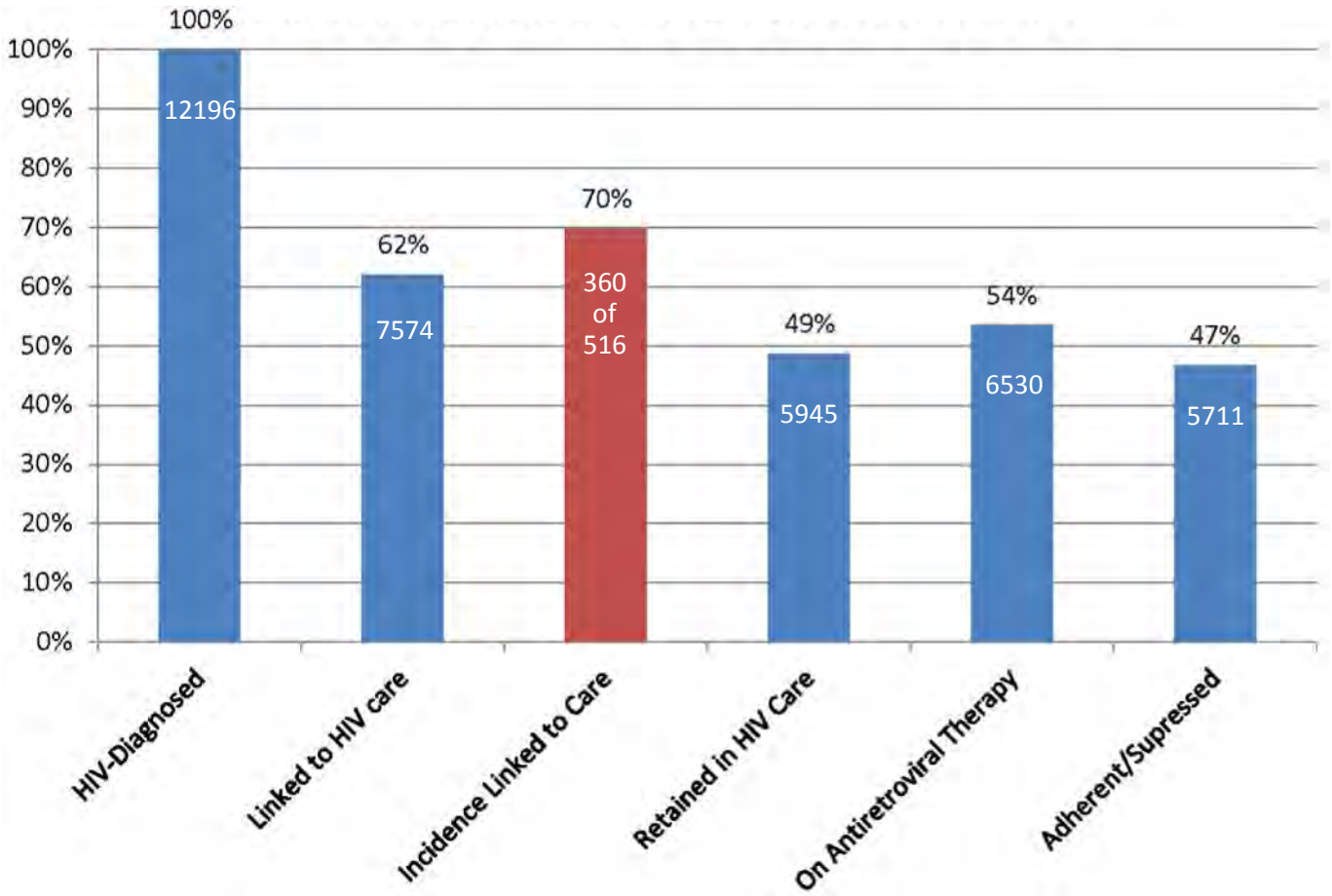


FIGURE 17
2014 Central Region
HIV Continuum of Care

The 2015 Arizona Department of Health Services Epidemiology Report shows the Central Region had 67% of the state population and 74% of the new HIV cases and 75% of the ongoing HIV cases. Census data from 2015 shows that Central Arizona reports approximately a quarter of people are under 18 years old. The percentage of HIV positive Whites (84%) and Latinos (31%) closely mirror the general state population rates. There is a higher percentage of African Americans/Blacks in Maricopa County (6% vs. statewide average of 5%) and a lower percent of Native Americans (3%) when compared to the statewide average of 5%. In 2014, there were 608 new HIV cases (an increase of 85 cases), while prevalence increased by 192 cases, suggesting an influx of previously diagnosed people living with HIV to the Central Region.

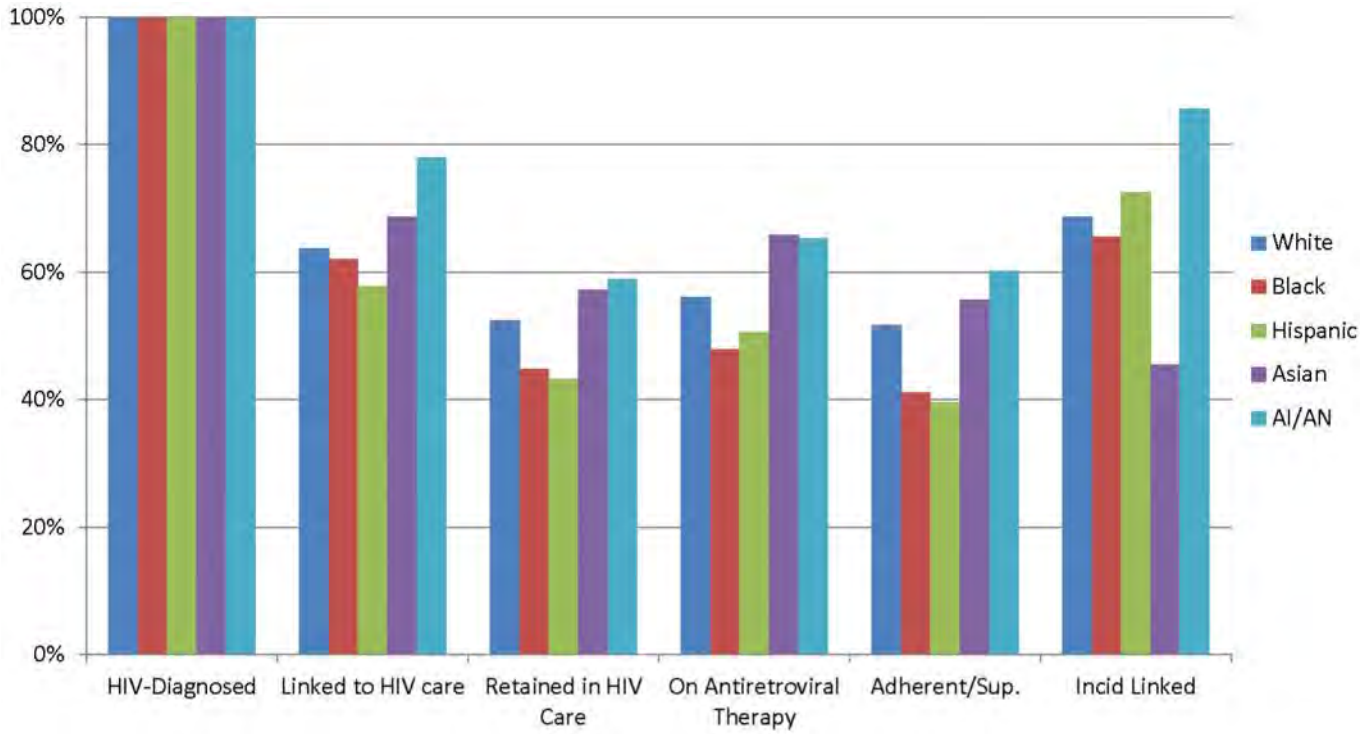


FIGURE 18
2014 Central Region HIV Continuum of Care by Race/Ethnicity

Review of continuum data in **Figure 20** by race/ethnicity shows that American Indians/Alaskan Native clients in the Central Region have the highest viral load suppression at 86%, followed by Hispanics at 72%. Latinos have the lowest rates of linkage to care (58%), and Blacks and Asians have the lowest rates of viral load suppression (45%).

In **Figure 21**, the most frequently reported risk factors for the Central Region are Men who have Sex with Men (7,492 people), Injection Drug Users (2,101 people) and High Risk Heterosexuals (1,283 people).

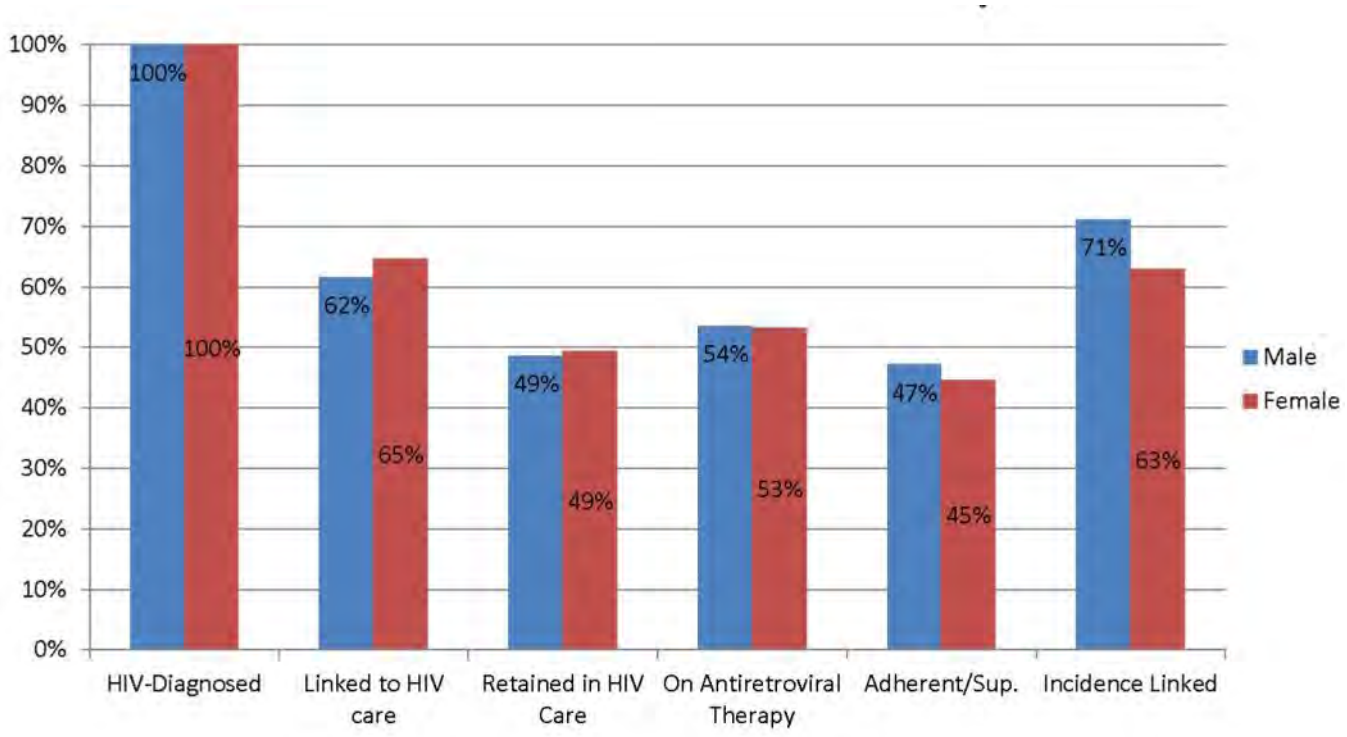


FIGURE 19
2014 Central Region HIV Continuum of Care by Gender

TABLE 21
Comparison of Central Region Incidence and Prevalence Totals by Year

Year	Prevalence	Incidence
2005	562	44
2006	606	27
2007	652	42
2008	706	39
2009	740	40
2010	747	45
2011	795	36
2012	896	33
2013	939	61
2014	1003	39

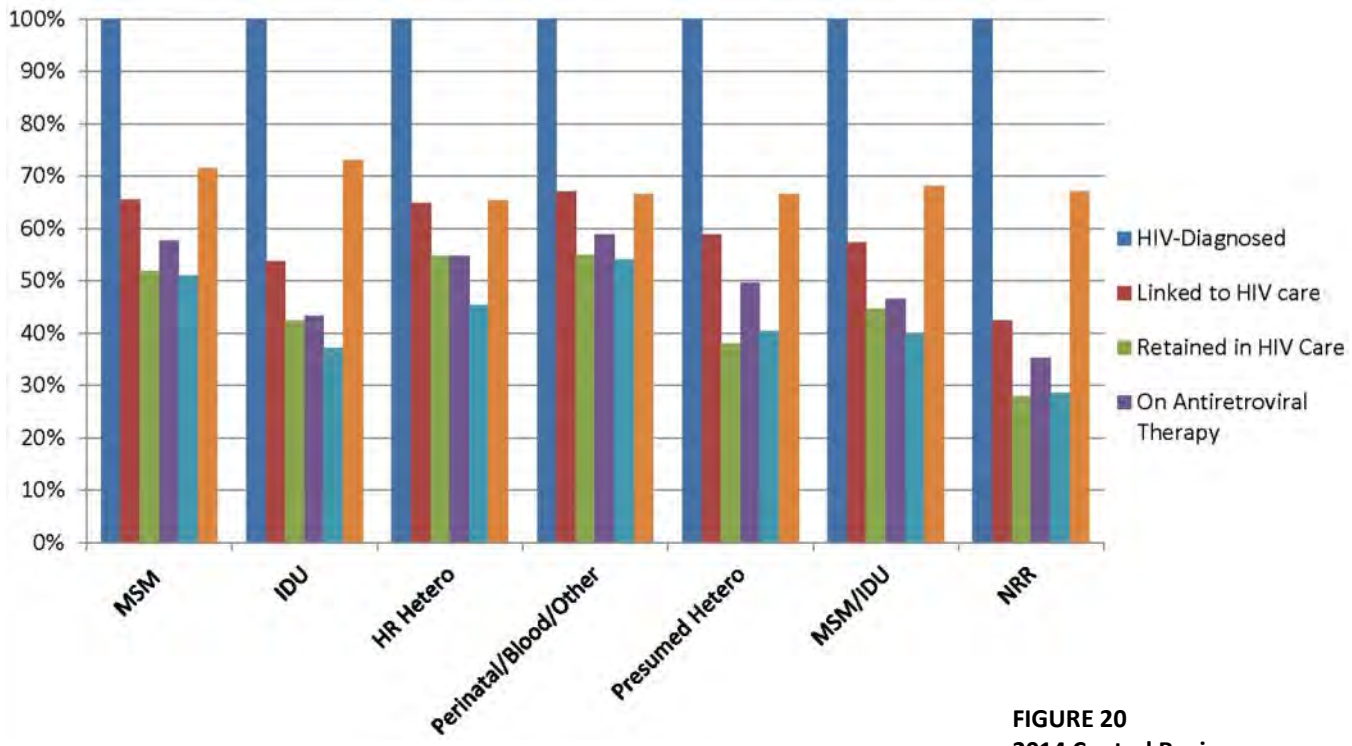


FIGURE 20
2014 Central Region
HIV Continuum of Care
By Risk Category

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk

TABLE 22
Central Arizona Regional Incidence 2009 to 2013

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	1544	63.1	14.35	595	24.3	5.53	2139	87.4	19.89
Female	230	9.4	2.13	77	3.1	0.71	307	12.6	2.84
TOTAL	**1774**	**72.5**	**8.23**	**672**	**27.5**	**3.12**	**2446**	**100.0**	**11.35**
By Age									
Under 2	4	0.2	0.65	0	0.0	0.00	4	0.2	0.65
2 to 12	14	0.6	0.40	0	0.0	0.00	14	0.6	0.40
13 to 19	71	2.9	3.40	5	0.2	0.24	76	3.1	3.64
20 to 24	343	14.0	23.07	41	1.7	2.76	384	15.7	25.83
25 to 29	353	14.4	22.33	81	3.3	5.12	434	17.7	27.45
30 to 34	257	10.5	16.62	92	3.8	5.95	349	14.3	22.57
35 to 39	228	9.3	15.40	95	3.9	6.42	323	13.2	21.82
40 to 44	189	7.7	12.92	108	4.4	7.38	297	12.1	20.30
45 to 49	138	5.6	9.71	79	3.2	5.56	217	8.9	15.27
50 to 54	87	3.6	6.39	89	3.6	6.53	176	7.2	12.92
55 to 59	57	2.3	4.76	34	1.4	2.84	91	3.7	7.60
60 to 64	21	0.9	1.93	31	1.3	2.85	52	2.1	4.79
65 and Above	12	0.5	0.44	17	0.7	0.62	29	1.2	1.06
Age Unknown	0	0.0	NA	0	0.0	N/A	0	0.0	NA
TOTAL	**1774**	**72.5**	**8.23**	**672**	**27.5**	**3.12**	**2446**	**100.0**	**11.35**
By Race/Ethnicity									
White Non-Hispanic	736	30.1	5.80	314	12.8	2.47	1050	42.9	8.27
Black Non-Hispanic	275	11.2	24.77	78	3.2	7.03	353	14.4	31.80
Hispanic	639	26.1	9.83	234	9.6	3.60	873	35.7	13.43
***A/PI/H Non-Hispanic**	39	1.6	4.86	14	0.6	1.74	53	2.2	6.60
****AI/AN Non-Hispanic**	65	2.7	14.93	30	1.2	6.89	95	3.9	21.82
*****MR/O Non-Hispanic**	20	0.8	N/A	2	0.1	N/A	22	0.9	N/A
TOTAL	**1774**	**72.5**	**8.23**	**672**	**27.5**	**3.12**	**2446**	**100.0**	**11.35**
By Mode of Transmission									
+MSM	1142	46.7	N/A	353	14.4	N/A	1495	61.1	N/A
++IDU	115	4.7	N/A	59	2.4	N/A	174	7.1	N/A
MSM / IDU	96	3.9	N/A	30	1.2	N/A	126	5.2	N/A
Heterosexual	164	6.7	N/A	79	3.2	N/A	243	9.9	N/A
+++O/H/TF/TPR	16	0.7	N/A	0	0.0	N/A	16	0.7	N/A
++++NRR/UR	241	9.9	N/A	151	6.2	N/A	392	16.0	N/A
TOTAL	**1774**	**72.5**	**8.23**	**672**	**27.5**	**3.12**	**2446**	**100.0**	**11.35**

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

TABLE 23
Central Arizona
Prevalence 2014

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	5374	43.1	245.69	5359	43.0	245.00	10733	86.1	490.69
Female	971	7.8	43.91	765	6.1	34.59	1736	13.9	78.50
TOTAL	**6345**	**50.9**	**144.25**	**6124**	**49.1**	**139.22**	**12469**	**100.0**	**283.47**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2 to 12	38	0.3	5.53	7	0.1	1.02	45	0.4	6.55
13 to 19	54	0.4	12.76	11	0.1	2.60	65	0.5	15.36
20 to 24	292	2.3	94.93	60	0.5	19.51	352	2.8	114.44
25 to 29	578	4.6	186.18	218	1.7	70.22	796	6.4	256.39
30 to 34	684	5.5	220.53	360	2.9	116.07	1044	8.4	336.59
35 to 39	709	5.7	243.66	545	4.4	187.30	1254	10.1	430.95
40 to 44	844	6.8	282.49	791	6.3	264.75	1635	13.1	547.24
45 to 49	929	7.5	331.56	1189	9.5	424.35	2118	17.0	755.91
50 to 54	969	7.8	340.69	1326	10.6	466.21	2295	18.4	806.90
55 to 59	608	4.9	236.87	777	6.2	302.71	1385	11.1	539.57
60 to 64	342	2.7	150.22	465	3.7	204.25	807	6.5	354.47
65 and Above	285	2.3	47.15	375	3.0	62.04	660	5.3	109.19
Age Unknown	13	0.1	N/A	0	0.0	N/A	13	0.1	N/A
TOTAL	**6345**	**50.9**	**144.25**	**6124**	**49.1**	**139.22**	**12469**	**100.0**	**283.47**
By Race/Ethnicity									
White Non-Hispanic	3314	26.6	128.57	3336	26.8	129.42	6650	53.3	257.99
Black Non-Hispanic	923	7.4	388.90	825	6.6	347.61	1748	14.0	736.50
Hispanic	1717	13.8	130.45	1668	13.4	126.73	3385	27.1	257.18
***A/PI/H Non-Hispanic**	111	0.9	62.73	78	0.6	44.08	189	1.5	106.81
****AI/AN Non-Hispanic**	157	1.3	173.15	159	1.3	175.35	316	2.5	348.50
*****MR/O Non-Hispanic**	123	1.0	N/A	58	0.5	N/A	181	1.5	N/A
TOTAL	**6345**	**50.9**	**144.25**	**6124**	**49.1**	**139.22**	**12469**	**100.0**	**283.47**
By Mode of Transmission									
+MSM	3934	31.6	N/A	3756	30.1	N/A	7690	61.7	N/A
++IDU	532	4.3	N/A	620	5.0	N/A	1152	9.2	N/A
MSM / IDU	390	3.1	N/A	599	4.8	N/A	989	7.9	N/A
Heterosexual	670	5.4	N/A	635	5.1	N/A	1305	10.5	N/A
+++O/H/TF/TPR	84	0.7	N/A	58	0.5	N/A	142	1.1	N/A
++++NRR/UR	735	5.9	N/A	456	3.7	N/A	1191	9.6	N/A
TOTAL	**6345**	**50.9**	**144.25**	**6124**	**49.1**	**139.22**	**12469**	**100.0**	**283.47**

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

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 1: **Prevention, Testing & Linkage to Care**

1.1.1.1 Annually, increase HIV testing by adding three testing sites and/or testing initiatives, focusing testing on target populations most at-risk for contacting HIV, including MSM, IDU, communities of color and the transgender individuals.

Metric: The number of testing sites and/or initiatives added each year.

Lead Program: HIV Prevention Program

Partners: Arizona AIDS Education and Training Center, Ryan White Programs

Start/End: 2017 to 2021

1.1.1.2 Increase the number of medical providers educated on HIV/PrEP, and ultimately prescribing PrEP, by three providers per year.

Metric: The number of providers educated about PrEP, and the prescribing PrEP each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

1.1.1.3 Annually, increase the number of health care professionals trained in knowledge of 4th generation algorithms for HIV testing by three providers per year.

Metric: The number of health care professionals trained in 4th generation HIV testing each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

1.1.1.4 Annually, present at least one linkage to care training, designed to increase collaboration and dialog among HIV agencies to reduce linkage to care timeframes.

Metric: The number of linkage to care trainings provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

1.1.1.5 Annually, develop and implement at least one social marketing initiative to target populations, designed to engage individuals to be tested for HIV and/or enter medical care.

Metric: The implementation of at least one social marketing initiative each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Arizona AIDS Education and Training Center, Community-Based Organizations

Start/End: 2017 to 2021

1.1.1.6 Conduct a one-year pilot of PrEP Evaluation Assistance at two locations. PrEP Evaluation Assistance is designed to educate and engage high-risk HIV negative people in the use of Pre-Exposure Prophylaxis as an HIV Prevention Method. Monitor and evaluate utilization and engagement.

Metric: Pilot Program initiated; utilization and engagement in PrEP monitored and evaluated

Lead Program: HIV Prevention Program

Partners: HIV Care Directions, Southwest Center for HIV

Start/End: 2017 to 2018

Strategy 1: Prevention, Testing & Linkage to Care *continued*

1.1.1.7 Assess the PrEP Evaluation Assistance pilot program. Based on performance, expand service delivery.

Metric: Based on pilot program performance, expand PrEP Evaluation Assistance services.

Lead Program: HIV Prevention Program

Partners: State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

1.1.1.8 Annually, develop and implement at least one PrEP-focused social marketing initiative focused on target populations, designed to engage individuals to become educated and engaged in PrEP.

Metric: The implementation of at least one social marketing initiative each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 2: **Education**

1.1.2.1 Annually, increase the number of HIV providers in Maricopa and Pinal Counties trained on diagnosis and management of HIV, by six per year statewide

Metric: The number of providers trained on the diagnosis and management of HIV each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities

Start/End: 2018 to 2021

1.1.2.2 Annually, provide training to Oral Health professionals in Maricopa and Pinal Counties on common oral manifestations as seen in patients with HIV.

Metric: The number of dentists trained each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities

Start/End: 2017 to 2021

1.1.2.3 Annually, present at least one regional provider training, in collaboration with the California HIV/STD Training Center.

Metric: The number of trainings provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

Strategy 2: Education *continued*

1.1.2.4 Beginning in 2018, and then annually, provide training for community health workers/ promotoras on HIV testing, prevention and linkage to care.

Metric: The number of trainings provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

1.1.2.5 Annually, present at least one regional CBO/provider training on trauma-informed care.

Metric: The number of trainings provided each year

Lead Program: Ryan White Part A Program

Partners: Arizona AIDS Education and Training Center, Other Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 3: **Community Engagement**

1.1.3.1 Develop and implement an annual community-based initiative to promote HIV awareness, testing/linkage to care, and engagement in care that is culturally and linguistically appropriate.

Metric: At least one initiative implemented each year; yearly assessment data demonstrating improved knowledge of HIV awareness, use of HIV testing/linkage to care services, and increased engagement in care

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2018

1.1.3.2 Collaboratively develop tools and processes with Immigration and Customs Enforcement and Border Health programs to coordinate HIV care during deportation.

Metric: Development of the tools and processes

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, Immigration and Customs Enforcement, Border Health programs, Community-Based Organizations

Start/End: 2017 to 2019

1.1.3.3 Annually, present a collaboratively developed HIV Symposium, offering program contractors and community stakeholders opportunities for education on service delivery and quality improvement, as well as engagement in HIV planning activities.

Metric: Presentation of the HIV Symposium each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Arizona AIDS Education and Training Center, HIV Providers, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: Streamline Processes

1.2.1.1 Establish a common enrollment application for Ryan White programs, including an online enrollment portal.

Metric: Completion of the online enrollment portal, and policies and procedures

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs

Start/End: 2017 to 2018

1.2.1.2 Implement processes that support Ryan White-eligible clients attending their first medical visit with a doctor on the same day as their HIV diagnosis.

Metric: The number of newly-diagnosed clients who are offered and attend a same day medical appointment

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, State/County Entities, HIV Prevention Program, Community-Based Organizations

Start/End: 2017 to 2019

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Community Engagement**

1.2.2.1 Annually, implement a strategy to engage traditional and non-traditional community partners serving target populations in activities that promote HIV testing, linkage to care, harm reduction and engagement in care.

Metric: The number of new, traditional and non-traditional partners engaged each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

1.2.2.2 Implement technology resources to expand partner services, in order to improve health and prevention outcomes.

Metric: Success of implementing technology that expands partner services

Lead Program: HIV Prevention Program

Partners: State/County Entities

Start/End: 2017 to 2019

1.2.2.3 Annually, assess people living with HIV, at-risk individuals in target populations, and providers to inform HIV planning, service delivery, and quality improvement initiatives.

Metric: Completion of a yearly assessment

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Patient-Centered Care**

1.2.3.1 Annually, complete at least one quality initiative that drives improvements to decrease entry to care timeframes.

Metric: Reduction in entry to care timeframes contributable to the implemented quality initiative

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Part A Early Intervention Services sub-recipients, other Part A sub-recipients, Community-Based Organizations

Start/End: 2017 to 2021

1.2.3.2 Annually, provide cultural competency, health equity, and/or CLAS trainings to sub-recipients, community-based organizations, and other service providers.

Metric: The number of trainings provided each year

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Prevention Program, Ryan White Part A Program sub-recipients

Start/End: 2017 to 2021

1.2.3.3 Establish a Spanish language version of HIVAZ.org.

Metric: Successful implementation of the Spanish language version of HIVAZ.org

Lead Program: HIV Prevention Program

Partners: Aunt Rita's Foundation

Start/End: 2017 to 2018

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Streamline Processes**

2.1.1.1 Formalize and implement processes between Part A Early Intervention Services sub-recipients and State and County correctional facilities, to improve linkages to HIV care and supportive services for recently released inmates.

Metric: Processes formalized and implemented

Lead Program: Ryan White Part A Program

Partners: Ryan White Part A sub-recipients for Early Intervention Services, Ryan White Programs, State/County Correctional Entities, HIV Prevention Program

Start/End: 2017 to 2018

2.1.1.2 Diversify accessibility to HIV prevention and care services for homeless clients by at least two new providers.

Metric: Two new providers offering HIV prevention and care services targeted to homeless people.

Lead Program: Ryan White Part A

Partners: Ryan White Part A sub-recipients, Ryan White Programs, HIV Prevention Program, HOPWA, Housing Services Providers

Start/End: 2017 to 2019

2.1.1.3 Implement HIV prevention strategies in correctional systems.

Metric: Successful implementation of HIV Prevention strategies in State/local correctional systems

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/Local Correctional Health Systems, CBOs

Start/End: 2018 to 2020

Strategy 1: Streamline Processes *continued*

2.1.1.4 Evaluate the feasibility of implementing a shared data system for prevention and care services, that includes linkage to care information.

Metric: An implementation evaluation is completed; action items are developed

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Education**

2.1.2.1 Develop a comprehensive, accessible, and culturally/linguistically appropriate library of health literacy resources for HIV positive and high-risk HIV negative clients, utilizing digital and traditional media formats.

Metric: Health literacy resources established

Lead Program: Ryan White Part A

Partners: Ryan White Programs, HIV Prevention Program, Arizona AIDS Education and Training Center

Start/End: 2017 to 2019

2.1.2.2 Annually, provide training to at least five medical providers related to the diagnosis and management of HIV, and trauma-informed care.

Metric: At least five HIV medical providers trained each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Patient-Centered Care**

2.1.3.1 By 2018, implement an electronic patient portal in the Ryan White Part C clinic, and provide ongoing education for clients on the use of patient portal technology.

Metric: Implementation of the Patient Portal system by 2018; the number of clients utilizing the system each year from 2019-on

Lead Program: Ryan White Part C Program

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2018

2.1.3.2 Annually, conduct quarterly reviews of Part A sub-recipient quality improvement initiatives that address linkage to care timeframes.

Metric: Reviews conducted each quarter

Lead Program: Ryan White Part A Program Clinical Quality Management Committee

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

2.1.3.3 Establish a baseline for culturally and linguistically appropriate patient-centered care for those who are HIV negative, including services related to PrEP, harm reduction, condom distribution, behavioral interventions, and other prevention interventions.

Metric: Baseline established

Lead Program: HIV Prevention Program

Partners: HIV Statewide Advisory Committee, Part A Planning Council's Community Health Planning and Strategies Committee

Start/End: 2018 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons diagnose with HIV infection who are virally suppressed to at least 80%.

Strategy 1: **Patient-Centered Care**

2.2.1.1 Annually, conduct quarterly reviews of viral load suppression data provided by Part A sub-recipient quality improvement initiatives designed to increase viral load suppression rates.

Metric: Quarterly reviews of viral load suppression data conducted

Lead Program: Ryan White Part A Program Clinical Quality Management Committee

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

2.2.1.2 Develop and implement a strategy to expand Part A-funded treatment adherence services, to improve viral load suppression rates among Ryan White Part A clients.

Metric: The development and implementation of the strategy

Lead Program: Ryan White Part A Program

Partners: Other Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2019

2.2.1.3 Develop and implement an HIV prevention strategy for HIV positive individuals, focusing on retention in care, treatment adherence, and viral suppression.

Metric: The development and implementation of the strategy

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2018

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons diagnose with HIV infection who are virally suppressed to at least 80%.

Strategy 2: **Community Engagement**

2.2.2.1 Biannually, conduct a culturally responsive media initiative that promotes retention in care and viral suppression to people living with HIV.

Metric: Completion of the media initiative every two years

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Statewide Advisory Group, Part A Planning Council's Community Health Planning and Strategies Committee, Ryan White Part C Consumer Advisory Board

Start/End: 2018 to 2020

2.2.2.2 Annually, expand the utilization of HIV care, prevention, and PrEP continuum of care models by at least one non-Ryan White funded medical practice.

Metric: At least one non-Ryan White medical practices engages in the use of continuum of care models each year

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center

Start/End: 2018 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Increase the percentage of persons diagnose with HIV infection who are virally suppressed to at least 80%.

Strategy 3: **Streamline Processes**

2.2.3.1 Establish baseline data that identifies the number of newly diagnosed clients that are virally suppressed within 180 days of entry to medical care, and develop a strategy to increase the number of clients that achieve viral suppression within this timeframe.

Metric: The baseline data is established, and a strategy to increase the number of clients is developed

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Surveillance Program, Arizona Regional Quality Group

Start/End: 2017 to 2019

2.2.3.2 Implement the proposed strategy to increase the percentage of newly diagnosed clients that are virally suppressed within 180 days of their first medical appointment.

Metric: The strategy is implemented; percentage change in the number of newly diagnosed clients that are virally suppressed within 180 of their first medical appointment

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Surveillance Program, Arizona Regional Quality Group

Start/End: 2019 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 1: **Funding**

3.1.1.1 Conduct an assessment of the capacity building opportunities for community-based organizations and providers seeking to diversify their funding sources.

Metric: Completion of the assessment

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2017

3.1.1.2 Annually, provide at least one capacity building opportunities to CBOs/providers seeking to diversify their funding sources.

Metric: At least one capacity building opportunity provided each year

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

3.1.1.3 Compile data from multiple sources, including continuums of care specific to each target population, to justify the need for funding, and disseminate this information to community partners.

Metric: The data is compiled, published and distributed to community partners

Lead Program: Arizona Regional Quality Group

Partners: Ryan White Programs, HIV Prevention Program, Surveillance, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

Strategy 1: Funding *continued*

3.1.1.4 Develop and implement an action plan to address disparities in populations that are most affected by HIV, with consideration for traditional and non-traditional funding sources.

Metric: Development and Implementation of the action plan

Lead Program: HIV Statewide Advisory Group

Partners: Ryan White Part A Planning Council, Community-Based Organizations

Start/End: 2019 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 2: **Patient-Centered Care**

3.1.2.1 Annually, train at least three non-Ryan White medical providers to enhance their knowledge of, and ability to link clients to Ryan White and Prevention services.

Metric: Three or more providers are trained each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

3.1.2.2 Annually, provide at least one training for funded and non-funded entities related to culturally and linguistically appropriate HIV care and prevention services.

Metric: At least one training provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, HIV Prevention Program, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 3: **Stigma Reduction**

3.1.3.1 Annually, implement at least one HIV stigma reduction social marketing initiative each year, utilizing new and traditional media.

Metric: At least one stigma reduction social marketing initiative implemented each year

Lead Program: HIV Prevention Program

Partners: Part A Planning Council, HIV Statewide Advisory Group, Ryan White Programs, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 4: **Population-Specific Assessment & Strategy Development**

3.1.4.1 Conduct an assessment of the health disparities, and HIV prevention and care needs of gay and bisexual men, young Black gay and bisexual men and Black females.

Metric: Completion of the assessment

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Part A Planning Council, HIV Statewide Advisory Group, Arizona AIDS Education and Training Center, Community-Based Organizations, National Association of State and Territorial AIDS Directors, HRSA technical consultants

Start/End: 2018

3.1.4.2 Develop and implement a strategy to address issues identified in the assessment. Establish advisory bodies, comprised of each target population, to inform activities and monitor outcomes.

Metric: Strategies developed and implemented

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Part A Planning Council, HIV Statewide Advisory Group, Community-Based Organizations

Start/End: 2018 to 2021

3.1.4.3 Annually, monitor and revise the strategy.

Metric: Strategies monitored and revised, as needed

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Part A Planning Council, HIV Statewide Advisory Group, Community-Based Organizations

Start/End: 2019 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 1: Community Engagement

3.2.1.1 Establish referral mechanisms and MOUs with the centralized homeless housing hubs, such as CASS Welcome Center, UMOM Family Housing Hub, and Mesa Family Housing Hub for referrals to Ryan White and HOPWA services.

Metric: Referral mechanisms are defined, and MOUs are established

Lead Program: Ryan White Part A Program

Partners: Local Housing Coordinators, HOPWA

Start/End: 2017 to 2018

3.2.1.2 Develop and implement a strategy that defines a more holistic approach to serving homeless individuals who are HIV positive (i.e., housing, mental health and substance abuse services, HIV care).

Metric: The strategy is developed and implemented

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part A Program, HOPWA, Housing Providers, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 2: **Funding**

3.2.2.1 Determine partnership opportunities with HOPWA to seek additional funding sources.

Metric: Partnership opportunities are determined

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, HOPWA

Start/End: 2018 to 2019

3.2.2.2 Explore opportunities to use Ryan White Part B rebate funds for housing services. Implement activities as funding allows.

Metric: Opportunities identified, activities initiated

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, HOPWA

Start/End: 2017 to 2018

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 3: **Patient-Centered Care**

3.2.3.1 Develop and implement a strategy to increase housing opportunities for HIV clients with increased challenges in obtaining housing such as a history of past felonies, disabilities, mental health issues and/or substance abuse.

Metric: Strategy developed and implemented

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HOPWA, Community-Based Organizations

Start/End: 2017 to 2018

3.2.3.2 Identify emergency housing options for homeless individuals.

Metric: Emergency housing options identified

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HOPWA, Community-Based Organizations

Start/End: 2018

3.2.3.3 Collaborate with the Southern Arizona AIDS Foundation Harm Reduction Program, other harm reduction programs, and HIV housing programs to evaluate and adopt best practices statewide.

Metric: Best practices evaluated and implemented as appropriate

Lead Program: Ryan White Part A Program

Partners: Ryan White Programs, HOPWA, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 1: **Coordinated Data Collection & Dissemination**

4.1.1.1 Identify and assess each Program's target populations related to health disparities, then develop and implement a strategy to reduce these disparities.

Metric: Strategy developed and implemented

Lead Program: Arizona Regional Quality Group

Partners: Ryan White Programs, HIV Prevention Program, HIV Surveillance

Start/End: 2017 to 2018

4.1.1.2 Share data among programs and providers to increase collaboration and maximize available funding to better address health disparities.

Metric: Data sharing agreements in place, and data sharing has begun

Lead Program: Arizona Regional Quality Group

Partners: Ryan White Programs, HIV Prevention Program, HIV Surveillance

Start/End: 2018 to 2021

4.1.1.3 Use data to identify and implement capacity building opportunities among new and traditional partners to address disparities in target populations.

Metric: Capacity-building opportunities identified and implemented

Lead Program: Arizona Regional Quality Group

Partners: Ryan White Programs, HIV Prevention Program, Medicaid

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 2: **Patient-Centered Care**

4.1.2.1 Annually, complete at least one quality initiative that drives improvements to decrease entry to care timeframes.

Metric: At least one quality initiative completed each year

Lead Program: Ryan White Part A Program Continuous Quality Management Committee

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities

Start/End: 2017 to 2021

4.1.2.2 Annually, collect and analyze needs assessment data to identify and implement strategies to improve patient centered care provided to Ryan White clients.

Metric: Data collected and analyzed; strategies developed and implemented

Lead Program: Ryan White Part A Planning Council

Partners: Ryan White Part A Program/Part A Continuous Quality Management Committee, HIV Statewide Advisory Group, Ryan White Programs, HIV Prevention Program

Start/End: 2017 to 2021

4.1.2.3 Annually, utilize consumer feedback to inform Ryan White Program quality improvement projects.

Metric: Consumer feedback activities completed, projects implemented based on analysis

Lead Program: Part A Continuous Quality Management Committee

Partners: Part A Planning Council, Ryan White Part A Program

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 3: **Stigma Reduction**

4.1.3.1 Establish partnerships with community stakeholders and entities that serve target populations to develop and implement strategies to address multiple types of stigma (individual, family, friends, providers, culture, etc.).

Metric: Partnerships Established

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Part A Planning Council, HIV Statewide Advisory Group, State/County Entities, Community-Based Organizations

Start/End: 2018 to 2021

4.1.3.2 Annually, implement at least one stigma reduction initiative each year, utilizing new and traditional media. Assess success and adjust strategies based on data.

Metric: At least one stigma reduction initiative implemented each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Part A Planning Council, HIV Statewide Advisory Group, State/County Entities, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 1: **Funding**

4.2.2.1 Assess opportunities to use rebate funds for housing services, and implement any strategies that are identified.

Metric: Opportunities assessed, and strategies implemented

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, HOPWA, Community-Based Organizations

Start/End: 2017 to 2018

4.2.2.2 Identify opportunities to combine programmatic resources to create efficiencies in contracting, improve service integration, and reduce duplication of effort and/or competition for funding.

Metric: Successful identification and implementation of new opportunities for efficiency

Lead Program: Ryan White Part B Program

Partners: All other Ryan White Programs, HIV Prevention Program

Start/End: 2018

Southern Region Plan

The Southern Region

Target Populations

- Men who have Sex with Men (MSM), especially youth and MSM of Color
- Hispanics, regardless of gender
- African Americans/Blacks regardless of gender
- Injection Drug Users

Activity Highlights

- Implementation of Pre-Exposure Prophylaxis (PrEP) Engagement Assistance programming, and efforts to increase consumer use of PrEP
- Increased HIV testing, and diversification of HIV testing locations, including opt-out HIV testing in hospital settings
- Engagement of community stakeholders and policy makers in advocacy for expanded HIV education, increased local HIV funding, and other HIV-centric issues
- Strengthening partnerships with providers, correctional facilities, and community-based organizations to expand availability and accessibility of quality housing for people living with HIV
- Consumer and provider training related to stigma reduction, cultural competency, and client empowerment
- Social marketing initiatives to increase HIV testing and awareness, PrEP engagement, and engagement in care

The Southern Region includes Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee, and La Paz counties. The 2014 population for this Region was 1,449,440. Pima County has the state's second highest prevalence (16%) and is home to Tucson, the state's second largest city. Four counties (Yuma, Pima, Santa Cruz, and Cochise) border Mexico. Hispanics account for a large percentage of the population of Southern Region counties, with the largest concentration being in counties along the international border. The Tohono O'odham Nation is the largest tribal area in Southern Arizona. Major HIV prevention issues in the Southern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, access to resources, and border issues.

The HIV Prevention and Ryan White Part B and C Programs provide HIV prevention and care services in the Southern Region.

CONTINUUM OF CARE DEFINITIONS

HIV-Diagnosed: Prevalent cases that have been diagnosed

Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year

Incidence Linked to HIV Care: Incident cases for the year of the spectrum that were linked with a documented lab test, doctor visit or medication use within 90 days of their diagnosis, but not on the same day of the diagnosis.

If a person has their first CD4, viral load or genotype on the same day as their diagnostic test the date of second CD4, viral load or genotype will be used as the linkage

Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or antiretroviral (ARV) use in the first and second six months of the year

On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable

Adherent/Suppressed: Prevalent cases whose last viral load of the calendar year was undetectable (<200 C/mL)

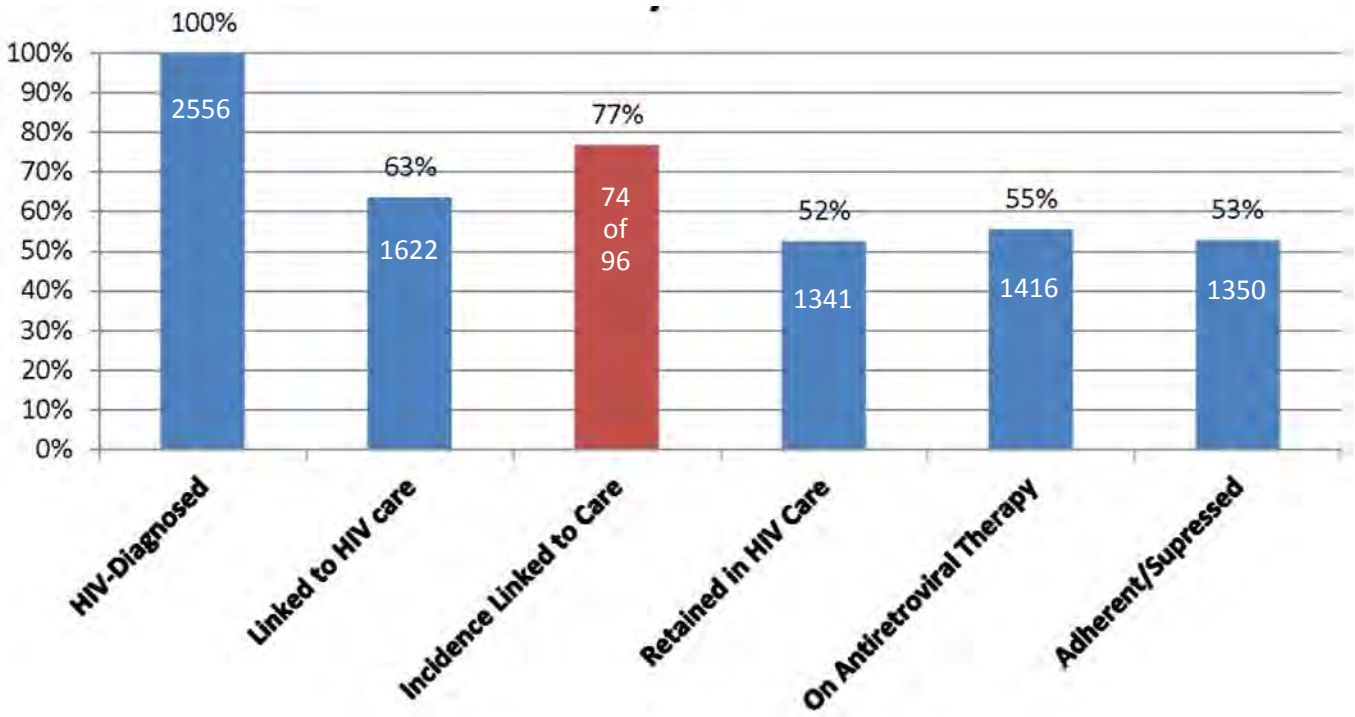


FIGURE 21
2014 Pima County
HIV Continuum of Care

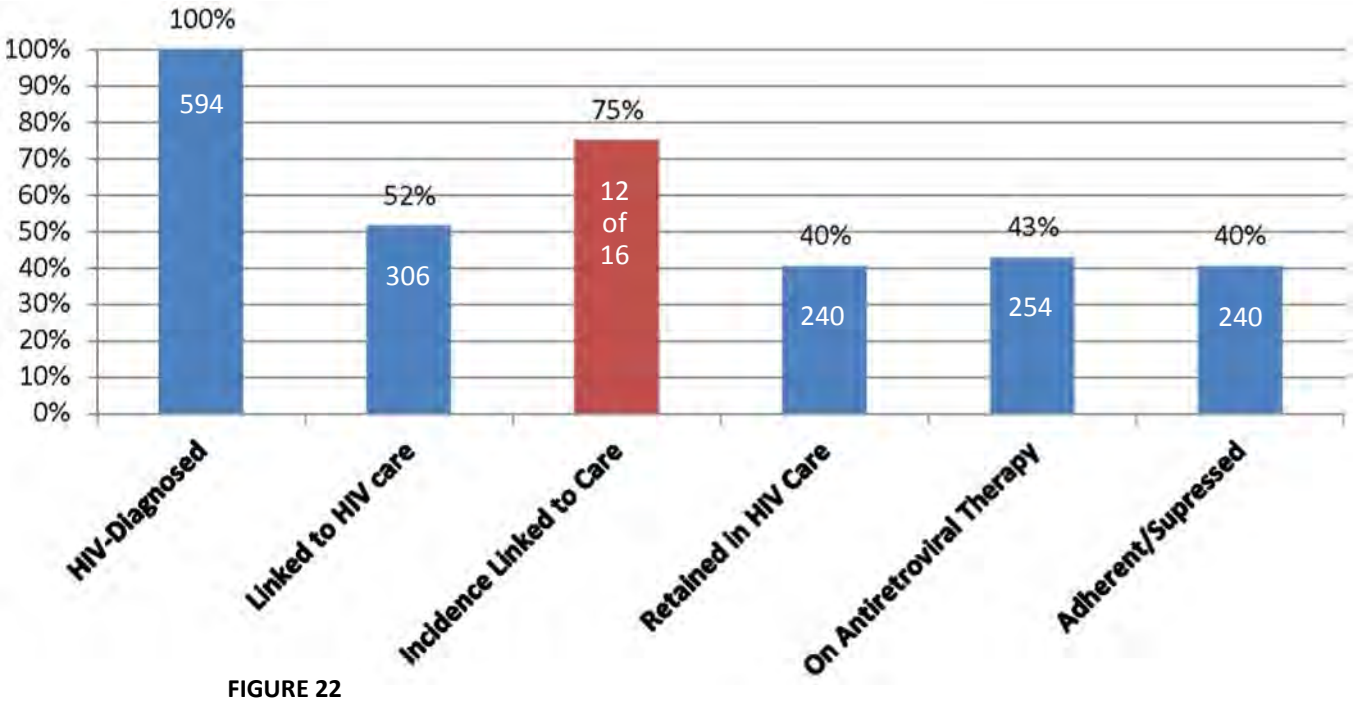


FIGURE 22
2014 Remaining
Southern Region
HIV Continuum of Care

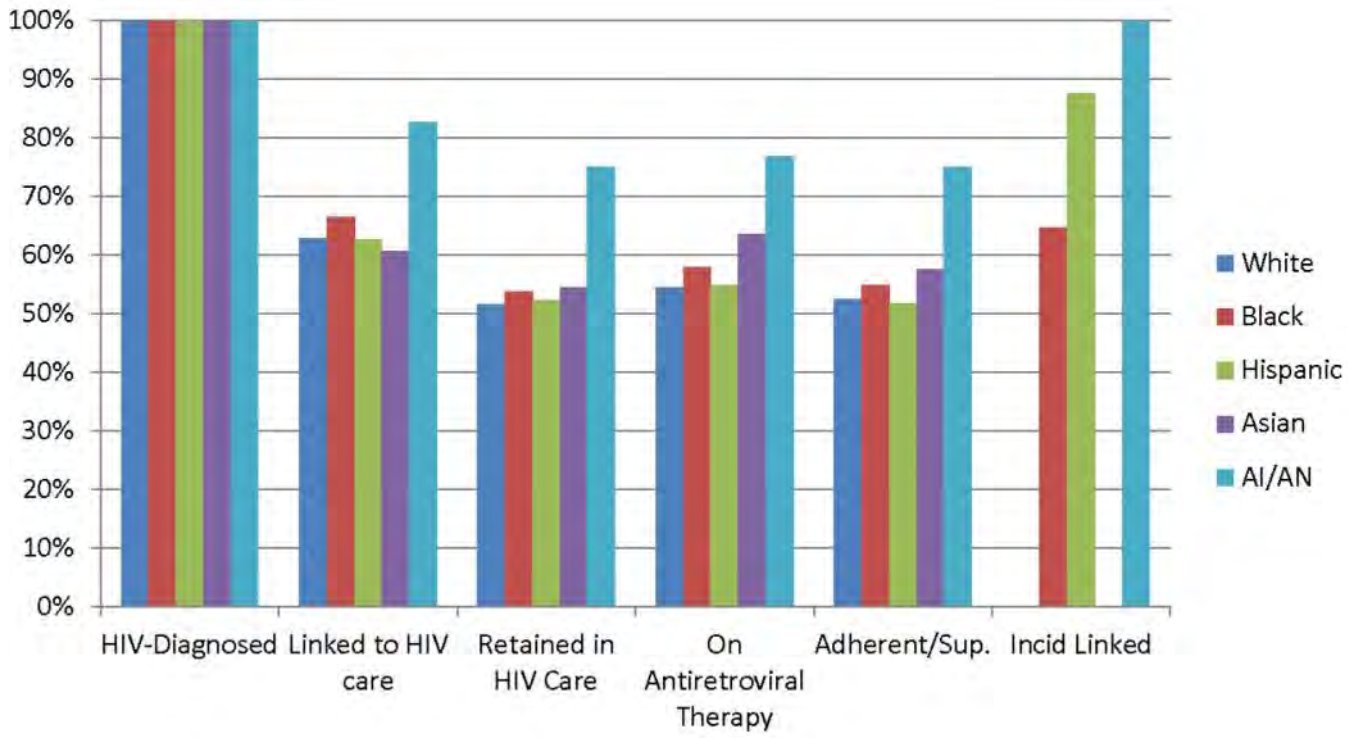


FIGURE 23
2014 Pima County HIV Continuum of Care by Race/Ethnicity

The 2015 Arizona Department of Health Services Epidemiology Report shows the Southern Region had 22% of the state population, 19% of the new HIV cases, and 19% of the ongoing HIV cases. Census data from 2015 shows that Southern Arizona has a higher than average percentage of Hispanics or Latinos in Santa Cruz County (83%), Greenlee County (46%) and Cochise County (35%). In 2014, the new cases dropped to 115 (19 case reduction from previous year), while prevalence increased by 142, indicating that at least 27 HIV positive people who were not diagnosed in Southern Arizona moved to the region.

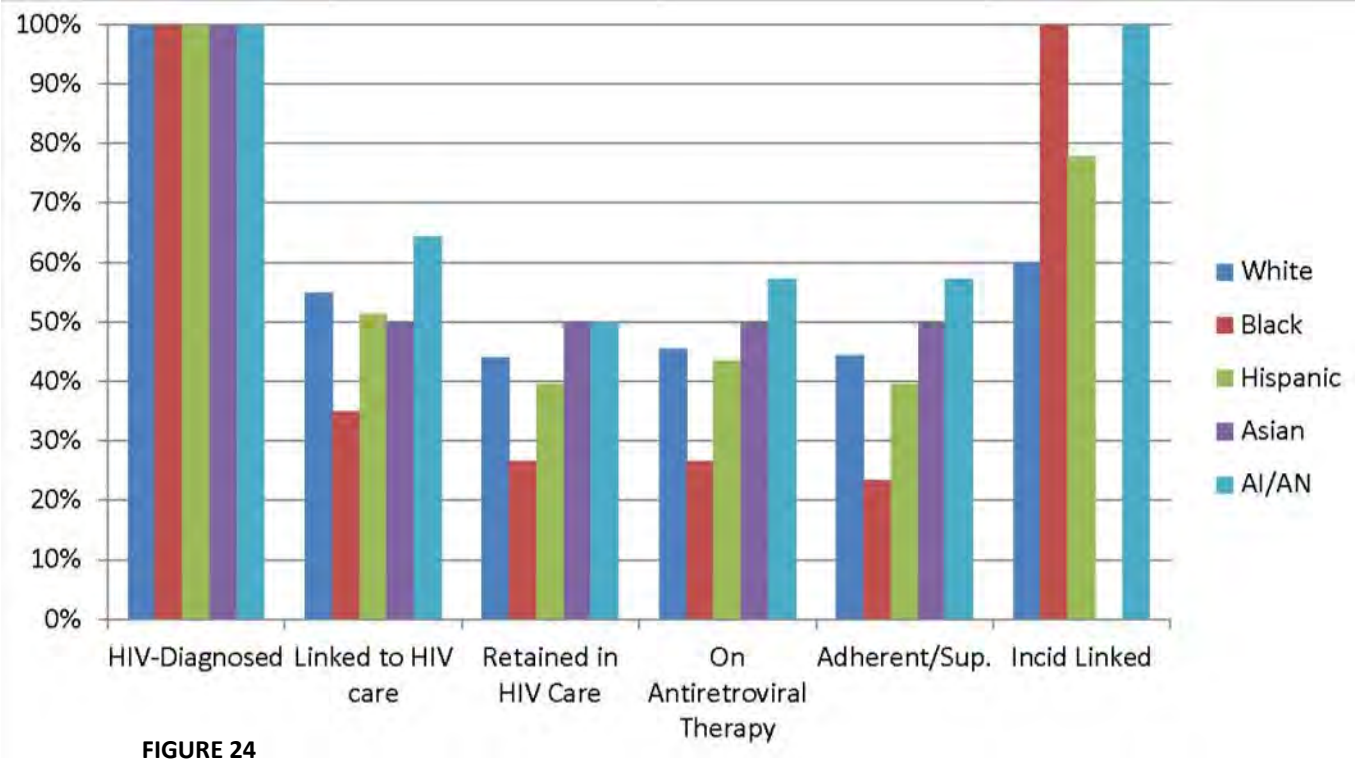


FIGURE 24
2014 Remaining Southern Region HIV Continuum of Care by Race/Ethnicity

TABLE 24
Comparison of Pima County and All Southern Region Incidence and Prevalence by Year, 2005 to 2014

Pima County Breakout			All Southern Region (including Pima County)		
Year	Prevalence	Incidence	Year	Prevalence	Incidence
2005	562	44	**2005**	**2226**	**163**
2006	606	27	**2006**	**2428**	157
2007	652	42	**2007**	**2558**	156
2008	706	39	**2008**	**2681**	125
2009	740	40	**2009**	**2758**	142
2010	747	45	**2010**	**2785**	149
2011	795	36	**2011**	**2879**	120
2012	896	33	**2012**	**2964**	95
2013	939	61	**2013**	**3075**	134
2014	1003	39	**2014**	**3217**	115

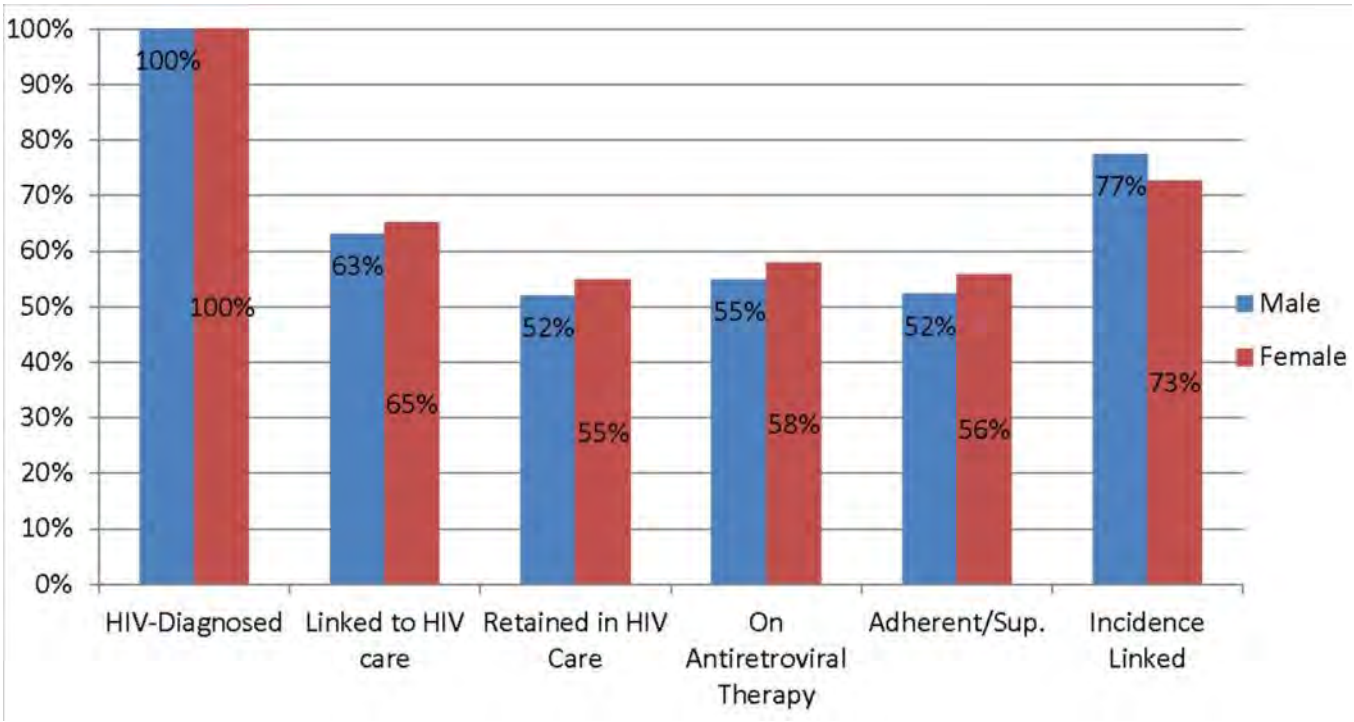


FIGURE 25
2014 Pima County HIV Continuum of Care by Gender

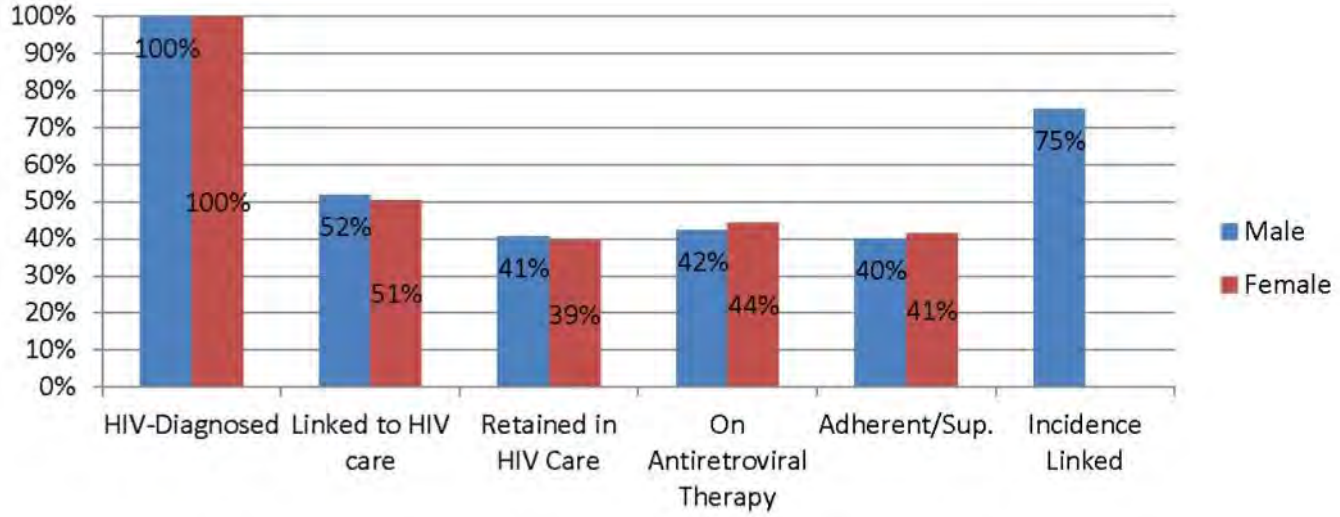


FIGURE 26
2014 Remaining Southern Region HIV Continuum of Care by Gender

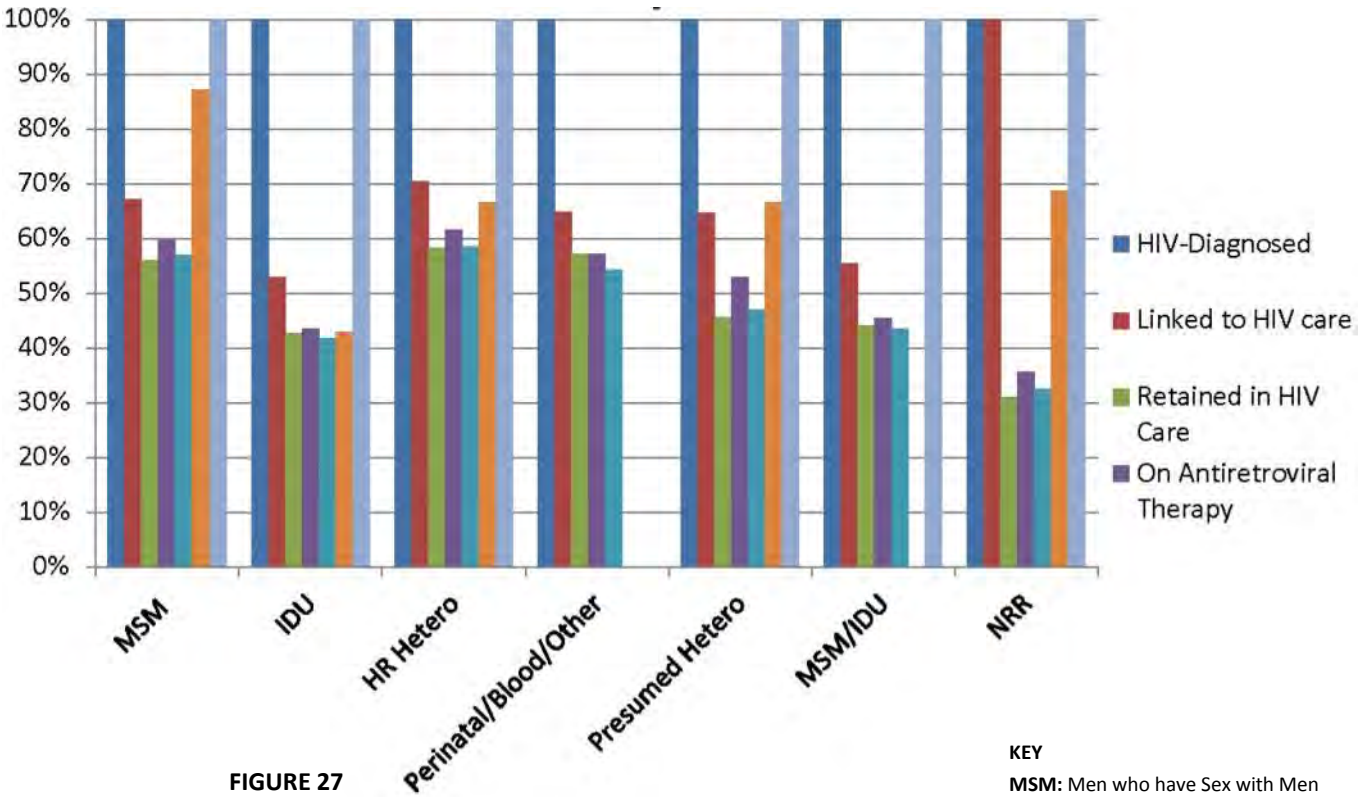


FIGURE 27
2014 Pima County
HIV Continuum of Care
by Risk Category

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk

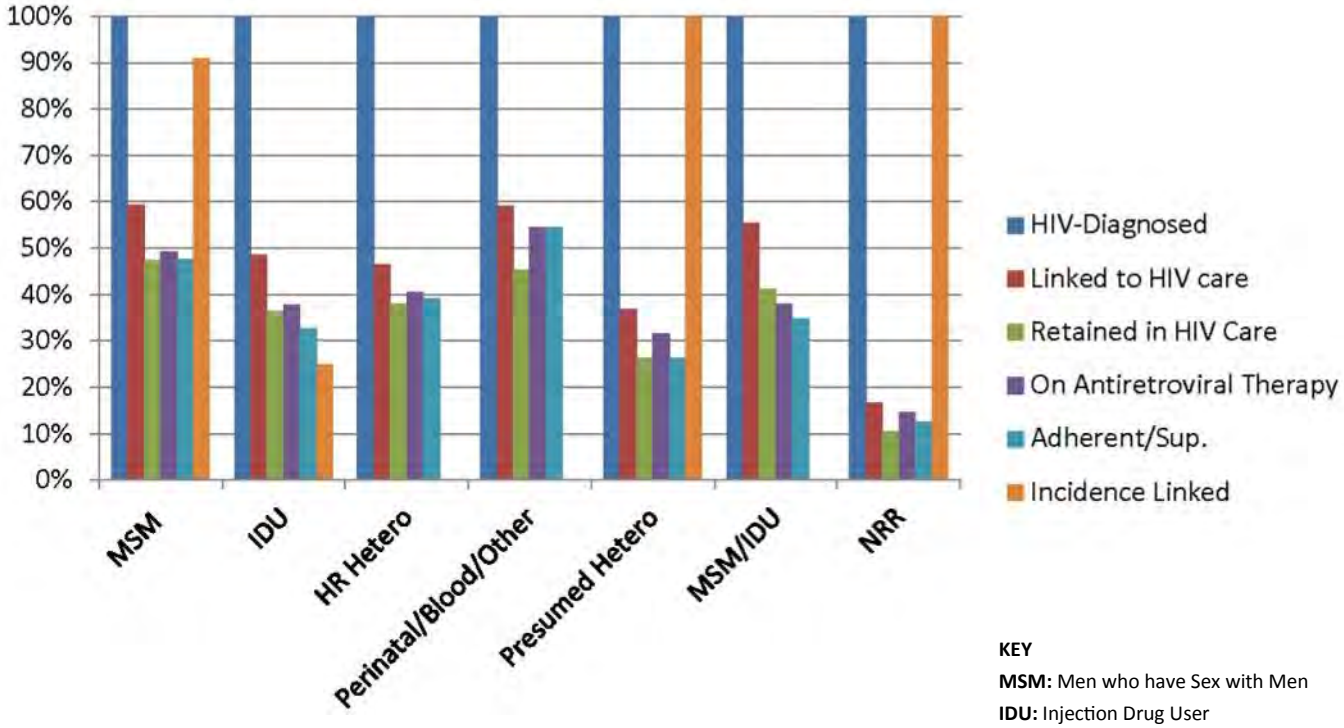


FIGURE 28
2014 Remaining Southern
HIV Continuum of Care
by Risk Category

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk

TABLE 25
Pima County Breakout
Incidence 2009 to 2013

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	216	50.9	8.83	140	33.0	5.72	356	84.0	14.55
Female	50	11.8	1.98	18	4.2	0.71	68	16.0	2.69
TOTAL	**266**	**62.7**	**5.34**	**158**	**37.3**	**3.17**	**424**	**100.0**	**8.52**
By Age									
Under 2	1	0.2	0.81	0	0.0	0.00	1	0.2	0.81
2 to 12	1	0.2	0.14	0	0.0	0.00	1	0.2	0.14
13 to 19	18	4.2	3.87	3	0.7	0.65	21	5.0	4.52
20 to 24	30	7.1	7.66	9	2.1	2.30	39	9.2	9.96
25 to 29	46	10.8	13.59	14	3.3	4.14	60	14.2	17.72
30 to 34	29	6.8	9.15	14	3.3	4.42	43	10.1	13.57
35 to 39	32	7.5	11.00	30	7.1	10.31	62	14.6	21.30
40 to 44	19	4.5	6.52	28	6.6	9.60	47	11.1	16.12
45 to 49	33	7.8	10.55	30	7.1	9.59	63	14.9	20.14
50 to 54	28	6.6	8.37	13	3.1	3.89	41	9.7	12.26
55 to 59	13	3.1	4.01	11	2.6	3.39	24	5.7	7.40
60 to 64	8	1.9	2.67	2	0.5	0.67	10	2.4	3.34
65 and Above	8	1.9	1.00	4	0.9	0.50	12	2.8	1.51
Age Unknown	0	0.0	NA	0	0.0	NA	0	0.0	NA
TOTAL	**266**	**62.7**	**5.34**	**158**	**37.3**	**3.17**	**424**	**100.0**	**8.52**
By Race/Ethnicity									
White Non-Hispanic	120	28.3	4.32	63	14.9	2.27	183	43.2	6.59
Black Non-Hispanic	37	8.7	19.98	18	4.2	9.72	55	13.0	29.70
Hispanic	94	22.2	5.41	63	14.9	3.63	157	37.0	9.04
***A/PI/H Non-Hispanic**	3	0.7	2.04	6	1.4	4.08	9	2.1	6.11
****AI/AN Non-Hispanic**	7	1.7	5.36	7	1.7	5.36	14	3.3	10.71
*****MR/O Non-Hispanic**	5	1.2	NA	1	0.2	NA	6	1.4	NA
TOTAL	**266**	**62.7**	**5.34**	**158**	**37.3**	**3.17**	**424**	**100.0**	**8.52**
By Mode of Transmission									
+MSM	152	35.8	NA	78	18.4	NA	230	54.2	NA
++IDU	18	4.2	NA	9	2.1	NA	27	6.4	NA
MSM / IDU	7	1.7	NA	3	0.7	NA	10	2.4	NA
Heterosexual	47	11.1	NA	43	10.1	NA	90	21.2	NA
+++O/H/TF/TPR	3	0.7	NA	0	0.0	NA	3	0.7	NA
++++NRR/UR	39	9.2	NA	25	5.9	NA	64	15.1	NA
TOTAL	**266**	**62.7**	**5.34**	**158**	**37.3**	**3.17**	**424**	**100.0**	**8.52**

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

TABLE 26
Pima County Breakout
Prevalence 2014

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	1008	38.6	205.43	1219	46.7	248.43	2227	85.3	453.86
Female	191	7.3	37.76	193	7.4	38.15	384	14.7	75.91
TOTAL	**1199**	**45.9**	**120.31**	**1412**	**54.1**	**141.69**	**2611**	**100.0**	**262.00**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2 to 12	9	0.3	6.69	3	0.1	2.23	12	0.5	8.92
13 to 19	13	0.5	13.85	0	0.0	0.00	13	0.5	13.85
20 to 24	46	1.8	51.76	9	0.3	10.13	55	2.1	61.89
25 to 29	63	2.4	105.05	30	1.1	50.03	93	3.6	155.08
30 to 34	84	3.2	133.15	52	2.0	82.43	136	5.2	215.58
35 to 39	96	3.7	170.18	83	3.2	147.13	179	6.9	317.31
40 to 44	131	5.0	227.13	164	6.3	284.35	295	11.3	511.48
45 to 49	160	6.1	278.92	245	9.4	427.09	405	15.5	706.01
50 to 54	228	8.7	354.10	331	12.7	514.06	559	21.4	868.16
55 to 59	156	6.0	240.36	230	8.8	354.38	386	14.8	594.74
60 to 64	103	3.9	168.89	157	6.0	257.43	260	10.0	426.32
65 and Above	105	4.0	61.36	108	4.1	63.11	213	8.2	124.47
Age Unknown	5	0.2	NA	0	0.0	NA	5	0.2	NA
TOTAL	**1199**	**45.9**	**120.31**	**1412**	**54.1**	**141.69**	**2611**	**100.0**	**262.00**
By Race/Ethnicity									
White Non-Hispanic	657	25.2	120.31	790	30.3	144.66	1447	55.4	264.97
Black Non-Hispanic	137	5.2	365.58	151	5.8	402.94	288	11.0	768.51
Hispanic	340	13.0	95.58	401	15.4	112.72	741	28.4	208.30
***A/PI/H Non-Hispanic**	14	0.5	45.04	23	0.9	74.00	37	1.4	119.04
****AI/AN Non-Hispanic**	25	1.0	95.56	28	1.1	107.03	53	2.0	202.59
*****MR/O Non-Hispanic**	26	1.0	NA	19	0.7	NA	45	1.7	NA
TOTAL	**1199**	**45.9**	**120.31**	**1412**	**54.1**	**141.69**	**2611**	**100.0**	**262.00**
By Mode of Transmission									
+MSM	690	26.4	NA	870	33.3	NA	1560	59.7	NA
++IDU	137	5.2	NA	156	6.0	NA	293	11.2	NA
MSM / IDU	78	3.0	NA	126	4.8	NA	204	7.8	NA
Heterosexual	150	5.7	NA	165	6.3	NA	315	12.1	NA
+++O/H/TF/TPR	26	1.0	NA	26	1.0	NA	52	2.0	NA
++++NRR/UR	118	4.5	NA	69	2.6	NA	187	7.2	NA
TOTAL	**1199**	**45.9**	**120.31**	**1412**	**54.1**	**141.69**	**2611**	**100.0**	**262.00**

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

TABLE 27
All Southern Arizona Regional Incidence (including Pima County) 2009 to 2013

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	278	51.3	7.79	179	33.0	5.02	457	84.3	12.81
Female	63	11.6	1.74	22	4.1	0.61	85	15.7	2.34
TOTAL	**341**	**62.9**	**4.74**	**201**	**37.1**	**2.79**	**542**	**100.0**	**7.53**
By Age									
Under 2	1	0.2	0.53	0	0.0	0.00	1	0.2	0.53
2 to 12	1	0.2	0.10	0	0.0	0.00	1	0.2	0.10
13 to 19	18	3.3	2.58	4	0.7	0.57	22	4.1	3.15
20 to 24	39	7.2	7.07	10	1.8	1.81	49	9.0	8.88
25 to 29	65	12.0	13.61	21	3.9	4.40	86	15.9	18.01
30 to 34	43	7.9	9.71	18	3.3	4.06	61	11.3	13.77
35 to 39	37	6.8	8.98	37	6.8	8.98	74	13.7	17.96
40 to 44	25	4.6	6.00	32	5.9	7.68	57	10.5	13.68
45 to 49	41	7.6	9.23	34	6.3	7.66	75	13.8	16.89
50 to 54	38	7.0	8.09	19	3.5	4.05	57	10.5	12.14
55 to 59	15	2.8	3.31	14	2.6	3.09	29	5.4	6.41
60 to 64	9	1.7	2.15	4	0.7	0.95	13	2.4	3.10
65 and Above	9	1.7	0.77	8	1.5	0.68	17	3.1	1.45
Age Unknown	0	0.0	NA	0	0.0	NA	0	0.0	NA
TOTAL	**341**	**62.9**	**4.74**	**201**	**37.1**	**2.79**	**542**	**100.0**	**7.53**
By Race/Ethnicity									
White Non-Hispanic	149	27.5	3.98	74	13.7	1.98	223	41.1	5.96
Black Non-Hispanic	46	8.5	18.92	20	3.7	8.23	66	12.2	27.14
Hispanic	127	23.4	4.47	90	16.6	3.17	217	40.0	7.64
***A/PI/H Non-Hispanic**	4	0.7	2.22	7	1.3	3.89	11	2.0	6.11
****AI/AN Non-Hispanic**	10	1.8	5.35	9	1.7	4.81	19	3.5	10.16
*****MR/O Non-Hispanic**	5	0.9	NA	1	0.2	NA	6	1.1	NA
TOTAL	**341**	**62.9**	**4.74**	**201**	**37.1**	**2.79**	**542**	**100.0**	**7.53**
By Mode of Transmission									
+MSM	190	35.1	NA	96	17.7	NA	286	52.8	NA
++IDU	30	5.5	NA	16	3.0	NA	46	8.5	NA
MSM / IDU	12	2.2	NA	7	1.3	NA	19	3.5	NA
Heterosexual	54	10.0	NA	52	9.6	NA	106	19.6	NA
+++O/H/TF/TPR	3	0.6	NA	0	0.0	NA	3	0.6	NA
++++NRR/UR	52	9.6	NA	30	5.5	NA	82	15.1	NA
TOTAL	**341**	**62.9**	**4.74**	**201**	**37.1**	**2.79**	**542**	**100.0**	**7.53**

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

TABLE 28
All Southern Arizona Regional Prevalence (including Pima County) 2014

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	1236	38.4	172.30	1497	46.5	208.69	2733	85.0	380.99
Female	248	7.7	34.28	236	7.3	32.62	484	15.0	66.90
TOTAL	**1484**	**46.1**	**102.99**	**1733**	**53.9**	**120.28**	**3217**	**100.0**	**223.27**
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2 to 12	12	0.4	5.89	3	0.1	1.47	15	0.5	7.37
13 to 19	15	0.5	10.81	1	0.0	0.72	16	0.5	11.53
20 to 24	50	1.6	40.79	12	0.4	9.79	62	1.9	50.58
25 to 29	88	2.7	99.15	37	1.2	41.69	125	3.9	140.84
30 to 34	113	3.5	125.23	63	2.0	69.82	176	5.5	195.05
35 to 39	131	4.1	163.05	114	3.5	141.89	245	7.6	304.94
40 to 44	156	4.8	190.33	200	6.2	244.02	356	11.1	434.35
45 to 49	208	6.5	252.49	294	9.1	356.89	502	15.6	609.39
50 to 54	271	8.4	298.63	387	12.0	426.46	658	20.5	725.09
55 to 59	183	5.7	201.02	284	8.8	311.97	467	14.5	512.99
60 to 64	117	3.6	137.88	198	6.2	233.34	315	9.8	371.22
65 and Above	134	4.2	53.66	140	4.4	56.06	274	8.5	109.72
Age Unknown	6	0.2	N/A	0	0.0	N/A	6	0.2	N/A
TOTAL	**1484**	**46.1**	**102.99**	**1733**	**53.9**	**120.28**	**3217**	**100.0**	**223.27**
By Race/Ethnicity									
White Non-Hispanic	785	24.4	106.94	949	29.5	129.28	1734	53.9	236.22
Black Non-Hispanic	174	5.4	354.84	175	5.4	356.88	349	10.8	711.72
Hispanic	445	13.8	76.41	529	16.4	90.83	974	30.3	167.23
***A/PI/H Non-Hispanic**	16	0.5	42.20	23	0.7	60.66	39	1.2	102.86
****AI/AN Non-Hispanic**	32	1.0	85.53	35	1.1	93.55	67	2.1	179.09
*****MR/O Non-Hispanic**	32	1.0	N/A	22	0.7	N/A	54	1.7	N/A
TOTAL	**1484**	**46.1**	**102.99**	**1733**	**53.9**	**120.28**	**3217**	**100.0**	**223.27**
By Mode of Transmission									
+MSM	827	25.7	N/A	1040	32.3	N/A	1867	58.0	N/A
++IDU	168	5.2	N/A	204	6.3	N/A	372	11.6	N/A
MSM / IDU	99	3.1	N/A	168	5.2	N/A	267	8.3	N/A
Heterosexual	194	6.0	N/A	205	6.4	N/A	399	12.4	N/A
+++O/H/TF/TPR	31	1.0	N/A	32	1.0	N/A	63	2.0	N/A
++++NRR/UR	165	5.1	N/A	84	2.6	N/A	249	7.7	N/A
TOTAL	**1484**	**46.1**	**102.99**	**1733**	**53.9**	**120.28**	**3217**	**100.0**	**223.27**

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

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 1: **Prevention, Testing & Linkage to Care**

1.1.1.1 Create renewed interest in HIV by implementing at least two targeted strategies (social marketing, town halls, etc.) designed to educate the community, foster conversation, and engage people to get tested for HIV and/or engage in medical care.

Metric: The number of strategies implemented each year; the number of new HIV tests each year and/or the number of people engaged to enter medical care

Lead Program: HIV Prevention Program

Partners: State/County Entities, Tribal Entities, Community-based Organizations

Start/End: 2017 to 2021

1.1.1.2 Conduct new, innovative initiatives to improve accessibility to free HIV testing, focusing on getting never-tested people tested. Initiatives might include home test kit delivery, routine HIV testing in medical centers, etc.

Metric: The number of initiatives implemented each year; the number of new HIV tests each year

Lead Program: HIV Prevention Program

Partners: All Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

1.1.1.3 Conduct a one-year pilot of PrEP Evaluation Assistance at Pima County Health Department. PrEP Evaluation Assistance is designed to educate and engage high-risk HIV negative people in the use of Pre-Exposure Prophylaxis .

Metric: Pilot Program initiated; utilization and engagement in PrEP monitored and evaluated.

Lead Program: Pima County Health Department

Partners: HIV Prevention Program

Start/End: 2017 to 2018

Strategy 1: Prevention, Testing & Linkage to Care *continued*

1.1.1.4 Assess the Pima County Health Department PrEP Evaluation Assistance pilot program. Based on performance, expand service delivery to additional entities.

Metric: Based on pilot program performance, expand PrEP Evaluation Assistance services.

Lead Program: HIV Prevention Program

Partners: State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

1.1.1.5 Annually, develop and implement at least one PrEP-focused social marketing initiative focused on target populations, designed to engage individuals to become educated and engaged in PrEP.

Metric: The implementation of at least one social marketing initiative each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 2: **Education**

1.1.2.1 Annually, provide at least one fact-based, culturally and linguistically appropriate HIV education opportunity to youth aged 13 to 19, and/or organizations serving youth.

Metric: The presentation of one education opportunity each year; the number of youth participants

Lead Program: HIV Prevention Program

Partners: Community-Based Organizations, Youth Organizations, School Boards

Start/End: 2019 to 2021

1.1.2.2 Annually, educate policy makers on the need to expand HIV/STD/pregnancy prevention education to youth.

Metric: Thee presentation of HIV/STD/pregnancy prevention information to policy makers each year; number of policy makers educated

Lead Program: HIV Statewide Advisory Group

Partners: Political Action Entities, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2019 to 2021

1.1.2.3 Identify local partners to advocate for increased support for HIV prevention initiatives, including syringe access.

Metric: The number of partners identified

Lead Program: HIV Statewide Advisory Group

Partners: State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2019

Strategy 2: Education *continued*

1.1.2.4 Biannually, present on HIV-related topics (HIV testing update, PrEP& PEP, initiating ARV therapy, continuity of care for patients returning to Mexico) to the Yuma Family Medicine Residency program.

Metric: One presentation completed every two years

Lead Program: Arizona AIDS Education and Training Center

Partners: Yuma Family Medicine Residency Program

Start/End: 2018 to 2020

1.1.2.5 Yearly, provide at least one education presentation to promotoras programs on HIV, including general HIV knowledge, HIV testing, PrEP, stigma reduction, and connecting patients to HIV care in Mexico.

Metric: At least one education presentation provided each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Promotoras Programs, State/County Entities, Tribal Entities, Border Health Programs, Community-Based Organizations

Start/End: 2017 to 2021

1.1.2.6 Yearly, provide at least one education presentation on HIV and opioids.

Metric: At least one education presentation completed each year

Lead Program: Arizona AIDS Education and Training Center

Partners: State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2018

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%.

Strategy 3: **Stigma Reduction**

1.1.3.1 Conduct an assessment of the HIV knowledge, stigma, behaviors, education and service needs of local target populations most at-risk for contracting HIV, and people who are living with HIV.

Metric: Completion of the assessment

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2018

1.1.3.2 Annually, implement at least two social marketing initiatives that address issues identified in the assessment, using local input to guide the implementation (campaign development, populations to target, methodologies, etc.).

Metric: At least two social marketing initiatives are implemented each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

1.1.3.3 Annually, implement at least one initiative (training, social marketing, provider update, etc.) that addresses internal/external HIV stigma reduction, including stigma among heterosexual people living with HIV.

Metric: At least one initiative implemented each year

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2019 to 2021

Strategy 3: Stigma Reduction *continued*

1.1.3.4 Assess systematic and provider behaviors related to HIV stigma when accessing/providing services, and develop a strategy to address identified issues.

Metric: Assessment completed; strategy developed

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 1: **Patient-Centered Care**

1.2.1.1 Develop and implement activities designed to provide newly diagnosed and returning-to-care clients with easy, rapid access to medication therapy, to eliminate delays to starting anti-retroviral therapy (ART) while waiting for program enrollment.

Metric: Activities developed and implemented; decrease in the average number of days it takes newly diagnosed clients to enter medical care

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, Community-Based Organizations, Local Health Providers/Pharmacists

Start/End: 2019 to 2021

1.2.1.2 Create and distribute guidelines to define and standardize HIV referral processes, focusing people living with HIV who are recently released from jail, identified in hospital emergency departments, and by primary care providers.

Metric: Guidelines developed and distributed; the number of entities/sites that receive the guidelines

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, Correctional Programs, Community-Based Organizations, Local Hospitals and Health Providers

Start/End: 2018 to 2019

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 2: **Streamline Processes**

1.2.2.1 Establish a statewide 24-hour telephone hotline for HIV information and referrals.

Metric: The hotline is established; the number of calls the hotline receives each year

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

1.2.2.2 Reduce paperwork among community providers by establishing a universal enrollment and data-sharing process for non-Ryan White services.

Metric: Completion of the universal enrollment process

Lead Program: Ryan White Part B Program

Partners: Community-Based Organizations

Start/End: 2018 to 2019

1.2.2.3 Establish a common enrollment application for Ryan White programs, including an online enrollment portal.

Metric: Completion of the common enrollment, online portal, and policies and procedures

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs

Start/End: 2017 to 2018

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 3: **Incentives for Care**

1.2.3.1 Develop and implement an incentive program for new patients who achieve viral suppression within a specific timeframe, and continue adherence for one year. Possible activities include expanding Club 95 (95% treatment adherence, treated to a nice dinner) and Club MedBox (create weekly med box, get free lunch), as well as other methodologies.

Metric: The incentive program developed and implemented; the number of clients who received and incentive

Lead Program: Ryan White Part B Program

Partners: Case Management Providers, State/County Entities, Community-Based Organizations

Start/End: 2018 to 2019

1.2.3.2 Develop and implement incentive programs for HIV testing that appeals to target populations most at risk for acquiring HIV.

Metric: The incentive program developed and implemented; the number of clients receiving an incentive

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, State/County Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

GOAL 1: REDUCE NEW HIV INFECTIONS.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 4: Stigma Reduction

1.2.4.1 Annually, implement at least one strategy to increase retention in care and normalize care for people living with HIV.

Metric: At least one strategy is implemented each year

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2019

1.2.4.2 Annually, provide at least one training for medical providers focused on eliminating systemic and individual behaviors that cause stigma against HIV clients when they access services.

Metric: At least one training is provided each year

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Provider Organizations

Start/End: 2017 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Patient-Centered Care**

2.1.1.1 Identify informal opportunities to expand peer-driven navigation and support for engagement in care/retention in care that are not agency-driven, such as an syringe exchange model used in Phoenix, the Tucson Interfaith HIV/AIDS Network volunteer model, and/or other models.

Metric: Service models and peer participants are identified; models are implemented

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2019

2.1.1.2 Annually, provide at least one training for point-of-entry providers, that addresses issues such developing supportive relationships with coworkers and clients, addressing compassion exhaustion, "freshness", and providing high-quality services.

Metric: At least one training provided each year; the number of providers trained

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Provider Organizations

Start/End: 2017 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Community Engagement**

2.1.2.1 Develop and implement outreach strategies that improve collaboration and communication with private medical providers and the Veterans Administration related to reporting of new HIV diagnoses and lab results for HIV clients.

Metric: Outreach strategies developed and implemented; evaluation of improvements in reporting

Lead Program: HIV Surveillance Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, Private Medical Providers

Start/End: 2017 to 2021

2.1.2.2 Develop and implement a community-led initiative to establish informal and formal methodologies to educate private providers regarding HIV reporting and HIV care.

Metric: The development and implementation of the initiative; the number of providers educated

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Programs, State/County Entities, Tribal Entities, Private Medical Providers, Community-Based Organizations

Start/End: 2017 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Prevention, Testing and Linkage to Care**

2.1.3.1 Annually, provide at least one training opportunity each year, designed to increase communication between HIV agencies to improve linkage to care/retention in care.

Metric: Presentation of at least one training each year.

Lead Program: HIV Prevention Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2018 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2 Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 1: Streamline Processes

2.2.1.1 Assess the ability of Pima County Health Department and community providers to increase availability of Benefits Navigation services, in order to decrease the number of clients who drop out of care due to difficulties navigating their benefits enrollment/re-enrollment and/or insurance coverage.

Metric: Completion of the assessment and implementation of Benefits Navigation services

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Community-Based Organizations

Start/End: 2017 to 2018

2.2.1.2 Implement an acuity-focused service delivery model for case management services, designed to improve care coordination of clients erratically engaged in care, and empower clients to transition from case-managed care to self-managed care.

Metric: Implementation of the service delivery model

Lead Program: Ryan White Part B Program

Partners: Case Management Providers, Community-Based Organizations, Ryan White Clients

Start/End: 2018 to 2019

2.2.1.3 Identify three-to-four Benefits Navigators to assist with off-season insurance enrollment.

Metric: Navigators identified and contracted

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Existing Benefits Navigators, Community-Based Organizations

Start/End: 2017 to 2019

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2 Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 2: Patient-Centered Care

2.2.2.1 Establish workgroups to evaluate service delivery models for mental health, substance use, and housing/homeless services, and post-incarceration engagement in care services.

Metric: The workgroups are established; an evaluation is completed

Lead Program: HIV Statewide Advisory Group

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

2.2.2.2 Develop and implement strategies to strengthen referral processes for people living with HIV who are recently-released from jail, identified in emergency departments, etc.

Metric: The strategies are developed and implemented

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Correctional Facilities, Hospitals, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

2.2.2.3 Evaluate and implement methods to incentivize people living with HIV who are released from correctional facilities to become engage in care.

Metric: Methods are evaluated and implemented; the number of clients receiving an incentive

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

Strategy 2: Patient-Centered Care *continued*

2.2.2.4 Educate private providers about the availability of Ryan-White funded HIV services, other HIV services available in the community, and the importance of referring clients to these services (better health outcomes, engagement in care, etc.).

Metric: The number of providers educated

Lead Program: Ryan White Part B Program

Partners: Private Medical Provider Networks, County/State Entities, Tribal Entities, Arizona AIDS Education and Training Center, Correctional Facilities, Community-Based Organizations

Start/End: 2018 to 2020

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2 Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 3: Data Standardization

2.2.3.1 Assess the ability to develop and implement a universal database/data sharing process among HIV partners.

Metric: Completion of the assessment; action items identified

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, County/State Entities, Tribal Entities, Arizona AIDS Education and Training Center, Correctional Facilities, Community-Based Organizations

Start/End: 2017 to 2019

2.2.3.2 Annually, expand the utilization of HIV care, prevention, and PrEP continuum of care models by at least one non-Ryan White funded medical provider

Metric: At least one non-Ryan White medical provider engages in the use of continuum of care models each year

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs, Arizona AIDS Education and Training Center

Start/End: 2018 to 2021

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2 Increase the percentage of persons with diagnosed HIV infection who are retained in care to at least 90%.

Strategy 4: **Education**

2.2.4.1 Biannually, provide at least one regional training for primary medical providers that includes information on HIV, extra-genital STD screening, and retention in care.

Metric: At least one training completed every two years

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2020

2.2.4.2 Increase the number of HIV providers who are trained in the diagnosis, treatment and management of HIV.

Metric: The number of providers trained each year

Lead Program: Arizona AIDS Education and Training Center

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations

Start/End: 2017 to 2021

2.2.4.3 Annually, present at least one regional provider training, in collaboration with national providers.

Metric: The completion of at least one regional provider training each year

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations

Start/End: 2017 to 2020

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 1: **Funding**

3.1.1.1 Complete an assessment of the housing needs of people living with HIV in Pima County.

Metric: The completion of the assessment; action items identified

Lead Program: HIV Statewide Advisory Group

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2018

3.1.1.2 Identify resources to address medication storage at safe spaces for people living with HIV who are homeless.

Metric: Identification of resources; information distributed to community stakeholders

Lead Program: HIV Statewide Advisory Group

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2019

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 2: **Quality Housing**

3.1.2.1 Collaborate with community partners to improve referral mechanisms and partnerships, in order to increase the ability of people living with HIV to find and obtain quality housing.

Metric: Referral mechanisms and partnerships evaluated; improvement activities completed

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2019

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 1: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Strategy 3: **Community Engagement**

3.1.3.1 Create a resource list of housing services providers.

Metric: Resource list completed and distributed to community stakeholders

Lead Program: HIV Statewide Advisory Group

Partners: Primavera Foundation, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2019

3.1.3.2 Identify key partners outside of the HIV community that can support people living with HIV to enter/engage in housing services, and promote the availability of HIV services to these entities.

Metric: Identification of partners

Lead Program: HIV Statewide Advisory Group

Partners: Primavera Foundation, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2019

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 1: **Community Engagement**

3.2.1.1 Assess, and then establish collaboration and service delivery among health-based and non-health-based community entities that "goes to the community" rather than expecting target populations to come to existing services.

Metric: Completion of the assessment; partnerships and service delivery revisions implemented

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2017 to 2021

3.2.1.2 Establish collaborations with colleges, fraternities/sororities, faith-based organizations/coalitions, organizations serving communities of color, etc. to provide education and awareness of HIV, engagement in HIV testing among target populations, and community mobilization to address issues that hinder communities of color from addressing HIV issues.

Metric: The number of collaborations established

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2017 to 2019

3.2.1.3	Establish HIV Statewide Advisory Group workgroups to address the service needs of target communities, and health disparities and social justice issues that affect entry to, and engagement in medical care. Recruit community partners to take participate in planning efforts and implementation of activities.
Metric:	The establishment of workgroups and recruitment of community partners
Lead Program:	HIV Statewide Advisory Group
Partners:	Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Social Justice Groups, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network
Start/End:	2017 to 2021

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 2: **Education**

3.2.2.1 Develop an Arizona-specific cultural competency training plan, with an expanded focus to include how intersections between homophobia, misogyny, racism, law enforcement interaction, and hiring practices impact HIV service delivery.

Metric: The development of the plan

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2018 to 2019

3.2.2.2 Annually, conduct at least one cultural-competency training according to the Arizona-specific plan.

Metric: At least one training conducted each year

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2019 to 2021

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females.

Strategy 3: **Stigma Reduction**

3.2.3.1 Annually, implement at least one peer-to-peer activity designed to reduce internal stigma among people living with HIV, and/or address wrap-around stigma (family members, friends, social networks, etc.).

Metric: At least one activity conducted each year

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

3.2.3.2 Annually, present at least one training for HIV care and prevention providers related to stigma reduction and trauma-informed care. Ideally, training should coincide with medical and/or other service delivery training.

Metric: At least one training is presented each year

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

Strategy 3: Stigma Reduction *continued*

3.2.3.3 Complete an assessment of HIV knowledge, stigma, trauma-informed care, behaviors, and education needs targeting communities of color and transmission routes.

Metric: The completion of the assessment

Lead Program: HIV Statewide Advisory Group

Partners: State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations, Social Justice Groups

Start/End: 2017 to 2019

3.2.3.4 Establish partner HIV testing as a standard of service delivery for HIV testing providers.

Metric: Partner HIV testing is established and adopted as a service delivery standard

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations

Start/End: 2018 to 2021

3.2.3.4 State and local entities collaboratively develop HIV prevention and care messaging that appropriately addresses target populations.

Metric: Population-specific messaging developed

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 3: Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 1: **Education**

3.3.1.1 Identify and evaluate existing and needed resources that can be utilized to improve service delivery, self-efficacy and engagement in care among youth who inject drugs.

Metric: Resources are identified and evaluated

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2018 to 2019

3.3.1.2 Develop and implement strategies to improve service delivery, self-efficacy and engagement in care among youth who inject drugs.

Metric: The strategies are implemented

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2019 to 2021

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 3: Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 2: **Prevention, Testing & Linkage to Care**

3.3.2.1 Biannually, implement at least one outreach initiatives to youth and persons who inject drugs, designed to engage individuals to be tested for HIV and/or enter medical care.

Metric: The implementation of at least one outreach initiative every two years

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2018 to 2020

3.3.2.2 Increase HIV testing sites for the youth and persons who inject drugs.

Metric: An increase in the number of HIV testing sites that provide services for youth and persons who inject drugs.

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2017 to 2021

GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 3: Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 3: **Community Engagement**

3.3.3.1 Establish a formalized processes to engage state, county and tribal entities, local providers and community stakeholders in ongoing dialog and collaboration to improve HIV services. Explore digital methods to conduct this activity.

Metric: Establishment of formalized processes

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

3.3.3.2 Develop and implement county-specific plans to obtain community engagement.

Metric: Specific community engagement plans are established for each County in the southern Region

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 1: **Funding**

4.1.1.1 Assess the availability of diverse funding opportunities, such as non-federal funding for Community-Based Organizations, and/or third-party reimbursement, for HIV prevention and care services.

Metric: The completion of the assessment; utilization of information to obtain non-federal funding

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2: **Community Engagement**

4.1.2.1 Biannually, present at least one training to community stakeholders on how to advocate for healthcare initiatives.

Metric: The presentation of at least one training every two years

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2020

4.1.2.2 Expand partnerships, especially with non-HIV providers, to increase HIV awareness and diversify HIV services for people living with HIV and those at high-risk for acquiring HIV.

Metric: Expansion of partnerships, as possible

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 3: **Policy Development**

4.1.3.1 Promote routine, opt-out testing as a standard of medical care.

Metric: The number of opportunities for promotion that occurred

Lead Program: Arizona AIDS Education and Training Center

Partners: Arizona Alliance of Community Health Centers, Hospitals, HIV Prevention Program, Ryan White Part B Program, Community-Based Organizations, Other Medical Organizations

Start/End: 2017 to 2021

4.1.3.2 Establish a community coalition to address HIV-related policy issues and educate policy makers on HIV issues.

Metric: Establishment of a community coalition

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Health Advocacy Groups

Start/End: 2018 to 2021

4.1.3.3 Annually, collaborate with community partners to present cat least one comprehensive sexual education program in a school and/or to youth groups.

Metric: The presentation of at least one comprehensive sexual education program each year

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, State/County Entities, Tribal Entities, Education Entities, Community-Based Organizations, Health Advocacy Groups

Start/End: 2018 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 4: **Prevention, Testing & Linkage to Care**

4.1.4.1 Establish same-day supplemental/confirmatory testing among testing providers, to decrease the timeframe between initial diagnosis, first labs, and first medical appointment.

Metric: Same-day confirmatory testing is established

Lead Program: HIV Prevention Program

Partners: HIV Prevention Program, Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2017 to 2021

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Strategy 1: **Patient-Centered Care**

4.2.1.1 Provide at least one training each year to healthcare providers, medical associations, and healthcare students to engage support and commitment for patient-centered care.

Metric: The presentation of at least one training per year; the number of participants

Lead Program: Arizona AIDS Education and Training Center

Partners: Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, Ryan White Part B Program, HIV Prevention Program

Start/End: 2017 to 2021

4.2.1.2 Assess community capacity to expand the availability of alternative, holistic approaches to HIV care.

Metric: The assessment is completed; action items are defined

Lead Program: Ryan White Part B Program

Partners: Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, HIV Prevention Program

Start/End: 2019 to 2021

4.2.1.4 Promote harm-reduction approaches to medical care to community providers.

Metric: Documentation that promotion activities occurred

Lead Program: Ryan White Part B Program

Partners: Arizona AIDS Education and Training Center, Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, HIV Prevention Program

Start/End: 2018 to 2021

4.2.1.5 Complete an assessment of patient-centered barriers to accessing medical care and supportive services.

Metric: The assessment is completed; action items developed

Lead Program: HIV Statewide Advisory Group

Partners: HIV Prevention Program, Ryan White Part B Program, County/State Entities, Tribal Entities, Correctional Entities, Community-Based Organizations

Start/End: 2019 to 2020

GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Strategy 2: **Streamline Processes**

4.2.2.1 Evaluate the ability for client enrollment in the Ryan White Program and ADAP to be completed by HIV testing staff, to allow for data submission and the scheduling of an initial medical appointment to occur at the time of diagnosis.

Metric: The completion of an evaluation; action steps defined

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations

Start/End: 2019 to 2021

Section 3
Monitoring and Evaluation

Monitoring and Evaluation

Monitoring the Integrated HIV Prevention and Care Plan will assist Programs and Planning Bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information, and analyzing information to inform decision-making, ultimately improving HIV prevention, care, and treatment efforts.

Updating Planning Bodies

The Ryan White Part A Planning Council, the HIV Statewide Advisory Group, the Ryan White Part C and D Community Advisory Boards, and the Ryan White and HIV Prevention Program sub-recipients will be updated on the progress of the implementation of the Plan. Surveillance and epidemiological data will be presented on a regular basis to the Planning Bodies, to assist in following trends, and planning activities and initiatives. The Planning Bodies have dedicated time on their meeting schedules to review the Plan implementation, and solicit feedback from members and stakeholders. The Planning Bodies will provide feedback to the Ryan White and HIV Prevention Program recipients.

Soliciting Feedback

Each year, the HIV Prevention and Ryan White Programs host an annual HIV Symposium. In addition to general stakeholder attendance, all Program sub-recipients are required to have representatives attend. During this meeting, the Programs will provide updates on the Plan's activities, and solicit feedback from participants.

The HIV Prevention and Ryan White Programs conduct regular community advisory board meetings, focus groups, and needs assessments of target populations. These activities will be used to gain feedback from people living with HIV, and those at-risk for acquiring HIV. The Programs are collaborating on the development of a web-based feedback component on the Ending HIV in Arizona page of HIVAZ.org, the state's comprehensive online HIV resource. This web page will be updated on Plan progress, and an email response component will allow for continuous feedback from site visitors. Feedback will be compiled quarterly and provided to the Planning Bodies for review and action.

Monitoring and Evaluating the Goals and Objectives of This Plan

Programs work together to monitor service utilization, develop new tracking mechanisms for acute and stage zero cases, and use geo-mapped epidemiological data to target service delivery. Information gathered from Ryan White sub-recipients, collaborative partners, and other local and national sources are also used to assess and improve health outcomes along the HIV care continuum.

The HIV Statewide Advisory Group will meet quarterly to review the progress of strategies and activities defined in the plan. The Community Health Planning & Strategies Committee of the Phoenix EMA Ryan White Planning Council meets monthly, and will conduct similar reviews. These Planning Bodies will meet jointly at least once per year to collectively evaluate the Plan.

The HIV Prevention and Ryan White Programs will utilize the National Quality Center's Arizona Regional Quality Group meetings, which are held quarterly, to conduct evaluations that help to improve the quality of the HIV service delivery system across all Arizona HIV programs.

Use of Surveillance and Program Data to Assess and Improve Health Outcomes

The HIV Prevention and Ryan White Programs collaborate with the HIV Surveillance Program, the STD Control Program, private laboratories, and the Arizona Department of Health Services state laboratory to assure that the most current, relevant data available is available for use to drive programmatic development, monitoring and evaluation. Surveillance data and HIV testing and Partner Services data are used to monitor trends and positivity rates, and track acute cases of HIV. Electronic lab reporting data is also evaluated.

We're going to end the HIV epidemic in Arizona.
You can help. Learn more at:

HIVAZ.ORG

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