

ARIZONA HIV/STI/HEP C INTEGRATED PLAN

2022-2026



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INTRODUCTION

Many agencies and partners in Arizona have come together to develop this unified Integrated Plan. Additionally, the Integrated Plan has, for the first time, taken a syndemic approach by incorporating sexually transmitted infections (STIs) and hepatitis C (hep C) into its goals, objectives, and strategies.

The Integrated Plan is structured around the four Ending the HIV Epidemic (EHE) pillars: diagnose, prevent, treat, and respond. The plan was written over nearly two years of collaboration, community engagement, and iterative development of the goals, objectives, and strategies.

Due to the inclusion of HIV, STIs (chlamydia, gonorrhea, syphilis), and hep C in the plan, as well as the unified nature of all programs being represented in the plan’s development, this iteration of Arizona’s Integrated Plan takes a high-level approach. It is intended as a framework from which individual entities can develop more specific and action-driven plans. Additional information on suggested activities and considerations for each objective has been compiled into a companion document, which will be readily available to all local entities during the Integrated Plan’s implementation.

Each pillar includes a selection of SMART goals that are based on the National HIV/AIDS Strategy (NHAS). Since this plan was written by and for community, many objectives do not follow a SMART format. Additionally, most metrics included are process indicators instead of outcome measures, to recognize the need and desire to track actions within the state on a timelier basis than high-level outcomes can provide.

The Integrated Plan’s metrics also recognize that Arizona’s HIV, STI, and hep C surveillance systems are at varying levels of capacity, and that setting measurable data-informed SMART goals for a syndemic plan presents additional challenges. During the monitoring and evaluation process each year, SMART objectives may be developed for implementation, based on current objective-level metrics and local interest and need.

Aside from the goals, objectives, and strategies, the Integrated Plan also includes a vision, foundational approaches, key populations, and a list of “If We Could, We Would” out-of-scope strategies. Each objective is accompanied by one or more call out boxes, which provide additional explanation about or examples for one of that objective’s strategies.

VISION

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

PLAN AT-A-GLANCE



DIAGNOSE

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

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



PREVENT

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

GOAL #2: Improve prevention efforts among priority populations



TREAT

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

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



RESPOND

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

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

METRICS AT-A-GLANCE



DIAGNOSE

- By 2026, Arizona will increase knowledge of HIV status to 95%, from a baseline of 83.5% in 2019.*



PREVENT

- By 2026, Arizona will reduce new HIV infections by 75%, from a 2017 baseline of 800 new infections.*
- By 2026, Arizona will reduce new HIV diagnoses by 75%, from a 2017 baseline of 726 new diagnoses.**
- By 2026, Arizona will increase PrEP coverage to 50%, from a baseline of 25.5% in 2021.*



TREAT

- By 2026, Arizona will increase linkage to care within 1 month of HIV diagnosis to 95%, from a baseline of 80.7% in 2021.**
- By 2026, Arizona will increase viral suppression among people diagnosed with HIV to 95%, from a baseline of 65.0% in 2021.**
- By 2026, Arizona will increase viral suppression among people diagnosed with HIV to 95%, among priority populations.



RESPOND

- By 2026, Arizona will continue to maintain a jurisdiction wide HIV CDR plan.
- By 2026, Arizona will develop and continue to maintain an STI outbreak plan.
- By 2026, Arizona will develop and continue to maintain a hepatitis C outbreak plan.

*Baseline data from AHEAD EHE Dashboard

**Baseline data from ADHS HIV Surveillance

FOUNDATIONAL APPROACHES

The foundational approaches represent the priorities of all Arizonans involved in developing this plan. They are overarching approaches that are vital to all efforts to end the epidemics of HIV, STIs, and hep C. They are included at the start of the Integrated Plan to ground the goals, objectives, and strategies in what matters to the community. Each foundational approach was identified through survey results, focus group data, community engagement sessions, and planning body input.

- ✓ 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

- Racism, discrimination, and white supremacy
- Transphobia
- Homophobia
- Xenophobia and anti-immigration
- “-isms”
- Inequalities and disparities
- Stigma and biases

KEY POPULATIONS

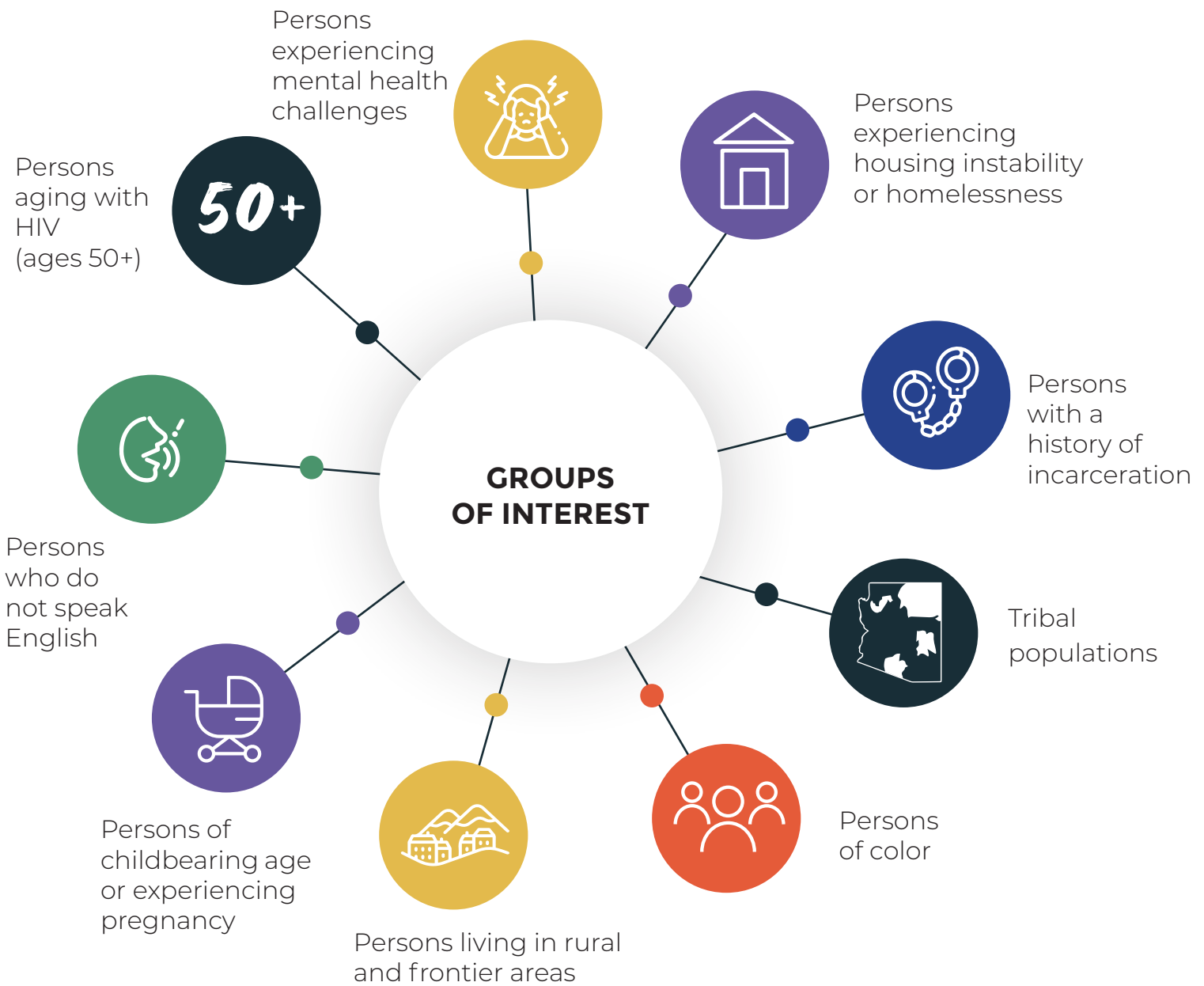
The priority populations and groups of interest are intended to guide programs and partners in their work throughout the pillars. Priority populations are those identified through surveillance data as being more greatly impacted by HIV, STIs, and hep C. Groups of interest are additional populations that were identified through statewide surveys, focus groups, community engagement sessions, and planning body input as needing increased support or attention. Most of the groups of interest are more heavily impacted by health inequities, social determinants of health, and environmental factors, all of which create greater barriers to accessing high-quality and equitable prevention and care services. The identification and inclusion of key populations in the Integrated Plan is done with a recognition that persons hold complex and intersectional identities.



GENDER EXPANSIVE EXPLANATION

Gender expansive is a term used to encompass a variety of gender identities and experiences. This includes, but is not limited to, transgender persons, nonbinary persons, two-spirit persons, and other identities related to gender. It does not refer to sexual preference or sexual orientation.

KEY POPULATIONS



IF WE COULD, WE WOULD!

A variety of strategies were identified during the planning process that fall outside of the scope of Arizona’s HIV, STI, and hep C programs. Instead of being incorporated into the pillars, they are listed as “If we could, we would” strategies. They are included to encourage external partners to incorporate these strategies into their own efforts.

- ✓ Advocacy and legislative changes related to:
 - Decriminalization of substance use and harm reduction services
 - Immigration policy and border agencies (e.g. ICE)
 - Reallocation to or increase of public health and health service budgets to improve general health and access to basic needs
- ✓ Increased housing units and housing programs
- ✓ Paying for PrEP/PEP medications and paying for supportive services for people on PrEP
- ✓ Increased substance use disorder treatment and mental health service availability
- ✓ Encouraging 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 and ability to pay for comprehensive 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
- ✓ Addressing the intersections of substance use and other determinants, including the need for harm reduction approaches at the policy and systems level

DIAGNOSE



GOAL #1

Improve and expand testing for HIV, STIs, and hep C

OBJECTIVE

1

Increase the availability of HIV, STI, and hep C 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, STI, and hep C testing
- e. Provide support to implement best practices for HIV, STI, and hep C 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
- Mobile testing
- Pop-up sites
- Bars
- Bath houses
- Pharmacies
- Homeless shelters
- Syringe services programs (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

DIAGNOSE



GOAL #1

Improve and expand testing for HIV, STIs, and hep C

OBJECTIVE

2

Improve access to testing for HIV, STIs, and hep C

- 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**



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, etc.
- Build trust within communities
- Increase education on the value and ease of getting tested

DIAGNOSE



GOAL #1

Improve and expand testing for HIV, STIs, and hep C

OBJECTIVE

3

Increase the utilization of HIV, STI, and hep C 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, STI, and hep C 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 related to sexual health, HIV, STIs, hep C and PrEP
- 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.

DIAGNOSE



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, STIs, or hep C
- e. Address misinformation and health care mistrust
- f. Allow for more flexibility in the types of social media and 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 HIV and STIs are still taboo within some communities

DIAGNOSE



GOAL #2

Decrease stigma for people living with or experiencing risk for HIV, STIs, and hep C

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, STIs, and hep C

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 demographic groups!

DIAGNOSE



GOAL #2

Decrease stigma for people living with or experiencing risk for HIV, STIs, and hep C

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 and STIs may have concerns about sharing HIV- and STI-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.

PREVENT



GOAL #1

Reduce new transmissions of HIV, STIs, and hep C

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 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

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.

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

PREVENT



GOAL #1

Reduce new transmissions of HIV, STIs, and hep C

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 and 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 areas
- 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 staff or recruiting volunteers with lived experience

PREVENT



GOAL #1

Reduce new transmissions of HIV, STIs, and hep C

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 and 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 organizations 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
- College campuses
- Correctional systems
- Local governments
- Community leaders



PREVENT



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 pregnant persons diagnosed with hep C and syphilis to receive proper care/treatment.**
- b. Build general awareness of hep C and STIs 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 their patients
- d. Ensure that efforts include ALL persons who can get pregnant, not just cisgender 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 and young children are tested, diagnosed, and treated for hep 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 bicillin (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

PREVENT



GOAL #2

Improve prevention efforts among priority populations

OBJECTIVE

5

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

- 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, STIs, and hep C 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 A: EXAMPLES

- Improved options for collecting data on sexual orientation and gender identity (SO/GI), 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

PREVENT



GOAL #2

Improve prevention efforts among priority populations

OBJECTIVE

6

Reduce disparities in new HIV, STI, and hep C transmissions among priority populations

- a. **Implement prevention strategies that address clients' intersectional risks as a result of their identities, 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, STIs, hep C) 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
- Sexual orientation
- Race and ethnicity
- Age and generational gaps
- Low health literacy
- Low tech literacy
- Non-English speakers
- Substance use
- Housing instability and homelessness
- Incarceration
- Foster care involvement
- Engagement in sex work
- Immigration status and documentation
- Refugee status
- Cultural preferences and beliefs
- Rural and frontier areas

TREAT



GOAL #1

Rapidly and effectively link all persons diagnosed with HIV, STIs, or hep C 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 and medications
- g. Increase and improve early intervention services (EIS) efforts using status neutral methods
- h. Educate all clients about HIV care during a new HIV 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 of linkage 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

TREAT



GOAL #1

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

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 and support around hep C screening and treatment best practices
- c. Increase the number of providers and primary care settings offering hep C treatment with direct acting antivirals (DAAs)
- d. Implement clinical services in high-impact and underserved settings to increase access to equitable care
- e. Implement pathways to community resources for supportive services
- f. Build a data system to track hep C navigation to treatment and enable analysis and 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



TREAT



GOAL #1

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

OBJECTIVE

3

Improve accessibility and awareness of treatment and navigation options for HIV, STIs, and hep C

- a. **Decrease barriers to accessing treatment**
- b. Help clients and agencies navigate the costs of treatment, such as the costs of appointments, medications, and labs
- c. Conduct more awareness building and 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.)
- 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



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 by using a status neutral approach

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

TREAT



GOAL #2

Keep all people with HIV in care, and cure all people diagnosed with STIs and hep C

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 medications
- f. Make it easier to access treatment and attend appointments
- g. Coordinate with systems serving people with HIV, including AHCCCS (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. U=U also contributes to reduced stigma and fear of HIV.

TREAT



GOAL #2

Keep all people with HIV in care, and cure all people diagnosed with STIs and hep C

OBJECTIVE

5

Increase the percentage of people with HIV who stay in care, and the percentage of people with STIs and hep C 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

TREAT



GOAL #2

Keep all people with HIV in care, and cure all people diagnosed with STIs and hep C

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
- 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

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 push clients away from pursuing care
- Improve communication to clients about changes to programs, eligibility requirements, renewal processes, and staff contacts

RESPOND



GOAL #1

Build capacity for CDR (cluster detection and response) and surveillance

OBJECTIVE

1

Implement and continue to advance cluster detection and response (CDR) for HIV

- a. **Develop and maintain a jurisdiction wide HIV CDR 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 STIs and hep C 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.

RESPOND



GOAL #1

Build capacity for CDR (cluster detection and response) and surveillance

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.

RESPOND



GOAL #1

Build capacity for CDR (cluster detection and response) and surveillance

OBJECTIVE

3

Improve and update surveillance systems and processes for HIV, STIs, and hep C

- a. Improve surveillance and epidemiology staff capacity
- b. Encourage and increase bi-directional communication of 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
- Better understanding HIV and hep C co-infection
- Improving HIV testing among persons diagnosed 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

RESPOND



GOAL #2

Strengthen statewide HIV, STI, and hep C prevention and 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, STI, and hep C programming
- b. Expand 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

RESPOND



GOAL #2

Strengthen statewide HIV, STI, and hep C prevention and care systems

OBJECTIVE

5

Increase development opportunities for the existing HIV/STI/hep C 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 HIV/STI/hep C 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, STIs, and hep C prevention and care, there is interest in the following training topics. Additionally, there is a strong desire for cross-training opportunities.

- Substance use and 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
- Status neutral (HIV testing to PrEP/PEP and HIV medications)

RESPOND



GOAL #2

Strengthen statewide HIV, STI, and hep C prevention and care systems

OBJECTIVE

6

Enhance the workforce pipeline for people not yet included in the HIV/STI/hep C 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
- 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



STRATEGY A: 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 applications
- Provide more mentorship opportunities
- Ensure that workloads are appropriately adjusted when persons take on additional roles and leadership opportunities



**Thank
you.**

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