The 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona: Southern Region
2017 to 2021
Integrated HIV Prevention and Care Plan for Arizona: Southern 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 concur 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 concur 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,

[Signature]

Chelsey Donohoo
Chair
Arizona HIV Statewide Advisory Group

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

150 North 18th Avenue, Suite 500, Phoenix, AZ 85007-3247  P | 602-542-1025  F | 602-542-1062  W | azhealth.gov
Health and Wellness for all Arizonans
September 23, 2016

LCDR Monique Richards
Public Health Analyst
HRSA/HAB/DMHAP
5600 Fishers Lane
Mail Stop 09W05B
Rockville, MD 20857

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

Dear Ms. Richards:

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

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

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

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

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

Sincerely,

[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
Randall Furrow
RJ Shannon
Robert Bourassa

HIV Prevention Program Staff
Ann Gardner
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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

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 Southern Region

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

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

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

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

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

**Strategies**
- Patient-Centered Care
- Streamline Processes
- Incentives for Care
- Stigma Reduction

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

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

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

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

**Strategies**
- Funding
- Quality Housing
- Community Engagement

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

**Strategies**
- Community Engagement
- Education
- Stigma Reduction

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

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

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

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

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

**Strategies**
- Patient-Centered Care
- Streamline Processes
- Funding
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>
<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 Symposiums  
- Contributed data for the Statewide Coordinated Statement of Need  
- Supports allowable programs with rebate funds throughout Arizona |
| Arizona Ryan White Part C Programs | - Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities  
- Co-hosted the HIV Symposiums  
- Contributed data for the Statewide Coordinated Statement of Need  
- Supported Central and Southern Region activities to inform planning efforts |
| Arizona Ryan White Part D Program | - Co-designed comprehensive statewide needs assessments of people living with HIV and high risk, impacted communities  
- Co-hosted the HIV Symposiums  
- Contributed data for the Statewide Coordinated Statement of Need  
- Supported Central Region activities to inform planning efforts |
| Arizona AIDS Education and Training Center | - Provided HIV training to stakeholders engaged in the development of the Plan  
- Coordinated Southern Region stakeholder engagement and planning sessions  
- Participated in the Financial and HIV Workforce Capacity Survey  
- Membership on the HIV Statewide Advisory Group  
- Provided technical assistance during Plan development  
- Conducted a Pre-Exposure Prophylaxis readiness assessment of providers and consumers |
| Arizona Regional Quality Group | - Participated in HIV 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 |
### Stakeholder Group Contributions to Plan Development

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Contributions</th>
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<tbody>
<tr>
<td><strong>Community Health Centers</strong></td>
<td>• Participated in the Financial and HIV Workforce Capacity Survey</td>
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<td>• Representatives have joined both Planning Bodies</td>
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<td></td>
<td>• Federally Qualified Health Center (FQHC) and FQHC look-a-like participation in HIV Symposums</td>
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<tr>
<td></td>
<td>• Southern Community Health Centers have hosted local community sessions for developing the integrated plan</td>
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<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>
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<td></td>
<td>• Allocates resources for HIV medications for eligible clients in the community</td>
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</table>
The Southern Region

Target Populations

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

Activity Highlights

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

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

The HIV Prevention and Ryan White Part B and C Programs provide HIV prevention and care services in the Southern Region.
FIGURE 2
2014 Pima County HIV Continuum of Care

FIGURE 3
2014 Remaining Southern Region HIV Continuum of Care
The 2015 Arizona Department of Health Services Epidemiology Report shows the Southern Region had 22% of the state population, 19% of the new HIV cases, and 19% of the ongoing HIV cases. Census data from 2015 shows that Southern Arizona has a higher than average percentage of Hispanics or Latinos in Santa Cruz County (83%), Greenlee County (46%) and Cochise County (35%). In 2014, the new cases dropped to 115 (19 case reduction from previous year), while prevalence increased by 142, indicating that at least 27 HIV positive people who were not diagnosed in Southern Arizona moved to the region.
FIGURE 5
2014 Remaining Southern Region HIV Continuum of Care by Race/Ethnicity

TABLE 1
Comparison of Pima County and All Southern Region Incidence and Prevalence by Year, 2005 to 2014

<table>
<thead>
<tr>
<th>Year</th>
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FIGURE 6
2014 Pima County HIV Continuum of Care by Gender

FIGURE 7
2014 Remaining Southern Region HIV Continuum of Care by Gender
FIGURE 8
2014 Pima County HIV Continuum of Care by Risk Category

FIGURE 9
2014 Remaining Southern HIV Continuum of Care by Risk Category

KEY
MSM: Men who have Sex with Men
IDU: Injection Drug User
HRH: High-Risk Heterosexual
NRR: No Reported Risk
### TABLE 2
Pima County Breakout Incidence 2009 to 2013

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* 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

20 SOUTHERN ARIZONA
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* Asian Pacific/Islander/Hawaiian  + Men having Sex with Men
** American Indian/Alaskan Native + Injection Drug Use
*** Multiple Race/Other Race    +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk
### TABLE 4
All Southern Arizona Regional Incidence (including Pima County) 2009 to 2013

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<td>Cases  % State Total Rate Per 100,000</td>
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<td>7  1.3  3.89</td>
<td>11  2.0  6.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**AI/AN Non-Hispanic</td>
<td>10  1.8  5.35</td>
<td>9  1.7  4.81</td>
<td>19  3.5  10.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>***MR/O Non-Hispanic</td>
<td>5  0.9  NA</td>
<td>1  0.2  NA</td>
<td>6  1.1  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>341  62.9  4.74</td>
<td>201  37.1  2.79</td>
<td>542 100.0  7.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Mode of Transmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;MSM&quot;</td>
<td>190 35.1  NA</td>
<td>96 17.7  NA</td>
<td>286 52.8  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;IDU&quot;</td>
<td>30  5.5  NA</td>
<td>16  3.0  NA</td>
<td>46  8.5  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM / IDU</td>
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<td>7  1.3  NA</td>
<td>19  3.5  NA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heterosexual</td>
<td>54 10.0  NA</td>
<td>52  9.6  NA</td>
<td>106 19.6  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;O/H/TF/TPR&quot;</td>
<td>3  0.6  NA</td>
<td>0  0.0  NA</td>
<td>3  0.6  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;NRR/UR&quot;</td>
<td>52  9.6  NA</td>
<td>30  5.5  NA</td>
<td>82 15.1  NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>341  62.9  4.74</td>
<td>201  37.1  2.79</td>
<td>542 100.0  7.53</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
++++ No Reported Risk/Unknown Risk
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
### TABLE 5
All Southern Arizona Regional Prevalence (including Pima County) 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>1236 38.4 172.30 1497 46.5 208.69</td>
<td>2733 85.0 380.99</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>248 7.7 34.28 236 7.3 32.62</td>
<td>484 15.0 66.90</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1484 46.1 102.99 1733 53.9 120.28</td>
<td>3217 100.0 223.27</td>
<td></td>
</tr>
</tbody>
</table>

#### By Age

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

SOUTHERN ARIZONA 23
GOAL 1: REDUCE NEW HIV INFECTIONS.

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

Strategy 1: Prevention, Testing & Linkage to Care

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

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

Lead Program: Pima County Health Department

Partners: HIV Prevention Program

Start/End: 2017 to 2018
Strategy 1: Prevention, Testing & Linkage to Care  continued

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2017 to 2021
GOAL 1: REDUCE NEW HIV INFECTIONS.

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

Strategy 2: Education

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

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

   Lead Program: HIV Prevention Program

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

   Start/End: 2019 to 2021

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

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

   Lead Program: HIV Statewide Advisory Group

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

   Start/End: 2019 to 2021

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

   Metric: The number of partners identified

   Lead Program: HIV Statewide Advisory Group

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

   Start/End: 2018 to 2019
Strategy 2: Education continued

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

**Metric:** One presentation completed every two years

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

**Partners:** Yuma Family Medicine Residency Program

**Start/End:** 2018 to 2020

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

**Metric:** At least one education presentation provided each year

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

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

**Start/End:** 2017 to 2021

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

**Metric:** At least one education presentation completed each year

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

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

**Start/End:** 2017 to 2018
GOAL 1: REDUCE NEW HIV INFECTIONS.

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

Strategy 3: Stigma Reduction

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

Metric: Completion of the assessment

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2017 to 2018

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

Metric: At least one initiative implemented each year

Lead Program: Ryan White Part B Program

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

Start/End: 2019 to 2021
1.1.3.4 Assess systematic and provider behaviors related to HIV stigma when accessing/providing services, and develop a strategy to address identified issues.

**Metric:** Assessment completed; strategy developed

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

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

**Start/End:** 2018
**GOAL 1:** REDUCE NEW HIV INFECTIONS.

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

**Strategy 1:** Patient-Centered Care

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

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

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

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

**Start/End:** 2019 to 2021

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

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

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

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

**Start/End:** 2018 to 2019
GOAL 1: REDUCE NEW HIV INFECTIONS.

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

Strategy 2: Streamline Processes

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

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

Metric: Completion of the universal enrollment process

Lead Program: Ryan White Part B Program

Partners: Community-Based Organizations

Start/End: 2018 to 2019

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

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

Lead Program: Ryan White Part B Program

Partners: Ryan White Programs

Start/End: 2017 to 2018
GOAL 1: REDUCE NEW HIV INFECTIONS.

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

Strategy 3: Incentives for Care

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

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

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2019

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

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

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021
**GOAL 1: REDUCE NEW HIV INFECTIONS.**

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

**Strategy 4: Stigma Reduction**

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

**Metric:** At least one strategy is implemented each year

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

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

**Start/End:** 2017 to 2019

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

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

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

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

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

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

**Strategy 1:** Patient-Centered Care

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

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

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

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

**Start/End:** 2018 to 2019

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

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

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

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

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

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

Strategy 2: Community Engagement

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

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

Lead Program: HIV Surveillance Program

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

Start/End: 2017 to 2021

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

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

Lead Program: Arizona AIDS Education and Training Center

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

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

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

Strategy 3: Prevention, Testing and Linkage to Care

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

Metric: Presentation of at least one training each year.

Lead Program: HIV Prevention Program

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

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

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

Strategy 1: Streamline Processes

2.2.1.1 Assess the ability of Pima County Health Department and community providers to increase availability of Benefits Navigation services, in order to decrease the number of clients who drop out of care due to difficulties navigating their benefits enrollment/re-enrollment and/or insurance coverage.

Metric: Completion of the assessment and implementation of Benefits Navigation services

Lead Program: Ryan White Part B Program
Partners: State/County Entities, Community-Based Organizations
Start/End: 2017 to 2018

2.2.1.2 Implement an acuity-focused service delivery model for case management services, designed to improve care coordination of clients erratically engaged in care, and empower clients to transition from case-managed care to self-managed care.

Metric: Implementation of the service delivery model

Lead Program: Ryan White Part B Program
Partners: Case Management Providers, Community-Based Organizations, Ryan White Clients
Start/End: 2018 to 2019

2.2.1.3 Identify three-to-four Benefits Navigators to assist with off-season insurance enrollment.

Metric: Navigators identified and contracted

Lead Program: Ryan White Part B Program
Partners: State/County Entities, Existing Benefits Navigators, Community-Based Organizations
Start/End: 2017 to 2019
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Patient-Centered Care

2.2.2.1 Establish workgroups to evaluate service delivery models for mental health, substance use, and housing/homeless services, and post-incarceration engagement in care services.

Metric: The workgroups are established; an evaluation is completed

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2018 to 2021

2.2.2.2 Develop and implement strategies to strengthen referral processes for people living with HIV who are recently-released from jail, identified in emergency departments, etc.

Metric: The strategies are developed and implemented

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Correctional Facilities, Hospitals, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2021

2.2.2.3 Evaluate and implement methods to incentivize people living with HIV who are released from correctional facilities to become engaged in care.

Metric: Methods are evaluated and implemented; the number of clients receiving an incentive

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2021
Strategy 2: Patient-Centered Care continued

2.2.2.4 Educate private providers about the availability of Ryan-White funded HIV services, other HIV services available in the community, and the importance of referring clients to these services (better health outcomes, engagement in care, etc.).

Metric: The number of providers educated

Lead Program: Ryan White Part B Program

Partners: Private Medical Provider Networks, County/State Entities, Tribal Entities, Arizona AIDS Education and Training Center, Correctional Facilities, Community-Based Organizations

Start/End: 2018 to 2020
GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Data Standardization

2.2.3.1 Assess the ability to develop and implement a universal database/data sharing process among HIV partners.

Metric: Completion of the assessment; action items identified

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2019

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

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

Lead Program: Ryan White Part B Program

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

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

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

Strategy 4: Education

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

Metric: At least one training completed every two years

Lead Program: Arizona AIDS Education and Training Center

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

Start/End: 2018 to 2020

2.2.4.2 Increase the number of HIV providers who are trained in the diagnosis, treatment and management of HIV.

Metric: The number of providers trained each year

Lead Program: Arizona AIDS Education and Training Center

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

Start/End: 2017 to 2021

2.2.4.3 Annually, present at least one regional provider training in collaboration with national providers.

Metric: The completion of at least one regional provider training each year

Lead Program: Ryan White Part B Program

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

Start/End: 2017 to 2020
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Funding

3.1.1.1 Complete an assessment of the housing needs of people living with HIV in Pima County.

Metric: The completion of the assessment; action items identified

**Lead Program:** HIV Statewide Advisory Group

**Partners:** Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

**Start/End:** 2017 to 2018

3.1.1.2 Identify resources to address medication storage at safe spaces for people living with HIV who are homeless.

Metric: Identification of resources; information distributed to community stakeholders

**Lead Program:** HIV Statewide Advisory Group

**Partners:** Ryan White Part B Program, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

**Start/End:** 2018 to 2019
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Quality Housing

3.1.2.1 Collaborate with community partners to improve referral mechanisms and partnerships, in order to increase the ability of people living with HIV to find and obtain quality housing.

Metric: Referral mechanisms and partnerships evaluated; improvement activities completed

Lead Program: Ryan White Part B Program

Partners: State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

Start/End: 2018 to 2019
GOAL 3: **INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.**

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

**Strategy 3: Community Engagement**

3.1.3.1 Create a resource list of housing services providers.

**Metric:** Resource list completed and distributed to community stakeholders

**Lead Program:** HIV Statewide Advisory Group

**Partners:** Primavera Foundation, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

**Start/End:** 2017 to 2019

3.1.3.2 Identify key partners outside of the HIV community that can support people living with HIV to enter/engage in housing services, and promote the availability of HIV services to these entities.

**Metric:** Identification of partners

**Lead Program:** HIV Statewide Advisory Group

**Partners:** Primavera Foundation, State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, HOPWA, Housing Providers, Correctional Facilities, Community-Based Organizations, Community Stakeholders

**Start/End:** 2018 to 2019
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Community Engagement

3.2.1.1 Assess, and then establish collaboration and service delivery among health-based and non-health-based community entities that “goes to the community” rather than expecting target populations to come to existing services.

Metric: Completion of the assessment; partnerships and service delivery revisions implemented

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2017 to 2021

3.2.1.2 Establish collaborations with colleges, fraternities/sororities, faith-based organizations/coalitions, organizations serving communities of color, etc. to provide education and awareness of HIV, engagement in HIV testing among target populations, and community mobilization to address issues that hinder communities of color from addressing HIV issues.

Metric: The number of collaborations established

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

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

3.2.1.3 Establish HIV Statewide Advisory Group workgroups to address the service needs of target communities, and health disparities and social justice issues that affect entry to, and engagement in medical care. Recruit community partners to take participate in planning efforts and implementation of activities.

Metric: The establishment of workgroups and recruitment of community partners

Lead Program: HIV Statewide Advisory Group


Start/End: 2017 to 2021
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Education

3.2.2.1 Develop an Arizona-specific cultural competency training plan, with an expanded focus to include how intersections between homophobia, misogyny, racism, law enforcement interaction, and hiring practices impact HIV service delivery.

Metric: The development of the plan

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2018 to 2019

3.2.2.2 Annually, conduct at least one cultural-competency training according to the Arizona-specific plan.

Metric: At least one training conducted each year

Lead Program: Ryan White Part B Program

Partners: HIV Prevention Program, State/County Entities, Tribal Entities, Community-Based Organizations, African American Health Coalition, NAACP, Black Lives Matter, Clinica Amistad, Hispanic Chamber of Commerce, UofA Mobile Clinic, Tribes, Tucson Indian Center, Border Health Network

Start/End: 2019 to 2021
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Stigma Reduction

3.2.3.1 Annually, implement at least one peer-to-peer activity designed to reduce internal stigma among people living with HIV, and/or address wrap-around stigma (family members, friends, social networks, etc.).

Metric: At least one activity conducted each year

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2021

3.2.3.2 Annually, present at least one training for HIV care and prevention providers related to stigma reduction and trauma-informed care. Ideally, training should coincide with medical and/or other service delivery training.

Metric: At least one training is presented each year

Lead Program: Ryan White Part B Program

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

Start/End: 2018 to 2021
Strategy 3: Stigma Reduction  continued

3.2.3.3 Complete an assessment of HIV knowledge, stigma, trauma-informed care, behaviors, and education needs targeting communities of color and transmission routes.

Metric: The completion of the assessment

Lead Program: HIV Statewide Advisory Group

Partners: State/County Entities, Tribal Entities, Local Medical Providers, HIV Prevention Program, Community-Based Organizations, Social Justice Groups

Start/End: 2017 to 2019

3.2.3.4 Establish partner HIV testing as a standard of service delivery for HIV testing providers.

Metric: Partner HIV testing is established and adopted as a service delivery standard

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021

3.2.3.5 State and local entities collaboratively develop HIV prevention and care messaging that appropriately addresses target populations.

Metric: Population-specific messaging developed

Lead Program: HIV Prevention Program

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

Start/End: 2018 to 2021
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 1: Education

3.3.1.1 Identify and evaluate existing and needed resources that can be utilized to improve service delivery, self-efficacy and engagement in care among youth who inject drugs.

Metric: Resources are identified and evaluated

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2018 to 2019

3.3.1.2 Develop and implement strategies to improve service delivery, self-efficacy and engagement in care among youth who inject drugs.

Metric: The strategies are implemented

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2019 to 2021
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 2: Prevention, Testing & Linkage to Care

3.3.2.1 Biannually, implement at least one outreach initiatives to youth and persons who inject drugs, designed to engage individuals to be tested for HIV and/or enter medical care.

Metric: The implementation of at least one outreach initiative every two years

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2018 to 2020

3.3.2.2 Increase HIV testing sites for the youth and persons who inject drugs.

Metric: An increase in the number of HIV testing sites that provide services for youth and persons who inject drugs.

Lead Program: HIV Prevention Program

Partners: Ryan White Part B Program, State/County Entities, Tribal Entities, Community-Based Organizations, Youth Organizations, Substance Use Providers, Case Management Providers

Start/End: 2017 to 2021
GOAL 3: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

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

Strategy 3: Community Engagement

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

**Metric:** Establishment of formalized processes

**Lead Program:** HIV Statewide Advisory Group

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

**Start/End:** 2018 to 2021

3.3.3.2 Develop and implement county-specific plans to obtain community engagement.

**Metric:** Specific community engagement plans are established for each County in the southern Region

**Lead Program:** HIV Prevention Program

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

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

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

Strategy 1: Funding

**4.1.1.1** Assess the availability of diverse funding opportunities, such as non-federal funding for Community-Based Organizations, and/or third-party reimbursement, for HIV prevention and care services.

**Metric:** The completion of the assessment; utilization of information to obtain non-federal funding

**Lead Program:** HIV Prevention Program

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

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

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

Strategy 2: Community Engagement

4.1.2.1 Biannually, present at least one training to community stakeholders on how to advocate for healthcare initiatives.

Metric: The presentation of at least one training every two years

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2018 to 2020

4.1.2.2 Expand partnerships, especially with non-HIV providers, to increase HIV awareness and diversify HIV services for people living with HIV and those at high-risk for acquiring HIV.

Metric: Expansion of partnerships, as possible

Lead Program: HIV Prevention Program

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

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

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

Strategy 3: Policy Development

4.1.3.1 Promote routine, opt-out testing as a standard of medical care.

Metric: The number of opportunities for promotion that occurred.

Lead Program: Arizona AIDS Education and Training Center

Partners: Arizona Alliance of Community Health Centers, Hospitals, HIV Prevention Program, Ryan White Part B Program, Community-Based Organizations, Other Medical Organizations

Start/End: 2017 to 2021

4.1.3.2 Establish a community coalition to address HIV-related policy issues and educate policy makers on HIV issues.

Metric: Establishment of a community coalition.

Lead Program: HIV Statewide Advisory Group

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

Start/End: 2018 to 2021
Strategy 3: Policy Development  continued

4.1.3.3 Annually, collaborate with community partners to present at least one comprehensive sexual education program in a school and/or to youth groups.

Metric: The presentation of at least one comprehensive sexual education program each year

Lead Program: HIV Statewide Advisory Group

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

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

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

Strategy 4: Prevention, Testing & Linkage to Care

4.1.4.1 Establish same-day supplemental/confirmatory testing among testing providers, to decrease the timeframe between initial diagnosis, first labs, and first medical appointment.

Metric: Same-day confirmatory testing is established

Lead Program: HIV Prevention Program

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

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

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

Strategy 1: Patient-Centered Care

4.2.1.1 Provide at least one training each year to healthcare providers, medical associations, and healthcare students to engage support and commitment for patient-centered care.

Metric: The presentation of at least one training per year; the number of participants

Lead Program: Arizona AIDS Education and Training Center

Partners: Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, Ryan White Part B Program, HIV Prevention Program

Start/End: 2017 to 2021

4.2.1.2 Assess community capacity to expand the availability of alternative, holistic approaches to HIV care.

Metric: The assessment is completed; action items are defined

Lead Program: Ryan White Part B Program

Partners: Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, HIV Prevention Program

Start/End: 2019 to 2021
Strategy 1: Patient-Centered Care continued

4.2.1.3 Promote harm-reduction approaches to medical care to community providers.

**Metric:** Documentation that promotion activities occurred

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

**Partners:** Arizona AIDS Education and Training Center, Local Healthcare Providers, Medical Schools, Colleges/Universities, Community-Based Organizations, HIV Prevention Program

**Start/End:** 2018 to 2021

4.2.1.4 Complete an assessment of patient-centered barriers to accessing medical care and supportive services.

**Metric:** The assessment is completed; action items developed

**Lead Program:** HIV Statewide Advisory Group

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

**Start/End:** 2019 to 2020
GOAL 4: ACHIEVE A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC.

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

Strategy 2: Streamline Processes

4.2.2.1 Evaluate the ability for client enrollment in the Ryan White Program and ADAP to be completed by HIV testing staff, to allow for data submission and the scheduling of an initial medical appointment to occur at the time of diagnosis.

Metric: The completion of an evaluation; action steps defined

Lead Program: Ryan White Part B Program

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

Start/End: 2019 to 2021
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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