

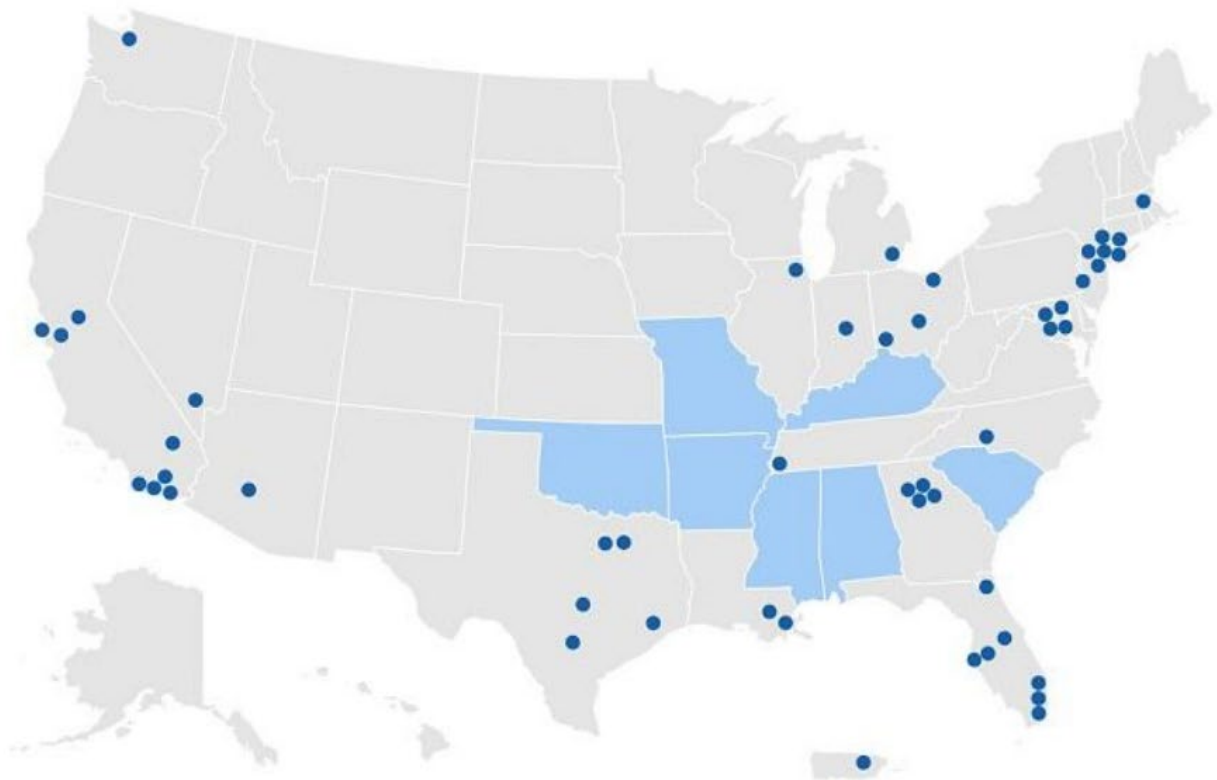
Ending the HIV Epidemic: A Plan for Oklahoma



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The Sexual Health and Harm Reduction Service (SHHRS) is charged with Ending the HIV Epidemic planning in Oklahoma. During the last few months and continuing in 2020, we conducted planning meetings with both staff and community members to complete this work. A central part of the planning will utilize the OHHPC (Oklahoma HIV and Hepatitis Planning Council), the body that represents community planning for HIV/AIDS Prevention and Care in Oklahoma.

During the 2019 State of the Union address, the Trump administration announced the new [“Ending the HIV Epidemic: A Plan for America.”](#) This will be a ten year initiative beginning in FY 2020 to achieve the important goal of reducing new HIV infections to less than 3,000 per year by 2030. Reducing new infections to this level would essentially mean that HIV transmissions would be rare and meet the definition of ending the epidemic. The initiative will focus efforts in 48 counties, Washington, DC, San Juan (PR), and seven states with substantial rural HIV burden.

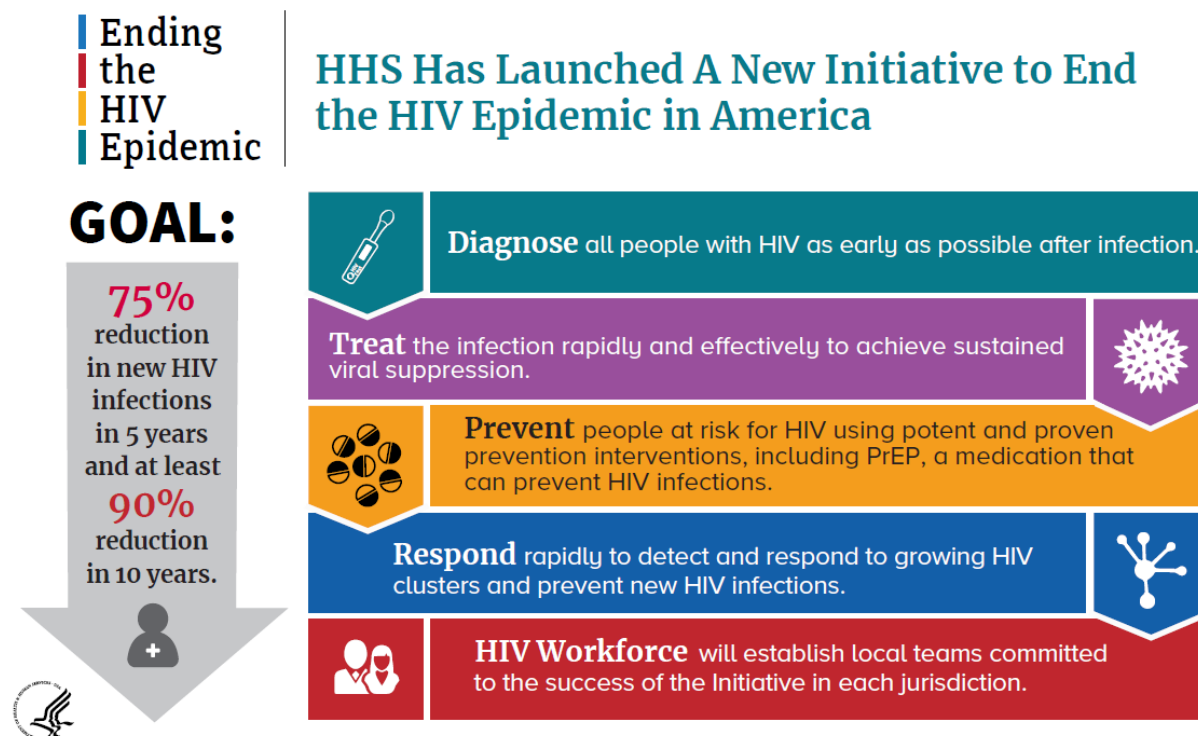


Geographic locations: The 48 counties, plus Washington, DC, and San Juan, PR, where >50% of HIV diagnoses occurred in 2016 and 2017, and an additional seven states with a substantial number of HIV diagnoses in rural areas. [View the list](#) (PDF - 44 kb)

Key Strategies in the Plan

The efforts will focus on four key strategies, also known as Pillars, which together can end the HIV epidemic in the U.S.

1. **Diagnose** all people with HIV as early as possible.
2. **Treat** HIV rapidly after diagnosis, and effectively, in all people with HIV to help them get and stay virally suppressed.
3. **Prevent** people at risk for using proven prevention interventions, including Pre-Exposure Prophylaxis (PrEP) and syringe service programs (SSPs).
4. **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.



HIV Trends in Oklahoma from 2013 to 2017

From 2013 to 2017, there was a 12% decrease in newly diagnosed HIV cases in Oklahoma. However, disparities in new cases by sex and race/ethnicity were detected (Figures 1 and 2). Males accounted for approximately 84% of new cases. Hispanics experienced a 104% increase in new cases, particularly Hispanic females who had a 600% increase. Among black females, there was a 24% increase in new cases. American Indians/Alaska Natives also experienced a 17% increase in new cases from 2015 to 2017, while Blacks had an 11% increase during this time. The magnitude of the increase in new cases also varied by mode of HIV transmission. Among men who have sex with men who also reported injection drug use, or “MSM/IDU”, there was an 80% increase in new cases, while we saw a decrease among those in all other transmission categories. Geographic disparities were also detected; for example, Lawton metropolitan statistical area had a 117% increase in new cases. The largest proportion of new cases was among those aged 20-29 years who made up 38% of all new cases, followed by those aged 30-39 years who made up 24% of all new cases.

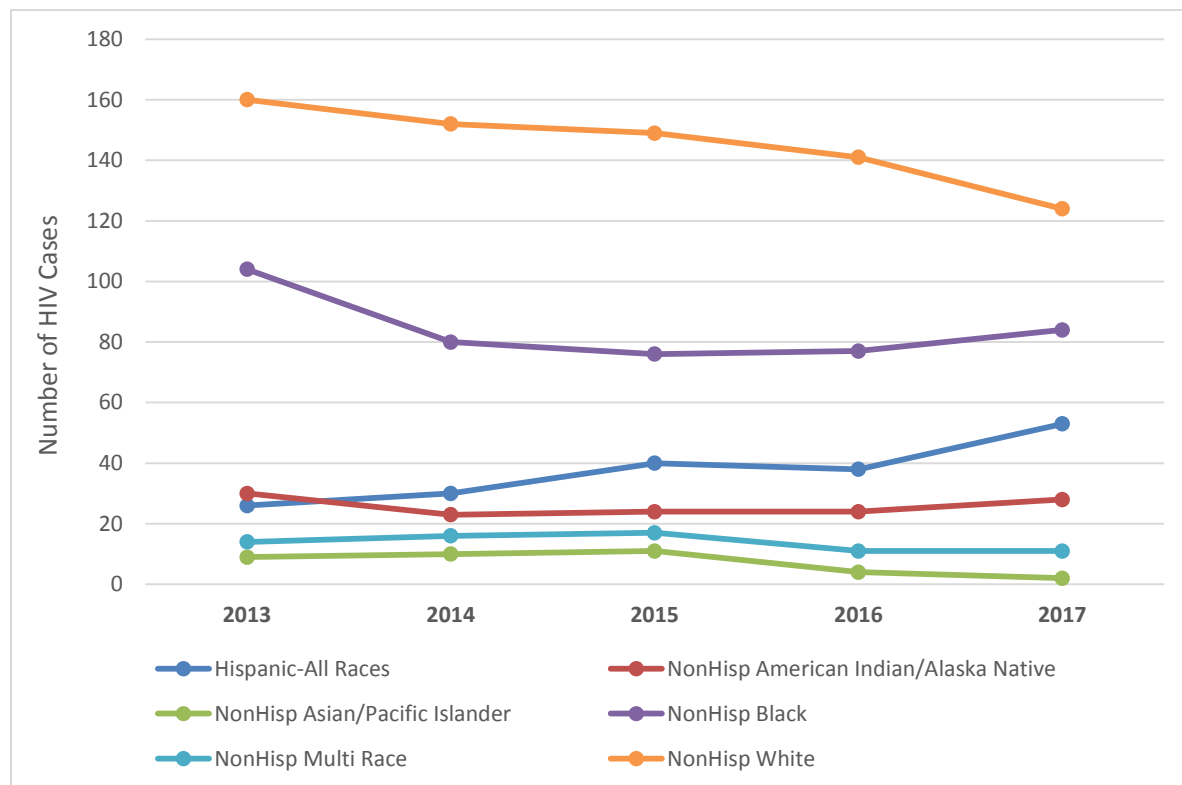


Figure 1. Newly Diagnosed HIV Cases by Race/Ethnicity, Oklahoma, 2013-2017

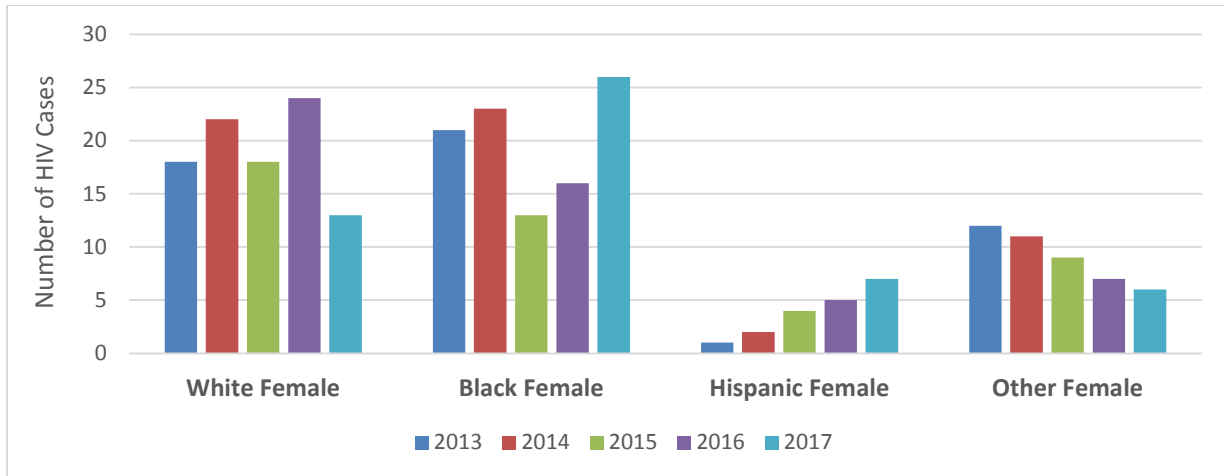


Figure 2. Newly Diagnosed HIV Cases among Females by Race/Ethnicity, Oklahoma, 2013-2017

Late testers are defined as persons having an AIDS diagnosis within three months of HIV diagnosis. This group accounted for approximately one-fifth of HIV cases. Hispanics had a 78% increase in late testers, and AI/ANs had a 33% increase, while all other races experienced a decrease (Figure 3). Males had a decrease of 10%, while there was no change among females. There was a 100% increase among MSM/IDU, and a 24% increase among MSM not reporting IDU. Rural, or non-metropolitan statistical areas, had a 40% increase in late testers.

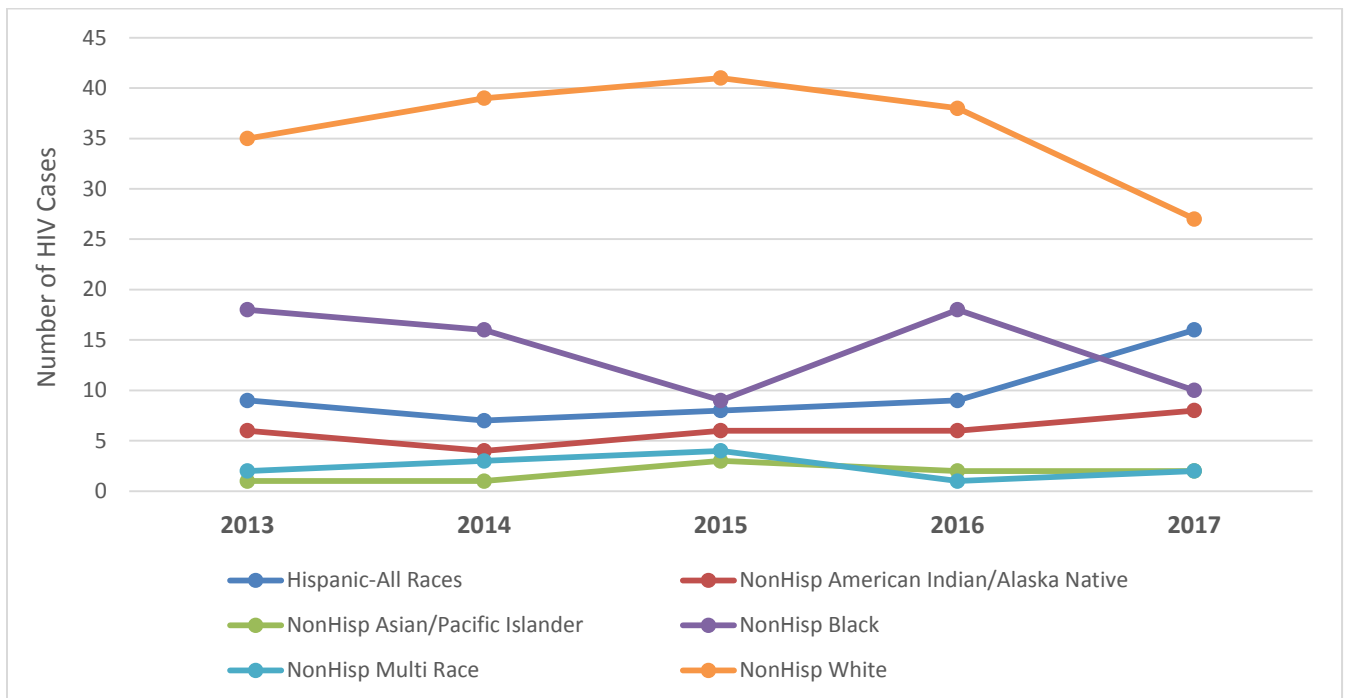


Figure 3. Newly Diagnosed Late Testers by Race/Ethnicity, Oklahoma, 2013-2017

Focusing on deaths among Oklahomans with HIV/AIDS, there was 3% decrease from 2013 to 2017. However, there was a 73% increase in persons who died within 1-5 years after HIV diagnosis (Figure 4). Of those persons who died within 1-5 years, 33% were female and 31% resided in a non-metropolitan statistical area.

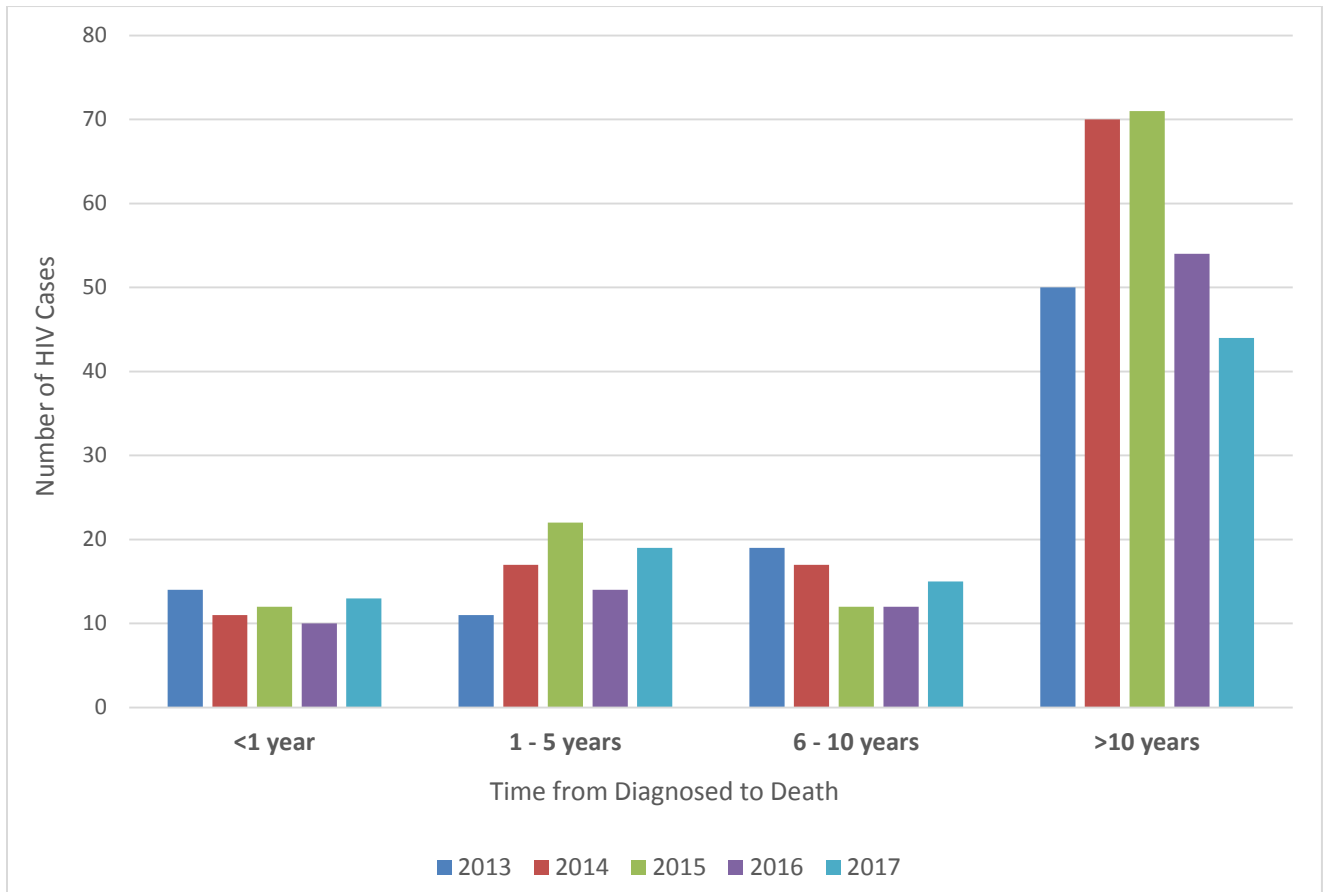


Figure 4. Time from Diagnosed to Death among Those Diagnosed with HIV/AIDS, Oklahoma 2013-2017

Current Situation Analysis

Jurisdictional strengths

- Increase in access for PrEP w/non physicians; free PrEP access
- Increase in community based access; CBO ability to find clients,
- Increase in state policy awareness around prevention
- County sexual health education comprehension
- Condom distribution
- U=U (viral suppression rate)
- Several outreach events (testing/education)
- HIV Prevention CO-OP
- Geographic – location of agencies
- Oklahoma State University Infectious Disease Clinic (OSU) can treat quickly (usually within a week)
- OSU PrEP clinic
- OSDH and partner agencies are good at identifying client partners
- At-risk communities (LGBTQ, Black, Hispanic) are now interested in PrEP and self-advocating, due to media/commercials lowering stigma

Jurisdictional Challenges

- Getting information to rural communities
- State laws and SSPs
- Opportunities for syringes/syringe service programs
- Stigma
- Funding for sexual health education/financial support
- Lack of provider education regarding PrEP
- LGBTQ affirming care
- Buy-in from religious organizations
- Prescribing providers
- Transportation
- Community knowledge/education/awareness
- Wait time for treatment at University of Oklahoma Infectious Disease Clinic (OUIDI)
- Lack of utilization of residency program at University of Oklahoma (OU) to train in the area of HIV
- Lack of access to PrEP for uninsured, since Oklahoma has not expanded Medicaid

- Funding
- Screening is not seen as a priority in primary care providers
- Stability of OSDH senior leadership, lack of buy-in
- Stigma and legislative push-back

Jurisdictional Champions

- Stop Harm on Tulsa Streets (SHOTS)
- Tulsa Chief of Police
- CBOs
- HIV Prevention CO-OP
- OSDH
- Ryan White Clinics
- OSU-Tulsa PrEP clinic and HIV clinic
- Pharmacies
- Diversity Family Health/Diversity Center/Expressions Community Center
- Dr. Jorge Mera of Cherokee Nation
- Schools

Jurisdictional Resources

- OSDH
- Pharmacies
- 340B programs
- Foundations
- Pharma Companies
- Free clinics
- Federal funding with potential increase
- 211
- Good network of HIV prevention community
- Contracted CBOS

Pillar One: Diagnose all people with HIV as early as possible.

Since 2006, CDC has recommended that all Americans aged 13 to 64 get tested for HIV at least once as part of routine health care, and that people with certain factors like community prevalence should get tested more often. This recommendation needs to be implemented with a fresh marketing campaign, both to clinicians and individuals. For sexually active adults, routine testing should always be offered by medical providers.

We must increase CDC and Oklahoma State funding streams for innovative outreach and testing for youth. According to the CDC, people ages 13 to 24 represent the age group with the highest rate of undiagnosed HIV, with 51% of teenagers and young adults living with HIV were undiagnosed as of 2013. In numbers, more than 31,000 youth are undiagnosed out of an estimated 60,900 youth living with the disease. Disproportionately high rates of new HIV transmissions also occur among individuals ages 25 to 34. While a ramp up and intensity needs to focus on young people, CDC and the state of Oklahoma must also think about tools and interventions to help maintain health across the life span.

Adults age 50 and older account for 15% of all new HIV diagnoses and 29% of all people living with HIV. Research shows that heterosexual and LGBTQ older adults are sexually active well into their mid-80s with a 2007 national study showing 53% of adults age 65-74 and 26% of adults age 75-85 report having one or more sexual partners, yet CDC guidelines recommend routine testing for people only to age 65, leaving out people over age 65 who could benefit from regular HIV testing. Few national or regional HIV prevention campaigns explicitly target older people, especially older people of color and LGBTQ older people. CDC should update their recommendations to anyone who reports high risk activity, regardless of age.

The CDC's August 2017 recommendations regarding the benefits of regular HIV testing of gay and bisexual men need further promotion and clarification; first, the CDC should invest in widely promoting the screening campaign and educational materials to clinicians and varied health care settings. As educational outreach efforts to clinicians who are outside of the usual public health channels need targeted, identifying the settings and types of providers who are missing even routine annual screening and providing education and materials to them is critical.

Goal: Normalize HIV testing in order to increase known HIV status

Key Activities:

- Marketing/mind shift/hopeful messages
- Educate providers to talk to patients
- Mobile/utilize tech to remind to test
- Change messaging techniques
- Partner with rural churches health ministry
- Engage with People Who Inject Drugs(PWID) and include in discussion on normalizing HIV testing
- Additional discussion, education, and promotion of testing for priority populations
- Expanding capacity to primary care physicians and mid-level practitioners (including training providers to ask relevant risk questions)
- Telemedicine and Project ECHO

Key Partners: Social media/public influencer, public health detailers, churches, communications agencies.

Timeline: 2020-2030

Resources:

- Funding
- Culture shift; the way we talk about it
- Focus group
- Language of young people

Expected Reach: All people

Measurement:

- Study messaging trends
- Sign up from mobile
- Follow marketing data

Point of contact: All, OHHPC, OSDH

Goal: Expand testing and education at rural community events with help of community partnerships

Key Activities: Building community partnerships in all 77 counties

Key Partners: Chamber of Commerce, Pharmacies, local businesses

Timeline/Key Dates: 2020 forward, local festival dates (at least 2 months out)

Resources needed: Festival promotions, person hours, festival materials

Expected reach: Everyone

Goal: Focus testing efforts in specific high-impact communities

Key Activities:

- Determine culturally relevant techniques
- Reflect the served community in employees
- Culturally informed healthcare by providers
- Engage and find trusted gate keepers
- Promote education and testing among younger population
- Implement SSPs to reduce risk of sharing injection equipment

- Screening to address high risk populations
 - People who inject drugs
 - People who have experienced incarceration
 - People experiencing homelessness
 - Immigrants and refugees
 - Baby boomers
 - Pregnant women and infants

Key Partners: Local businesses, churches, CBOs that work with selected population, specific trusted providers, peer mentors

Timeline: 2021

Resources: Focus group data, digital info sharing, access to home test kits, informational/supportive handouts, expansion of Medicaid coverage for HIV testing, treatment, and medication for at-risk individuals in criminal justice settings, drug treatment facilities, SSPs and other high impact settings; state leadership advocacy and financing options;

Reach: Statewide, rural, communities of color, disproportional affected communities

Measurement: Decrease in late testers by race/ethnicity, a temporary increase in positivity

Lead Organizations: Latino Community Development Agency (LCDA), Guiding Right, Inc.(GRI), Health, Outreach, Prevention, Education, Inc. (HOPE), Red Rock, OSDH, IHS, Tribal government, other agencies

Goal: *De-stigmatize HIV testing and make it easier to access home testing kits*

Key Activities: Develop app (postmate-ish/delivery kits) to order home HIV/STD kits

Key Partners: Tech developers, OSDH

Timeline/Key Dates: 2021

Resources needed: App developers, take out boxes/bags, home test kits, delivery drivers (to include training); Promote treatment as prevention and use of PrEP for high-risk population; Testing in high impact settings with linkage to care (e.g. EDs, FQHCs,

Substance use treatment facilities , SSPs, Corrections (including juvenile detention centers), Homeless services (including group homes), Behavioral health services, etc.); expansion of Medicaid coverage for HIV testing, treatment, and medication for at-risk individuals in criminal justice settings, drug treatment facilities, SSPs and other high impact settings; state leadership advocacy and financing options

Expected reach: State wide

Measurement/Evaluation: App tracking of orders and option of full blood draw

Lead organization: OSDH & other testing orgs (GRI, Red Rock, etc)

Point of Contact: TBD

Pillar Two: Treat HIV rapidly after diagnosis, and effectively, in all people with HIV to help them get and stay virally suppressed.

Highly effective antiretroviral therapy, taken as treatment or prevention, provides the means to end our HIV epidemic, even without a vaccine or cure, by dramatically reducing new HIV cases, ending AIDS deaths, and eliminating disparities in access to quality HIV prevention and treatment. We now know that for people living with HIV, retention in HIV treatment that suppresses viral load to an undetectable level both sustains optimal individual health and eliminates risk of sexual transmission of the virus. Successful HIV prevention for HIV-negative individuals is available through a combination of sexual health education, routine HIV screening, wide access to both pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for those who need it, syringe access and other harm reduction services, and comprehensive insurance coverage of these interventions as essential preventive health care services.

The most effective prevention measure is to identify People Living With HIV/AIDS (PLWHA) through testing, facilitate immediate treatment, and assist everyone living with HIV in staying on the HIV medications so that they remain healthy and their viral loads reach and are kept at undetectable levels, thus preventing sexual transmission of the virus.

Goal: Increase access to HIV care.

Key Activities:

- Increase use of rapid start treatment
- Increase number of providers who can treat HIV
- Increase number of case managers to handle the resulting increase in clients
- Enable PharmDs to initiate ARV treatment to get patients on meds faster
- Use AIDS Education and Training Center (AETC) to educate providers on treating HIV
- Use mobile vans in rural areas for testing, treatment, checkups, PrEP

- Increase telemedicine usage to reach rural areas
- Strengthen relationships between case managers and doctors
- Increase private physician/OBGYN awareness of HIV resources for clients testing positive
- Increase collaboration between health care providers, CBOs, and state agencies (loaning clinic space, donating supplies/test kits, providing training)
- Create an attractive website for HIV resources for doctors and patients

Key Partners:

IHS, tribes, CBOs, Ryan White program, Private ID doctors, OBGYNs, Nursing Association, VA, faith-based organizations, CDC, NIH, OK Medical Association, Diversity Center, Primary Medical Care Association, corporate sponsors (pharmaceutical and technology companies who may provide donations),

Timeline: 12 months

Resources: Healthcare providers, time, money, donations of facility space, supplies and equipment, mobile space, leadership buy-in.

Measurement: Increase number of HIV care providers by 50%

Point of contact: Co-chair OHHPC

Goal: Increase retention in care.

Key Activities:

- Increase number of case managers and outreach case managers
- Increase mental health/SA services (utilize Medicaid mental health care out criteria for HIV)
- Improve collaboration with DOC for discharged offenders
- Conduct assessment for barriers to staying in care
- Increase cultural diversity and competency of HIV care physicians

Key Partners: DOC/county jails, OSDH Ryan White, CHDs, CBOs, case managers, therapists/mental health specialists, OHCA

Timeline: 12 months

Resources: Healthcare providers, in-care barrier assessment tool

Reach: Statewide

Measurement: Ensure 95% stay in care, collect quarterly data

Point of contact: Family members, churches, social networks

Goal: Increase number of ART-prescribing providers by 25% by 2022

Key activities:

- Evaluate scope of practice of mid-level providers
- Baseline number of providers prescribing
- Find best practice for training for ART education

Key partners: Universities, any healthcare partner, FQHCs, mid-level provider associations

Timeline: Start: 2020; Measure date: 2022

Resources needed: Trainers, funding, EMR infrastructure

Expected reach: statewide

Measurement and evaluation: Reduction in time from diagnosis to Initiation of ART; Initiation to viral suppression; Pre/post number of prescribers

Lead organization/s: OHHPC, OSDH, Southern Plains Tribal Health Board (SPTHB), Ryan White clinics, AETCs, FQHCs

Goal: *Create peer-mentoring program as part of linkage for newly diagnosed patients with HIV.*

Key activities: Create position at OSDH: Peer mentor linkage officer to support outreach and recruitment of pts from other organizations; new position in SHHR. MOUs, evaluate existing peer mentor programs (San Francisco), find best practices across the nation.

Key partners: OSDH, CBOs, Case Managers, Chuck Courtney (*in memoriam*)

Timeline: January 1, 2021

Resources needed: Funding for new position, peer mentoring training, quality measurements.

Expected reach: state-wide

Measurement and evaluation: Funding, staff in position, retention and suppression rates.

Lead organization: OSDH

POC: Kristen Eberly, Sally Bouse

Pillar 3: Prevent new HIV Transmission by using proven interventions, including PrEP and syringe services programs

HIV services must be comprehensive and include high quality, medically-accurate, age-appropriate, culturally-responsive, HIV, reproductive and sexual health education at all levels; truly routine screening for HIV for all persons over age 15 as preventive care; broad and equitable access to pre-exposure prophylaxis (PrEP) for those vulnerable to HIV; wide access to non-occupational and occupational post-exposure prophylaxis (PEP); syringe access and other harm reduction services as needed by people living with HIV and HIV-negative persons; and insurance coverage of HIV prevention, including PEP and PrEP as essential preventive healthcare services.

The nation is currently experiencing an opioid crisis involving the misuse of prescription opioid pain relievers as well as heroin and fentanyl. The increase in substance use has resulted in concomitant increases in injection drug use across the country. This has caused not only large increases in overdose deaths, but also tens of thousands of viral hepatitis infections annually and is threatening recent progress made in HIV prevention. The most effective way for individuals who inject drugs to avoid the negative consequences of injection drug use is to stop injecting. However, many people are unable or unwilling to do so, or they have little or no access to effective treatment. Approximately 775,000 Americans report having injected a drug in the past year. In 2017, 14% of high school students reported using opioids without a prescription and 1.5% reported having ever injected drugs.

Syringe services programs (SSPs) are proven and effective community-based prevention programs that can provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to infectious disease care and substance use treatment. SSPs reach people who inject drugs, an often hidden and marginalized population. ***Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other***

infections. Research shows that new users of SSPs are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don't use the programs. SSPs that provide naloxone also help decrease opioid overdose deaths. SSPs protect the public and first responders by facilitating the safe disposal of used needles and syringes.

Viral hepatitis, HIV, and other blood-borne pathogens can spread through injection drug use if people use needles, syringes, or other injection materials that were previously used by someone who had one of these infections. Injecting drugs can also lead to other serious health problems, such as skin infections, abscesses and endocarditis. The best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of infection and prevent outbreaks.

During the last decade, the United States has seen an increase in injection drug use — primarily the injection of opioids. Outbreaks of hepatitis C, hepatitis B and HIV infections have been correlated with these injection patterns and trends. The majority of new hepatitis C virus (HCV) infections are due to injection drug use, and the nation has seen a 3.5-fold increase in reported cases of HCV from 2010 to 2016, reaching a 15- year high. New HCV virus infections are increasing most rapidly among young people, with the greatest incidence among individuals under 30.

Until recently, CDC had observed a steady decline since the mid-1990s in HIV diagnoses attributable to injection drug use. However, recent data show progress has stalled. Notably, new HIV infections among white people who inject drugs, the group most affected by the expanding opioid epidemic, increased 10% from 2014 to 2015. The estimated lifetime cost of treating one person living with HIV is near \$450,000. Hospitalization in the US due to substance-use related infections alone costs over \$700 million annually. In the United States, the estimated cost of providing health care services for people living with chronic HCV infection is \$15 billion annually. SSPs can help reduce these healthcare costs by preventing viral hepatitis, HIV, endocarditis and other infections.

Syringe services programs can benefit communities and public safety by reducing needlestick injuries and overdose deaths, without increasing illegal injection of drugs or criminal activity. Studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles. As many as one in every three officers may be stuck by a used needle during his or her career. Needle stick injuries are among the most concerning and stressful events experienced by law officers. A study compared the prevalence of improperly disposed of syringes and self-reported disposal practices in a city with SSPs (San Francisco) to a city without SSPs (Miami) and found eight times as many improperly disposed of syringes in Miami, the city without SSPs. People who inject drugs in San Francisco also reported higher rates of safe disposal practices than those in Miami. Data from CDC's National HIV Behavioral Surveillance system in 2015 showed that the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes.

Evidence demonstrates that SSPs do not increase illegal drug use or crime.

<https://www.cdc.gov/ssp/syringe-services-programs-summary.html>

Goal: Legalization of SSPs

Key activities: Gathering statistical data, evaluating the effectiveness of SSPs, gathering current support data, engagement with stakeholders, community assessment, cost benefit analysis

Key Partners: OSDH, SPTHB, Diversity Center, Guiding Right, CBOs, Equality Center, Substance Abuse Treatment Centers, Dept of Mental Health and Substance Abuse Services, Law Enforcement, legislators, governor, local government

Key dates/timeline: Legislative session (March 22, 2020)

Resources needed: funding, community/activist man-power, data, OSU Center for Wellness and Recovery, Legislative buy-in, law enforcement leaders, community outreach

Expected Reach: State Legislators

Measurement/Evaluation: legalization or not (measurement), process evaluation: support data, did it make it to committee, etc.

Lead organization: Community based activity groups

Point of contact: TBD

Goal: Everyone at risk has access to PrEP for HIV transmission

Key activities: education/CTR outreach, PrEP fair, PrEP promotion/Social Media

Key Partners: Providers, CBOs, Pharmacies

Timeline/Key Dates: within a year (12mo)

Resources Needed: CBOs (staffers)/Advertising funds, Pharma, 340B, locations (rural), colleges, OSDH

Expected Reach: 15,000 promotion and 2500 engagement, 625 PrEP uptake (25% of CTR)

Measurement/Evaluation: Logic Model

Lead Organization: CBOs

Point of Contact: PrEP Navigator

Goal: Increase number of PrEP Providers

Key Activities: educational measures to providers about PrEP, ECHO Sessions, Education Sessions, Creating cooperative agreements w/Pharm D Prescribers, PrEP for telemedicine, LGBTQ affirming care, practice facilitation

Key partners: Health systems, health departments, medical schools (course, education to medical school students and staff), social justice, organizations, licensing associations

Timeline/Key Dates: Implementing practitioner training by the end of 2021, social marketing campaign by end of 2020, telemedicine for PrEP by 2022, final measure of increase by 2025

Resources needed: manpower, funding for marketing and training, training facilities

Expected Reach: statewide

Measurement/Evaluation: 100% increase by 2023, 150% increase by 2025

Lead Organization: OSDH

Point of Contact: TBD/Public health detailer

Notes: Focus on medical students

Goal : *Establish PrEP/PEP program in all county health departments.*

Key Activities:

- Educate providers at county health departments (CHDs), get buy-in from leadership
- Work to reduce burdensome regulations
- Ensure HBV testing can be done at OSDH public health lab (PHL)
- Increase collaboration with OSDH, Oklahoma City-County Health Department (OCCHD) and Tulsa City-County Health Department (TCCHD).
- Implement standing order for PrEP using CDC guidelines (similar to STI treatment)
- Ensure rapid testing available in CHDs
- Ensure PEP can be administered after hours (to meet 72 hr exposure guideline)

Key Partners: OSDH PHL and SHHRS, commercial laboratories, CHD's, Denver Prevention Training Center (PTC), Southern AETC, drug manufacturers

Timeline: 3-4 years for full implementation

Resources: Funding and increased staff for PHL, education and equipment, OSDH leadership buy-in/support, PrEP/PEP medications

Expected Reach: Statewide, all 77 counties

Measurement: Develop data collection program (increase in total PrEP clients, decrease in new diagnoses)

Lead Organization: OSDH SHHRS

Point of contact: OSDH SHHRS

Goal: Develop a condom mail out program for the public.

Key Activities:

- Develop “Pleasure Kits” containing condoms, lube, and educational material that can be left in hotel rooms, passed out by community, kept at fire stations, etc.
- Implement referral cards/codes to earn points and incentives for referring friends.
- Collaborate with other agencies who do not normally do HIV prevention work, but work with the target populations, especially in rural areas (other state agencies, in-home behavioral health providers, law enforcement officers, fire stations, Habana Inn)
- Establish a website for mail order condom requests
- Use the website to collect data and market future educational materials to clients.

Key Partners: OSDH SHHRS, other state agencies, hotels (Habana Inn)

Timeline: 12 months

Resources: Condoms, lube, brochures/educational materials, website other than OSDH, funding, postage, additional staff

Expected Reach: Statewide

Measurement: Number of requests from website, number of condoms distributed.

Lead Organization: OSDH SHHRS

Point of contact: OSDH SHHRS staff

Goal: *HIV/STI Prevention education (K-12, higher Ed, providers, etc)*

Key Activities: Promoting trainings/seminars/health fairs/workshops

Key partners: OSDH/providers/pharma, CBOs

Timeline/Key Dates: 12-24 months

Resources Needed: Education materials/presentation materials/locations/
speakers/CBOs/OSDH

Expected Reach: 20,000

Measurement/Evaluation: sign-in sheets, evaluation sheets, project investigator (evaluation)

Lead organization: CBO/OSDH

Point of Contact: Program managers

Notes: To create presentations/schedule presentations

Goal: *Increase role of FQHCs in HIV prevention.*

Key Activities:

- Identify FQHC locations and assess services/programs provided.
- Increase collaboration between FQHC's.

Key Partners: FQHC's and Oklahoma Primary Care Association (OKPCA)

Timeline: 2 years

Resources: Funding, knowledge of federal plan funding opportunities

Expected Reach: Statewide, rural areas (100 clinics across the state)

Measure: TBD

Lead Organization: OKPCA, SHHRS, OHHPC

Point of contact: OKPCA

Pillar 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

To end the HIV epidemic, it is critical to deliver timely, appropriate care and prevention services wherever HIV is spreading. With CDC support, state and local health departments are using several strategies to detect and respond to growing clusters of HIV infection. Cluster detection strategies, such as partner services and monitoring for increases in HIV diagnoses, have been used by some health departments for many years. Now, many health departments are also using a newer strategy – HIV molecular analysis – to detect growing clusters of HIV infection more quickly and precisely than ever before, allowing prevention and treatment services to be directed where they are needed most.

**Detecting Clusters through HIV Molecular Analysis:
5 Things to Know**

- 1** Molecular analysis identifies groups of HIV strains that are very similar. Because HIV evolves quickly, **similar viral strains** signal that HIV transmission is occurring rapidly within a common network. 
- 2** Health departments can use molecular analysis to quickly identify areas where HIV may be spreading and provide prevention and treatment services, **breaking the chain of transmission**. 
- 3** Molecular analysis uses laboratory data that are already generated through **routine medical care** after a person is diagnosed with HIV. 
- 4** Molecular analysis examines the genetics of the virus – not the person – and **doesn't identify who infected whom**. 
- 5** As health departments collect and analyze molecular data, they must follow state and local laws and strict CDC guidelines designed to **protect data and maintain privacy and confidentiality**. Personal identifying information is not shared with CDC. 

The SHHRS and the OHHPC are currently in the beginning stages of exploring molecular HIV surveillance. Oklahoma currently has laws criminalizing HIV exposure to others. This raises the concern for the potential misinterpretation of what can be inferred from membership in molecular clusters; possible criminal prosecution poses a real risk to people living with HIV. Furthermore, even perceived danger to people living with HIV that MHS data could be used to incriminate them could deter them from seeking prevention and care services.

SHHRS surveillance and DIS constantly monitors for HIV and STI outbreaks throughout the state. The current HIV outbreak plan below, details the steps currently taken if an outbreak is determined.

HIV OUTBREAK RESPONSE PLAN

Oklahoma State Department of Health
HIV/STD Service

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OUTBREAK RESPONSE PLAN

Per CDC definition, the HIV/STD Service defines a HIV outbreak as an increased group of HIV cases related by geography and/or case association. Geography can be defined as small as a hangout or as large as an entire county. Case associations are grouped by chain of infection.

When a HIV outbreak has been identified, the HIV Outbreak Response Plan should be implemented.

Regardless of whether an increase in cases is labeled an “outbreak”, some level of the Outbreak Response Plan may be initiated for a “cluster” of cases. If the cluster of cases is not deemed an outbreak at the time but there is high potential of an outbreak, a “DIS blitz” should be considered to assist with locating partners, conducting interviews, etc. to provide rapid response and intervening in the potential outbreak. If Outbreak Response Activities occur before an outbreak is declared, the County Health Department Regional Director and staff should be notified.

OUTBREAK RESPONSE TEAM RESPONSIBILITIES

An Outbreak Response Responsibilities list with description of responsibilities and action items should be maintained (on the ORP Checklist) by the DISM for each of the following personnel:

- ☐ **Agency Leadership Team:** HIV Service Director, State Epidemiologist, and Deputy Commissioner for Prevention and Preparedness (responsible to ensure the appropriate personnel and resources are allocated to the outbreak response.
- ☐ **Disease Intervention Services Manager (DISM)** (Serves as the outbreak coordinator. At a minimum coordination includes: Advising Regional Director and District Nurse Manager (DNM) of the county involved in the outbreak and determine the involvement they would like to have in outbreak activities, engaging the appropriate stakeholders, ensuring the collection of outbreak specific data, establish any outbreak specific meetings to include DIS staff, media, HIV/STD service leadership, etc., providing updated information, maintaining action items list and ensuring completion of items, ongoing review of case information and outbreak activities, etc.)
- ☐ **Front Line Supervisor (FLS)** (At a minimum is responsible for: DIS activities of the outbreak efforts, meet with DISM weekly to provide updates and request additional resources/ activities needed, maintaining weekly update response report, maintaining case update files in Outbreak folder, relay DIS response updates to DISM, inform local health department of outbreak and advise who the lead DIS will be, ongoing review of cases and outbreak activities, etc.)
- ☐ **Lead DIS** (Clinic Liaison, ongoing review of all cases involved in outbreak, outreach recommendations, DIS recommendations, etc.)
- ☐ **DIS Team** (i.e., assists with Field Records (FRs), cooperates in blitzes, etc.)
- ☐ **HIV Prevention Administrative Programs Manager (APM)** (Administrative actions such as HAAN Alert, communicate with appropriate CDC personnel, etc.)
- ☐ **Surveillance APM** (i.e, specific data updates, Field Surveillance Specialist (FSS) coordination)
- ☐ **Field Surveillance Specialist (FSS)** (i.e, provider education, additional DIS activities if needed, venipuncture at outreach if needed/applicable)

- ☐ **HIV/STD Nurse** (i.e, assist with venipuncture if needed, provider education)
- ☐ **Health Education Manager** (i.e, activities of the Health Educators if needed)

OUTBREAK DETECTION

The DIS and FLS have the first opportunity to identify outbreaks or potential outbreaks through observation and plotting cases. If an outbreak is suspected through case investigation or surveillance review, information should be presented to the Program Manager (DISM) for review.

OUTBREAK DETECTION MEETING

A meeting should be arranged including the FLS and DISM to review available information and determine the likelihood of an outbreak.

PRIOR TO OUTBREAK DETECTION MEETING

- FLS should ensure all case information should be up to date in PHIDDO
- An Outbreak Case Review form should be completed on each case (Completed by the FLS or DISM)
- DISM should submit a data request to surveillance for data pertaining to possible outbreak cases (such as all HIV cases from CY and PY separated by race, sex, age, risks, positives per morbidity week or month)
- DISM should create a new folder in the Outbreak Folder to maintain all outbreak related files
- DISM should create an Outbreak Case Information file, Outbreak Partner Information file, ORP checklist file, and Action Items file, in the Named Outbreak Folder

ITEMS TO BE COMPLETED AND REVIEWED:

- Definition of an Outbreak – The occurrence of more cases of disease than normally expected within a specific place or group of people over a given period of time.
- Morbidity : Review surveillance data to determine if there has been an unexpected rise in morbidity
- All case information such as
 - Infected client information
 - Location of testing
 - Partners and Social Contacts
 - Hangouts
 - Risks
 - Other related information

OUBREAK POSSIBILITY DETERMINATION

Once the case information has been reviewed and it is determined there is a high possibility of an outbreak, an Initial HIV/STD Outbreak Response Team Meeting should take place including the DISM, APM, FLS, and Surveillance APM to determine if the Outbreak Response Protocol should be initiated.

OUTBREAK RESPONSE PLAN INITIATION

INITIAL HIV/STD OUTBREAK RESPONSE TEAM MEETING

Once an outbreak has been determined the DISM should determine and engage HIV/STD Outbreak Response Team (typically APM, DISM, FLS, Lead DIS, and Surveillance APM) to meet and determine if the Outbreak Response Plan should be initiated.

The following should take place at the initial HIV/STD Outbreak Response Meeting:

CASE REVIEW

Presentation of the case information should be presented.

- Number of cases
- Overview of cases
- Surveillance data
- Map
- Algorithm

OUTBREAK DETERMINATION

Members should determine if the situation should be deemed an outbreak and if the Outbreak Response Plan should be initiated.

If it is determined the situation is an outbreak and the Outbreak Response Plan should be initiated, the following should occur:

CASE DEFINITION

A confidential outbreak case definition should be created and documented on the Outbreak Response Team Initial Meeting Checklist (ATTACHMENT A).

A confidential case definition includes criteria for person, place, time, and clinical features. These should be specific to the outbreak under investigation.

“Person” describes key characteristics the patients share in common. For example, this description may include: age, sex, race, occupation and exclusion criteria.

“Place” typically describe a specific geographic location (county, city) or facility association with the outbreak (X High School, Y Hangout).

“Time” is used to delineate a period of time associated with disease onset for the cases under investigation. Limiting the time period enables exclusion of similar infections which are unrelated to the outbreak of interest.

Initially, **“clinical features”** should be simple and objectives (e.g. positive test results). The clinical criteria may later be characterized by the presence of specific laboratory findings.

*The components of an outbreak case definition can vary for each outbreak.

OUTBREAK RESPONSE INFORMATION

The following, if applicable, should be determined and documented on the Outbreak Response Team Initial meeting Checklist. The documentation should also include the staff responsible if applicable.

- ☐ Lead DIS
- ☐ Regional Director, DNM and Charge Nurse of County Health Department
- ☐ Additional Stakeholders in Outbreak
- ☐ Target Population or geographic area
- ☐ Resources Available
- ☐ Staff and partners needed
- ☐ What services will be needed by the County Health Department
- ☐ Possible Outreach Locations
- ☐ Follow-up Items List

Once the initial HIV/STD Outbreak Response Team Meeting has completed, the DISM will arrange a meeting with the HIV/STD Outbreak Response Team and County Stakeholders for an Initial Stakeholders Meeting. The Director should inform the state epi of the outbreak.

INITIAL STAKEHOLDERS MEETING

Once the Outbreak Response Plan has been initiated, the Director of the County Health Department and other stakeholders should be notified of the outbreak. The HIV/STD Outbreak Response Team should meet with the County Health Department Regional Director and other County Stake holders to provide outbreak information and determine action items for the Outbreak Response Plan.

PRIOR TO INITIAL STAKEHOLDERS MEETING

DISM should create an Initial Outbreak Summary to provide to stakeholders including information from the HIV/STD Outbreak Response Team Initial Meeting.

INTRODUCTION

DISM should distribute the following at the Initial Stakeholders Meeting

- ☐ Surveillance Data
- ☐ Map
- ☐ Algorithm
- ☐ Completed Initial HIV/STD Outbreak Response Team Initial Meeting Completed Checklist

The following outbreak Information should be provided to stakeholders.

- ☐ Outbreak Definition
- ☐ Outbreak Response Plan
- ☐ Roles of the Outbreak Response Team
- ☐ Purpose of the Stakeholders Meeting (Inform of the outbreak and determine activities needed)

OUTBREAK REVIEW

- ☐ Outbreak Case Information should be presented
- ☐ Information obtained from the Initial HIV/STD ORT Meeting should be presented

OUTBREAK ACTIVITIES AND RESPONSIBILITIES

The following information should be decided and documented on the Outbreak Response Initial Stakeholders Meeting Checklist (ATTACHMENT B) at the Initial Stakeholders Meeting

- ☐ County Health Department participation including clinic hours and client accessibility
- ☐ Health Educator activities
- ☐ Outreach opportunities
- ☐ HAAN/MEDIA
- ☐ Health Provider Education/Awareness (facilities and information to provide)
- ☐ Blitz (Educate other stakeholders and determine the possible need)
- ☐ Additional outbreak activities to implement
- ☐ Additional information needed
- ☐

PROCEEDING INITIAL STAKEHOLDERS MEETING

Once the initial stakeholders meeting has concluded, the County Health Department Regional Director (or designee) and other stakeholders should notify their agency staff of the outbreak and action plan.

The DISM should create a summary of the meeting and provide to stakeholders.

ONGOING OUTBREAK RESPONSE ACTIVITIES

The DISM should coordinate activities and ensure action items are met. As action items are completed, responsible staff should inform the DISM.

BLITZ

A blitz is a group of outbreak response team members responding the outbreak as a large group with specific activities on designated days. A blitz is beneficial for completing several action items in a short amount of time and to expedite the intervention efforts.

When a blitz is scheduled, the DISM should coordinate the activities and ensure each Outbreak Response Team Member knows his/her responsibilities. The FLS is responsible for the DIS portion of the blitz.

FLS RESPONSIBILITIES FOR DIS BLITZ

BEFORE:

- ☐ Inform County Health Department of blitz activities being arranged (may be done by DISM or Lead DIS)
- ☐ Arrange a blitz headquarters
- ☐ Ensure the most current information is available and provided for each investigation needed
- ☐ Ensure record searches are completed
- ☐ Organize Field Investigations that need completed
- ☐ Create a system to document updated activities

DURING:

- ☐ Assign investigations to DIS
- ☐ Track DIS activities completed throughout the blitz
- ☐ Be available for guidance and assistance

After:

- ☐ Providing a summary of the blitz results to the DISM
- ☐

UPDATES

The DISM is responsible for ensuring regular Outbreak Response updates to all stakeholders. The updates will include, but not limited to, ongoing activities, upcoming activities, case updates, new case detections, etc.

The DISM, FLS and others deemed appropriate should meet on a determined basis for outbreak investigation updates included but not limited to new case information, outbreak activities, case closures, new cases, narrative reviews, newly identified items, barriers, ideas, needs, etc. The DISM should coordinate the information provided at the update meeting.

OUTBREAK RESPONSE CLOSURE

Once the Outbreak Coordinator determines the outbreak has been investigated to completion, a short-term and long-term evaluation should be completed.

SHORT-TERM EVALUATION

A meeting will be held including HIV/STD Outbreak Response Team for a short-term evaluation.

The DISM should prepare and include the following information for the Short-Term Evaluation meeting:

- ☐ Worker statistics including
 - ✓ Number assigned cases closed
 - ✓ Number assigned cases interviewed Number assigned cases interviewed within 3, 5, and 7 days
 - ✓ Number assigned cases re-interviewed within 3 days
 - ✓ Total partners/cluster initiated
 - ✓ Partner/cluster index
 - ✓ Number of partners/social contacts examined within 3, 5, and 7 days
 - ✓ Number of New partners/social contacts not examined
- ☐ Narrative Including
 - ✓ Background
 - ✓ Outbreak Response Efforts
 - ✓ Review of the Outbreak including demographic information
 - ✓ Barriers
 - ✓ Outcomes, discussing the impact of the worker statistics
 - ✓ Lessons Learned
 - ✓ Summary

The short-term evaluation should also be offered to other HIV/STD staff or partners of the outbreak.

LONG-TERM EVALUATION

The following 6 months after Outbreak Response ending, the DISM should

- ☐ Closely monitor morbidity in the geographical area
- ☐ Compare Outbreak narratives for most likely successful/unsuccessful strategies
- ☐ Identify additional barriers, problems, and solutions
- ☐ Modify strategy for future outbreaks

For outbreak plan appendices, please contact SHHRS.