ARIZONA 2022-2026 HIV/STI/HEP C INTEGRATED PLAN

VISION

End the epidemics of HIV, STIs, and hepatitis C and reduce disparities by improving prevention and care.

FOUNDATIONAL APPROACHES

- ✓ Take a syndemic approach
- ✓ Recognize intersectionality
- ✓ Allow for local adaptation and autonomy
- ✓ Encourage and support innovation
- ✓ Address systemic systems and barriers in all programs and activities
- ✓ Apply a health equity and social justice lens
- ✓ Integrate persons with lived experience at all levels

Examples of systemic systems and barriers:
Systemic racism & white supremacy
Transphobia
Homophobia
Xenophobia & anti-immigration
"-isms"
Inequalities & disparities
Stigma & biases

DIAGNOSE

GOAL #1: Improve and expand testing for HIV, hep C, and STIs

Objective #1: Increase the availability of HIV, hep C, and STI testing, with a focus on integrated HIV/STI/hep C testing

a. Increase and expand testing within health care settings outside of HIV/STI/Hep C clinics
b. Create more opportunities and mechanisms for routine and opt-out HIV/STI/Hep C testing within health care settings
c. Increase non-traditional locations and partners for testing
d. Increase sites that offer integrated options for testing, instead of siloed HIV, hep C, and testing
e. Provide support to implement best practices for HIV, hep C, and STI testing in healthcare settings
f. Increase the hours that testing is available, with a focus on expanding outside of "work" hours
g. Expand the ways to receive and conduct a test, and who can perform a test

STRATEGY C: EXAMPLES
Federally qualified health centers (FQHCs)
Mobile testing
Pop-up sites
Pharmacies
Homeless shelters
SSPs & harm reduction sites
Food banks
Behavioral health facilities
SUD treatment facilities
College campuses
Health fairs and community events
Local jails and prisons
Juvenile detention centers
Private agencies and organizations
Faith-based organizations

Objective #1 Metrics:

- # funded testing sites
  - # that are non-traditional or non-health care locations
  - # reporting integrated testing availability
- # integrated testing events at sites funded for HIV testing (syphilis, GC, CT, hep C)
- % primary syphilis cases that know their HIV status
- % secondary syphilis cases that know their HIV status

Objective #2: Improve access to testing for HIV, hep C, and STIs

a. Increase and expand access to free and/or low-cost testing options
b. Adjust and expand the location of testing sites to improve access, particularly in underserved areas
c. Promote and expand the availability of HIV home test kits

d. Promote and pursue innovative options for home collections for STI and hep C testing
e. Improve the ease of getting tested by reducing barriers and delays to testing

Objective #2 Metrics:
- ➢ # funded testing sites with free or reduced cost testing
- ➢ # HIV home test kits distributed

STRATEGY E: EXAMPLES
Only collect required and necessary information
Remove outdated HIV consent documentation requirements
Consider social and structural determinants of health such as finances, stigma, transportation, child care
Build trust within communities
Increase education on the value and ease of getting tested

Objective #3: Increase the utilization of HIV, hep C, and STI testing to improve the percentage of people who know their HIV status and/or receive a STI or hep C diagnosis

a. Increase awareness around HIV, hep C, and STI testing and the benefit of diagnosis/knowledge of status
b. Increase the percentage of complete testing profiles to ensure a client who starts the testing process gets a diagnosis
c. Increase the percentage of HIV tests done with a status neutral approach, which leads to an "action" after each test
d. Educate more medical care providers and other agency staff to bring them up to speed on all topics that are sexual health, HIV, STI, Hep C and PrEP related
e. Increase follow up testing for persons with a negative result but experiencing ongoing exposure or risk
f. Increase testing sites offering co-location of sexual health services and resources
g. Reduce disparities in the knowledge of status and receipt of diagnosis
h. Provide incentives or motivators for people to get tested and know their status/diagnosis

STRATEGY C: EXPLANATION
A status neutral approach means people have access and support to stay on highly effective interventions, like PrEP and HIV treatment, regardless of their HIV status. Status neutral service begins with an HIV test—the pathway to prevention and treatment.

It can improve service efficiency, address HIV-related stigma, and improve health equity by better tackling social determinants of health regardless of HIV status.

Objective #3 Metrics:
- ➢ # HIV tests reported
- ➢ # hep C antibody tests reported
- ➢ # hep C RNA tests reported
- ➢ # hep C reflex tests reported
  - ○ If available, % of reported hep C tests that are reflex tests

GOAL #2: Decrease stigma for people living with or experiencing risk for HIV, STIs, and hep C

Objective #4: Increase awareness of HIV, STIs, and hep C through social media, marketing, and other mechanisms

a. Build general awareness about HIV, STIs, and hep C to normalize them
b. Develop and implement communications based on the intended audience to achieve improved messaging and uptake
c. Ensure and support persons with lived experience to be involved in development and implementation of campaigns, surveys, media, etc.
d. Ask and support people in the community to share their story with HIV, hep C, or STIs
e. Address misinformation and health care mistrust
f. Allow for more flexibility in the types of social media & marketing used to build awareness
g. Pursue and provide more financial support for social media and marketing efforts

STRATEGY B: EXAMPLES
Ensure messages are crafted with cultural humility and are culturally appropriate
Make sure images are representative of many populations and experiences
Provide more facts-based and educational messaging → don't be vague!
Take a harm reduction approach to messaging
Use motivational interviewing techniques
Use appropriate and current language, terms, and slang
Recognize that STIs and HIV are still taboo within some communities

Objective #4 Metrics:
- ➢ 100% of state-funded awareness and marketing activities include persons with lived experience
- ➢ # awareness campaigns or social media campaigns initiated and/or implemented
  - ○ # people reached

Objective #5: Increase non-traditional and syndemic partners to improve public awareness of and education about HIV, STIs, and hep C

a. Be more innovative in how we collaborate with and attract non-traditional and syndemic partners
b. Reach out to partners that already have relationships with their own clients who we don't have access to
c. Engage community members to provide "boots on the ground" messaging about HIV, STIs, and hep C
d. Train frontline staff about HIV, STIs, and hep C at organizations where people with or experiencing risk for HIV, STI, Hep C receive services
e. Support and implement more social and support groups, and encourage them to discuss HIV, hep C, and STIs

STRATEGY A: EXAMPLES

Incorporate incentives for partners to engage with our programs
Provide support for partners to participate in programs, attend training, and raise their own awareness of HIV, STIs, and hep C
Offer more "quick hits" options for partners to share facts about HIV, STIs, and hep C
Better communicate the value of collaboration to potential partners
Consider partnering with agencies that meet people at unique places, events, or experiences - not just on demographic groups!

Objective #5 Metrics:

- # agencies/partners engaged in HIV, STI, hep C education and awareness activities
  - # who are new to this work

Objective #6: Improve HIV/STI partner services outcomes

a. Increase capacity building opportunities and support for entities providing partner services
b. Educate more providers on what to do when their patients test positive, especially for HIV, in order to prepare patients for partner services
c. Incentivize, educate, and support the original patient to provide information
d. Leverage lessons learned from COVID-19 contact tracing and case investigations
e. Improve timeliness and quality of HIV/STI case investigations
f. Increase status neutral messaging used during partner services activities
g. Ensure access to expedited partner therapy (EPT)
h. Conduct capacity building for the state hep C team to prepare for their own case investigations

STRATEGY C: EXPLANATION

Due to HIV-related stigma and discrimination against the LGBTQ+ community, people with and impacted by HIV may have concerns about sharing HIV-related information with a health department staff member during partner services activities.

Building trust with potential recipients of partner services is essential to improving the outcomes of partner services.

Objective #6 Metrics:

- Partner services metrics for HIV:
  - # newly diagnosed index patients eligible for partner services interview
  - # partners named
  - # partners notifiable
  - # partners notified
  - # partners tested
  - Ratio partners named per newly diagnosed index patient interviewed

- ➢ Partner services metrics for STI:
  - Total # of syphilis cases interviewed
    - Total # of syphilis cases interviewed among pregnant females under 45
  - # partners initiated (named)
  - # partners tested within 30 days of index patient's test
  - # of partners treated (preventively or for infection) within 30 days of index patient's test or treatment index
  - # of new cases of syphilis found through partner services

DIAGNOSE

OUTCOMES

- Increase knowledge of HIV status to 95% *(2019: 83.5%*)*

**Baseline data from AHEAD EHE Dashboard*

KEY PARTNERS

- State health department
- County health departments
- Tribal health departments
- Community-based organizations
- Medical providers, clinics, and FQHCs
- Academic institutions and partners
- Marketing partners
- Persons with lived experience or experiencing risk for HIV, STIs, or hep C

POTENTIAL FUNDING RESOURCES

- CDC
- HRSA
- IHS
- SAMHSA

MONITORING DATA SOURCES*

- ADHS HIV Prevention Data
- ADHS HIV Surveillance
- ADHS STI Control Data
- ADHS Hepatitis C Surveillance

*See Data Sharing & Use narrative for more information.

PREVENT

GOAL #1: Reduce new transmissions of HIV, hep C, and STIs

Objective #1: Improve and expand PrEP coverage

a. Increase equitable access and reduce disparities to PrEP services by making it easier to access
b. Build system capacity to offer PrEP services
c. Assist clients to overcome barriers to staying on PrEP to improve retention and support clients to maintain coverage
d. Improve and broaden equitable awareness of PrEP services among persons experiencing risk for HIV
e. Consider data projects to better understand PrEP use, impact, and equity
f. Increase and promote alternative forms of PrEP
g. Improve PrEP referral processes following a negative HIV test
h. Provide more comprehensive education to clients and agencies about PrEP to address misinformation, misconceptions, and stigma

STRATEGY F: EXPLANATION

Alternative forms of PrEP include on-demand (or "2-1-1") PrEP and injectable PrEP. There are expectations for the approval of additional forms and schedules of PrEP in upcoming years.

STRATEGY C: EXAMPLES

Maintain and expand PrEP lab support to cover costs
Increase availability of PrEP appointments, including weekend and evening hours
Help clients understand what their insurance does and does not cover
Provide PrEP and PrEP navigation services at non-traditional locations, such as mobile vans or places frequented by people who use drugs
Encourage telehealth for PrEP initiation and follow up
Consider an incentive program for PrEP retention
Consider the value of PrEP retention case managers to boost PrEP retention

Remember: consider equity in ALL of our work to reduce barriers to PrEP!

Objective #1 Metrics:

- Increase % of PrEP linkage after a negative HIV test
- # clients engaged in PrEP navigation services
- # clients who received a prescription for PrEP
- # clients receiving PrEP lab support

Objective #2: Expand access to syringe services programs (SSPs) and harm reduction services

a. Increase access by increasing the number and geographic coverage of SSPs and harm reduction services
b. Provide capacity building for new and existing SSPs to adopt and implement best practices and emerging standards of care

c. Increase awareness, resources, and education to assure drug user health, promote SSPs, and reduce stigma
d. Build more wrap around services & referrals into SSPs and harm reduction entry points
e. Ensure better access to SSPs for priority populations, especially in underserved areas
f. Enhance HIV, STI, and hep C testing and prevention services among people who use drugs
g. Review and update programs and policies within statewide HIV/STI/Hep C prevention and care systems to ensure they align with harm reduction approaches

STRATEGY B: EXAMPLES

Ensure access in all geographic areas, including rural regions
Use evidence-based mechanisms, such as needs-based syringe distribution
Limit collection of unnecessary personal and identifiable data
Consider mail-based options
Support development of data collection mechanisms for monitoring and evaluation
Provide training on providing destigmatizing services
Promote hiring SSP staff or recruiting SSP volunteers with lived experience

Objective #2 Metrics:

- # SSPs/harm reduction service locations
- # training events on harm reduction or drug user health
  - If available, # of participants

Objective #3: Improve and expand sexual health prevention mechanisms

a. Take a sex positive approach to improve how we talk about sex in our training, work, and education
b. Improve and expand PEP awareness and use
c. Maintain access to condoms, lubrication, and other barrier methods
d. Provide and promote more education & awareness of U=U for HIV
e. Emphasize preventative health in general, which will lead to improved sexual health
f. Be innovative and timely in response to emerging sexual health trends
g. Increase prevention strategies and evidence-based sexual health education at all levels and ages, and pursue collaborations with local organization to ensure access to sexual health services and resources

STRATEGY G: EXAMPLES

Mobile services (e.g. mobile vans)
Maternal and child health programs
Foster care programs
School-based or school-focused sexual health clinics
School-based sexual health clinics
College campuses
Correctional systems
Local governments
Community leaders

Objective #3 Metrics:

- # training events on sex positivity or sexual health
  - If available, # of participants

GOAL #2: Improve prevention efforts among priority populations

Objective #4: Reduce preventable cases of perinatal hep c and syphilis among pregnant persons

a. Increase accessibility for persons diagnosed with hep C and syphilis to receive proper care/treatment.
b. Build general awareness of STIs/hep C among pregnant or soon-to-be pregnant persons
c. Provide additional education for medical providers about perinatal hep C and STI burden and risks, and support them to have more effective and non-judgmental discussions with patients
d. Ensure that efforts include ALL persons who can get pregnant, not just cis females
e. Conduct more targeted testing for hep C, STIs, and HIV among pregnant persons
f. Build our partner networks among other agencies that serve pregnant persons and persons of childbearing age
g. Ensure that newborns are tested, diagnosed, and treated for hepatitis C and congenital syphilis according to best practices
h. Build surveillance capacity to track and analyze perinatal hep C

STRATEGY A: EXAMPLES
Increase resources for providers to access or stock BIC for syphilis treatment
Consider accessibility for border communities
Provide care/treatment in multiple languages, such as Spanish
Educate persons about the full course of their treatment, and the need to complete treatment as prescribed

Objective #4 Metrics:

- Reduced disparities in rates of STI diagnoses by priority populations
- # of pregnant females under 45 with syphilis
- # and % of females under 45 with syphilis who were adequately treated
- Ratio of prevented/averted congenital syphilis cases
- # cases perinatal hep C reported

Objective #5: Improve collection and use of data to enhance our understanding of who is experiencing risk for HIV, hep C, and STIs

a. Explore how to have our data be more representative of clients' demographic "realities"
b. Establish our priority populations and geographic targets based on data
c. Improve data quality for new diagnoses of HIV, hep C, and STIs to understand the impact of testing and prevention activities
d. Explore and encourage syndemic data projects and innovative pilot programs
e. Collaborate with research specialists and other teams for data access, expertise, and sharing
f. Develop mechanisms for ongoing community engagement and bidirectional data sharing opportunities

STRATEGY D: EXAMPLES
Improved options for collecting data on sexual orientation, gender identity, race and ethnicity, and housing status
Increased options for self-identification and intersectional identities
Consider community considerations and interests when making changes to data collection mechanisms and protocols

Objective #5 Metrics:
- ➢ # data projects undertaken
- ➢ Improved SO/GI data for HIV, STI, and hep C reporting

Objective #6: Reduce disparities in new transmissions among priority populations

a. Implement prevention strategies that address clients' intersectional risks as a result of their identity, circumstances, and experiences
b. Address social and structural determinants of health and co-occurring conditions that impede access to services and exacerbate disparities
c. Ensure that representatives and partners from priority populations are involved during plan implementation and monitoring
d. Track new diagnoses (HIV, hep C, STIs) by priority populations to set baselines, identify trends, and monitor progress goals
e. Recognize the importance of trauma and trauma-informed approaches by taking more holistic approaches to prevention
f. Develop communication strategies to proactively prevent additional stigma to heavily stigmatized communities

STRATEGY A: EXAMPLES
Intersectional risks may include:
- Gender identity
- Race and ethnicity
- Age and generational gaps
- Low health literacy
- Low tech literacy
- Non-English speakers
- Substance use
- Housing instability & homelessness
- Incarceration
- Foster care involvement
- Engagement in sex work
- Immigration status and documentation
- Refugee status
- Cultural preferences and beliefs
- Rural and frontier regions

Objective #6 Metrics:
- ➢ Reduced disparities in rates of new HIV diagnoses by priority populations
- ➢ Reduced disparities in PrEP coverage by race/ethnicity and gender identity
- ➢ Reduced disparities in hep C diagnoses by priority pops

PREVENT

OUTCOMES

- Reduce new HIV infections by 75% from 2017 baseline *(2017: 800 new infections*)*
- Reduce new HIV diagnoses by 75% from 2017 baseline *(2017: 726 new diagnoses**)*
- Increase PrEP coverage to 50% *(2020: 19.7%*)*

**Baseline data from AHEAD EHE Dashboard*
***Baseline data from ADHS HIV Surveillance*

KEY PARTNERS

- State health department
- County health departments
- Tribal health departments
- Syringe services programs (SSPs) and harm reduction organizations
- Pregnancy and child health partners
- Community-based organizations
- Medical providers, clinics, and FQHCs
- Academic institutions and partners
- Marketing partners
- Persons with lived experience or experiencing risk for HIV, STIs, or hep C
- Persons who use or have used dugs

POTENTIAL FUNDING RESOURCES

- CDC
- HRSA
- IHS
- SAMHSA

MONITORING DATA SOURCES*

- ADHS HIV Prevention Data
- ADHS HIV Surveillance
- ADHS STI Control Data
- ADHS Hepatitis C Surveillance

*See Data Sharing & Use narrative for more information.

TREAT

GOAL #1: Rapidly and effectively link all persons diagnosed with HIV, hep C, or STIs to care/cure

Objective #1: Improve linkage to care after a new HIV diagnosis or returning to care

a. Reduce disparities in linkage to care
b. Increase the reach and accessibility of Rapid Start programming, including at non-HIV agencies
c. Provide more education for HIV testing sites to support them in getting persons linked to care, reducing stigma, and increasing awareness of U=U
d. Improve linkage to care for at-home HIV tests
e. Improve re-linkage to care, including a unified definition of who is "out of care" and/or "returning to care"
f. Implement more activities/programs to link persons to supportive services, not just medical care & medications
g. Increase and improve early intervention services (EIS) efforts using status neutral methods
h. Educate all clients about HIV care during a new diagnosis to reduce client stress and stigma

STRATEGY A: EXAMPLES

Provide low-barrier access to HIV treatment
Reduce stigma, particularly for persons of color and gender expansive persons
Provide linkage to care in Spanish and other non-English languages, or provide translation and interpretation services
Improve processes to ensure that persons leaving incarceration are linked to care upon release
Improve linkage in rural communities with limited "rapid start" infrastructure
Train staff in tribal areas to implement linkage to care
Provide medications at initial visit before waiting for additional labs, to reduce cost burdens to link to care
Better educate persons newly diagnosed with HIV on what linkage to care includes, and the value of HIV treatment to achieve viral suppression

Objective #1 Metrics:

- Increase linkage to care within 1 month of HIV diagnosis to 95%
- 95% of Rapid Start clients linked to care within 5 days
- # (or %) of people with HIV identified as out of care that are re-linked to care

Objective #2: Improve the navigation pathway from hep C diagnosis to cure

a. Implement and use navigation activities to connect people living with hep C to medical treatment as rapidly as possible
b. Support providers by providing education & support around hep C screening & treatment best practices
c. Increase the number of providers and primary care settings offering hep C treatment with DAAs (direct acting antivirals)
d. Implement clinical services in high-impact and under-served settings to increase access to equitable care
e. Implement pathways to community resources for supportive services
f. Build a data system to track navigation to treatment and enable analysis & quality improvement
g. Address and educate persons on systems-level policies and barriers to hep C treatment

STRATEGY G: EXAMPLES
Vaccination requirements
Sobriety restrictions
Prior authorizations
Specialist requirements
Required lab panels
Cost and insurance coverage

Objective #2 Metrics:

- Hep C navigation program initiated
- # people engaged in hep C navigation services
- % of hep C diagnoses linked to care
- # of providers doing hep C treatment

Objective #3: Improve accessibility and awareness of treatment and navigation options for HIV, hep C, and STIs

a. Decrease barriers to accessing treatment
b. Help clients and agencies navigate the costs of treatment, such as appointments, medications, and labs
c. Conduct more awareness building & coordination to enable clients and staff to know what exists and who can do what
d. Encourage and focus on integration of an agency or site's ability to do "linkage" after they do a test for HIV, STIs or hep C
e. Improve screening processes for enrollment and getting persons enrolled into benefits (Ryan White, Medicaid, insurance, etc.)

STRATEGY A: EXAMPLES
Increase reduced-cost or free treatment options
More options for "immediate" linkage to a medical appointment
Reduce requirements for paperwork and data collection to initiate linkage to care
Streamline benefits screening and enrollment processes
Address transportation issues and needs
Increase telehealth options
Increase personal choice of pharmacy for medication pick-up
Destigmatize linkage to care, especially using a status neutral approach

Remember: All forms and mechanisms of treatment should be available to all persons, regardless of insurance or immigration status.

f. Provide syndemic training to more providers and supportive staff on HIV/STI/Hep C treatment best practices
g. Ensure that persons conducting at-home testing are aware of and able to access appropriate treatment services

Objective #3 Metrics:

- # providers trained on treatment best practices (HIV rapid start, syphilis treatment, hep C treatment)
- Among early syphilis cases, % treated with the recommended treatment (injection of BPG) within 14 days of specimen collection
- Median number of days to first dose of treatment (any) for all adult syphilis cases at all stages

GOAL #2: Keep all people with HIV in care, and cure all people diagnosed with hep C and STIs

Objective #4: Increase the percentage of people with HIV who are virally suppressed

a. Identify, engage, or re-engage people with HIV who are not in care or not virally suppressed
b. Increase adherence to HIV treatment to achieve and maintain long-term viral suppression
c. Reduce disparities in viral suppression
d. Build U=U awareness to encourage persons with HIV to stay virally suppressed
e. Provide and promote more options/coverage for medication
f. Make it easier to access treatment and attend appointments
g. Coordinate with systems serving people with HIV, including AHCCCS (state Medicaid), for efforts to increase viral suppression rates

STRATEGY D: EXPLANATION

U=U is an acronym for **Undetectable = Untransmittable.** This phrase refers to the many studies showing that when a person with HIV is virally suppressed ("undetectable"), they do not transmit HIV to their sexual partners ("untransmittable"). People with HIV can maintain viral suppression by taking HIV medications.

U=U means that people with HIV who are virally suppressed are also helping to prevent ongoing transmission of HIV, which is called "treatment as prevention." U=U also contributes to reduced stigma and fear of HIV.

Objective #4 Metrics:

- Increase viral suppression among people with diagnosed HIV to 95% among priority populations

Objective #5: Increase the percentage of people with HIV who stay in care, and the percentage of people with hep C and STIs who get to cure

a. Improve retention and adherence to care/treatment by addressing social and structural determinants of health that act as barriers to care/cure
b. Increase access to treatment by making it more physically accessible
c. Track and reduce disparities in who stays in care
d. Improve referrals and follow up for behavioral health and mental health services
e. Recognize the value of and need for support groups for people with HIV
f. Incentivize people getting into and staying in care
g. Increase availability of benefits and navigation services
h. Promote and support HIV case management and care coordination services, especially for Ryan White clients

STRATEGY A: EXAMPLES
Housing instability or homelessness
Food insecurity and nutrition
Employment
Poverty
Substance use
Behavioral health
Mental health
Transportation
Financial literacy
Health literacy
Child care
Reliance on smartphones and internet access

Objective #5 Metrics:
- % of people with HIV retained in care
- Reduce # of hepatitis-C related deaths
- % of persons diagnosed with syphilis that were adequately treated

Objective #6: Adjust treatment and care systems to be more client-centered

a. Adjust our systems to “make it easier” to get things done
b. Strengthen client capacity and confidence to navigate care systems
c. Encourage co-location of services to increase the availability of integrated services

STRATEGY A: EXAMPLES
Increase options for telehealth appointments
Provide resources to engage virtually (i.e., headsets, internet access, phones, tablets)
Promote collaboration to streamline efforts across agencies
Increase access to mail-order medications
Increase flexibility of appointment locations and times
Reduce paperwork for benefits enrollment and renewals
Improve staff consistency to improve care coordination
Address stigma and discrimination within medical settings that pushes clients away from pursuing care
Improve communication to clients about changes to programs, eligibility requirements, renewal processes, and staff contacts

d. Provide training to providers, case managers, pharmacy staff, and other agency staff on how to better serve clients
e. Build capacity among clients and agencies to more effectively use digital and virtual platforms
f. Expand and support peer programs
g. Be proactive in adapting our treatment and care systems to changing client demographics, such as the aging HIV population and increasing hep C diagnoses among young persons
h. Conduct evaluations of care systems, and implement and monitor data-driven improvements

Objective #6 Metrics:

- # subrecipients/funded agencies using telehealth
- # of clients who complete skill building programs (Leadership Academy, NDU, etc.)
- Reduce average time to RW and/or ADAP approval

TREAT

OUTCOMES

- Increase linkage to care within 1 month of HIV diagnosis to 95% *(2021: 80.7%*)*
- Increase viral suppression among people with diagnosed HIV to 95% *(2021: 65.0%*)*

**Baseline data from ADHS HIV Surveillance*

KEY PARTNERS

- State health department
- County health departments
- Tribal health departments
- Ryan White Parts A, B, C, D, and F
- Arizona Health Care Cost Containment System (AHCCCS)
- Social service organizations
- Community-based organizations
- Medical providers, clinics, and FQHCs
- Academic institutions and partners
- Persons with lived experience or experiencing risk for HIV, STIs, or hep C
- Peer networks and support groups

POTENTIAL FUNDING RESOURCES

- CDC
- HRSA
- IHS
- SAMHSA
- VA

MONITORING DATA SOURCES:

- ADHS HIV Prevention Data
- ADHS HIV Surveillance
- ADHS Ryan White Part B
- ADHS AIDS Drug Assistance Program (ADAP)
- Maricopa County Department of Public Health - Ryan White Part A (RWPA)
- ADHS STI Control Data
- ADHS Hepatitis C Surveillance
- AHDS Hepatitis C Navigation Program

*See Data Sharing & Use narrative for more information.

RESPOND

GOAL #1: Build capacity for CDR (cluster detection & response) and surveillance

Objective #1: Implement and continue to advance CDR for HIV

a. Develop and maintain a jurisdiction wide HIV cluster detection and response plan
b. Increase capacity for rapid detection of active HIV transmission clusters
c. Increase capacity to respond to active HIV transmission clusters and outbreaks
d. Consider potential for integration of hep C and STIs into CDR efforts

STRATEGY A: EXPLANATION

HIV cluster detection and response (CDR) identifies communities affected by rapid HIV transmission. It helps public health agencies and communities identify where to boost HIV prevention and treatment services and programs by identifying "clusters" of new HIV diagnoses.

Each state is responsible for maintaining its own CDR plan, to ensure steps and partners are in place to respond to any identified clusters of concern.

However, CDR has raised concerns around informed consent and bodily autonomy. Working with the community to build trust is vital to achieving goals related to CDR.

Objective #1 Metrics:

- CDR outbreak plan maintained
- % of HIV molecular labs performed and reported
- CDR metrics:
  - # clusters investigated
  - # clusters of concern identified
  - # escalated clusters initiated
  - # clusters closed out
- Hep C outbreak plan developed
- STI outbreak plan updated
- STI outbreak plan maintained

Objective #2: Improve awareness of CDR activities for HIV

a. Improve public awareness of how and why we collect data, and how it is shared and used
b. Increase public awareness of CDR plans and activities
c. Emphasize the need for community buy-in from, and meaningful involvement of, persons with lived experience and affected by CDR
d. Increase the number and diversity of people trained on and informed about CDR
e. Increase the number of partners included in CDR activities
f. Educate providers on the value of molecular labs and CDR

STRATEGY F: EXPLANATION

Molecular data analysis can help to rapidly and comprehensively identify HIV clusters or outbreaks. Health care providers conduct drug resistance testing as a routine part of clinical care to find the best HIV medication for their patients. This testing generates genetic sequences from the virus (NOT the person).

When these sequences are submitted to the health department, they can be applied to cluster detection and response activities. Health departments can analyze these sequences to identify groups, or clusters, of similar HIV sequences to help agencies better target prevention and care resources.

Objective #2 Metrics:

- # CDR training events held
  - If available, # of people trained
- # partners involved in CDR activities
- # CDR awareness events held
  - If available, # of participants

Objective #3: Improve and update surveillance systems and processes for HIV, hep C, and STIs

a. Improve surveillance and epidemiology staff capacity
b. Encourage and increase bi-directional communication data
c. Strive to provide and disseminate more real-time data for tracking plan progress
d. Explore quality metrics for data to guide quality improvement efforts and equity efforts
e. Strengthen public health system-level capacity and programming for hep C data and surveillance
f. Pursue more syndemic data opportunities among HIV, STIs, hep C, and other conditions

STRATEGY F: EXAMPLES

Using STI diagnoses to prompt PrEP referrals
Understanding HIV and hep C co-infection
Improving HIV testing among persons with STIs
Building capacity to better understand other conditions, such as substance use and behavioral health, with regards to HIV, STI, and hep C status
Better use data to guide action, and to monitor and implement state and local plans

Objective #3 Metrics:

- # surveillance projects/improvements initiated and completed
- # data sharing agreements or partnerships
- Hep C case investigations initiated

GOAL #2: Strengthen statewide HIV, STI, and hep C prevention & care systems

Objective #4: Enhance our syndemic partner network by strengthening existing partnerships and developing new partnerships

a. Increase collaboration (coordination) and multidisciplinary involvement in HIV, hep C, and STI programming
b. Expanding the number and diversity of partners conducting HIV, STI, and hep C prevention and care activities
c. Reimagine how we partner with other agencies, and what "partnership" entails
d. Integrate programs and planning to address the syndemic of HIV/STIs/Hep C and substance use and mental health disorders

STRATEGY C: EXAMPLES

Reimagine and expand who should be a part of our networks and our planning bodies
Develop a "tiers of engagement" approach to partnerships to organize differing levels of engagement
Consider community mobilization approaches
Find meaningful ways for tangential partners to be included in our work
Take more syndemic approaches to integration and collaboration
Better document our partnerships, and intentionally crosswalk partners across HIV, STI, and hep C programs

Objective #4 Metrics:

- # partners engaged in HIV, hep C, and STI efforts
  - # who are new to this work
- Partner analysis undertaken (e.g. crosswalk)
- # organizations funded to do care and prevention work

Objective #5: Increase development opportunities for the existing prevention and care workforce

a. Provide adequate and relevant training opportunities and resources
b. Improve training content, delivery, and sustainability
c. Reduce gaps in the existing workforce's capacity and knowledge by building capacity for implementing best practices for diagnosis, prevention, and treatment
d. Provide support for workforce members outside of training and skill building to increase retention and reduce burnout
e. Provide agencies with support for training, or encourage them to pursue additional support
f. Celebrate and amplify the diversity of our workforce by better supporting underrepresented workforce members
g. Conduct an assessment of systems-level forces and provider behaviors to identify training and/or support needs
h. Encourage and provide resources for agencies to train on and implement trauma-informed supervision and cultural humility

STRATEGY A: EXAMPLES

Aside from clinical and programmatic training on HIV, STI, and hep C prevention and care, we would also like to see training on:

- Substance and polysubstance use
- Substance use disorder (SUD) treatment
- Harm reduction and drug user health
- Trauma-informed approaches
- Health equity
- Sex positivity
- Cultural humility and cultural responsiveness
- Culturally and linguistically appropriate services (CLAS)
- Compassion fatigue, burnout prevention, and self-care
- Patient-centered care
- Hiring practices
- Phlebotomy

Additionally, there is a strong desire for cross-training opportunities.

Objective #5 Metrics:

- # training events held for existing workforce
  - If available, # of types of trainings or training topics
  - If available, # people trained to provide training

Objective #6: Enhance the workforce pipeline for people not yet included in the prevention and care workforce

a. Expand who is reached by and involved with community engagement efforts
b. Emphasize the need to treat community members as experts
c. Increase the percentage and/or number of new hires with lived experience and/or from priority populations
d. Find more successful and impactful mechanisms to include people with lived experience in meaningful and sustainable ways

STRATEGY D: EXAMPLES

Develop career paths, not just entry points
Provide support once persons are hired, not just during the hiring process
Pay people with lived experience for all of their work and expertise
Support professional development and training opportunities
Ensure that persons with lived experience have opportunities to pursue positions and skills outside of peer roles
Consider re-titling peer positions to not “out” persons during future interviews and job applications
Provide more mentorship opportunities
When adding a leadership role to a person’s workload, ensure that the workload is appropriately adjusted to match their new responsibility

e. Identify and support existing agencies composed of persons with lived experience and/or from priority populations
f. Engage, employ, and provide public leadership opportunities at all levels for persons with lived experience
g. Improve recruiting efforts conducted through educational/academic programs

Objective #6 Metrics:

- # of reported new hires at funded agencies with lived experience
- # of reported new hires at funded agencies from priority populations
- # training or education events held for community members

RESPOND
OUTCOMES - N/A
KEY PARTNERS - State health department - County health departments - Tribal health departments - Capacity building and training providers - Community-based organizations - Medical providers, clinics, and FQHCs - Academic institutions and partners - Marketing partners - Persons with lived experience or experiencing risk for HIV, STIs, or hep C
POTENTIAL FUNDING RESOURCES - CDC - HRSA - IHS
MONITORING DATA SOURCES: - ADHS HIV Prevention Data - ADHS HIV Surveillance - ADHS STI Control Data - ADHS Hepatitis C Surveillance *See Data Sharing & Use narrative for more information.

KEY POPULATIONS

The identification of key populations is with a recognition that persons hold complex and intersectional identities.

PRIORITY POPULATIONS

- ✓ Gay, bisexual, and other men who have sex with men (MSM), especially of color
- ✓ Young persons (ages 18-34), especially of color
- ✓ Gender expansive persons
- ✓ People who use or have used substances

GROUPS OF INTEREST

- ✓ Persons experiencing housing instability
- ✓ Persons with a history of incarceration
- ✓ Persons of color
- ✓ Persons of childbearing age or experiencing pregnancy
- ✓ Persons who don't speak English
- ✓ Tribal populations
- ✓ Persons aging with HIV (ages 50+)
- ✓ Persons experiencing mental health challenges

IF WE COULD, WE WOULD!

- Advocacy and legislative changes
  - Immigration policy and border agencies (e.g. ICE)
  - Decriminalization of substance use and harm reduction services
  - Reallocation or increase of public health & health service budgets to improve general health & access to basic needs
- Increasing housing units and housing programs
- Paying for PrEP medications & paying for supportive services for people on PrEP
- Increasing substance use disorder treatment and mental health service availability
- Encourage policy to support comprehensive sex education and the implementation of age- and developmentally-appropriate sexual health education for K-12
- Ensuring all persons within or being released from the correctional system are provided with HIV/STI/Hep C prevention and treatment, in accordance with protocol and best practices
- Bolder and more explicit messaging from state agencies around sexual health and drug use topics
- Additional funding for harm reduction supplies
- Increased programs for persons engaging in sex work
- Increased collaboration with agencies supporting persons who have experienced intimate partner violence and/or sexual violence
- Address the intersections of substance use and other determinants, including the need for harm reduction approaches at the policy and systems level