1. Agenda

    Documents:

        2016-06-01 AGENDA.PDF

2. Meeting Material 6

    Documents:

        2016-06-01 MEETING MATERIAL 6.PDF

3. Meeting Material 5

    Documents:

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4. Meeting Material 4

    Documents:

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5. Meeting Material 3

    Documents:

        2016-06-01 MEETING MATERIAL 3.PDF

6. Meeting Material 2

    Documents:

        2016-06-01 MEETING MATERIAL 2.PDF

7. Meeting Material 1

    Documents:

        2016-06-01 MEETING MATERIAL 1.PDF

Community Health Planning & Strategies Committee

Cheri Tomlinson, Vice Chair

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Wednesday, June 1, 2016
5:00 pm to 7:00 pm
Public Health
4041 North Central Avenue, Phoenix
14th Floor, Training Room

AGENDA

Welcome, Introductions and Declarations of Conflict-of-Interest

Determination of quorum

Review of the Minutes and Action Items
The committee will review the summary minutes of the previous meeting. Please inform the Chair of any revisions that should be incorporated into the summary minutes.

Chair and Administrative Agent Update
The Chair will review the recent activity of the committee and provide comments.

Integrated HIV Prevention and Care Plan
The committee will work on activities for the comprehensive plan. The continuation of review of activities for Goals 1-3 will occur and the committee will continue onto Goal 4 activities. Voting may occur to take action on discussion items.

Determination of Agenda Items for the Next Meeting
Attendees will discuss possible topics for the next meeting. Responsibilities for action items may be assigned.

Current Event Summaries
This is the time for Planning Council members to share a brief summary of current events. Members of the work group cannot propose, discuss, deliberate, or take legal action on any matter voiced during this time.

Call to the Public
This is the time for the public to comment. Members of the committee cannot propose, discuss, deliberate, or take legal action on any matter voiced during this time.

Adjourn
This committee generally meets on the **first Wednesday** of each month.

Members and guests of the Planning Council may attend either in person or via telephone conference call. Documents distributed during this meeting may be requested from Planning Council Support. Funding is provided by the United States Department of Health and Human Services, the federal Ryan White HIV/AIDS Program, and the Maricopa County Department of Public Health.

AGENDA *continued*

Meeting Ground Rules

- Many attendees are very sensitive to fragrances, so please refrain from using colognes and perfumes at Planning Council meetings or events.
- The public is encouraged to take part in all of our discussions. However, due to time constraints, the Chair may choose to limit the number of people who may speak and/or the length of time allowed for discussion.
- Everyone is expected to respect the authority of the Chair.
- Anyone who wishes to comment should raise their hand to be recognized to talk.
- Please be courteous when others are talking. No sidebar conversations please.
- Please remain calm and focused on the topic at hand.
- Stay open-minded and flexible to allow for and honor individual difference and diversity.

Pima County

Pima County Goal 1

National Goal 1: Reducing new HIV infections

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

Local Objective:

Strategy 1: Prevention, Testing and Linkage to Care (pages 9, 10)

Activity 1: Work with local agencies to determine process times for HIV/STI screening and treatment. Collaborate on ways to decrease times, improve services.

Activity 2: Work with community to increase access points for testing.

Activity 3: Include HIV testing as part of comprehensive services, bundled with other services and screenings.

Strategy 2: Education (pages 1, 2)

Activity 1: Provider education on reimbursable services. Verification of services. Utilize benefits eligibility specialists.

Activity 2: Provider education on CLAS standards, socioeconomic, language and health literacy aspects.

Activity 3: Provider education (medical and community) on technical language and processes.

Strategy 3: Stigma (Patient Centered Care, pages 13, 14)

Activity 1: Create awareness about HIV not defining the person, allow for changing behaviors.

Activity 2: Create/Implement stigma-reduction education that coincides with medical training for HIV. IE: teaching hospitals, AETC trainings statewide

Activity 3: Community assessment of HIV knowledge, stigma, behaviors, education needs. Specifically Latino population, transmission routes.

National Objective 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Local Objective:

Strategy 1: Patient Centered Care (pages 13, 14)

Activity 1: Create/Implement stigma-reduction education that coincides with medical training for HIV. IE: teaching hospitals, AETC trainings statewide

Activity 2:

Strategy 2: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1:

Activity 2:

Strategy 3: Incentives for Care (Patient Centered Care, pages 13, 14)

Activity 1:

Activity 2:

Pima County Goal 2

National Goal 2: Increasing access to care and improving health outcomes for people living with HIV

National Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Local Objective:

Strategy 1: Patient Centered Care (pages 13, 14)

Activity 1:

Activity 2:

Strategy 2: Community Engagement (Collaboration, pages 11, 12)

Activity 1:

Activity 2:

Strategy 3: Stigma (Patient Centered Care, pages 13, 14)

Activity 1:

Activity 2:

National Objective 5: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Local objective:

Strategy 1: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1:

Activity 2:

Strategy 2: Patient Centered Care (pages 13, 14)

Activity 1:

Activity 2:

Strategy 3: Data Standardization (Data, pages 7,8)

Activity 1:

Activity 2:

Pima County Goal 3

National Goal 3: Reducing HIV-related disparities and health inequities

National Objective 7: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.

Local Objective:

Strategy 1: Funding (pages 5, 6)

Activity 1:

Activity 2:

Strategy 2: Quality Housing (Patient Centered Care, pages 13, 14)

Activity 1:

Activity 2:

Strategy 3: To Be Determined

Activity 1:

Activity 2:

National Objective 9: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.

Local Objective:

Strategy 1: Community Engagement (Collaboration, pages 11, 12)

Activity 1:

Activity 2:

Strategy 2: Education (pages 1, 2)

Activity 1:

Activity 2:

Strategy 3: Stigma (Patient Centered Care, pages 13, 14)

Activity 1:

Activity 2:

Pima County Goal 4

National Goal 4: Achieving a more coordinated response to the HIV epidemic

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

Local Objective:

Strategy 1: Funding (pages 5, 6)

Activity 1: Dedicated STI/HIV testing, comprehensive sexual health.

Activity 2: Pursue other types of funding. ACA reimbursement for bundled services.

Strategy 2: Community Engagement (Collaboration, pages 11, 12)

Activity 1: Advocacy education for providers, communities and individuals on how to advocate for healthcare.

Activity 2:

Strategy 3: Policy (pages 3,4)

Activity 1: Recommendations from state health department, other bodies, in stigma-reduction, HIV specific training.

Activity 2:

National Objective 5: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Local Objective:

Strategy 1: Patient Centered Care (pages 13, 14)

Activity 1:

Activity 2:

Strategy 2: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1:

Activity 2:

Strategy 3: To Be Determined

Activity 1:

Activity 2:

Northern Region

Northern Region Goal 2

National Goal 2: Increasing access to care and improving health outcomes for people living with HIV

National Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Local Objective

Strategy 1: Prevention, Testing and Linkage to Care (pages 9, 10)

Activity 1: Provider Education- Increase number of health care providers who are knowledgeable about linkage to care and integration in primary care: AETC, Project ECHO (provider to provider educ)

Activity 2: Research strategies for best fit in the community, ie: Social Network Strategies, Provider/Agency education

Activity 3: Build collaborations with substance abuse agencies in N. AZ, promote testing and linkage to care

Strategy 2: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1: Clear referral processes for all steps of linkage. Utilize HIVAZ.org and other resources.

Activity 2: Clear communication between health entities (County, State, Providers) and healthcare agencies serving native populations.

Activity 3: Clearly identified care navigation in all communities.

Strategy 3: Patient Centered Care (pages 13, 14)

Activity 1: Culturally competent, warm hand-offs between service providers

Activity 2: Increase in provider (health and community) education for culturally competent care issues- ie: motivational interviewing, trauma-informed care, ARTAS, cultural competency. Available in community, online, on-demand etc.

National Objective 5: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Local Objective:

Strategy 1: Patient Centered Care (pages 13, 14)

Activity 1: Identify health team models or strategies that would be effective in rural communities.

Activity 2: Identify barriers being experienced by healthcare providers, assets available in community.

Strategy 2: Funding (pages 5, 6)

Activity 1: Specify funding and services for retention in care. Community services (street outreach) for re-engagement.

Activity 2: Pursue other funding (outside of CDC and HRSA) ie: foundation and research funding.

Activity 3: Partnerships more lucrative for both community agencies and medical providers- ie: lowering ED recidivism, ACA/insurance knowledge around treatment.

Strategy 3: Data Standardization (Data, pages 7,8)

Activity 1: Streamline assessment/intake processes and share data among providers. Collectively guide needs and services.

Activity 2: Creation of universal tools.

Northern Region Goal 3

National Goal 3: Reducing HIV-related disparities and health inequalities

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

Local Objective:

Strategy 1: Stigma (Patient Centered Care, pages 13, 14)

Activity 1: Assessment of stigma surrounding HIV in Northern Arizona. What factors, needs, barriers exist?

Activity 2: Provider education to promote routine testing as part of wellness. Reduce provider stigma regarding HIV.

Strategy 2: Community Engagement (Collaboration, pages 11, 12)

Activity 1: Community engagement around de-stigmatizing HIV testing.

Activity 2: Collaboration with Native communities around culturally competent sexual health education and messaging.

Strategy 3: Funding (pages 5, 6)

Activity 1: Determining availability of funding for routine testing- ie ACA, insurance etc. What needs to be bundled and what needs to be separated to get best funding for services.

Activity 2: Integrating other services, STI screenings, HCV. Bundling those services for reimbursement.

Activity 3: Identify low-cost/free resources or other resources for co-infection both locally and in surrounding areas.

National Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Local Objective: copy and paste from Goal 2- objective

Strategy 1: Patient Centered Care (pages 13, 14)

Activity 1:

Activity 2:

Strategy 2: Community Engagement (Collaboration, pages 11, 12)

Activity 1:

Activity 2:

Strategy 3: Stigma (Patient Centered Care, pages 13, 14)

Activity 1:

Activity 2:

Northern Region Goal 4

National Goal 4: Achieving a more coordinated response to the HIV epidemic

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

Local Objective:

Strategy 1: Community Engagement (Collaboration, pages 11, 12)

Activity 1: Add community members to current collaborations, resources available in Northern area. Ie: local planning, task forces, town halls. Consider location, methods of communication.

Activity 2: Develop methods for community input that are more confidential. Resources/media in appropriate places for each rural community.

Activity 3: Create county specific engagement plans.

Strategy 2: Prevention, Testing and Linkage to Care (pages 9, 10)

Activity 1: Integrate HIV testing into sexual health care, STI, HIV, HCV.

Activity 2: Coordinate with other agencies, programs who are doing testing. Consider needs of various age groups and populations.

Strategy 3: Education (pages 1, 2)

Activity 1: Identify institutions serving youth and young adults who are open to providing programming in sexual health.

Activity 2: Partner with Office of Women's and Children's Health – reproductive health program to include HIV.

Activity 3: Partner with RBHA services to provide sexual health education.

Activity 4: Determine best practices in sexual health education to provide resources to entities. Curriculum, videos for provider waiting rooms etc.

Activity 5: Partner with Universities/Colleges for Education

National Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Local Objective: Copy from Goal 2, add state sponsored support, guidance, standardized materials, coordinated at state level also. Resources and tools available across state.

Strategy 1: Prevention, Testing and Linkage to Care (pages 9, 10)

Activity 1:

Activity 2:

Strategy 2: Patient Centered Care (pages 13, 14)

Activity 1:

Activity 2:

Strategy 3: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1:

Activity 2:

RWPA Goal 1

National Goal 1: Reducing new HIV infections

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

Local Objective:

Strategy 1: Prevention, testing and linkage to care

Activity 1: Increase Partner testing by adding additional testing sites per year. (need to figure out what is reasonable to add per year).

Activity 2: Increase community provider education in PrEP by adding 10% per year for 5 years.

Activity 3: Increase health care professionals trained in knowledge of 4th generation algorithms for HIV testing by 10% per year for 5 years.

Activity 4: Increase communication between HIV agencies on linkage to care improvement by offering 1 collaborative training per year on linkage to care.

Strategy 2: Education

Activity 1: Expand the number of HIV providers trained on diagnosis and management of HIV by 6 per year statewide.

Activity 2: Beginning in 2017, provide training in Phoenix for Oral Health professionals on common oral manifestations as seen in patients with HIV.

Activity 3: Provide regional collaborative training annually with California HIV/STD Training Center.

Activity 4: Provide annual training for promotoras on HIV testing.

Strategy 3: Community Engagement

Activity 1: Conduct annual Needs Assessment on priority populations with one of those years including prevention and testing needs.

Activity 2: Improve communication with ICE and Border Health programs to coordinate HIV care during deportation process.

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

Local Objective:

Strategy 1: Streamlined processes

Activity 1: Complete joint application implementation by mid-year 2017.

Activity 2: Implement processes that support same day medical appt. at time of new diagnosis.

Activity 3: Increase the # of HIV specialists available to provide HIV services by end 2017.

Strategy 2: Community engagement

Activity 1: 90/90/90 (John to expand)

Activity 2: Increase the use of technology resources to improve partner notification and expand partner services.

Activity 3: Create community outreach groups to increase community awareness of prevention, testing and linkage to care.

Strategy 3: Patient-centered care

Activity 1: Conduct needs assessment. (See 1.1.3.1)

Activity 2: Provide annual cultural competency training that addresses gaps identified in annual needs assessment.

RWPA Goal 2

National Goal 2: Increasing access to care and improving health outcomes for people living with HIV

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

Local Objective

Strategy 1: Streamlining the process

Activity 1: Formalize processes between EIS/ADOC to improve linkage of recently released inmates to community HIV care and services.

Activity 2: Continue to improve statewide centralized resource for linking individuals to HIV prevention, care and service providers (HIVAZ.org).

Activity 3: Explore walk-in or mobile services for homeless clients seeking care.

Strategy 2: Education

Activity 1: Continue to develop health literacy resources for HIV positive and high risk HIV negative clients.

Activity 2: Expand the number of HIV providers trained on diagnosis and management of HIV by 6 per year statewide.

Strategy 3: Patient Centered Care

Activity 1: Patient portal (Cheri and Nicole to expand).

Activity 2: Using CQM Committee, conduct quarterly PDSAs that address linkage to care timeframes.

National Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 80%.

Local Objective:

Strategy 1: Patient Centered Care

Activity 1: Using CQM Committee, conduct quarterly PDSAs to address viral load suppression rates.

Activity 2: Expand treatment adherence services to improve viral load suppression.

Strategy 2: Community engagement

Activity 1: Conduct media campaign to increase consumer awareness of "Treatment as Prevention" and" Know Your Numbers".

Activity 2: Expand Continuum of Care data models into medical practices outside of RW providers.

Strategy 3: Streamlining the process

Activity 1: Develop baseline data that identifies the number of newly diagnosed clients that are virally suppressed by 180 days.

Activity 2: Increase # of newly diagnosed clients that are virally suppressed within 180 days by 5%/year.

RWPA Goal 3

National Goal 3: Reducing HIV-related disparities and health inequalities

National Objective 1: Reduce disparities in the rate of new diagnosis by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in Arizona.

Local Objective:

Strategy 1: Funding

Activity 1: Identifying capacity of organizations to apply for funding.

Activity 2: Establish baseline for each continuum of care area.

Strategy 2: Patient-centered care

Activity 1: Address co-occurring issues for newly diagnosed clients.

Activity 2: Provide training for culturally appropriate HIV care.

Strategy 3: Stigma

Activity 1: Implement at least 1 stigma reduction media initiative each year utilizing new and traditional media.

National Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.

Local Objective:

Strategy 1: Community Engagement

Activity 1: Partner with community organizations (i.e. Circle the City, MC Healthcare for the Homeless) to establish referrals into Ryan White services. Debby to reword.

Strategy 2: Funding

Activity 1: Explore partnership with HOPWA to seek additional funding opportunities. Jeremy to research further.

Activity 2: Explore opportunities to use rebate funds for housing services.

Strategy 3: Patient-centered care

Activity 1: Develop and implement strategies to provide housing opportunities for HIV clients with a history of past felonies and/or substance abuse.

Activity 2: Explore emergency housing.

Activity 3: Confer with SAAF Harm Reduction program and HIV housing.

RWPA Goal 4

National Goal 4: Achieving a more coordinated response to the HIV epidemic

National Objective 1: Reduce disparities in the rate of new diagnosis by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, and Black females living in Arizona.

Local Objective:

Strategy 1: Funding

Activity 1: Encourage more collaboration among providers to better coordinate funding opportunities.

Activity 2:

Strategy 2: Patient-centered care

Activity 1: Expand distribution of condoms to include more health care professionals.

Activity 2: Doctor/MCM interaction.

Activity 3: Utilize consumer focus groups/surveys to drive/inform/strengthen quality improvement projects at recipient and sub-recipient levels.

Strategy 3: Stigma

Activity 1: Organize group of HIV+ people to disclose publicly.

Activity 2:

National Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.

Local Objective:

Strategy 1: Community engagement

Activity 1: Partner with community organizations (i.e. Circle the City, MC Healthcare for the Homeless) to establish referrals into Ryan White services. Debby to reword.

Activity 2:

Strategy 2: Funding

Activity 1: Explore opportunities to use rebate funds for housing services.

Activity 2:

Strategy 3: Patient-centered care

Activity 1: Confer with SAAF Harm Reduction program and HIV housing.

Activity 2:

Northern Region Goal 1

National Goal 1: Reducing new HIV infections

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

Local Objective:

Strategy 1: Community Engagement (Collaboration, pages 11, 12)

Activity 1: Create formalized process to engage state/county entities, tribal leaders, and local providers (coalitions, meetings, symposiums, etc.) to communicate and collaborate to improve HIV services. Explore digital methods to conduct this activity. **2018**

Activity 2: Establish at least 6 consumer-centric activities to engage clients in medical care and supportive services using traditional methods (support groups, peer mentoring, doc talks, etc.) and digital methods (online forums, video conferences/webinars, chats, etc.) **2018**

Activity 3: Engage new community partners to promote HIV testing/medical care (flyers, posters, urinal screens, traditional media, etc.).

Activity 4: Expand the provider network offering HIV testing as a routine part of care for all clients.

Strategy 2: Education (pages 1, 2)

Activity 1: Expand digital prevention/testing media (It's only Dangerous, STD testing, HIVAZ.org) to target Northern Arizona consumers. **2017**

Activity 2: Provide regional trainings for primary medical providers to include HIV, extra-genital STD screening, common oral manifestations of HIV disease. **YR 1: 2017, YR 2: 2019**

Activity 3:

Activity 4:

Strategy 3: Prevention, Testing and Linkage to Care (pages 9, 10)

Activity 1: Engage Flagstaff Medical Center to implement semi-targeted opt-out HIV testing in their emergency department. (semi-targeted: patients at risk, have clinical indications) **2020**

Activity 2: Engage Flagstaff Medical Center to eliminate written consent for HIV testing. **2018**

Activity 3: Implement free at-home HIV/STD testing opportunities (mail order, pdf voucher for free kits, vending machine, etc.). **2017**

Activity 4: Implement same-day supplemental/confirmatory testing among testing providers, to decrease the time from diagnosis-lab-first medical appointment. **2018**

National Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Local Objective:

Strategy 1: Funding (pages 5, 6)

Activity 1: Provide additional funding for support services that enable a client to get to their first lab visit and doctor appointment. **2018**

Activity 2: Carmen to provide funding to expand Affordable Care Act navigation services. **2017**

Activity 3: Provide organizations with technical assistance regarding grant writing, sustainability, billing capacity, etc.

Activity 4:

Strategy 2: Patient Centered Care (pages 13, 14)

Activity 1: Provide training for culturally appropriate HIV care (co-train with allies that can support participation). Explore opportunities to collaborate with other training opportunities that may have better participation. Project Echo, or AETC self-appraisal prior to implementation. Specific to how the HIV diagnosis is shared – ensure that it supports client engagement in care.

Activity 2: Media campaigns: Educates client about seeking care from knowledgeable, culturally appropriate providers, and the ability to switch providers for more comprehensive care. Ask the HIV docs from Greater Than AIDS. Educate providers about HIVAZ.org, create step-by-step for linkage to care for Northern AZ.

Activity 3: Create and distribute guidelines for HIV referrals, standard referral processes for discharge, focusing on jails, emergency departments and primary care providers (will need ROI, MOUs, etc. for information sharing).

Activity 4: Identify methods to expand the HIV provider base, including telemedicine (UA: provider to patient, Project Echo: provider to provider), provider recruitment, identifying incentives to encourage providers to offer services in the area, and provider training.

Strategy 3: Streamline Processes (Data, pages 7, 8; Mixed Bag, pages 15, 16)

Activity 1: Implement same-day confirmatory testing among testing providers, to decrease the time from diagnosis-lab-first medical appointment. **2018**

Activity 2: Identify methodologies to enhance EIS service delivery. **2017**

Activity 3: Create online application for Ryan White/ADAP services. **2017**

Activity 4: Develop reporting methodologies to accurately determine linkage to care timeframes.

RWPA Comprehensive Plan

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	Comments

GREEN **Goal 1:** Reduce new HIV infections

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

Local Objective

GREEN **Strategy 1:** Prevention, testing and linkage to care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.1.1.1**	Increase Partner testing by adding additional testing sites per year.(need to figure out what is reasonable to add per year).								
GREEN	**1.1.1.2**	Increase community provider education in PrEP by adding 10% per year for 5 years.								
GREEN	**1.1.1.3**	Increase health care professionals trained in knowledge of 4th generation algorithyms for HIV testing by 10% per year for 5 years.								
GREEN	**1.1.1.4**	Increase communication between HIV agencies on linkage to care improvement by offering 1 collaborative training per year on linkage to care.								

GREEN **Strategy 2:** Education

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.1.2.1**	Expand the number of HIV providers trained on diagnosis and management of HIV by 6 per year statewide.								
GREEN	**1.1.2.2**	Beginning in 2017, provide training in Phoenix for Oral Health professionals on common oral manifestations as seen in patients with HIV.								
GREEN	**1.1.2.3**	Provide regional collaborative training annually with California HIV/STD Training Center.								
GREEN	**1.1.2.4**	Provide annual training for promotoras on HIV testing.								

GREEN **Strategy 3:** Community engagement

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.1.3.1**	Conduct annual Needs Assessment on priority populations with one of those years including prevention and testing needs.								
GREEN	**1.1.3.2**	Improve communication with ICE and Border Health programs to coordinate HIV care during deportation process.								
GREEN	**1.1.3.3**									
GREEN	**1.1.3.4**									

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

GREEN **Strategy 1:** Streamlined processes

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.2.1.1**	Complete joint application implementation by mid-year 2017.								
GREEN	**1.2.1.2**	Implement processes that support same day medical appt. at time of new diagnosis.								
GREEN	**1.2.1.3**	Increase the # of HIV specialists available to provide HIV services by end 2017.								
GREEN	**1.2.1.4**									

GREEN **Strategy 2:** Community engagement

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.2.2.1**	90/90/90 (John to expand)								
GREEN	**1.2.2.2**	Increase the use of technology resources to improve partner notification and expand partner services.								
GREEN	**1.2.2.3**	Create community outreach groups to increase community awareness of prevention, testing and linkage to care.								
GREEN	**1.2.2.4**									

GREEN **Strategy 3:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**1.2.3.1**	Conduct needs assessment. (See 1.1.3.1)								
GREEN	**1.2.3.2**	Provde annual cultural competency training that addresses gaps identified in annual needs assessment.								
GREEN	**1.2.3.3**									
GREEN	**1.2.3.4**									

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Comments

GREEN **Goal 2:** Increasing access to care and improving health outcomes for people living with HIV

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

GREEN **Strategy 1:** Streamlining the process

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.1.1.1**	Formalize processes between EIS/ADOC to improve linkage of recently released inmates to community HIV care and services.								
GREEN	**2.1.1.2**	Continue to improve statewide centralized resource for linking individuals to HIV prevention, care and service providers (HIVAZ.org).								
GREEN	**2.1.1.3**	Explore walk-in or mobile services for homeless clients seeking care.								
GREEN	**2.1.1.4**									

GREEN **Strategy 2:** Education

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.1.2.1**	Continue to develop health literacy resources for HIV positive and high risk HIV negative clients.								
GREEN	**2.1.2.2**	Expand the number of HIV providers trained on diagnosis and management of HIV by 6 per year statewide.								
GREEN	**2.1.2.3**									
GREEN	**2.1.2.4**									

GREEN **Strategy 3:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.1.3.1**	Patient portal (Cheri and Nicole to expand)								
GREEN	**2.1.3.2**	Using CQM Committee, conduct quarterly PDSAs that address linkage to care timeframes.								
GREEN	**2.1.3.3**									
GREEN	**2.1.3.4**									

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Comments

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

GREEN **Strategy 1:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.2.1.1**	Using CQM Committee, conduct quarterly PDSAs to address viral load suppression rates.								
GREEN	**2.2.1.2**	Expand treatment adherence services to improve viral load suppression.								
GREEN	**2.2.1.3**									
GREEN	**2.2.1.4**									

GREEN **Strategy 2:** Community engagement

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.2.2.1**	Conduct media campaign to increase consumer awareness of "Treatment as Prevention" and" Know Your Numbers".								
GREEN	**2.2.2.2**	Expand Continuum of Care data models into medical practices outside of RW providers.								
GREEN	**2.2.2.3**									
GREEN	**2.2.2.4**									

GREEN **Strategy 3:** Streamlining the process

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**2.2.3.1**	Develop baseline data that identifies the number of newly diagnosed clients that are virally suppressed by 180 days.								
GREEN	**2.2.3.2**	4+								
GREEN	**2.2.3.3**	Increase # of newly diagnosed clients that are virally suppressed within 180 days by 5%/year.								
GREEN	**2.2.3.4**									

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		Comments
GREEN	**Goal 3:** Reducing HIV-related disparities and health inequities	
GREEN	**Objective 1:** **Reduce disparities in the rate of new diagnosis by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in Arizona.**	

GREEN **Strategy 1:** Funding

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.1.1.1**	Identifying capacity of organizations to apply for funding.								
GREEN	**3.1.1.2**	Establish baseline for each continuum of care area.								
GREEN	**3.1.1.3**									
GREEN	**3.1.1.4**									

GREEN **Strategy 2:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.1.2.1**	Address co-occurring issues for newly diagnosed clients.								
GREEN	**3.1.2.2**	Provide training for culturally appropriate HIV care.								
GREEN	**3.1.2.3**									
GREEN	**3.1.2.4**									

GREEN **Strategy 3:** Stigma

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.1.3.1**	Implement at least 1 stigma reduction media initiative each year utilizing new and traditional media.								
GREEN	**3.1.3.2**									
GREEN	**3.1.3.3**									
GREEN	**3.1.3.4**									

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Comments

GREEN **Objective 2: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.**

GREEN **Strategy 1:** Community engagement

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.2.1.1**	Partner with community organizations (i.e. Circle the City, MC Healthcare for the Homeless) to establish referrals into Ryan White services. Debby to reword.								
GREEN	**3.2.1.2**									
GREEN	**3.2.1.3**									
GREEN	**3.2.1.4**									

GREEN **Strategy 2:** Funding

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.2.2.1**	Explore partnership with HOPWA to seek additional funding opportunities. Jeremy to research further.								
GREEN	**3.2.2.2**	Explore opportunites to use rebate funds for housing services.								
GREEN	**3.2.2.3**									
GREEN	**3.2.2.4**									

GREEN **Strategy 3:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**3.2.3.1**	Develop and implement strategies to provide housing opportunites for HIV clients with a history of past felonies and/or substance abuse.								
GREEN	**3.2.3.2**	Explore emergency housing.								
GREEN	**3.2.3.3**	Confer with SAAF Harm Reduction program and HIV housing.								
GREEN	**3.2.3.4**									

RWPA Comprehensive Plan

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GREEN **Goal 4:** Achieving a more coordinated response to the HIV epidemic

GREEN **Objective 1:** **Reduce disparities in the rate of new diagnosis by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females living in Arizona.**

GREEN **Strategy 1:** Funding

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.1.1.1**	Encourage more collaboration among providers to better coordinate funding opportunities.								
GREEN	**4.1.1.2**									
GREEN	**4.1.1.3**									
GREEN	**4.1.1.4**									

GREEN **Strategy 2:** Patient-centered care

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.1.2.1**	Expand distribution of condoms to include more health care professionals.								
GREEN	**4.1.2.2**	Doctor/MCM interaction.								
GREEN	**4.1.2.3**	Utilize consumer focus groups/surveys to drive/inform/strengthen quality improvement projects at recipient and sub-recipient levels.								
GREEN	**4.1.2.4**									

GREEN **Strategy 3:** Stigma

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.1.3.1**	Organize group of HIV+ people to disclose publicly								
GREEN	**4.1.3.2**									
GREEN	**4.1.3.3**									
GREEN	**4.1.3.4**									

GREEN **Objective 2:** **Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.**

GREEN **Strategy 1:** Community engagement

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.2.1.1**	Partner with community organizations (i.e. Circle the City, MC Healthcare for the Homeless) to establish referrals into Ryan White services. Debby to reword.								
GREEN	**4.2.1.2**									
GREEN	**4.2.1.3**									

										Comments
GREEN	**4.2.1.4**									

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		Comments
GREEN	**Strategy 2:** Funding	

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.2.2.1**	Explore opportunities to use rebate funds for housing services.								
GREEN	**4.2.2.2**									
GREEN	**4.2.2.3**									
GREEN	**4.2.2.4**									

GREEN	**Strategy 3:** Patient-centered care	

Status	Goal. Objective. Activity	Activity	Staff (FTE)		Timeline			Performance Metric	Partners	Comments
			Lead	Team members	Start Date	End Date	% Complete			
GREEN	**4.2.3.1**	Confer with SAAF Harm Reduction program and HIV housing.								
GREEN	**4.2.3.2**									
GREEN	**4.2.3.3**									
GREEN	**4.2.3.4**									

EDUCATION: 5 Year Vision

EDUCATION	EDUCATION	EDUCATION
State supported sex education all levels	Education (eliminate ignorance)	Decrease stigma
Comprehensive sex ed in schools	Hope-Upcoming new drugs Tx (treatment)	Stigma
School sexual health curriculae	Cultural competency anti-oppression	Stigma
Broad HIV education in schools	Education/media campaign	More education about HIV
Support 4 client decided RR (risk reduction)	Educate rural provider+HCW's	Youth education
Education + expanded opportunities for PrEP+PEP		Education for youth
More focus on reproductive + sexual health		Comprehensive sex ed
More education for HIV+ people		Harm reduction
		Policy supportive of SAP/sex work
		Decrease (educ.)
		Client education
		Increase general community awareness

EDUCATION: Issues to Address

EDUCATION	COMMUNITY EDUCATION	EDUCATION	KNOWLEDGE IS POWER	EDUCATION	ADVOCACY	MEDICAL OUTREACH
Create specific educational campaigns for target populations	Importance of medication education for anyone getting ART by pharmacists, docs case managers	Community education	Medical students receive more HIV education	Improve cultural competency within organizations	Educate HC professional i.e. PCP, dentists	No cards added
Provide comprehensive sex education in schools to parents and students	Community education (what it's like to be poz).	Public edu	Education policies for schools	Expand culturally diverse media exposure	Educate govt entities	
Client education & buy in		Provider skill set testing & treatment	Greater education + support from legislators	ART social marketing/media	Educate school board	
Education must emphasize personal responsibility at 8th grade level		Self esteem education		Education standards provider cultural relevancy	Document + articulate benefits of svcs	
Grantors funding education projects; not just direct services		Community buy in from leadership		Expand knowledge to private providers		
Kit focusing on HIVAZ.org on a full-time basis		Recruit volunteers		Assess to schools to provide HIV education		
Staff education & buy-in		Hold community forums		Open communication in schools		
Consistent, continuous training for case managers + providers				HIPAA training/data sharing agreements		
Stigma education				Uniform data collection/reporting - monitoring & adherence		

POLICY: 5 Year Vision

POLICY CHANGES	POLICY CHANGES	POLICY DEVELOPMENT
Routine testing	MH/SA (mental health/substance abuse) in-Pt Tx (in-patient treatment)	Destigmatize sexual health
Faster linkage to care	Critical incident funding	Stigma HIV gone
Engagement from everyone	ADAP greater than 500% FPL (federal poverty level)	Cont. collaboration w/state & local partners
Integration between agencies/parts		Educated legislators
Services avail for all		Need more money
Easily accessible services for all		Focused determination to achieve goal
All drugs legal		Political will to end HIV
More focus on mother child care		HRSA $ support for critical $ funding

POLICY: Issues to Address

POLICY CHANGES	POLICY	POLICIES	POLICY
Education system involvement in prevention activities	Barrier: Gov't restriction Solution: Education for politicians	Provide edu to legislators	Med. Provider buy-in
Government red tape	HIV policy institutes: municipalities, cities, state, etc.	Sponsor for bill (P)	Advocate for policy change
Government changes in policies concerning legalizing drugs	Legalization for comprehensive sexual education for everyone paid for by the state	Statewide edu & advocacy	Collaborative advocacy
Changes in policies concerning social media parts	Barrier: Campaign finance laws Solution: Revising to new policies for campaigning	Buy-in from leadership & key people	Cheaper retail HIV test kit
Policy changes	Law need to be changed/legal issues need to be reviewed	Inertia & burnout - freshen it up!	Policy based intervention
	Make county lines flexible		Political dissension on prevention & harm reduction resources

FUNDING: 5 Year Vision

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FUNDING	FUNDING
Have resources available	More client level funding
Additional funds available	More funding
Standard, transparent costs for medical procedures	Funding for care continuum to address needs
Universal health care - single payer	Implement funding for care continuum
More funds on prevention than treatment	Allocate funding to eliminate disparities (SA, BH, Homelessness)
	Find the people living under bridges

FUNDING: Barriers to Address

FUNDING	FUNDING	MONEY!	FUNDING $
Funders that listen	Increase funding by mixing funding streams collaborate	Reduction in siloed funding streams	Availability/access to direct funding
Consumer informed funding	Innovative funding options	Find more sources of unrestricted funding	Fair distribution of resources
Flexible community based funding	Integrate programs/funding to increase L+R	"We've always done it this way" mentality	Finding funding sources
Flexible funding It's your money… spend where you need it, know your population	Identify local resources	HOPWA formula	State requires adequate funding for front line services
Barrier: Expense of care/prevention Solution: Redirection of funding	Show $ savings, advantages & disadvantages	Greater funding to find a cure	Use data to express/explain need
	Leverage funding, e.g. transportation @ vs. center & ADOT funded transport		

DATA: 5 Year Vision

DATA	DATA	REDUCED ADMIN BURDEN	INTEGRATION COLLABORATION SYSTEMS	ELIMINATE MIDDLE MAN (BARRIERS)
Reporting & data collection & utilization	Improved data + info sharing	Data & EMR sharing for re-linkage	No separation of Ryan White parts	Focus on useable data
Measurable outcomes	1 uniform & consistent database (i.e. ASIIS)	Centralized HER	An integrated model of care	Decreased paperwork
Data		Shared electronic health records	Statewide and regional planning councils	Simplify access to care
		Reduce barriers to care	True integration	Site based Tx (treatment)
		Co-location of services	Joining prevention with care	
		One stop provider services	Streamlined eligibility	
		Rapid linkage to care after testing	Data that shows where to focus efforts	
		Less paperwork burden	Data from Native communities	
			Data that reflects positive change	
			Expand provider network	
			Continue to build and strengthen HCP relationships (circle of care)	
			Reduce barriers to care	

DATA: Barrier to Address

DATA STANDARDS STANDARDIZATION	DATA	DATA	DECREASED BURDEN	UTILIZATION
Universal data sharing system	Easy data sharing	Transmit data safely, securely & lawfully	Too many variations in requirements	Integration of funding
Creating standards that are the same 4 all agencies	Standardize variables and measures for all agencies + databases	Universal data system	Annual Ryan White /ADAP enrollment	Better evaluation
Data			Streamline the process	Simplify paperwork to expedite access to expand care
Statistics not addressed with community			Data sharing	Processes too lengthy - simplify
			1 EHR (electronic health record) for all providers	

PREVENTION, TESTING & LINKAGE TO CARE: 5 Year Vision

HARM REDUCTION	LINKAGE & RETENTION	PREVENTION		PREVENTION & TESTING	ROUTINE TESTING
Condoms in jail	Care available and affordable	Standardized testing	Stigma	All HIV+ know status	Testing routine
Needle exchanges	Retention	Increased opt-out testing	Reduce stigma	Make testing more inviting	Routine opt-out testing test everyone!
Stable funding for effective syringe access programs	Care retention	Needle sharing program	Early sex education	PCPs embrace CDC testing recommendations	Access to testing
Statewide NEP/SAP	Linkage within 30 days	Clean needles education	PrEP widely available	Make testing more "inviting"	Testing for all
	Early linkage	Increased sexual education and free condoms	No new Dx (diagnoses) in 14-24 age group	Increase testing	Early detection
			Reduce new diagnoses by X%	Patients get diagnosed + linked to medical services in the same day	Communication between consumer & provider
			Prevention through increased education/ awareness	Make condoms fun!	
				Improved sexual history taking + routine testing	
				More support from collaboration (hookup apps)	

PREVENTION, TESTING & LINKAGE TO CARE: Barriers to Address

PREVENTION + TESTING	ROUTINE TESTING
Comfortable setting	Program to offer education to PCPs (primary care providers) in community re: HIV testing for everyone
4th gen+lab+POC (point of care) rapid (HIV test)	Policy changes statewide
Outreach with Eds (emergency departments) (like pregnant woman Ryan White project)	Educate about HIV testing importance
PrEP program	Primary care education
Outreach to PCPs about testing	Empower people to ask for HIV testing
Creation of compelling + consumer relevant message campaigns	

COLLABORATION: 5 Year Vision

COLLABORATION	COMMUNITY ENGAGEMENT	RESOURCES	SERVICES CLIENT CARE
Engage communities	Community coalition	Increased collaboration communication	Availability of services
Collaborative HIV community	Assess then adjust emerging culture	Increased collaboration within agencies	Encourage integration by avoiding blaming & shaming
Eliminate collabortation barriers	Volunteers (HIV/AIDS+)	Integrated system	HCP (health care providers) involvement in planning activities
Effective collaboration	Generosity of time to contribute to the cause	State-wide campaign	Healthy people
Increase community awareness of HIV services		Data sharing system	Acceptance/willingness to change status quo
Accountability from everyone		Increased church involvement	
		Supportive services	
		Mixed multiple models	
		More $$	
		Funding	
		Community resources $=available	
		Tools	

COLLABORATION: Barriers to Success

COLLABORATION	INTEGRATION COLLABORATION SYSTEMS	COORDINATED STATEWIDE EFFORT	COLLABORATION	COMMUNICATION	DISSEMINATION	COMMUNITY
Funding	Relocate all local programs under one umbrella	Organize group of HIV+ people to disclose publicly	Collaborative partnerships vs. silos	Better use of communication	Unified message	Diverse community partnerships that address HIV & sexual health
Collaboration on funding and coordination between agencies	Provider willingness- geographic inaccessibility	More people speaking up & out	Competition, territorialism & egos - set them aside!!	Regular meetings of ASOs	Provide information to everyone	Faith leaders who act as advocates
Collaboration when applying for grants/funding	Data sharing agreements (EMR)	Coordinated HIV educational campaign	Better understanding of other cultures		Dissemination of information	Develop Poz role model/leaders
Increased resources and funding	Shared CW	Wide dissemination of education				Populations @ risk buy-in for prevention efforts
Services client care	Breakdown federal silos					Barrier: tunnel vision Solution: More open to change
Strong universal programs						

PATIENT CENTERED CARE: 5 Year Vision

PATIENT CENTERED CARE	CLIENT BASED	EMPOWERMENT	CULTURAL COMPETENCY	BARRIER REDUCTION	SUPPORTIVE SERVICES
High intensity patient services	Accountability	Self-Managing Clients	Educated, self-empowered youth	Address basic needs (housing, food, transportation, etc)	Expansion of services/# of clients reached
Intensive support for high-risk clients	Goal planning	Retain clients in care	Youth volunteers w/HIV clients	Housing options	More resource allocation to rural areas of need
Outreach educate/test	Case management involvement	Ongoing education for Healthcare Professionals & Patients (Medication/Disease State)	FLAAVA focus group	Transportation options	Expand Services (vision)
Increase education to non-HIV sensitive community	Frame of mind		True cultural competency	Reduce barriers	Transportation
Compassion burnout counseling	Relationship communication				Personal/not teleconference mental health rural
Communication develop relationships	Act in the best interest of client	Client based			Housing everywhere
Better teamwork					Housing
					Mental Health
					All brand medications covered by insurance
					Substance abuse services everywhere

PATIENT CENTERED CARE: Barriers to Success

CLIENT CENTERED ISSUES	EMPOWERMENT	PATIENT EMPOWERMENT	PATIENT ENGAGEMENT	INTERVENTION	STIGMA	STIGMA/ EDUCATION	STIGMA	STIGMA REDUCTION
Encourage more family support to patients	substance abuse treatment	Patient involvement	Pledge patients to be VL suppressed	Empowerment projects/interventions	Expand education through national campaign + commercials	Compassion	Less stigma (more public knowledge) includes status	0 (zero) "gay disease" make routine
Prioritize client's basic needs (housing, food) before HIV education & other services	Comfortable setting	Identify and locate partners	Access to client medical records	Present at social work conference	Community engagement as standard op. procedure	Eliminated stigma	Reduced stigma	Remove stigma
Client compliance/medication adherence	Buddy/mentor (peer mentoring)	Pay patients for undetectable results	Dr education HIV testing as part of physical			Reduce stigma	Reduce stigma of HIV+	Coming "out" campaign to reduce stigma
Client based	Client motivation to participate in service		Expand access to condoms & needles			Equality for LGBTs	Encourage "community" for + and -	Coordinated HIV prevention campaign
	Health literacy training					Debunk AIDS myth in Africa through education	Break stigma	Expand access to condoms + clean needles *+ access*
						Early education	No fear of others finding out	Free HIV testing everywhere
						Project HIVAZ	Closer connection between at-risk + health care community	Gay youth support + interventions
						Social media tools	Better connect with MSM pop.	Peer to peer
						Increased events	Campaign HIV/AIDS as a disease not stigmatize to MSM	
						Youth education		
						HCP (health care providers) trained to understand HIV		
						Clear consistent message		

MIXED BAG: 5 Year Vision

DREAMS	THE WHOLE ENCHILADA	INNOVATION	NEXT GENERATION!	MEDS	BEST PRACTICES	ACCESS	ACCESS	ACCESS
Unlimited resources	Flexible funding for care opportunities	PREP in different forms	HIV testing as routine test	No fear! Doctor + medication availability	Client-centered programs	Access to phone apps/internet	Access to specialized care in rural areas	Easy access to care transportation funding
The most robust data infrastructure dedicated to a single disease (in history)	Without boundaries	Vaccine for HIV	Normalizing testing	Med adherence + simplest therapy	Integrate HIV services into primary care	Access to meds *(also coded as access)*	Easy access (no mazes)	Accessibility of care (continuum in AZ)
Clients happy to see us	Disparity free	Incentives	Mandatory testing	Everyone on meds	Doctor/MCM (medical case manager) interaction	Cross state connections for people moving	Access 4 testing in all POEs clients opt out…	Access to behavioral, SA (substance abuse), dental, housing ($) *+ access*
Compile HIV info for research	Comfortable & safe	Innovate	PCPs take sexual health Hx (history)	Research towards cure + new meds	Viral suppression	Media	Free HIV testing everywhere	Stop meth use!
A cure	Community support of HIV+ people	Phoenix AIDS Memorial	Empowerment at ALL levels		Joint funding	Electronic sharing of medical records	Universal health care including the undocumented	Client data sharing
	Clients receptive to guidance		Understanding Medicaid/ACA		Health Information exchange	Housing	Increase linkage to substance abuse & MH (mental health)	PrEP more easily available
	Close relationship between community & healthcare professionals		Developing HIV workforce and capacity		Reduce disparities	Substance Abuse Tx (treatment)	One stop shop - every service in one place	Health equity
			Develop CBO		Build trust between vulnerable populations & providers	Initialize PrEP referrals (non-Maricopa)	Increased interagency collaboration	Client Incentives
					Treatment adherence		Make condoms (prevention) fun!	Increase Client trust
					Best practices		Prevention Star	Prevention programming support services VHRN.
					Feeling of fulfillment w achievement of success			Education
								Intervention

MIXED BAG: Barriers to Success

DREAMS	STAKEHOLDERS
Improved grantor/ political understanding of resources needed	Gain support of Governor & legislature
Ability to think BIG	Pharm partners

Sum of Card Count Row Labels	Total
Prevention, Testing & Linkage	71
Patient Centered Care (Holistic Focus)	41
Streamlined processes at grantee, provider and client level	38
Stigma	35
Education	30
Community Engagement and Collaboration	23
Policy	19
Funding	11
DATA, STANDARDIZATION AND RESEARCH	8
Mixed Bag	5
Grand Total	**281**