

# Plan for the Central Region

## 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

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**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 contracting 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

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**1.1.1.2** Increase the number of medical providers educated on HIV/PrEP, and ultimately prescribing PrEP, by six 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

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**1.1.1.3** Annually, increase the number of health care professionals trained in knowledge of 4th generation algorithms for HIV testing by six 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

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

**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 to additional entities statewide.

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

**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

**PrEP initiatives added to this section**

## 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

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**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

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**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

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**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*

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

**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

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**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

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

**Metric:** 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

**Start/End:** 2017 to 2018

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**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

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**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

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**1.2.1.1** 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

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**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

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**1.2.1.3** Increase the number of HIV providers available to provide HIV services, including PrEP, by 25%.

**Metric:** # of new HIV providers available to provide HIV services

**Lead Program:** RWPF/AETC

**Partners:** RWPF/AETC, HIV Prevention Program

**Start/End:** 2017 to 2021

Redundant with 1.1.1.2

## 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

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**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

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**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

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**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

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**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

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**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

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**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**

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**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

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**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

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**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*

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**2.1.1.4** Explore shared data systems with client linkage data for prevention and care.

**Metric:** Implementation of shared data systems

**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**

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**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

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**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**

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**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

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**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

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**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**

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**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

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**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

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**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**

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**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

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**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**

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**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

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**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

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**3.1.1.1** Conduct an assessment of the capacity building needs for diversifying funding opportunities for CBOs/providers offering HIV care and support services.

**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

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**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

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**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:** Ryan White Part A Program

**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*

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**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

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**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

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**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

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**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

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**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

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**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

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**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

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**3.2.1.1** Establish referral mechanisms and MOUs with the centralized homeless housing hubs (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

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**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

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

**Metric:** Partnership opportunities are determined

**Lead Program:** Ryan White Part A Program

**Partners:** Ryan White Programs, HOPWA

**Start/End:** 2018 to 2019

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**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

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**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

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**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

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**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

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**4.1.1.1** Identify, 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

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**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

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**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

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**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

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**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

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**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

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**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

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**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: Community Engagement

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

**Metric:** Referral mechanism in place

**Lead Program:** Ryan White Part A Program

**Partners:** HOPWA

**Start/End:** 2018

Identical to 3.2.3.1. If removed, revise numbering to end of section.



## **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 2: Funding**

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**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

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**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 efficiencies

**Lead Program:** Ryan White Part B Program

**Partners:** All other Ryan White Programs, HIV Prevention Program

**Start/End:** 2018

## 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 3: Patient-Centered Care

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**4.2.3.1** Collaborate with the Southern Arizona AIDS Foundation Harm Reduction program, and HIV housing programs to evaluate opportunities to adopt best practices in other areas of the state.

**Metric:** Best practices reviewed and implemented as appropriate

**Lead Program:** Ryan White Part B Program

**Partners:** Ryan White Part A Program, SAAF, HOPWA, Ryan White Programs, HIV Prevention Program

**Start/End:** 2018 to 2021

**This is identical to 3.2.3.3**

