

ENDING THE HIV EPIDEMIC

Prepared by the Arizona Department of Health Services' HIV
Prevention Program and the Ryan White Part B Care and Services
Program

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ARIZONA DEPARTMENT
OF HEALTH SERVICES

Introduction

The Ending the HIV Epidemic (EHE) plan for Maricopa County, AZ, was built upon the voices of our community members. Although our plan is structured around the four pillars of Diagnose, Treat, Prevent, and Respond, our community members shared many common themes, concerns, and opportunities that did not fall within a particular pillar. These themes, concerns, and opportunities impact all activities within the pillars, and are included in this plan as a recognition of their importance to our work in Maricopa County, and more widely in the state of Arizona.

Additionally, we recognize that the EHE plan is not the only plan for reducing the impacts of HIV in Maricopa County and Arizona. By engaging and communicating with other agencies working on HIV in throughout the state, we have enhanced this plan's alignment with the [2017-2021 Integrated HIV Prevention and Care Plan for Arizona](#) (integrated jurisdictional plan) and the EHE plan created and implemented by the Ryan White Part A Phoenix EMA. We will strive to continue aligning our plans and efforts with the integrated jurisdictional plan, the Ryan White Part A EHE plan, targeted plans created by agencies focusing on certain activities and populations, the City of Phoenix Fast Track Cities priorities, and the EHE activities supported by the Indian Health Service.

Themes, Concerns, and Opportunities

The following themes, concerns, and opportunities are those that our community members consider critical to our work to end the HIV epidemic in Maricopa County.

COVID-19 Pandemic

The impact of COVID-19 on HIV prevention and care services, and on individuals both at-risk and living with HIV, has been unprecedented. As COVID-19 continues to disrupt services and pose challenges to physical, mental, social, and economic wellbeing of Arizonans, we must continue to adapt our expectations and priorities. We will remain flexible, and allow our service providers the space to adjust their work to best meet their needs and the needs of their clients.

Although current data suggests that people living with HIV who are virally suppressed are not at elevated risk for COVID-19 or its complications, we must recognize the fear of COVID-19 among those living with HIV, and the trauma caused by COVID-19's similarities to the HIV epidemic during the last decades of the 20th century.

Although COVID-19 has caused immeasurable harm, it has also highlighted opportunities, such as increased acceptance and use of telehealth, increased and improved community awareness of contact tracing, and a willingness to deviate from the status quo and be innovative.

Importance of Recognizing and Addressing Racism and Trauma

The events of 2020 have pulled back the curtain on the long-standing inequities experienced by people of color. In our actions and in our words, we will vocalize the need to combat racism and for infusing our work with the tenets of social justice, and the need to understand and address the trauma experienced both by communities and by individuals.

Anti-racism must be woven into all facets of our work, and we must be action-oriented to not just recognize the impact and existence of racism, but to do better to address and combat it. We recognize that this work will not happen overnight, and we do not pretend to know how to solve these ongoing challenges.

We are committing to ongoing conversation that spurs action, and to involving a wider, more diverse, and more representative set of communities and individuals in our engagement, planning, and implementation efforts to ensure that we raise the voices of those who experience racism and trauma. Only by raising these voices will we have the lived experience and personal expertise to craft more concrete and community-based actions.

Need for New Voices and Strengthening Voices

Although our community engagement efforts to develop this plan were successful in reaching and including many individuals who had not participated in HIV planning efforts before, they also reinforced that we must continue to improve our outreach and engagement. We must intentionally bring people to

the table who can speak to their own communities. We must intentionally raise the voices of those who can speak to racism, discrimination, social justice, trauma, and the social determinants of health.

To better identify and engage new voices, and to strengthen their participation, we recognize that we cannot just invite people to our existing table. We must adapt our systems and approaches to bring our systems to them, and to build new tables when our existing ones do not support equal and representative participation.

Prioritized Populations

Within each pillar, certain strategies and activities call out particular priority populations. In addition, there are a handful of priority population groups that we will intentionally consider throughout our work.

Prioritized populations include, but are not limited to:

- Gay and bisexual men of color, especially young gay and bisexual men of color
- Transgender, gender non-conforming, and non-binary individuals
- Latinx/Hispanic community
- Black/African American community, including Black/African American women
- Youth (aged 18 to 30 years old)
- Native Americans/American Indians, including tribes, reservations, and Urban Indians
- Individuals who use drugs
- Individuals experiencing economic instability and/or housing instability
- Persons who are foreign born, regardless of where they are diagnosed

Intersectionality

When we target our actions and attention to certain population groups, we must recognize the impact of intersectionality. When we recognize that people have many intersecting identities, we can be more intentional to ensure that our programs are not painting people into a singular and simplified “box” based on just one aspect of their identity.

Our identities can compound protection, but they can also compound risk. Better recognizing and addressing intersectionality will help our programs to reflect the complexity of identity, and allow us to develop better programs that improve outcomes for our partners, clients, and wider communities.

Ongoing Community Engagement Efforts

The process of developing this plan has demonstrated the importance of engaging both traditional and new community members, and developing proactive plans for ongoing, sustained engagement across the entire plan development process. Our five focus areas for community engagement are explained in detail further along in this plan.

General Workforce Development Strategies

Workforce development is built into each of the four pillars of this plan. Overall, we aim to keep our focus on developing the skills of people within our communities in order to strengthen our current workforce while also ensuring that our future workforce is well-equipped to serve our communities while also being more representative of those that they serve. Professional development opportunities may include programs such as leadership training, skills building training, paid internships, outreach positions, and programs that specifically target individuals who are living with HIV, at risk for HIV, and/or members of communities disproportionately affected by HIV.

Additionally, we want to continue enhancing our ability to conduct workforce development through virtual platforms and distance learning mechanisms. We will continue leveraging our statewide resources for training while also looking to learn from and leverage what is happening in other jurisdictions.

Innovation

During COVID-19, Maricopa County has had incredible success with scaling up its existing home testing program with HIV home test kits. Setting up a pilot home testing program in 2017, long before the emergence of the COVID-19 pandemic, is an example of how taking bold action allows our county, and our state, to benefit from innovative and forward-thinking approaches.

We will strive to continue supporting our partners and communities to be bold, and to implement and adopt innovative ideas and strategies to improve the future landscape of HIV for all Arizonans. There are promising new long-acting medications, alternative formulations for pre-exposure prophylaxis (PrEP), mechanisms for engagement, and strategies for reducing inequality among priority populations. We will prepare for what is to come, and take proactive steps to push Maricopa County into the 2020s and beyond.

Pillar One: Diagnose

See additional detail in Appendix E: Diagnose.

Goals:

- Increase integrated testing in Maricopa County by 20% over the next 3 years.
- Increase HIV testing in Maricopa County using a variety of testing methods.

Key Strategies:

1. Increase HIV testing, integrated with STD and HCV testing
2. Decrease barriers to HIV testing
3. Increase awareness for HIV testing and diagnosis
4. Increase education options to improve HIV testing
5. Improve partner services outcomes
6. Address determinants that influence client ability to receive and participate in HIV programs

Key Partners:

State and local health departments, including state HIV Prevention, HIV Surveillance, and STD programs; Maricopa County Public Health Clinic; Ryan White HIV/AIDS Program, including Part B, Part A Phoenix EMA, and sub-recipients; agencies conducting Rapid Start, early intervention services (EIS), and HIV testing; community-based organizations; sub-recipients of the state HIV Prevention program; statewide advisory groups; universities and colleges, including medical and nursing schools; harm reduction programs; correctional facilities; medical providers, including non-HIV system providers; community health centers; STD clinics; FQHCs; emergency departments, urgent care, and hospitals; case management agencies; tribal leaders and agencies; laboratories; media; Pacific AIDS Education and Training Center (PAETC) Arizona; behavioral health agencies.

Potential Funding Resources:

CDC HIV Prevention and Surveillance programs; Ryan White HIV/AIDS Program; Bureau of Primary Health Care; local (city or county) funding; behavioral health and correctional funding sources; City of Phoenix Fast Track Cities; private funding sources.

Estimated Funding Allocations: See Appendix E: Diagnose

Outcomes:

- # newly identified persons with HIV
- # HIV tests conducted (overall and by priority populations)
- # integrated tests conducted
- # people trained
- # agencies offering HIV testing
- # “hits” from media campaign
- % newly identified persons with HIV receiving partner services

Monitoring Data Sources:

HIV surveillance data; RWHAP data; client surveys; media campaign data; training reports.

Pillar Two: Treat

See additional detail in Appendix F: Treat.

Goals:

- Engage 90% of persons diagnosed with HIV in ongoing care and treatment.
- Reach 90% viral suppression.

Key Strategies:

1. Improve engagement and linkage to care
2. Overcome barriers to retention in care
3. Strengthen client capacity and confidence to navigate the HIV care system
4. Address determinants that influence client ability to receive and participate in HIV care
5. Build capacity to more effectively use digital and virtual platforms
6. Promote collaboration to leverage/streamline efforts across organizations and agencies

Key Partners:

State and local health departments, including state HIV Surveillance and HIV Prevention programs; Maricopa County Public Health Clinic; Ryan White HIV/AIDS Program, including Part B, Part A Phoenix EMA, Central Eligibility, and sub-recipients; agencies conducting Rapid Start, EIS, and HIV testing; community-based organizations; medical providers, including non-HIV system providers; community health centers; FQHCs; emergency departments, urgent care, and hospitals; case management agencies; colleges and universities, including medical and nursing schools; Pacific AIDS Education and Training Center (PAETC) Arizona; media; University of Arizona Data to Care (D2C); Housing Opportunities for Persons with AIDS (HOPWA); substance use and behavioral health service agencies; Arizona Health Care Cost Containment System (AHCCCS – state Medicaid program); City of Phoenix Fast Track Cities; HIV planning groups.

Potential Funding Resources:

CDC HIV Prevention and Surveillance programs; Ryan White HIV/AIDS Program; Bureau of Primary Health Care; SAMHSA and AHCCCS; HOPWA.

Estimated Funding Allocations: See Appendix F: Treat

Outcomes:

- % individuals with a new HIV diagnosis linked to care within 5 days
- % clients retained in care
- % clients achieving viral suppression
- # clients screened for and linked to supportive services
- # individuals identified as not in care who are returned to care
- # people trained
- # agencies providing Rapid Start
- # agencies/providers utilizing telehealth or online platforms

Monitoring Data Sources:

HIV surveillance data; RWHAP and ADAP data; D2C data and reports; client surveys; training reports; HOPWA data; AHCCCS data.

Pillar Three: Prevent

See additional detail in Appendix G: Prevent.

Goals:

- Increase access to PrEP by 20% for priority populations over the next 3 years.
- Improve drug user health outcomes as related to HIV, STDs, and hepatitis C.

Key Strategies:

1. Increase access to PrEP services
2. Build system capacity to offer PrEP services
3. Overcome barriers to staying on PrEP
4. Improve awareness of PrEP services
5. Enhance services among people who use drugs

Key Partners:

State and local health departments, including state HIV Prevention, HIV Surveillance, and STD programs; Maricopa County Public Health Clinic; Ryan White HIV/AIDS Program, including Part B, Part A Phoenix EMA, and sub-recipients; PrEP navigation agencies; PrEP providers; agencies conducting HIV testing; community-based organizations; sub-recipients of state HIV Prevention program; medical providers, including non-HIV system providers; community health centers; STD clinics; FQHCs; emergency departments, urgent care, and hospitals; laboratories; Pacific AIDS Education and Training Center (PAETC) Arizona; media; current PrEP users; agencies serving people who use drugs; harm reduction organizations.

Potential Funding Resources:

CDC HIV Prevention and Surveillance programs; Ryan White HIV/AIDS Program; Bureau of Primary Health Care; SAMHSA and AHCCCS; CDC Viral Hepatitis program.

Estimated Funding Allocations: See Appendix G: Prevent

Outcomes:

- % individuals with a negative HIV test who are referred for PrEP
- # PrEP prescriptions
- % PrEP clients retained on PrEP
- % PrEP-eligible individuals who are on PrEP (overall, and by priority populations)
- # PrEP providers
- # people trained
- # “hits” from media campaign
- # clients referred and linked to substance use and harm reduction services
- # HIV/STD/HCV tests provided within programs for people who use drugs
- # clients tested at programs for people who use drugs who are linked to HIV care

Monitoring Data Sources:

HIV surveillance data; RWHAP data; HIV Prevention PrEP data; client surveys; media campaign data; training reports; AHCCCS data; STD data; viral hepatitis data.

Pillar Four: Respond

See additional detail in Appendix H: Respond.

Goal:

- Increase capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks in 1 year.

Key Strategies:

1. Develop and maintain a jurisdiction wide cluster detection and response plan
2. Increase capacity for rapid detection of active HIV transmission clusters
3. Increase capacity to respond to active HIV transmission clusters and outbreaks
4. Increase public awareness of response plans and activities

Key Partners:

State and local health departments, including state HIV Prevention, HIV Surveillance, STD, and Viral Hepatitis programs; Ryan White HIV/AIDS Program, including Part B, Part A Phoenix EMA, and sub-recipients; statewide advisory groups; laboratories; community leaders and stakeholders; Pacific AIDS Education and Training Center (PAETC) Arizona; community-based organizations; medical providers; media.

Potential Funding Resources:

CDC HIV Prevention and Surveillance programs.

Estimated Funding Allocations: See Appendix H: Respond

Outcomes:

- # clusters identified
- # active clusters responded to
- # stakeholders engaged in plan development
- # people trained

Monitoring Data Sources:

HIV surveillance data; community assessment.

Community Engagement

The EHE plan for Maricopa County was constructed on the basis of what was learned during community engagement sessions held between April 2019 and October 2020. These sessions included a full-day workshop, 15 in-person unstructured focus groups with a graphic recorder, 16 virtual feedback sessions, 8 virtual wordsmithing sessions, and multiple virtual meetings with the Statewide Advisory Group.

This plan has demonstrated the importance of engaging both traditional and new community members, and developing proactive plans for ongoing, sustained engagement across the entire plan development process.

Moving forward, our jurisdiction will focus on five core aspects to ensure our community engagement continues to be productive, representative, and impactful.

1. We will strive to expand who is reached by and involved with community engagement efforts by:

- Prioritizing populations that have been overlooked or excluded from past efforts
- Using community gatekeepers/influencers and current members of planning groups to engage people or populations that have not previously been involved
- Exploring using providers to recruit clients for engagement efforts
- Improving who is reached by surveys, needs assessments, etc.
- Conducting a gap analysis to see which agencies and planning bodies are engaging which communities, and which communities are being left out
- Being intentional about the barriers to engagement BEFORE beginning community engagement efforts, and address identified barriers

2. We will widen the ways that community members can be engaged in community engagement efforts by:

- Providing ways for people to be engaged in less structured ways, varying levels of engagement and participation
- Creating ways for people to engage that does not require an up-front, long-term commitment
- Considering smaller and more frequent symposium/conferences/trainings
- Being intentional about different strategies to use for youth engagement

3. We will emphasize the need to treat community members as experts by:

- Incentivizing and compensating participation in engagement
- Providing ongoing engagement instead of one-off events
- Ensuring that engagement happens throughout processes - create ongoing feedback loops that include engagement at all steps instead of just as a formality at the beginning and end of a project
- Providing ways for community members to learn or personally develop through their participation, to ensure that they benefit from the processes of engagement
- Re-envisioning what it means to be “qualified” to conduct outreach and engagement work, to see experience as a qualification instead of just formal education/training

4. We will focus on better using peers and clients as leaders within their own communities by:

- Improving the representation of communities impacted by and at-risk for HIV in planning groups, including people living with HIV and people on PrEP
- Better preparing and recruiting people to join planning groups, including teaching peers and clients the skills they need to join planning bodies and take on leadership roles (e.g., the Leadership Academy)
- Teaching people how to communicate with planning groups and agencies, and how to elevate concerns and interests to the right channels
- Creating active opportunities for peers and clients to be involved and represent their communities
- Employing “facilitation rotation” to give peers (and clients) opportunities to lead their own groups and develop their skills as leaders
- Considering the development of a Speaker’s Bureau to give peers and clients the training and opportunity to share their stories
- Using peers and clients as social influencers to bring additional people “to the table” for engagement
- Learning from peers and clients about how to better engage their communities
- Giving peers and clients the tools they need to build peer networks for outreach, education, and engagement on their own

5. We will improve our use of virtual platforms to engage with community members and to conduct community engagement efforts by:

- Using technology/social media for sharing and learning
- Exploring new platforms to allow people to share their feedback and experiences
- In the context of COVID-19, exploring more virtual ways to conduct engagement
- Recognizing and addressing that using technology for engagement creates barriers for certain populations (e.g., unstably housed, low-income, without access to internet)

Recognizing the ever-changing landscape presented by COVID-19 and the ongoing shifts in the populations affected by HIV in Maricopa County, community engagement will aim to be adaptable and flexible to adjust to new challenges and opportunities.

Community Engagement Process to Develop the EHE Plan

Community engagement for the EHE plan began in April of 2019 with the Annual HIV Symposium. Groups were developed based on geographical area, with the Maricopa County group focusing their discussion on EHE topics.

In February and March 2020, 15 unstructured engagement sessions were held, each focusing on either a population or a topic of interest. Recruitment was focused on HIV prevention and care clients, people living with HIV, community members, and providers serving those populations and areas, as well as planning group members. Group size ranged from 5 to 18 participants, with an original goal of 10-12 participants in each session. Each session was two hours long, with two discussion facilitators, 1-2

notetakers and a visual/graphic recorder. The visual/graphic recorder used a large canvas board to draw the main themes from each meeting.

Every effort was made to assure the comfort of the participants. All participants were informed that notes were being taken both traditionally and visually, that they had the option to ask that anything they shared not be included in the notes, and that no names would be used in either type of note taking. Incentives were provided at the end of each session. Sign in sheets were used, but only for tracking of the incentives. Questions were used only to spark conversation, instead of in the style of a structured focus group. The facilitators provided follow-up or clarifying questions during discussions as needed.

Groups conducted were:

- ✓ Men who have sex with men (MSM) Prevention Initiatives
- ✓ Young MSM Prevention Initiatives
- ✓ HIV/STD Initiatives
- ✓ Social Determinants of Health (2 sessions)
- ✓ Community Planning (3 sessions based on the Northern, Central, and Southern regions)
- ✓ Women, both living with and affected by HIV
- ✓ State and local health departments
- ✓ Hispanic/Latinx community, which was conducted and visually recorded in Spanish
- ✓ Transgender Health
- ✓ LGBTQ Youth
- ✓ Black/African American community (2 sessions)

Sessions focused on Native American/American Indian populations and people who use drugs were planned, but did not take place due to the emergence of the COVID-19 pandemic. Recognizing that both of these population groups experience lower average viral suppression rates, we will be pursuing engagement opportunities as the plan continues to evolve. Engagement will include developing a comprehensive list of contacts for representatives of and agencies who serve Native American/American Indian individuals who live on tribal lands as well as in urban settings.

Meetings of the Statewide Advisory Group (SWAG) for the majority of 2020 focused on the EHE plan development, and allowed for conducting additional community engagement with SWAG members. During June and July 2020, 16 virtual webinars were held to gather community input on the draft plan and workforce development. This draft was compiled directly from the information gathered in the February and March 2020 community engagement sessions. Three sessions were held for each pillar, along with additional sessions to review workforce development, community engagement, and the plan's overall priorities and themes. These sessions built on the information collected from the in-person sessions, and ensured that engagement was ongoing instead of a one-off event.

The input from these sessions was used to continue drafting the EHE plan, and an additional 8 virtual webinars were held in October 2020 for discussion and refinement of the plan. Two sessions were held to review each pillar in more depth. The full draft plan was presented to SWAG members in late October

2020, and, following further discussion and refinement, concurrence was sought from SWAG in November 2020.

Proposed Community Engagement Process to Monitor and Update the EHE Plan

Following submission of the plan in December 2020, community engagement will continue in order to refine the plan, respond to any questions or concerns from the CDC review of the plan in early 2021, monitor implementation of the plan, and adjust the plan as needed with regards to new technology, new medications, new funding, new priorities, or a changing environment like the one created by the COVID-19 pandemic.

Community engagement will be continued virtually until in-person groups can be safely conducted. Groups that have been involved in the plan development process will continue to be engaged. Additionally, stakeholders who have been identified as unrepresented or underrepresented in the development phase will be sought out for engagement. Efforts will be made for engagement to be actionable, by reviewing plan development, assessing current status, allowing for open and honest conversation about what should be adjusted during implementation, and giving space for ongoing feedback, questions, and concerns. The aim of the next phase of community engagement will be to ensure that plan implementation is aligned with the engagement and feedback provided during the development phase, and that the plan remains a living document that responds to ongoing environmental, social, technological, political, and financial changes.

Proposed Ongoing Feedback Process to Monitor and Update the EHE Plan

Following submission of the EHE plan in December 2020, the Arizona Department of Health Services (ADHS) will prepare updates at least once per year for the SWAG. The updates will include current progress, significant changes to data, challenges encountered, and any proposed changes to the plan. Updates will be shared by ADHS staff during a quarterly SWAG meeting, and SWAG members will be able to provide input, share feedback, request changes, and ask questions.

Additionally, the public-facing website on which the plan will be available will have an option to submit feedback, which will be sent to ADHS staff. This feedback will be continually gathered, and incorporated into the plan's ongoing updates.