Petersen HIV Clinics

STRATEGIC PLAN

2027 - 2029

Petersen HIV Clinics

Who are the Petersen Clinics?

THE PETERSEN HIV CLINICS (PHC) at the University of Arizona (U of A) provide specialty HIV care and prevention services in southern Arizona, including Pima, Yuma, Cochise, Graham, Greenlee, and Santa Cruz Counties. We deliver medical care within the Banner University Medical Center's North and South Campuses and currently serve about 1,000 patients with HIV and approximately 300 patients accessing biomedical HIV prevention services (PEP/PrEP).

Approximately 1,700 patients are served by other area providers. There are an estimated 900 people with HIV in southern Arizona who are either out of care or for whom it is unclear who provides their HIV care. We collaborate in partnership with other area providers to ensure comprehensive and coordinated service provision and access for the community of people with HIV and those at risk for HIV.

We have long standing, supportive relationships with our community partners at COPE Community Services, CODAC, El Rio Special Immunology Associates, Pima County Health Department, Southern Arizona AIDS Foundation, Tucson Interfaith HIV/AIDS Network, and Veteran Affairs. We work together to ensure southern Arizona has a strong, accessible continuum of care available at various points of entry.

Our Mission, Vision, and Values

Mission

To provide exceptional, person-centered HIV care and prevention through a stigma-free, team-based approach.

Vision

We envision a community where people experience innovative, holistic, specialized HIV care and case management services, with access to PrEP and PEP.

Values

Our values guide our work. We are:

COMMITTED TO FAIR TREATMENT

We see HIV as an issue requiring justice for all, and we strive to decrease unequal conditions in health care through the services we provide.

TRUSTWORTHY

We are committed to integrity and ethical practices to foster patient and provider trust.

COMPASSIONATE

We believe in a caring and empathetic approach to patient-centered care.

INNOVATIVE

We use innovation to create new ways of reaching shared goals.

MULTIDISCIPLINARY

We believe a multidisciplinary team achieves the best holistic care for each person.

EXPERT

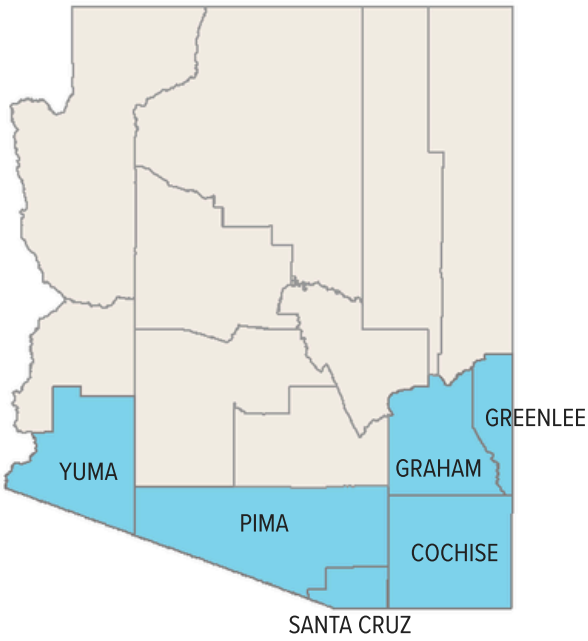
Our highly skilled and experienced team works with patients to provide exceptional specialized care.

Our Work in Southern Arizona

PHC serves six fairly rural counties in southern Arizona (percent of people living in unincorporated areas in 2025 in parentheses);[1] Cochise (39%), Graham (52%), Greenlee (52%), Pima (34%), Santa Cruz (59%), and Yuma (27%).

Barriers to HIV care and prevention in this region include limited healthcare delivery in rural areas, stigma and discrimination, limited transportation, minimal access to many key health and supportive resources, insecurity of basic needs such as food or safe housing, and immigration/border issues. Four of the six counties served by PHC (Yuma, Pima, Santa Cruz, and Cochise) border Mexico, which creates unique challenges in access to care, retention in treatment, and HIV prevention.

Reach of Petersen HIV Clinics



County	Square miles	2025 population[1]	2024 HIV Incidence[2]	2024 HIV Prevalence[2]
Cochise	6,219	129,042	5.4	226.1
Graham	4,641	40,277	7.5	102.2
Greenlee	1,848	9,687	10.3	62
Pima	9,189	1,093,761	11.4	298.1
Santa Cruz	607	51,324	11.8	183.8
Yuma	5,519	222,125	8.7	175.2

**Per 100,000 people*

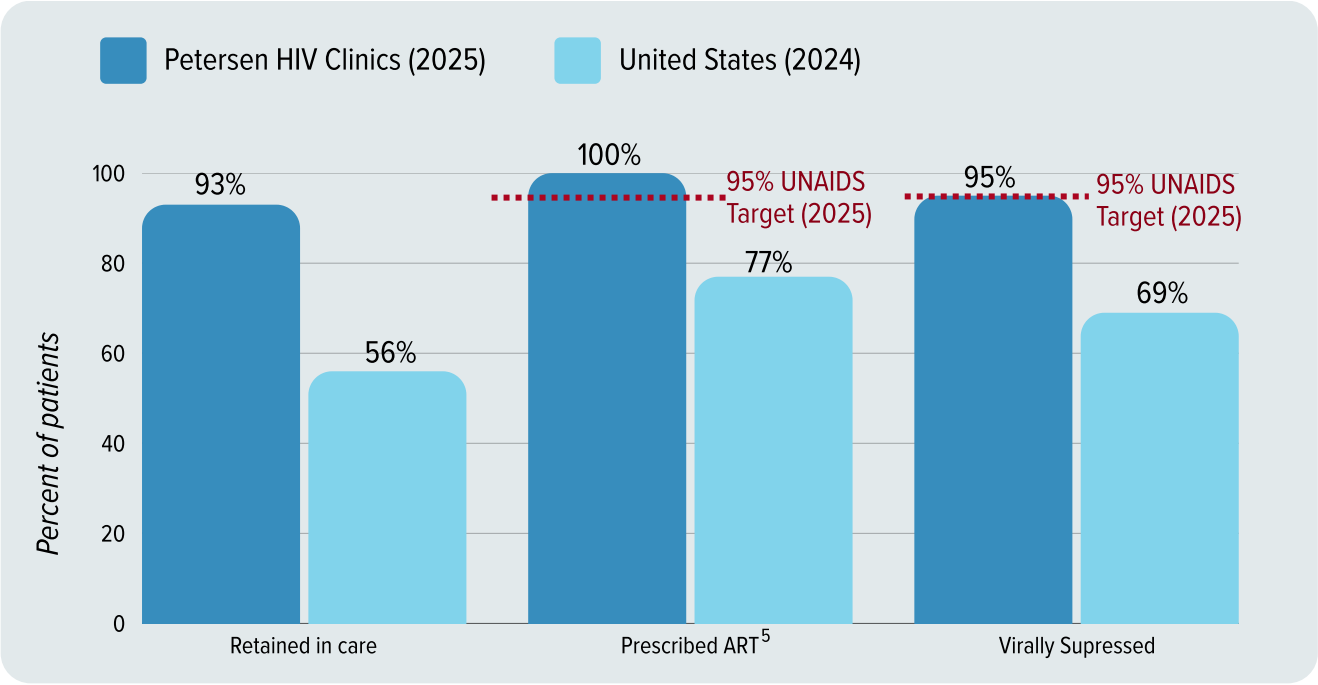
1. Arizona Office of Economic Opportunity. July 1, 2025 Population Estimates for Arizona's Counties, Incorporated Places and Unincorporated Balance of Counties. Accessed July 13, 2026. https://oeo.az.gov/sites/default/files/data/popest/2025_Estimates/July1_2025_Arizona_Population_Estimates.pdf.
2. Arizona Department of Health Services. HIV Surveillance County Tables, 2024. Accessed July 13, 2026. https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/hiv-epidemiology/reports/2024/2024-hiv-aids-county-tables.pdf.

Our Work in Southern Arizona

Despite these barriers, patients at PHC have consistently strong health outcomes. PHC serves nearly 1,000 people with HIV, and in 2025, 93% were retained in care (defined as two medical visits within a 12-month period). Among those retained in care, 100% were prescribed antiretroviral therapy (ART), and 95% of those on ART achieved viral suppression. Overall, PHC met or nearly met the UNAIDS targets across the HIV care continuum while consistently outperforming the national average.

PHC also provides HIV preventive care to 140 patients receiving HIV pre-exposure prophylaxis (PrEP) and approximately 150 patients receiving HIV post-exposure prophylaxis (PEP) through the program annually.

HIV Care Continuum: Petersen HIV Clinics against UNAIDS Targets[3] and United States overall[4]



3. UNAIDS. Understanding measures of progress towards the 95–95–95 HIV testing, treatment and viral suppression targets. Accessed July 14, 2026. https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf.

4. Centers for Disease Control and Prevention (CDC). National HIV Prevention and Care Objectives: 2026 Update. Accessed July 14, 2026. https://www.cdc.gov/hiv-data/nhss/national-hiv-prevention-and-care-objectives-2026.html.

5. The United States data used for comparison to "prescribed ART" at Petersen HIV Clinics is based on the percent of patients nationwide who "received some medical care".

Our Strategies

Despite how much we have accomplished, there is always room to improve and enhance our services. To that end, we have identified four core strategies that will guide our work over the next three years:

CORE STRATEGY 1

Continue to strengthen vital HIV care and treatment services

CORE STRATEGY 2

Enhance access to HIV prevention interventions

CORE STRATEGY 3

Empower community voice through advisory opportunities

CORE STRATEGY 4

Invest in staff well-being, communication, and organization infrastructure

Our Initiatives

Within each core strategy we have a series of initiatives that drive our improvements:

1. Continue to strengthen vital HIV care and treatment services.

- Maintain stability in core HIV services while expanding some services to meet the needs of patients
- Expand behavioral health services
- Expand preventative screenings and integrate lifestyle and integrative medicine programs for people with HIV
- Identify and tailor care for priority populations among people newly diagnosed with HIV

2. Enhance access to HIV prevention interventions

- Identify and engage new patients who could benefit from HIV prevention, with a focus on priority populations
- Enhance access to PrEP and PEP through expanded payment support and services

3. Empower community voice through advisory opportunities

- Maintain and strengthen the Community Advisory Board (CAB) and Team-Rx group (T-Rx)
- Integrate creative engagement strategies for the CAB and T-Rx
- Ensure meaningful participation in the CAB and T-Rx through communicating a clear purpose

4. Invest in staff well-being, communication, and organization infrastructure

- Build clear, efficient, and accountable communications
- Strengthen team coordination and operational efficiency
- Support sustainable workloads and ensure equitable distribution of work
- Create clear pathways for professional development, growth, and staff retention

More details about the steps we will take to accomplish each of these initiatives are found on the following pages.

CORE STRATEGY 1

Continue to strengthen vital HIV care and treatment services

1.1: Maintain stability in core HIV services while expanding some services to meet the needs of patients	Y1	Y2
• Implement strategies to gather updated SOGI data, contact and insurance information, and other necessary data directly from patients outside the clinic visit		☑
• Identify peer support strategies and opportunities to promote gender-balanced, resilient patient support and engagement		☑
• Partner with community agencies to expand opportunities for connection and community among people with HIV in southern Arizona	☑	
• Identify resources and build partnerships with community organizations that can assist patients with housing supports	☑	
• Explore becoming a clinical trial site to expand prevention and treatment options, in partnership with T-Rx	☑	
• Continue to assess the unique needs of aging patients and evaluate whether current efforts are effective or require adjustment		☑
• Increase visibility of PHC's tailored services and support for people with HIV who are aging	☑	
• Collaborate with Banner Peds ID to enhance financial assistance resources for families with children with HIV, addressing barriers to improve care engagement and outcomes	☑	
• Strengthen systems for panel management to ensure patients are retained and receive the highest quality care	☑	
• Continue systems and strategies that encourage patients to maintain a viral suppression rate ≥95% clinic-wide	☑	☑

1.2: Expand behavioral health services	Y1	Y2
• Explore hiring an LCSW to expand provision of behavioral health support to patients through direct therapy services and/or groups	☑	
• Strengthen behavioral health referral systems through internal and external partnerships and provide financial support		☑
• Integrate retention and care strategies with a focus on out-of-care and high-needs patients		☑

Continue to strengthen vital HIV care and treatment services

1.3: Expand preventative screenings and integrate lifestyle and integrative medicine programs for people with HIV	Y1	Y2
• Expand use of High-Resolution Anoscopy (HRA) for eligible patients and evaluate how improved accessibility impacts screening uptake and early detection of anal dysplasia and cancer	☑	
• Consistently pair health screenings (mammograms, DEXA scans, colonoscopy) with patient education to normalize preventative screenings as standard HIV care		☑
• Assess the prevalence of diabetes, heart disease, and obesity among our patient population and examine associations with HIV care continuum metrics		☑
• Develop and implement comprehensive lifestyle and integrative medicine programs to address comorbidities and support whole-person health		☑
• Measure whether participation in the lifestyle/integrative program improves disease outcomes, retention in care, and viral suppression		☑

1.4: Identify and tailor care for priority populations among people newly diagnosed with HIV	Y1	Y2
• Identify key socio-demographic priority populations among newly diagnosed patients	☑	
• Examine underutilization of services among identified priority populations	☑	
• Establish new relationships with providers, organizations and community leaders to increase access for these priority groups	☑	

CORE STRATEGY 2

Enhance access to HIV prevention interventions

2.1: Identify and engage new patients who could benefit from HIV prevention, with a focus on priority populations	Y1	Y2
• Explore the expanding populations already being served and identify populations who are still being missed	☑	
• Evaluate the existing social marketing campaign for the PEP/PrEP programs to understand what has worked well and what can be built upon for the future	☑	
• Launch round 2 of the PrEP/PEP marketing campaign on social media, focusing on media used by priority populations, including women	☑	
• Develop patient-friendly service lists/marketing material with clear eligibility, how to access PrEP/PEP services, etc., to improve PrEP/PEP visibility inside and outside of clinic		☑

2.2: Enhance access to PrEP and PEP through expanded payment support	Y1	Y2
• Increase utilization of PHC PrEP copay assistance for medical visits, laboratory services, behavioral health, and medications to improve access to and retention in PrEP care.	☑	
• Expand access to PEP by increasing the number of outpatient pharmacies that can directly bill PHC for PEP medication bridges		☑
• Dedicate resources to improve financial support to families with children who need PEP, via Banner Peds ID	☑	

CORE STRATEGY 3

Empower community voices through advisory opportunities

3.1: Maintain and strengthen the Community Advisory Board (CAB) and Team-Rx group (T-Rx)	Y1	Y2
• Clarify clinic branding (PHC vs. PC) to ensure PrEP and prevention services are visible without erasing HIV identity	☑	
• Increase diversity and representation in the CAB and T-Rx through promotion to the diverse client base, supplemented with 1:1 outreach for patients who may be a good fit	☑	
• Maintain incentives and accessibility through gift cards, food, and transportation to CAB and T-Rx meetings	☑	☑
• Encourage feedback by sharing how CAB input influences Petersen program decisions and continuing to elicit input	☑	☑

3.2: Integrate creative engagement strategies for the CAB and T-Rx	Y1	Y2
• Support CAB members in engaging patients through peer outreach opportunities and one-on-one conversations to increase awareness of and participation in the CAB		☑
• Host “Meet & Greet” events with the CAB and T-Rx	☑	
• Partner with local HIV service organizations for broader reach	☑	
• Improve outreach and communication through enrolling people in the CAB and T-Rx listservs, distributing CAB and T-Rx brochures/flyers explaining purpose and value, partner organization newsletters, and reminders before meetings	☑	
• Develop and implement concrete strategies for effectively engaging with monolingual Spanish-speaking patients, welcoming them to the CAB and T-Rx and encouraging them to provide input on services	☑	

3.3: Ensure meaningful participation in the CAB and T-Rx through communicating a clear purpose	Y1	Y2
• Develop and begin utilizing structured agendas	☑	
• Welcome new voices at meetings to ensure they are able to fully engage	☑	☑
• Ensure meetings and activities are accessible, inclusive, and responsive to member needs and preferences	☑	☑
• Elicit feedback and input about CAB and T-Rx activities and experience, and take action steps to incorporate feedback		☑

CORE STRATEGY 4

Invest in Staff Wellbeing, Communication, and Organizational Infrastructure

4.1: Build clear, efficient, and accountable communications	Y1	Y2
• Strengthen staff engagement with PHC policies, procedures, user guides, and training resources by leveraging Relias as a centralized platform for delivering, tracking, and maintaining current program documentation and educational content.	☑	
• Develop a formal PHC code of conduct that promotes professionalism and accountability and provides a framework for resolving conflicts		☑

4.2: Strengthen team coordination and operational efficiency	Y1	Y2
• Continue to fine tune roles, to address areas of overlap and clarify who is responsible for each aspect of patient care	☑	
• Ensure sustainable growth through sufficient and efficient infrastructure	☑	
• Continue to have structured collaboration opportunities and team-building spaces such as the Employee Engagement Committee	☑	☑

4.3: Support sustainable workloads and ensure equitable distribution of work	Y1	Y2
• Define caseload or panel capacity standards and adjust caseload to account for patient acuity		☑
• Ensure equitable distribution of work and regularly assess workload balance across staff, while reducing unnecessary redundancy among EIS, MCM, CC, and CMC teams		☑
• Ensure that all staff have a clear understanding of roles, responsibilities, and division of tasks	☑	☑

CORE STRATEGY 4

Invest in Staff Wellbeing, Communication, and Organizational Infrastructure

4.4: Create clear pathways for professional development, growth, and staff retention	Y1	Y2
• Formalize professional development systems through regular career conversations with supervisors and clear pathways for advancement	☑	
• Expand access to training opportunities that include local and non-travel options or on-site training (leadership, communication, clinical topics)	☑	
• Clarify what opportunities are eligible to be covered by PHC professional development funds	☑	
• Centralize opportunity sharing to ensure all staff have access	☑	
• Develop succession planning systems through understudy/shadowing opportunities and internal pipeline development for leadership roles		☑
• Look for ways to enhance recruitment and hiring to increase the proportion of qualified LGBTQ+ people and men, to ensure maximum alignment between staff and patient demographics	☑	

Acknowledgements

Thank you to the many people who contributed to the development of this strategic plan, including Petersen HIV Clinics (PHC) staff and our Community Advisory Board. We also thank our PHC patients for showing up and being part of the community that makes PHC special.

FACENTE CONSULTING
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The strategic planning process and this strategic plan document were facilitated and designed by Facente Consulting.

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