Wisconsin Integrated HIV Prevention & Care Plan 2017-2021

Envisioning the End of the HIV Epidemic

Overview

What is the purpose of the Integrated HIV Plan?

The Wisconsin Integrated HIV Prevention and Care Plan is a living document, covering the period of 2017-2021. It is focused on integrating and prioritizing prevention and care services for people in Wisconsin who are living with HIV (PLWH) and those at risk.

Why is the Integrated HIV Plan important today?

Major developments in science, public policy, and other advances over the past several years, as well as the progression of the HIV epidemic, are reasons for reassessing and refocusing strategic planning. Some of these developments include:

- Expanded health care coverage options for people living with and at risk for HIV infection.
- New HIV testing technologies and development of national recommendations for HIV screening of all persons aged 15 to 65 years.
- Scientific studies demonstrating the benefits of early treatment and improved health outcomes for people living with HIV.
- Pre-exposure prophylaxis (PrEP) showing that persons at substantial risk can reduce their risk for acquiring HIV infection by over 90% when taking an HIV medication once a day.
- Digital tools and technologies that efficiently extend the reach and impact of prevention services, promote HIV testing, and assist people in linking, accessing, and remaining engaged in care.

How was the Integrated HIV Plan developed?

The HIV integrated plan covers the five-year period 2017-2021 and was a collaboration between the Wisconsin AIDS/HIV program, the Statewide Action Panning Group (SAPG), representatives from agencies receiving Ryan White funding, community partners, people living with HIV, consumers of services, and populations at risk.

What requirements does the Integrated HIV Plan address?

The HIV Integrated Plan fulfills the federal funding requirements of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). It also meets the federal requirement regarding HIV prevention and care planning activities as well as the Statewide Coordinated Statement of Need, a Congressional requirement for the Ryan White program.

HIV Does Not Impact All People in Wisconsin Equally

While anyone can become infected, the HIV epidemic in Wisconsin is concentrated in key populations, as noted in the epidemiologic section of the HIV Integrated Plan and other statistical reports. The HIV Integrated Plan is directed at ensuring that funding and resources are allocated according to the epidemiological profiles in Wisconsin and that cost-effective, scalable interventions are prioritized for communities where HIV is most concentrated in the following groups:

- Gay, bisexual, and other men who have sex with men *of all races and ethnicities*
  (noting the particularly high burden of HIV among Black gay and bisexual men)
- Black women and men
- Latino men and women
- People who inject drugs
- Youth aged 13 to 24 years
  (noting the particularly high burden of HIV among young Black gay and bisexual men)
- Transgender women
  (noting the particularly high burden of HIV among Black transgender women)

10 Key Elements: Envisioning the End of the HIV Epidemic

The Integrated HIV Plan is a forward-looking document that envisions the end of the HIV epidemic by committing resources and taking bold action. The Integrated HIV Plan calls on stakeholders and affected community members to commit and jointly engage in putting the Integrated HIV Plan in action by placing intensified efforts in the following areas:

Target HIV resources to the right people, in the right places, and with the right actions.

Increase access to PrEP: one pill, once a day can help prevent HIV.

Streamline testing, prevention, and treatment services for sexually transmitted infections, viral hepatitis, and HIV.

Promote the health of gay and bisexual men.

Promote drug user health.

Grow HIV/STI/HCV partner services.

Make sure community members know about their health insurance options while helping underserved populations in choosing their health care coverage.

Support patient-centered care that focuses on patient's basic needs, such as housing.

Increase use of data to improve HIV health outcomes.

Encourage policies and practices that reduce discrimination.

Goals, Objectives, and Strategies

Goal 1: Reduce new infections

Objective 1.1: Increase the percentage of people living with HIV who know their serostatus to at least 90% by 2020.

Objective 1.2: Reduce the number of new diagnoses by at least 25%.

HIV Testing

Activity 1A: Increase targeted HIV testing of high-risk populations in nonclinical settings.

Activity 1B: Provide comprehensive sexually transmitted infections (STI) and/or hepatitis C virus (HCV) testing to high-risk populations and people living with HIV (PLWH).

Activity 1C: Improve desirability of HIV testing to high-risk individuals by offering more client-centered options.

Activity 1D: Support availability of HIV testing as a routine service to the overall population of Wisconsin.

Strategy 2 HIV Partner Services

Activity 2A: Increase client acceptance of HIV partner services (PS).

Activity 2B: Improve PS strategies through effective information and evaluation.

Activity 2C: Improve HIV PS inter-program coordination and collaboration.

Activity 2D: Integration of HIV PS and STI disease intervention services (DIS).

Strategy 3 Pre-Exposure Prophylaxis (PrEP)

Activity 3A: Expand availability of PrEP.

Activity 3B: Increase knowledge of and referral for PrEP in HIV/STI testing and HIV PS.

Strategy 4 Data to Impact (Prevention Services)

Activity 4A: Data improvement: increase utilization of data to appropriately target prevention services to HIV-negative persons, revise STI reporting form to capture gender of sex partners, and enhance data collection and analysis.

Strategy 5 Health Promotion and Community Wellness

Activity 5A: Utilize community information resources to raise overall awareness.

Activity 5B: Mobilize communities to address anti-HIV, anti-gay, and other barriers to HIV prevention and care.

Strategy 6 Testing and Treatment for STIs

Activity 6A: Increase routine testing for STIs for HIV-positive individuals and HIV-negative men who have sex with men (MSM).

Activity 6B: Encourage increased use of site-specific testing (oral, anal, urogenital) for STIs in MSM to ensure STI screening is consistent with the client's behavioral risk.

Activity 6C: Increase availability of rapid STI testing (e.g., syphilis testing) at clinics and sites providing rapid HIV testing to MSM.

Strategy 7 Comprehensive HIV/STI Prevention Services for Gay and Bisexual Men

Activity 7A: Use a comprehensive health approach to engage gay and bisexual men in health services.

Activity 7B: Linkage services based on *Data to Impact*: link at-risk HIV-negative gay and bisexual men to follow-up HIV/STI testing and referral for PrEP.

Strategy 8 Condom Promotion and Distribution

Activity 8A: Continue to support outreach education, distribution, and promotion of condoms at sites frequented by MSM and other at-risk groups (Pride festivals, gay bars, community events, harm reduction outreach sites, etc.).

Strategy 9 Injection Drug User Health

Activity 9A: Support community wellness and harm reduction services for persons who inject drugs (PWID) to increase an individual's engagement with health services and reduce secondary negative health impacts in the community.

Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV

Objective 2.1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Objective 2.2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.

Objective 2.3: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%.

Objective 2.4: Reduce the percentage of persons with diagnosed HIV infection who are homeless to no more than 5%.

Objective 2.5: Reduce the death rate among persons with diagnosed HIV infection by at least 33%.

Strategy 1

Maximize the Use of Medical Case Managers (MCM) and Linkage to Care Specialist (LTCS) in Ensuring Linkage, Retention, and Viral Suppression

Activity 1A: Increase the capacity of MCM and LTCS to effectively link or reengage HIV positive people into HIV care.

Strategy 2

Expand the Capacity of HIV PS to Promote Linkage, Retention, and Reengagement in Medical Care

Activity 2A: Increase the capacity of PS providers to effectively link or reengage infected individuals into HIV care

Strategy 3

Promote Participation in the AIDS Drug Assistance Program (ADAP)

Activity 3A: Effectively manage the ADAP formulary to ensure ongoing access to all Food and Drug Administration (FDA) approved antiretrovirals and to other medications used to treat HIV and hepatitis C for eligible ADAP clients.

Activity 3B: Streamline the ADAP application process.

Strategy 4

Promote Access to Health Insurance for People Living with HIV

Activity 4A: Promote and encourage enrollment in appropriate private and public insurance.

Activity 4B: Conduct cost benefit analysis of available insurance plans and promote awareness of cost effective plans among agencies serving people with HIV.

Strategy 5

Ensure Access to and Retention in HIV Medical Care to Promote Viral Suppression, Positive Health Outcomes, and Reduce Infection Transmission

Activity 5A: Ensure that clients are able to access affordable and coordinated HIV medical care.

Activity 5B: HIV medical clinics should assess the accessibility and acceptability of services and make modifications as necessary.

Activity 5C: Improve the education of HIV medical staff in successful prevention, linkage, and retention strategies.

Activity 5D: HIV medical providers should provide care across the HIV care continuum by promoting HIV prevention services and integrating screening and testing for other common comorbidities.

Strategy 6

Ensure Screening and Referrals to Appropriate Services for Mental Health and Substance Abuse

Activity 6A: Maintain appropriate mental health and substance abuse screening delivery by medical providers and MCMs.

Activity 6B: Assess the need for expanded coverage and ensure access to mental health and alcohol and other drug abuse (AODA) services through third party (including Medicaid and private insurance) billable services and actions.

Strategy 7

Incorporate Delivery of Support Services as a Way to Promote Engagement and Retention in Medical Care

Activity 7A: Ensure safe and stable housing for each client, recognizing it is a foundation that allows clients to engage in health care.

Activity 7B: Facilitate client access to safe and reliable transportation to access medical care.

Strategy 8

Improve Data Utilization to Promote Linkage and Retention to Care and Viral Suppression

Activity 8A: Improve data sharing across programs and agencies to facilitate linkage and reengagement in HIV medical care.

Activity 8B: Develop a Data to Care program to relink out-of-care individuals to HIV medical care.

Activity 8C: Use client-level data to improve service quality and health outcomes.

Goal 3: Reduce HIV-Related Disparities and Health Inequities

Objective 3.1: Reduce new diagnoses by at least 33% in:

- Men who have sex with men (MSM), ages 15-59, statewide.
- Young Black MSM, ages 15-29, statewide.
- Black women, ages 15-59, statewide.
- Residents of Milwaukee County, ages 15-29.

Objective 3.2: Promote equity in care outcomes at each stage of the HIV care continuum. Reduce disparities in care outcomes for:

- Blacks (compared to Whites).
- People exposed to HIV through injection drug use (compared to those exposed through male-to-male sexual contact and through high-risk heterosexual contact.
- Young people, ages 15-29 (compared to people ages 30 and older).

LEVEL 1: SOCIAL NETWORKS

Strategy 1 Social Media

Activity 1A: Expand the use of social media to address issues that affect social and sexual networks for MSM and social and equipment-sharing networks of persons who inject drugs (PWID).

Popular Opinion Leader/Peer Models

Activity 2A: Expand opinion leader and other peer models within communities experiencing health disparities.

Addressing Networks of PWID

Activity 3A: Expand prevention strategies that address networks of PWID who share equipment.

LEVEL 2: ORGANIZATIONS

Strategy 4 Culturally and Linguistically Appropriate Services (CLAS)

Activity 4A: Support and enhance the provision of culturally and linguistically appropriate services.

Strategy 5 Diversification of the Workforce

Activity 5A: Expand the diversity of the workforce, particularly at the decision-making levels.

Strategy 6 Wrap-around Services and Improved Collaboration among Organizations

Activity 6A: Support local and regional interagency collaboration focused directly on increasing the capacity of service organizations to provide expanded client services.

LEVEL 3: COMMUNITY

Strategy 7 Enhanced Community Sensitivity Responsiveness

Activity 7A: Support and enhance collaborative efforts among community partners—in addressing social determinants and factors that contribute to HIV-related disparities in communities.

LEVEL 4: HEALTH POLICY AND LEGISLATION

Strategy 8 Public Policy Leadership by Community Partners

Activity 8A: Community partners assume strategic leadership promoting responsive public policy that supports the public health of affected populations.

Goal 4: Achieving a More Coordinated Response to the HIV Epidemic

Objective 4.1: Increase the coordination of HIV programs across the prevention and care continuum and enhance collaboration among the state and local health agencies (e.g., Medicaid, mental health, substance abuse services, community-based organizations, health care providers, and local health departments).

Objective 4.2: Develop improved mechanisms to monitor and evaluate progress in achieving the goals and objectives of the HIV Integrated Plan.

Strategy 1 Community Planning

Activity 1A: Statewide Action Planning Group (SAPG)—actively encourage community engagement and input for the planning, prioritizing, and implementation of HIV prevention and care services.

Activity 1B: Coordination and integration with other planning processes.

Strategy 2 Community Leadership and Capacity Building

Activity 2A: Support existing and emerging leaders to work in their communities.

Strategy 3 Workforce Development

Activity 3A: Train front-line, volunteers, and management-level staff across the HIV prevention and care continuum.

Activity 3B: Expand the diversity of the workforce, particularly at the decision-making levels.

Strategy 4 Accountability

Activity 4A: Make program data accessible and available by ensuring that data are analyzed, summarized, utilized in resource allocation, and disseminated to federal, state, and community partners.

Activity 4B: Provide regular reporting on strategy goals by developing a system to monitor the progress of contracted agencies in meeting the HIV Integrated Plan goals and objectives.

Strategy 5 Program Integration

Activity 5A: Ensure coordinated service delivery by integrating HIV, viral hepatitis, and STI planning and service delivery at state and local levels.

Strategy 6 Research

Activity 6A: Research that impacts community needs: ensure that community-focused research engages client and community members in planning, implementation, and evaluation of research activities.

Measuring Outcomes

The implementation of the HIV Integrated Plan and progress toward its outcomes will be evaluated both quantitatively and qualitatively. Outcomes will be shared with the SAPG, on the AIDS/HIV Program website, through *Wisconsin AIDS/HIV Program Notes*, and by routine contact with grantees, local health departments, and other partners and stakeholders.

Quantitative Measures

- An **annual progress report** will assess progress in achieving the HIV Integrated Plan objectives.
- An annual update of the **HIV care continuum** will report the level of linkage and engagement in care and viral suppression for PLWH.
- Annual **surveillance reports** for HIV, HCV, and STIs will be used to report epidemiologic/sociodemographic data related to the goals and objectives of the HIV Integrated Plan.

Qualitative Measures

Input is obtained during:

- SAPG meetings
- Grantee site visits
- Local agency consumer feedback and satisfaction surveys
- Other meetings with partners and stakeholders
- Monthly AIDS/HIV program staff meetings

Links

Wisconsin Integrated HIV Prevention and Care Plan
https://www.dhs.wisconsin.gov/publications/p01582.pdf

National HIV Strategy for the United States Updated to 2020
https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf

Wisconsin HIV Needs Assessment Qualitative Report: Findings from Client and Key Informant Interviews
https://www.dhs.wisconsin.gov/publications/p01221.pdf

Wisconsin AIDS/HIV Program
https://www.dhs.wisconsin.gov/aids-hiv/index.htm

Wisconsin HIV Statistical Reports
https://www.dhs.wisconsin.gov/aids-hiv/data.htm

Wisconsin Hepatitis C Program
https://www.dhs.wisconsin.gov/viral-hepatitis/hcv-program.htm

Sexually Transmitted Diseases
https://www.dhs.wisconsin.gov/std/index.htm

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