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

Douglas A. Ducey | Governor     Cara M. Christ, MD, MS | Director

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Health and Wellness for all Arizonans
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 Egurola
Deborah Reardon-Maynard
Felicia McLean
Haley Coles
Harold Thomas
Jai Smith
Jamal Brooks-Hawkins
Jeremy Bright
Jeremy Hyvarinen
Kara Ihrke
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HIV Prevention Program Staff
Ann Gardner
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Tiana Galindo

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Carmen Batista
Claudia Cardiel
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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

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>225</td>
<td>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</td>
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<tr>
<td>1,483 man hours specifically to strategic planning for Arizona’s regional communities</td>
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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.

![FIGURE 1 Northern, Central and Southern Regions](image)
The Northern Region

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

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

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

Mohave county, in the Northern Region, was identified by the CDC as one of 221 counties nationwide at risk for an HIV/Hepatitis outbreak.
Northern 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
- Community Engagement
- Education
- Prevention, Testing & Linkage to Care

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
- Funding
- Patient-Centered Care
- Streamline Processes

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

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

Strategies
- Patient-Centered Care
- Funding
- Data Standardization

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

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

Strategies
- Stigma Reduction
- Community Engagement
- Funding

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

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

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

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

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

Strategies
- Prevention, Testing & Linkage to Care
- Streamline Processes
- Patient-Centered Care
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 Symposiums  
• Contributed data for the Statewide Coordinated Statement of Need                                                                                                                                                                                                                                                                                  |
| Phoenix EMA Ryan White Part A Program | • Lead the small government leadership team for the Integrated Plan  
• Co-designed comprehensive statewide needs assessments of people living with HIV and high risk populations  
• Co-wrote the Plan. Lead for the Financial and Human Resources Inventory  
• Co-hosted the HIV Symposiums  
• Contributed data for the Statewide Coordinated Statement of Need                                                                                                                                                                                                                                                                             |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Arizona Ryan White Part B Care and     | - Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities  
| Services Program                        | - Co-wrote the Plan. Lead program for the development of the Statewide Coordinated Statement of Need  
|                                        | - Co-hosted the HIV Symposums  
|                                        | - 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 Symposums  
|                                        | - 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 Symposums  
|                                        | - Contributed data for the Statewide Coordinated Statement of Need  
|                                        | - Supported Central Region activities to inform planning efforts                                                                                                                                                              |
| Arizona AIDS Education and Training    | - Provided HIV training to stakeholders engaged in the development of the Plan  
| Center                                 | - 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 Symposums  
|                                        | - 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       | - Supported Northern Region Needs Assessment activities, and conducted regional focus groups to inform planning efforts  
| Program                                | - 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  
<p>|                                        | - Developed data capture and export methodologies, to provide data for planning                                                                                                                                               |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| **Community Health Centers**      | • Participated in the Financial and HIV Workforce Capacity Survey  
• Representatives have joined both Planning Bodies  
• Federally Qualified Health Center (FQHC) and FQHC look-a-like participation in HIV Symposia  
• Southern Community Health Centers have hosted local community sessions for developing the integrated plan                                                                 |
| Medicaid                          | • Membership on the Phoenix EMA Ryan White Planning Council  
• Provided data for the Statewide Coordinated Statement of Need  
• Participated in Financial and HIV Workforce Capacity Survey  
• Allocates resources for HIV medications for eligible clients in the community                                                                                           |
| Medicare                          | • Participated in Financial and HIV Workforce Capacity Survey  
• Allocates resources for HIV medications for eligible clients in the community                                                                                                                                                |
| Veterans Health Administration    | • Contributed to Statewide Coordinated Statement of Need  
• Allocates resources for HIV medications for eligible clients in the community                                                                                                                                              |
| Housing and Urban Development     | • Representation on the Planning Bodies  
• Actively participated in the development of the plans for the Central and Southern Regions  
• Participated in the Financial and HIV Workforce Capacity Survey  
• Allocates resources for HIV medications for eligible clients in the community                                                                                                                                         |
Northern Region Plan
The Northern Region

Target Populations

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

Activity Highlights

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

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

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

CONTINUUM OF CARE DEFINITIONS

HIV-Diagnosed: Prevalent cases that have been diagnosed
Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year
Incidence Linked to HIV Care: Incident cases for the year of the spectrum that were linked with a documented lab test, doctor visit or medication use within 90 days of their diagnosis, but not on the same day of the diagnosis. If a person has their first CD4, viral load or genotype on the same day as their diagnostic test the date of second CD4, viral load or genotype will be used as the linkage
Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or antiretroviral (ARV) use in the first and second six months of the year
On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable
Adherent/Suppressed: Prevalent cases whose last viral load of the calendar year was undetectable (<200 C/mL)
In 2014, HIV incidence dropped to 39 (22 case reduction from previous year), while prevalence increased by 64, indicating that at least 25 HIV positive people who were not diagnosed in Northern Arizona moved into the region.

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

In Figure 17, the most frequently reported risk factors for Northern Arizona are Men who have Sex with Men (319 people), Injection Drug Users (207 people), and Men who have Sex with Men who are Injection Drug Users (98 people).
FIGURE 3
2014 Northern Arizona
HIV Continuum of Care
by Race/Ethnicity

FIGURE 4
2014 Northern Arizona HIV
Continuum of Care by Gender
FIGURE 5
2014 Northern Arizona HIV Continuum of Care by Risk Category

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

TABLE 1
Comparison of Northern Region Incidence and Prevalence Totals by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence</th>
<th>Incidence</th>
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<tbody>
<tr>
<td>2005</td>
<td>562</td>
<td>44</td>
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<td>2006</td>
<td>606</td>
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<td>2007</td>
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<tr>
<td>2008</td>
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<tr>
<td>2009</td>
<td>740</td>
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<tr>
<td>2010</td>
<td>747</td>
<td>45</td>
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<tr>
<td>2011</td>
<td>795</td>
<td>36</td>
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<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>
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</table>
### TABLE 2
Northern Arizona Regional Incidence 2009 to 2013

<table>
<thead>
<tr>
<th></th>
<th>Emergent HIV</th>
<th>Emergent AIDS</th>
<th>Emergent HIV &amp; AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% State Total</td>
<td>Rate Per 100,000</td>
<td>% State Total</td>
</tr>
<tr>
<td><strong>By Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>100</td>
<td>46.5</td>
<td>5.16</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>10.2</td>
<td>1.12</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>56.7</td>
<td>3.12</td>
</tr>
<tr>
<td><strong>By Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 2</td>
<td>0</td>
<td>0.0</td>
<td>0.00</td>
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<tr>
<td>2 to 12</td>
<td>0</td>
<td>0.0</td>
<td>0.00</td>
</tr>
<tr>
<td>13 to 19</td>
<td>1</td>
<td>0.5</td>
<td>0.27</td>
</tr>
<tr>
<td>20 to 24</td>
<td>18</td>
<td>8.4</td>
<td>6.82</td>
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<td>25 to 29</td>
<td>25</td>
<td>11.6</td>
<td>12.16</td>
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<td>30 to 34</td>
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<td>7.35</td>
</tr>
<tr>
<td>35 to 39</td>
<td>17</td>
<td>7.9</td>
<td>8.94</td>
</tr>
<tr>
<td>40 to 44</td>
<td>12</td>
<td>5.6</td>
<td>5.77</td>
</tr>
<tr>
<td>45 to 49</td>
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<td>7.79</td>
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<td>50 to 54</td>
<td>7</td>
<td>3.3</td>
<td>2.52</td>
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<td>55 to 59</td>
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<td>60 to 64</td>
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<td>0.9</td>
<td>0.70</td>
</tr>
<tr>
<td>65 and Above</td>
<td>1</td>
<td>0.5</td>
<td>0.13</td>
</tr>
<tr>
<td>Age Unknown</td>
<td>0</td>
<td>0.0</td>
<td>NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>56.7</td>
<td>3.12</td>
</tr>
<tr>
<td><strong>By Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Non-Hispanic</td>
<td>46</td>
<td>21.4</td>
<td>1.81</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>3</td>
<td>1.4</td>
<td>6.61</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>5.1</td>
<td>2.13</td>
</tr>
<tr>
<td>*A/PI/H Non-Hispanic</td>
<td>1</td>
<td>0.5</td>
<td>2.27</td>
</tr>
<tr>
<td>**AI/AN Non-Hispanic</td>
<td>58</td>
<td>27.0</td>
<td>7.65</td>
</tr>
<tr>
<td>***MR/O Non-Hispanic</td>
<td>3</td>
<td>1.4</td>
<td>NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>56.7</td>
<td>3.12</td>
</tr>
<tr>
<td><strong>By Mode of Transmission</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>52</td>
<td>24.2</td>
<td>NA</td>
</tr>
<tr>
<td>IDU</td>
<td>26</td>
<td>12.1</td>
<td>NA</td>
</tr>
<tr>
<td>MSM / IDU</td>
<td>13</td>
<td>6.0</td>
<td>NA</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>17</td>
<td>7.9</td>
<td>NA</td>
</tr>
<tr>
<td>O/H/TF/TPR</td>
<td>0</td>
<td>0.0</td>
<td>NA</td>
</tr>
<tr>
<td>NRR/UR</td>
<td>14</td>
<td>6.5</td>
<td>NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>56.7</td>
<td>3.12</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

18 NORTHERN ARIZONA
### TABLE 3
Northern Arizona Prevalence 2014

#### By Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Prevalent HIV</th>
<th>Prevalent AIDS</th>
<th>Prevalent HIV &amp; AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases % State Total Rate Per 100,000</td>
<td>Cases % State Total Rate Per 100,000</td>
<td>Cases % State Total Rate Per 100,000</td>
</tr>
<tr>
<td>Male</td>
<td>346 34.5 88.62</td>
<td>473 47.2 121.5</td>
<td>819 81.7 209.77</td>
</tr>
<tr>
<td>Female</td>
<td>90  9.0 22.69</td>
<td>94  9.4 23.70</td>
<td>184 18.3 46.40</td>
</tr>
<tr>
<td>TOTAL</td>
<td>436 43.5 55.40</td>
<td>567 56.5 72.04</td>
<td>1003 100.0 127.44</td>
</tr>
</tbody>
</table>

#### By Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Prevalent HIV</th>
<th>Prevalent AIDS</th>
<th>Prevalent HIV &amp; AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases % State Total Rate Per 100,000</td>
<td>Cases % State Total Rate Per 100,000</td>
<td>Cases % State Total Rate Per 100,000</td>
</tr>
<tr>
<td>Under 2</td>
<td>0 0.0 0.00</td>
<td>0 0.0 0.00</td>
<td>0 0.0 0.00</td>
</tr>
<tr>
<td>2 to 12</td>
<td>1 0.1 0.97</td>
<td>1 0.1 0.97</td>
<td>2 0.2 1.93</td>
</tr>
<tr>
<td>13 to 19</td>
<td>6 0.6 8.32</td>
<td>2 0.2 2.77</td>
<td>8 0.8 11.09</td>
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<tr>
<td>20 to 24</td>
<td>17 1.7 31.17</td>
<td>5 0.5 9.17</td>
<td>22 2.2 40.34</td>
</tr>
<tr>
<td>25 to 29</td>
<td>27 2.7 64.08</td>
<td>14 1.4 33.23</td>
<td>41 4.1 97.31</td>
</tr>
<tr>
<td>30 to 34</td>
<td>35 3.5 87.33</td>
<td>26 2.6 64.87</td>
<td>61 6.1 152.20</td>
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<td>35 to 39</td>
<td>36 3.6 96.54</td>
<td>39 3.9 104.58</td>
<td>75 7.5 201.12</td>
</tr>
<tr>
<td>40 to 44</td>
<td>66 6.6 163.28</td>
<td>62 6.2 153.38</td>
<td>128 12.8 316.66</td>
</tr>
<tr>
<td>45 to 49</td>
<td>62 6.2 139.40</td>
<td>107 10.7 240.58</td>
<td>169 16.8 379.98</td>
</tr>
<tr>
<td>50 to 54</td>
<td>81 8.1 149.99</td>
<td>111 11.1 205.55</td>
<td>192 19.1 355.54</td>
</tr>
<tr>
<td>55 to 59</td>
<td>53 5.3 91.13</td>
<td>101 10.1 173.66</td>
<td>154 15.4 264.80</td>
</tr>
<tr>
<td>60 to 64</td>
<td>25 2.5 42.77</td>
<td>58 5.8 99.23</td>
<td>83 8.3 141.99</td>
</tr>
<tr>
<td>65 and Above</td>
<td>27 2.7 16.39</td>
<td>41 4.1 24.89</td>
<td>68 6.8 41.29</td>
</tr>
<tr>
<td>Age Unknown</td>
<td>0 0.0 NA</td>
<td>0 0.0 NA</td>
<td>0 0.0 NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>436 43.5 55.40</td>
<td>567 56.5 72.04</td>
<td>1003 100.0 127.44</td>
</tr>
</tbody>
</table>

#### By Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prevalent HIV</th>
<th>Prevalent AIDS</th>
<th>Prevalent HIV &amp; AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Non-Hispanic</td>
<td>267 26.6 52.44</td>
<td>337 33.6 66.19</td>
<td>604 60.2 118.64</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>16 1.6 161.68</td>
<td>18 1.8 181.89</td>
<td>34 3.4 343.57</td>
</tr>
<tr>
<td>Hispanic</td>
<td>46 4.6 43.19</td>
<td>57 5.7 53.51</td>
<td>103 10.3 96.70</td>
</tr>
<tr>
<td>*A/PI/H Non-Hispanic</td>
<td>8 0.8 84.45</td>
<td>6 0.6 63.34</td>
<td>14 1.4 147.79</td>
</tr>
<tr>
<td>**AI/AN Non-Hispanic</td>
<td>90 9.0 59.21</td>
<td>142 14.2 93.42</td>
<td>232 23.1 152.63</td>
</tr>
<tr>
<td>***MR/O Non-Hispanic</td>
<td>9 0.9 NA</td>
<td>7 0.7 NA</td>
<td>16 1.6 NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>436 43.5 55.40</td>
<td>567 56.5 72.04</td>
<td>1003 100.0 127.44</td>
</tr>
</tbody>
</table>

#### By Mode of Transmission

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Prevalent HIV</th>
<th>Prevalent AIDS</th>
<th>Prevalent HIV &amp; AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>216 21.5 NA</td>
<td>284 28.3 NA</td>
<td>500 49.9 NA</td>
</tr>
<tr>
<td>IDU</td>
<td>67 6.7 NA</td>
<td>86 8.6 NA</td>
<td>153 15.3 NA</td>
</tr>
<tr>
<td>MSM / IDU</td>
<td>46 4.6 NA</td>
<td>89 8.9 NA</td>
<td>135 13.5 NA</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>57 5.7 NA</td>
<td>70 7.0 NA</td>
<td>127 12.7 NA</td>
</tr>
<tr>
<td>O/H/TF/TPR</td>
<td>6 0.6 NA</td>
<td>6 0.6 NA</td>
<td>12 1.2 NA</td>
</tr>
<tr>
<td>NRR/UR</td>
<td>44 4.4 NA</td>
<td>32 3.2 NA</td>
<td>76 7.6 NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>436 43.5 55.40</td>
<td>567 56.5 72.04</td>
<td>1003 100.0 127.44</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

---

NORTHERN ARIZONA 19
GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Community Engagement

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

Metric: Establishment of formalized processes

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2018 to 2021

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

Metric: At least one training is presented each year

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2019
Strategy 1: Community Engagement continued

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

Metric: The number of additional community partners engaged each year

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2019

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

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

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2021
GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Education

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021

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

Metric: At least one training completed every two years

Lead Program: Arizona AIDS Education and Training Center

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

Start/End: 2018 to 2020
GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Prevention, Testing & Linkage to Care

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

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

**Lead Program:** Coconino County Health Department

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

**Start/End:** 2018 to 2021

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

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

**Lead Program:** HIV Prevention Program

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

**Start/End:** 2018 to 2021

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

**Metric:** Same-day supplemental/confirmatory testing implemented

**Lead Program:** HIV Prevention Program

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

**Start/End:** 2017 to 2020
Strategy 1: Prevention, Testing & Linkage to Care  

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

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

**Lead Program:** HIV Prevention Program

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

**Start/End:** 2017 to 2021

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

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

**Lead Program:** HIV Prevention Program

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

**Start/End:** 2017 to 2021

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

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

**Lead Program:** Arizona AIDS Education and Training Center

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

**Start/End:** 2017 to 2021
GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Funding

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

   Metric: Increased availability of support services

   Lead Program: Ryan White Part B Program
   Partners: Community-Based Organizations
   Start/End: 2017 to 2021

1.2.1.2 Expand Affordable Care Act benefits navigation services.

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

   Lead Program: Ryan White Part B Program
   Partners: State/County Entities, Tribal Entities, Community-Based Organizations
   Start/End: 2017 to 2019

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

   Metric: The number of technical assistance opportunities requested and provided

   Lead Program: HIV Prevention Program
   Partners: Ryan White Part B Program, Arizona AIDS Education and Training Center
   Start/End: 2017 to 2021
**GOAL 1:** INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

**Strategy 2: Patient-Centered Care**

<table>
<thead>
<tr>
<th>1.2.2.1</th>
<th>Annually, provide at least one training for Ryan White sub-recipients, community-based organizations, and other service providers, focusing on such topics as cultural competency, health equity, disclosure of HIV diagnosis, and/or CLAS training. Explore opportunities to collaborate with other local training opportunities to increase participation. A self-appraisal should be implemented prior to each training.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric:</strong></td>
<td>Presentation of at least one training opportunity each year</td>
</tr>
<tr>
<td><strong>Lead Program:</strong></td>
<td>Ryan White Part B Program</td>
</tr>
<tr>
<td><strong>Partners:</strong></td>
<td>HIV Prevention Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Community-Based Organizations, Medical Providers</td>
</tr>
<tr>
<td><strong>Start/End:</strong></td>
<td>2017 to 2021</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.2.2.2</th>
<th>Annually, implement at least one social marketing initiative to educate clients about seeking HIV care from knowledgeable, culturally appropriate providers, and the ability to switch providers for more comprehensive care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric:</strong></td>
<td>At least one marketing initiative implemented each year</td>
</tr>
<tr>
<td><strong>Lead Program:</strong></td>
<td>HIV Prevention Program</td>
</tr>
<tr>
<td><strong>Partners:</strong></td>
<td>Ryan White Part B Program, Arizona AIDS Education and Training Center, State/County Entities, Tribal Entities, Aunt Rita’s Foundation, Community-Based Organizations</td>
</tr>
<tr>
<td><strong>Start/End:</strong></td>
<td>2017 to 2021</td>
</tr>
</tbody>
</table>
Strategy 2: Patient-Centered Care  continued

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

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

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2019

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

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

Lead Program: Arizona AIDS Education and Training Center

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

Start/End: 2018 to 2021

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

Metric: The resources are developed and distributed throughout the community

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2017 to 2021
GOAL 1: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Streamline Processes

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

Metric: Methodologies are defined, implemented and evaluated

Lead Program: Ryan White Part B Program
Partners: State/County Entities, Tribal Entities, Northern Arizona Healthcare Providers
Start/End: 2018 to 2019

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

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

Lead Program: Ryan White Part B Program
Partners: Ryan White Programs
Start/End: 2017 to 2018

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

Metric: The reporting methodologies are developed and utilized

Lead Program: Ryan White Part B Program
Partners: HIV Prevention Program, HIV Surveillance Program, State/County Entities, Tribal Entities, Northern Arizona Healthcare Providers, Community-Based Organizations
Start/End: 2017 to 2019
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Prevention, Testing & Linkage to Care

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

Metric: At least one training is presented each year

Lead Program: Arizona AIDS Education and Training Center

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

Start/End: 2017 to 2021

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

Metric: The number of collaborations established.

Lead Program: Coconino County Health Department

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

Start/End: 2017 to 2021
Strategy 1:  Prevention, Testing & Linkage to Care  continued

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

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

Lead Program:  HIV Prevention Program

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

Start/End:  2017 to 2021
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Streamline Processes

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

Metric: Activities are developed and implemented, and evaluated annually

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2021

2.1.2.2 Clearly identified care navigation processes for all communities.

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

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2019

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

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

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2019
Strategy 2: **Streamline Processes continued**

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

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

**Lead Program:** Arizona AIDS Education and Training Center

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

**Start/End:** 2017 to 2019

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

**Metric:** The number of trainings provided each year

**Lead Program:** Arizona AIDS Education and Training Center

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

**Start/End:** 2018 to 2021
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Patient-Centered Care

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

**Metric:** The implementation of a standardized referral process

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

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

**Start/End:** 2017 to 2021

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

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

**Lead Program:** Arizona AIDS Education and Training Center

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

**Start/End:** 2017 to 2021

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

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

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

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

**Start/End:** 2018 to 2019
Strategy 3: Patient-Centered Care continued

2.1.3.4 Evaluate the capacity of service organizations to enable clients to receive medical and supportive service appointments at their home or other convenient location, when feasible. As an alternative, evaluate the need and ability to provide increased access to transportation services.

Capacity to provide offsite medical and supportive service appointments is evaluated; the need and ability to provide increased transportation services is evaluated; action items developed

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2019
**GOAL 2:** INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

**Strategy 1:** Patient-Centered Care

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

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

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

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

**Start/End:** 2019 to 2020

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

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

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

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

**Start/End:** 2018 to 2019
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Funding

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

Metric: Service delivery and funding evaluated

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2019

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

Metric: Completion of the assessment

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2019

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

Metric: Completion of needs assessment, Key informant interviews

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2019
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Data Standardization

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

Metric: Completion of the universal enrollment process

Lead Program: Ryan White Part B Program

Partners: Community-Based Organizations

Start/End: 2018 to 2019

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

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

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2020
GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

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

Strategy 1: Stigma Reduction

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

Metric: Assessment completed

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2017 to 2019

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

Metric: The establishment of partnerships

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021
GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

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

Strategy 2: Community Engagement

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

Metric: At least one initiative implemented every two years

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2019

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

Metric: The development of materials

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2020
GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUALITIES.

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

Strategy 3: Funding

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2019

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

Metric: Successful identification and implementation of new opportunities for efficiency

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2019

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

Metric: Assessment completed; action items developed

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2019
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 1: Community Engagement

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

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

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2017 to 2018

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

Metric: At least one training provided each year

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2018 to 2021
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 2: Prevention, Testing & Linkage to Care

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

Metric: The development and implementation of activities

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

Metric: The number and types of collaborative activities

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 3: Education

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2018

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

Metric: Partnership established

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021

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

Metric: Partnership established

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021
Strategy 3: Education continued

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

Metric: Partnership established

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 1: Prevention, Testing and Linkage to Care

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

Metric: An increase in the number of referrals

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2021
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 2: Streamline Processes

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

Metric: The provision of capacity building assistance

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2020
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:

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