

Oklahoma

Integrated HIV Prevention & Care Plan

Including the Statewide Coordinated Statement of Need

2017-2021



Prepared by
Oklahoma State Department of Health - HIV/STD Service
September 2016

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Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

The Ryan White Treatment and modernization Act requires that grantees conduct activities to enhance coordination across Ryan White Program Parts in the development of the Statewide Coordinated Statement of Need and the Comprehensive Plan. The purpose of the SCSN is to provide a collaborative mechanism to identify and address the significant HIV care issues related to the needs of People Living With HIV (PLWH), and to maximize coordination, integration and effective linkages across the Ryan White Program Parts B, C and D in Oklahoma. HRSA strongly encourages grantees to use the SCSN to support statewide HIV planning; including using the goals outlined in the SCSN to set measurable objectives, to inform resource allocation decisions, create a statewide comprehensive plan, as well as conduct other activities to enhance the statewide delivery of HIV care and services.

The Comprehensive Plan will include data from local needs assessments and/or statewide needs assessments that meet the legislative requirements. These identified needs, particularly HIV related core service needs, should be a primary impetus for developing the Comprehensive Plan, guiding the state in setting goals, identifying clinical performance measures, and making resource allocations. Health Resources and Services Administration's (HRSA) primary goals are to achieve "100% access, 0% disparity" for all PLWH.

The integrated HIV Prevention and Care Plan is a vehicle for Oklahoma to identify HIV prevention and care needs, existing resources, barriers, and gaps and to outline strategies to address them. It is the intent of this integrated plan to increase efficiencies in the use of planning resources, as contribute to resultant improvements in program effectiveness and health outcomes HIV at-risk and infected populations. The integrated plan, including the SCSN, also articulates the existing and needed collaboration among PLWH, service providers, funded program implementers, and other stakeholders.

The Integrated HIV Prevention and Care Plan for Oklahoma aligns with the goals of the National HIV/AIDS Strategy (NHAS) and uses the principles and the intent of the HIV Care Continuum to inform the needs assessment process and the service delivery implementation.

A. Epidemiologic Overview - Oklahoma Population and Demographics

Oklahoma is located in the geographic center of the United States, ranks 29th in population among the 50 states, covers 68,594.92 square miles, and is divided into 77 counties. Although Oklahoma has 77 counties, almost half of the population (49.8%) lives in 5 counties: Oklahoma (776,864) Tulsa (639,242), Cleveland (274,458), Canadian (133,378), and Comanche (124,648). Oklahoma and Tulsa counties account for 36.2% of the total population.

Oklahoma contains three major metropolitan statistical areas (MSA): Oklahoma City MSA, Tulsa MSA, and Lawton MSA. Combined, these three MSAs comprise 63.2% of Oklahoma's population. According to the 2015 U.S. Census Bureau, Oklahoma has an estimated population of 3,911,338 which is an increase of 119,380 (3.0%), from 2010.

The majority of Oklahomans reported their race as White (74.8%), followed by American Indian and Alaska Native (9.1%), Black (7.8%), other (6.0%), Asian (2.2%), Native Hawaiian other Pacific Islander (less than 0.2%), and other/multi race (6.0%). Hispanic Oklahomans of any race constituted 10.1% of the population. Non-Hispanic Whites accounted for 66.5% of the Oklahoma population.

By Age and Sex

The majority (75.4%) of Oklahomans were age 18 years or older in 2015 with more than half (58.1%) of being between the ages of 20 and 64. Almost fifteen percent (14.7%) of Oklahomans were 65 years and older. Persons under the age of five comprised 8.2% of the population and youth (13-24 years) accounted for 16.7% of the 2015 population.

The median age was 37.4 years and females accounted for 50.5 of the total population. Half (50.2%) of Oklahoma males age 15 years and older were currently married, compared to 46.7% of females.

By Income

The state of Oklahoma has a higher rate of poverty (16.6%) than the remainder of the United States (15.6%). In 2015, there were 1.45 million households in Oklahoma with the average household size of 2.6 people and average family size of 3.2. The median household income in Oklahoma was \$46,235 and the median value of owner-occupied homes was \$115,500. The average Oklahoman commutes approximately 21.2 minutes to work each day. Only 61.3% of Oklahomans 16 years and older were in the civilian labor force in 2015.

By Education

A majority (86.7%) of Oklahomans 25 years of age and older had a high school diploma or higher, and 23.8% had a bachelor's degree or higher. Of persons five years and older, 90.4% spoke English only at home.

CHLAMYDIA

Chlamydia, caused by the bacterium *Chlamydia trachomatis*, is the most commonly reported, notifiable sexually transmitted disease (STD) in the United States and the most prevalent, reportable STD in Oklahoma.

In 2015, a total of 21,025 cases were reported in Oklahoma, approximately a 15% increase in the number of cases from 2013 (18,278). Oklahoma had an incidence rate of 537.5 cases per 100,000 in 2015, a 13.2% rate increase compared to 2013 (474.7 cases per 100,000) and a 38.1% rate increase compared to 2011 (389.1 cases per 100,000).

By Sex

In 2015, 70.9% of the reported cases were among females. The rate of chlamydia among females was 2.4 times higher than that of males (754.9 per 100,000 population, compared to 315.9 per 100,000 population). Chlamydia, known as a “silent” disease, is typically asymptomatic; only about 30% of females experience symptoms and as many as one in four males have no symptoms.

By Age

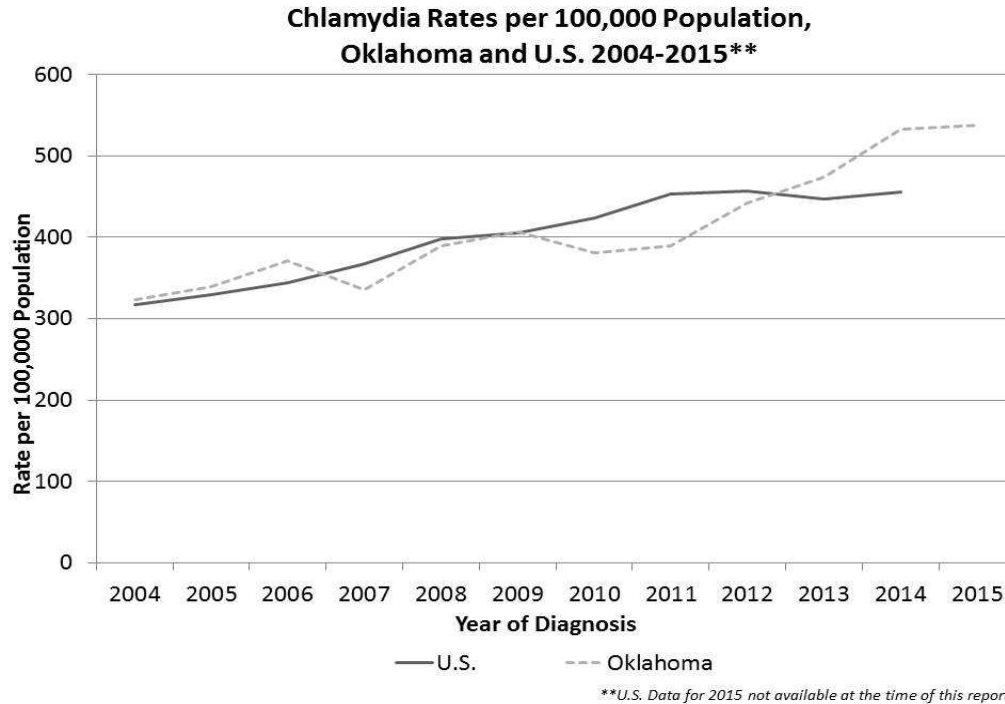
Chlamydia occurs in all ages, but age group 20 to 24 years (8,279; 39.4%) had the largest proportion of cases and accounted for a little over one-third of Oklahoma chlamydia infections. This age group also had the highest rate (2,887.4 per 100,000 population). This group was followed closely by age groups 15 to 19 years (5,887; 28.0%) and 25 to 39 years (3,786; 18.0%).

By Race/Ethnicity

Whites had the largest proportion of chlamydia cases in 2015 (8,053; 38.3%), followed by Blacks (4,578; 21.8%), Other/Unknown Race (2,901; 13.8%), and Hispanics (2,293; 10.9%). Blacks were disproportionately affected by chlamydia in Oklahoma. Although blacks made up 21.8% of the cases, they only account for 7.4% of the population of Oklahoma. The rate among Blacks was 1,574.6 per 100,000, 5 times the rate of Whites and almost 3 times the state rate.

By Geography

Over half (56.0%) of Oklahoma morbidity is attributed to four counties: Oklahoma (5,235), Tulsa (4,310), Cleveland (1,206), and Comanche (1,013). These counties are also part of the metropolitan statistical areas in Oklahoma. However, the four counties with the highest rates of infection were Comanche (812.7 per 100,000), Muskogee (781.9 per 100,000), Custer, (716.1 per 100,000), and Pontotoc (709.5 per 100,000).



GONORRHEA

After chlamydia, gonorrhea is the second most prevalent sexually transmitted disease reported in Oklahoma. Gonorrhea is caused by *Neisseria gonorrhoea*, a bacterium that can grow and multiply in warm, moist areas of the reproductive tract, mouth, throat, eyes, and anus.

In 2015, a total of 6,542 cases were reported in Oklahoma, approximately a 6.6% increase in the number of cases from 2014 and a 23.4% increase from 2013. In 2015, Oklahoma had an incidence rate of 167.3 per 100,000, which was a 5.8% rate increase when compared to 2014, a 21.5% rate increase compared to 2013 (137.7 per 100,000), and a 48.8% rate increase compared to 2011 (112.4 per 100,000).

By Sex

In years past, men made up the majority of gonorrhea cases in the U.S., but since 2002 women have made up the majority of cases. Oklahoma has followed a similar trend. In Oklahoma, women have accounted for over half (3,580; 54.7%) of gonorrhea cases reported in 2015, with an incidence rate of 181.3 per 100,000, a 2.8% increase since 2014 (176.3 per 100,000). Males accounted for 45.3% (2,962) of cases.

By Age Group

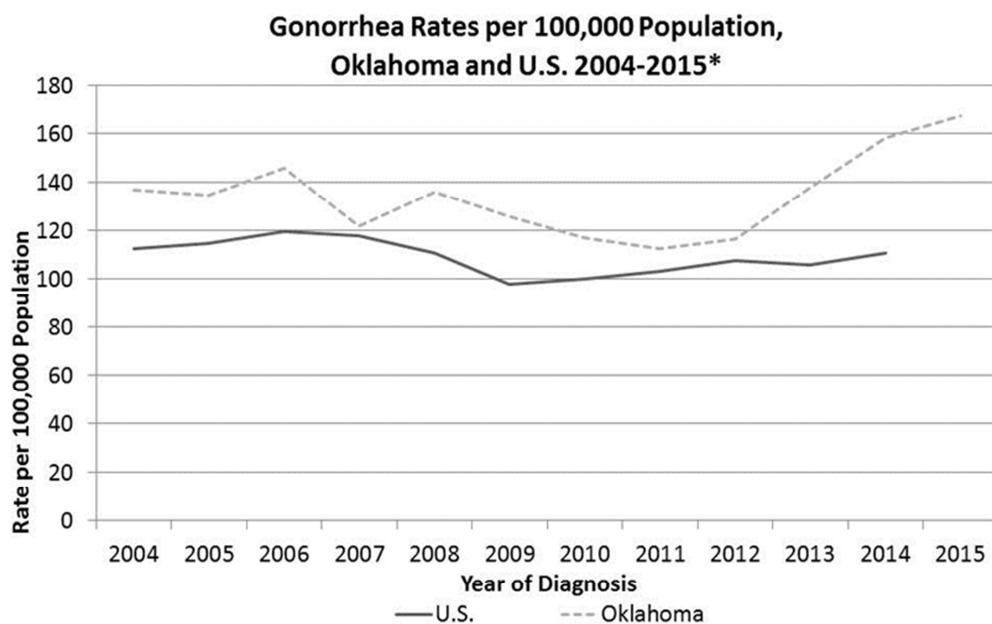
The age group of gonorrhea cases is slightly older when compared to chlamydia cases. Age groups 20 to 24 years (2,301; 35.2%) and 25 to 29 years (1,379; 21.1%) make up the two largest groups of cases, followed closely behind by age group 15 to 19 years (1,304; 19.9%).

By Race/Ethnicity

Whites and Black tied for the largest proportion of gonorrhea cases in 2015 (2,285; 34.9%), followed by Other/Unknown Race (2,901; 13.8%), and Hispanics (2,293; 10.9%). Blacks were disproportionately affected by chlamydia in Oklahoma. Although blacks made up 21.8% of the cases, they only account for 7.4% of the population of Oklahoma. The rate among Blacks was 785.9 per 100,000, almost 9 times the rate for Whites and almost 5 times the state rate.

By Geography

A little over half (52.6%) of gonorrhea cases in Oklahoma is attributed to two counties: Oklahoma (1,846) and Tulsa (1,595). However, four different counties had the highest rates of infection in 2015: Choctaw (320.1 per 100,000), Muskogee (298.4 per 100,000), Comanche (282.4 per 100,000), and Carter (260.8 per 100,000). Choctaw County was almost two times higher (1.9 times) than the overall state rate.



PRIMARY & SECONDARY SYPHILIS

Syphilis is a genital, ulcerative sexually transmitted disease caused by the bacterium *Treponema pallidum*. Many signs and symptoms of syphilis are indistinguishable from many other diseases, giving it the nickname “the great imitator”. Syphilis is passed from person to person by direct contact with a syphilis sore or lesion (called a chancre). Typically, syphilis transmission occurs during vaginal, anal, or oral sex. Pregnant females with the disease can also pass it to their unborn children.

In 2015, a total of 209 cases of primary and secondary (P&S) syphilis were reported in Oklahoma, a 38.4% increase from 2014 and a 77.1% increase in the number of cases from 2013 (118). The P&S syphilis rate in 2015 was 5.3 per 100,000 population, representing a rate increase of 35.9% since 2014 (3.9 per 100,000) and a 70.9% (3.1 per 100,000) rate increase since 2013.

Gender and Age Group

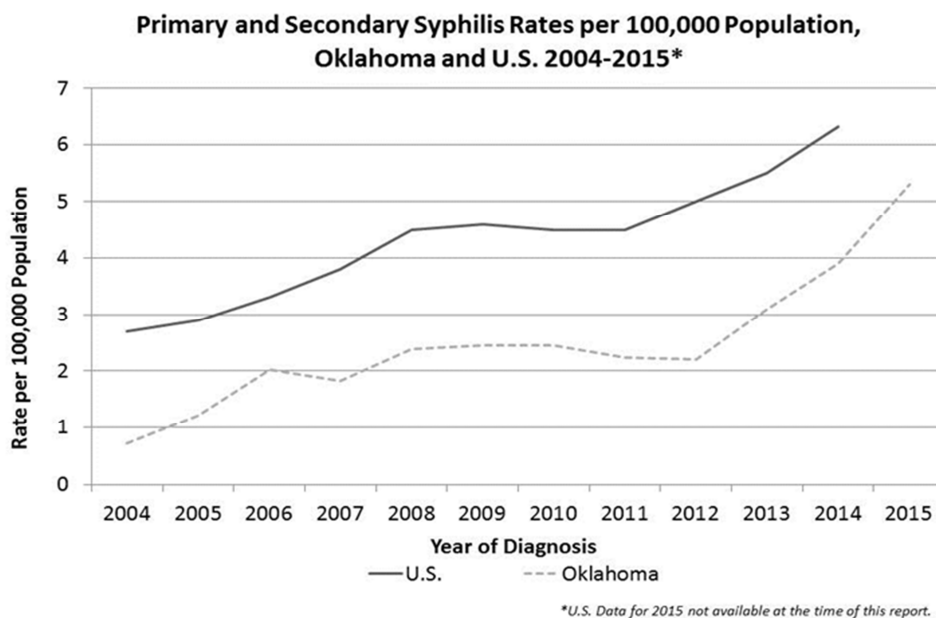
Although females represent the majority of cases for most STDs, syphilis cases are dominated by males. Males accounted for 90.0% (188) of the P&S syphilis cases in Oklahoma while 10.0% (21) were female. The rate among males (9.7 per 100,000) was 9 times higher than the rate for females (1.1 per 100,000). Males experienced a 36.6% rate increase from 2014 (136 cases; 7.1 per 100,000), while the rate among females increased 37.5% from 2014 (15 cases; 0.8 per 100,000).

Race/ Ethnicity

Whites had the largest proportion of P&S cases in 2015 (119; 56.9%), followed by Blacks (42; 20.1%) and Hispanics (23; 11.0%). Blacks were disproportionately affected by P&S in Oklahoma. Although blacks made up 20.1% of the cases, they only account for 7.4% of the population of Oklahoma. The rate of P&S among blacks was 14.4 per 100,000 population, 2.7 times higher than the overall state rate.

Geography

Oklahoma County, Tulsa County and Cleveland County had the largest number of cases from 2015, accounting for 68.9% (144) of the state’s morbidity. Although Pawnee County only had two cases, this county had the highest rate at 12.2 per 100,000. Oklahoma County (93) had the highest number of reported cases and the second highest rate at 12.0 per 100,000, more than two times higher than the state rate. Nowata County had the third highest rate (9.5 per 100,000) followed by Pushmataha County (8.9 per 100,000).



HEPATITIS C

Hepatitis B Virus and Hepatitis C Virus are leading infectious causes of morbidity/mortality and disproportionately affect the foreign-born, racial/ethnic minorities, persons born during 1945-1965 (Birth Cohort), and medically underserved/underinsured populations.

From 2010 to 2014, there were 40 to 115 acute HBV cases reported to the state of Oklahoma each year. The incidence rates of acute HBV in Oklahoma (1.0 to 3.1/100,000 population) were slightly higher than the rates in the US (0.9 to 1.1/100,000 population). There were 86 newly reported confirmed chronic hepatitis B cases in 2014 for the state.

Oklahoma had higher incidence rate of newly diagnosed acute cases of hepatitis C compared with the national average. Preliminary result of 2015 data indicated that there were 92 acute HCV cases in Oklahoma. Males accounted for 53.3% (49) of the acute HCV cases, and females accounted for 46.7% (43) of the cases. More than one third of the acute HCV cases were 20~29 years old, which accounted for 35.9% of all cases. And 30~39 years old accounted for 27.2%, 40~49 years old accounted for 18.5%. More than half (56.5%) of the acute HCV cases reported in 2015 were White, followed by American Indian (19.6%) and Multiracial group (12.0%).

In addition of the acute HCV, there were 1,488 chronic HCV cases in Oklahoma. The chronic hepatitis cases could be under-reported due to 1) the fact that only 50% of those living with HCV are aware of their infection and most have not received recommended care and treatment. 2) Oklahoma's HCV surveillance system focused on acute hepatitis cases, and only investigate chronic HCV cases under 40 years of age. 3) Similar to HCV, only 60% of the persons living with HBV in the US have been tested.

Hepatitis C Cases Diagnosed in Oklahoma, 2015

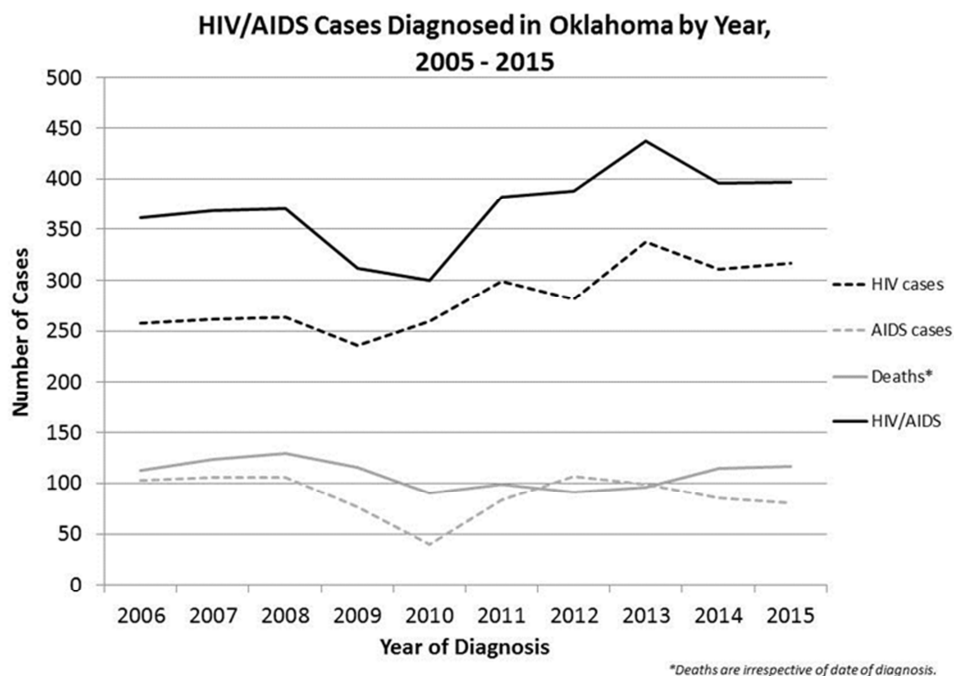
Cases	Acute HCV		Past or Present HCV	
	Number	(%)	Number	(%)
Total	92	100.0	1,488	100.0
Age (in years)	Number	(%)	Number	(%)
0 – 14	0	0.0	14	0.9
15 – 19	2	2.2	35	2.4
20 – 24	13	14.1	228	15.3
25 – 29	20	21.7	292	19.6
30 – 34	11	12.0	318	21.4
35 – 39	14	15.2	314	21.1
40 – 44	8	8.7	135	9.1
45 – 49	9	9.8	43	2.9
50 and over	15	16.3	107	7.2
Unknown	0	0.0	2	0.1
Race/Ethnicity	Number	(%)	Number	(%)
White	52	56.5	767	51.6
Black	3	3.3	38	2.6
Asian/Pacific Islander	2	2.2	13	0.9
American Indian/Alaska Native	18	19.6	159	10.7
Hispanic (All Races)	16	17.3	454	30.4
Multiple Race				

HIV/AIDS**Overview**

HIV/AIDS surveillance began in 1982 in the state of Oklahoma. By the end of 2015, an estimated 10,120 HIV/AIDS cases have been diagnosed among residents of Oklahoma. Of total cumulative cases diagnosed in Oklahoma, 43.1% (4,364) are known to be deceased. The remaining 5,756 cases were living with HIV/AIDS in Oklahoma as of December 31, 2015 at a rate of 147.2 cases per 100,000 population. In 2015, 317 cases were newly diagnosed with HIV in Oklahoma at a rate of 8.1 per 100,000. Of the newly diagnosed HIV cases, 76 cases were also diagnosed with AIDS in 2015. Additionally, there were 80 new AIDS cases diagnosed among cases diagnosed with HIV in a year prior to 2015.

Nationally, Oklahoma is a medium morbidity state for HIV infections. In 2014, the most recently available national surveillance data, Oklahoma ranked 26th in rate of diagnoses of HIV infection and 30th in number of diagnoses of HIV infection among adults and adolescents in the United States and 6 dependent areas. Among adults and adolescents, the 2014 rate of HIV diagnoses was 10.5 per 100,000 compared to the total rate of 16.6 cases per 100,000.

In Oklahoma, the burden of HIV disease is not distributed equally among the population. Significant HIV-related health disparities exist by sex, race/ethnicity, age, geographic location, and sexual orientation in Oklahoma.



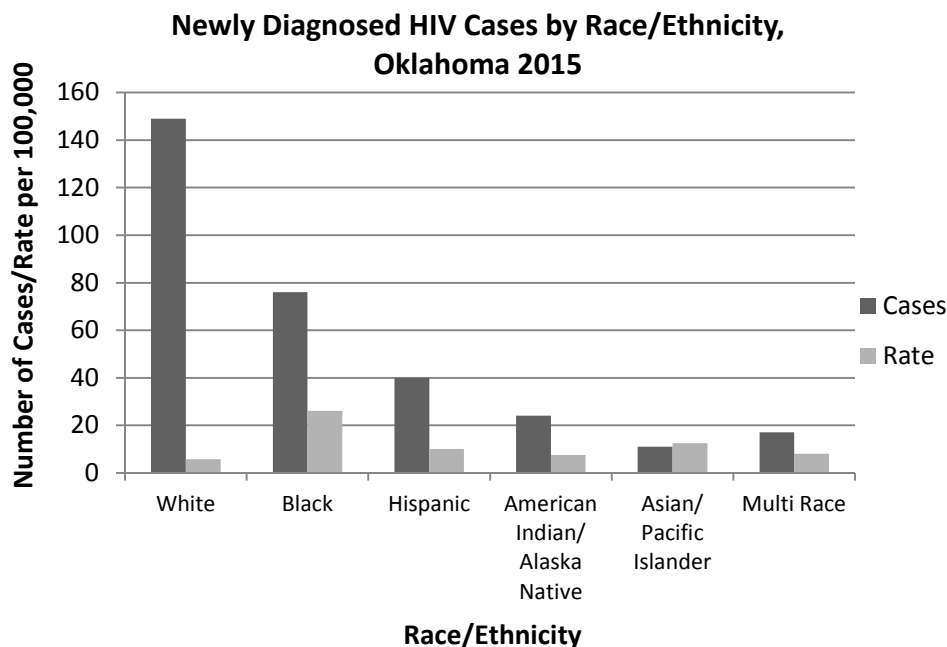
NEWLY DIAGNOSED HIV CASES

By Race

Of the 317 new HIV cases in 2015:

- 47.0% (149) were White
- 24.0% (76) were Black
- 12.6% (40) were Hispanic
- 7.6% (24) were American Indian/Alaska Native
- 3.5% (11) were Asian/Pacific Islander
- 5.4% (17) were Multi Race

Blacks had the highest rate of newly diagnosed HIV cases in 2015 (26.1 cases per 100,000 population) among all the racial and ethnic groups in Oklahoma. This rate was 3.2 times higher than state rate (8.1 cases per 100,000) and 4.6 times higher than the rate for Whites (5.7 cases per 100,000). Asian/Pacific Islanders had the second highest rate of newly diagnosed cases (12.5 cases per 100,000), but accounted for the smallest number of cases. Hispanics (10.1 cases per 100,000) had the third highest rate, followed by American Indians/Alaska Natives (7.5 cases per 100,000). The rate among Multi Race was 8.0 cases per 100,000.



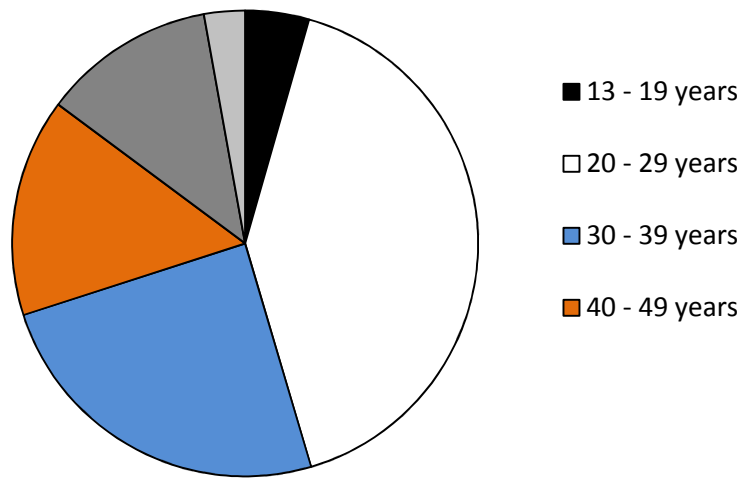
By Sex

Males accounted for 86.1% (273) of the newly diagnosed cases and females accounted for 13.9% (44). The 2015 HIV rate among males, (14.1 cases per 100,000) was 6.4 times higher than the rate among females (2.2 cases per 100,000). Among males, Whites (131; 48.0%) accounted for the highest number of cases, followed by Blacks (63; 23.1%). However, Black males (43.4 cases per 100,000) had the highest rate among males and White males (10.2 cases per 100,000) had the lowest rate. Among females, Whites (18; 40.9%) accounted for the highest number of the cases, followed closely by Blacks (13; 29.5%). Black females (8.9 cases per 100,000) had the highest rate among females and White females (1.4 cases per 100,000) had the lowest rate.

By Age

The 20-29 years age group had the highest number of newly diagnosed HIV cases in 2015 (130; 41.0%) as well as the highest rate (23.3 cases per 100,000). The 30-39 years age group had the second highest number of cases (78; 24.6%) and the second highest rate (15.2 cases per 100,000) among the age groups. The 40-49 years age group accounted for 15.1% (48) of the cases, followed by the 50-59 years age (38; 12.0%). Teenagers (13-19 years) accounted for 4.4% (14) of the new cases in 2015 and 2.8% (9) of the cases were aged 60 years and over.

Newly Diagnosed HIV Cases by Age Group, Oklahoma 2015

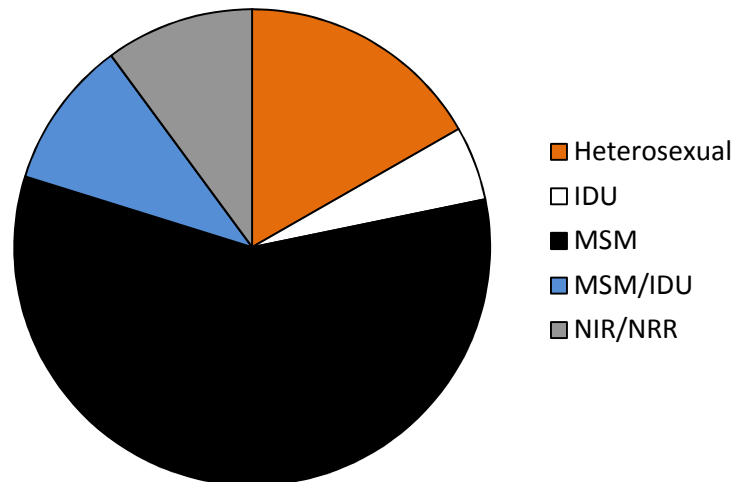


By Mode of Transmission

Of the 2015 newly diagnosed HIV cases:

- 58.0% (184) were men who have sex with men (MSM)
- 16.7% (53) were heterosexual contact
- 10.1% (32) were MSM and injection drug use (IDU)
- 5.0% (16) were IDU
- 10.1% (32) were no reported risk or no identified risk

Newly Diagnosed HIV Cases by Risk, Oklahoma 2015

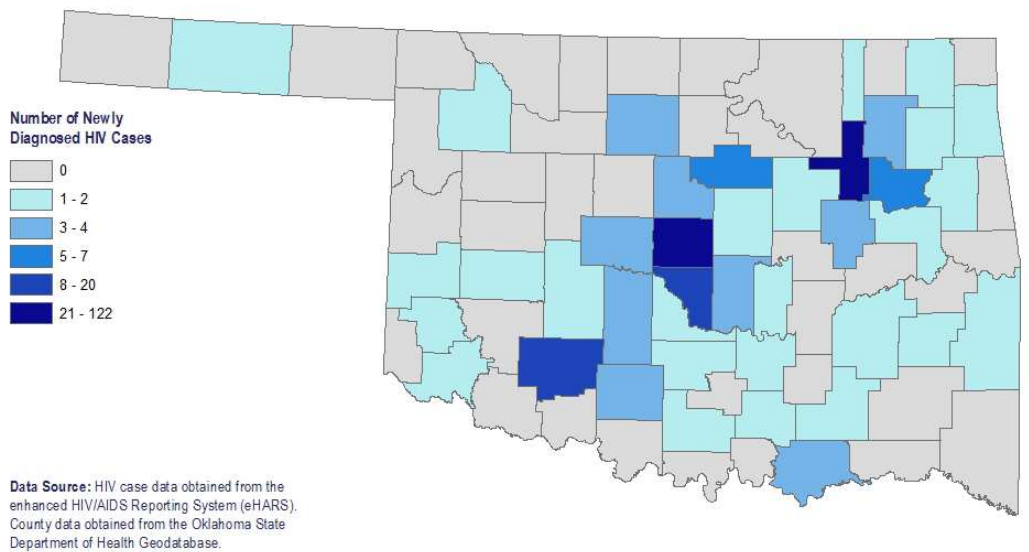


By Geography

Four counties in Oklahoma accounted for almost 75% of the 2015 newly diagnosed HIV cases: Oklahoma (122; 38.5%), Tulsa (79; 24.9%), Cleveland (20; 6.3%), and Comanche (16; 5.0%). The rate in Oklahoma county was 15.7 cases per 100,000 and the highest rate among these four counties. Despite having fewer cases, Comanche county (12.8 cases per 100,000) had a higher rate of newly diagnosed HIV cases than Tulsa county (12.4 cases per 100,000) and Cleveland county (7.3 cases per 100,000).

The Oklahoma City metropolitan statistical area (MSA) accounted for 48.9% (155) of the 2015 newly diagnosed HIV cases in Oklahoma. The Oklahoma City MSA had a rate of 11.4 cases per 100,000, which was the second highest HIV rate among the MSAs. Approximately 30% of the new HIV cases were diagnosed in the Tulsa MSA (94; 29.7%). The HIV rate in the Tulsa MSA was 9.6 cases per 100,000, which was the third highest rate among the MSAs. The Lawton MSA accounted for 5.0% (16) of the newly diagnosed cases with a rate of 12.2 cases per 100,000, the highest rate among the MSAs. In 2015, 16.4% (52) of the new HIV cases were diagnosed in counties that were not part of one of these three MSAs.

Newly Diagnosed HIV Cases by County, Oklahoma 2015



Created: 08.03.2016

Projection/Coordinate System: USGS Albers Equal Area Conic

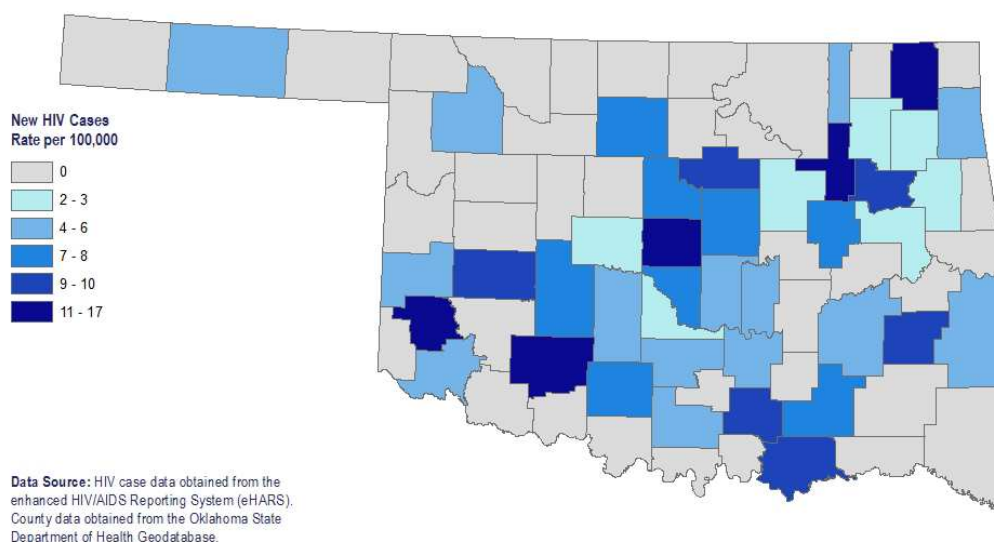


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Newly Diagnosed HIV Rate by County, Oklahoma 2015



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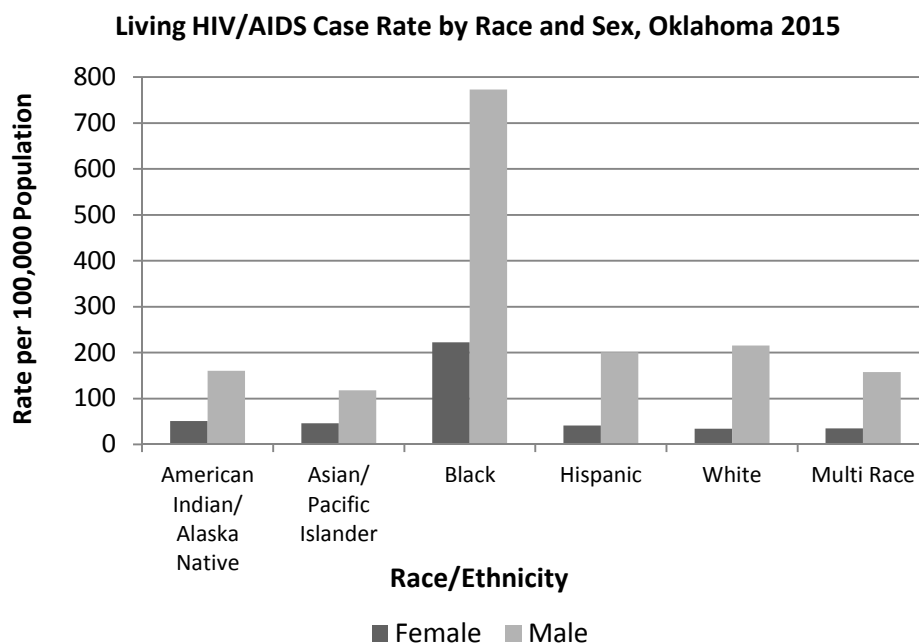
LIVING HIV/AIDS CASES

By Race

Of the 5,756 persons living with HIV/AIDS at the end of 2015:

- 55.7% (3,206) were White
- 25.1% (1,446) were Black
- 8.6% (495) were Hispanic
- 5.9% (337) were American Indian/Alaska Native
- 1.2% (71) were Asian/Pacific Islander
- 3.5% (201) were Multi Race

At the end of 2015, Blacks had the highest rate of living HIV/AIDS cases (497.3 cases per 100,000) among the race/ethnic groups in Oklahoma. Hispanics (124.9 cases per 100,000) had the second highest rate, followed closely by Whites (123.2 cases per 100,000). The rate among American Indians/Alaska Natives was 104.8 cases per 100,000 and the rate among Multi Race was 94.8 cases per 100,000. Asian/Pacific Islanders had the lowest rate of persons living with HIV/AIDS (80.5 cases per 100,000) in Oklahoma. Blacks are disproportionately affected by HIV/AIDS in Oklahoma, as the rate for Blacks living with HIV/AIDS was 3.4 times higher than the state rate (147.2 cases per 100,000) and 4.0 times higher than the rate of Whites living with HIV/AIDS in Oklahoma.



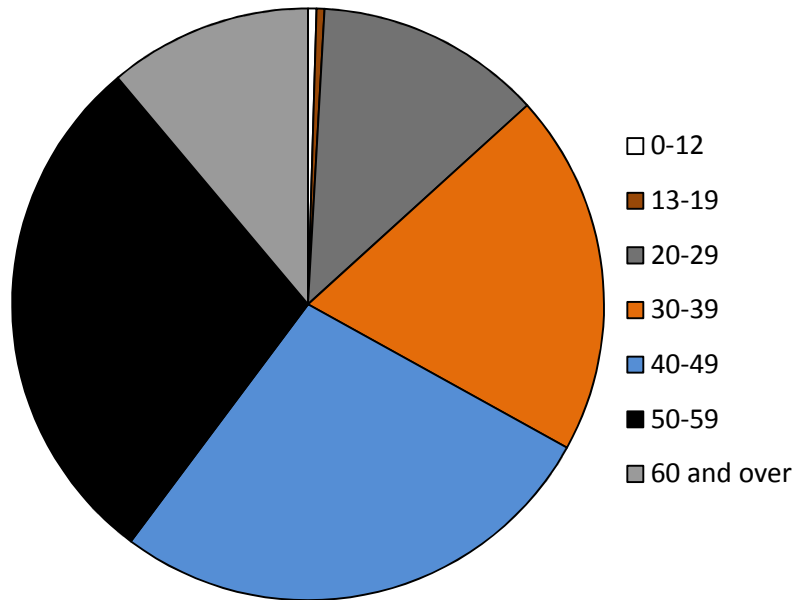
By Sex

Males accounted for 82.7% (4,762) of the HIV/AIDS cases living in Oklahoma, while females only accounted for 17.3% (994). The rate of males (245.8 cases per 100,000 population) living with HIV/AIDS in Oklahoma was 4.9 times higher than the rate of females (50.3 cases per 100,000 population). Of the race/sex groups, Black males had the highest rate of living with HIV/AIDS (773.1 cases per 100,000), followed by Black females (222.5 cases per 100,000), White males (215.3 cases per 100,000), and Hispanic males (200.7 cases per 100,000).

By Age

By current age group, the 50-59 years age group (1,650; 28.7%) has the highest burden of living HIV/AIDS cases in Oklahoma, followed very closely by the 40-49 years age group (1,564; 27.2%). The 30-39 years age group (1,138; 19.8%) accounted for the third highest number of cases. The 20-29 years age group (713) accounted for 12.4%, and the 60 years and over (640) accounted for 11.1%. Teenagers (25; 0.4%) and children 12 years and under (26 cases; 0.5%) combined to account for less than 1% of the living HIV/AIDS cases. The 40-49 years age group had the highest rate of 339.9 cases per 100,000, followed by the 50-59 years age group at 321.6 cases per 100,000.

Living HIV/AIDS Cases by Current Age Group, Oklahoma 2015



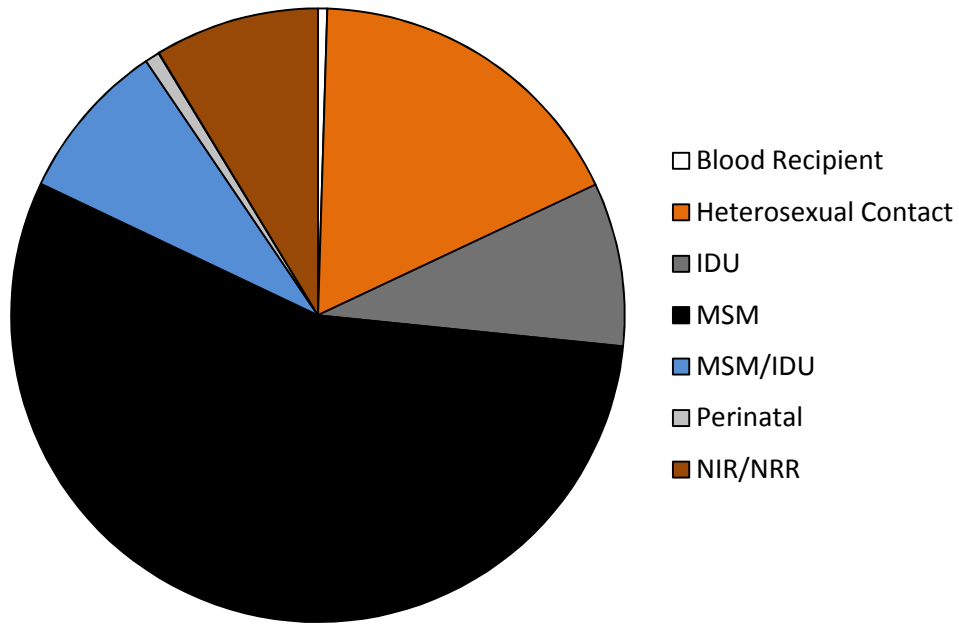
By Mode of Transmission

Of the 5,756 HIV/AIDS cases living in Oklahoma:

- 55.4% (3,191) were men who have sex with men (MSM)
- 17.5% (1,008) were heterosexual contact
- 8.6% (496) were injection drug use (IDU)
- 8.5% (488) were MSM and IDU
- 0.8% (45) were perinatal
- 0.5% (28) were blood recipients
- 8.7% (500) were no reported risk or no identified risk

Among males, MSM was the most commonly reported risk factor accounting for 67.0% (3,191) of the cases. Heterosexual contact was the second most common risk factor among males accounting for 11.4% (543), followed by cases reporting both MSM and IDU (488; 10.2%). Among females, heterosexual contact (465; 46.8%) was the most commonly reported risk factor, followed by IDU (208; 20.9%).

Living HIV/AIDS Cases by Risk, Oklahoma 2015

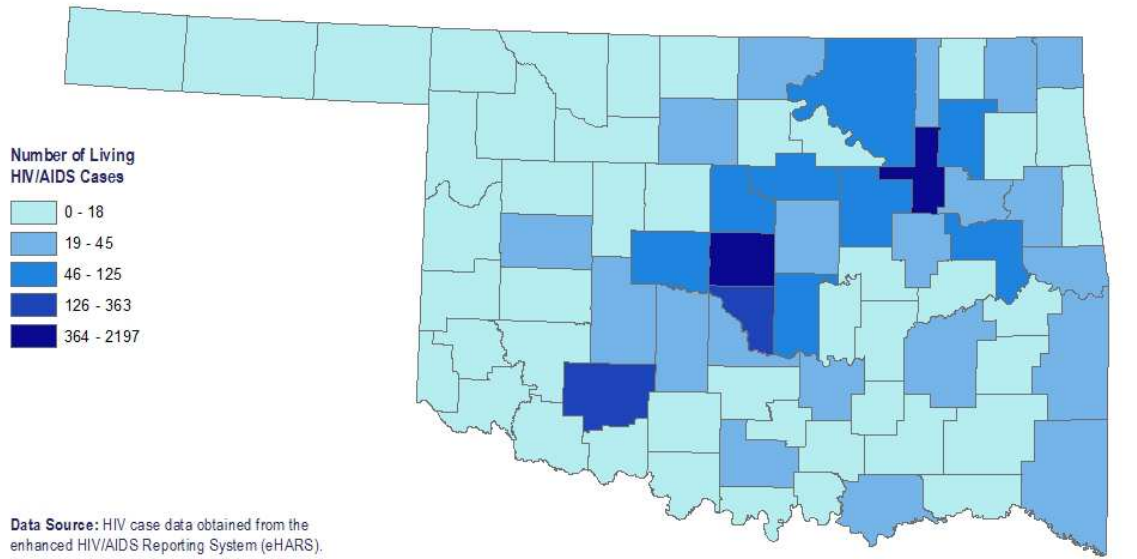


By Geography

Approximately 75% of the living HIV/AIDS cases reside in four counties: Oklahoma (2,197; 38.2%), Tulsa (1,542; 26.8%), Cleveland (363; 6.3%), and Comanche (201; 3.5%). Oklahoma county had the highest rate of cases living with HIV/AIDS (282.8 cases per 100,000). Tulsa county had the second highest rate of cases living with HIV/AIDS cases (241.2 cases per 100,000).

The Oklahoma City MSA accounted for nearly half of the living HIV/AIDS cases (2,826; 49.1%) and had the largest rate (208.0 cases per 100,000) among the MSAs. The Tulsa MSA accounted for 31.2% (1,797) of the living cases and had the second highest rate at 183.2 cases per 100,000. The Lawton MSA accounted for 3.5% (203) of the living cases. Approximately 17% (930; 16.6%) of the living HIV/AIDS cases resided in counties outside of these MSAs in Oklahoma.

Living HIV/AIDS Cases by County, Oklahoma 2015



Data Source: HIV case data obtained from the enhanced HIV/AIDS Reporting System (eHARS). County data obtained from the Oklahoma State Department of Health Geodatabase.

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Projection/Coordinate System: USGS Albers Equal Area Conic



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Newly Diagnosed HIV Cases and Living HIV/AIDS Cases, Oklahoma 2015				
	Newly Diagnosed HIV Cases		Living HIV/AIDS Cases	
	Number	Percent	Number	Percent
Race/Ethnicity				
American Indian/Alaska Native	24	7.6%	337	5.9%
Asian/Pacific Islander	11	3.5%	71	1.2%
Hispanic (All Races)	40	12.6%	495	8.6%
Black	76	24.0%	1,446	25.1%
White	149	47.0%	3,206	55.7%
Multiple Race	17	5.4%	201	3.5%
Sex				
Female	44	13.9%	994	17.3%
Male	273	86.1%	4,762	82.7%
Age at Diagnosis				
0 - 12 years	0	0.0%	59	1.0%
13 - 19 years	14	4.4%	223	3.9%
20 - 29 years	130	41.0%	2,072	36.0%
30 - 39 years	78	24.6%	1,942	33.7%
40 - 49 years	48	15.1%	995	17.3%
50 - 59 years	38	12.0%	373	6.5%
60 years and over	9	2.8%	90	1.6%
Unknown	0	0.0%	2	<0.1%
Risk				
Blood Recipient	0	0.0%	28	0.5%
Heterosexual Contact	53	16.7%	1,008	17.5%
IDU	16	5.0%	496	8.6%
MSM	184	58.0%	3,191	55.4%
MSM/IDU	32	10.1%	488	8.5%
Perinatal	0	0.0%	45	0.8%
Unknown/NIR/NRR	32	10.1%	500	8.7%
Total	317	100%	5,756	100%

B. HIV Care Continuum 2015

Using 2015 HIV surveillance data, a diagnosed-based HIV Care Continuum was created for Oklahoma. A diagnosed-based approach shows each step of the continuum as a percentage of the number of persons living with HIV, who have been diagnosed, as opposed to a prevalence-based approach in which each step is the percentage of the total number of persons living with HIV (diagnosed and undiagnosed infection). Oklahoma chose the diagnosis-based continuum because this the most accurate data available and this approach is the beneficial for infection service delivery planning. As diagnosed persons are known to the health department they are the persons that can be most effectively targeted for interventions to help link and retain in care.

The 2015 Oklahoma HIV Care Continuum includes three of the four recommended steps for a diagnosis-based approach. The first step is *linkage to care* which is defined as the percentage of persons diagnosed with HIV, in Oklahoma in 2015 that had one or more viral load or CD4 tests within three months after diagnosis. This step has a different denominator than the other two steps of the continuum. The second step is *retained in care* which is defined as the percentage of diagnosed persons living with HIV at the end of 2015 who had 2 or more documented viral load or CD4 tests performed at least three months apart in 2015. The third step of the continuum is *viral load suppression* defined as the percentage of individuals living with HIV at the end of 2015 whose most recent HIV viral load within 2015 was less than 200 copies/mL. The recommended step of the care continuum that was omitted was *antiretroviral use* because this information is only readily available for Ryan White clients and a measure of only these clients would severely underestimate antiretroviral use in Oklahoma in 2015.

Of the 317 HIV cases diagnosed in Oklahoma in 2015, 73.5% (233) were linked to care. Of the 5,756 persons living with HIV, in Oklahoma at the end of 2015, 65.1% (3,747) were retained in care and 46.8% (2,696) were virally suppressed.

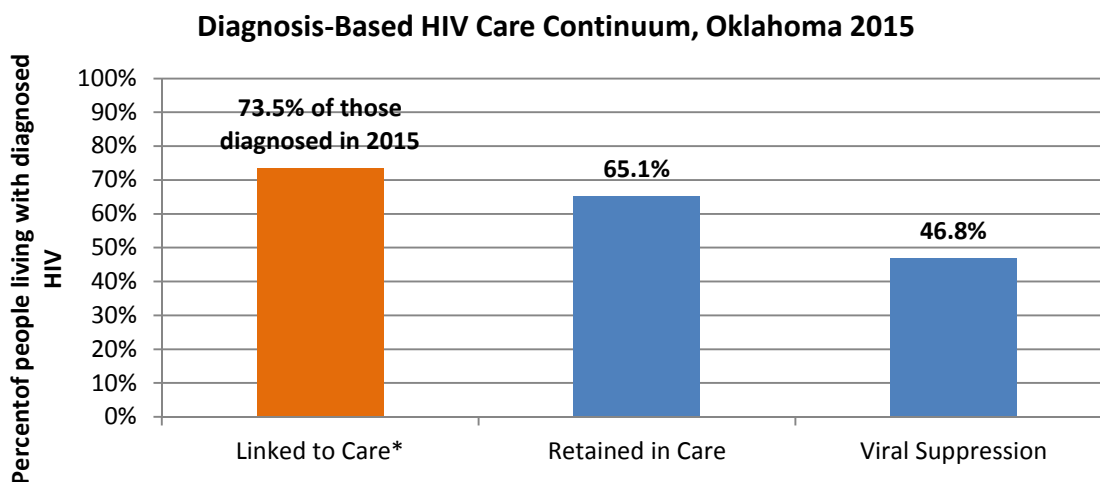
Disparities in the percentage of 2015 newly diagnosed persons linked to care existed by race/ethnicity. Asian/Pacific Islanders (100%) had the highest percentage of persons linked to care, however this group also accounted for the smallest number of new HIV cases in 2015. Whites (77.9%) had the second highest percentage of linked to care, followed by American Indian/Alaska Natives (70.8%), Blacks (68.4%), and Hispanics (65.0%). Multi Race (64.7%) had the lowest percentage of cases linked to care. Males and females had similar percentages of cases linked to care, 73.3% and 75.0% respectively. Disparities in linkage to care also existed by risk group. Cases classified as heterosexual contact (84.9%) had the highest percentage of cases linked to care. MSM (73.4%) had the second highest percentage of persons linked to care, followed by MSM/IDU (71.9%). IDU (62.5%) and NIR (62.5%) cases had the same percentage of cases linked to care.

Disparities in the percentage of persons living with HIV retained in care and virally suppressed in 2015 were observed among the racial/ethnic groups. Multi Race had the

highest percentage of cases retained in care (76.6%) and virally suppressed (55.7%). Asian/Pacific Islanders had the second highest percentage retained in care (74.6%) and virally suppressed (54.9%). American Indian/Alaska Natives had the third highest percentage retained in care (73.6%) followed by Whites (67.3%), however Whites had a higher percentage of persons who were virally suppressed (50.5%) than American Indian/Alaska Natives (45.5%). Blacks and Hispanics had the lowest percentages of cases retained in care (60.2% and 53.3% respectively) and who were virally suppressed (40.3% and 38.2% respectively).

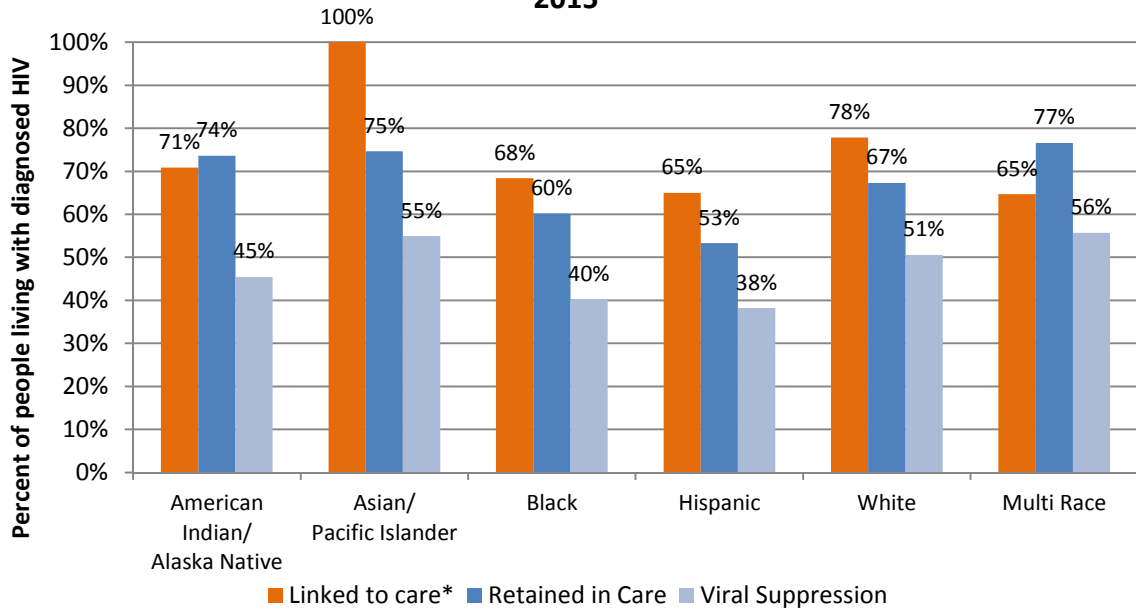
Males and females had similar percentages of persons retained in care in 2015 and virally suppressed. Of the males, 65.4% were retained in care and 47.3% were virally suppressed. Females had slightly lower percentages retained in care (63.6%) and virally suppressed (44.5%) than males. Across risk groups small variations were seen in the percentage of persons retained in care and virally suppressed. MSM/IDU had the highest percentage of cases retained in care (68.6%), followed very closely by MSM (68.6%).

The additional risk groups had comparable percentages retained in care: 64.4% of cases reporting other risks (includes blood recipients and perinatal exposure), 63.3% of heterosexual cases, and 62.1% of IDU cases. NIR cases had the lowest percentage of cases retained in care at 46.8%. MSM had the highest percentage of cases virally suppressed (50.4%). MSM/IDU (45.9%) had the second highest percentage of virally suppressed cases, followed by heterosexual contact (45.0%), IDU (44.0%), and other risk (42.5%). NIR cases had the lowest percentage of virally suppressed cases at 32.4%.



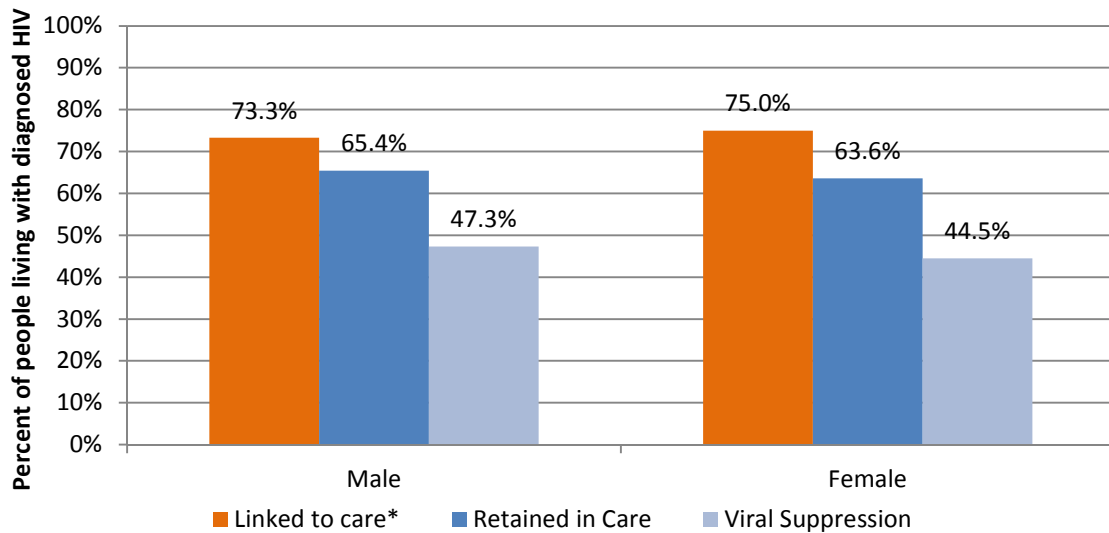
**Linkage to care measures the percentage of people diagnosed with HIV in 2015 who had one or more documented viral load or CD4 tests within 3 months of diagnosis. It is calculated differently from other steps and cannot be directly compared to other steps*

Diagnosis-Based HIV Care Continuum by Race/Ethnicity, Oklahoma 2015



*Linkage to care measures the percentage of people diagnosed with HIV in 2015 year who had at least 1 viral load or CD4 test within 3 months of diagnosis. It is calculated differently and it cannot be directly compared to other steps.

Diagnosis-Based HIV Care Continuum by Sex, Oklahoma 2015



*Linkage to care measures the percentage of people diagnosed with HIV in 2015 year who had at least 1 viral load or CD4 test within 3 months of diagnosis. It is calculated differently and cannot be directly compared to other steps.

The HIV Care Continuum is currently utilized to plan and prioritize a targeted response to the needs of PLWH in Oklahoma. Targeted testing to high risk individuals was implemented through prevention CTR contracts with a required 1% positivity rate and contractors include community based organizations (CBOs) that serve Hispanics, Blacks, IDUs and youth – key populations that are less likely to be tested and linked to care. The care continuum is also reflective of the challenges to care provision that the Oklahoma State Department of Health (OSDH) has identified and continues to work towards identifying solutions for improvement.

Oklahoma’s health care workforce is a story of shortage and maldistribution. Currently the Health Resources Services Administration (HRSA) designates all but 4 of Oklahoma’s counties as complete or partial primary care health professional shortage areas (HPSA)¹. With a shortage of primary health care providers, locating care providers willing to care for and treat HIV is a daunting task. The HIV Care Continuum will allow the OSDH HIV care and prevention services to continue to monitor the impact of available resources or lack of needed resources for those PLWH. It is only with additional resources that OK will see improved engagement and outcomes particularly in the areas of retention in care and viral suppression.

¹ Retrieved from https://www.ok.gov/health/document/HPSA_Primary

C. Financial and Human Resources Inventory

Funding Source	Public or Private	Funded Service Provider Agencies	Type of Service	Amount	Components Impacted
Ryan White – Part B,C,D, and Emerging Communities	Public	OSDH, University of Oklahoma Health Sciences Center, Oklahoma State University Medical Center, RAIN, Tulsa Cares, HSI and University of Oklahoma Pharmacy	Care and Treatment Services	\$ 10,446,900	HIV diagnosis, linked to care, retained in care, on ART, and achieving viral suppression
State Dollars Maintenance of Effort	Public	OSDH	Care and Treatment Services	\$786,000	HIV diagnosis, linked to care, retained in care, on ART, and achieving viral suppression
AETC	Public	Texas Oklahoma AIDS Ed Training Center	Care and Treatment Services	\$19,738	Linked to care, retained in care, on ART, and achieving viral suppression
CDC HIV Prevention & Surveillance	Public	Oklahoma State Department of Health	Prevention	\$ 2,284,061	HIV diagnosis, linked to care, retained in care, on ART, and achieving viral suppression
HUD/HOPWA	Public	City of Oklahoma City Housing and Community Development Planning Department	Housing	\$ 1,131,030	Linked to care, retained in care, on ART, and achieving viral suppression
Other	Private	Oklahoma AIDS Care Fund	Prevention, Care and Treatment Services	\$320,500	HIV diagnosis, linked to care, retained in care, on ART, and achieving viral suppression

Inventory of Services by Agency in Oklahoma:

- **Oklahoma State Department of Health** – Provides HIV education and training, supports HIV testing, surveillance activities, partner services, linkage to care, and provides administration of the Ryan White part B program to ensure low-income Oklahomans have access to quality medical care, HIV medications through the AIDS Drug Assistance Program (ADAP), Health Insurance premium and co-pay assistance through the Health Insurance Assistance Program (HIAP) and other RW part B allowable services.
- **Oklahoma Department of Human Services, Division of AIDS Coordination & Information Services** – Provides HIV non-medical case management
- **University of Oklahoma Health Sciences Center, Infectious Disease Institute (OUHSC-IDI)** – Provides primary & specialty HIV medical care, lab services, treatment adherence counseling, medical case management, HIV testing, radiology services, translation services, dental assistance, medication assistance, HIV/STD education, Consumer Advisory Board, peer mentor program, nutrition services, mental health services and clinical research. Partially funded by Ryan White Part B, C, and D.
- **Oklahoma State University Medical Center, Internal Medicine Specialty Services (OSUMC-IMSS)** – Provides outpatient primary and specialty HIV medical care, treatment adherence counseling, mental health and substance abuse services, psychiatry, dental services, lab services, transportation, medication assistance, and medical case management. Also coordinates and supports statewide home health services for RW clients. Partially funded by Ryan White Part B and C.
- **HSI** - Provides premium payments for the HIAP funded by Ryan White Part B.
- **University of Oklahoma Pharmacy** – Provides medications statewide for the ADAP funded by Ryan White Part B.
- **RAIN** – Provides HIV testing, non-medical case management, dental assistance, transportation assistance, HIV prevention education, and support for a transitional living facility. Also supports a farmers market for the HIV community. Partially funded by Ryan White Part B.
- **Guiding Right, Inc.** – Provides HIV testing, linkage to care services, HIV and STD education, support groups, African American Faith Community for AIDS Prevention, the SISTA Project, Many Men, Many Voices, and HOPWA.
- **Be the Change** - HIV Network program that provides transportation and moving services to HIV clients.
- **Children’s Hospital Foundation** - A dedicated nurse practitioner for 20 children and their families to help navigate the HIV community as the children learn and understand their disease and the impact it will have on their relationships in adolescent life and beyond.
- **Expressions Community Center** – Provides a facility for community based organizations to offer HIV testing, non-medical case management, HOPWA, mental health services, support groups, and other HIV related services to the LGBT community in Oklahoma City.

- **Heartline 2-1-1** – Telephone services that provide crisis intervention, suicide prevention and HIV service navigation.
- **H.O.P.E.** – Provides HIV testing and linkage to care services, HIV and STD education, and MSM outreach.
- **Latino Community Development Agency** – Provides bilingual HIV testing services, HIV and STD outreach and education, HIV support groups, HIV adult and teen prevention classes, HOPWA, linking to care services, and offers the Breaking the Silence program that provides culturally sensitive counseling, testing and referrals to help reduce HIV infection and transmission in the Latino community.
- **Indian Health Services** – HIV testing and linkage to care services, HIV prevention education, and general medical care
- **Legal Aid Services Oklahoma** - Provides free legal services in civil matters to low-income Oklahomans who have HIV/AIDS including assistance with housing problems, income maintenance problems, consumer problems, employment problems, family law issues, and end-of-life planning.
- **MAMA Knows** – Provides HIV, HCV and STD education and early detection programs that are culturally appropriate, as well as HIV linkage to care, HIV screening and testing for rural areas located in south central Oklahoma.
- **Oklahoma AIDS Care Fund** – Provides financial support to multiple agencies across Oklahoma to provide various HIV/AIDS services. They directly support the emergency assistance program, education services, testing programs and advocacy programs of the organization.
 - **Emergency financial assistance** for clients with no other means to pay for medical, housing, utilities, or prescriptions.
 - **Educational outreach for HIV prevention**
 - **Purchase of HIV test kits** to provide free testing through a partnership with the Oklahoma State Department of Health
 - **Advocacy** initiative to inform Oklahoma legislatures about HIV/AIDS services and issues affecting HIV/AIDS positive individuals and their families.
- **Other Options** - Provides food and nutritional supplements for distribution in the food pantry.
- **Planned Parenthood** – Provides the Get Real program to bring to individuals and groups the information skills motivation and means to reduce the transmission of HIV.
- **Winds House** - Provides transitional & supportive housing in **Oklahoma City** for individuals living with HIV and AIDS
- **Tulsa CARES** – Provides social case management, mental health services, nutrition services including a food pantry, HOPWA, transportation assistance, prescription assistance, and bilingual case management.
- **Veterans Administration (VA)** - located in the Oklahoma City provides HIV outpatient and inpatient medical care to qualified veterans.

The HIV Workforce capacity in Oklahoma is sufficient to sustain prevention service provision. A varied and robust group of individuals, some licensed and some paraprofessionals provide HIV prevention services after completion of several trainings provided by the OSDH HIV prevention health education staff. HIV care services are provided by multi-level practitioners and licensed personnel such as medical social workers, LPNs, RNs, ARNPs, PAs, MDs and DOs. PharmD staff is utilized in the clinics to assist with prescribing of appropriate ARV therapy and adherence evaluation and peer navigators assist in the clinics as well. Oklahoma's capacity for HIV medical treatment is limited due to a lack of primary medical providers which has impacted the OUHSC-IDI Part C clinic in Oklahoma City. This has created barriers to getting newly diagnosed persons into care within the 90 day parameter set by the NHAS due to continued vacancies of key medical provider staff at the clinic. Rural areas have a critical shortage of medical providers which requires that clients travel to the nearest MSA for HIV care.

Ryan White case managers both medical and non-medical are instrumental in the coordination of Ryan White funded services and non-Ryan White funded services for clients. Ryan White is always payer of last resort so if clients have access to other same services not funded by Ryan White then that client must access those services first. CTR counselors and Disease Intervention Specialists (DIS) are charged with linking clients to prevention and care services through their work with clients. Through the Oklahoma HIV Hepatitis Planning council (OHHPC) much information is shared and networking occurs which allows for utilization and access of those at risk for HIV or HIV infected to all available services, both prevention and care. OSDH further assists clients with the production of both a HIV care and HIV prevention resource guide offering them contact information, service descriptions, eligibility criteria and means to self-access these services.

Access to HIV medical care is the most needed resource for PLWH at this time. A task force has been established to address the issues related to this and meets on an every-other-month basis. This task force is composed of HIV care and prevention stakeholders and providers. A linkage to care coordinator position was created and is providing extensive follow-up to newly diagnosed persons to ensure that they are linked to a medical provider and attend their first medical appointment.

D. Assessing Needs, Gaps, and Barriers

Prevention and Care needs of PLWH were determined in a treatment needs assessment conducted in the spring of 2016. This process began with discussion at the OHHPC meeting. and it was determined that the evaluation committee would produce the needs assessment. The OHHPC is composed of 15-25 voting members who include 5 PLWH, 5 prevention stakeholders, 5 treatment and care stakeholders and 10 at large members. Any other interested persons may attend the meeting but do not have voting privileges. The evaluation subcommittee is composed of care and prevention staff and volunteers as well as consumers. During the evaluation subcommittee meeting it was

decided that the needs assessment would be administered at facilities and organizations providing care and support services to PLWH. It was also decided that an incentive would be offered for completion of the survey.

Targeted sites were the two state Part C clinics, RAIN and Tulsa Cares as well as two food pantries, one in the Oklahoma city MSA and the other in the Tulsa MSA, that provide food to PLWH. The surveys were administered over the course of 6 weeks and then returned to the OSDH for analysis. Two hundred and sixty six completed surveys were received and utilized for analysis. One Hundred and thirty surveys with a postage paid return envelope were mailed out to persons identified as being out of care within the last year. Of those surveys only one completed survey was returned. Results of the survey are in the chart below. Of significance, only 2 survey respondents had never been in care so the survey results cannot be generalized to the HIV infected community.

Number of Responses for the Importance, Utilization, and Lack of Access to Medical and Social Services, Ordered by Highest Lack of Access (n=267)

Medical or Social Services	<i>This service is important to me.</i>	<i>I have used this service, in the past 12 months.</i>	<i>I did not have access to this service, but I needed it.</i>
Emergency Financial Assistance	75	11	18
Dental Care	167	70	15
Legal Assistance	58	9	13
Housing Assistance	99	34	12
Home Health	41	11	10
Transportation to Medical Appointments	89	44	9
Buddy/Companion	40	11	9
Employment Services	49	5	8
HIV Prevention for Positives/Risk Reduction	58	14	8
Nutritional Counseling	62	19	7
Support Groups	68	25	7
Substance Abuse Services	40	13	6
Food Bank/Pantry	121	61	6
Physical Rehabilitation	35	11	6
Health Education	44	10	6
Health Insurance Assistance	169	99	5
Inpatient Services	73	27	5
Mental Health Services	101	49	5
Child Care	20	5	5
Child Welfare	15	2	5
Day Care for Adult	17	3	5
Client Advocacy	43	9	5
Medical Case Management	154	82	4
Non-medical Case Management	125	81	4
Outpatient Medical Care	153	93	3
HIV Counseling, Testing, and Referral	61	20	3
Medication Assistance	199	131	2
HIV Medication Adherence	112	51	2

Service needs/gaps of persons at risk for HIV include education, testing and treatment. With the continued reduction in prevention funds services have been reduced and availability of these resources is not sufficient to support the need in all areas of the state. Needs that have been diminished by this reduction include the inability to aggressively identify individuals at high risk of HIV but unaware of their diagnosis; reduction in disseminating HIV/STD prevention messages and less outreach efforts to high risk populations, and decreasing the ability to implement universal HIV testing. Lack of funding has also made the possibility of providing medication for PREP impossible at this time.

The top three service needs/gaps of PLWH identified with the 2016 needs assessment are emergency financial services, dental and legal services. Emergency financial assistance is somewhat limited and certainly availability is not as great for those persons in the rural areas of the state. Dental Service funding has continued to be increased annually for the last 4 years and is quite robust on both sides of the state. Legal Services are not as available on the Eastern side of the state and again rural areas are impacted by the lack of local services. None of the top service needs are of statistical significance but further evaluation is warranted.

Barriers to HIV prevention and care services reveal a multitude of issues in Oklahoma:

- Social and structural barriers include stigma and poverty. Many persons at risk for HIV or those living with HIV are worried about persons in their community finding out about their status or high risk behaviors and do not access services in their community. Transportation then to other areas is limited or unavailable due their impoverished status.
- There are no federal, state, or local policy barriers to prevention or care services.
- County health departments present no barriers to care as these services are not offered through the counties. Staff capacity and lack of public health oriented nursing staff have created some barriers to prevention services.
- Program barriers include capacity related to access to HIV medical care as well as the decrease in funding for prevention services.
- Service provider barriers as discussed throughout this plan include lack of medical providers especially medical specialty providers necessary for complicated HIV care.
- Client barriers are the most significant barriers to care and prevention services. Transportation for those persons living in rural or underserved communities is a huge barrier for prevention services and to some degree for care services although assistance is available through Ryan White for those persons who are eligible. Inability to navigate the system is another issue and the need for peer navigators is a solution that is being considered. Mental illness is a significant

barrier to care and prevention services and Oklahoma's decreased funding over the last several years has contributed to a mental health crisis. IDU and drug abuse are also significant client barriers to services.

E. Data: Access, Sources and Systems

Data utilized for the needs assessment and development of the HIV Care Continuum included data from HIV surveillance, HIV prevention, Ryan White programs, and the Oklahoma Health Care Authority (OHCA). Data systems included CAREWare, EHARS, Medicaid data, xPEMS, and the Public Health Investigation and Disease Detection of Oklahoma (PHIDDO) which supports Ryan White ADAP data.

The integration of the HIV surveillance, prevention and care within the HIV/STD Service at the OSDH facilitated complete sharing of data from all areas and a data agreement with the OHCA allows for exchange of data.

No data or information was identified as unavailable to the OHHPC that would have been used for the needs assessment.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

NHAS GOAL 1: Reducing new HIV infections

2017-2021 SMART Objective (Local): By 2021, decrease the number of new infections by 10% (317 to 285)

2017-2021 SMART Objective (Local): By 2021, decrease the number of persons living with HIV who are not aware of their HIV status by 5% (from 21% to 16%)

Strategy: Support and strengthen integrated and patient-centered HIV and related screening and linkage to related services

Timeframe	Responsible Parties	Activity	Target population	Data Indicators
By the end of 2021:	CDC funded Health Departments and Community Based Organizations	Deliver intensified HIV testing, referral services.	Youth (less than 30 years)	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed positive persons
By the end of 2021:	CDC funded Health Departments and Community Based Organizations	Deliver intensified HIV testing, referral services.	All African American and Hispanic persons in Oklahoma	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed positive persons
By the end of 2021:	CDC funded Health Departments and Community Based Organizations	Deliver intensified HIV testing, referral services.	MSM and MSM/IDU in Oklahoma	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed positive persons

NHAS GOAL 2: Increase access to care and improving health outcomes for people living with HIV

2017-2021 SMART Objective (Local): By 2021, increase the number of newly diagnosed HIV cases linked to medical care by 10% (from 73% to 83%)

2017-2021 SMART Objective (Local): By 2021, increase the number of persons living with HIV who are virally suppressed by 10% (from 47% to 57%)

Strategy: Support and strengthen capacity to implement innovative and culturally appropriate models to more effectively deliver care along the care continuum.

Timeframe	Responsible Parties	Activity	Target population	Data Indicators
By the end of 2021:	Ryan White Part B Grantee and Service Providers	Develop alternative payment mechanisms for medical services	All persons living with HIV/AIDS in Oklahoma	<ul style="list-style-type: none"> • Number of persons in HIV medical care • Number and percent of persons with suppressed viral load
By the end of 2021:	Ryan White Part B Grantee and Service Providers	Increase the number of available providers of HIV care	All persons living with HIV/AIDS in Oklahoma	<ul style="list-style-type: none"> • Number of persons in HIV medical care • Number and percent of persons with suppressed viral load

NHAS GOAL 3: Reducing HIV-Related disparities and Health Inequities

2017-2021 SMART Objective (Local): By 2021, ensure HIV Prevention Providers (including: HIV education, HIV testing, and linkage to care) serve African American, Hispanic, and MSM population in Oklahoma.

2017-2021 SMART Objective (Local): By 2021, implement a statewide HIV education media campaign targeting high risk populations in Oklahoma focusing on risk factors, testing, and treatment information.

Strategy: Implement wide scale approaches to reduce HIV infections and improve health outcomes in high risk communities.

Timeframe	Responsible Parties	Activity	Target population	Data Indicators
By the end of 2021:	CDC funded Health Department	Ensure HIV prevention services include providers who serve high risk populations	MSM, MSM & IDU, African Americans, and Hispanics	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed positive persons
By the end of 2021:	Ryan White Part B Grantee and CDC funded Health Department	Increase awareness and early identification of HIV infection among high risk groups in Oklahoma	MSM, MSM & IDU, African Americans, Hispanics, and persons living in underserved areas of Oklahoma	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed positive persons • Number of persons in HIV medical care

B. Collaborations, Partnerships, and Stakeholder Involvement

The OHHPC played an integral part in the development of the plan, with participation and input from care and prevention partners heavily involved as well. The OHHPC Evaluation Committee developed, distributed, and analyzed the needs assessment the results contributed to a core component of the comprehensive plan. All stakeholders and key partners were involved in the planning process at some level. Please see letter of concurrence (*Appendix A*)

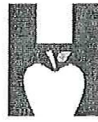
C. People Living with HIV and Community Engagement

The people involved in the development of the state plan included consumers of services and reflect the epidemic in Oklahoma. Service providers and stakeholders working directly with those infected and affected by HIV were involved in each step of the process as well. The communities impacted by HIV are included in the planning group and planning process and provide critical insight to the development of solutions to health problems and issues related to gaps and barriers to care and prevention services. We have identified that more representation from the Hispanic and Black communities to address the issues that impact their people are needed as the plan is implemented and improvements are made.

Section III: Monitoring and Improvement

The OSDH care and prevention staff will report annually to the OHHPC, updating them on the progress of plan implementation. Through dialog and feedback information will be collected and utilized for improvements to the plan. Surveillance, care, and prevention data will be analyzed on a quarterly basis to evaluate the implementation of the goals and objectives of the plan and the impact on the HIV Care Continuum. Utilization of the Epidemiology Profile data guided by the OHHPC will allow for identification of areas of need and concentration of services.

Appendix 1.



Oklahoma State Department of Health
Creating a State of Health

CDC/HRSA Project Officer

Dear Kim Brown and Daphne Kennebrew:

The Oklahoma HIV/Hepatitis Planning Council *concurs* with the following submission by the Oklahoma State Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body, e.g. planning council, advisory council, HIV planning group, planning body, has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body *concurs* that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The OHHPC Evaluation subcommittee participated in the Care Needs Assessment and provided active feedback during the preparation process. The OHHPC met on October 24, 2016, for a final review and voted unanimously to concur with the plan.

The signature(s) below confirms the *concurrence* of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: *Sumas Creedon* Date: *11/14/2016*
Amy L. Nelson *11-14-16*

Planning Body Chair(s)

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1000 NE 10th Street
Oklahoma City, OK 73117-1207
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