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

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
602-506-6321
maricopa.gov/rwpc
Contents

Letters of Concurrence........................................................................................................... i

Acknowledgements ................................................................................................................ iii

Foreword .................................................................................................................................. 1

Executive Summary ................................................................................................................ 3

Contributions of Stakeholders and Key Partners ............................................................... 9

Central Region Plan .............................................................................................................. 13

Monitoring and Evaluation ................................................................................................. 49
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  
Chair  
Arizona HIV Statewide Advisory Group

Chelsey Donohoo  
Chair  
Arizona HIV Statewide Advisory Group
September 23, 2016

LCDR Monique Richards  
Public Health Analyst  
HRSA/HAB/DMHAP  
5600 Fishers Lane  
Mail Stop 09W058  
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,

[Signature]

John Sapero  
Chair  
Phoenix EMA Ryan White Planning Council
Acknowledgements

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

Committee Members
Carmen Batista
Cynthia Trottier
Debby Elliott
Guillermo (Gil) Velez
John Sapero
Nicole Turcotte
Randall Furrow

Ryan White Part A
Program Staff
Alaina Rinne
Chavon Boston
Evelyn Bester
Jane Wixted
Jeremy Hyvarinen
Kaila Johnson
Rose Conner
Victoria Jaquez

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
- Haley Coles
- Harold Thomas
- Jai Smith
- Jamal Brooks-Hawkins
- Jeremy Bright
- Jeremy Hyvarinen
- Kara Ihrke
- Randall Furrow
- RJ Shannon
- Robert Bourassa

**HIV Prevention Program Staff**
- Ann Gardner
- Deborah Reardon-Maynard
- John Sapero
- Tiana Galindo

**Ryan White Part B Program Staff**
- Carmen Batista
- Claudia Cardiel
- Greg Romero
- Jessica Alvidrez
- Jimmy Borders
- Laura Kroger
- LisaMarie Bates
- Lora Andrikopoulos
- Louisa Vela
- Lynelle Brooks-Dorsey
- Nicole Vandrovec

**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

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,

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  
Program Manager  
Ryan White Part A Program  
Maricopa County

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
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.

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.
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 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.
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.

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

More than 70% of Arizona’s HIV incidence and prevalence occurs in Maricopa county, in the Central Region.
Central Region Objectives and Strategies to Achieve the National HIV/AIDS Strategy's
Goal 1: Reduce New Infections.

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

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

**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**
- Streamline Processes
- Community Engagement
- Patient-Centered Care

---

Central Region 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.

**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

---

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

**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

---

Central Region Objectives and Strategies to Achieve the National HIV/AIDS Strategy’s
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.

**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
Contributions of Stakeholders and Key Partners
<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Contributions to Plan Development</th>
</tr>
</thead>
</table>
| 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 Symposiaums  
● 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                                                                                                                                                                                                                                                                                                                                                   |
<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Contributions to Plan Development</th>
</tr>
</thead>
</table>
| 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 Symposia  
• 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 Symposia  
• 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 Symposia  
• 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 Symposia  
• 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 |
<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Contributions to Plan Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Health Centers</strong></td>
<td>• Participated in the Financial and HIV Workforce Capacity Survey</td>
</tr>
<tr>
<td></td>
<td>• Representatives have joined both Planning Bodies</td>
</tr>
<tr>
<td></td>
<td>• Federally Qualified Health Center (FQHC) and FQHC look-a-like participation in HIV Symposums</td>
</tr>
<tr>
<td></td>
<td>• Southern Community Health Centers have hosted local community sessions for developing the</td>
</tr>
<tr>
<td></td>
<td>integrated plan</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>• Membership on the Phoenix EMA Ryan White Planning Council</td>
</tr>
<tr>
<td></td>
<td>• Provided data for the Statewide Coordinated Statement of Need</td>
</tr>
<tr>
<td></td>
<td>• Participated in Financial and HIV Workforce Capacity Survey</td>
</tr>
<tr>
<td></td>
<td>• Allocates resources for HIV medications for eligible clients in the community</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>• Participated in Financial and HIV Workforce Capacity Survey</td>
</tr>
<tr>
<td></td>
<td>• Allocates resources for HIV medications for eligible clients in the community</td>
</tr>
<tr>
<td><strong>Veterans Health Administration</strong></td>
<td>• Contributed to Statewide Coordinated Statement of Need</td>
</tr>
<tr>
<td></td>
<td>• Allocates resources for HIV medications for eligible clients in the community</td>
</tr>
<tr>
<td><strong>Housing and Urban Development</strong></td>
<td>• Representation on the Planning Bodies</td>
</tr>
<tr>
<td></td>
<td>• Actively participated in the development of the plans for the Central and Southern Regions</td>
</tr>
<tr>
<td></td>
<td>• Participated in the Financial and HIV Workforce Capacity Survey</td>
</tr>
<tr>
<td></td>
<td>• Allocates resources for HIV medications for eligible clients in the community</td>
</tr>
</tbody>
</table>
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.
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.
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).
TABLE 1
Comparison of Central Region Incidence and Prevalence Totals by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>562</td>
<td>44</td>
</tr>
<tr>
<td>2006</td>
<td>606</td>
<td>27</td>
</tr>
<tr>
<td>2007</td>
<td>652</td>
<td>42</td>
</tr>
<tr>
<td>2008</td>
<td>706</td>
<td>39</td>
</tr>
<tr>
<td>2009</td>
<td>740</td>
<td>40</td>
</tr>
<tr>
<td>2010</td>
<td>747</td>
<td>45</td>
</tr>
<tr>
<td>2011</td>
<td>795</td>
<td>36</td>
</tr>
<tr>
<td>2012</td>
<td>896</td>
<td>33</td>
</tr>
<tr>
<td>2013</td>
<td>939</td>
<td>61</td>
</tr>
<tr>
<td>2014</td>
<td>1003</td>
<td>39</td>
</tr>
</tbody>
</table>
FIGURE 5
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>
<thead>
<tr>
<th></th>
<th>Emergent HIV</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>% State Total</td>
<td>Rate Per 100,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1774</td>
<td>72.5%</td>
<td>8.23</td>
<td></td>
</tr>
<tr>
<td><strong>By Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1544</td>
<td>63.1%</td>
<td>14.35</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>230</td>
<td>9.4%</td>
<td>2.13</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1774</td>
<td>72.5%</td>
<td>8.23</td>
<td></td>
</tr>
<tr>
<td><strong>By Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 2</td>
<td>4</td>
<td>0.2%</td>
<td>0.65</td>
<td>4</td>
</tr>
<tr>
<td>2 to 12</td>
<td>14</td>
<td>0.6%</td>
<td>0.40</td>
<td>14</td>
</tr>
<tr>
<td>13 to 19</td>
<td>71</td>
<td>2.9%</td>
<td>3.40</td>
<td>71</td>
</tr>
<tr>
<td>20 to 24</td>
<td>343</td>
<td>14.0%</td>
<td>23.07</td>
<td>343</td>
</tr>
<tr>
<td>25 to 29</td>
<td>353</td>
<td>14.4%</td>
<td>22.33</td>
<td>353</td>
</tr>
<tr>
<td>30 to 34</td>
<td>257</td>
<td>10.5%</td>
<td>16.62</td>
<td>257</td>
</tr>
<tr>
<td>35 to 39</td>
<td>228</td>
<td>9.3%</td>
<td>15.40</td>
<td>228</td>
</tr>
<tr>
<td>40 to 44</td>
<td>189</td>
<td>7.7%</td>
<td>12.92</td>
<td>189</td>
</tr>
<tr>
<td>45 to 49</td>
<td>138</td>
<td>5.6%</td>
<td>9.71</td>
<td>138</td>
</tr>
<tr>
<td>50 to 54</td>
<td>87</td>
<td>3.6%</td>
<td>6.39</td>
<td>87</td>
</tr>
<tr>
<td>55 to 59</td>
<td>57</td>
<td>2.3%</td>
<td>4.76</td>
<td>57</td>
</tr>
<tr>
<td>60 to 64</td>
<td>21</td>
<td>0.9%</td>
<td>1.93</td>
<td>21</td>
</tr>
<tr>
<td>65 and Above</td>
<td>12</td>
<td>0.5%</td>
<td>0.44</td>
<td>12</td>
</tr>
<tr>
<td>Age Unknown</td>
<td>0</td>
<td>0.0%</td>
<td>NA</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1774</td>
<td>72.5%</td>
<td>8.23</td>
<td>1774</td>
</tr>
<tr>
<td><strong>By Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Non-Hispanic</td>
<td>736</td>
<td>30.1%</td>
<td>5.80</td>
<td>736</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>275</td>
<td>11.2%</td>
<td>24.77</td>
<td>275</td>
</tr>
<tr>
<td>Hispanic</td>
<td>639</td>
<td>26.1%</td>
<td>9.83</td>
<td>639</td>
</tr>
<tr>
<td>*A/PI/H Non-Hispanic</td>
<td>39</td>
<td>1.6%</td>
<td>4.86</td>
<td>39</td>
</tr>
<tr>
<td>**AI/AN Non-Hispanic</td>
<td>65</td>
<td>2.7%</td>
<td>14.93</td>
<td>65</td>
</tr>
<tr>
<td>***MR/O Non-Hispanic</td>
<td>20</td>
<td>0.8%</td>
<td>N/A</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1774</td>
<td>72.5%</td>
<td>8.23</td>
<td>1774</td>
</tr>
<tr>
<td><strong>By Mode of Transmission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>1142</td>
<td>46.7%</td>
<td>N/A</td>
<td>1142</td>
</tr>
<tr>
<td>*IDU</td>
<td>115</td>
<td>4.7%</td>
<td>N/A</td>
<td>115</td>
</tr>
<tr>
<td>MSM / IDU</td>
<td>96</td>
<td>3.9%</td>
<td>N/A</td>
<td>96</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>164</td>
<td>6.7%</td>
<td>N/A</td>
<td>164</td>
</tr>
<tr>
<td>**O/H/TF/TPR</td>
<td>16</td>
<td>0.7%</td>
<td>N/A</td>
<td>16</td>
</tr>
<tr>
<td>***NRR/UR</td>
<td>241</td>
<td>9.9%</td>
<td>N/A</td>
<td>241</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1774</td>
<td>72.5%</td>
<td>8.23</td>
<td>1774</td>
</tr>
</tbody>
</table>

* 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>
<thead>
<tr>
<th>TABLE 3</th>
<th>Central Arizona Prevalence 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevalent HIV</td>
</tr>
<tr>
<td></td>
<td>Cases</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5374</td>
</tr>
<tr>
<td>Female</td>
<td>971</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6345</td>
</tr>
<tr>
<td>By Age</td>
<td></td>
</tr>
<tr>
<td>Under 2</td>
<td>0</td>
</tr>
<tr>
<td>2 to 12</td>
<td>38</td>
</tr>
<tr>
<td>13 to 19</td>
<td>54</td>
</tr>
<tr>
<td>20 to 24</td>
<td>292</td>
</tr>
<tr>
<td>25 to 29</td>
<td>578</td>
</tr>
<tr>
<td>30 to 34</td>
<td>684</td>
</tr>
<tr>
<td>35 to 39</td>
<td>709</td>
</tr>
<tr>
<td>40 to 44</td>
<td>844</td>
</tr>
<tr>
<td>45 to 49</td>
<td>929</td>
</tr>
<tr>
<td>50 to 54</td>
<td>969</td>
</tr>
<tr>
<td>55 to 59</td>
<td>608</td>
</tr>
<tr>
<td>60 to 64</td>
<td>342</td>
</tr>
<tr>
<td>65 and Above</td>
<td>285</td>
</tr>
<tr>
<td>Age Unknown</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6345</td>
</tr>
<tr>
<td>By Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White Non-Hispanic</td>
<td>3314</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>923</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1717</td>
</tr>
<tr>
<td>*A/PI/H Non-Hispanic</td>
<td>111</td>
</tr>
<tr>
<td>**AI/AN Non-Hispanic</td>
<td>157</td>
</tr>
<tr>
<td>***MR/O Non-Hispanic</td>
<td>123</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6345</td>
</tr>
<tr>
<td>By Mode of Transmission</td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>3934</td>
</tr>
<tr>
<td>IDU</td>
<td>532</td>
</tr>
<tr>
<td>MSM / IDU</td>
<td>390</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>670</td>
</tr>
<tr>
<td>O/H/TF/TPR</td>
<td>84</td>
</tr>
<tr>
<td>NRR/UR</td>
<td>735</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6345</td>
</tr>
</tbody>
</table>

* 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
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


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 diagnosed 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
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
ALL THINGS HIV IN ARIZONA