
Wisconsin Integrated HIV Prevention and Care Plan 2017-2021

Envisioning an End of the HIV Epidemic



Wisconsin Department of Health Services
Division of Public Health
Bureau of Communicable Diseases
AIDS/HIV Program
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Envisioning an End of the HIV Epidemic: 10 Key Elements

Together, we envision an end to the HIV epidemic and commit to taking bold action to make this happen. Equipped with science-based tools and resources that can make new HIV infections and cases of AIDS rare, we strongly encourage stakeholders and affected community members across Wisconsin to commit to engaging with us in putting this Integrated HIV Plan into action.

We will make this happen by intensifying efforts and focusing resources in the following areas:

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

Reducing new HIV infections and ensuring the best health outcomes for persons living with HIV (PLWH) requires the following actions:

- Addressing disparities and inequities in new HIV infections and HIV outcomes.
- Timely diagnosis of HIV.
- Prompt engagement, re-engagement and retention of PLWH in medical care.
- Targeting HIV prevention resources to people and areas with the greatest burden of disease by prioritizing science-based strategies that are scaled up and tailored to effectively reach and engage those at highest risk of acquiring HIV, particularly men who have sex with men (MSM), and especially MSM of color.
- Inclusive and deliberate community engagement, with active involvement of community members in decision making and development of public policy.
- Continuing development of a workforce that is committed to and competent in science-based best practices and highly skilled in program management, leadership, and the delivery of state-of-the-art health and support services.
- Focusing leadership development and capacity building efforts in communities most affected by HIV.

2. Scale up access to pre-exposure prophylaxis (PrEP).

PrEP is a relatively new but critically important and powerful prevention tool for people who do not have HIV infection but who are at very high risk and who want to *prevent* HIV infection by taking a pill every day—a medication that can reduce the risk of HIV infection by over 90%. There is a need to scale up access to PrEP by engaging and expanding the number of service providers offering PrEP and focusing efforts on communities with the highest rate of new infections. There is also a need for offering financial assistance to access PrEP and to provide guidance and support to people to be successful with their medication routine and needed medical follow-up.

3. Integrate testing, prevention, and treatment services for sexually transmitted infections (STI), viral hepatitis, and HIV.

Common risk behaviors are associated with STIs, hepatitis C (HCV), and HIV infection. Untreated STIs and HIV infection increase the risk of acquisition and transmission of both infections. STI treatment is critical in preventing the transmission of HIV. If STIs are left untreated, the HIV epidemic will persist. Similarly, bloodborne transmission of HIV and hepatitis B and C infections, especially among people who inject drugs (PWID), increases the risk for co-infection. Because STI, HIV, and viral hepatitis screening and treatment are traditionally supported with different funding streams, these services may not be fully integrated at the service delivery level. State and local health departments, community-based agencies, and other health care providers need to ensure that HIV, STI, and viral hepatitis testing and other services are integrated, seamless, and tailored to each client's specific risks and their prevention and treatment needs. At the same time, routine HIV testing needs to be expanded within community clinics and emergency departments.

4. Promote the health of gay and bisexual men.

Gay and bisexual men have many of the same health concerns as men who are not gay or bisexual. All men should maintain a healthy diet and body weight, exercise regularly, limit alcohol consumption, and avoid exposure to cigarette smoke. Many other recommendations for promoting health behaviors such as wearing a seatbelt, washing hands, and getting screened for diseases regularly apply to all men. However, gay and bisexual men are more likely to experience certain adverse health outcomes and may face the contributing factor of discrimination. Studies demonstrate that gay and bisexual men have higher rates of recreational drug use, HIV infection, anal cancer, and depression and anxiety than other men. There is a need for community-based comprehensive health services that are culturally and linguistically appropriate for gay and bisexual men, that promote positive sexual health, that focus on screening and preventing the disproportionate health issues faced by gay and bisexual men, and that promote general physical and mental wellbeing.

5. Promote harm reduction and other health services for PWID.

The intersection of drug use and the acquisition and transmission of HIV infection is a serious and complex public health issue. Persons who inject drugs continue to be at increased risk not only for HIV but for hepatitis C virus and other infections, as well as being at risk of death due to accidental overdose. Community drug user health and harm reduction services are needed for persons who inject drugs. The primary focus of drug user health and harm reduction services is to increase an individual's engagement with health services and reduce secondary negative health impacts (transmission of HIV and other communicable diseases) in the community. Services include harm reduction and education on vein care and proper cleaning of injection sites; access to sterile syringes and other injection equipment for active users; wide availability of naloxone to reverse opioid overdoses; referral and linkage to HIV, viral hepatitis, other STIs, and tuberculosis prevention care and treatment services; referral and linkage to hepatitis A

virus and hepatitis B virus vaccination; and referral to mental health services, physical health care, social services, and recovery support services.

6. Develop comprehensive HIV/STI/HCV partner services.

Wisconsin has a successful HIV Partner Services Program that assists persons with HIV infection in notifying their sexual and/or needle-sharing partners of the partner's possible exposure to HIV. However, the Program can be strengthened by reconfiguring its structure to provide comprehensive and expanded partner services in the areas of HIV, sexually transmitted infections, and hepatitis C infection, and through a statewide network of full-time dedicated staff providing:

- Client assessment and referral for prevention services.
- Partner elicitation.
- Assistance in partner notification.
- Comprehensive testing for co-infection.
- Referral for PrEP.
- Rapid linkage to needed medical care and support services.
- Re-engagement services for individuals who are not in care.

7. Enhance HIV prevention and client health outcomes by supporting comprehensive, patient-centered care that addresses the patient's basic needs, such as housing.

Getting and staying healthy requires more than health care. Prompt and continuing engagement in health care is critically important for PLWH but the lack of basic needs such as food, shelter, and having emotional support competes with the priorities for health and self-care. Stable housing is one of the greatest unmet needs of PLWH. Homelessness and unstable housing are conditions that are associated with a broad range of poor physical and mental health outcomes, including increased HIV risks and early death. PLWH risk losing their housing because of increased medical costs, limited incomes, and reduced or lack of employment due to poor physical and mental health. The lack of secure and stable shelter, food, income, hygiene, and physical and behavioral health care greatly compromises the ability of PLWHs to be healthy. Efforts must be intensified to ensure access to resources that assist PLWH in meeting their basic human needs and independence.

8. Ensure access to high-quality health care by educating communities about their health insurance options and assisting underserved populations in enrolling in health care coverage.

Although there are new options for health insurance under the Affordable Care Act, many individuals remain uninsured or underinsured. Access to high-quality health care is important for everyone but is especially important for persons needing medical treatment. Ensuring that people have access to medical care will help address the service gap for PLWH who are not engaged in care and not on antiretroviral medications. This will increase the health and longevity of PLWH and will significantly

reduce the risk of HIV transmission. It will also improve opportunity for preventive services, including testing and PrEP for HIV-negative people at risk. Continuing outreach efforts are needed to keep people aware and better informed about health care coverage options. Underserved populations need special assistance in understanding and enrolling in health care coverage programs.

9. Increase use and integration of data to improve HIV health outcomes.

The use of data is critical in monitoring population health and improving health outcomes. Multiple data systems and data resources from a broad variety of programs and entities are needed to conduct surveillance, program planning, quality improvement and evaluation, clinical management, and research. It is a challenge to optimize and integrate data systems in ways that make them compatible, interchangeable, and useful to enhance the quality of clinical care, public health, and overall decision making. There is a need for managers and users of data systems to collaborate, maintain the quality of data, and optimize data systems to enhance data sharing and to continue to ensure the security and confidentiality of data. “Data to Impact” refers to the use of individual-level data to prioritize public health follow-up. “Data to Care” uses laboratory data to identify those who have been diagnosed with HIV but are out of medical care. Similarly, data on new STIs and health status of sex and needle-sharing partners of HIV-negative persons helps prioritize resources for follow-up for further HIV and STI testing and referral to PrEP.

10. Promote policies and practices that reduce discrimination.

Stigma and discrimination affecting people living with HIV, LGBT communities, and communities of color serve as barriers to effective HIV prevention, care, and support services. Many people are afraid to seek HIV information and prevention services and are reluctant to disclose their HIV status to family members and partners for fear of being judged and stigmatized. This can cause PLWH to be reluctant in accessing or continuing engagement in services and in taking medications. State and local government, service providers, policy makers, and community leaders should actively support policies and practices that eliminate all forms of discrimination and stigmatization. Prevention, care, and support services need to be client centered, culturally responsive, and linguistically appropriate for all populations and address the unique needs of marginalized and disenfranchised populations.

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Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired immune deficiency syndrome
AODA	Alcohol and other drug abuse
ARCW	AIDS Resource Center of Wisconsin
ARV	Antiretroviral medications
ASO	AIDS service organization
CAIR	Center for AIDS Intervention Research
CBO	Community-based organization
CD4	Type of white blood cell particularly impacted by HIV infection
CDC	Centers for Disease Control and Prevention (Federal)
CLAS	Culturally and linguistically appropriate services
CTR	Counseling, testing, and referral
CY	Calendar year
DHS	Department of Health Services (Wisconsin)
DIS	Disease investigation specialist
DOC	Department of Corrections (Wisconsin)
DON	Determination of need
DPH	Division of Public Health (within DHS for Wisconsin)
DPI	Department of Public Instruction (Wisconsin)
EBD	Elderly, blind or disabled
ED	Emergency department
eHARS	Electronic/enhanced HIV AIDS Reporting System
EIS	Early intervention services
FDA	Food and Drug Administration
FTM	Female to male (Transgender)
GPR	General purpose revenue (State funds)
HAART	Highly active antiretroviral therapy
HAB	HIV/AIDS Bureau (Office in the federal Health Resources and Services Administration)
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HIV-positive	HIV-infected, person has tested positive on standard HIV-antibody test
HIV PS	HIV partner services
HOPWA	Housing Opportunities for People with AIDS
HPV	Human papilloma virus
HRH	High-risk heterosexual
HRSA	Health Resources and Services Administration (Federal)
IAP	Insurance Assistance Program
IBM	Insurance benefit manager
IRC	(Wisconsin HIV/STD/HCV) Information Referral Center

LGBT	Lesbian, gay, bisexual, transgender (not always in this order)
LGBTQ	Lesbian, gay, bisexual, transgender, questioning
LHD	Local health department
LTC	Long-term care or linkage to care
LTCS	Linkage to care specialist
MA	Medical Assistance, also called Medicaid
MAI	Minority AIDS Initiative
MAPP	Medicaid Purchase Plan
MAT	Medication-assisted treatment
MATEC	Midwest AIDS Training and Education Center
MCM	Medical case manager
MMWR	Morbidity and Mortality Weekly Report
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSM	Men who have sex with men
MSM/IDU	Men who have sex with men and are also injection drug users
MTF	Male to female (transgender)
NAS	National AIDS Strategy
NASTAD	National Alliance of State and Territorial AIDS Directors
NHAS	National HIV/AIDS Strategy
nPEP	Non-occupational post-exposure prophylaxis
NPIN	National Prevention Information Network
PEP	Post-exposure prophylaxis
PCC	Personalized cognitive counseling
PCP	Primary care provider
PLWH	Persons living with HIV
POL	Popular opinion leader
PrEP	Pre-exposure prophylaxis—use of protease inhibitors in persons at risk for HIV to reduce the risk of infection if they are exposed
PS	Partner services
PS Web	Partner services web-based data system
PWID	People who inject drugs (formerly IDU, injection drug use/user)
QI	Quality Improvement
RSR	Ryan White Services Report (client-level data report beginning in 2009)
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAPG	Statewide Action Planning Group
SBIRT	Screening, brief intervention, and referral to treatment
SCSN	Statewide Coordinated Statement of Need
SPNS	Special Projects of National Significance
SSP	Syringe Support Program
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
TA	Technical assistance

TIC	Trauma informed care
TB	Tuberculosis
TGA	Transitional Grant Area
UMOS	United Migrant Opportunities Services
WEDSS	Wisconsin Electronic Disease Surveillance System
WSLH	Wisconsin State Laboratory of Hygiene (also referred to as SLH)
YMSM	Young men who have sex with men
YRBS	Youth Risk Behavior Survey

Introduction

The Wisconsin Integrated HIV Prevention and Care Plan is a strategic plan of the Wisconsin Department of Health Services that is focused on ensuring a coordinated public health response in Wisconsin to the AIDS/HIV epidemic for the period 2017-2021. While great progress has been made over the past three decades regarding HIV prevention and treatment of persons with HIV infection, the HIV epidemic remains a public health priority. To this end, the Integrated HIV Plan focuses on expanding the capacity of Wisconsin's HIV care and prevention service systems to implement high-quality, scientifically sound, culturally competent services that reach persons at highest risk and those affected by HIV infection.

The development of the Integrated HIV Plan is especially important at this time because of major scientific, policy, and other advances over the past several years:

- **New Health Insurance Options:** Persons living with and at risk for HIV have increased options for health care coverage under the Affordable Care Act and Wisconsin's Medicaid reform.
- **HIV Testing:** New HIV diagnostic tests and expanded testing efforts have emerged. Screening of all persons aged 15 to 65 years for HIV is now a grade "A" recommendation of the U.S. Preventive Services Task Force. New health plans under the ACA must offer HIV screening without cost sharing.
- **Benefits of HIV Treatment and Treatment as Prevention:** Scientific studies have demonstrated that early treatment promotes improved health outcomes for those with HIV. People adhering to effective antiretroviral therapies and having suppressed viral loads can reduce the risk of sexual transmission of HIV by 96%. Antiretroviral therapy for pregnant women with HIV has dramatically reduced the risk of transmission during pregnancy and childbirth.
- **Pre-Exposure Prophylaxis (PrEP):** In 2012, the Food and Drug Administration approved the daily use of the drug Truvada® for PrEP. To make best use of this new HIV prevention tool, the U.S. Public Health Service and the Wisconsin AIDS/HIV Program have released clinical practice guidelines to assist clinicians in providing PrEP and related services to persons at substantial risk for HIV infection. When taken consistently, PrEP can reduce one's risk for acquiring HIV by over 90%.
- **HIV Care Continuum:** The HIV Care Continuum is universally recognized as an important conceptual model that illustrates the sequential steps or stages people go through from initial diagnosis of HIV infection to achieving the goal of viral suppression. It is used to monitor engagement in care and health outcomes; identify health disparities, prioritize strategies and interventions; and evaluate the impact of prevention, care, and treatment initiatives.

- **Digital Tools and Technology:** Digital technology and social media have changed how information is delivered and exchanged, resulting in enhanced and efficient ways to extend the reach and impact in providing information, promoting HIV testing, and assisting people in linking, accessing, and remaining engaged in care.

The Wisconsin Integrated HIV Prevention and Care Plan 2017-2021 replaces the *Wisconsin HIV/AIDS Strategy 2012-2015*, the previous statewide consolidated HIV prevention and care plan. It fulfills a funding requirement of two federal agencies—the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The Integrated HIV Plan meets the federal requirement regarding HIV prevention and care planning activities as well as the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for grantees of the Ryan White HIV/AIDS Program.

The [Wisconsin AIDS/HIV Program](#) is responsible for coordinating and overseeing the development of the Integrated HIV Plan, in collaboration with the [Statewide Action Planning Group](#) (SAPG), Wisconsin’s HIV community planning body. Development of the Integrated HIV Plan was a major focus of SAPG meetings and deliberations in 2015 and 2016. Group discussions and feedback from SAPG members helped shape and inform the development of objectives and priorities for the Wisconsin 2017-2021 Integrated HIV Plan.

During their deliberations on the Integrated HIV Plan, SAPG members identified the following core values and guiding principles that should serve as a foundation for planning and implementing HIV services in Wisconsin:

- *Respect*
- *Diversity*
- *Accountability*
- *Leadership*
- *Collaborative Partnerships*
- *Commitment*
- *Empowerment*
- *Equity*
- *Excellence*
- *Trust*

In addition to the key role of the SAPG, the planning process for the Integrated HIV Plan included engagement with other key stakeholders, including representatives of all Ryan White Parts, community partners, persons living with HIV (PLWH), consumers of services, and populations at risk. Progress in meeting the expectations of the Integrated HIV Plan will be reviewed with and reported to these groups on a periodic basis.

The Wisconsin AIDS/HIV Program was established in 1983 and is responsible for overseeing and coordinating state public health programs and activities addressing the AIDS/HIV epidemic. The AIDS/HIV Program is located within the [Bureau of Communicable Diseases](#) and is an operating unit within the [Wisconsin Division of Public Health](#), the lead public health agency within the [Wisconsin Department of Health Services](#). The AIDS/HIV Program has five major areas of focus: surveillance, prevention, care, hepatitis C, and community planning.

HIV-related prevention and care services in Wisconsin are provided through a statewide, regionally based AIDS service organization (the AIDS Resource Center of Wisconsin), a variety of

community-based agencies, local health departments, tribal health centers, academic centers, and other public and private health care agencies.

Alignment of the Integrated HIV Plan with State and Federal Strategic Plans and Frameworks

The Integrated HIV Plan is the single HIV-specific plan serving the entire state. It addresses primarily HIV but also acknowledges the important overlap, commonalities, and synergies of the epidemic with that of hepatitis C infection, sexually transmitted infections, and tuberculosis. Successful outcomes in implementing the Integrated HIV Plan will contribute to achieving positive outcomes in each of these other areas.

The Integrated HIV Plan is consistent with and complements other strategic health plans. [*Healthiest Wisconsin 2020*](#), the state health plan, is directed at improving health across the life span, eliminating health disparities, and achieving health equity. The Integrated HIV Plan addresses several priority areas identified in *Healthiest Wisconsin 2020*:

- *Access to high-quality health services.*
- *Alcohol and drugs.*
- *Communicable diseases.*
- *Health disparities.*
- *Reproductive and sexual health.*
- *Social, economic, and educational factors that influence health.*

In 2016, the Wisconsin Department of Health Services is developing a five-year health improvement plan through the [*Wisconsin Health Improvement Planning Process \(WI-HIPP\)*](#). Part of the planning process includes a Wisconsin health assessment that will provide an overview of the health of the people of Wisconsin and will summarize data that will guide the selection of top priorities for the state health improvement plan. The health improvement plan will build on the foundation of the state health plan *Healthiest Wisconsin 2020* and the work completed by local health departments and hospitals in community health assessments and improvement plans throughout the state. The Integrated HIV Plan will support several of the WI-HIPP priorities. The WI-HIPP priorities include:

- *Alcohol abuse*
- *Nutrition and physical activity*
- *Opioid abuse*
- *Suicide*
- *Tobacco*

The Integrated HIV Plan addresses the four major goals of the [*National HIV/AIDS Strategy*](#), which was updated in July 2015:

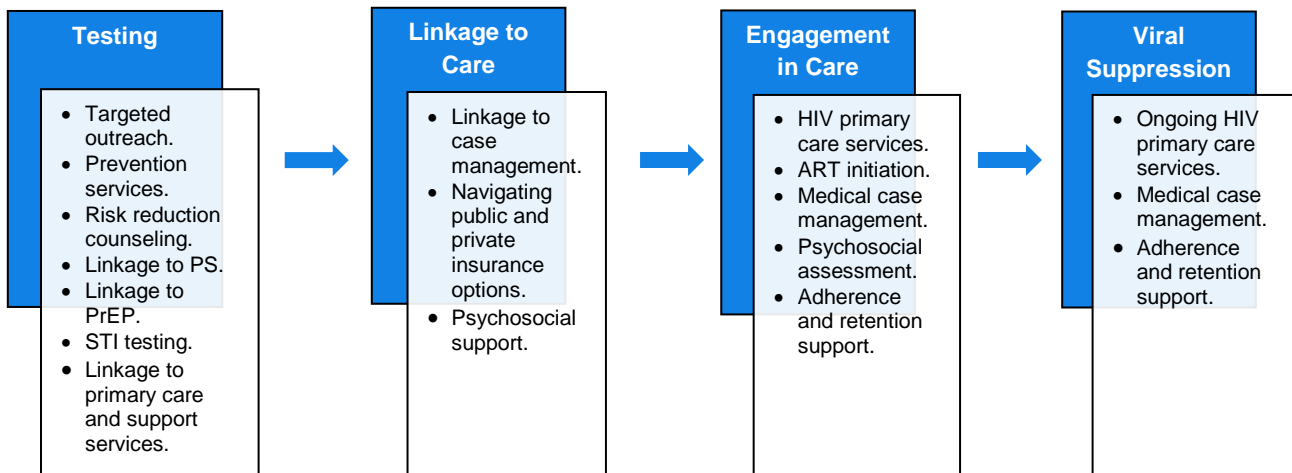
- *Reducing new HIV infections.*
- *Increasing access to care and improving health outcomes for people living with HIV.*
- *Reducing HIV-related disparities and health inequities.*
- *Achieving a more coordinated national response to the HIV epidemic.*

Consistent with the National HIV/AIDS Strategy, the Integrated HIV Plan looks toward 2021 with a commitment to respond to these priorities and realities:

- *The HIV epidemic continues to be a major health issue in the United States.*
- *Most people can live long, healthy lives with HIV if they are diagnosed and get treatment.*
- *Certain populations bear a disproportionate burden of HIV.*
- *People must have access to tools and education to prevent HIV transmission.*
- *Every person diagnosed with HIV needs immediate access to treatment and care that is non-stigmatizing, competent, and responsive to the needs of the diverse populations impacted by HIV.*

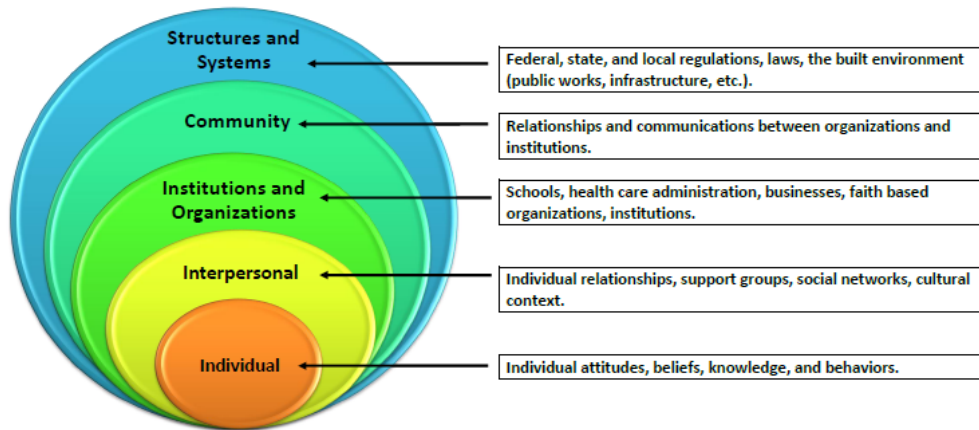
The Integrated HIV Plan incorporates and utilizes the nationally recognized strategic planning framework of an HIV continuum of care, a conceptual model outlining the sequential steps or stages people go through from initial diagnosis of HIV infection to achieving the goal of viral suppression. The model is used to monitor and evaluate services, identify health disparities, and to ensure the delivery of comprehensive HIV prevention and care services. The Wisconsin HIV continuum is addressed in detail in [Section I.B.](#) of this Integrated HIV Plan.

Figure 1. HIV Care Continuum



The Integrated HIV Plan aligns with and endorses an ecological model of public health (Figure 2) that acknowledges the multiple factors and spheres of influence that impact the health of individuals and communities. These factors and domains (individual, interpersonal, organizational, community, and public policy) have the potential to promote and ensure health equity (conditions under which people have full and equal access to resources and opportunities to lead healthy lives) or they can be factors that contribute to health inequities and disparities, resulting from constrained resources and limited opportunities for healthy living.

Figure 2. Ecological Model of Health¹



The ecological model is closely associated with the social determinants of health—the conditions and environments in which people are born, live, learn, work, play, and age. These factors affect a range of health and quality of life outcomes and include contextual factors such as poverty, lack of access to health care, and mental health issues that can increase the risk for HIV. In the development of the Integrated HIV Plan, the social determinants of health and related ecological factors have been important considerations in identifying key strategies and activities that support prevention and care services for persons at risk or living with HIV.

¹ Centers for Disease Control and Prevention [Internet]. Social ecologic model [reviewed 2013 Aug 2; cited 2016 Jul 11]. Available from: <http://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity/framing-the-issue.html>

SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT

A. Epidemiologic Overview

This epidemiologic overview is based primarily on HIV surveillance data. HIV surveillance consists of confidential, name-associated reporting of confirmed HIV infection and AIDS to the state epidemiologist, as required by Wis. Stat. § 252.15. Case reports are submitted to the Wisconsin AIDS/HIV Program from private physicians, hospitals, clinics, ambulatory care facilities, sexually transmitted disease clinics, the Wisconsin correctional system, family planning clinics, perinatal clinics, Indian health clinics, blood and plasma centers, military entrance processing stations, and laboratories performing HIV testing.

Laboratory-based reporting is also required by law. Laboratories performing confidential name-associated HIV confirmatory testing and routine monitoring of HIV infection report to the AIDS/HIV Program the name of the patient and the name of the ordering physician for all positive samples. This is useful in identifying newly infected persons and monitoring health outcomes and health disparities.

Once collected, surveillance data are used by AIDS/HIV Program staff to:

- Define the trends and affected populations of the HIV epidemic in Wisconsin.
- Identify the magnitude and extent of medical, economic, and social impacts.
- Identify levels and trends of HIV infection that are necessary for developing, targeting, and evaluating prevention and care programs.

The results of these analyses can then be used by prevention staff to focus interventions, identify objectives for planning groups, identify trends, and provide essential data for program planning and resource allocation. The numbers of cases of AIDS and HIV are also used to determine program funding from the federal and state government.

In addition to the data presented below, additional data on HIV infection and related co-morbidities in Wisconsin can be found at:

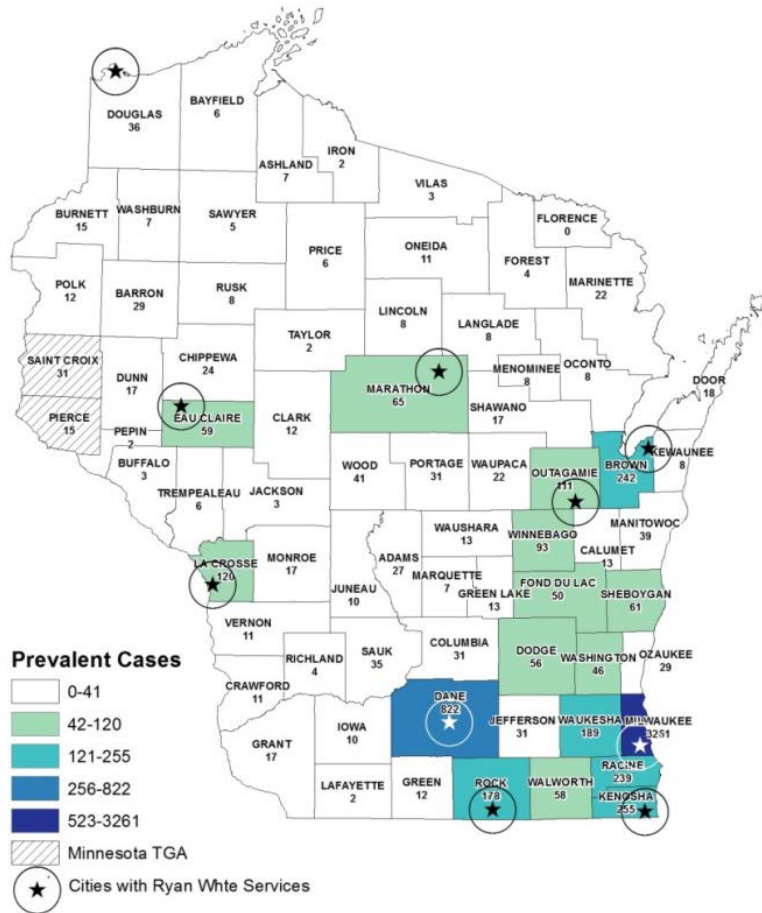
- HIV infection: <https://www.dhs.wisconsin.gov/aids-hiv/data.htm>
- Hepatitis C infection: <https://www.dhs.wisconsin.gov/viral-hepatitis/hcv-data.htm>
- Sexually transmitted infections: <https://www.dhs.wisconsin.gov/std/data.htm>
- Tuberculosis: <https://www.dhs.wisconsin.gov/tb/data.htm>

1. JURISDICTION OVERVIEW

a. Ryan White Funding

Various agencies in Wisconsin receive Ryan White Parts B, C, D, and F funding. Funded agencies are concentrated in counties with the highest HIV prevalence (Figure 3). Pierce and Saint Croix counties are part of the Part A funded Minneapolis-St. Paul Transitional Grant Area (TGA).

Figure 3. HIV prevalence and Ryan White-funded service locations, Wisconsin, 2015



Data source: Wisconsin Enhanced HIV/AIDS Reporting System (eHARS)

b. Wisconsin Demographic Highlights

Population

Wisconsin’s population in 2014 was estimated to be 5.7 million. Wisconsin’s county populations range from 4,300 to 950,000, with the most populous counties in the southeastern region of the state.

Race and Ethnicity

Eighty-three percent of Wisconsin’s population is non-Hispanic White, followed by 6.8% non-Hispanic-Black, 6.5% Hispanic, 2.8% Asian, and 1% American Indian. Wisconsin’s Black population is concentrated in southeastern counties; Hispanic and Asian residents live primarily in the southeastern, southern, and central parts of the state; and American Indians live primarily in Milwaukee County, northeastern, and northern counties.

Age

The median age of people living in Wisconsin is 39.2 years, with almost one quarter (23%) of the population under age 18 and 15% ages 65 and older. However, age varies by racial and ethnic group. The median age of non-Hispanic Whites is 42.8, whereas other racial/ethnic

groups have a median age of 31 or younger. Wisconsin’s northern and central counties generally have a median age at 43 or above, whereas the southern part of the state has a median age under age 43. This likely reflects the distribution of non-Hispanic Whites and other racial/ethnic groups across the state.

Socioeconomic Status

Thirteen percent of Wisconsin residents are living in poverty, compared to 15.4% nationally. However, 21.6% of Milwaukee County residents, Wisconsin’s most populated county, live in poverty. Menominee County had the highest proportion of residents living in poverty, at 31.4%. Living in poverty means that someone lives at or below 100% of the federal poverty level, which was \$25,250 annually for a household of four people in 2015.

Sexual Orientation

An estimated 8% of students in Wisconsin public high schools, and 18% of Milwaukee Public School students, identify as lesbian, gay, or bisexual (LGB). Among Wisconsin adults, 2% identify as LGB, and an estimated 5% of adult males in Wisconsin are men who have sex with men (MSM).

For more information on the demographic characteristics of Wisconsin’s population that are related to HIV infection, see the Wisconsin HIV Integrated Epidemiology Profile 2010-2014 at <https://www.dhs.wisconsin.gov/publications/p01294.pdf>.

c. Characteristics of People living with HIV

1.) Aware of HIV Infection

Newly Diagnosed

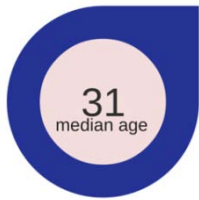
Trend: During 2015, 225 new cases of HIV infection were diagnosed in Wisconsin. Between 2009 and 2015, both the number and the rate of new infections declined. The number of new diagnoses over the last decade ranged from a low of 221 in 2014 to a high of 284 in 2009, with an average of 247 new diagnoses per year. The HIV diagnosis rate in Wisconsin is the ninth lowest among the 50 states in 2014.



Sex: Seven times as many males as females were diagnosed with HIV during 2015 (196 males and 29 females). Between 2006 and 2015, the HIV diagnosis rate increased among younger (ages 13-29) males, and declined among older (ages 30-59) males and females. The diagnosis rate fluctuated for younger females.

Gender: Since 1982, 37 known transgender individuals have been diagnosed with HIV in Wisconsin. During 2006–2015, there were 30 new HIV diagnoses in this population. Thirteen of the 30 were Black, 10 were Hispanic, and 21 of the 30 were under age 30 at the time of diagnosis.

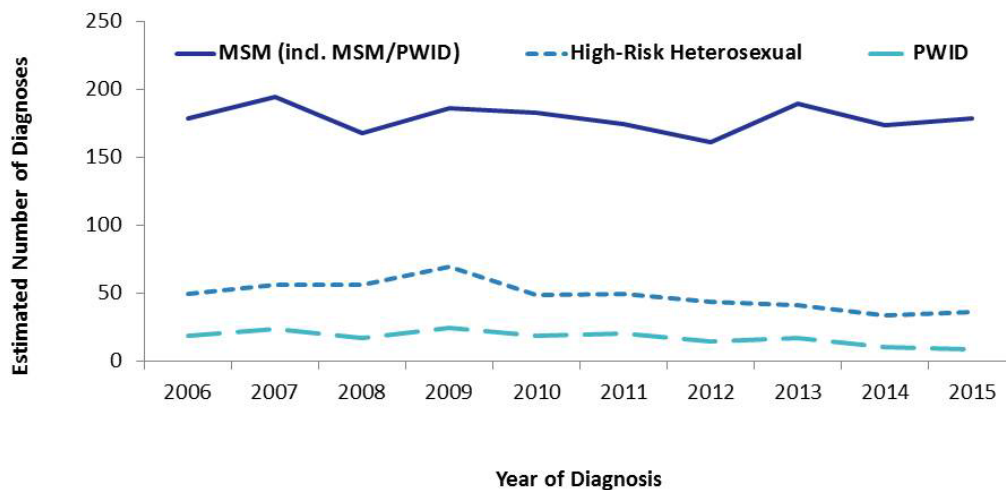
Racial/ethnic groups: HIV infection disproportionately affects racial/ethnic minorities. During 2015, 62% of new diagnoses were among racial/ethnic minorities, despite minorities making up just 17% of Wisconsin’s population. During 2011-2015, the HIV diagnosis rate for males was 13-fold higher among Blacks, six-fold higher among Hispanics, and two-fold higher among Asians and American Indians compared to Whites. For females, the HIV diagnosis rate was 25-fold higher among Blacks and eight-fold higher among Hispanics compared to Whites.



Age: The median age at HIV diagnosis was 31 years in 2015 but varied considerably by risk exposure group. The median age at diagnosis was 29 years for MSM overall, 33 years for those with high-risk heterosexual contact, and 54 years for those with a history of injection drug use.

Risk: After adjusting for unknown risk, MSM accounted for 80% of new diagnoses in 2015, including 3% among MSM who also injected drugs. High-risk heterosexual contact and injection drug use (excluding MSM/PWID) accounted for the other 16% and 4% of new diagnoses respectively. From 2006 to 2015, the number of HIV diagnoses was stable among MSM and declined among those with high-risk heterosexual contact and people who inject drugs (PWID), as shown in Figure 4.

Figure 4. HIV diagnoses by estimated risk exposure group†, Wisconsin, 2006-2015



†Data have been statistically adjusted to account for those with unknown risk.

Young MSM: Young MSM (ages 13-29) accounted for 40% of all new diagnoses in Wisconsin during 2015. The number of new diagnoses among young Black MSM has increased over the last decade; however, the increase was less steep in recent years. The number of new diagnoses fluctuated among young White MSM and was stable among young Hispanic MSM during the decade.

Geography: During 2015, HIV cases were diagnosed in 33 of the 72 counties in Wisconsin. However, the distribution was uneven: Milwaukee County cases accounted for 53% of new diagnoses, Dane County for 9%, Kenosha County for 6% and Rock County for 4%. The

Department of Corrections and all other counties each accounted for fewer than 4% of diagnoses.

Disease status at diagnosis: The proportion of individuals who progressed to AIDS within 12 months of HIV diagnosis declined from 38% in 2012 to 28% in 2014. The proportion of concurrent HIV and AIDS diagnoses also declined, from 30% in 2012 to 18% in 2015. These cases represent individuals living for several years with undiagnosed HIV infection, which may lead to poorer health outcomes and increased opportunities for disease transmission.

Diagnoses outside of Wisconsin: In addition to the 225 cases diagnosed in Wisconsin during 2015, 209 individuals previously diagnosed with HIV infection moved to Wisconsin from another state.

Prevalent Cases

As of the end of 2015, 6,868 individuals reported with HIV or AIDS were presumed to be alive and living in Wisconsin. Three-quarters (74%) of these were first diagnosed in Wisconsin; the others were initially diagnosed elsewhere.

Estimated HIV prevalence varies by demographic group. More than one in three (36%) Black MSM is estimated to be living with HIV, compared to 10% of Hispanic and 4% of White MSM. Fewer than 1 in 1,000 females and non-MSM males in Wisconsin are HIV-



positive. Within the non-MSM groups, the prevalence is highest among Blacks, at about 1.3%.

Nearly half (47%) of all PLWH reside in Milwaukee County. Dane County has the second highest proportion (12%), followed by Kenosha and Brown counties, with 4% each. Racine, Waukesha, and Rock counties and the Wisconsin Department of Corrections each have 3% of the state’s prevalent cases. All other counties have 2% or fewer of the state’s HIV cases.

The median age of PLWH is 48 years, whereas the median age at HIV diagnosis is 32 years. Thus, services for PLWH need to address health conditions of aging in addition to HIV infection, while prevention efforts should target the younger age groups.

Deaths

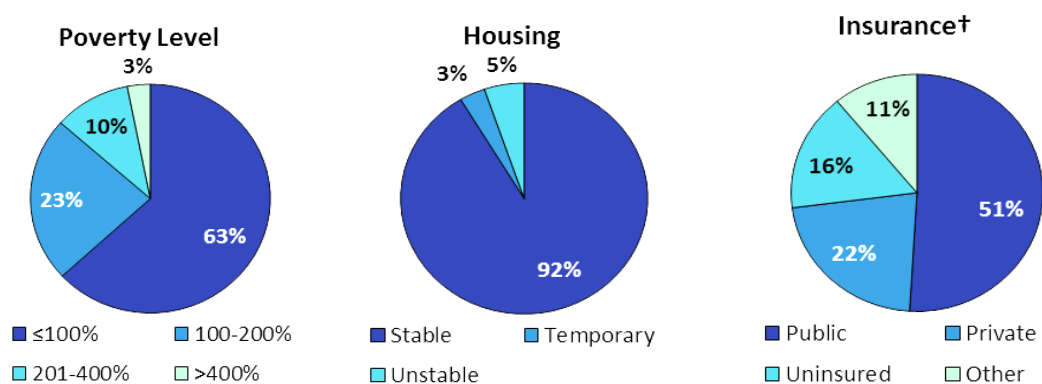
Deaths occurring in PLWH have declined markedly since the early 1990s. Deaths peaked in 1993 (373 deaths). In 2014, the most recent year with complete data, 81 deaths among PLWH are known to have occurred in Wisconsin. HIV as the primary cause of death is also on the decline—41 of the 81 reported deaths in 2014 were primarily due to causes other than HIV,

while 40 had HIV indicated as the primary cause of death. The median age at death rose from age 37 in 1990 to age 57 in 2014, indicating that people are living longer with HIV.

Socio-Demographics

Demographic information among PLWH is only available for people receiving care through a Ryan White-funded agency, which represents about 63% of all PLWH in Wisconsin during 2014. According to a national study, clients of Ryan White-funded agencies tended to have less high school education, had incomes at or below the poverty level, lacked health insurance, had a history of homelessness or incarceration, were more likely to suffer from depression, and were more likely to report unmet needs for dental care, housing, transportation, and food than clients of agencies that did not receive Ryan White funding.² While all of these data elements are not available for Wisconsin’s Ryan White population, poverty, housing, and insurance status for clients served during 2014 are shown below. (Housing status is available for clients included in the Ryan White Services Report (RSR); however, the data represent a point in time and therefore it is likely that temporary and unstable housing are underreported.) Among PLWH in Wisconsin who received care at a Ryan White-funded facility during 2014, 63% were at or below the federal poverty level, 8% had temporary or unstable housing, and 16% lacked health insurance.

Figure 5. Percent of clients served at Ryan White-funded agencies during 2014 by federal poverty level, housing, and insurance status, Wisconsin



Data Source: 2014 Ryan White Services Report (RSR)

†Other includes combination insurance types, military, and unknown.

For more information on the demographic and socio-demographic characteristics of PLWH in Wisconsin, see the Wisconsin HIV Integrated Epidemiology Profile 2010-2014 at <https://www.dhs.wisconsin.gov/publications/p01294.pdf> or the Wisconsin Department of Health Services HIV/AIDS Surveillance Annual Review at <https://www.dhs.wisconsin.gov/aids-hiv/data.htm>.

² Bradley H, Viall AH, Wortley PM, et al. Ryan White HIV/AIDS program assistance and HIV treatment outcomes. CID 2016;62(1):90-98.

Co-Infections

Sexually Transmitted Infections (STI)

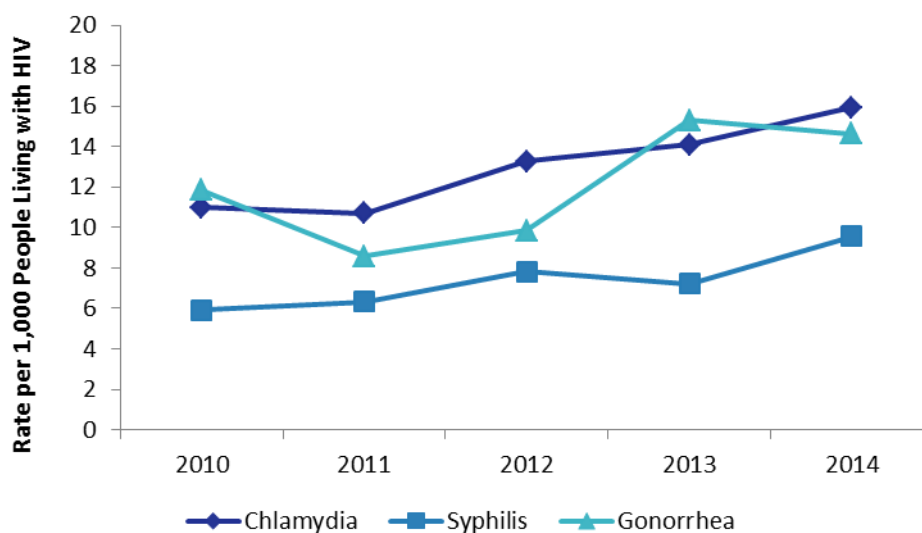
For the purpose of this document, co-infection is defined as an STI report within 30 days of, or any time after, the date of HIV diagnosis. Among PLWH in Wisconsin during 2014 (n=6,899), 66 were diagnosed with early syphilis, 101 with gonorrhea, and 110 with chlamydia.

These numbers yield rates that are 300 times higher than the general Wisconsin population for syphilis, 20 times higher for gonorrhea, and four times higher for chlamydia. Rates of all three diseases among PLWH have shown an increasing trend over the last five years (2010-2014).

Most (>70%) STIs among co-infected individuals occurred among PLWH who reported male-male sexual contact at the time of HIV diagnosis. Almost half of STI diagnoses occurred more than five years after HIV diagnosis.

Among people living with HIV, rates of all STIs showed an increasing trend during 2010-2014 (Figure 6).

Figure 6. Rate of sexually transmitted infections per 1,000 people living with HIV, Wisconsin, 2010-2014



Data Source: Wisconsin Electronic Disease Surveillance System (WEDSS) and Enhanced HIV/AIDS Reporting System (eHARS)

Overall STI case rates per 100,000 population for Wisconsin in 2014 were: chlamydia: 406, gonorrhea: 72, and syphilis: 5.³

Hepatitis C

Among PLWH in Wisconsin during 2014, 632 (9%) were co-infected with the hepatitis C virus (HCV). Injection drug use was the most common HIV risk factor for those with HIV-HCV co-

³ Wisconsin Department of Health Services [Internet]. Sexually transmitted diseases (STDs) case surveillance data, 2014. Available from: <https://www.dhs.wisconsin.gov/std/2014datamap.htm>

infection (55%), followed by male-male sexual contact (22%). Over 70% of HCV diagnoses followed HIV diagnosis by one year or more.

Tuberculosis

While HIV–TB co-infections are common globally, the rate of co-infection in Wisconsin is low. During 2010-2014, 294 people in Wisconsin developed TB disease, but only nine were co-infected with HIV. One-third of co-infected individuals were foreign-born.

For more information on infections commonly occurring with HIV in Wisconsin, see the Wisconsin HIV Integrated Epidemiology Profile 2010-2014 at <https://www.dhs.wisconsin.gov/publications/p01294.pdf>.

Highlights of HIV Care Services

In addition to the HIV care continuum presented in the next section, there are other data sources that highlight the utilization, needs, and successes of HIV care services in Wisconsin.

HIV Partner Services—Linkage to Care

Of 885 index cases assigned to Partner Services (PS) during 2013-2014, 628 (71%) were located and interviewed by PS staff. Of those interviewed, 98% were linked to HIV medical care before or within six months of being interviewed. Of those not interviewed, 83% were still linked to care within six months of PS assignment.

Ryan White-Funded Services Utilization

During 2014, 4,319 unique clients received a Ryan White-funded service in Wisconsin. The most commonly used services were outpatient medical care (53% of clients), medical case management (43% of clients), treatment adherence counseling (37% of clients), and oral health care (32% of clients).

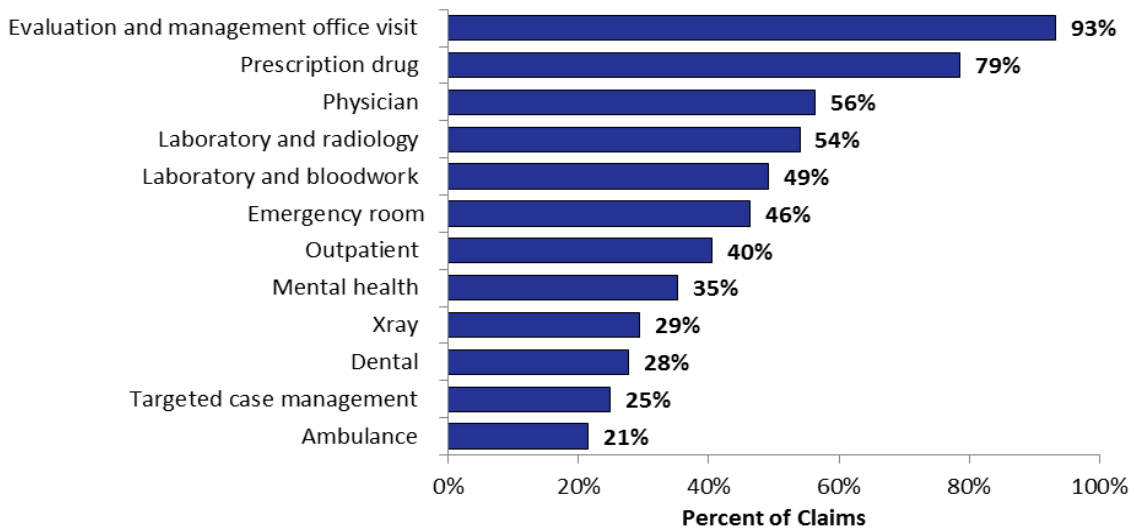
During 2014, there were 1,989 unique users of the AIDS Drugs Assistance Program (ADAP). As a result of the Affordable Care Act and eligibility changes for Wisconsin's Medicaid program, a greater proportion of ADAP users are insured. In 2014, 80% of ADAP users were insured compared to just 60% and 73% in 2012 and 2013 respectively.

Medicaid Services Utilization

During 2010-2014, an average of 2,200 clients with HIV received annual medical services or prescription drugs covered by Wisconsin Medicaid/Badger Care. This accounts for about 0.3% (3 in 1,000) of the approximately 770,000 total annual Medicaid clients, and 32% of people reported and living with HIV in Wisconsin.

More than 90% of Medicaid clients with HIV claims had an evaluation and management office visit and 73% filled prescriptions for HIV medications (Figure 7).

Figure 7. Claims by service category† among Medicaid clients with HIV claims, Wisconsin, 2014

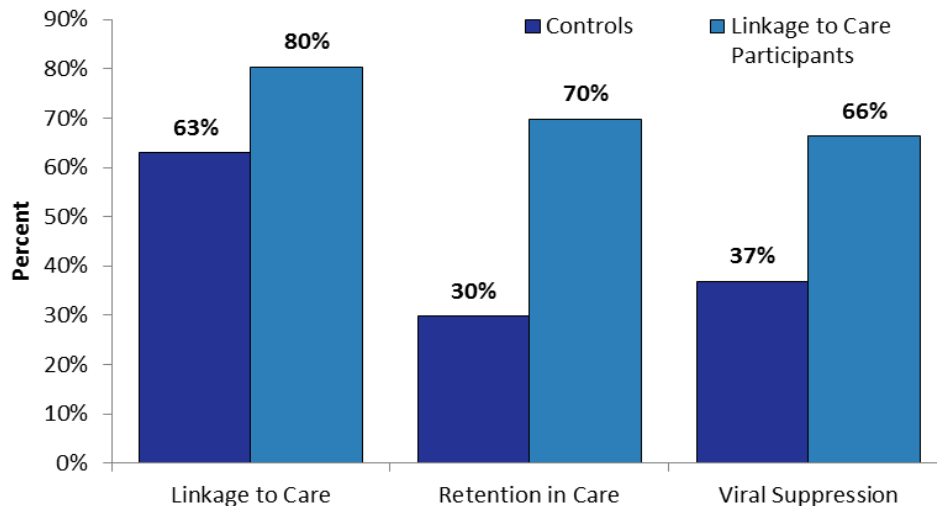


†Service categories with claims by more than 20% of all HIV-positive Medicaid clients.
Data Source: Wisconsin Medicaid Program

Linkage to Care Program Preliminary Outcomes

In 2012 Wisconsin implemented a new Linkage to Care patient navigation program as part of an initiative funded by the Health Resources and Services Administration (HRSA) to develop and evaluate innovative programs and practices to increase access to HIV medical care. The patient navigators work with PLWH for up to nine months to link individuals to care and retain them in care by reducing barriers that have caused, or may cause, a lapse from care. Preliminary evaluation data have shown improvement in linkage to care, retention in care, and viral suppression, compared to control subjects (Figure 8).

Figure 8. Linkage to care program preliminary outcomes



Data Source: Preliminary Linkage to Care evaluation results as of July 23, 2015.

For more information on care-related data sources and outcomes, see the Wisconsin HIV Integrated Epidemiology Profile 2010-2014 at <https://www.dhs.wisconsin.gov/publications/p01294.pdf>.

2. Unaware of HIV Status

Due to increased testing efforts, the number of PLWH who are unaware of their infection is decreasing. The most recent CDC estimates⁴ indicate that, nationally, 12.8% of people (about 1 in 8) living with HIV are unaware of their infection. This percentage varies considerably by demographic group. For the first time in 2015, CDC provided state-level estimates of the percentage of people unaware of their HIV infection.⁵ The estimate for Wisconsin is 16.2% (about 1 in 6), 27% higher than the national estimate. When the national number (12.8%) is applied to the Wisconsin population, it yields an estimate of about 1,000 PLWH who are unaware of their status. Use of the Wisconsin number (16.2%) yields an estimate of about 1,300 people.

Figure 9 shows the estimated proportion of PLWH who are unaware of their HIV status by demographic group. Figure 10 shows the estimated number unaware in Wisconsin using national estimates because state-level estimates are unavailable by demographic group. Nationally, youth ages 13-24 years are the most likely to be unaware of their HIV status (44.2%).

⁴ Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. HIV Surveillance Supplemental Report [Internet]. 2015;20(2) [cited 2016 March 15]. Available from: http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillancereport_vol20_no2.pdf.

⁵ Centers for Disease Control and Prevention. Prevalence of diagnosed and undiagnosed HIV infection—United States, 2008–2012. MMWR 2015;64(24):657-662. Available from: <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6424a2.htm>

Figure 9: Estimated percentage of those with HIV who are unaware of their HIV infection, by demographic group, United States, 2013

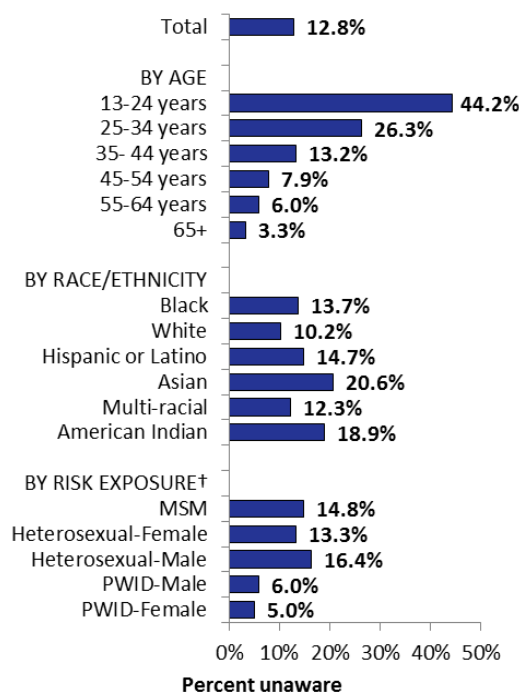
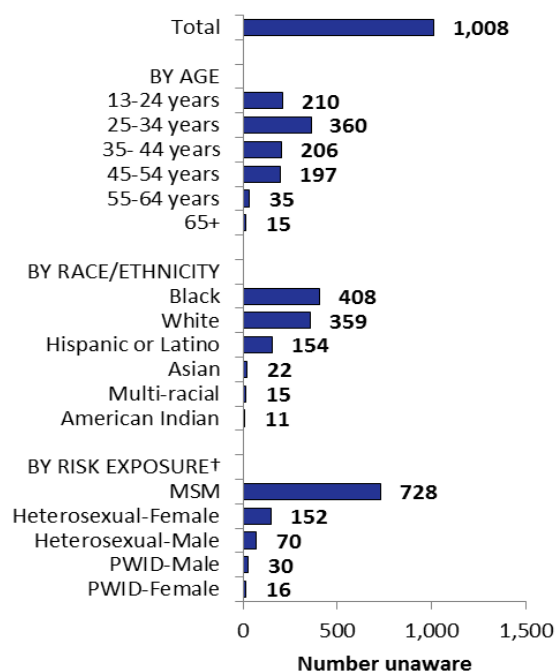


Figure 10: Estimated number unaware of their HIV infection, using CDC national estimates, by demographic group, Wisconsin, 2015



†MSM=Men Who Have Sex with Men; PWID=People Who Inject Drugs

These findings have implications for planning HIV testing services. Once people are aware of their infection, they are at lower risk of transmitting HIV for two reasons: they are more likely to reduce their risk behaviors, and they are more likely to receive medical care and have access to antiretroviral medications that reduce their viral load—the amount of virus circulating in the body. These estimates of the number unaware of their infection can guide priority-setting and population-targeting for testing services.

3. INDICATORS OF RISK FOR HIV Infection

a. HIV Risk Factors

Male-Male Sexual Contact

The primary risk behavior for HIV infection in Wisconsin is male-male sexual contact, accounting for an estimated 80% of new HIV diagnoses during 2015. Using published estimates for Wisconsin,⁶ 5.4% of men ages 18 and older are MSM, or about 116,000 Wisconsin males. The estimate is lower for Black MSM (4.3%) and slightly higher for White MSM (5.6%).

⁶ Lieb S, Fallon SJ, Friedman SR, et al. Statewide estimation of racial/ethnic populations of men who have sex with men in the U.S. Public Health Rep 2011;126(1):60-72.

However, using estimates of recent male-male sexual contact (within the past 12 months) in the Midwest,⁷ and national estimates of high-risk sexual behavior,⁸ an estimated 7,800 MSM in Wisconsin may be at risk for HIV infection, including about 350 Black MSM in Milwaukee.⁹

Nationally, the lifetime risk of HIV diagnosis among all MSM is 1 in 6.¹⁰ However, significant disparities exist, with the lifetime risk of Black MSM 1 in 2, Hispanic MSM 1 in 4, and White MSM 1 in 11.

Injection Drug Use

Injection drug use accounted for 4% of HIV diagnoses in 2015, with nine new diagnoses attributed to injection drug use. The number of diagnoses attributed to injection drug use has decreased by 75% over the last decade (2006-2015). However, the lifetime risk of HIV diagnoses among PWID is still high, at 1 in 23 for women and 1 in 36 for men.¹⁰

While HIV has not, to date, been associated with the increase in hepatitis C or hepatitis C clusters in Wisconsin, as it has in other parts of the country. Increased attention is being placed on HIV-infected individuals newly diagnosed with hepatitis C to prevent new drug-use associated HIV infections.¹¹

Using estimates of *recent* injection drug use (within the past 12 months) in the Midwest,⁷ and national estimates of injection drug use with shared needles,⁸ an estimated 2,500 injection drug users in Wisconsin may be at risk for HIV infection.⁹

Although HIV diagnoses attributed to injection drug use are decreasing, increases in hepatitis C diagnoses as well as heroin-related emergency department visits, hospitalizations, and deaths, suggests that injection drug use is on the rise among some populations, including young adults and people in rural areas (Figure 11).¹²

⁷ Oster AM, Sternberg M, Lansky A, I. Population size estimates for men who have sex with men and persons who inject drugs. *J Urban Health* 2015; 92(4):733-743.

⁸ Smith DK, Van Handel M, Wolitski RJ, et al. Vital signs: estimated percentages and numbers of adults with indications for preexposure prophylaxis to prevent HIV acquisition—United States, 2015. *MMWR* 2015;64(46):1291-1295. Available from:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a4.htm?s_cid=mm6446a4_w

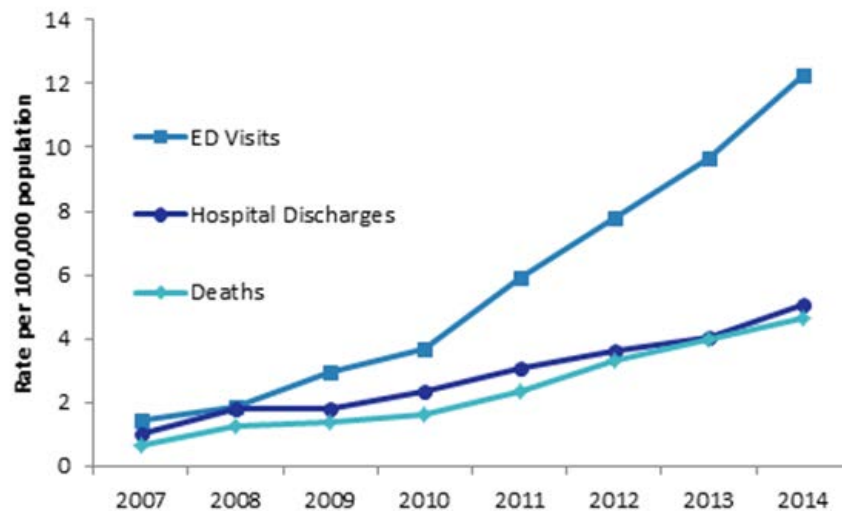
⁹ Gasiorowicz, M. Estimated number of men who have sex with men and people who inject drugs with indications for HIV pre-exposure prophylaxis in Wisconsin. Wisconsin AIDS/HIV Program Notes. March 2016 Supplement. Available from: <https://www.dhs.wisconsin.gov/publications/p00792-16-march-sup.pdf>. Accessed April 16, 2016.

¹⁰ Conference on Retroviruses and Opportunistic Infections [Internet]. Lifetime risk of HIV diagnosis in the United States. 2016. Available from: <http://www.cdc.gov/nchhstp/newsroom/2016/croi-2016.html>. Accessed May 18, 2016.

¹¹ Peters PJ, Pontones P, Hoover KW, et al. HIV Infection linked to injection use of oxymorphone in Indiana, 2014–2015. *N Engl J Med* 2016; 375:229-239.

¹² Wisconsin Department of Health Services [Internet]. Epidemiologic Profile of Hepatitis C Virus (HCV) in Wisconsin 2014. Available from: <https://www.dhs.wisconsin.gov/publications/p0/p00860.pdf>.

Figure 11. Rates of heroin-related emergency department visits, hospital discharges, and deaths, Wisconsin, 2007-2014



High-Risk Heterosexual Contact

High-risk heterosexual contact is defined as heterosexual contact with a high-risk partner, such as an injection drug user, a bisexual male, or a person with HIV infection. High-risk heterosexual contact accounts for the second highest proportion of HIV diagnoses (16%), but accounts for the majority (86%) of diagnoses among women. Although high-risk heterosexual contact is the second most common transmission route for HIV infection in Wisconsin, the lifetime risk of HIV diagnosis among heterosexuals is the lowest of the three risk groups, at 1 in 241 for heterosexual women and 1 in 473 for heterosexual men.¹⁰

According to national estimates,⁸ 0.4% of heterosexual individuals reported a high-risk sexual partner within the past 12 months, which would equate to 13,000 Wisconsin residents ages 15-59.

Lesbian, Gay, and Bisexual Youth

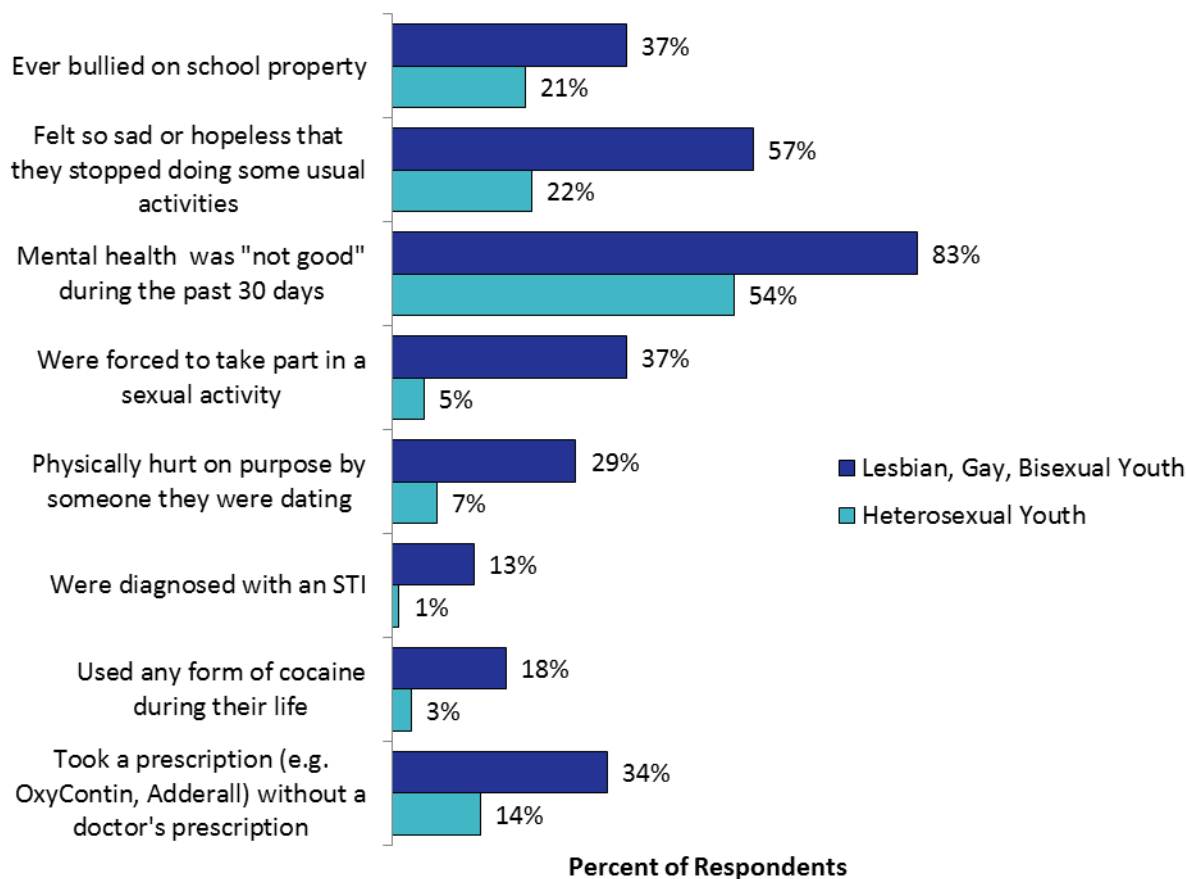
Wisconsin data from the Youth Risk Behavior Survey (YRBS) show a higher prevalence of mental health disorders, lack of safety, sexual abuse, and substance use among lesbian, gay, and bisexual youth compared to heterosexual youth (Figure 12),¹³ which could lead to higher HIV risk. For example, young adults with anxiety or depression are more likely to engage in high-risk activities such as prostitution, drug use, and sex with high-risk partners.¹⁴ In addition, a study of gay and bisexual men found that those who had been abused were more likely to engage in unprotected sex and injection drug use.¹⁵

¹³ Department of Public Instruction [Internet]. 2013 youth risk behavior survey results: risk behaviors and sexual identity report. Available from <http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/yrbs13hssexualid.pdf>. Accessed December 2, 2015.

¹⁴ Center for AIDS Prevention Studies [Internet]. How does mental health affect HIV prevention? September 2001. Available from <http://caps.ucsf.edu/archives/factsheets/mental-health>. Accessed December 2, 2015.

¹⁵ Bartholow BN, Doll LS, Joy D, et al. Emotional, behavioral and HIV risks associated with sexual abuse among adult homosexual and bisexual men. *Child Abuse and Neglect* 1994;9:747-761.

Figure 12. Select Wisconsin Youth Risk Behavior Survey Responses† Comparing Lesbian, Gay, and Bisexual Youth to Heterosexual Youth, 2013



†Questions are paraphrased for graphing. The complete questions can be found at <http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/yrebs13hssexualid.pdf>.

For more information on HIV-related data sources and outcomes, see the website of the Wisconsin AIDS/HIV Program, HIV/AIDS Statistics and Reports, at <https://www.dhs.wisconsin.gov/aids-hiv/data.htm>. See also the Wisconsin HIV Integrated Epidemiology Profile 2010-2014 at <https://www.dhs.wisconsin.gov/publications/p01294.pdf>.

B. HIV Care Continuum

The HIV care continuum continues to be an important framework for understanding and assessing the status of HIV care and treatment in the United States as well as prevention efforts directed at early detection and prevention of transmission (treatment as prevention). The HIV care continuum illustrates the stages through which PLWH can progress in the management of

their HIV infection—diagnosis, linkage to care, retention in care, and the ultimate goal of viral suppression. Taken collectively for a given population, the care continuum shows the proportion of PLWH who are engaged at each stage of the continuum and is therefore a useful tool to:

- Monitor engagement in care and health outcomes.
- Identify health disparities.

- Prioritize strategies and interventions.
- Evaluate the impact of prevention, care, and treatment initiatives.

Methods

The continua presented below are diagnosis-based, using the same stages and definitions used by the CDC to develop the national diagnosis-based continuum,¹⁶ and using data from the National HIV Surveillance System, with the following exceptions:

- The national continuum is based on individuals ≥ 13 years of age, whereas Wisconsin includes people of all ages.
- *Antiretroviral Use* is included in the national continuum but these data are not available in Wisconsin.
- Wisconsin includes an *In Care* stage (also described in the federal guidance but not depicted on the national continuum), which acknowledges that some PLWH may be engaged in care but do not meet the federal definition of retention.

The definitions of the care continuum stages are described in Table 1.

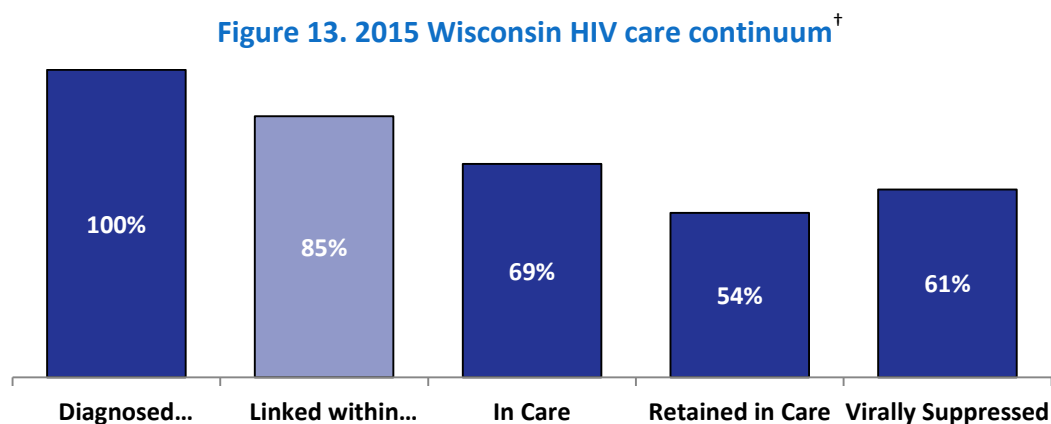
Table 1. Wisconsin HIV care continuum stage definitions

Care Stage	Measurement Definition
Diagnosed and Living with HIV	Number of PLWH who were reported with HIV in Wisconsin at the end of 2014 and who were presumed still alive and living in Wisconsin at the end of 2015.
Linked within Three Months of Diagnosis	Number of PLWH newly diagnosed during 2015 that had evidence of a CD4, viral load, or HIV-1 genotype test with a specimen collection date within three months of the HIV diagnosis date, divided by the number of PLWH newly diagnosed during 2015. Specimens collected on the date of diagnosis were excluded as they are considered part of the diagnostic workup. Linkage is shown in a different color in the continuum as it represents a different population than the other care stages.
In Care	Number of PLWH who had evidence of at least one CD4, viral load, or HIV-1 genotype test during 2015 divided by the number diagnosed and living with HIV.
Retained in Care	Number of PLWH who had evidence of at least two CD4, viral load or HIV-1 genotype tests that were ≥ 90 days apart during 2015 divided by the number diagnosed and living with HIV.
Virally Suppressed	Number of PLWH whose last viral load test result during 2015 was <200 copies/mL divided by the number diagnosed and living with HIV. Those without a viral load test during 2015 were considered unsuppressed.
Virally Suppressed among Those Tested	Number of PLWH whose last viral load test result during 2015 was <200 copies/mL divided by the number who had at least one viral load test during 2015. This measure may not be depicted on all continua.

¹⁶ Centers for Disease Control and Prevention [Internet]. Understanding the HIV care continuum. July 2016. Available from: <https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf> (Accessed Aug 7, 2016)

Results

Figure 13 shows the 2015 HIV care continuum for all Wisconsin cases.



[†]Reflects laboratory data received through April 5, 2016.

Data Source: Enhanced HIV/AIDS Reporting System (eHARS)

- **Diagnosed and Living with HIV** [n=6,337 or 100%]: Based on prevalence data from the prior year, 6,337 were still alive and living in Wisconsin as of December 31, 2015, and therefore had the opportunity to receive HIV medical care throughout 2015.
- **Linked within Three Months of Diagnosis** [n=191/225 or 85%]: Among 225 people newly diagnosed with HIV infection during 2015, 85% had laboratory evidence of linkage to care within three months of diagnosis. An additional 20 people were linked to care more than three months after diagnosis; the remaining 14 remain unlinked at the time of this analysis. Using the definition of timely linkage presented in the most recent National HIV/AIDS Strategy,¹⁷ 64% of people newly diagnosed were linked to care within one month of diagnosis.
- **In Care** [n=4,398/6,337 or 69%]: Of those diagnosed and living with HIV, 69% had at least one care visit during 2015.
- **Retained in Care** [n=3,391/6,337 or 54%]: Of those diagnosed and living with HIV, 54% had at least two visits, 90 days apart, during 2015.
- **Virally Suppressed** [n=3,874/6,337 or 61%]: Of those diagnosed and living with HIV, 61% had suppressed viral load as of their last viral load test in 2015. The remaining 39% of individuals had a viral load \geq 200 copies/mL at their last test during 2015 or did not have a viral load test during 2015 and are therefore assumed to have detectable viral load.
- **Viral Suppression among Those Tested** [n=3,874/4,334]: While not shown in Figure 13, most (89%) PLWH who had at least one viral load test (indicating some care) were virally suppressed as of their last viral load test during 2015.

Table 2 shows the percentages at each stage of the HIV care continuum by select demographic characteristics.

¹⁷ Office of National AIDS Policy [Internet]. National HIV/AIDS strategy of the United States: updated to 2020. July 2015. Available from: <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>.

Table 2. Comparison of 2015 Wisconsin HIV care continuum by select demographic characteristics.†

	Linkage Numbers	Number Diagnosed and Living with HIV	Linked within Three Months of Diagnosis	In Care	Retained in Care	Virally Suppressed (VS)	Virally Suppressed among Those Tested	Statistically Significant Differences‡
Statewide	191 of 225	6,337	85%	69%	54%	61%	89%	Not applicable
Geography								
City of Milwaukee (MKE)	88 of 105	2,676	84%	73%	58%	62%	87%	<ul style="list-style-type: none"> • In care: MKE > Non-MKE • Retained: MKE > Non-MKE • VS among those tested: Non-MKE > MKE
State excluding City of Milwaukee (Non-MKE)	103 of 120	3,516	86%	69%	52%	62%	92%	
Sex								
Male (M)	166 of 196	5,078	85%	68%	52%	61%	91%	<ul style="list-style-type: none"> • In care: F > M • Retained: F > M • VS among those tested: M > F
Female (F)	25 of 29	1,259	86%	74%	59%	62%	85%	
Race/Ethnicity								
White (W)	77 of 85	2,958	91%	72%	54%	67%	94%	<ul style="list-style-type: none"> • Linkage: W > H • In care: W > B and H; B > H • VS: W > B and H • VS among those tested: W > B and H; H > B
Black (B)	74 of 89	2,371	83%	68%	53%	56%	84%	
Hispanic (H)	26 of 34	817	76%	62%	52%	54%	88%	

Table 2. Continued

	Linkage Numbers	Number Diagnosed and Living with HIV	Linked within 3 Months of Diagnosis	In Care	Retained in Care	Virally Suppressed (VS)	Virally Suppressed among Those Tested	Statistically Significant Differences†
Age								
13-29 Years (13-29)	88 of 104	657	85%	74%	54%	59%	81%	<ul style="list-style-type: none"> • In care: 13-29 > 30+ • VS among those tested: 30+ > 13-29
30 and Older (30+)	103 of 121	5,644	85%	69%	53%	61%	90%	
Transmission Risk§								
MSM (including MSM/PWID)	131 of 154	3,698	85%	72%	55%	65%	91%	<ul style="list-style-type: none"> • Linkage: All categories > PWID • In care: MSM and HRH > PWID and unknown risk • Retained: MSM and HRH > PWID and unknown risk • VS: MSM and HRH > PWID and unknown risk; Unknown risk > PWID • VS among those tested: MSM > all other risk categories
High Risk Heterosexual (HRH)	20 of 23	905	87%	74%	57%	63%	87%	
Unknown Risk	38 of 43	1,090	88%	62%	48%	54%	88%	
PWID	2 of 5	349	40%	58%	48%	48%	84%	

†The populations are mutually exclusive within categories (e.g., within race/ethnicity) but not across categories. Reading the table by row shows the HIV care continuum for a specific population, while reading the table by column allows a comparison of each stage in the care continuum across populations.

‡Statistically significant at $p < 0.05$. Relationships not mentioned may be numerically different but not statistically different.

§MSM=Men who have sex with men. PWID=people who inject drugs.

Discussion

PLWH in Wisconsin have generally experienced positive health outcomes, including timely linkage to care and viral suppression among those in care. However, more work needs to be done to improve retention in care, which will ultimately improve viral suppression.

Despite some positive outcomes, health disparities persist and have been relatively unchanged over the past few years. There were few differences in linkage to care but, in general, the following groups were more likely to be in care, or retained in care: those living in the city of Milwaukee, females, Whites, individuals 13-29 years old, and people with risk exposures of MSM or high-risk heterosexual contact. Therefore, those living outside of Milwaukee, males, minorities, and those with injection drug use or unknown risk were least likely to be in or retained in HIV medical care. However, of those in care, there were disparities in viral load suppression which are very different than disparities in HIV care status. PLWH in the city of Milwaukee, females, minorities, ages 13-29, and all risk categories other than MSM were the least likely to be virally suppressed when in care.

Conclusion

The HIV care continuum is a useful tool for planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction, with the goal of improving engagement and outcomes at each stage of the continuum. Wisconsin will continue to use the HIV care continuum to:

- Form the foundation of the Integrated HIV Plan.
- Monitor, track, and disseminate measures of linkage, retention, and viral suppression, including being part of the evaluation metrics and overall objectives of the Integrated HIV Plan.
- Identify health disparities and service gaps that direct resource allocation and may be used for competitive funding applications.
- Evaluate the efficacy of interventions designed to improve linkage, retention, and viral suppression.
- Serve as the basis for a Data to Care program in which out of care individuals are identified and actively re-engaged in HIV medical care.

For additional analysis of the HIV Care Continuum in Wisconsin, refer to the May 2016 issue of [*Wisconsin AIDS/HIV Program Notes*](#), “Wisconsin 2015 HIV Care Continuum: Statewide and Select Population Groups.” Available at <https://www.dhs.wisconsin.gov/publications/p00792-16-may.pdf>. See also:

- Office of National AIDS Policy. National HIV/AIDS Strategy. Improving outcomes: accelerating progress along the HIV care continuum. December 2013. Available from: https://www.whitehouse.gov/sites/default/files/onap_nhas_improving_outcomes_dec_2013.pdf
- Centers for Disease Control and Prevention. Understanding the HIV care continuum. Available from https://www.cdc.gov/hiv/pdf/dhap_continuum.pdf

C. Financial and Human Resources Inventory

HIV Service Systems in Wisconsin

HIV prevention and care services in Wisconsin are provided through a variety of public and private health and human service agencies. ARCW, as the state designated ASO, is organized regionally and is responsible for ensuring statewide access to prevention and care services. In addition to the ASO's work, local health departments, private health care organizations, community-based organizations (CBOs), academic health and research centers, tribes, and other entities work to provide Wisconsin residents with a comprehensive system of HIV prevention and care.

HIV Prevention Services

HIV Testing

HIV testing includes HIV antigen and antibody (Ag/Ab) testing, individualized risk reduction counseling, and referral to additional services. HIV testing is conducted by the statewide ASO, a variety of CBOs, and local health departments.

Partner Services

HIV PS involve the systematic and confidential notification of sex and syringe sharing partners of PLWH. PS are conducted by select local health department providing jurisdictional or regional PS. There are 19 local health departments supported to provide HIV PS and early intervention services.

Comprehensive HIV prevention services for high-risk populations

For persons at ongoing high risk for HIV, there are effective behavioral and biomedical interventions that can help them remain uninfected. Some of these interventions work to reduce HIV risk by assisting clients in accessing services that address mental health and substance abuse as well as PrEP and post-exposure prophylaxis (PEP).

Harm reduction outreach for PWID

Harm reduction outreach services are field- and agency-based face-to-face interventions for individuals with injection drug risks, including MSM/PWID that are not in substance use treatment. Services include referrals to substance abuse treatment, instruction on prevention of HCV and HIV infections, injection drug use hygiene, and collection of used syringes for infection control. ARCW is supported to provide harm reduction outreach for PWID.

Health Promotion and Community Wellness

Health promotion services are directed at meeting information and awareness needs of specific populations and communities. These include hotline information and referral services, faith-based prevention education, awareness day observances, LGBT and minority health promotion and capacity building, coordination of community focus groups, health literacy and referral for homeless LGBT youth, and tribal health education and awareness activities. There are eight agencies supported to provide HIV-related health promotion services. Community wellness services for MSM promote the health and wellbeing of gay men by promoting sexual health practices and services, including routine testing for STIs, distribution of condoms and promotion of condom use, engagement of community members and providers in response to community concerns for disease outbreaks, and promotion of recommended vaccinations.

HIV Care Services

Ryan White Part B: HRSA awards Part B funds to states and territories for the provision of medical and support services. The Wisconsin DHS is the recipient of these funds and subcontracts with the statewide ASO, CBOs, local public health departments, and academic health centers to provide medical care, oral health care, mental health and substance abuse care, medical case management, housing and transportation assistance, and legal services to PLWH. The Part B award comprises multiple funding opportunities including the Minority AIDS Initiative (MAI) and ADAP earmark. The MAI funds support outreach services to connect minority PLWH in Milwaukee to the ADAP and appropriate medical care. The ADAP earmark funds support both the ADAP and the Insurance Assistance Program, which are administered directly by the AIDS/HIV Program.

Ryan White Part C: HRSA directly grants Part C funds to health care agencies for the provision of HIV early intervention and ambulatory medical services. In Wisconsin, ARCW, Milwaukee Health Services Inc., Sixteenth Street Community Health Center, and the UW HIV/AIDS Comprehensive Care Program receive these funds.

Ryan White Part D: Part D funds are awarded by HRSA to the Medical College of Wisconsin—Department of Pediatrics to deliver HIV services to women, children, and adolescents through the Primary Care Support Network.

Ryan White Part F: The Midwest Training and Education Center (MATEC)-Wisconsin is supported with Ryan White Part F funds awarded to the University of Illinois-Chicago to provide targeted, multidisciplinary education and training programs for health care providers treating people living with HIV.

Ryan White Part F Special Projects of National Significance (SPNS): SPNS funds are opportunities for entities to develop innovative models to support the care and treatment of PLWH. The DHS has been a participant in a four-year SPNS initiative to develop a sustainable model to help PLWH link to and remain engaged in medical care.

Mike Johnson Life Care and Early Intervention Services: Allocated by the Wisconsin State Legislature to the statewide ASO, these GPR funds support the provision of both medical care and support services.

Additional HIV Prevention and Care Activities

State and federal funds support public information resources, training for providers, community planning, and evaluation of HIV prevention and care activities. ARCW provides HIV, HCV, and STI information and referral services through a toll-free AIDSline and web-based information and referral. The University of Wisconsin-Madison Continuing Studies (HIV Outreach Project) coordinates the HIV community planning process and provides training for HIV providers conducting HIV testing, medical case management, HIV PS, and other community based services. The Medical College of Wisconsin—Center for AIDS Intervention Research conducts evaluation of early intervention services, STD/HIV disease intervention services, PrEP, and other services.

A detailed review of the state and federal funds that DHS subcontracts to the state-designated ASO, CBOs, LHDs and other agencies is included in [Appendix II](#).

Funding Amounts and Workforce Dedicated to HIV Services

Twenty HIV service providers¹⁸ that are funded, in part, by the Wisconsin DHS and federal agencies were surveyed to collect information on financial (from both public and private funding sources) and human resources dedicated to HIV services in 2016 (Table 3). Agencies were asked to describe the workforce dedicated to HIV prevention, direct clinical care, and support services, as well as HIV research, program evaluation, technical assistance, or program improvement activities with direct impact on these services. Financial resources budgeted for the current year as of May 1, 2016, were requested and used to estimate funding for HIV in 2016.

The Financial and Human Resource Inventory describes funding amounts by source of funding, service provided, population of focus, and geographic area served. The inventory is representative of direct HIV prevention and care services in Wisconsin but is not inclusive of all HIV/AIDS care in the state. For example, funding totals do not reflect costs of HIV antiretroviral drugs and health care provided by Medicaid, Medicare, private insurance companies, and funding for clinical trials and other clinical research. Human resources described as the HIV workforce is an underestimate as it does not include clinicians who care for HIV patients outside of state, federally funded agencies, nor local and state health department staff.

Table 3. HIV service providers included and not included in the financial resource inventory.

Services provided by the following agencies are represented:		Agencies and services not represented:
<ul style="list-style-type: none"> • AIDS Resource Center of Wisconsin • Brady East STD (BESTD) Clinic • Black Health Coalition • City of Milwaukee • Diverse and Resilient • Greater Milwaukee Center for Health • Holton Street • Legal Aid Society • Local Health Departments • Luther Consulting • Midwest AIDS Training and Education Center • Medical College of Wisconsin 	<ul style="list-style-type: none"> • Milwaukee Health Services, Inc. • Outreach Community Health Center • Outreach, Inc. • Pathfinders • Sixteenth Street Community Health Center • Tribal Nations • United Migrant Opportunity Services (UMOS) • UW HIV/AIDS Comprehensive Care Program • UW Training System/HIV Outreach Project • Wisconsin State Laboratory of Hygiene 	<ul style="list-style-type: none"> • Pharmacies and pharmaceuticals • Medicaid • Medicare • Private insurance • Local public health services beyond Partner Services • STD Program and local STD efforts • Wisconsin Division of Public Health AIDS/HIV Program

Public and private funding sources for HIV prevention, care, and support services in Wisconsin total \$24,612,616. While the various federal sources provide over 45% of available funding, state general purpose revenue (GPR) funds comprise the largest sole-source of support with 22% of available funds (Table 4).

Pharmacy costs for HIV treatment are not included in the inventory table and account for a large amount of funding for HIV treatment. For example, in addition to prevention, medical

¹⁸ The 19 local health departments and 11 tribal clinics providing services were not directly surveyed but their funding from DHS is included in the appropriate figures and tables.

care, and support services, ARCW reported over \$24,000,000 in pharmacy expenses in 2013.¹⁹ The Wisconsin ADAP, which provides access to HIV drug therapies based on income eligibility, paid over \$11,000,000 to pharmacies in 2015. Medicaid paid \$29,800,000 on HIV antiretroviral drugs in 2015 for recipients with HIV. A summary of prescription drugs and medical services for PLWH paid by Medicaid in 2015 is included in [Appendix III](#).

Table 4. Funding sources for HIV/AIDS prevention, medical care, support services, and research, Wisconsin, 2016.

Funding Source: State	Amount	Percent of Total
State General Purpose Revenue (GPR)	\$5,320,791	22%
Funding Source: Federal	Amount	Percent of Total
Ryan White Part B	\$4,332,325	18%
Ryan White Part C	\$1,921,484	8%
Centers for Disease Control and Prevention (CDC)	\$1,659,138	7%
Ryan White Part D	\$777,016	3%
National Institutes of Health Grant	\$633,118	3%
Housing Opportunities for Persons with AIDS (HOPWA)	\$436,858	2%
Alcohol and Other Drug Abuse (AODA)	\$418,846	2%
Ryan White Part F	\$369,426	2%
Federal Office Minority Health	\$54,142	<1%
Health Resources and Services Administration	\$43,469	<1%
Federal FQHC 330 Grant	\$38,000	<1%
Substance Abuse and Mental Health Services Administration	\$30,000	<1%
Funding Source: Local	Amount	Percent of Total
Local Governmental (County or City)	\$549,770	2%
Funding Source: Other	Amount	Percent of Total
Reimbursement ²⁰	\$3,725,235	15%
Private Donor	\$3,132,301	13%
Other	\$607,977	2%
Private Grant	\$371,720	2%
340B Pharmaceutical Rebate	\$191,000	1%
Grand Total All Sources	\$24,612,616	100%

Prevention, medical, and support services account for 24%, 65%, and 11% of Wisconsin's financial resources for HIV services, respectively. Of prevention services, 20% is allocated to harm reduction for people who inject drugs. Harm reduction services include referrals to substance abuse treatment, instruction on prevention of HCV and HIV infections, injection drug use hygiene, and collection of used syringes for infection control. No federal or state funds are used toward the purchase of needles or syringes for the purposes of injection of any illegal drug. An additional 20% comes from private donors to the statewide ASO and is used for general prevention services. Of medical services, outpatient and medical case management together comprise over half of funding (59%). The majority of support services funded are housing (41%) and food assistance (22%) for people with HIV, Table 5.

¹⁹AIDS Resource Center of Wisconsin. Innovation. ARCW 2013 Annual Report. Available at: http://www.arcw.org/content/content/files/ARCW_AR_2013_WEB.pdf

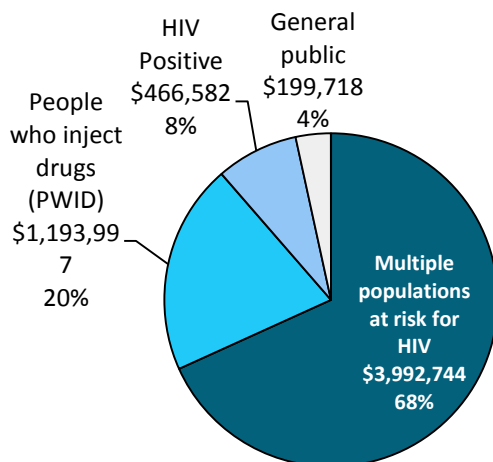
²⁰ Reimbursement revenue from insurance companies billed for services (e.g., mental health, outpatient, PrEP, medical case management, HIV testing, and transportation services).

Table 5. Funding: HIV/AIDS prevention, medical care and support services, Wisconsin, 2016

Service Category	Amount	Percent of Funding for Service Category
Prevention Services		
Other	\$1,191,981	20%
Harm Reduction for People Who Inject Drugs	\$1,193,997	20%
HIV Testing	\$918,390	16%
Health Promotion and Community Wellness	\$586,179	10%
Research	\$512,107	9%
Quality Improvement, Quality Assurance, and Training	\$488,800	8%
HIV Partner Services	\$373,000	6%
Condom Distribution	\$291,892	5%
PrEP	\$266,695	5%
Faith-Based HIV Prevention Education	\$35,000	1%
Prevention Services Total	\$5,858,041	100%
Medical Services		
Outpatient or Ambulatory Health Services	\$5,836,386	36%
Medical Case Management	\$3,677,198	23%
Health Insurance Premium Program	\$1,700,400	11%
Mental Health Services	\$1,610,259	10%
Oral Health Care	\$1,452,067	9%
Research	\$607,746	4%
Early Intervention Services	\$548,407	3%
Quality Improvement, Quality Assurance and Training	\$282,700	2%
Home and Community-Based Health Services	\$192,729	1%
Other	\$136,478	1%
Substance Abuse Outpatient Care	\$71,554	<1%
Medical Services Total	\$16,115,925	100%
Support Services		
Housing	\$1,069,086	41%
Food Bank/Home Delivered Meals	\$576,159	22%
Legal Services	\$438,945	17%
Non-Medical Case Management	\$232,687	9%
Quality Improvement, Quality Assurance and Training	\$240,623	9%
Medical Transportation	\$63,975	2%
Linguistic Services	\$1,440	0%
Emergency Financial Assistance	\$2,735	0%
Outreach Services	\$10,000	0%
Other	\$3,000	0%
Support Services Total	\$2,638,650	100%
Grand Total	\$24,612,616	

The majority (88%) of grants and program funds for prevention services are awarded to serve specific populations at risk for HIV (Figure 14). In 2016, 20% of funds were directed to PWID and 68% of funds for prevention serve multiple people at risk (e.g. MSM, LGBT, and others with risk factors for HIV infection). Examples of prevention funds that serve those with HIV include HIV PS, health education, and condom distribution. An additional 8% of the funds were directed at reducing the risk of transmission of persons infected with HIV. Only 4% of funds were directed to persons at lower risk (designated as the general public).

Figure 14. Funding for HIV prevention services by population, Wisconsin, 2016



Funding for HIV/AIDS medical and support services is concentrated in the southeastern region of the state, where HIV prevalence is highest (Table 6). More than one third of funding for medical services is not devoted to a specific region but is used to ensure the delivery of care statewide (\$8,189,941). Because the statewide funds are not budgeted toward a specific region of the state, they are not shown in regional breakout in Table 6. Statewide funds include insurance company reimbursement for HIV care, funds received from private donors, and funding for medical and care research.

Of prevention services, 24% are targeted to the northern region of Wisconsin, which has the lowest percentage of people living with HIV of the five regions. A large amount of HIV prevention in this region is harm reduction for PWID. Harm reduction services are aligned with a recent shift of the heroin epidemic toward rural areas in Wisconsin²¹ and support HIV prevention in this population.

Table 6. Funding amounts for HIV/AIDS services, by public health region, Wisconsin, 2016^a

Region	% of Prevalent HIV Cases		Prevention Services		Medical Services		Support Services		Total	
	%	Amount	%	Amount	%	Amount	%	Amount	%	
Southeastern	62%	\$3,091,210	64%	\$6,598,79	66%	\$1,413,49	89%	\$11,103,504	68%	
Southern	18%	\$277,577	6%	\$2,449,39	25%	\$148,087	9%	\$2,875,062	18%	
Northeastern	11%	\$195,000	4%	\$554,553	6%	\$25,384	2%	\$774,937	5%	
Western	6%	\$130,000	3%	\$244,025	2%	\$4,333	0%	\$378,358	2%	
Northern	3%	\$1,140,706	24%	\$149,141	1%	\$1,000	0%	\$1,290,847	8%	
Grand Total	100%	\$4,834,493	100%	\$9,995,91	100%	\$1,592,30	100%	\$16,422,709	100%	

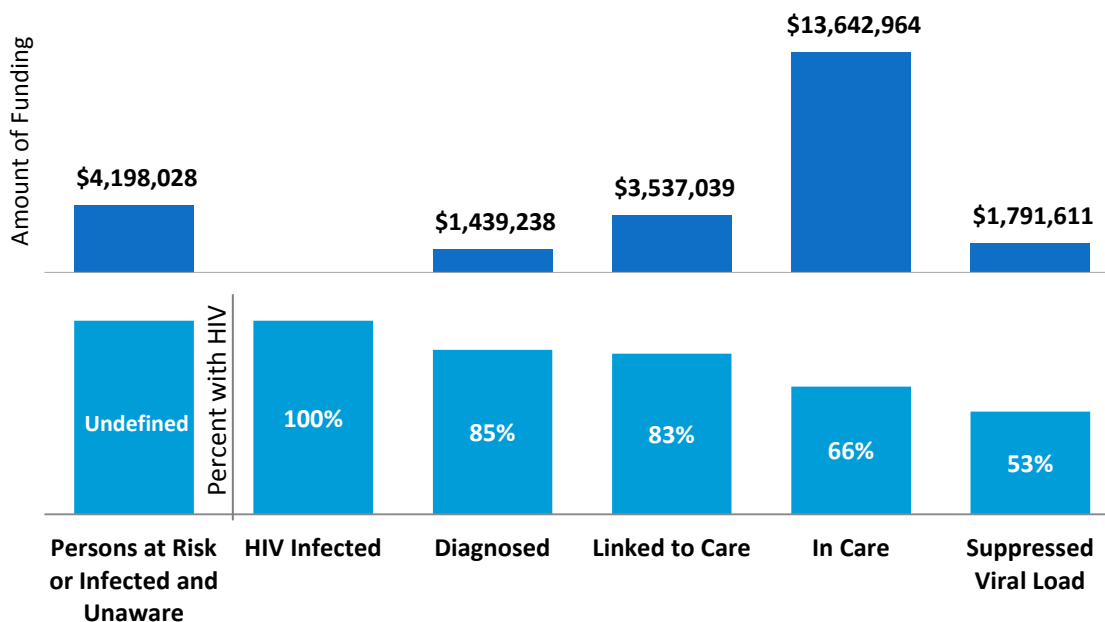
^a Table excludes \$8,189,941 used to support HIV prevention and care sources statewide instead of in a specific region.

^b Prevalent HIV cases by region, excluding correctional facilities, Wisconsin HIV Surveillance Data, 2016.

²¹ Meiman J, Tomasallo C, Paulozzi L. Trends and characteristics of heroin overdoses in Wisconsin, 2003-2012. 2015. Drug Alcohol Depend.152:177-84.

Funded services were allocated with the segment of the 2014 Wisconsin Care Continuum (Figure 15) they were expected to impact. The majority of funding from the Wisconsin DHS and federal agencies aligns with and directly impacts the proportion of PLWH in care (55% of total funds). This amount includes medical care, case management, health insurance premium programs, supportive services, food and housing assistance, mental health services, transportation, and a portion of medical care and case management.

Figure 15. HIV/AIDS service funding by care continuum step, Wisconsin, 2016



Funds for HIV prevention services include HIV testing, training on HIV testing and counseling, and HIV Partner Services. These impact persons at risk for HIV infection or those who are infected with HIV and unaware, and precede the first step of the Care Continuum.

Early Intervention Services, HIV PS, and research dedicated to improving linkage to care align with and impact the percentage of PLWH that are diagnosed and linked to care.

Finally, funds with a specific impact on viral load suppression include the health insurance premium program and case management. In 2016, the majority of funding for HIV antiretroviral drugs with an impact on viral load suppression is provided by insurance companies or pharmacy reimbursement, the total amount of which is not reflected in this resource inventory.

Description of HIV/AIDS Workforce

Wisconsin employs 212 full-time equivalent staff at agencies funded to provide HIV prevention, care, and treatment services. In addition, 50 full-time equivalent staff are devoted to HIV-related program support and research to improve HIV prevention and care in Wisconsin (Figure 16). This does not include physicians, nurses, and other clinical staff providing care in privately managed agencies. It also does not include AIDS/HIV Program staff or local health department staff who are not direct service providers.

Figure 16. Wisconsin HIV/AIDS workforce by service, 2016

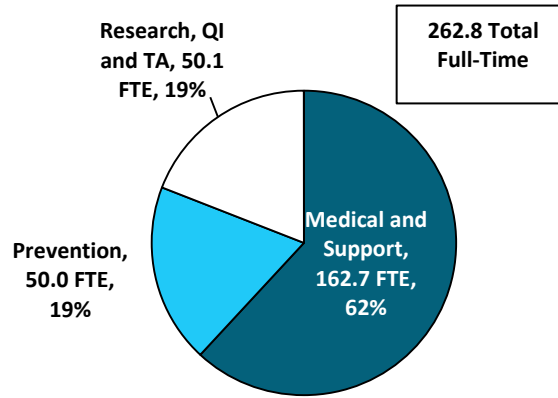
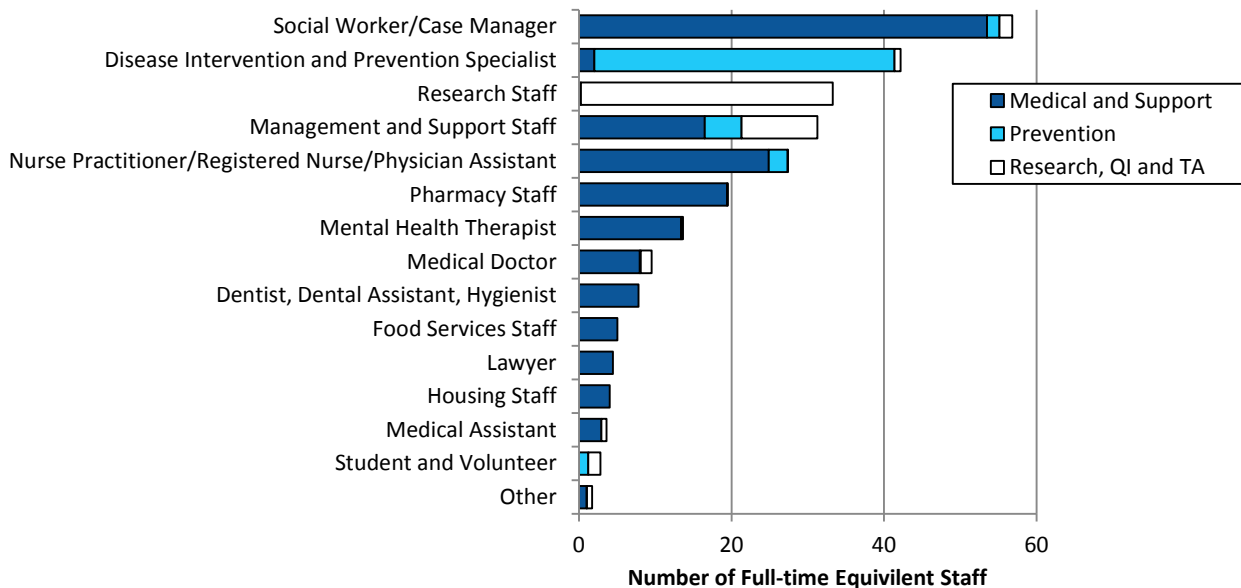


Figure 17 shows the number of FTE staff funded, in part, by the Wisconsin DHS and federal agencies that are dedicated to medical and support services (dark blue bar), prevention services (light blue bar) and research, quality improvement, or technical assistance (white bar). Of the prevention workforce, the majority are specialists who provide HIV prevention education, counseling and testing services, case-based investigation, and intervention (39 FTE, 78%). The prevention workforce also includes program directors and support staff (5 FTE, 10%), social workers and clinical staff (4 FTE, 8%), and research and student support (2 FTE, 4%).

Figure 17. Wisconsin workforce dedicated to HIV/AIDS prevention, medical and research services, 2016



The medical and support workforce includes 163 FTE of which 53 (33%) are case managers or social workers, 33 (20%) have a professional clinical degree, 17 (10%) provide program management or office support, 19 (12%) are pharmacy staff, 8 (5%) are dental staff, and 13 (8%) are mental health professionals. Support services are provided by staff that primarily assist with housing (4 FTE), lawyers (5 FTE), and food service providers (5 FTE).

The information provided in this section represents the AIDS/HIV Program's first look at developing a comprehensive *Financial and Human Resources Inventory*. The methodology used may be modified in subsequent years to ensure the data serves as a useful tool for PLWH, providers, stakeholders, and other entities looking to develop their own inventory or understanding of resources available in Wisconsin.

D. Assessing Needs, Gaps, and Barriers

The AIDS/HIV Program conducted a qualitative needs assessment in 2015 to solicit information from consumers and key informants to identify most needed services, service gaps, barriers to services, and potential areas for improvement. In addition to this formal process, a variety of activities also inform the Wisconsin AIDS/HIV Program's ongoing assessment of services for people who are both HIV-infected and for those at risk for infection. These activities include:

- Input from the Statewide Action Planning Group that advises the Program.
- Community and AIDS/HIV Program staff feedback regarding salient issues that are affecting availability, access, and acceptance of services in different regions of the state.
- Key data sources that highlight, either directly or indirectly, the needs of people affected by HIV.

The sections below describe these assessment activities and their results. The results apply to PLWH who know their status but who are out of care, PLWH who are engaged in HIV medical care, and persons at higher risk for HIV infection. In addition, the results identify disparities in access to care and resources for certain populations and highlight the need for enhanced coordination along the care continuum.

2015 Qualitative Needs Assessment

Interviews of consumers and key informants were conducted between February and October 2015 based on survey instruments developed to capture 1) specific challenges and barriers for consumers to access HIV-related services; 2) services utilized and needed; and 3) feedback for broad improvements to the state's system of HIV prevention and care service system. Twenty-eight consumers and 46 key informants were interviewed.

The AIDS/HIV Program worked with HIV-related organizations to enlist their clients for interviews. Clients were individuals who have ever received HIV prevention or care services at the agency or clinic. Most of the clients interviewed were living with HIV, although clients at risk for HIV were also included. Interviews occurred either in-person or on the phone, and clients were offered an incentive for participating. Most interviews were conducted one-on-one. Two group interviews were conducted with community advisory boards. Urban and rural clients were recruited, but the majority resided in the Milwaukee metropolitan area, which is the epicenter of the HIV epidemic in Wisconsin.

Key informants were individuals working in grant-funded agencies that provide HIV prevention or care services—primarily CBOs, the ASO, health centers, and health departments. A majority of key informants worked in the Milwaukee metropolitan area (68%). Similar to the clients, key informants were located in the Milwaukee area that bears the greatest burden of infection and has the greatest number of services. However, rural providers did provide input into the unique needs of consumers living in greater Wisconsin.

The complete report of the qualitative needs assessment report can be found at: <https://www.dhs.wisconsin.gov/publications/p01221.pdf>

Prevention and Care Service Needs

In addition to medical care, the qualitative needs assessment identified the following services as those most often used and needed for people living with or at risk for HIV:

- Housing
- Transportation
- Mental health and alcohol or drug abuse (AODA) services
- Medical case management
- Access to and navigation of health care insurance
- AIDS drug assistance program
- Dental care
- Food pantry
- HIV testing
- Condom distribution

The importance of these service needs is consistent with reviews of the literature, as well as with the experience of staff in the field.

HIV Prevention and Care Service Gaps and Barriers

Consumers and key informants interviewed for the qualitative needs assessment described service gaps differently. Clients who experience certain barriers and circumstances on a daily basis may consider them to be ordinary and not think of them as obstacles to HIV care. One consumer who had been homeless for seven years did not reveal during the interview that he was homeless or how lack of food or unstable housing may have affected his HIV care. Another client was three hours late for the scheduled interview because she could not find transportation. When asked if transportation was an issue for her and whether transportation affected her HIV care, she reported “no.”

In contrast, key informants succinctly described macro-level issues that affected the availability of services that clients need. In analyzing the interviews, AIDS/HIV Program staff combined the macro-level analysis with the anecdotal accounts of consumers to identify service gaps and their related barriers that most affected the continuum of care. The following are service gaps that were identified through this process.

Housing

Key informants consistently cited homelessness as a problem among people at high risk for or infected with HIV. A key informant noted “you will do all sorts of things to get a home” and getting housing is so much more important than the possibility of feeling sick in the future. As a result, housing services are the most commonly utilized service. However, key informants implied that they are also one of the most difficult services to access. The most frequently mentioned issues regarding housing and shelter were:

- Housing is generally very expensive and hard to find.
- People living with HIV might face restrictions that prevent them from accessing affordable housing such as no-drug policies (including tobacco use), that require

individuals to be completely clean before and throughout their stay. Individuals with a criminal record may have to pay a higher security deposit than the standard one.

- There is stigma associated with some housing complexes, since they are known as the “AIDS house” in the community.
- Transgender individuals may face additional challenges. Men’s shelters may not allow transgender persons because they may be sought for sex. Women’s shelters may not allow transgender individuals with male sexual anatomy.
- Housing services have long waiting lists.
- Clients have concerns about the safety of some of the housing complexes.
- Emergency shelter is very limited, particularly in the Milwaukee area.

Transportation

Access to transportation was named frequently as an issue for many individuals. Key informants discussed the various ways they assist people living with HIV to obtain transportation (distribution of bus tickets, cab rides, use of their own vehicle, etc.). However, these resources are limited and transportation remains a challenge for many individuals. Reasons why transportation services are difficult to access include:

- Individuals may live too far to use the bus system. This is especially true in rural areas.
- For Milwaukee, most key informants agree that the public bus system is not sufficient. Individuals who cannot get to their appointments independently may rely on friends or family members to drive them to their appointments. This might require HIV disclosure, reliance on other people’s schedules, and reimbursement for gas.
- Some transportation services require individuals to schedule transportation up to two days in advance. Clients typically only call for services when they need it immediately.
- There is a lack of non-English speaking transportation services.

Mental Health and AODA Services

Key informants agreed that mental health and substance abuse treatment are needed for many people living with HIV. Although there has been an increased effort to provide mental health services in Wisconsin, access still remains a problem. The majority of key informants believe that the mental health needs are greater than the capacity available in the state. Challenges individuals encounter when trying to access or maintain mental health or AODA services include:

- Long waiting lists for treatment.
- Unavailability of psychiatric services due to a shortage of psychiatrists in Wisconsin.
- Affordability of treatment, particularly for substance abuse services which may not be sufficiently covered by the person’s health insurance.
- Stigma of needing mental health or AODA services.

Services to Navigate Health Coverage

Services to support navigation of health coverage were noted often. Key informants, particularly case managers and Linkage to Care Specialists, mentioned how much time was spent helping clients enroll for health insurance through the Affordable Care Act or through BadgerCare Plus. But support for health coverage does not stop after enrollment. Some consumers do not understand their coverage or do not access care because they do not know what services are available to them.

- A client dropped out of medical care for over a year because she lost her job and her health insurance. She did not know the ADAP was an option and assumed she was automatically ineligible for services.
- A consumer with a stable job and consistent insurance had difficulties understanding his coverage for HIV treatment and medications. He had to learn about his deductibles and copays and re-budget accordingly. It took him approximately two years to sort through the financial logistics of his HIV care. Other people might not be so persistent.
- An undocumented client was not sure whether she was eligible for assistance.

The following services were also mentioned as those that are needed but are limited in their availability. These services were mentioned less frequently than those listed above, but were identified as important to a subset of key informants.

- ***HIV pre-exposure prophylaxis (PrEP) for people at high risk for HIV***

There are several gaps related to PrEP services:

- Insufficient promotion of PrEP to increase awareness in the community.
- Lack of providers willing to offer PrEP.
- Limited services to assist clients with obtaining PrEP, navigating financial coverage, and supporting adherence and behavioral risk reduction.

- ***Support groups for PLWH***

Key informants stated that clients want a variety of support groups, especially focused on their specific demographics vs. one support group for all HIV-positive clients in an area. Support groups are available in some settings but are often not accessed by clients due to transportation, time, or confidentiality concerns. Support groups are needed that better address the issues of the specific populations they hope to serve.

- ***More and better coordination of prevention services***

Some key informants discussed the need to direct increased innovation and coordination towards HIV prevention services, particularly regarding HIV testing and condom distribution. Suggested needs include:

- Additional approaches to encourage HIV testing beyond the use of incentives and the venue of PrideFest, the annual LGBT celebration in Milwaukee.
- Increased condom distribution at bars and clubs.
- Better coordination between agencies regarding their outreach testing activities.
- Adding comprehensive sexual health services at HIV testing sites, including STI testing.

- ***Hepatitis C treatment***

Key informants working with PWID talked about hepatitis C being an increasing health problem that needs to be addressed. Although there are syringe services programs, there are not that many providers that treat hepatitis C or services to support people with hepatitis C. For individuals co-infected with HIV and HCV, the ADAP covers the cost of certain HCV treatment.

Overarching Barriers

The following issues are overarching barriers, many of which impact the entire care continuum.

Stigma

Consistently, both key informants and consumers cited stigma as one of the greatest barriers to

accessing HIV care and prevention services. Stigma refers to both external judgment from others and feelings of personal shame or internal judgment. It is associated both with HIV infection and homosexuality. Examples of how stigma creates barriers to testing and participating in HIV care include:

- Some clients may not attend their appointments or will only attend if they are not seen entering through the front door. This is especially true if the agency has an obvious HIV affiliation.
- Some clients are worried about being seen at the pharmacy picking up their HIV medication. One client would pick up her medications at 3:00 am to avoid being seen.

Perceived Confidentiality

Clients stated that people typically do not want to get tested when they can be seen by others, regardless of test results. This includes testing done at outreach venues or at an ASO where they may be seen or know the staff. PLWH are concerned about going to the pharmacy to get their medication because their conversations with the pharmacist may be overheard. Accessing services in rural areas is an even bigger problem because there is no place for clients to be anonymous. Regardless of location, clients are concerned that their information does not stay confidential even though they know there are state and federal confidentiality laws in effect.

Misinformation

Both clients and key informants stated that there continues to be misinformation about HIV in the community and that this deters people from getting tested or recognizing that they may be at risk for HIV infection. They noted that too many people are unaware that HIV remains a health issue and that many are uninformed about HIV transmission. Some people view a diagnosis of HIV as a death sentence and avoid knowing their HIV status because of what has previously considered a dreaded outcome.

Ineffective Provider Interactions

Both clients and key informants shared concerns regarding medical providers who had ineffective interactions with their patients. This included providers who were not educated about HIV, were uncomfortable talking about sexual health issues, missed opportunities for providing HIV testing, or were not culturally competent in providing services to specific populations. These interactions compounded already existing mistrust of the medical system in certain communities. The following are examples that were cited in the interviews:

- A client switched providers because his provider was unwilling to consider other HIV medications despite the significant side effects he was experiencing.
- A nurse put on two pairs of gloves in front of a client during a medical visit.
- A client interacted with several providers who, even though they knew he was a gay male, never offered him an HIV test.
- A client interacted with providers at a major hospital who said they do not think about HIV.
- A client with HIV-related symptoms had to ask his provider to be tested for HIV after two wrong diagnoses.

Clients who do not feel comfortable talking with their medical provider may drop out of care rather than try to advocate for themselves or find another provider.

Competing Priorities

Obtaining HIV care competes with other priorities in the lives of PLWH, including responsibilities of family, work, or dealing with basic needs for food and shelter. Some clients indicated that they needed to choose between their medical appointments and their employment, since their appointments could only be made during business hours.

Barriers Related to Medication Adherence

Several barriers to medication adherence were noted:

- For people living with others, it is hard to keep private the fact that one is taking HIV medications.
- For individuals with transient living situations, having a safe space to store HIV medications may be a challenge.
- People who cycle in and out of the jail system may experience difficulties trying to maintain HIV treatment in jail or returning to regular treatment after release.
- Younger individuals with HIV may not think about long-term health and may not feel sick. Taking medications for the first time can be a major life adjustment.
- Side effects of medications make it difficult for individuals to adhere to a treatment regimen. Almost all clients interviewed had to switch HIV medication at some point due to side effects.

Clients talked about having “pill fatigue.” One client mentioned that she threw her medication away because she was tired of taking them. During one of her medical visits, the doctor (who was unaware of what she had been doing) saw her lab values and told her to keep doing what she was doing. Upon hearing this remark, this client felt that her decision was validated and continued to neglect her medication. After having an increased viral load result at her next visit, her physician realized there was a problem. He took time to ask her about her medication routine and to educate her on the virus, lab results, and HIV medication’s role. After that visit, this client was provided additional support such as direct observed therapy (DOT). She worked with nurses to develop a plan to take her medication every day and learned to reframe negative thoughts about her medication.

Several additional barriers have been identified through the Program’s range of needs assessment activities. These barriers are summarized in Table 7.

Table 7. Barriers Identified Through Needs Assessment Activities

Social and Structural Barriers
<ul style="list-style-type: none"> • Internal and external stigma—layering effect (being black, gay, and HIV-positive). • Racial disparities. • Poverty.
Federal, State, or Local Legislative/Policy Barriers
<ul style="list-style-type: none"> • Housing policies that affect the availability of low-income housing and reduce access for people with substance abuse issues or criminal records. • Lack of convenient, low-cost public transportation options. • Navigating the health insurance system and affordability of plans on the exchange for those above 100% FPL.
Health Department Barriers
<ul style="list-style-type: none"> • Decreased federal funding for prevention services. • Staffing issues <ul style="list-style-type: none"> ○ Local health departments—competing priorities, budget limitations, staffing shortages, needing to stay up to date on HIV-related information and trainings. ○ Need for culturally competent staff members reflective of the population served. • Communication barriers (e.g., inability to text, use dating apps for outreach).
Program/Operational Barriers
<ul style="list-style-type: none"> • Multiple databases—duplication of data entries, access issues. • Data sharing—between STD and HIV Programs, CTR sites, and medical providers. • Health information systems needing upgrading, automation, and integration. • Limited availability of funding and funding that is categorically restricted to support specific areas or activities.
Service Provider Barriers
<ul style="list-style-type: none"> • Lack of mental health specialists. • Insufficient or inaccessible AODA services. • Primary care physicians and emergency department (ED) providers not involved or engaged in routine HIV testing.
Client Barriers
<ul style="list-style-type: none"> • Lack of low-cost or convenient transportation. • Homelessness/housing instability. • Difficulty navigating the health and human service systems. • Concerns regarding confidentiality. • Lack of psychosocial support from families, friends, and others. • Poverty. • Stigma. • Competing priorities. • Cost of medical expenses. • Medication and appointments creates a constant “reminder” of HIV. • Mental health concerns. • Comorbid conditions. • Mistrust in the medical system. • Relationship with providers. <ul style="list-style-type: none"> ○ Cultural competency issues. ○ Difficulty communicating with the provider (e.g., asking questions, discussing concerns, sexual health issues). ○ Needing to start over with new provider due to turnover.

Needs Assessment as Part of the Statewide Action Planning Group (SAPG)

The SAPG promotes consumer engagement and provides a forum for community members and partners, including PLWH, to exchange information and ideas, identify needs, and provide input on the development and delivery of HIV prevention and care services. The entire SAPG meets throughout the state five times during the year, while smaller work committees meet as needed. Additionally, the SAPG assists members with travel to national conferences to learn about other initiatives and share that knowledge with the SAPG and the community.

The SAPG consists of 25 to 30 official members who serve two-year terms, with the option to renew membership for a second term. The current membership includes representation from a variety of sectors. Some members represent more than one area. The membership currently includes: eight PLWH; six representatives from Ryan White Part C funded agencies; nine representatives from prevention-based organizations; three members from tribal-based clinics; four mental health providers, one representative from the Wisconsin Department of Corrections; two representatives from local public health departments; 17 members from CBOs; three clinical providers; two researchers; three epidemiologists; and three housing specialists. Communities at high risk for HIV are also represented: 37% of members are gay or bisexual; 3% of the group is PWID, and 3% are MSM and PWID. Black members comprise 30% of the group, 10% of the group is Latino, 3% is Native American, and the remaining 57% are white. The five annual meetings are open to the public and are regularly attended by community members. Additional information regarding the SAPG can be found at <http://www.wihiv.wisc.edu/communityplanning/>.

Needs Assessment Activities through Community and Staff Input

AIDS/HIV Program staff work closely with service providers to evaluate uptake of services and identify ongoing issues affecting the receipt of those services. This is done through:

- Meetings throughout the year with staff who work directly with clients, such as case managers, linkage to care specialists (who work primarily with out-of-care and newly diagnosed clients), testing staff, PS providers, and prevention workers from CBOS.
- Topic specific meetings (e.g., increase of syphilis among MSM) to update stakeholders and obtain input regarding relevant factors and solutions from agency staff and community members.
- Regional meetings facilitated by state staff to coordinate area provider activities and discuss issues impacting their communities.
- Grantee contract monitoring visits that evaluate successful interventions and determine problems that negatively affect uptake of services.

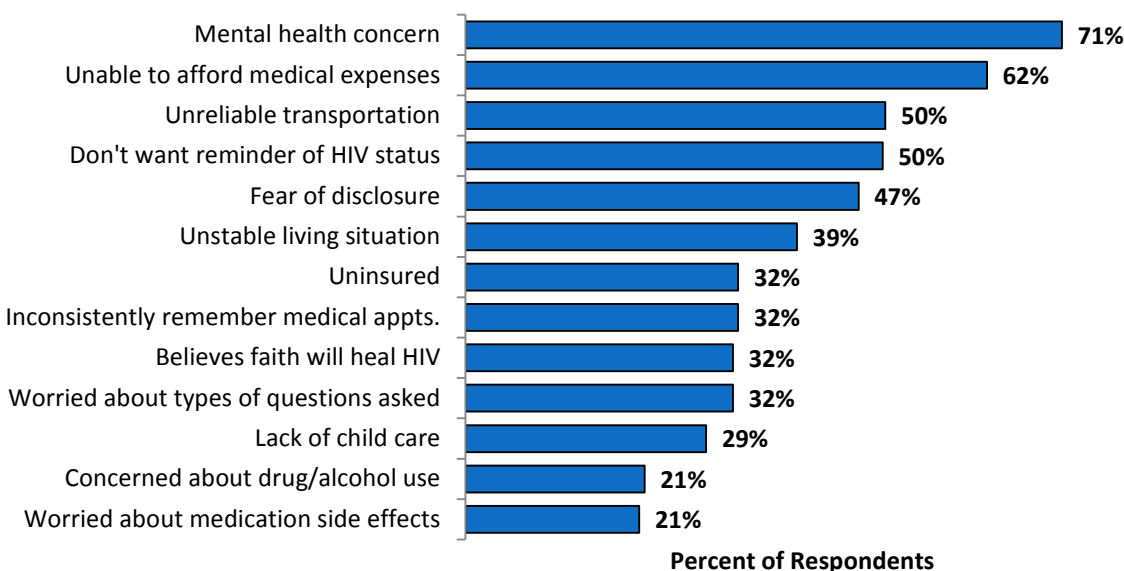
Direct input from clients is obtained by agencies through their Consumer Advisory Boards and client satisfaction surveys.

In 2015, AIDS/HIV Program staff were asked to complete a written survey as part of a strategic planning process to identify activities that the program should no longer conduct or support and to determine new activities that should be implemented. This survey created a formal process to tap into the staff's expertise beyond their position responsibilities. The responses to this survey serve as an additional reference to the development of the Integrated HIV Plan.

Other needs assessment data sources

Section E of the Integrated HIV Plan indicates the numerous data sources, both formal and informal, that the Program consults to assess needs and identify barriers to services. One noteworthy source is the barriers survey, which clients complete upon enrollment to the Linkage to Care program and again at discharge. Its purpose is to identify potential barriers to HIV care and to evaluate whether barriers were reduced as a result of enrolling in the program. The most common potential barriers to care were a mental health concern (71%), inability to afford medical expenses (62%), unreliable transportation (50%), not wanting to be reminded of HIV status (50%), and fear of disclosure when seeking medical care (47%) (Figure 18).

Figure 18. Linkage to care program intake barriers survey†



† Percentages were based on the number of respondents who indicated the potential barrier, divided by the 315 total survey respondents. The child care percentage was based on the 112 respondents for whom the question was applicable. Barriers that were noted by 20% or more of respondents are shown.

When looking specifically at individuals who were out of care for a period of six months or longer, the most common barriers were similar to those shown below. However, there were some barriers to care reported more frequently among out-of-care individuals, such as unstable housing (53%), inconsistently remembering medical appointments (46%), being worried about medication side effects (27%), distrusting the medical system (26% vs. 18% among all respondents), and feeling discriminated against (23% vs. 17% among all respondents).

E. DATA ACCESS, SOURCES, AND SYSTEMS

1. Primary Needs Assessment Data Sources

Described below are the data sources and systems used to conduct the needs assessment and develop the HIV care continuum. Also described are policies that served as facilitators or barriers to conducting the needs assessment and developing the care continuum, as well as data that were not available, but would have been helpful in conducting these activities.

a. Needs Assessment

Wisconsin's HIV needs assessment consisted primarily of qualitative interviews conducted during 2015, both with people living with HIV and key informants. The interview process is described in detail in Section D. Section D also describes other qualitative data sources, including input from the Statewide Action Planning Group, and from the community and AIDS/HIV Program staff members.

In addition to qualitative input, several internal data sources are used regularly to direct program activities and resource allocation and were used to guide the development of this Integrated HIV Plan. Current and future use of these data sources are described below.

- **Enhanced AIDS/HIV Surveillance System (eHARS)** eHARS is the HIV surveillance database used by all jurisdictions that receive federal funding to conduct HIV surveillance activities. Data in eHARS are used to describe the trends in HIV diagnoses and prevalent cases using the demographic information available on individuals infected with HIV, including race/ethnicity, age, county of residence, transmission risk, gender, and HIV-diagnosis related information. eHARS also contains the results of laboratory test results, including CD4 counts, viral load results, and HIV-1 sequences. These data are used to assess HIV care outcomes, including linkage and retention to care, and viral suppression. Laboratory data, in conjunction with demographic data, are used to identify health disparities.
- **EvaluationWeb:** EvaluationWeb is a web-based system developed by Luther Consulting, LLC that is used by federal grantees to collect and report publicly funded HIV testing and prevention activities. The data are used to monitor grantee performance and track and monitor testing activities in Wisconsin. EvaluationWeb is also an important source of risk information for individuals newly diagnosed with HIV infection.
- **PartnerServicesWeb:** PartnerServicesWeb is a web-based system developed by Luther Consulting, LLC that is used in Wisconsin to track PS activities. The database is used both to assign cases to the appropriate jurisdiction and for tracking contact attempts, case notes, linkage to care, and partner elicitation and testing. PartnerServicesWeb is also an important source of information on client location, linkage to care, transmission risk, co-morbidities, and client needs.
- **AIDS Drug Assistance Program (ADAP) Database:** The ADAP database contains information on clients currently or previously enrolled in the ADAP program, including locating information, medical provider, income, and insurance status. The database is used to manage ADAP client eligibility but can also be used to locate out of care clients, monitor insurance status, and has claims data that can serve as markers of HIV care.
- **Ryan White Services Report (RSR):** The RSR is a de-identified client-level data report required by HRSA of all agencies that provide services to clients using Ryan White funds. Ryan White grantees make these reports available to the AIDS/HIV Program to monitor service utilization, linkage and retention to care, viral suppression, and other client outcomes, such as insurance and housing status.
- **Wisconsin Medicaid Program:** The Wisconsin Medicaid program maintains claims information on medical visits, laboratory visits, and pharmaceuticals for its recipients. The Wisconsin AIDS/HIV Program receives aggregate data to monitor service utilization among people living with HIV and has begun to use these data to track uptake of PrEP.

In the future, name-associated Medicaid data would be helpful to identify unreported cases of HIV infection, obtain information on use of antiretroviral medication, and monitor the health outcomes of Medicaid recipients infected with HIV.

- **Wisconsin Electronic Disease Surveillance System (WEDSS):** WEDSS is Wisconsin's communicable disease surveillance and management system. Data include client demographics and locating information for individuals diagnosed with communicable diseases, including sexually transmitted infections, tuberculosis, and hepatitis C. WEDSS data are routinely linked to eHARS to identify individuals co-infected with HIV and to make appropriate follow-up and testing efforts. In the future, HIV case and laboratory data will be integrated into WEDSS, which will reduce the number of systems used to capture HIV-related data (e.g., PSWeb and STD-MIS), enhance disease follow-up for people living with HIV, and share additional data for providers who work with infected individuals.
- **U.S. Census and American Community Survey (ACS):** Data from the U.S. Census and ACS provide demographic information at the census tract that are not available in many of the Division of Public Health and AIDS/HIV Program's internal data systems, including income, employment status, and other markers commonly associated with better or worse health. In conjunction with data on testing, new diagnoses, and care patterns, these data can be used to identify geographies where additional HIV prevention or care services may be needed.
- **National HIV Surveillance Data:** Data published from the Centers for Disease Control and Prevention are used to compare and contrast the Wisconsin and national HIV epidemics.
- **Grantee Performance Measures:** Ryan White grantees that receive Part B funds from DHS are required to submit bi-annual performance measures. These measures are reviewed and discussed during Quality Collaborative meetings to identify best practices and areas for improvement.
- **Linkage to Care Program Evaluation:** In 2011 Wisconsin was one of six states that received federal funding from the HRSA's HIV/AIDS Bureau's Special Projects of National Significance (SPNS) program. The specific initiative was to develop novel systems to improve linkage to care, retention in care, and viral suppression among hard-to-reach populations. Qualitative and quantitative evaluation results on both process and outcome measures, for example, the Barriers Survey results described in Section D have identified needs, barriers, and gaps that will be address in the Integrated HIV Plan.

b. HIV Care Continuum

Wisconsin's HIV care continuum, and those displaying various demographic groups, is based solely on case and laboratory data stored in eHARS. For detailed methods on the development of Wisconsin's HIV care continuum, see the May 2016 issue of [*Wisconsin AIDS/HIV Program Notes*](#), "Wisconsin 2015 HIV Care Continuum: Statewide and Select Population Groups." Available at <https://www.dhs.wisconsin.gov/publications/p00792-16-may.pdf>.

2. Data Policies Impacting the Needs Assessment and Care Continuum

a. Facilitators

These data policies and practices facilitated the development of the Needs Assessment and HIV Care Continuum:

Needs Assessment

- The AIDS/HIV Program prevention, surveillance, and care programs are integrated and co-located, which facilitates the data sharing and data integration required for the needs assessment. For example, authorized staff members have access to eHARS, EvaluationWeb, PartnerServicesWeb, and the ADAP database.
- The AIDS/HIV Program is located within the same Bureau as the STD, HCV, and TB programs, which also facilitates data sharing on co-infected cases. In addition, some staff have access to eHARS and WEDSS, which allows for data matching to identify co-infected individuals.
- While not federally required, Ryan White grantees have agreed to submit their RSR to the AIDS/HIV Program for statewide analyses of recipients of Ryan White-funded care.

HIV Care Continuum

- Wisconsin has had name-based HIV and AIDS reporting since the beginning of the HIV epidemic (initiated AIDS case reporting in 1982 and HIV case reporting in 1985) and therefore has a mature and complete HIV surveillance system.
- All CD4 cell counts and viral load test results have been reportable to the HIV surveillance unit since 2011.
- Over 88% of laboratory records reported to the surveillance unit are reported electronically.
- Lab reports are imported daily. Over 98% of HIV laboratory test results are imported into eHARS within 60 days of specimen collection.
- Wisconsin conducts required surveillance activities in a timely manner to ensure accurate surveillance data, including death matches to local and national vital records data and Routine Interstate Duplicate Review (RIDR).

b. Missing Data

Despite the amount of high-quality data available to conduct the needs assessment and develop the HIV care continuum, some data were unavailable. Missing data are described below, as are policies or practices that served as barriers to conducting the needs assessment of developing the HIV care continuum.

Needs Assessment

- For clients to participate in the qualitative interviews that were part of the needs assessment, the AIDS/HIV Program depended on grant-funded agencies for client referrals. While efforts were made to ensure specific groups were represented (e.g., Black MSM, people of color, individuals living in Milwaukee), all clients who were

referred by a grant-funded agency were offered an interview. As a result, certain groups may be overrepresented and others underrepresented such as transgender persons.

- Statewide data on housing status, mental health service needs, substance use, and sex workers are not available. Housing status is available for clients included in the RSR, however, the data represent a point in time and do not include periods of unstable housing a client may have faced during the year. Utilization of mental health and substance use services are also available via the RSR, but this does not allow a comparison of needs with service availability.
- The Statewide Action Planning Group is a valuable source of input on statewide planning efforts. However, some voices are known to be missing, such as those less than 25 years of age and transgender individuals.

HIV Care Continuum

- Several states use various data sources to develop their HIV care continuum, including eHARS, medical visit data from the Medical Monitoring Project or CAREWare, ADAP fill dates, Medicaid claims data, or a care marker database that integrates data across systems to provide a single source of care pattern data for individuals. Wisconsin does not receive funding to participate in the Medical Monitoring Project nor is CAREWare used. Data from other sources are available but not integrated; therefore, Wisconsin's HIV care continuum is based solely on eHARS data.
- Statewide antiretroviral (ARV) use data are not available for display on the HIV care continuum. However, data are available on a subset of individuals, including those enrolled in the ADAP and those included in RSR. In the future, client level Medicaid data may fill this gap for a subset of individuals.
- Some laboratory data are known to be systematically missing. Prior to 2015, viral load data is known to be missing for individuals receiving HIV medical care at Veterans Affairs (VA) clinics across the state. During 2015, the VA began to submit viral load data electronically to the HIV surveillance program. In addition, laboratory data is known to be missing for individuals living in Wisconsin but receiving HIV medical care in another state. Efforts will be made during 2016 to obtain missing laboratory data on these individuals.
- It is likely that the HIV care continuum underestimates the proportion of PLWH in Wisconsin who are in medical care. First, Wisconsin has a significant number of cases with no laboratory or other data in eHARS in the last five years, indicating that these individuals may be deceased or living out of state. Matches will be conducted during 2016 to update eHARS vital status and state of residence for applicable individuals. Second, the recognized definition of retention (two medical visits separate by at least 90 days during a 12-month period) may underestimate actual retention, as stable individuals may have HIV medical appointments just once per year.

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Plan

GOAL ONE: 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%.

See [Appendix I](#) for the rationale, assumptions, and annual targets for Objectives [1.1](#) and [1.2](#).

Strategy 1: HIV Testing

Approximately 1.2 million people in the U.S. are living with HIV, and one in eight people don't know they are infected. Nearly 45,000 people find out they have HIV every year. More than 90% of new HIV infections in the U.S. could be prevented by testing and diagnosing people living with HIV and making sure they receive early, ongoing treatment. Newer testing technologies improve the ability to detect HIV infection in very early stages, including during acute infection.

HIV testing is the gateway to prevention and care:

- People who test HIV negative have more prevention tools available today than ever before, including PrEP (pre-exposure prophylaxis). Among people at increased risk for HIV, regular testing for HIV improves health outcomes even if those at increased risk do become infected with HIV.
- People who test positive can take HIV medicines that can keep them healthy for many years and greatly reduce their chance of passing HIV to others. There is evidence that people who test HIV positive take steps to keep others from being exposed to the virus. People who are unaware of their HIV status miss out on the benefits of treatment (including reduced viral load) and may unintentionally expose others to HIV.

The CDC has outlined guidelines for HIV testing in a range of settings, including *routine HIV screening* in clinics and emergency departments,²² and *targeted testing* such as social network HIV testing or outreach site testing reaching groups at highest risk.²³

²² Centers for Disease Control and Prevention [Internet]. HIV testing in clinical settings. Available from: <http://www.cdc.gov/hiv/testing/clinical/>

²³ Centers for Disease Control and Prevention [Internet]. HIV screening and testing. Available from: <http://www.cdc.gov/hiv/guidelines/testing.html>

Terminology Note: The CDC and many public health authorities, including the Wisconsin DHS, use the term STD (*sexually transmitted diseases*) when referring to their infection control programs. Many clinicians use the term STI (*sexually transmittable infection*) when referring to syphilis, chlamydia, and other illnesses. For consistency with these conventions, this document uses “STD Program” and similar terms when discussing public health projects working with these diseases, and “STIs” when referring to the group of infections collectively.

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

- Support test site use of and access to 4th generation (combined antigen/antibody) tests that can diagnose HIV earlier, and other improved technologies.
- Use of phone apps, social media, and online tools to improve recruitment methods, promote testing, and reduce stigma.
- Use data analysis to evaluate and improve the efficiency of HIV testing efforts to reach high-risk populations.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM (men who have sex with men) • Black MSM • Young MSM • Male to female transgender persons • PWID (persons who inject drugs) • Female sex partners of MSM and male PWID • Sex workers 	<ul style="list-style-type: none"> • CBOs • ASO 	<ul style="list-style-type: none"> • Achieve move to 4th generation testing by all testing partners by 12/31/2017. • Strategies developed and reviewed annually. • Annual review of testing site data to assess performance. 	<ul style="list-style-type: none"> • Increased number of individuals from high-risk populations tested for HIV for the first time. • Increased number of contacts made to individuals by service providers using social media platforms. • Increased number of individuals tested who say they were reached by social media. • Increased availability of 4th generation and other advanced testing to targeted populations.

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

- Increase capacity of HIV test providers to screen for HCV and STIs, including extragenital site testing.
- Increase percentage of PLWH who are routinely screened (at minimum annually) for STIs and/or HCV.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> All populations targeted for HIV testing PLWH 	<ul style="list-style-type: none"> CBOs Healthcare providers AIDS care providers Wisconsin AIDS/HIV, HCV, and STD Programs 	<ul style="list-style-type: none"> Develop HIV, STD, and HCV cross-training protocols by 06/30/2018. Annual review of emerging testing technologies. Annual performance assessment. 	<ul style="list-style-type: none"> Increase in individuals receiving STI and HCV testing along with HIV testing. Increase in number of agencies offering STI and HCV testing along with HIV testing services. Increase in PLWH routinely screened for STIs.

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

- Identify factors that increase population interest in HIV testing.
- Deliver innovative, effective, and culturally appropriate prevention interventions in conjunction with HIV testing—personalized cognitive counseling (PCC), couples testing, peer navigators, etc.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> MSM Black MSM 	<ul style="list-style-type: none"> CBOs Healthcare providers University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> Train/refresh providers on PCC and couples protocol by 12/30/16. Evaluate performance by 12/30/2017 and annually thereafter. 	<ul style="list-style-type: none"> Increase in number of providers able to deliver a variety of services along with testing. Increase in number of high-risk individuals receiving additional services along with HIV testing.

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

- Monitor women identified in PeriData.Net® as receiving HIV screening during routine perinatal care.
- Identify potential partnerships, technical support needs (including assistance with policies and procedures), and other activities to encourage routine HIV screening in emergency departments (EDs) across Wisconsin.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> Wisconsin residents ages 15-65 years All pregnant women 	<ul style="list-style-type: none"> Healthcare providers Birthing hospitals Emergency departments Blood and plasma centers AIDS/HIV Program 	<ul style="list-style-type: none"> Annual review of PeriData.net data. Annual analysis by Surveillance Unit of provider sites identifying significant numbers of new seropositive individuals. 	<ul style="list-style-type: none"> Increase in number of providers with policies supporting opt-out routine HIV screening.

Strategy 2: HIV Partner Services

HIV PS are services provided by highly trained public health professionals, offered routinely to persons with HIV infection and their sexual and needle-sharing partners (see <http://www.cdc.gov/nchhstp/partners/partner-services.html>). In Wisconsin, these services are provided by local health department staff. In Wisconsin, 19 LHDs provide HIV PS. Seven LHDs conduct PS only for residents in their jurisdiction, while the remaining 12 conduct PS for up to 13 jurisdictions in addition to their own. Disease Investigation Specialists (DIS) are public health outreach workers who are responsible for finding and counseling people with a variety of STIs and their contacts. The duties of DIS and HIV PS positions are very similar and have become even more so over the past few years.

A critical function of PS is partner *notification*, a process through which infected persons (called *index clients*) are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure. Other functions of PS include testing partners for HIV, prevention counseling, testing index clients and partners for STIs (such as syphilis or gonorrhea), and linkage to medical care and other vital services. The motivation behind HIV PS is that by providing comprehensive services to index clients and their partners, public health staff will encourage positive behavior change, improved health outcomes, and reduced infectiousness. This will result in decreased HIV transmission and reduced HIV incidence.

Greater integration of HIV PS along with STI follow-up services at the state and local levels is also a priority. Many STIs share common risk factors with HIV. Syphilis is a disease disproportionately affecting MSM, and HIV/syphilis co-infections and cases of gonorrhea in MSM continue to increase.

Activity 2A: Increase client acceptance of HIV PS:

- Increase client awareness and understanding of the purpose and scope of PS.
- Improve HIV PS provider proficiency and comfort in working with HIV clients through increased access to training on client-centered services and cultural competency.
- Improve use of social media/electronic communication (websites, smartphone apps, etc.) to reach partners of index clients who utilized those services to meet partners.
- Work towards creating a full-time and dedicated PS workforce through CDC certification for all PS staff when this process becomes available.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • HIV PS Clients • PLWH, known sexual and drug sharing partners of HIV-positive persons 	<ul style="list-style-type: none"> • AIDS/HIV Program • Local HD HIV PS staff • University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> • By 12/31/2017, update the training curriculum to emphasize cultural competency, particularly with MSM and transgender populations. • Provider outcome data reviewed annually to assess performance. 	<ul style="list-style-type: none"> • HIV PS acceptance rate (percent of index clients agreeing to participate in PS) • Number of clients linked to care • Number of partners identified • Identification of new infections

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

- Improve the ability of HIV PS providers to access data through EvaluationWeb, WEDSS, eHARS, etc., to monitor and evaluate the efficacy of client referrals to HIV testing, linkage to care services, and PrEP.
- Transition HIV PS case assignment and documentation from the federal HIV PS Web service to WEDSS in order to streamline HIV PS Provider access to essential client health data.

Target Population	Responsible Parties	Timeframe	Data Indicators
PS staff	AIDS/HIV Program evaluation, epidemiology and PS staff	<ul style="list-style-type: none"> • Data analyzed annually. • By 12/31/2016, establish a transition plan for WEDSS. • By 12/31/2017, complete transition of HIV PS to WEDSS. 	<ul style="list-style-type: none"> • Proportion of HIV PS cases with complete referral and service data within 90-day target • Proportion of HIV PS cases with complete referral and service data at end of year.

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

- *Work with the STD, Linkage to Care, and HCV Programs and others to improve collaboration and information sharing, and to look for strategies to cross-train staff and maximize the impact of available resources. Wherever possible, work towards full integration of HIV and/or STD and/or HCV services.*
- *Work with non-governmental partners (CBOs and ASOs) to improve HIV PS client contact outcomes, HIV testing of named partners, linkage to care for seropositive persons, and linkage to PrEP for high-risk individuals.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • HIV PS clients • HIV PS providers 	<ul style="list-style-type: none"> • AIDS/HIV Program evaluation, epidemiology, and PS staff • STD Program staff • HCV Program staff • ASO and CBOs • Local HDs • University of Wisconsin HIV Training System 	Annually update cross-training with STI, care staff, and other key programs.	<ul style="list-style-type: none"> • Number of HIV PS clients (index and partners) with documentation of comprehensive STI and HCV testing and treatment. • Proportion of HIV PS providers with data sharing agreements with local service providers, ASO and CBOs (increase). • Number of cases lost to HIV PS follow-up (decrease)

Activity 2D: Integration of HIV PS and STI Disease Intervention Services

- *All HIV/Syphilis Disease Intervention Specialists (DIS) cross trained in the CDC Passport to PS program and ISTD (Introduction Sexually Transmitted Disease Intervention) courses.*
- *HIV PS providers to begin providing syphilis disease intervention services*
- *Combine case assignment functions for HIV PS and syphilis DIS, both to utilize WEDSS system.*

- Increase attention to gonorrhea and chlamydia cases in MSM—modify paper STD case report form to capture sex and gender of sex partners.

Target Population	Responsible Parties	Timeframe	Data Indicators
PLWH and STI diagnoses	<ul style="list-style-type: none"> • AIDS/HIV Program and Wisconsin STD Program • University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> • Cross-training completed by 12/30/2017. • Modify paper STD case report form to capture sex and gender of sex partners by 6/30/2017. • Move HIV PS case assignment functions to WEDDS by Dec 30, 2017. 	<ul style="list-style-type: none"> • Documentation of completed training for all providers. • Capture of partner gender data for chlamydia and gonorrhea.

Strategy 3: Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day. The pill (brand name Truvada®) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently.²⁴ Federal guidelines released in 2014 recommend that PrEP be considered for people who are HIV-negative and at substantial risk for HIV.²⁵

The HRSA strongly encourages Ryan White HIV/AIDS Program (RWHAP) recipients and providers to participate with the implementation of PrEP by leveraging their existing expertise and administrative and clinical infrastructures to set up PrEP programs. RWHAP recipients and providers are poised to use their HIV systems, clinical expertise, and structural capacity to support the expansion of PrEP services across the country. Examples include: states building a PrEP access program using non-RWHAP funds within the RWHAP AIDS Drug Assistance Program infrastructure; clinics developing comprehensive PrEP services using a percentage of HIV clinical and program staff that is not funded by RWHAP to provide PrEP services; and accessing the AIDS Education and Training Centers program to train clinicians and staff on PrEP.

Activity 3A: Expand availability of PrEP

- Maintain updated policy and procedure recommendations for Wisconsin providers who are dispensing or considering dispensing PrEP.
- Maintain a regular working group of clinicians, providers, and community key informants to assist providers in developing and maintaining an effective PrEP program in their practice, and to look at issues of community access and attitudes about PrEP.

²⁴ <http://www.cdc.gov/hiv/prevention/research/prep/>

²⁵ <http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf>

- Assist providers in developing and supporting “wrap-around” services to increase the success of PrEP adherence (e.g., prevention case management).
- Collaborate with family planning and STI providers to expand provision of PrEP.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • PWID at high-risk of acquiring HIV 	HIV medical and other service providers	<ul style="list-style-type: none"> • By end 12/31/2016, complete initial policy recommendations. • Support ongoing, review annually. 	Number and demographic characteristics of clients using PrEP from sentinel providers and Medicaid data.

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

- Assist HIV testing programs in developing PrEP referral policies and procedures, as well as client-level tools such as PrEP screening checklists.
- Provide online and in-person training to HIV testing and care staff about PrEP and ways in which clients can be educated and encouraged to consider PrEP.
- Ensure policies are inclusive of nPEP (non-occupational post-exposure prophylaxis) for clients where this is more appropriate than PrEP.
- Create resources to inform primary care providers about PrEP, the availability of PrEP and client referrals for PrEP

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • PWID at high-risk of acquiring HIV 	<ul style="list-style-type: none"> • Publically funded HIV and STD test sites • University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> • By 12/31/2016, identify effective referral practices and disseminate to HIV testing sites. • By 12/31/2016, develop training materials for HIV testing staff. • Monitor progress annually. 	<ul style="list-style-type: none"> • Number of testing staff trained. • Testing and PS data forms; referral source for new PrEP clients.

Strategy 4: Data to Impact (Prevention Services)

Data to Impact is a new strategy that involves the targeted use of public health data to identify and prioritize follow-up with specific individuals in order to improve public health outcomes.

Data to Impact has two aspects:

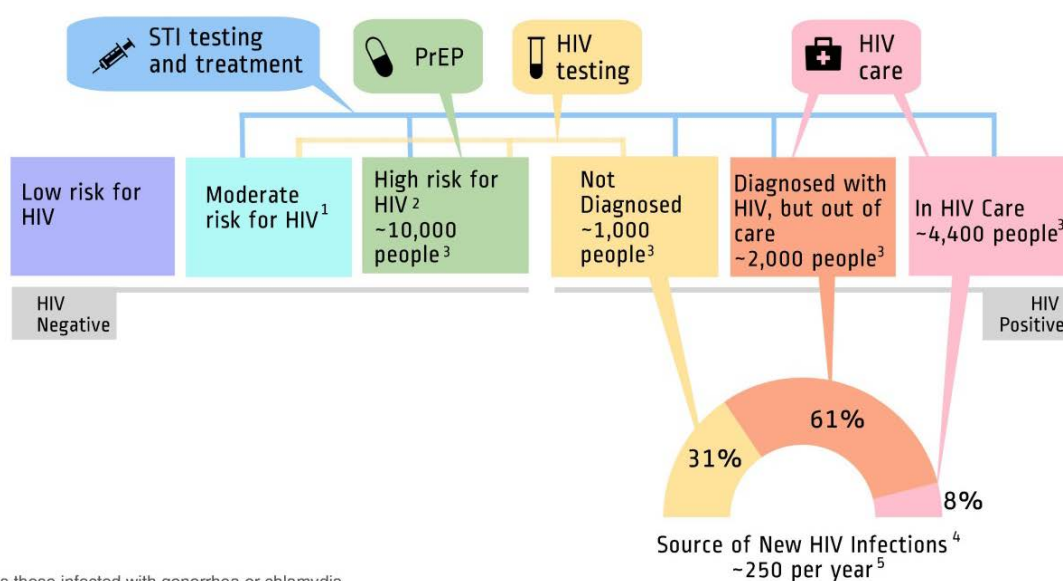
- Preparation of data to identify and prioritize individuals.
- Follow-up and linkage to service.

Data to Care represents a subset of the public health strategy known as Data to Impact. It aims to use data to identify PLWH who are not receiving HIV care in order to link them to care and it also supports the HIV care continuum. Engaging or re-engaging people in HIV care benefits PLWH by improving their health. People living with HIV who are *not* receiving HIV care are the source of 61% of new HIV infections. Re-engaging people in care also helps reduce their HIV viral load and treat STIs, thereby reducing the risk of HIV transmission.

Data to Testing and PrEP addresses the other component of *Data to Impact*. It identifies HIV-negative persons at high risk in order to offer them HIV and STI testing and PrEP.

As shown in Figure 19. below, *Data to Impact* addresses both PLWH (represented on the right half of the figure) and uninfected people (represented on the left half of the figure). The colored areas that make up the continuum band indicate people at various stages of risk, awareness of HIV status, and care status. Critical interventions for people at various stages along the continuum are shown above the continuum band. Conditions resulting from the absence of interventions are shown below the continuum band.

Figure 19. Data to Impact Continuum
Sources of New HIV Infections and Selected HIV/STI Interventions



1. Includes those infected with gonorrhea or chlamydia
 2. Includes those infected with syphilis
 3. Wisconsin estimates as of December 2015
 4. Skarbinski, J. et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. JAMA Inter Med 2015 Apr;175(4):588-96. <http://www.ncbi.nlm.nih.gov/pubmed/25706928>
 5. Approximate number of HIV diagnoses per year, Wisconsin



Data to Impact activities are described below and elsewhere in the following area of the Integrated HIV Plan:

- **Goal 1, Strategy 7:** Comprehensive HIV/STI prevention services for gay and bisexual men, *Activity 7A: Linkage Services based on Data to Impact.*
- **Goal 2, Strategy 8:** Improve data utilization to promote linkage and retention to care and viral suppression, *Activity 8B: Develop a Data to Care program to re-link out-of-care individuals to HIV medical care.*

Activity 4A: Data Improvement

- *Improve systems and use of data for HIV-negative individuals consistent with security and confidentiality laws and standards.*
- *Revise Wisconsin STD reporting form to collect data on gender of sex partners.*

- Complete transition of HIV status data into WEDSS to enable review of HIV status by MSM with an STI.
- Improve data collection and analysis systems to enable identification and prioritization of high-risk negatives for follow-up.

Target Population	Responsible Parties	Timeframe	Data Indicators
Data improvement activities address people at risk of acquiring HIV and syphilis and of transmitting syphilis.	<ul style="list-style-type: none"> • Wisconsin AIDS/HIV and STD Programs • DPH Office of Health Informatics 	<ul style="list-style-type: none"> • Follow security and confidentiality standards (ongoing). • Make revisions to Wisconsin STD reporting form in 2017. • Transition HIV data to WEDSS by 12/31/2017. • Pilot method for merging data to prioritize for follow-up in 2017. • Roll-out method statewide by 2019. 	<ul style="list-style-type: none"> • Monitor progress in data improvement steps. • STI testing rate in HIV treatment clinics.

Strategy 5: Health Promotion and Community Wellness

Health promotion has been defined by the World Health Organization (WHO) as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health." Health Promotion aims to assist people, organizations, and communities to change lifestyle behaviors to move toward a state of improved health, to increase health knowledge, and enhance practices of wellness.

In addressing Goal 1 (reducing new infections), partners and stakeholders at state and local levels will collaboratively focus on reducing stigma directed at PLWH and LGBT people in affected communities, and promoting HIV testing, condom use, harm reduction, overdose prevention services, and PrEP in high-risk communities. Health promotion activities will also focus on increasing the population’s knowledge of available health services and the availability of resources to access them.

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

- Utilize existing channels (SAPG, AIDS/HIV Program Notes listserv, DPH website, University of Wisconsin HIV/AIDS Outreach Project, etc.) to distribute current epidemiologic information on HIV, STIs, and HCV to the general public.
- Make data about Wisconsin’s HIV epidemic accessible to the general population through short reports, infographics, etc., for use at HIV awareness and other events.
- Continue to collaborate with the CDC National HIV Prevention Information Network (NPIN) and the Wisconsin Information Referral Center (IRC)/AIDSline to distribute information about HIV to the general population.

Target Population	Responsible Parties	Timeframe	Data Indicators
General population	<ul style="list-style-type: none"> AIDS/HIV Program Prevention Team AIDS/HIV Program Epi and Surveillance staff 	Ongoing, evaluated annually.	Process monitoring (# of materials distributed, # of website views, etc.)

Activity 5B: Mobilize communities to address stigma creating barriers to HIV prevention and care.

- Work with institutions and prominent peers such as tribal leaders, family planning agencies, and staff at Department of Corrections (DOC) and Department of Public Instruction (DPI) to implement tools like CLAS (cultural and linguistically appropriate services) and trauma-informed care to address institutional stigma.
- Coordinate events with CBOs around key awareness days (National Latino HIV/AIDS Awareness Day, National Black HIV/AIDS Awareness Day, etc.), providing funding to support HIV testing, distribution of condoms and information about the impact of stigma to event attendees.
- Utilize events such as the Week of Prayer for the Healing of HIV/AIDS to engage faith communities in conversations about stigma and its impact.

Target Population	Responsible Parties	Timeframe	Data Indicators
General population	<ul style="list-style-type: none"> AIDS/HIV Program ASO and CBOs LHDs 	Ongoing, evaluated annually.	<ul style="list-style-type: none"> Process monitoring (# of materials distributed, event attendance, etc.) Survey processes (focus groups, community readiness assessment, etc.)

Strategy 6: Testing for and Treatment of STIs

According to the CDC (<http://www.cdc.gov/std/hiv/stdfact-std-hiv.htm>), strong STI prevention, testing, and treatment can play a vital role in comprehensive programs to prevent sexual transmission of HIV. Evidence from intervention studies indicates that detecting and treating STIs may reduce HIV transmission. STI treatment reduces an individual’s risk of contracting HIV if exposed, and in HIV-infected individuals decreases both the amount of HIV in genital secretions and how frequently HIV is found in those secretions.

Activity 6A: Increasing routine testing for STIs for HIV-positive individuals and HIV-negative MSM.

- Encourage inclusion of routine STI testing in policies and procedures and add activities to work plans for Program-funded HIV care and testing providers.
- Assess HIV testing sites and HIV care providers to determine capacity for additional STI testing.
- Develop training and resource plan for increasing HIV test provider capacity for provision of routine STI testing.
- 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.
- Increase availability of rapid STI testing (e.g., syphilis testing) at clinics and sites providing rapid HIV testing to MSM.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> HIV-positive persons MSM 	<ul style="list-style-type: none"> Wisconsin AIDS/HIV Program Wisconsin STD Program Grantee providers of STI and HIV testing Other clinics providing HIV and STI services University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> Capacity assessment by end of 2016. Training and resource plan by 06/30/2017. Additional work plan goals included in 2018 contracts. Training and resource plan by end of 2016, updated as needed. Additional work plan goals included in 2017 contracts. Analyze program data on STI testing to assess progress annually. Evaluate annually. 	<ul style="list-style-type: none"> STI testing rate in HIV treatment clinics. Survey of availability and use of site-specific testing.

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

All men should maintain a healthy diet and body weight, exercise regularly, limit alcohol consumption, avoid exposure to cigarette smoke, and follow a variety of health promotion measures. However, gay and bisexual men are more likely to experience certain adverse health outcomes. Studies demonstrate that gay and bisexual men have higher rates of recreational drug use, HIV infection, anal cancer, and depression and anxiety than other men. There is a need for community-based comprehensive health services that are culturally and linguistically appropriate for gay and bisexual men, that promote positive sexual health, that focus on screening and preventing the disproportionate health issues faced by gay and bisexual men, and that promote general physical and mental wellbeing. The overall goal of this strategy for the Wisconsin AIDS/HIV Program is to increase availability of comprehensive services for MSM individuals to include interventions such as basic wellness screenings, vaccinations, and emerging health alerts.

Activity 7A: Use a comprehensive health approach to engage gay and bisexual men in health services, increasing general wellness, and reducing susceptibility to STIs and HIV.

- Encourage overall health awareness by increasing availability of basic wellness screening (blood pressure, smoking cessation, etc.) at clinics, outreach sites, and events serving gay and bisexual men.
- Promote the CDC-recommended vaccinations for gay and bisexual men (hepatitis, seasonal flu, and HPV)
- Engagement with the gay community and providers who serve them on emergent or immediate disease issues that disproportionately impact gay and bisexual men (e.g., community-specific outbreaks of syphilis, meningitis, or methicillin-resistant *Staphylococcus aureus*).

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • Gay, bisexual, and other MSM • Young Black MSM 	<ul style="list-style-type: none"> • AIDS/HIV Program • LHD partners • Community health centers and other clinics 	<ul style="list-style-type: none"> • Do formative evaluation of wellness screening and vaccination possibilities in 2016, begin implementing in 2017. • Engage on emergent disease issues. 	<ul style="list-style-type: none"> • Vaccination availability and uptake rate at key provider locations. • Survey of clinics and sites to assess wellness service availability and utilization. • Process evaluation of response to emergent disease issues.

Activity 7B: Linkage Services based on Data to Impact

Assign prioritized HIV-negative individuals, including cases of rectal gonorrhea to Linkage Specialists for follow-up HIV/STI testing and referral to PrEP.

Target Population	Responsible Parties	Timeframe	Data Indicators
Gay and bisexual men at risk of acquiring and transmitting HIV and syphilis	<ul style="list-style-type: none"> • AIDS/HIV Program • DHS and local public health partners • ASO and CBOs 	<ul style="list-style-type: none"> • Pilot prioritization for follow-up of high-risk seronegative MSM with a limited number of sites in 2017. • Roll-out prioritization of follow-up statewide by 2019. 	<ul style="list-style-type: none"> • Number of seronegative MSM assigned and reached for follow-up under Data to Impact. • Number referred to each of PrEP, and HIV and STI testing. • Number of new HIV and STI diagnoses among those contacted for follow-up.

Strategy 8: Condom Promotion and Distribution

According to the CDC, consistent and correct use of male and female latex condoms can reduce the risk of STIs, including HIV.²⁶ There are several ways to promote condom use among people at high risk for HIV. Structural-level interventions (such as distributing free condoms in diverse venues) and social marketing campaigns can address the social, economic, and political environments that shape and constrain individual, community, and societal health outcomes. The goal of condom promotion and distribution is to increase condom use by creating an environment where at-risk communities find increased availability, accessibility, and acceptability of condoms.

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.)

²⁶ Centers for Disease Control and Prevention [Internet]. Condom effectiveness. Available from: <http://www.cdc.gov/condomeffectiveness/>

- Continue regionally coordinated condom distribution using the ASO offices as delivery points for partner agencies and at-risk community members.
- Increase use of social media and smartphone applications (iCondom, CondomFinder, etc.) to promote community acceptance.
- Work with the ASO and community partners (Family Planning, LGBT Organizations, etc.) to review condom distribution apps and campaigns developed by CDC, condom manufacturers and other entities, and recommend appropriate use based on local needs and conditions.
- Develop plans to reduce condom stigma by periodic and occasional distribution at broader community events (World AIDS Day, etc.) in cooperation with local community partners.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • Young MSM • Sexually active PWID • General population 	<ul style="list-style-type: none"> • AIDS/HIV Program • ASO • CBOs • Local health departments • Other partners 	Ongoing	<ul style="list-style-type: none"> • Number of condoms distributed statewide. • Number of condoms distributed at targeted outreach sites. • Number condoms distributed at community events.

Strategy 9: Injection Drug User Health

Persons who inject drugs (PWID) continue to be at increased risk not only for HIV but for hepatitis C virus (HCV) and other infections, as well as being at risk of death due to accidental overdose. Community drug user health and harm reduction services are needed for persons who inject drugs. The primary focus of drug user health and harm reduction services is to increase an individual’s engagement with health services and reduce secondary negative health impacts (transmission of HIV and other communicable diseases) in the community. The CDC has identified health concerns that are specific to PWID.²⁷ NASTAD (the *National Alliance of State and Territorial AIDS Directors*) outlines several items essential to improving PWID health outcomes:

- Regular testing for HIV and HCV.
- Support for policies and programs that allow for broad access to sterile syringes and other drug injection equipment (“works”) through needle exchanges and pharmacy sales.
- Broad distribution of and education on naloxone as a counter to opiate overdose.
- Increasing the ability of Infectious Disease staff to facilitate “warm hand-off” of clients to treatment-on-demand programs.
- Clients enrolled in health plans that cover naloxone and MAT (medication-assisted treatment such as suboxone, vivitrol, and methadone replacement therapy).

²⁷ Centers for Disease Control and Prevention [Internet]. Dear colleague letters. Syringe services programs for people who inject drugs. March 30, 2016. Available from: http://www.cdc.gov/nchhstp/dear_colleague/2016/dcl-033016-syringe-services-programs-for-pwid.html

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

- Support co-location of priority HIV prevention services, including HIV testing, condom distribution, and PrEP referral services with syringe service programs (SSP), programs serving transgender individuals using injectable hormones outside of clinical settings, and other programs serving PWID who are not currently in treatment programs.
- Support SSPs in a manner consistent with federal guidance, encouraging provider capacity to provide comprehensive services including education on vein care and proper cleaning of injection sites, education on and provision of naloxone to reverse opioid overdoses; referral and linkage to HIV, viral hepatitis, other STDs, and TB prevention care and treatment services, referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination, as well as referral to mental health services, physical health care, social services, and recovery support services.
- Establish and support a statewide determination of need (DON) for SSPs based on local HIV and HCV epidemiologic data, submit for CDC review and update as needed, and make the DON available for Wisconsin providers requesting federal funds for SSPs.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • PWID (persons who inject drugs) • Transgender individuals using injectable hormones outside of clinical settings 	<ul style="list-style-type: none"> • AIDS/HIV Program • Local public health partners • Providers serving target populations • Providers conducting SSPs 	<ul style="list-style-type: none"> • Establish DON with CDC by 11/01/2016. • Meet with SSP providers in Wisconsin and review change in guidelines by 11/01/2016. • Evaluate progress annually. 	<ul style="list-style-type: none"> • Survey of clinics and sites to determine availability and utilization of community wellness and harm reduction services for PWID. • Availability of services for PWID, tracked through program-level data (# individuals served, # materials distributed).

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE 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%.

See [Appendix I](#) for the rationale, assumptions, and annual targets for Objectives [2.1](#), [2.2](#), [2.3](#), [2.4](#) and [2.5](#).

Strategy 1: Maximizing the Use of Medical Case Managers and Linkage to Care Specialists in Ensuring Linkage, Retention, and Viral Suppression

The central goal of medical case managers (MCM) and linkage to care specialists (LTCS) are to support linkage to and ongoing client engagement in HIV medical care by ensuring that client needs are met. Ultimately, this will result in HIV viral load suppression and a reduction in new HIV infections. Meeting client needs may include assisting clients in obtaining insurance, stable housing, access to food, or helping clients to access mental health or substance abuse services. While clients work to achieve positive clinical outcomes, these providers also assist clients in achieving independence, a sense of empowerment, and self-sufficiency.

There are many similarities to the MCM and LTCS services, but also some differences. MCM and LTCS both conduct their services via initial intake and assessment, service plan development and implementation related to client needs, referral for services, and ultimately discharge.

During service provision, MCM and LTCS:

- Regularly assess and screen clients to ensure linkage to proper services.
- Monitor viral load results to promote treatment adherence and assist clients in understanding their lab results.
- Continually monitor insurance status and assess eligibility for other benefit programs.
- Provide clients with the skills, knowledge, and resources to increase their ability to independently manage their HIV disease.
- Continue to build relationships with key referral sources across the care continuum.

The MCM and LTCS have similar job expectations, although the LTCS have higher and complex need (acuity) clients and smaller caseloads, which allows for more frequent client contact and field visits. The LTCS are limited to approximately nine months. Evaluation of both MCM and LTCS programs have shown improved clinical outcomes for clients.

Activity 1A: Increase the capacity and longevity of MCM and LTCS to maximize linkage, retention, and viral suppression.

- Expand the availability of LTCS to be statewide.
- Increase the number of MCM statewide in order to reduce caseloads and allow for a more proactive approach to serving clients.
- Expand the role of LTCS to locate individuals never linked to care or who need to be relinked to care, as part of the Data to Care program.
- Recruit, promote, and support a cultural and linguistically diverse leadership and MCM/LTCS workforce that are responsive to the population in the service area.
- Educate and train leadership and MCM/LTCS workforce in culturally and linguistically appropriate practices and trauma informed care on an ongoing basis.
- Evaluate the need for specialized case management models to serve unique patient populations (e.g., adolescent and pediatric patients, people leaving corrections, clients in need of life-long case management, older PLWH).

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • LTCS • MCM • Supervisors of LTCS and MCM 	<ul style="list-style-type: none"> • Agencies offering MCM • Agencies offering LTCS • AIDS/HIV Program • University of Wisconsin HIV Training System 	LTCS expansion to begin in 2017, and be reevaluated annually thereafter	<ul style="list-style-type: none"> • Increase breadth of training topics offered to MCM and LTCS. • Increase in the number of LTCS. • Increase number of clients served by LTCS. • Decreased average case load per MCM. • Development of trainings and professional development for agency leadership. • Development and delivery of CLAS trainings for frontline workforce.

Strategy 2: Expanding Capacity of HIV PS to Promote Linkage, Retention, and Re-engagement in Medical Care

While PS has traditionally focused on partner notification and partner elicitation, an increasing focus area is the role of PS staff in ensuring that clients and their partners are engaged in HIV medical care. This assurance role may include verifying HIV care status for clients and partners or actively linking or relinking infected individuals to care. PS providers currently link newly diagnosed individuals to HIV medical care, medical case management, and LTCSs, or confirm that services are already accessed by obtaining consent to contact the client’s medical provider.

However, due to the field skills that PS providers possess and their legal authority to exchange client information with HIV surveillance programs and clinical providers, PS providers are increasingly being used nationwide to locate and re-engage people who have fallen out or were never linked to HIV medical care.

The capacity of LHD staff to conduct additional activities, such as the re-engagement efforts described above, varies across the state depending on how PS is conducted. Some LHDs have PS providers who are dedicated to PS for HIV or both HIV and sexually transmitted infections. However, PS providers in other health departments are conducting PS and disease follow-up for a variety of health conditions, in addition to serving in other health department roles.

Activity 2A: Increase the capacity of PS providers to effectively link or re-engage infected individuals into HIV care.

- *Allocate additional resources to increase PS providers’ capacity to locate clients, notify partners, and link individuals to care. Further consolidate PS to allow for PS providers who are dedicated to HIV-related PS and re-engagement efforts.*
- *Cross-train PS providers on care-related topics, such as antiretroviral therapy, care payment options, and counseling clients on linkage, retention, and medication adherence.*
- *Build stronger relationships between PS providers and other health care providers, by educating providers along the continuum of their responsibility to engage and the benefits of engaging PS for their clients.*
- *Improve the collection and documentation of client-level care-related information to ensure that PS data are accurate and that linkage to care is verified.*
- *Transition HIV PS data management from PSWeb to WEDSS to allow PS providers to access care-related information.*

Target Population	Responsible Parties	Timeframe	Data Indicators
PS providers	<ul style="list-style-type: none"> • AIDS/HIV Program • PS providers and supervisors • University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> • Complete PS consolidation by 2019. • Update PS protocol by the end of December 31, 2018. • Transition to WEDSS in 2017. 	<ul style="list-style-type: none"> • Increased training opportunities offered to PS staff. • Documented linkage and re-engagement procedures in the PS protocol. • Documented successful transition from PSWeb to WEDSS.

Strategy 3: Promoting Participation in the AIDS Drug Assistance Program (ADAP)

ADAP provides medication assistance to eligible low-income people with HIV infection. To be eligible for medication assistance an individual must live in Wisconsin and have:

- A documented HIV infection.
- Gross household income at or below 300% of the federal poverty level.
- No health insurance or insufficient insurance coverage to pay the cost of ADAP formulary medications.

ADAP clients may obtain their covered medications from the ADAP enrolled pharmacy of their choice. Currently, ADAP covers 78 medications, including all FDA-approved antiretrovirals. The ADAP attempts to ensure that any FDA-approved medications considered for inclusion on the ADAP formulary are carefully reviewed by an ad hoc external panel of HIV and other clinicians in collaboration with DHS staff. Pharmacies bill ADAP for the cost of covered medications less any portion paid by the client’s health insurance, if applicable. ADAP reimburses pharmacies at the Medicaid specialty pharmacy drug reimbursement rate. During calendar year 2015, ADAP served 1,656 individuals. For more information about ADAP see the ADAP web page at <https://www.dhs.wisconsin.gov/aids-hiv/adap.htm>

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

- *The ADAP will continue to cover the cost of all antiretroviral medications and related therapies for uninsured individuals. As new medications become FDA approved, they will be vetted by the ad hoc clinician panel and, as appropriate, added to the formulary to ensure client access.*
- *A quarterly review will examine the ADAP formulary, client enrollment, and client utilization data to determine the Program’s current and future viability.*

Target Population	Responsible Parties	Timeframe	Data Indicators
ADAP clients	<ul style="list-style-type: none"> • ADAP staff • Ad hoc committee members 	<ul style="list-style-type: none"> • Ongoing quarterly review of ADAP utilization. • Add hepatitis C and mental health medications by July 2017 if recommended by the ad hoc advisory committee and approved by DHS. 	<ul style="list-style-type: none"> • Newly approved antiretrovirals will be added to the formulary within 60 days of the FDA approval date. • ADAP drug utilization and expenditures.

Activity 3B: Streamline the ADAP application process.

- *Review the initial application and recertification processes to identify possible efficiencies that can be implemented.*
- *Implement a web-based enrollment process allowing case managers to directly enroll clients.*
- *Develop audience-appropriate materials including webinars and other electronic media to educate clients, providers, and partners about the ADAP regarding:*

- Covered benefits.
- Eligibility criteria.
- Enrollment processes.
- Evaluate ADAP materials for cultural appropriateness and competence.
 - Written materials should be at proper reading levels and available in multiple languages.
 - Utilize translation services for non-English speaking clients calling the ADAP.
- Identify ways to improve coordination and communication with case managers to ensure clients are accurately completing application recertification materials, submitting all necessary documentation, and meeting deadlines.
 - Continue to facilitate referrals for clients eligible for public or private insurance.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> ● Low-income PLWH ● Health care providers 	<ul style="list-style-type: none"> ● ADAP staff ● MCM ● University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> ● Review and revised ADAP written materials by December 2017 ● Implement online enrollment during 2017 	<ul style="list-style-type: none"> ● ADAP utilization and expenditures ● Interpretation services utilization ● Percentage of recertifications submitted electronically

Strategy 4: Promoting access to Health Insurance for People Living with HIV

The Insurance Assistance Program (IAP) provides insurance assistance to eligible low-income people with HIV infection. To be eligible for the IAP an individual must:

- Live in Wisconsin.
- Have a documented HIV infection.
- Have gross household income at or below 300% of the federal poverty level.
- Be ineligible for Medicaid for the elderly, blind, or disabled (EBD) or the BadgerCare Plus Standard Plan unless the member must pay a premium to obtain coverage.
- Have an existing health insurance policy that includes prescription drug coverage or be eligible to purchase coverage through the Health Insurance Marketplace.

IAP pays health insurance premiums on behalf of eligible program participants for the following types of insurance:

- Employer-based group health insurance
- COBRA continuation of group health insurance
- “Silver” level plans purchased through the Health Insurance Marketplace (HealthCare.Gov)
- Medicaid Purchase Plans (MAPP)
- Medicare Part D Prescription Drug Plans
- Medicare supplemental plans (paid for with non-federal funds)

IAP pays health insurance premiums only, while ADAP covers the cost of deductibles, copayments, and coinsurance for clients with health insurance for ADAP formulary medications only. During calendar year 2015, the IAP served 867 individuals. For more information about the IAP, see the IAP web page at <https://www.dhs.wisconsin.gov/aids-hiv/hipsp.htm>.

Activity 4A: Promote and encourage enrollment in appropriate private and public insurance options and coordinate benefits with ADAP and IAP.

- The IAP will continue to work directly with clients and case managers to ensure clients are aware of eligibility for public and private insurance options and to facilitate active referrals for these options.
- Support health insurance literacy with clients.
- Improve data systems to accurately and efficiently coordinate ADAP and IAP benefits with Medicaid and private insurers.
 - Explore utilization of an insurance benefit manager (IBM) to improve IAP premium payment processes.
- The IAP will continue to cover the cost of insurance premiums for eligible individuals.

Target Population	Responsible Parties	Timeframe	Data Indicators
Low-income PLWH	<ul style="list-style-type: none"> • ADAP/IAP Staff • MCMs 	Ongoing	IAP utilization and expenditures.

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

- Agencies will be knowledgeable about available policies in their area and work with clients to ensure they enroll in an appropriate plan.
- The IAP will conduct cost/benefit analyses to determine:
 - If non-Marketplace plans may be a cost-effective alternative for individuals not eligible for employer-based, Marketplace, or other public health insurance coverage.
 - If additional coverage support like copay assistance should be provided.

Target Population	Responsible Parties	Timeframe	Data Indicators
Low-income PLWH	<ul style="list-style-type: none"> • ADAP staff • Contract staff 	Annually	<ul style="list-style-type: none"> • IAP utilization and expenditures. • Percentage of ADAP clients with health insurance coverage.

Strategy 5: Ensuring Access to and Retention in HIV Medical Care to Promote Viral Suppression, Positive Health Outcomes, and Reduce Infection Transmission

Access to and participation in HIV medical care is an essential component for helping HIV-positive individuals achieve viral suppression and overall positive health outcomes. HIV medical care includes diagnostic testing, risk assessment, preventive care and screening, diagnosis of common physical and mental health conditions, education and counseling on health issues, continuing care and management of chronic conditions, and prescribing and managing medication therapies including antiretrovirals. Clients who are successfully linked and retained in medical care and achieve viral suppression are less likely to transmit HIV infection than HIV-positive individuals who are not engaged in medical care.

Wisconsin has a well-developed medical care network providing services in the statewide ASO, community-based facilities, private clinics, and academic centers. Through Ryan White Parts B and C, four agencies receive funding to provide outpatient medical care. Additionally, state general purpose revenue funds support the provision of outpatient medical care through the statewide ASO. Surveillance data shows that 89% of individuals who engaged in medical care and had at least one viral load test during 2015 were virally suppressed. The activities detailed below will further build and expand the medical care network while enhancing and improving health outcomes.

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

- *The AIDS/HIV Program will coordinate with recipients of Ryan White funding (Parts B, C, and D) to ensure adequate coverage of HIV medical care over a wide range of clinic types.*
- *Medical staff at HIV clinics should assist clients in obtaining insurance services, enrolling in the AIDS Drug Assistance Program, and ensuring ongoing, timely re-enrollment in these programs.*
- *Agencies serving PLWH should consider a multidisciplinary, medical home model of care to ensure clients receive comprehensive and continuous care that maximizes their health outcomes.*
- *Agencies develop innovative approaches, including evaluating the possible benefits of telemedicine, to enhance access and retention in care for clients who live in rural areas or do not have access to reliable transportation.*

Target Population	Responsible Parties	Timeframe	Data Indicators
Low-income PLWH	<ul style="list-style-type: none"> • ADAP/IAP Staff • HIV care providers (including MCMs, LTCs, and benefits specialists) • Wisconsin site of the Midwest AIDS Training and Education Center 	<ul style="list-style-type: none"> • Review insurance eligibility annually at open enrollment. • Review insurance coverage at each medical visit. 	<ul style="list-style-type: none"> • Decreased proportion of uninsured clients. • Increased proportion of eligible clients recertifying annually for ADAP.

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

- Examples of areas to improve include stigma reduction across all staff levels, expanded hours of operation, and need for alternative service locations.
- Clients should have a routine means of providing feedback about their satisfaction with services (e.g., annual surveys, comment cards).
- Clinics should work to cross-train primary care providers and develop strategies to recruit new HIV specialists to counteract the impact of a workforce that is nearing retirement.

Target Population	Responsible Parties	Timeframe	Data Indicators
PLWH in medical care	<ul style="list-style-type: none"> • HIV Care Providers (including clinicians, MCMs, and LTCSSs) • HIV clinic management 	<ul style="list-style-type: none"> • Annual cultural competency training. • Minimum annual satisfaction surveys. • Minimum annual review of clinic operations and policies. 	<ul style="list-style-type: none"> • Review client feedback during grantee site visits. • Patient satisfaction surveys.

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

- The Wisconsin AIDS/HIV Program will improve coordination and collaboration with the Midwest AIDS Training and Education Center (MATEC) around provider-based strategies to improve linkage to and retention in HIV care.
- The AIDS/HIV Program will continue to support the HIV Treaters Meetings as a way to promote provider education through the sharing of case studies and best practices.
- The AIDS/HIV Program will actively highlight changes or updates to treatment guidelines and support provider training as appropriate. The most current web-based treatment guidelines can be found at <https://aidsinfo.nih.gov/guidelines>.
- HIV medical clinic staff should be educated on the availability and role of PS and LTCSSs at meetings and conferences, as appropriate.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • HIV Care Providers (including clinicians, MCMs, and LTCSSs) • PS staff 	<ul style="list-style-type: none"> • MATEC • AIDS/HIV Program • University of Wisconsin HIV Training System 	<ul style="list-style-type: none"> • Monthly MATEC Treaters meetings. • Annual evaluation of training and education needs. 	<ul style="list-style-type: none"> • Documented regular meetings between the AIDS/HIV Program and MATEC. • Participation in HIV Treaters Meetings.

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

- Provide additional counseling and messaging about preventing HIV transmissions to clients with detectable viral loads while on treatment and those diagnosed with sexually transmitted infections.
- Offer HIV testing to the sexual or needle-sharing partners of their clients.
- Re-engage HIV PS if there is knowledge of ongoing risk behavior.
- Engage the Primary Care Support Network for technical assistance and support in preventing perinatal HIV transmission for HIV-infected pregnant women
- Regularly screen for mental health, substance abuse, housing status, food shortage, and other common client needs and facilitate connections with these services.
- Routinely screen clients for hepatitis C, tuberculosis, and sexually transmitted infections with an emphasis on syphilis testing.
- Link clients with HIV to routine oral health care.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • PLWH in medical care • PLWH with a detectable viral while on antiretroviral treatment • PLWH who inject drugs • HIV-positive pregnant women 	<ul style="list-style-type: none"> • HIV Care Providers (including clinicians, MCMs, and LTCSS) • PS providers • Primary Care Support Network 	<ul style="list-style-type: none"> • Minimum of annual screens for all clients. • Review transmission risk at each appointment. • Duration of pregnancy. 	<ul style="list-style-type: none"> • Increased proportion of clients with annual risk screen. • Increased proportion of medical care clients screened annually for mental health and AODA.

Strategy 6: Ensuring Screening and Referrals to Appropriate Services for Mental Health and Substance Abuse

National and Wisconsin studies estimate that 50% of PLWH also experience significant mental health issues that prevent them from actively engaging in and adhering to medical care. Unaddressed mental health issues and substance abuse are prevalent barriers to retention in care and viral suppression. Regular mental health screening is a required [HAB performance measure](#). Case managers, psychologists, therapists, psychiatrists, and general medical providers may all contribute to mental health care for PLWH. Screening, Brief Intervention, and Referral to Treatment ([SBIRT](#)) is a comprehensive, evidence-based, and integrated public health approach to the delivery of early intervention for those engaged in risky or problem substance use. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. Since 2012, the Wisconsin AIDS/HIV Program has trained over 40 medical case managers in SBIRT.

Since January 1, 2010, Badger Care Plus and Medicaid have covered [SBIRT screens](#). SBIRT provides referral to specialty treatment for those who present with a substance use disorder, as defined by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Some clinics may have the staff resources to address most of the mental health and AODA

needs of their clients while others may not. Referral networks are critical for filling the gap. There are a number of factors that, when present, can further increase risk for mental illness in PLWH. In many cases substance abuse, stigma, and experiences of trauma can increase risk for mental illness in PLWH. Receiving an HIV diagnosis can be a traumatic experience and present an immediate barrier to care. These risk factors also pose significant barriers to accessing HIV primary care. Incorporating mental health and alcohol and other drug abuse (AODA) screening and care into HIV interventions can improve overall treatment outcomes.

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

- Identify effective alcohol and AODA and mental health screening protocols in use at grantee agencies and promote their use in all agencies.
- Confirm the delivery of annual AODA and mental health screenings by medical providers or MCMs.
 - Monitor the implementation of SBIRT across the state.
 - Offer SBIRT Advancing Practice Workshops with trained SBIRTers to ensure implementation within workflow.
 - Invest in workforce development by providing annual or biennial 60-hour SBIRT training to non-licensed MCMs so they can better assist clients with harm reduction.
- Facilitate access to Trauma Informed Care (TIC) training.

Target Population	Responsible Parties	Timeframe	Data Indicators
SBIRT trained non-clinical HIV care providers (including MCM and LTCS)	<ul style="list-style-type: none"> • SBIRT Program Coordinator for the Department of Health Services • HIV Care Services Coordinator • University of Wisconsin HIV Training System 	Delivery of new SBIRT or TIC training or booster sessions at a minimum of once annually.	<ul style="list-style-type: none"> • Documented delivery of screenings. • Increased delivery and implementation of SBIRT into workflow. • Increased number of grantee staff trained in SBIRT and TIC.

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

- Conduct a statewide mental health and AODA outpatient services review, paying special attention to accepted forms of insurance, waitlists or availability, and inpatient versus outpatient care.
- Strengthen partnerships with state programs, including Medicaid and other public and private payer services, to better link clients to mental health and AODA care and treatment.
- Explore ways to increase access to treatment, by exploring feasibility of telemedicine and by AIDS/HIV Program participation in statewide coalitions and task forces.
- The ADAP will establish an ad-hoc advisory committee to guide the ADAP staff on the possible expansion of the ADAP formulary to include mental health medications and hepatitis treatments as appropriate.

Target Population	Responsible Parties	Timeframe	Data Indicators
SBIRT-trained HIV care providers (including MCM, LTCS, RNs, NPs, and physicians)	AIDS/HIV Program staff (HIV Care Services Coordinator; ADAP/IAP Coordinators; HIV Care and Surveillance Supervisor)	<ul style="list-style-type: none"> Resource Assessment completed by December 2017 and updated annually Initial ADAP formulary expansion considerations made by July 2017 	<ul style="list-style-type: none"> Completed statewide mental health and AODA inpatient and outpatient resource review Documented strategies to increase access to mental health or substance abuse treatment

Strategy 7: Incorporating Delivery of Support Services to Promote Engagement and Retention in Medical Care

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of PLWH. The provision of support services is designed to help clients maintain engagement in medical care and achieve viral suppression. Funded support services include housing services, food pantry, legal services, and medical transportation.

In Wisconsin, many support services are either provided directly or coordinated by the ASO and other CBOs. Additional HIV-related support services are provided by other agencies and through a variety of funding sources such as support for housing funded under the federally funded Housing Opportunities for Persons with AIDS (HOPWA) Program administered by the Wisconsin Department of Administration.

Access to housing is an important precursor to getting many people into a stable treatment regimen. Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy. People who are homeless are at greater risk for having contact with communicable diseases and infections, malnutrition, stress, lack of water to maintain personal hygiene, and lack of refrigeration for medication.²⁸ Homelessness inhibits the long-term, consistent care needed for many, with the result that problems are aggravated, making them more dangerous and more costly. Homelessness also increases the likelihood of excessive use of the ED, inpatient treatment and crisis services. Increased access to permanent supportive housing will improve the health of those living with HIV or hepatitis C.

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

- *Ensure MCMs and LTCSs prioritize the need for each client to have stable housing.*
- *Ensure the client is actively involved in the process of determining stable housing so that solutions address the client's needs and preferences.*

²⁸ Office of Disease Prevention and Health Promotion [Internet]. Social determinants of health. Available from: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> (Retrieved June 9, 2016).

- *Work with stakeholders to identify and prioritize housing assistance needs, such as emergency shelter, security deposit assistance and more case managers.*
- *Identify housing resources that work with special populations, including those releasing from prison or jail, families, individuals with AODA/mental health concerns, and clients who are transgender.*
- *Coordinate efforts with local housing resources, including Housing Opportunities for Persons With AIDS (HOPWA), Community Action Coalition, Outreach Community Health Center, Housing Authority for the City of Milwaukee, and others.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • Post-incarcerated PLWH • Transgender PLWH • PLWH with families • PLWH with substance use concerns 	<ul style="list-style-type: none"> • Wisconsin AIDS/HIV Program staff • Case managers • MCM • LTCS 	<ul style="list-style-type: none"> • Development of statewide housing resource inventory completed by December 2017 and updated annually. • Minimum of annual housing reviews for all clients. • Begin client housing need assessment three months before release from incarceration. 	<ul style="list-style-type: none"> • Development of a housing resource inventory. • Ensure Acuity Index accurately reflects stable housing as a priority. • Annual site visits to demonstrate concurrence of Acuity Index between case manager and client.

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

- *Maintain commitment to transportation assistance to ensure clients are able to attend medical and case management appointments.*
- *Maximize existing transportation resources.*
 - *Ensure Medicaid eligible individuals are enrolled in Medicaid and utilizing covered services.*
 - *Better equip case manager staff with skills to assist clients in exploring use of friends and family for transportation assistance.*
- *Evaluate alternative transportation options.*
 - *Utilize volunteer drivers and agency dedicated transportation vehicles.*
 - *Explore utilization of telemedicine to increase access to medical services, including mental health support.*
 - *Enable MCMs and LTCS to meet with clients in the field.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • PLWH in rural areas • PLWH without access to a personal and reliable automobile 	<ul style="list-style-type: none"> • MCM • LTCS 	<ul style="list-style-type: none"> • Transportation needs reviewed when scheduling appointments. • Transportation needs reviewed annually during case management assessment. 	<p>Documented agency strategies to ensure clients have reliable transportation.</p>

Strategy 8: Improving Data Utilization to Promote Linkage and Retention to Care and Viral Suppression

The use of data is critical for evaluating the quality and effectiveness of programs, allocating resources, monitoring the trends of the HIV epidemic, and recently for targeted individual-level outreach. Data sharing is also important for reducing service duplication, creating efficiencies for agencies and clients, and improving data and service quality.

One important new national strategy is Data to Care.²⁹ Data to Care, which is one component of the Data to Impact strategy described in [Goal 1, Strategy 4](#), is a public health strategy that aims to use individual-level data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV care continuum. This strategy also encompasses the individual-level data that clinics may use to identify clients who are out of care or at risk of falling out of care. The goals of a Data to Care program are to increase the number of HIV-diagnosed individuals who are engaged in care and virally suppressed, and prevent disease transmission. During the next few years, a comprehensive Data to Care program will be developed and implemented in Wisconsin, which will include the following key operational steps: 1) routinely run list of individuals who are not in care, 2) determine whether clients are eligible for outreach, 3) prioritize eligible clients, 4) assign priority clients for outreach, 5) conduct outreach and engagement activities, and 6) evaluate outcomes.

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

- *Agencies collecting information on HIV-infected individuals should develop routine processes for ensuring that multiple data systems have complete and consistent information.*
- *The AIDS/HIV Program will improve the data sharing relationship with the Wisconsin Medicaid Program.*
- *The AIDS/HIV Program and agencies serving HIV-infected individuals should explore enhanced data sharing between agencies, and between agencies and the AIDS/HIV Program, in order to more effectively and efficiently monitor client linkage and retention to care, and to minimize service duplication.*
- *The AIDS/HIV Program will incorporate HIV diagnoses and related laboratory data into WEDSS to improve the outreach, treatment, and care coordination of individuals co-infected with HIV and STIs, hepatitis C, and TB.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • Staff at agencies serving people living with HIV • AIDS/HIV Program 	<ul style="list-style-type: none"> • Staff at agencies serving people living with HIV • AIDS/HIV Program 	Starting in 2017, utilize data from ADAP and Medicaid to update eHARS records.	<ul style="list-style-type: none"> • Increase the number of systems used to update eHARS records. • Transition to WEDSS in 2017.

²⁹ Centers for Disease Control and Prevention [Internet]. Effective interventions. High impact prevention. Data to care. Available from:

<https://effectiveinterventions.cdc.gov/en/highimpactprevention/publichealthstrategies/DatatoCare.aspx>

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

- The AIDS/HIV Program will develop internal processes to identify, prioritize, and assign out-of-care cases for outreach.
- The AIDS/HIV Program will develop an outreach model, including identifying outreach staff, developing protocols, and providing training on outreach procedures and maintaining client confidentiality.
- Agencies that provide medical services to HIV-infected individuals should routinely identify clients who have not been seen in a defined period and initiate outreach efforts.
- Agencies that provide medical services to HIV-infected individuals should routinely share out-of-care patient lists to the AIDS/HIV Program for assistance in determining which clients are eligible for outreach.

Target Population	Responsible Parties	Timeframe	Data Indicators
PLWH with no care in 12 months	<ul style="list-style-type: none"> • Clinics serving PLWH • AIDS/HIV Program 	<ul style="list-style-type: none"> • Data to Care protocol developed in Year 1. • Annual Data to Care outcomes. 	<ul style="list-style-type: none"> • Documented Data to Care protocol • Number of clients re-engaged via Data to Care efforts

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

- Agencies that provide services to HIV-infected individuals should develop formal processes for reviewing agency performance measures (e.g., retention to care, gaps in care, prescription of antiretroviral therapy), monitoring client satisfaction, and implementing quality improvement initiatives.
- Agencies that provide services to HIV-infected individuals should engage HIV-infected individuals in all aspects of the quality management process.

Target Population	Responsible Parties	Timeframe	Data Indicators
People living with HIV	<ul style="list-style-type: none"> • Agencies serving people living with HIV • AIDS/HIV Program 	Assessed during quarterly Quality Collaborative meetings	<ul style="list-style-type: none"> • Increased number of agencies that formally obtain client feedback. • Increased number of agencies with ongoing Quality Improvement (QI) programs.

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 15-59

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 (PWID) (compared to those exposed through male-to-male sexual contact [MSM] and through high-risk heterosexual contact [HRH])
- Young people, ages 15-29 (compared to people ages 30 and older)

See [Appendix I](#) for the rationale, assumptions, and annual targets for Objectives [3.1](#) and [3.2](#).

Reducing HIV-related health disparities and inequities must be a major priority. A health disparity occurs when a population's overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates differ significantly from that of the general population. Addressing disparities requires focusing on disproportionately affected communities and populations; implementing structural approaches to HIV prevention and care that address conditions such as housing, education, employment, and food security; and reducing stigma and eliminating discrimination associated with HIV infection.³⁰

The National Strategy identifies critical steps to achieving success in the overall strategy including:

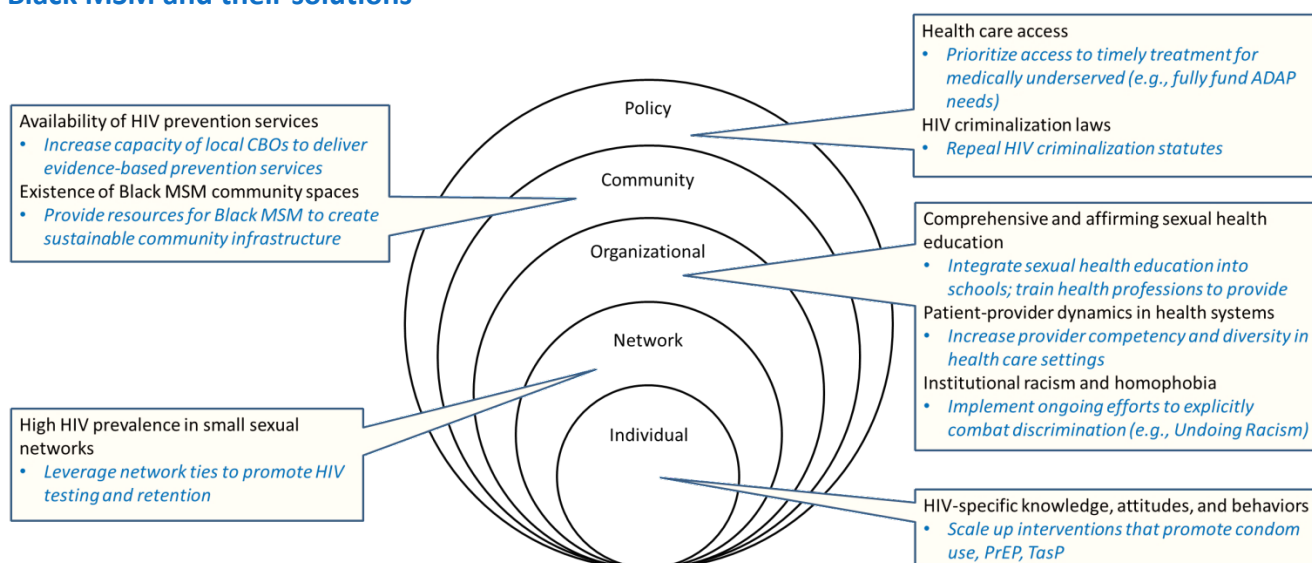
- Reducing HIV-related disparities in communities at high risk for HIV infection.
- Adopting structural approaches to reduce HIV infections and improve health outcomes in high-risk communities. Structural approaches extend beyond the individual's risk behaviors and include approaches such as education, employment, housing, and comprehensive sexual education for youth.
- Reducing stigma and eliminating discrimination associated with HIV status. People who experience stigma and discrimination may engage in increased risk behaviors and experience worse health outcomes.

³⁰ The White House [Internet]. Office of National AIDS Policy. National HIV/AIDS strategy for the United States. Updated to 2020. July 2015:37. Available from: <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>.

Framework

Goal 3 strategies of the Integrated HIV Plan are based on a social-ecological framework originally developed by Mathews *et al.*,³¹ to address the HIV epidemic among Black MSM. This framework is relevant for members of other populations at risk for HIV and living with HIV. Goals 1 and 2 of the Integrated HIV Plan focus primarily on services for *individuals* at risk of acquiring HIV and those living with HIV. Goal 3, addressed in this section of the Integrated HIV Plan, focuses on the *broader contexts* within which people exist and acknowledges that modifying individual behaviors and improving services alone will not eliminate HIV disparities. The social-ecological framework has five levels. At each level there are opportunities to both *increase* and *decrease* the risk of HIV transmission as well as *improve* and *impede* health outcomes.

Figure 20. Conceptual framework depicting the factors sustaining the HIV epidemic among Black MSM and their solutions³²



LEVEL 1: SOCIAL AND SEXUAL NETWORKS

Social and sexual networks comprise interpersonal relationships including family, friends, neighbors, and others that directly influence health and health behaviors in multiple ways. Networks can serve to both increase transmission risk, through sexual or needle-sharing exposure, and *reduce* transmission by reinforcing healthful social norms (Baral *et al.*³²). “If we acknowledge the strength of these networks to spread infection, it is long past time to work with Black MSM in leveraging these networks to spread health” (Mathews). Strategies that focus on the social network should strive to focus not on negative statistics and behaviors, but on positive, asset-based messages that focus on the strength and power of the network (Mathews).

³¹ Mathews DD, Smith JC, Brown AL, Malebranche DF. Reconciling epidemiology and social justice in the public health discourse around the sexual networks of black men who have sex with men. *AJPH* 2016;106(5):808-814.

³² Baral S, Logie CH, Grosso A, Wirtz A, Beyrer C. *BioMed Central [Internet]* (2013). Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. Available from: <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-482>.

Strategy 1: Social Media

Social media are electronic communication technologies that provide ways to create and share information (including text, pictures, audio, and video). Social media promote social networking and the development of virtual communities. Social media have successfully supported, promoted, and assisted in the delivering of HIV prevention and care services in the areas of HIV, STI and hepatitis C testing; PrEP; medication adherence; retention in care; communicable disease intervention; health literacy; sexual and holistic health care; and drug-user health. While social media can be efficient and effective ways to communicate and share information, the application of social media in HIV prevention and care services must be implemented in ways that ensure confidentiality and safeguard personally identifiable information.

Activity 1A: Expand the use of social media to address issues that affect social and sexual networks of MSM and social and equipment-sharing networks of PWID.

- Collaborate with local agencies in developing policies for expanded use of social media by staff responsible for implementing HIV prevention interventions and care services for MSM and PWID.
- Work with peer leaders, especially in the young MSM, MSM of color communities, and young PWID to develop and effectively deliver social media messages about the availability and benefits of prevention and care services.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • YBMSM • Transgender women • PWID • PLWH 	ASO CBOs	<ul style="list-style-type: none"> • Strategies developed and reviewed annually. • DPH-funded organizations develop policies regarding use of social media by 12/31/2017. 	<ul style="list-style-type: none"> • Increase in number of posts and other analytic metrics. • Process data on posts: <ul style="list-style-type: none"> ○ Number ○ Topics ○ Audience

Strategy 2: Popular Opinion Leader/Peer Approaches

Popular Opinion Leader (POL) is an HIV/AIDS risk-reduction program in which groups of trusted, well-liked people are recruited and trained to conduct a novel and particular type of outreach. This outreach focuses on a specific risk-influencing factor—a community norm, such as endorsement of safer-sex behaviors. Opinion leaders endorse targeted risk-reduction behaviors by having casual, one-on-one conversations with their peers in their own social network (friendship group).³³ POL and other models that rely on peers benefit from peers’ potential ability to access underserved networks. In order to be effective, peers need leadership development and capacity-building opportunities.

³³ Kelly JA, St. Lawrence JS, Diaz YE, et al. HIV risk behavior reduction following intervention with key opinion leaders of population: an experimental analysis. American Journal of Public Health. 1991;81(2):168–171.

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

- Recruit community leaders and peers from priority populations as opinion leaders to implement prevention and care outreach efforts and other interventions that address health disparities.
- Provide ongoing support and technical assistance to opinion leaders in implementing and evaluating the effectiveness of prevention and care efforts.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • YBMSM • Transgender women • PWID • PLWH 	CBOs	<ul style="list-style-type: none"> • Reviewed annually • Strategies developed and reviewed annually • POL/peer intervention models will vary across agencies • Social media will be a key venue 	<ul style="list-style-type: none"> • Increase in number of trained POL/peers • POL process data: <ul style="list-style-type: none"> ○ Number ○ Demographic characteristics ○ Topics/messages

Strategy 3: Addressing Networks of PWID

Injection drug use is a social behavior that can involve a network of individuals who are associated closely with each other and frequently isolated from others due to injection drug use. Social networks can facilitate the transmission of HIV and can also serve as a venue to diffuse prevention information and support behavior change. Network interventions focus on the *network of users* rather than the *individual user* and may include use of social media, popular opinion leader models, and secondary distributors of safe injection equipment and health promotion messages.

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

- Implement expanded prevention and care outreach to networks of PWID through peer educators, informal leaders, and network members.
- Implement comprehensive syringe services programs that, in addition to accessing safer injection drug use supplies, support:
 - Referral to substance use disorder treatment programs.
 - Counseling and testing for HIV, hepatitis C, STIs, and TB.
 - Linkage to HIV care, substance use treatment, PrEP and PEP services, hepatitis C treatment, hepatitis A and B vaccination, PS, reproductive health services, and other medical, social, and mental health services.
 - Education on safer injection practices, wound care, and sexual health.
 - Overdose prevention.

Target Population	Responsible Parties	Timeframe	Data Indicators
Networks of PWID who share injection equipment.	CBOs	Strategies developed and reviewed annually.	Process data on: <ul style="list-style-type: none"> • approach • number reached • topics

LEVEL 2: ORGANIZATIONS

For the purposes of this Integrated HIV Plan, organizations include institutions that provide health; education; employment training and support; social, civic, and youth services; faith-based organizations, correctional institutions, and others. Like social networks, *organizations* can both support and hinder members of populations experiencing health disparities. Strategies at this level focus on improving the quality of services, organizational ability to effectively serve people needing services, and collaboration among organizations to better meet the needs of people disproportionately affected by HIV and other conditions.³⁴

Strategy 4: Culturally and Linguistically Appropriate Services (CLAS)

The National CLAS Standards are the benchmarks that service providers and organizations follow to serve diverse communities through culturally and linguistically appropriate services (CLAS) that are respectful of, and responsive to, individual cultural health beliefs and practices, preferred languages, health-literacy levels, and communication needs. CLAS are directed at advancing health equity, improving quality, and eliminating health care disparities. Culturally and linguistically appropriate HIV services are responsive to the special needs and life contexts of those who are marginalized because of race, ethnicity, socioeconomic status (SES), sexual orientation, age, gender, or other characteristics.

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

- Support organizations that serve and reflect populations most impacted by HIV.
- Prioritize CLAS services through agency-wide plans and commitments of human and financial resources.
- Provide training to service providers to more effectively serve lesbian, gay, bisexual, and transgender people, PWID, people of color, immigrants and refugees, people with disabilities, and others.
- Provide or support translation services.
- Develop materials with attention to the general literacy and health literacy levels of the audience.

Target Population	Responsible Parties	Timeframe	Data Indicators
Staff at organizations	<ul style="list-style-type: none"> • Medical providers • Local health departments • ASO • CBOs • University of Wisconsin HIV Training System 	Strategies developed and reviewed annually	More culturally responsive services process data on: <ul style="list-style-type: none"> • Agency plans to enhance CLAS • Human and financial resources allocated • Number trained

³⁴ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV prevention with adults and adolescents with HIV in the United States, 2014. December 11, 2014. Available from: <http://stacks.cdc.gov/view/cdc/26062>

Strategy 5: Diversification of the Workforce

Diversity in the HIV workforce is important for several reasons. Individuals from underrepresented populations and members of populations disproportionately affected by HIV are more likely to serve their own populations, thereby increasing access to services for these populations.³⁵ Greater diversity in the workforce should increase trust in the health and human service delivery systems and increase utilization of services. Opportunities for members of populations disproportionately affected by HIV to see a service provider from their own community should improve the quality of communication, comfort level, partnership, and decision making in patient/client-provider relationships. Service providers from racial and ethnic minority and socioeconomically disadvantaged backgrounds are more likely to provide leadership and advocacy for policies and programs aimed at improving services for vulnerable populations, thereby increasing access and quality, and ultimately health outcomes.

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

- Support opportunities for hiring, retention, capacity-building, and advancement of staff who are members of populations disproportionately affected and infected by HIV to ensure that decision-makers increasingly represent those most burdened by the disease.
- Support organizations to develop of workforce plans and track hiring, retention, and promotion of staff with attention to representation in populations affected and infected by HIV.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • YBMSM • Transgender women • PWID • PLWH 	CBOs	Strategies developed and reviewed annually.	<ul style="list-style-type: none"> • Organizations’ workforce development plans • Number of staff/volunteers enrolled in specific capacity-building efforts • Number hired/promoted

Strategy 6: Wrap-around Services and Improved Collaboration Among Organizations

Wrap-around services are non-clinical services that contribute to the success of HIV treatment by providing critical resources for PLWH and their families. Examples of these support services include housing, legal assistance, food, transportation, post-incarceration needs, employment assistance, education and training, and counseling and referral for needed services. Because no single organization can meet every client’s needs, it is critically important that organizations collaborate to facilitate referrals for these services.

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

- Build strong collaborative relationships among community agencies providing wrap-around services for PLWH.

³⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. The rationale for diversity in the health professions: a review of the evidence. October 2006. Available from: <http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf>

- *Establish formal interagency referral arrangements between service providers of HIV and wrap-around services.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • YBMSM • Transgender women • PWID • PLWH 	CBOs and others serving these populations	Strategies developed and reviewed annually	Improved referral networks

LEVEL 3: COMMUNITY

The definition regarding who and/or what constitutes a “community” varies based on the context but generally includes network ties, relationships between organizations and groups, and geographical/political regions.³⁶ It can be thought of as a network of networks. For the purpose of this document, community includes both informal and formal entities that interface with members of populations that experience health disparities, including families and neighborhoods, as well as broader and virtual communities. Examples of community entities include:

- For MSM of diverse backgrounds, virtual communities connected by social media and apps.
- For Black MSM, the house and ball community, with both local and national infrastructure.

Strategy 7: Enhanced Community Sensitivity and Responsiveness

Enhancing community sensitivity and responsiveness involves the use of community-level interventions that yield long-term community outcomes. Community interventions examine and respond to complex social, political, and cultural contexts within communities and, by their nature, focus on the social determinants of health of communities. This type of intervention requires close collaboration and committed partnerships across multiple sectors and active engagement of community members. An intervention that is focused on increasing community awareness, sensitivity, and responsiveness typically utilizes a variety of print and electronic media, including use of social media and public awareness campaigns.

Activity 7A: Support and enhance collaborative efforts among community partners.

- *Change conditions and behaviors that bear upon HIV-related disparities. Examples include: adverse childhood experiences, age of sexual debut, number of partners, cross-generational partnering, inequalities and violence based on gender, intimate partner violence, stigma based on gender identity and gender presentation, and disclosure of sexual orientation and HIV status.*
- *Engage the HIV community, including people at risk for and living with HIV, service providers, researchers, decision-makers, faith community leaders, and others, in developing the strategy and tracking progress.*

³⁶ Baral S, Logie CH, Grosso A, Wirtz A, Beyrer C. BioMed Central [Internet] (2013). Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. Available from: <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-482>.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • LGBT people • PWID • PLWH (particularly in communities of color and rural areas)	CBOs and others serving these populations	Strategies developed and reviewed annually	Track initiatives designed to address stigma <ul style="list-style-type: none"> • Focus areas • Media • Reach

LEVEL 4: HEALTH POLICY AND LEGISLATION

Laws and policies of any state provide the general framework for shaping the risk of marginalized populations as well as the general population. These policies and their financing and implementation either promote or decrease the community’s ability to provide preventive or harm reduction services.³⁷

Strategy 8: Public Policy Leadership by Community Partners

High-quality and effective HIV treatment and prevention interventions are important but also need to be supplemented by community leadership and political support in order to be sustained. “Communities directly affected by HIV offer a unique expertise and understanding in developing services to meet the needs of people seeking out and utilizing HIV treatment, prevention and support services.”³⁸ These communities serve important advocacy and leadership roles by partnering with local human service delivery systems and other community leaders, including leaders in municipal, state, and national government and those in political arenas.

Leadership in monitoring and supporting public policy and legislative initiatives involving public health is critically important in effecting positive change within disproportionately affected communities. Legislation relevant to members of affected communities includes syringe services programs and medication-assisted treatment services; opioid legislation; absence of HIV criminalization laws; health care legislation; legal protections for populations facing discrimination; comprehensive sexual health education for school-aged youth; and collection of LGBT data in population-based surveys and electronic health records.

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

Community partners actively collaborate in monitoring, supporting, expanding, and amending public policy to ensure the public health of communities disproportionately affected by HIV.

³⁷ Baral S, Logie CH, Grosso A, Wirtz A, Beyrer C. BioMed Central [Internet] (2013). Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. Available from: <http://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-13-482>.

³⁸ Barr D, Odetoyinbo M, Mworeko L, Greenberg J. The leadership of communities in HIV service delivery. AIDS. 2015 July;29 Suppl 2:S121-7.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none">• LGBT people• PWID• PLWH	<ul style="list-style-type: none">• Community partners serve as advocates• Policy makers	Strategies developed and reviewed annually.	Track policy initiatives that affected these populations

GOAL 4: ACHIEVE 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, and community-based organizations, health care providers, local public health departments).

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

See Appendix I for the rationale and assumptions associated with Objectives 4.1 and 4.2.

Strategy 1: Community Planning

Community planning is important to the development and implementation of HIV care and prevention services. It provides a forum to assess need, develop priorities, and engage affected communities. Wisconsin has a long history of combined HIV care and prevention planning. The Wisconsin Statewide Action Planning Group (SAPG) has 25 to 30 ambassadors, chosen through a competitive application and selection process, to facilitate communication in the regions of the state, participate in developing a joint HIV prevention and care services plan, and advise the AIDS/HIV Program on the development, implementation, and prioritization of HIV prevention and care services in Wisconsin.

Activity 1A: Statewide Action Planning Group (SAPG)

- *Create a venue to actively encourage community engagement and input for the planning, prioritizing, and implementation of HIV prevention and care services.*
- *Monitor and promote the allocation of public funding to ensure that it aligns with the geographic distribution of the epidemic, focuses on high-risk populations, and utilizes a combination of effective evidence-based interventions.*
- *Supports submission and oversight of the Integrated HIV Plan through a concurrent process.*
- *Provides a forum for the presentation of information and progress related to the Integrated HIV Plan (listening to and obtaining feedback from clients and populations at risk), and reports back to the state and community on the progress of the Integrated HIV Plan.*
- *Provides an opportunity to enhance the knowledge and leadership capacity of SAPG members, enabling them to better serve their communities and agencies.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • SAPG • Community stakeholders • Contracted agencies 	<ul style="list-style-type: none"> • SAPG members • AIDS/HIV Program • Wisconsin HIV/AIDS Outreach Project 	Reviewed annually	<ul style="list-style-type: none"> • Annually update Integrated HIV Plan • Letter of Concurrence • Funding allocation plans

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

- Improve infrastructure and AIDS/HIV Program capacity to better integrate the planning of HIV prevention and care, STI, TB, and HCV services in Wisconsin.
- Integrate community and stakeholder planning efforts with planning efforts of the AIDS/HIV Program.
- Actively develop opportunities to integrate HIV planning information and tools into other state and community planning activities (WI-HIPP, State Council on Alcohol and other Drug Abuse and others).

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • SAPG • Community stakeholders • Contracted agencies 	<ul style="list-style-type: none"> • Contracted agencies • AIDS/HIV Program 	<ul style="list-style-type: none"> • Over five-year period, ongoing • Annual plan assessment 	<ul style="list-style-type: none"> • Integrated HIV Plan • Interface with other state and local plans

Strategy 2: Community Leadership and Capacity Building

Building capacity and developing leadership in communities that are marginalized and disproportionately affected by HIV is critical to reducing disparities in HIV, STIs, and HCV. Communities include gay and bisexual men, particularly gay and bisexual men in rural areas and men of color, transgender women, PWID, communities of color, tribal communities, and others.

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

- Work with stakeholders and partners who work directly with disproportionately affected communities and regularly seek their input. Solicit and encourage ideas for community collaborations that can provide opportunities for community members to assume leadership roles.
- Provide data, documents, and other tools related to HIV prevention and access to care to community leaders to share within their communities.
- Support community leaders in sharing information in their own communities to build awareness about HIV, STIs, HCV and in striving to foster positive social norms and health outcomes.
- Incorporate opinion leader concepts into program evaluation and SAPG member recruitment.
- Share leadership development opportunities including group meetings, training, and webinars with emerging leaders in communities affected by HIV.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • Staff and community leaders (especially in tribal communities and Milwaukee) • Faith community leaders 	<ul style="list-style-type: none"> • SAPG • AIDS/HIV Program • Contracted Agencies 	<ul style="list-style-type: none"> • Review annually 	<ul style="list-style-type: none"> • Trainings conducted • Training curricula developed • Events led by community leaders

Strategy 3: Workforce Development

A well-trained, culturally diverse workforce is critical to the planning, implementation, and evaluation of high-quality HIV care and prevention services. Collaboration with the state’s technical schools, undergraduate institutions, and schools of public health to recruit and train public health, community providers, and a health care workforce that is diverse in racial and cultural backgrounds is critical.

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

- *Target trainings for staff, volunteers, supervisors, and peers on cultural responsiveness and self-reflection. When possible, use existing training opportunities to cross-train staff on prevention and care.*
- *Provide training on culturally and linguistically appropriate services (CLAS) and provide skill building opportunities for SAPG members, HIV care and prevention services providers and management staff, and allied community stakeholders.*
- *Develop and support continuing education opportunities for HIV care and prevention line and management staff in community-based agencies.*
- *Include principles of TIC and CLAS into training programs.*
- *Conduct trainings for AIDS/HIV Program staff on cultural responsiveness.*
- *Integrate staff training plans into agency quality assurance and quality improvement plans.*
- *Encourage funded providers to prioritize staff training and leadership development in their agency work plans.*
- *Provide training to prepare staff to implement emerging activities, including follow-up with individual clients under Data to Impact activities, comprehensive HIV prevention/wellness approaches for gay and bisexual men, injection drug user health, and social determinants of health.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • SAPG • Community stakeholders • Contracted agencies 	<ul style="list-style-type: none"> • Contracted agencies • AIDS/HIV Program • University of Wisconsin HIV Training System 	Review annually	<ul style="list-style-type: none"> • Training materials • Course curricula • Agency work plans

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

- *Support opportunities for hiring, retention, capacity-building, and advancement of staff who are members of populations disproportionately affected by HIV to ensure that decision-makers increasingly represent those most burdened by the disease.*
- *Support organizations to develop workforce plans and track hiring, retention, and promotion of staff with attention to representation of populations affected by HIV.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • MSM • YBMSM • Transgender women • PWID • PLWH 	ARCS and CBOs	Strategies developed and reviewed annually	<ul style="list-style-type: none"> • Organizations' workforce development plans • Number of staff/volunteers enrolled in specific capacity-building efforts • Number hired/promoted

Strategy 4: Accountability

A strong program, project monitoring, and data infrastructure are necessary to ensure that agencies are able to implement programs, document program outcomes, and disseminate program successes. Tracking the progress of the Integrated HIV Plan over time through performance measurement provides an opportunity to assess and improve on practices, processes, activities, and systems. Monitoring and reporting systems should be developed that provide feedback and data reports and they should be provided to partners for implementing program improvement. Monitoring and reporting systems should be accessible and transparent.

Activity 4A: Make program data accessible and available.

- Ensure that program, surveillance, and health disparity resource data are captured, summarized, and disseminated to federal, state, and community partners.
- Ensure that resource allocation is data-driven and based on the strategies of the Integrated HIV Plan and SAPG recommendations.
- Modernize data systems and ensure interoperability so that data systems can exchange information and work together to achieve desired data analysis outcomes (e.g., WEDSS, eHARS, STI data)

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • Community stakeholders • Contracted agencies 	<ul style="list-style-type: none"> • AIDS/HIV Program • Contracted Agencies 	<ul style="list-style-type: none"> • Over five-year period, ongoing • Data are analyzed yearly 	Data reports analyzed and disseminated

Activity 4B: Provide regular reporting on strategy goals.

- Develop a system of contract monitoring that demonstrates the progress in meeting the Integrated HIV Plan goals and objectives.
- Ensure that agencies improve contract monitoring systems including site visits and the State's "reporting back" to funded agencies.
- Ensure that funded agencies have evaluation, quality assurance, and quality improvement plans as part of their overall work plans (client satisfaction surveys, needs assessments, community advisory boards).
- Provide training and technical assistance to funded agencies and contracted agencies on the use of epidemiologic and program data to improve program evaluation.

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> Community stakeholders Contracted agencies Federal funders State funders 	<ul style="list-style-type: none"> AIDS/HIV Program SAPG Contracted Agencies 	<ul style="list-style-type: none"> Over five-year period, ongoing Annual performance assessments 	<ul style="list-style-type: none"> Quality assurance and quality improvement plans developed. Training and technical assistance plans developed. Updates provided to decision makers. Client satisfaction surveys.

Strategy 5: Program Integration

Program integration is focused on ensuring coordination of services and close collaboration among providers and in planning processes. Program collaboration is directed at organizing and blending interrelated health issues, activities, and prevention and care strategies to facilitate comprehensive delivery of services

Activity 5A: Ensure Coordinated Service Delivery

- *Integrate the coordinated HIV, viral hepatitis, and STI planning and service delivery at the state and local level.*
- *Integrate the HIV, viral hepatitis, and STI surveillance systems.*
- *Develop program guidance and funding requirements to ensure that HIV care and prevention services are coordinated at the community/regional level.*
- *Ensure that HIV care and prevention programs integrate and address housing, substance abuse, and mental health services as part of their service plans.*
- *Continue the strong collaboration of the AIDS/HIV Program with the Department of Corrections (DOC), Department of Public Instruction (DPI), Medicaid, the Wisconsin State Laboratory of Hygiene (WSLH), and local public health departments.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> Community stakeholders Contracted agencies Federal funders State funders 	<ul style="list-style-type: none"> AIDS/HIV Program SAPG Contracted agencies STD Program 	<ul style="list-style-type: none"> Over five-year period, ongoing Annual performance assessments 	<ul style="list-style-type: none"> Quality assurance and quality improvement plans developed Training and technical assistance plans developed Client satisfaction surveys

Strategy 6: Research

HIV care and prevention research should be collaborative and include community, state, and academic partners. Research projects should ensure that results, tools, and products are disseminated to affected communities.

Activity 6A: Research that impacts community needs

- *Support research projects that evaluate and improve the performance of HIV care and prevention programs.*

- *Support research projects that are culturally and linguistically appropriate.*
- *Ensure that research projects support the goals and strategies of the Integrated HIV Plan to include:*
 - *Client and community involvement in the planning phase.*
 - *Engagement of community members and funded agencies in the project implementation.*
 - *Feedback to communities on project results.*

Target Population	Responsible Parties	Timeframe	Data Indicators
<ul style="list-style-type: none"> • SAPG • Community stakeholders • Contracted agencies • Academic Research Partners 	<ul style="list-style-type: none"> • AIDS/HIV Program • UW Madison • Medical College of Wisconsin 	Over 5-year period, ongoing	<ul style="list-style-type: none"> • Research protocols • Research reports disseminated. • Tool kits developed

B. Collaborations, Partnerships, and Stakeholder Involvement

Since the very beginning of the epidemic, the AIDS/HIV Program in the Wisconsin Department of Health Services has coordinated Wisconsin’s public health response to HIV. The Program’s approach to the epidemic has emphasized collaboration and coordination among human service providers and disciplines, public and private agencies, individuals and communities at risk for HIV infection, and persons living with HIV infection.

Strong working relationships are maintained with community partners (academic, governmental, and private nonprofit organizations) through ongoing collaborations, consultation and training, as well as financial support of competitive grants and contractual agreements. Collaborative partnerships are established with traditionally funded agencies, state agencies, local health departments, and non-traditional community-based agencies, organizations, and institutions. There is a long history and targeted focus on successful collaborations and support in developing the capacity of ethnic minority and sexual and gender minority groups to respond to the HIV epidemic in their communities.

Community planning includes partnerships as well as community engagement

In Wisconsin, community engagement is a major focus of statewide planning. The [Wisconsin Statewide Action Planning Group](#) (SAPG) is the primary HIV statewide planning body that advises the Wisconsin AIDS/HIV Program on the development, implementation, and prioritization of HIV prevention and care services in Wisconsin. The goal of the Wisconsin HIV community planning process is to plan for a continuum of high-quality and effective HIV/AIDS prevention, care, and treatment services to meet the current and future needs of individuals and communities at risk for HIV infection.

The SAPG comprises 25 to 30 [members](#) who are broadly representative of affected communities and key stakeholders in Wisconsin, characteristic of Wisconsin’s HIV epidemic as it relates to geography, sexual orientation, age, gender, race/ethnicity, life experiences, and HIV status. The leadership team of the SAPG is composed of the Community Co-Chair, Health

Department Co-Chair, and Community Co-Chair Elect. SAPG members are chosen by the membership through a competitive application and selection process. The SAPG meets for day-long meetings five times per year to provide input to the AIDS/HIV Program. SAPG members also facilitate communication and expanded engagement throughout the state.

Meetings of the SAPG in 2015 and 2016 have been a major venue for facilitating stakeholder and community member involvement in the development of the Integrated HIV Plan. In preparing for this activity, AIDS/HIV Program internal workgroups developed draft materials for review and discussion by the SAPG. Internal AIDS/HIV Program workgroups were formed based on the key components of an integrated HIV plan as identified in federal guidance materials.

In June 2015, SAPG members were briefed on the then recently released federal guidance for the Integrated HIV Plan and Statewide Coordinated Statement of Need for CY 2017-2021. At that time, members were also informed about initial plans for conducting a statewide HIV needs assessment. Subsequent SAPG meetings in 2015 and 2016 were focused on presentations and facilitated group discussions regarding HIV prevention and care services and activities in Wisconsin—services and activities that related to the four major goals of the National HIV/AIDS Strategy and which were focus areas for the development of Wisconsin’s Integrated HIV Plan. During SAPG group discussions, content experts and others familiar with HIV prevention and care services in Wisconsin gave brief overviews of related services and activities. This was followed by group discussions facilitated by Wisconsin AIDS/HIV Program staff who posed general questions to the groups to help frame discussions. Summaries of the group discussions were recorded and posted on the Wisconsin HIV Outreach Project website for SAPG members’ review and comment. Group discussions and feedback from SAPG members helped shape and inform the development of objectives and priorities for the Wisconsin Integrated HIV Plan 2017-2021.

The AIDS/HIV Program facilitates engagement and collaborative planning with agencies funded under Parts B, C, D, and F of the federal Ryan White HIV/AIDS Program. Wisconsin does not receive Part A funding. All Wisconsin providers who receive Ryan White funding other than Part B also receive Part B funding. Engagement of these providers occurs through contractual working relationships, membership and invitational participation in SAPG meetings, and through periodic grantee meetings and trainings supported by the AIDS/HIV Program. All Wisconsin Ryan White grantees have been actively involved in the development of the Integrated HIV Plan through participation in needs assessment and input and review of the Integrated HIV Plan.

Need for expanded collaboration and partnerships

Expanded collaborations and partnerships are needed among individuals and agencies not yet fully engaged in HIV community planning, including stakeholders, health and human service providers, and others, in the following areas:

- Health care providers, particularly those in the private sector, who are needed to play a more active role in ensuring access to a continuum of HIV services and promoting critically important prevention services such as HIV testing and PrEP.

- Blood and plasma centers conducting HIV testing.
- Service providers from the identified needs and service gaps in the areas of housing, transportation, mental health, peer psychosocial support, and hepatitis C prevention and treatment.

To better address the major gap in housing for PWLH, the AIDS/HIV Program will foster partnerships with non-HIV service stakeholders who provide housing assistance and advocacy.

Table 9 at the end of Section C highlights and summarizes HIV-related community engagement and collaborative partnership activities in Wisconsin.

The following letter of concurrence from the SAPG is in response to the requirement of the CDC and HRSA for a letter of concurrence from the co-chairs of the planning body and the health department.

Scott Walker
Governor



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The Statewide Action Planning Group (SAPG), Wisconsin's HIV prevention and care planning body, concurs with the following submission by the Wisconsin Department of Health Services in response to the guidance set forth for health departments and HIV planning groups funded by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

The SAPG has reviewed the Wisconsin Integrated HIV Prevention and Care Plan 2017-2021 to verify that it describes how programmatic activities and resources are allocated to the most disproportionately affected populations and geographical areas bearing the greatest burden of HIV disease. The SAPG concurs that this Plan fulfills the requirements of the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The SAPG collaborated closely with the Wisconsin AIDS/HIV Program in developing the Integrated HIV Plan. Meetings of the SAPG were a major venue for facilitating stakeholder and community member involvement. During SAPG meetings in 2015 and 2016, content experts and others familiar with HIV prevention and care services in Wisconsin gave overviews of related services and activities. Group discussions and feedback from SAPG members, as well as their involvement in needs assessments, helped shape and inform the objectives and priorities for the Wisconsin 2017-2021 Integrated Plan.

The signatures below confirm the concurrence of the planning body with the Wisconsin Integrated HIV Prevention and Care Plan 2017-2021.

Handwritten signature of Daniel Ross in black ink.

Daniel Ross
Statewide Action Planning Group
Community Co-Chair

Handwritten signature of James M. Vergeront, MD in black ink.

James M. Vergeront, MD
Statewide Action Planning Group
Health Department Co-Chair

C. People Living with HIV and Community Engagement

Community engagement is a concept that was endorsed and set in motion by PLWH early in the course of the HIV epidemic. The *Denver Principles*, a declaration of PLWH self-empowerment from the early 1980s, asserted that *people are first and their health condition second*. The declaration called for PLWH to be actively engaged in setting their agendas, planning their own strategies, to be equal participants in public forums, and to being represented and involved with decision-making bodies of service provider organizations.

In Wisconsin, community engagement is both a process and a guiding principle of public health. It involves the active participation of community members and stakeholders in identifying needs, planning and prioritizing resources to meet needs, and taking action to improve health outcomes. As a guiding principle, community engagement is a commitment and belief that community involvement is essential in identifying health disparities and in implementing interventions that are directed at ensuring health equity. Community engagement is built on trust and respect between community members and stakeholders. It involves a commitment from service providers and other stakeholders to engage community members in ongoing dialogues, deliberate and active listening, participation in decision-making, and engagement in implementing interventions.

Community engagement through community planning

The Statewide Action Planning Group, as noted in more detail in the previous section of this Integrated HIV Plan, promotes consumer engagement and provides a forum for community members and partners, including PLWH, to exchange information and ideas and provide input on the development and delivery of HIV prevention and care services.

Development of the Integrated HIV Plan was a major focus of SAPG meetings and deliberations in 2015 and 2016. Group discussions and feedback from SAPG members helped shape and inform the development of objectives and priorities for the Integrated HIV Plan. Staff at the AIDS/HIV Program directly disseminated updates about development of the Integrated HIV Plan to local consumer advisory groups comprising consumers at Ryan White-funded agencies.

Based on the membership configuration of the SAPG for 2016 and anticipated membership changes in the near future, SAPG membership would be enhanced and further reflect the HIV epidemic in Wisconsin when future recruiting of SAPG members focuses on the following groups:

- People with HIV infection who are not linked to or who are out of medical care.
- People with HIV who live in areas that are less resource rich.
- People and communities at risk of acquiring HIV.
- Community members and service providers not part of the planning process, specifically:

- Native Americans
- Asian/Pacific Islanders
- Latinos
- Youth
- Seniors
- Transgender persons
- Persons who inject drugs (PWID)
- MSM/PWID

Community engagement through needs assessment

Community member engagement was a central part of statewide needs assessment activities in 2015 and in preparing for the development of the Integrated HIV Plan. The Wisconsin AIDS/HIV Program collected information examining the needs of clients and the gaps and barriers they face when accessing HIV prevention and care services. Information was collected through qualitative interviews with clients and key informants.

Community engagement through the Wisconsin Minority Health HIV Partnership Initiative

Community engagement is the major focus of the Wisconsin Minority Health HIV Partnership Initiative, a collaborative partnership between the Wisconsin Minority Health Program and the Wisconsin AIDS/HIV Program. This initiative is directed at increasing knowledge of serostatus among Black, Latino, and Native American people who are HIV positive in the Milwaukee metropolitan area. Community engagement is focused on increasing:

- The number of currently HIV-positive Black, Latino, and Native American individuals who are aware of their HIV status and/or are actively participating in adequate medical care.
- The number of people among target populations (Black, Latino, and Native American) reached through awareness events around HIV and related topics during the project period.
- The availability of culturally and linguistically appropriate services for minority populations at risk for HIV provided by local clinical, community health, and support organizations during the project period.

Community forums as a continuing commitment to community engagement

PLWH need venues to have a voice in strategic planning beyond SAPG and to ensure that the AIDS/HIV Program and key stakeholders have an accurate assessment of resource gaps and needs across the state. To address this, the AIDS/HIV Program will partner with ASO and CBO staff and PLWH to organize ad hoc client forums at least twice annually in various regions of the state.

The following table highlights HIV-related community engagement and collaborative partnership activities in Wisconsin.

Table 9. Wisconsin AIDS/HIV Supported Partnerships and Community Engagement		
Focus	Participants and Purpose	Frequency and Location
Statewide Action Planning Group (SAPG)	HIV consumers and providers meet to provide input to the Wisconsin AIDS/HIV Program regarding HIV service needs and gaps.	Five day-long meetings annually, various locations in Wisconsin.
Milwaukee HIV/Black MSM Meetings	HIV service providers, community members, and other stakeholders meet to plan and discuss responses to the epidemic of HIV and STIs in black MSM in Milwaukee.	Periodic meetings, Milwaukee.
Topic-Specific Meetings	Meetings coordinated by the Wisconsin AIDS/HIV Program focus on specific topics including, but not limited to, linkage to care, HIV clusters, social media, grant activities, and coordination of services for YBMSM.	Usually one-time, variety of locations in Wisconsin.
Social Media Workgroup	Meeting of providers and community members to discuss effective messaging and strategize around social media use for HIV prevention and care.	As needed, meet via conference call and communicate via email between calls.
PrEP Workgroup	Meeting of health care providers and community stakeholders to discuss and make decisions on resources, direction, and communication of PrEP access and uptake in Wisconsin.	Bi-monthly meetings in Milwaukee and Madison and through conference calls.
Milwaukee PrideFest HIV Testing Workgroup	Meeting of providers and stakeholders to share data on and make decisions related to planning and implementing HIV testing at PrideFest in Milwaukee.	Meets monthly from January-June in Milwaukee.
Needs Assessment	Formal assessment of needs, gaps, and barriers related to HIV prevention and care services.	As required by Ryan White funding.
Regional Provider Group Meetings	Discussions are facilitated among HIV prevention and care service providers to foster collaboration and service coordination.	Bi-annually in Appleton, La Crosse, and Madison. Annually in northern Wisconsin.
Milwaukee Community-Based Organization (CBO) Meetings	HIV prevention service providers working at CBOs meet for capacity building and to share activities.	Bi-monthly, variety of locations in Milwaukee.
Tribal AIDS Coordinators Meetings	Tribal AIDS coordinators meet to foster capacity building and share resources and activities.	Quarterly, variety of tribal community settings.
HIV Case Managers/Linkage to Care Meetings	HIV case managers and linkage to care specialists meet for training, and to foster collaboration, coordination, and capacity building.	Semi-annual/annual meetings in various locations in Wisconsin.
HIV PS Meetings	HIV PS providers meet for capacity building, training, and to foster coordination.	Annually in two locations in Wisconsin.
HIV Treeters Meetings	HIV clinicians and case managers meet through the Midwest AIDS Training and Education Center to review and discuss case presentations and evaluate clinical best practices.	Bimonthly via videoconferencing.
Quality Collaborative	Representatives of Ryan White-funded agencies meet to focus on improving delivery of services and client outcomes.	Quarterly in various locations.
Research	Academic partners are supported to conduct qualitative needs assessments and research that engage community members.	Periodic
AIDS/HIV Awareness Days	Local agencies are supported to provide community engagement activities in observance of AIDS/HIV Awareness Days.	Events supported and held in Milwaukee, Madison and other locations around the state.

Table 9. Wisconsin AIDS/HIV Supported Partnerships and Community Engagement		
Focus	Participants and Purpose	Frequency and Location
Correctional Health Interagency Collaboration Meetings	Staff from the Wisconsin Department of Corrections, State Laboratory of Hygiene, University of Wisconsin Population Health, and Wisconsin AIDS/HIV Program collaborate in planning and implementing HIV and hepatitis C services in Wisconsin correctional settings.	Quarterly, held in Madison at the Department of Corrections.
Resource Inventory and Capacity Building	The AIDS/HIV Program inventories HIV-related resources and needs and supports capacity building of local agencies to address priority needs.	Ongoing.
Community Partnership Teams (CPT)	Representatives of CBOs meet with the City of Milwaukee Health Department and AIDS/HIV Program to discuss updates in STI and HIV rates in Milwaukee, share upcoming events, and strategize around HIV and STI prevention.	Quarterly in Milwaukee.
Consumer and Community Advisory Boards (CABs) and Client Forums	HIV service agencies host CABs and community forums to solicit feedback and advice on agency services, and to provide forums for client education and support.	As determined by local agency service providers.
Focus Groups	Agencies hold focus groups on various topics throughout the year, including focus groups required by some funding sources	As needed
Social Media	HIV service agencies with social media platforms such as Facebook and Twitter are able to obtain feedback from community members and share information.	N/A
Research	Academic centers conduct qualitative assessments and research involving engagement of community members.	Periodic
AIDS/HIV Awareness Days	Local agencies conduct community engagement activities in observance of AIDS/HIV awareness days.	Periodic
Statewide and regional conferences	Academic centers and private nonprofit agencies sponsor HIV-related educational conferences that engage community members.	Annual
Statewide Action Planning Group (SAPG)	SAPG members will be briefed throughout the year about ongoing implementation of the Integrated HIV Plan and through a more formal mid-year update.	Ongoing and July 2017
Partners and Stakeholders	AIDS/HIV Program partners, public and private health care providers, and other interested parties will receive a mid-year progress report through the electronic publication <i>Wisconsin AIDS/HIV Program Notes</i> .	July 2017
Wisconsin AIDS/HIV Program Grantees	Contract monitors will conduct site visits and maintain ongoing communication to assess and report on grantee progress in meeting relevant objectives of the Integrated HIV Plan.	Ongoing
Partners and other Service Providers	Updates on progress in meeting relevant objectives of the Integrated HIV Plan will be included in annual meetings of service providers and at educational and training activities supported by the AIDS/HIV Program.	Ongoing

Table 9. Wisconsin AIDS/HIV Supported Partnerships and Community Engagement		
Focus	Participants and Purpose	Frequency and Location
Consumer and Community Advisory Boards (CABs) and Ad Hoc Client Forums	Updates on progress in meeting objectives of the Integrated HIV Plan will be shared with CABs and community forums to solicit feedback and reflect on unmet needs and gaps in service.	Annually

SECTION III: MONITORING AND OUTCOME IMPROVEMENT

Monitoring and evaluation are the management tools that reflect an ongoing commitment to the improvement of public health. They involve the assessment of policies, staff, and services to determine if they are aligned with quality standards and whether they are achieving their desired results. Program monitoring and evaluation of health outcomes involve the periodic and systematic collection and analysis of information in order to assist stakeholders and service providers to:

- Better understand the outcomes of program initiatives.
- Improve program effectiveness.
- Make decisions about current and future program priorities.

Ultimately, monitoring and evaluation activities undertaken as an integral part of the Integrated HIV Plan are directed at:

- Ensuring and improving the health outcomes of PLWH.
- Decreasing health disparities of people and communities disproportionately affected by HIV.
- Ensuring that prevention efforts are effective in promoting the health and wellbeing of people at risk for HIV as well as the general population.

The implementation of the Integrated HIV Plan and progress toward the Plan's outcomes will be evaluated both quantitatively and qualitatively. Quantitative evaluation will consist of annual measurement of the plan objectives and key data indicators described in each section of the Plan. Qualitative input will be obtained both formally and informally as described below. These data will provide information on the status of the Plan's implementation, identify areas that need modification, and identify targets for additional or future efforts not described in the current Plan.

A. QUANTITATIVE EVALUATION

1. Plan Objectives

Each year, progress toward the overall plan objectives will be measured using the data and methods described for each objective. The plan objectives were designed to be consistent with those of the National HIV/AIDS Strategy and to provide a benchmark for the overall implementation of the plan's strategies and activities. At the end of each year, a progress report will be drafted that documents the annual progress toward each objective and a brief narrative about each measure. The progress report will be disseminated as follows:

- **Statewide Action Planning Group (SAPG)**
The annual progress report will be presented at one of the five SAPG meetings held each year around the state. In addition to presenting the report, small groups will discuss implementation of the plan's activities, successes, and opportunities for improvement. This feedback will be documented and will be used by the AIDS/HIV Program staff to modify the plan's activities as necessary.
- **AIDS/HIV Program Notes**
The annual progress will be summarized and disseminated via the Wisconsin AIDS/HIV Program Notes, which is an electronic communication that periodically highlights select

aspects of the HIV epidemic and the delivery of prevention, care, and treatment services in Wisconsin. Program Notes is sent to over 1,000 stakeholders statewide.

- **Grantee Site Visits**

Progress on the plan's objectives and activities will be discussed with funded grantees during annual site visits. Grantees funded through the Centers for Disease Control and Prevention and the Health Resources and Services Administration play key roles in implementing the Plan's activities, and therefore their progress will be evaluated and discussed during site visits.

- **Miscellaneous Meetings**

Progress toward specific objectives will be discussed at relevant meetings during the year, for example, annual community-wide meetings in Milwaukee, Community Partnership Team (CPT) meetings, and Ryan White Quality Collaborative meetings.

2. Activity Indicators

In addition to the overall plan objectives, each of the proposed strategies and activities within the plan is associated with indicators, which can be used to document progress toward meeting the objectives of the plan. Many of the indicators are process measures and therefore may more directly reflect the actual implementation of the plan's activities. These indicators will play a critical role in documenting successes, as significant progress may be made without observing statewide improvement in the overall plan objectives.

Select indicators that best describe the work that has been done to implement the plan's activities will be included in the annual progress report and disseminated as described above. The other indicators will be monitored at least semiannually and will be discussed at internal care and prevention meetings, monthly staff meetings, during relevant trainings with stakeholders, and with grantees during site visits or other meetings.

3. HIV Care Continuum

The HIV care continuum is also a direct indicator of the success of the plan's implementation and the status of HIV care in Wisconsin. Wisconsin's HIV care continuum is updated annually and is included in the annual HIV surveillance summary, the five-year epidemiology profile, and a dedicated AIDS/HIV Program Notes issue. The HIV care continuum is also included during most presentations about the status of HIV care in Wisconsin. In addition to the statewide continuum, the Program Notes also describe the continuum for various subgroups, for the Ryan White population, and for the state over time. In the future, the Program Notes may also describe the continuum for Wisconsin Medicaid recipients. The HIV care continuum data will be used to evaluate progress made overall, but especially progress in improving access to care and health outcomes, and reducing health disparities.

4. Surveillance Reports

Each year, surveillance reports are developed for HIV, hepatitis C, and STIs. These reports will be used to evaluate both implementation of the plan and progress toward the overall plan objectives. These reports will continue to be used to develop new strategies, policies, and plans, especially as they relate to the overall goals and objectives of the Wisconsin Integrated HIV Plan.

5. Other Data Sources

The data sources described in *Section E. Data Access, Sources, and Systems* are routinely used by the HIV, STD, and HCV program to evaluate and monitor trends, identify populations disproportionately affected, identify health disparities, and monitor and evaluate the implementation of improvement initiatives. These data sources will continue to be used to regularly assess progress toward the HIV prevention and care activities outlined in the Plan.

B. QUALITATIVE EVALUATION

Qualitative input will be obtained during SAPG meetings, grantee site visits, monthly AIDS/HIV Program staff meetings, and other routine meetings with stakeholders, as described above. SAPG and CPT meetings continue to be the venue during which feedback is most often obtained by members of the affected populations.

C. STRATEGY FOR USING DATA TO ASSESS AND IMPROVE HEALTH OUTCOMES

As noted above, surveillance and other programmatic data will be utilized in assessing progress in improving health outcomes along the HIV Care Continuum. This will include the utilization of annual surveillance reports developed for HIV, hepatitis C, and sexually transmitted infections. The multiple data sources described in *Section E. Data Access, Sources, and Systems* are routinely used to evaluate and monitor epidemiologic and programmatic trends. The analyses of these data sources and reports will inform short- and long-term strategic planning and the allocation of resources to impact the quality of the HIV service delivery system in Wisconsin and to assess and improve health outcomes that are aligned with the goals and objectives of the Integrated HIV Plan.

Appendices

Appendix I

Integrated HIV Plan Objectives: Rationale, Measurements, Assumptions

OBJECTIVE 1.1

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

WISCONSIN HIV/AIDS STRATEGY GOAL

Reducing new HIV Infections

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective focuses on “increasing serostatus awareness among persons living with HIV infection (PLWH), as this awareness (i.e., being diagnosed with HIV infection) is necessary to access HIV medical care and support services. In addition, analyses suggest that people unaware of their HIV infection may account for about one third of new infections, so increasing knowledge of serostatus is central to reducing new infections as well as improving health outcomes.”¹ Nationally, the Centers for Disease Control and Prevention (CDC) estimates that 87.2% of PLWH are aware of their infection.² Undiagnosed HIV is particularly an issue among the younger population. The percent of PLWH with diagnosed HIV among persons aged 13-24 is only 55.8%.² In Wisconsin, CDC estimates that 84.7% of PLWH in the state are aware of their infection as of 2012—lower than the national average.³

BASELINE YEAR

2010

NUMERATOR

Number of persons ages ≥ 13 years at diagnosis with diagnosed HIV infection at the end of the calendar year.

DENOMINATOR

Estimated number of persons ages ≥ 13 years with HIV infection (diagnosed or undiagnosed) at the end of the calendar year.

DATA SOURCE

National HIV Surveillance System

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015). Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

² Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveillance Supplemental Report* 2015;20(No. 2). <http://www.cdc.gov/hiv/library/reports/surveillance/>. Published July 2015. Accessed [13 Nov, 2015].

³ Hall IH, An Q, Tang T., *et al.* Prevalence of diagnosed and undiagnosed HIV infection—United States, 2008-2012. (2015) *MMWR*:64(24):657-662. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6424a2.htm>

DATA AVAILABILITY

Data on the estimated percent of people with undiagnosed HIV are not calculated locally, but rather are calculated for each state by the CDC. For this indicator, Wisconsin will use the data released annually by the CDC.

POPULATION COVERAGE

Includes entire state of Wisconsin. Estimates are for persons aged ≥ 13 years at diagnosis.

DATA SOURCE LIMITATIONS

Data are estimates, based on diagnoses, severity of disease at diagnoses, and deaths, and are statistically adjusted for incomplete reporting, reporting delays, and missing transmission risk.

ANNUAL TARGETS

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
83.9%	84.3%	84.7%	85.7%	86.3%	86.8%	87.5%	88.1%	88.6%	89.2%	90%

REFERENCES AND RELATED MATERIALS

An HIV surveillance supplemental report including these data is released annually; data from prior years may be updated. Surveillance supplemental reports are available on the web at <http://www.cdc.gov/hiv/library/reports/surveillance/>.

OBJECTIVE 1.2

Reduce the number of new diagnoses by at least 25% by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Reducing new HIV Infections

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective focuses on reducing new infections. Per the National Strategy, “The 25% reduction in diagnoses is an ambitious target because it requires and encompasses improvement in all other indicators and in overall prevention, treatment, and care efforts.”

BASELINE YEAR

2010

NUMERATOR

The three-year average of the number of HIV diagnoses among persons of all ages during the calendar year and two preceding years reported to the Wisconsin HIV Surveillance Program. For example, the year 2020 number will be an average of the number of HIV diagnosis in 2020, 2019, and 2018.

DENOMINATOR

None

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program. During the annual release, past years’ data are also updated.

DATA SOURCE LIMITATIONS

HIV diagnosis data may not be representative of all PLWH because not all infected persons have been tested. Anonymous tests, though rare in Wisconsin, are also not reported.

ANNUAL TARGETS

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
253*	246*	222*	250*	223*	225	220	214	209	203	197

*actual value

REFERENCES AND RELATED MATERIALS

An HIV surveillance report including new diagnoses data is released annually and available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/data.htm>. The number of diagnoses will continue to be updated over time and reflected in subsequent surveillance review updates and Wisconsin HIV Integrated Plan updates.

NOTES

As noted in the National Strategy, “Using diagnosis data to track progress in reducing new HIV infections has some challenges. First, these data must be interpreted with consideration for trends in HIV testing, as changes in testing can lead to changes in diagnosis trends that are not related to trends in new infections. For example, if HIV diagnoses decrease, evaluation is required to determine whether this decrease is due to fewer HIV tests being conducted or HIV tests being performed on persons at lower risk, versus an indication of a decline in new HIV infections. Second, efforts to increase the percentage of PLWH who know their HIV status require an increase in diagnoses—meaning that, at least initially, achieving progress toward Objective 1 may have a negative impact on progress toward Objective 2. Over the longer term, diagnosing individuals who were previously undiagnosed will ultimately result in increased linkage to and retention in care and treatment, increased viral suppression, and decreased transmission to uninfected partners. This will reduce new infections, which will be reflected in a decrease in the number of new diagnoses.”¹

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (July 2016). Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf

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 percent by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Increasing access to care and improving health outcomes for people living with HIV

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective focuses on the benefits of rapid linkage into HIV medical care to both individuals—better health outcomes—and populations—lower community viral load, particularly immediately after infection when viral loads are highest.¹ Nationally, CDC estimates that 72.6% of persons newly diagnosed with HIV were linked to HIV medical care within one month.² In Wisconsin, 68% of people newly diagnosed with HIV infection during 2014 were linked within one month.

BASELINE YEAR

2012

NUMERATOR

Number of persons newly diagnosed with HIV infection during the calendar year that were linked to care within one month of their diagnosis date as measured by a documented test result for a CD4 count, viral load, or HIV genotype. Laboratory results collected on the date of diagnosis are excluded as they are considered part of the diagnostic workup.

DENOMINATOR

Number of persons newly diagnosed with HIV infection during the calendar year.

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program.

POPULATION COVERAGE

Includes entire state of Wisconsin.

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015). Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

² Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveillance Supplemental Report* 2015;20(No. 2). <http://www.cdc.gov/hiv/library/reports/surveillance/>. Published July 2015. Accessed [2 Feb 2016].

DATA SOURCE LIMITATIONS

HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in June 2011. While the Wisconsin AIDS/HIV Program is unaware of labs in the state currently *not* reporting viral load and CD4 results, it is possible that there are missing data. Prior to 2015, for example, data from the Veteran’s Affairs Medical Centers were unavailable. Additionally, when PLWH move out of Wisconsin and the surveillance system is not informed, an individual’s lack of lab results may incorrectly indicate the person is out of care.

ANNUAL TARGETS

The years below reflect the year of HIV diagnosis.

2012	2013	2014	2015	2016	2017	2018	2019	2020
65.3%*	69.7%*	67.9%*	70.7%	73.6%	76.4%	79.3%	82.1%	85.0%

*actual value

Past years’ data will be updated as new data become available.

REFERENCES AND RELATED MATERIALS

A detailed report on the Wisconsin HIV care continuum is released annually as a Wisconsin AIDS/HIV Program Notes report and is available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/notes.htm>.

OBJECTIVE 2.2

Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90% by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Increasing access to care and improving health outcomes for people living with HIV

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective emphasizes that “in order for PLWH to realize the full benefit of HIV medical care, they must stay in care over time. Doing so helps to achieve viral suppression that can improve health outcomes, reduce the risk of HIV transmission, and lower the number of new infections.”¹ The National Strategy notes that the 2020 target will be difficult to reach, as the current percent of PLWH retained in HIV medical care is 53.8%.² As of 2014, an estimated 51% of PLWH in Wisconsin were retained in care.

BASELINE YEAR

2012

NUMERATOR

Number of persons with diagnosed HIV infection that had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count, viral load, or HIV genotype.

DENOMINATOR

Number of persons with diagnosed HIV infection diagnosed by previous year-end and alive at year-end.

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program.

DATA SOURCE LIMITATIONS

HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in June 2011. While the Wisconsin AIDS/HIV Program is unaware of labs in the state *not* reporting viral load and CD4 results, it is possible that there are missing data. Prior to 2015, for example, data from the Veteran’s Affairs Medical Centers were unavailable. Additionally, when PLWH move out of

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015).

Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

² Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveillance Supplemental Report* 2015;20(No. 2). <http://www.cdc.gov/hiv/library/reports/surveillance/>. Published July 2015. Accessed [2 Feb 2016].

Wisconsin and the surveillance system is not informed, an individual’s lack of lab results may incorrectly indicate the person is out of care.

ANNUAL TARGETS

The years below reflect the year in which retention to care is being evaluated.

2012	2013	2014	2015	2016	2017	2018	2019	2020
50.8%*	49.1%*	51.3%*	57.8%	64.2%	70.6%	77.1%	83.5%	90.0%

*actual value

Past years’ data will be updated as new data become available.

REFERENCES AND RELATED MATERIALS

A detailed report on the Wisconsin HIV care continuum is released annually as a Wisconsin AIDS/HIV Program Notes report and is available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/notes.htm>.

NOTES

This objective utilizes the federal definition of retention in care: two care visits that are at least 90 days apart during the calendar year. However, many providers in Wisconsin and other jurisdictions follow a one care visit per year model. Wisconsin’s annual continuum of care analyses include an extra “in care—1 visit per year” bar to provide information on PLWH potentially following this alternative care model. For example, in 2014, 66% of diagnosed PLWH had at least one care visit, while 51% had at least two visits 90 days apart. For this objective, Wisconsin will utilize the federal definition of twice per year. Thus, there may be an underrepresentation of people engaged in care.

Wisconsin considers people to be alive and living with HIV in Wisconsin if their last known address is in Wisconsin and there are no confirmed reports of death. Therefore individuals who are deceased or who have moved out of Wisconsin are likely included in the measurement of retention. Wisconsin’s annual estimates for retention may change in the future if last known address or vital status is updated for a significant number of people.

OBJECTIVE 2.3

Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80% by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Increasing access to care and improving health outcomes for people living with HIV

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective quantifies the crucial “endpoint of the continuum of care.”¹ Like Objective 4, the National Strategy notes that this 2020 target will be difficult to reach, as the current percent of PLWH retained in HIV medical care is 50.1%.² As of 2014, an estimated 53% of PLWH in Wisconsin had a suppressed viral load.

BASELINE YEAR

2012

NUMERATOR

Number of persons with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. Viral suppression was defined as a viral load result of <200 copies/mL at the most recent viral load test. People without a viral load test within the past 12 months were considered unsuppressed.

DENOMINATOR

Number of persons with diagnosed HIV infection diagnosed by previous year-end and alive at year-end.

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program.

DATA SOURCE LIMITATIONS

HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in June 2011. While the Wisconsin AIDS/HIV Program is unaware of labs in the state not reporting viral load results, it is possible that there are missing data. Additionally, when PLHIV move out of Wisconsin and the

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015). Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

² Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveillance Supplemental Report* 2015;20(No. 2). <http://www.cdc.gov/hiv/library/reports/surveillance/>. Published July 2015. Accessed [2 Feb 2016].

surveillance system is not informed, an individual’s lack of lab results may incorrectly indicate the person is out of care.

ANNUAL TARGETS

The years below reflect the year in which viral suppression is being evaluated.

2012	2013	2014	2015	2016	2017	2018	2019	2020
48.6%*	51.0%*	52.9%*	57.4%	62.0%	66.5%	71.0%	75.5%	80.0%

*actual value

REFERENCES AND RELATED MATERIALS

A detailed report on the Wisconsin HIV care continuum is released annually as a Wisconsin AIDS/HIV Program Notes report and is available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/notes.htm>.

NOTES

Wisconsin considers people to be alive and living with HIV in Wisconsin if their last known address is in Wisconsin and there are no confirmed reports of death. Therefore individuals who are deceased or who have moved out of Wisconsin are likely included in the measurement of retention. Wisconsin’s annual estimates for viral load suppression may change in the future if last known address or vital status is updated for a significant number of people.

OBJECTIVE 2.4

Reduce the percentage of persons living with HIV who are homeless to no more than 5% by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Increasing access to care and improving health outcomes for people living with HIV.

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective acknowledges that “housing status in an important factor affecting access to HIV care and health outcomes.”¹ PLWH can be at risk for losing housing “due to compounding factors, such as increased medical costs and limited incomes or reduced ability to keep working due to related illnesses.”² Given that housing is a basic need, PLHIV are unlikely to be able to fully engage in HIV-related medical care until housing issues are addressed. As the National AIDS Housing Coalition states, “the end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness.”³

BASELINE YEAR

2011

NUMERATOR

Number of persons who received a service at a Ryan White-funded facility during the calendar year and are reported on the Ryan White Services Report (RSR) as having temporary or unstable housing.

DENOMINATOR

All persons who received a service at a Ryan White-funded facility during the calendar year and whose housing status was reported on the RSR.

DATA SOURCE

Ryan White Services Report

DATA AVAILABILITY

The client level data file submitted annually to the Health Services and Resources Administration (HRSA) as part of the RSR is also submitted to the Wisconsin Department of Health Services for analysis of service utilization and health outcomes.

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015). Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

² U.S. Department of Housing and Urban Development: HIV/AIDS Housing. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing. Access 15 Feb 2016.

³ National AIDS Housing Coalition vision. Retrieved from <http://nationalaidshousing.org/>. Accessed 15 Feb. 2016

DATA SOURCE LIMITATIONS

An estimated 63% of PLHIV in Wisconsin receive at least one service at a Ryan White-funded facility on an annual basis. However, these individuals may not represent the housing status of all PLWH. In addition, the RSR reflects housing at year-end, and therefore underestimates periods of housing instability during the year.

ANNUAL TARGETS

2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
10.2%*	11.3%*	9.0%*	8.6%*	8.0%	7.4%	6.8%	6.2%	5.6%	5.0%

*actual value

REFERENCES AND RELATED MATERIALS

Ryan White housing statistics for all states, by year, can be found on the web at <http://hab.hrsa.gov/stateprofiles/Default.aspx>. Information about reporting housing status in the RSR is described in the Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual is available at <https://careacttarget.org/category/topics/ryan-white-services-report-rsr?hm=y>.

OBJECTIVE 2.5

Reduce the proportion HIV-attributable deaths among PLWH to 20% by 2020.

WISCONSIN HIV/AIDS STRATEGY GOAL

Increasing access to care and improving health outcomes for people living with HIV.

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective specifies that “reducing mortality is an anticipated outcome of achieving all the goals of the Strategy.”¹ With improved care and treatment, the numbers of deaths primarily attributable to HIV should continue to decline; however, as PLWH continue to age, they may die of other causes. This objective captures HIV as the primary cause of death.

BASELINE YEAR

2010

NUMERATOR

Number of deaths occurring in Wisconsin during the calendar year where HIV was listed as the primary cause of death.

DENOMINATOR

Total number of deaths of persons known to have HIV infection.

DATA SOURCE

Wisconsin HIV Surveillance System (via Wisconsin Vital Records, matches with the National Death Index and Social Security databases, and provider reports)

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program. During the annual release, past years’ data are also updated.

DATA SOURCE LIMITATIONS

Death data are subject to many limitations. First, for the purposes of this objective, we will limit our scope to deaths occurring in Wisconsin. These are the deaths that Wisconsin care and prevention programs and providers can directly impact. There is a possibility that the Wisconsin HIV Surveillance System will not capture all Wisconsin deaths among PLWH—for example, if the death is not reported to the System or if it is not possible to match someone in the surveillance and death databases. Cause of death coding is also subject to error. Our analyses define HIV-related deaths as deaths where HIV was listed as the primary cause of death, the first space on the death certificate. If HIV was listed elsewhere on the death certificate as a contributing, but not primary cause of death, it will not be captured in this analysis.

¹ National HIV/AIDS Strategy for the United States: Updated to 2020, Indicator Supplement (August 2015). Retrieved from: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf

ANNUAL TARGETS

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HIV-related	50*	40*	35*	34*	40*						
Non-HIV-related	38*	50*	42*	48*	41*						
Total deaths among PLHIV in WI	88*	90*	77*	82*	81*						
% deaths HIV-related	56.8%*	44.4%*	45.5%*	41.5%*	49.4%*	44.5%	39.6%	34.7%	29.8%	24.9%	20.0%

*actual value

REFERENCES AND RELATED MATERIALS

An HIV Surveillance Supplemental Report including these data is released annually; data from prior years may be updated. Surveillance Supplemental Reports are available on the web at <http://www.cdc.gov/hiv/library/reports/surveillance/>.

OBJECTIVE 3.1

Reduce new HIV diagnoses by at least 33% by 2020 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 15-59.

WISCONSIN HIV/AIDS STRATEGY GOAL

Reducing disparities in new HIV diagnoses in specific demographic groups and geographic areas.

OBJECTIVE RATIONALE

According to the National HIV/AIDS Strategy, “To address disparities requires focusing on disproportionately affected communities and populations...” This objective in the Wisconsin Strategy identifies reducing the number of new diagnoses in populations most affected by 33%. Only by reducing new diagnoses in most affected populations by a greater percentage than in the overall population (25% reduction, Objective 2), will disparities be reduced.

BASELINE YEAR

2010

NUMERATOR

For MSM, young Black MSM, and Milwaukee County residents, the three-year average of the number of HIV diagnoses among persons of all ages during the calendar year and two preceding years reported to the Wisconsin HIV Surveillance Program. For example, the year 2020 number will be an average of the number of HIV diagnosis in 2020, 2019, and 2018. For Black women, because of small numbers, compare the average annual number diagnoses in the periods 2010-2015 and 2016-2020.

DENOMINATOR

None

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program. During the annual release, past years' data are also updated.

POPULATION COVERAGE

The entire state of Wisconsin for the three demographic populations; the geographic focus area is Milwaukee County.

DATA SOURCE LIMITATIONS

HIV diagnosis data may not be representative of all PLWH because not all infected persons have been tested. Anonymous tests, though rare in Wisconsin, are also not reported.

ANNUAL TARGETS

	Number of Diagnoses											Target reduction in diagnoses, 2010-2020
	Actual						Target					
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	
All Populations (Objective 1.1)	253	246	222	250	221	225	218	211	204	197	190	25%
Populations experiencing disparities (Objective 3.1)												33%
• MSM ages 15-59, Wisconsin	188	183	167	197	176	177	167	157	146	136	126	33%
• Young Black MSM, Wisconsin	51	46	39	48	51	45	43	41	39	36	34	33%
• Black Females, ages 15-59, Wisconsin, annual average	10.5						7.0					33%
• Milwaukee City Residents, ages 15-59	136	116	102	110	116	105	102	99	97	94	91	33%

REFERENCES AND RELATED MATERIALS

An HIV surveillance report including new diagnoses data is released annually and available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/data.htm>. The number of diagnoses will continue to be updated over time and reflected in subsequent surveillance review updates and Wisconsin HIV/AIDS Strategy updates.

OBJECTIVE 3.2

Promote equity in care outcomes at each stage of the HIV care continuum. Specifically, reduce disparities in care outcomes for:

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

WISCONSIN HIV/AIDS STRATEGY GOAL

Decrease disparities in HIV care outcomes for people living with HIV who are members of populations that have historically experienced worse health outcomes compared to their peers.

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective focuses reducing disparities in care outcomes for populations most impacted. In Wisconsin, these are Blacks, PWID and young people, ages 15-29.

BASELINE YEAR

2011

VALUE

Continuum of care data by population will be reviewed. If there are disparities for the specified population at any stage of the continuum, the value is “yes.” The 2020 target value is “no,” indicating that there will be no disparities at any stage of the continuum. Stages of the HIV care continuum include:

- Percent linked to HIV care within three months of diagnosis.
- Percent in HIV care.
- Percent retained in HIV care.
- Percent virally suppressed.
- Percent viral suppression among those with a viral load test.

DATA SOURCE

Wisconsin HIV Surveillance System

DATA AVAILABILITY

Data are released annually by the Wisconsin AIDS/HIV Program.

POPULATION COVERAGE

Includes entire state of Wisconsin.

DATA SOURCE LIMITATIONS

HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in June 2011. While the Wisconsin AIDS/HIV Program is unaware of labs in the state currently not reporting viral load

and CD4 results, it is possible that there are missing data. Prior to 2015, for example, data from the Veteran’s Affairs Medical Centers were unavailable. Additionally, when PLHIV move out of Wisconsin and the surveillance system is not informed, an individual’s lack of lab results may incorrectly indicate the person is out of care.

ANNUAL TARGETS

Selected Population	Compared to Reference Population	Actual Values			Target
		2011	2014	2015	2020
		Are there disparities at one or more stages of the continuum?			
Blacks	Whites	Yes	Yes	Yes	No
PWID	MSM and HRH	Yes	Yes	Yes	No
15-29 years	30+ years	Yes	Yes	Yes	No

Past years’ data will be updated as new data become available.

REFERENCES AND RELATED MATERIALS

A detailed report on the Wisconsin HIV care continuum is released annually as a Wisconsin AIDS/HIV Program Notes report and available on the web at <https://www.dhs.wisconsin.gov/aids-hiv/notes.htm>

The following two process objectives are directed at ensuring coordination and collaboration in implementing the Integrated HIV Plan.

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, local health departments).

WISCONSIN HIV/AIDS STRATEGY GOAL

Achieving a more coordinated response to the HIV epidemic.

OBJECTIVE RATIONALE

In alignment with the National HIV/AIDS Strategy, this Wisconsin objective focuses on increasing collaborative efforts across government agencies, non-governmental organizations, and the private sector in order to achieve an effective and efficient coordinated response in implementing the Integrated HIV Plan. Activities identified in the National HIV/AIDS Strategy that have contributed to successful coordination include:

- Persistent advocacy from PLWH and their allies, pressing all sectors to do more, better, and faster.
- Engagement of affected communities and mobilization of broad sectors of society to take action against a condition that is highly stigmatized and associated with sexuality, substance use, and other issues that magnify cultural divides.
- Innovations in prevention and care programs that reflect a strong consumer perspective and incorporate multi-disciplinary approaches.
- Focused and sustained efforts to understand and respect differences in culture, language, and values across multiple populations and various disciplines.

OBJECTIVE 4.2

Develop improved mechanisms to monitor and evaluate the progress in achieving the goals and objectives of the Wisconsin Integrated HIV Prevention and Care Plan 2017-2021.

WISCONSIN HIV/AIDS STRATEGY GOAL

Achieving a more coordinated response to the HIV epidemic.

OBJECTIVE RATIONALE

The Integrated HIV Plan requires ongoing monitoring and evaluation to ensure progress in meeting the goals and objectives of the Integrated HIV Plan. Consistent with recommended actions of the National HIV/AIDS Strategy, the Integrated HIV Plan is aligned achieving the following:

- Strengthening coordination across data systems and ensuring the timely use of data to assess and improve health outcomes.
- Utilizing monitoring and evaluation findings to guide resource allocation that will have the greatest impact on achieving Integrated HIV Plan goals and objectives.
- Enhancing accountability and providing public reporting on Integrated HIV Plan goals.
- Ensuring coordinated and integrated program planning that is committed and actively engaged in assessing and improving health outcomes.

Appendix II

2016 HIV Prevention and Care Contracted Agencies and Services

Note: The following table identifies HIV prevention and care services and the respective agencies funded in 2016 by the Wisconsin Department of Health Services (DHS), Division of Public Health. Funding was awarded from several funding sources and on a variety of 12-month cycles. The table does not include an agency's HIV-related services or other agencies providing HIV services that are supported through sources other than DHS.

ARCW – Statewide		
Prevention	\$15,780	Statewide information and referral hotline, Internet outreach and coordination of condom distribution and promotion.
Care	\$82,778	Housing services
ARCW – South		
Prevention	\$125,000	<ul style="list-style-type: none"> • Targeted HIV CTR with high-risk populations (MSM, IDU, sex partners at risk). • IDU harm reduction outreach. • HIV prevention education outreach to MSM venues. • PrEP referral and counseling support
Care	\$858,845	<ul style="list-style-type: none"> • Outpatient/ambulatory medical care. • Oral health services. • Medical case management. • Medical transportation. • Legal services. • Food bank/home-delivered meals.
ARCW – Southeast		
Prevention	\$475,000	<ul style="list-style-type: none"> • Targeted HIV CTR with high-risk populations (MSM, IDU, sex partners at risk). • Internet-based health education and information services targeting MSM. • IDU harm reduction outreach. • HIV prevention education outreach to MSM venues. • PrEP referral and counseling support.

Care	\$3,218,049	<ul style="list-style-type: none"> • Outpatient/ambulatory medical care. • Oral health services. • Mental health services. • Outpatient substance abuse services. • Medical case management. • Medical transportation. • Legal services. • Food bank/home-delivered meals.
ARCW – Northeast		
Prevention	\$100,000	<ul style="list-style-type: none"> • Targeted HIV CTR with high-risk populations (MSM, IDU, sex partners at risk). • IDU harm reduction outreach. • HIV prevention education outreach to MSM venues. • PrEP referral and counseling support.
Care	\$543,525	<ul style="list-style-type: none"> • Outpatient/ambulatory medical care. • Oral health services. • Mental health services. • Medical case management. • Medical transportation. • Food bank/home-delivered meals.
ARCW – North		
Prevention	\$60,000	<ul style="list-style-type: none"> • Targeted HIV CTR with high-risk populations (MSM, IDU, sex partners at risk). • IDU harm reduction outreach. • HIV prevention education outreach to MSM venues.
Care	\$126,572	<ul style="list-style-type: none"> • Medical case management. • Medical transportation.
ARCW – West		
Prevention	\$50,000	<ul style="list-style-type: none"> • Targeted HIV CTR with high-risk populations (MSM, IDU, sex partners at risk). • IDU harm reduction outreach. • HIV prevention education outreach to MSM venues.
Care	\$296,817	<ul style="list-style-type: none"> • Mental health services. • Medical case management. • Medical transportation. • Food bank/home-delivered meals.

BESTD Clinic (aka Brady Street Clinic)		
Prevention	\$31,000	HIV testing in high-risk communities.
Black Health Coalition		
Prevention	\$96,000	<ul style="list-style-type: none"> Faith-based HIV CTR in high prevalence Black neighborhoods. HIV prevention capacity building with faith-based communities.
Brown County HD		
Care	\$12,000	<ul style="list-style-type: none"> HIV Partner Services / Linkage to care. (<i>Coordinated by Prevention Unit</i>)
Diverse and Resilient		
Prevention	\$79,000	<ul style="list-style-type: none"> Capacity building for providers serving MSM youth statewide. Ongoing group for transgender Black <i>SHEBA</i>.
Eau Claire City/County Health Department		
Care	\$75,000	HIV partner services / linkage to care. (<i>Coordinated by Prevention Unit</i>)
Kenosha County Health Department		
Care	\$13,000	HIV partner services / linkage to care. (<i>Coordinated by Prevention Unit</i>)
La Crosse County Health Department		
Care	\$16,000	Partner services/linkage to care.
Legal Aid Society of Milwaukee, Inc.		
Care	\$35,000	Legal services.
Local Health Departments (multiple agencies)		
Prevention	\$113,880	<ul style="list-style-type: none"> HIV testing through fee-exempt testing and provision of HIV test kits. Fee-for-service HIV partner services within local jurisdictions.
Luther Consulting, Inc.		
Prevention	\$10,800	Transition cost from Wisconsin Module of <i>EvaluationWeb</i> to CDC <i>EvaluationWeb</i>
Care	\$10,000	Coordination of web-based data reporting consistent with requirements of HRSA's Ryan White Services Report (client-level data report).

Public Health of Madison and Dane County		
Prevention	\$21,000	HIV partner services (“PCRS”) for multi-county jurisdiction.
Care	\$20,000	Partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Marathon County Health Department		
Care	\$9,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Midwest AIDS Training and Education Center (MATEC)		
Care	\$29,575	Support for HIV Treaters’ Meeting.
Medical College of Wisconsin—Center for AIDS Intervention Research		
Care	\$43,496	Linkage to care qualitative evaluation.
Medical College of Wisconsin—Infectious Disease Clinics		
Care	\$388,737	<ul style="list-style-type: none"> • Medical case management. • Mental health services. • Outreach
Medical College of Wisconsin—Pediatrics Department		
Care	\$250,000	Medical case management (statewide for HIV + pregnant women, their newborns, and family members).
City of Milwaukee Health Department		
Prevention	\$144,000	HIV partner services in southeast Wisconsin.
Care	\$53,000	Partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Milwaukee Health Services, Inc.		
Care	\$32,000	Medical Case Management.
OutReach, Inc.		
Prevention	\$25,000	Condom distribution as a structural and community intervention (TG and MSM).

Outreach Community Health Center		
Care	\$32,000	Medical Case Management.
Price County Health Department		
Care	\$8,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Racine Health Department		
Care	\$13,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Rock County Health Department		
Care	\$13,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Sixteenth Street Community Health Center		
Prevention	\$90,000	<ul style="list-style-type: none"> • PrEP referral and counseling support • HIV CTR with Latino high-risk populations (MSM, IDU, sex partners at risk). • Group prevention with Latina TG populations <i>CHICAS</i>.
Care	\$224,000	<ul style="list-style-type: none"> • Outpatient/ambulatory medical care. • Oral health care. • Mental health services. • Medical case management (bilingual services).
Holton Street Clinic		
Prevention	\$88,000	Outreach and clinic CTR targeting MSM and partners at risk.
Tribal Health Clinics (Bad River, Ho Chunk, Lac Courte Oreilles, Lac du Flambeau, Menominee, Oneida, Potawatomi, Red Cliff, Sokaogon, St. Croix, Stockbridge-Munsee)		
Prevention	\$77,000	HIV capacity building grants of \$7,000 each for 11 Tribal nations to support HIV social networks testing, high risk testing strategies and culturally-specific prevention education.
UMOS		
Prevention	\$65,000	<ul style="list-style-type: none"> • Targeted CTR with high-risk Latino/a high-risk populations (MSM, IDU, sex partners at risk). • Condom Distribution as Structural & Community Intervention (Latino MSM).

UW Hospital and Clinics		
Care	\$557,625	<ul style="list-style-type: none"> • Outpatient/ambulatory medical care. • Mental health services. • Outpatient substance abuse services. • Medical case management. • Linkage to care quantitative evaluation.
UW Professional Development and Applied Studies		
Prevention	\$80,000	<ul style="list-style-type: none"> • Capacity building/training for HIV prevention providers. • Community planning coordination.
Care	\$120,000	<ul style="list-style-type: none"> • Medical and non-medical case management training. • Community planning coordination.
UW-State Laboratory of Hygiene		
Prevention	\$250,000	Staffing and support of statewide HIV CTR Program.
Waukesha County Health Department		
Care	\$13,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>
Winnebago County Health Department		
Care	\$11,000	HIV partner services/linkage-to-care. <i>(Coordinated by Prevention Unit)</i>

Appendix III

**Prescription Drugs and Medical Services for People Living with HIV
Paid by Medicaid in 2015**

Medicaid serves as an important payer for costs of prescription drugs and medical services for people living with HIV in Wisconsin. At the end of 2015, 6,868 people had been diagnosed with HIV and were presumed to be living in Wisconsin. In 2015, 4,839 (70%) had evidence of an HIV care visit.¹ Of these, 3,137 (65%) had one or more claims paid by Medicaid. Total costs paid by Medicaid in Wisconsin for drugs and services for people living with HIV were \$57.7 million.

Service category	Total Amount Paid in 2015	Percent of 3,137 patients that received this service in 2015
Total	\$57,755,871	100%
Drugs		
Antiretroviral	\$29,754,606	55%
Other drug	\$5,511,003	77%
Hospital		
Inpatient	\$7,666,456	13%
Outpatient	\$2,871,168	55%
Emergency room	N/A ²	49%
Psychiatric	\$360,056	3%
Home care	\$3,243,708	8%
Physician	\$1,987,314	72%
Laboratory and radiology		
X-ray	\$233,690	40%
Lab and blood	\$1,268,611	56%
Narcotic treatment—lab	\$56,166	1%
Mental health and drug abuse	\$1,184,633	35%
Nursing home	\$966,223	1%
Evaluation and management	\$948,311	99%
Transportation		
Emergency ambulance	\$224,195	19%
Non-emergency medical transportation (NEMT)	\$352,923	94%
Home health	\$365,304	11%
Dental	\$232,796	34%
Targeted case management	\$96,674	17%
Hospice	\$47,281	0%

¹ A care visit is defined as a CD4, viral load, or genotype test reported in the HIV surveillance system and with sample collection date of 2015

² ER claims can be a subset of the other claims in the Hospital group. In order to avoid double counting, paid amounts for ER claims are not shown.

Appendix IV

Acknowledgements

The development of the Wisconsin HIV Integrated Prevention and Care Plan 2017-2021 was a major undertaking that drew upon the knowledge and wisdom of a broad spectrum of dedicated individuals—persons living with HIV, community members at risk of HIV infection, health and human service providers, community leaders and advocates, academic staff and researchers, staff from public and private sectors, and numerous others from a variety of other venues. Sincere gratitude is directed to the many individuals who contributed to this vitally important resource for Wisconsin.

Over 2015 and 2016, the Wisconsin Statewide Action Planning Group, the state’s HIV planning body, collaborated closely with and assisted the Wisconsin AIDS/HIV Program in developing the Wisconsin HIV Integrated Prevention and Care Plan for the Wisconsin Department of Health Services. Over these two years, the following individuals (both past and present members and staff) assumed key roles in facilitating the development of the Integrated HIV Plan.

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