Marion County, Indiana

Ending the HIV Epidemic (EHE) Plan 2021-2025

FINAL VERSION – December 1, 2020

Context note 1: Progress against COVID-19 is central to the HIV effort

This Marion County EHE plan is being released during an unprecedented pandemic. In early 2020, SARS-CoV-2, the coronavirus that causes COVID-19 disease, spread rapidly across the United States and the world, infecting over 440 million people, killing at least a million (as of November 2020), and causing great uncertainty, including for people at risk for HIV, STIs, and viral hepatitis.

The SARS-CoV-2 pandemic has worsened existing challenges in public health and health services. Many of the populations and communities disproportionately affected by HIV, STIs, and viral hepatitis are particularly vulnerable to disruptions in health services and supportive services and the related economic consequences of the pandemic, including unemployment, loss of housing and increased food insecurity. The SARS-CoV-2 pandemic has also accelerated adoption of new approaches to health, including meeting with clients via telemedicine, distributing self-testing collection kits, offering multi-month medication refills, and partnering with pharmacies and retail health clinics to ensure continuity of care.

It is likely that the disruptions caused by SARS-CoV-2 and COVID-19 will continue to influence responses to HIV, STIs, and viral hepatitis through mid-2021. In that context, the Marion County Public Health Department, the Indiana Department of Health, and the many organizations and leaders participating in the Ending the HIV Epidemic Task Force are committed to innovate and integrate and leverage all available resources to advance efforts to address infectious diseases that threaten public health.

Context note 2: Progress in racial equity and justice is central to the HIV effort

Race matters in the HIV response. The burden of HIV in Marion County is carried disproportionately by people of color, particularly by African Americans, in patterns that are linked to larger social, economic, legal and health disparities. Accordingly, the Marion County EHE plan integrates a commitment to equity and justice throughout its stated values, priorities and strategies.

In that context, the Marion County Public Health Department, the Indiana Department of Health, and the many organizations and leaders participating in the Ending the HIV Epidemic Task Force commit to a focus on racial equity and justice as a central aspect of achieving progress against HIV, STIs, and viral hepatitis during the coming years.

Contents

Attachments

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Introduction

Dear colleagues:

In February 2019, at the State of the Union Address, the President announced an intention to end the US HIV epidemic by reducing new infections by 75% within 5 years and by 90% within 10 years.

Marion County, Indiana, home to the city of Indianapolis and center of one of the ten largest metropolitan areas of the Midwestern US and Great Lakes region, was selected as one of the priority jurisdictions named by the Department of Health and Human Services (DHHS) for Ending the HIV Epidemic (EHE) investments.

On behalf of the Marion County Public Health Department (MCPHD), Indiana Department of Health (IDOH), and the Marion County Ending the HIV Epidemic (EHE) Task Force, we present the following Marion County five-year plan for Ending the HIV Epidemic efforts.

This plan to control and ultimately end the local HIV epidemic is timely:

- HIV treatments are highly effective and allow people living with HIV to lead long, healthy lives and avoid transmission of HIV to their partners.
- Effective prevention options, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and syringe access, can help people vulnerable to HIV to protect themselves from contracting the virus.
- Our experience of the SARS-CoV-2 / COVID-19 epidemic has heightened awareness about the importance of public health and health care. Leaders at all levels of government and society have gained increased appreciation for the need for public education about health, access to prevention options, access to testing, access to healthcare and health coverage, and laws and policies that promote health while advancing people's rights, freedoms and opportunities.
- Now, federal funding totaling $3.3 million has been allocated in 2020 to EHE efforts in Marion County, signaling the possibility of strong sustained federal, state and local commitments to implementing the goals and strategies outlined in this plan.

Hundreds of people from more than 50 governmental and non-governmental agencies, institutions and organizations have participated in the development of this plan. We encourage you to read it and consider how you can participate in or contribute to these efforts.

In Marion County and central Indiana in the early 1980s, the first responses to the HIV epidemic were started by individuals in our communities, clinics and local health departments who had the vision and courage to act. To end the HIV epidemic during the coming decade, this plan reaches for that same vision and courage. Now is the time to act. We owe our past and future no less.

Signed:

Virginia A. Caine, MD, Director, Marion County Public Health Department
Kristina Box, MD, Indiana State Health Commissioner
Darrin Johnson, PhD, MPA, BU Wellness Network - EHE Task Force co-chair
Gloria King, EdD, Manager, Diversity & Inclusion, Eskenazi Health - EHE Task Force co-chair
Jarnell Burks-Craig, Minority Health Coalition of Marion County - EHE Task Force co-chair
Paula French, Co-founder, Step-Up, Inc. - EHE Task Force co-chair

Vision, Values, and Goal

Vision

We believe that Marion County and Indiana can become a place where new HIV transmissions and cases of AIDS are rare, people living with HIV have treatment and services to support health and prevention, and few people are vulnerable or exposed to the virus.

Values

Every person has potential to achieve better health. With sufficient information, services, support and structural change, every person has the ability to address the leading preventable health issues and epidemics in Marion County and Indiana.

Communities are Marion County's most important source of innovation and effective health promotion. This plan actively encourages the involvement of all community organizations, including faith-based groups, local businesses, community centers, schools and universities, and a range of charities.

Health services and supportive services can always be improved. This plan aims for improvements in service design and delivery and recognizes the value of integrating HIV services with other health and supportive services to meet people's needs in efficient and effective ways.

Diversity is a strength. Here in the crossroads of America, Indianapolis and Indiana have always benefitted from the diversity of people – individuals of all ages, traditions, backgrounds, and circumstances – who have come here to live and work. We cannot be isolated from each other, especially in combatting an epidemic. We gain capacity, skills and insights by working together across diverse perspectives and open communication and debate.

Stigma has no place in an epidemic response. Efforts to end the HIV epidemic should be informed by evidence, including scientific evidence and community-generated evidence, and should confront and reject stereotypes, stigma, discrimination and criminalization that impede effective programming. This plan defines strategies and actions that follow best evidence without prejudice about illness or disability, sexuality and sexual expression, gender and gender expression, addiction and drug use, mental health, poverty, social and economic class, neighborhood and region, age, accent and language, and racial, ethnic or national background.

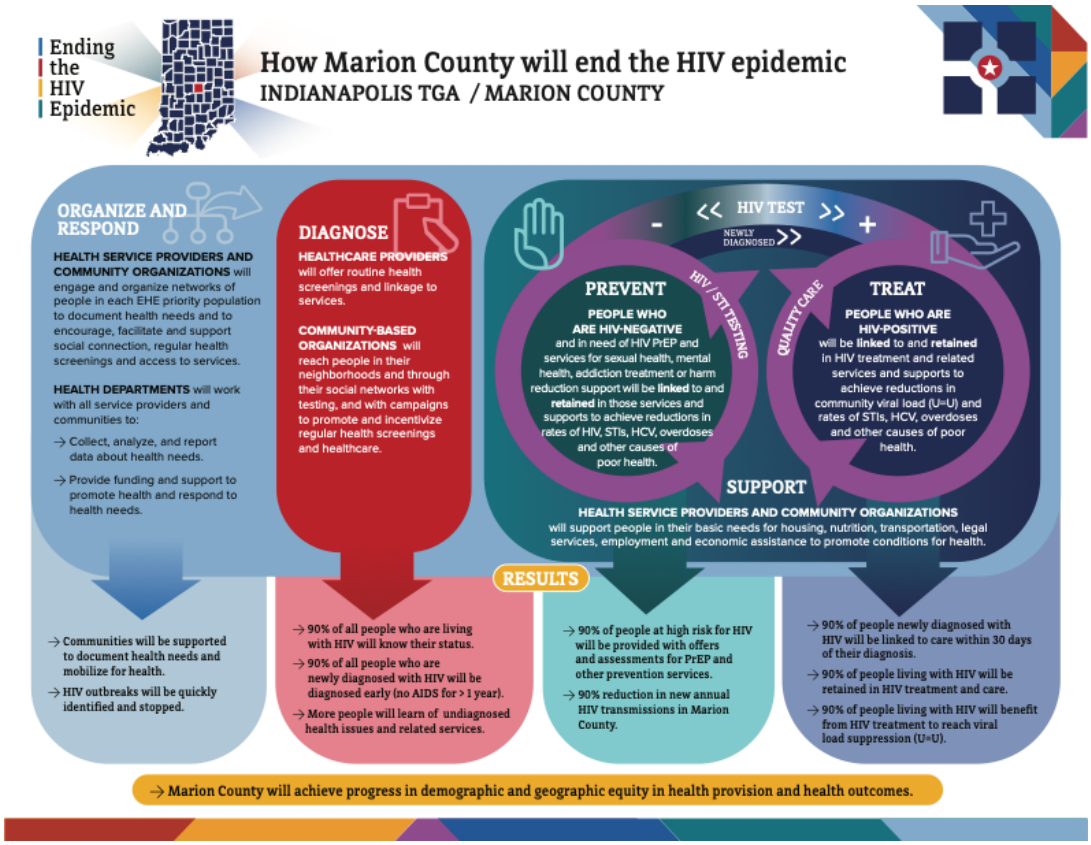
Ending the HIV epidemic requires a collective effort. The HIV epidemic, now approaching its fifth decade, has been allowed to persist for too long. The many organizations and leaders involved in the Marion County EHE Task Force and described in this EHE Plan have the ability and responsibility to act, together and now.

Goal

This Marion County plan sets a goal, aligned with the Federal Ending the HIV Epidemic goal, to reduce the number of new HIV infections in the United States by 75% by 2025, and then by at least 90% by 2030, for an estimated 2,000 total HIV infections averted in Marion County during the coming decade.

Ending the HIV Epidemic Plan at a Glance

Table 1. Infographic describing EHE pillars and intended results



The scope of this plan is **Marion County, Indiana**, which is one of the jurisdictions named by the Department of Health and Human Services (DHHS) for initial Ending the HIV Epidemic investments. Marion County encompasses the city of Indianapolis and is at the center of a larger multicounty greater Indianapolis, a greater Indianapolis Transitional Grant Area (TGA), and the state of Indiana.

"Ending the HIV epidemic" is defined by the US Department of Health and Human Services (DHHS) Ending the HIV Epidemic (EHE) initiative as reducing HIV transmissions by 90% by 2030 through a combination of efforts to diagnose, treat and prevent HIV, document and respond to emerging HIV outbreaks and other health needs, and advance demographic and geographic equity in health services and health outcomes.

"Ending the HIV epidemic" is not the end of the effort...

If and when a 90% reduction in HIV transmissions is achieved, the HIV response can then shift to a long-term effort to sustain treatment, prevention and outbreak response efforts until HIV is no longer a public health threat. An instructive analogy is the US polio epidemic, in which effective polio vaccines and public health efforts reduced poliovirus transmissions by 90% by 1960 and ended all transmissions in the subsequent years. Yet, as of 2020, over 125,000 Americans continue to live with post-polio syndrome and remain important to health services and public health, including as activists for equal access and rights of disabled people and for global polio eradication efforts still underway in Africa and Asia. (See Attachment 1 for additional discussion of terms and definitions, including how the concept of ending epidemics is defined).

Table 2. Marion County EHE Plan – Goals and Strategies at a Glance
DIAGNOSE
Goal: All HIV-positive people will learn of their status as early as possible.
Strategy 1.1: Expand health provider-initiated testing. **Strategy 1.2:** Expand community-based testing.
TREAT
Goal: All people living with HIV will be retained in care and benefit from HIV treatment to reach viral suppression (U=U).
Strategy 2.1: Further streamline linkage to care. **Strategy 2.2**: Retain and reengage people in HIV treatment and care. **Strategy 2.3:** Reduce stigma associated with HIV treatment, STIs, mental health and addictions.
PREVENT
Goal: All people in priority populations will be offered regular screenings and referrals for sexual health and behavioral health needs, including access to nPEP, PrEP and other HIV prevention services.
Strategy 3.1: Promote sexual health and behavioral health **Strategy 3.2:** Increase access to and provision and use of PrEP **Strategy 3.3:** Increase access to syringe access and harm reduction services
SUPPORT, ORGANIZE AND RESPOND
Goal: Community organizations, service providers and the county and state health departments will collaborate to document and respond to entrenched and emergent health needs and barriers in the HIV response in priority populations and quickly identify, prevent and stop HIV outbreaks.
Strategy 4.1: Increase access to supportive services. **Strategy 4.2:** Support community organizing to document health needs and barriers to HIV programming, mobilize community-led responses, and work with IDOH and MCPHD to quickly identify and stop HIV outbreaks. **Strategy 4.3:** Improve data systems and digital technology for improved health surveillance.
WORKFORCE AND MANAGEMENT
Goal: IDOH, MCPHD and all HIV providers will invest in workforce diversity and competency, and related management and accountability of the HIV workforce and of governmental and non-governmental agencies, organizations and institutions.
Strategy 5.1: Invest in diversity and linguistic and cultural competency of the HIV workforce and improve recruitment and retention of community-facing frontline health workers. **Strategy 5.2:** Invest in technical competency of medical providers, supportive service providers and community health workers through trainings, residencies, mentorships, fellowships and scholarships. **Strategy 5.3:** Engage with a diverse range of provider and community networks to foster innovation, coordination and shared accountability by all agency leaders, service providers and frontline workers toward collective impact.

Table 3. Key organizations in the Marion County EHE Plan

Marion County
Ending the HIV Epidemic (EHE) Plan

Participating Organizations

Ending the HIV Epidemic Task Force Co-Chairs:

- Darrin Johnson, PhD, MPA, Executive Director, BU Wellness Network
- Gloria King, EdD, Manager, Diversity & Inclusion, Eskenazi Health
- Jarnell Burks-Craig, President, Minority Health Coalition of Marion County
- Paula French, Co-founder, Step-Up, Inc.

Marion County EHE Task Force Members	• Marion County Public Health Department (MCPHD) - Bell Flower Clinic - Ryan White Program • Indiana Department of Health (IDOH) • Community Health Network - Community Hospital North • Eskenazi Health ID Clinic • Eskenazi Health Diversity & Inclusion • HealthNet • IU Health LifeCare • Shalom Health Care	• BU Wellness • Central Indiana Association of Black Social Workers • Choose Forward • Concerned Clergy of Indianapolis • Concord Neighborhood Center • Continuud • Damien Center • Indiana Primary Health Care Association • Indiana Youth Group • Indianapolis Urban League	• La Plaza • Meals on Wheels Purpose of Life Ministries • Minority Health Coalition of Marion County • Radio One • Step-Up • The Health Foundation of Greater Indianapolis • Trinity Haven • Violence Free Living • Volunteers of America • Women in Motion • WRTV-6
Additional EHE Plan contributors via interviews and surveys)	• Marion County Public Health Department - Substance Use Outreach Services - Safe Syringe Access Services - Adolescent Health Action Center • Marion County Jail • City-County Council • Indiana State Department of Corrections • Eskenazi Health - Emergency Department - Family Planning - Sandra Eskenazi Mental Health Center (SEMHC)	• African American Coalition of Indianapolis • Chatham Health • CHIP - Coalition for Homeless Intervention & Prevention • Eastern Star Church • GenderNexus • Anthem Blue Cross Blue Shield • Broadway United Methodist Church • CAFÉ - Community Alliance of the Far Eastside	• Dress for Success • Indiana Recovery Alliance • IUPUI – LGBTQ+ Center • John Boner Neighborhood Centers • Julian Center • LifeSmart Youth • Planned Parenthood • Red Elephant AIDS Awareness and Prevention • Servants of Christ Lutheran Church
Others named in the EHE Plan	• Alivio Medical Center • Ascension St Vincent Hospital • Aspire Indiana Health • CVS Minute Clinics • Franciscan Health • Indiana Housing and Community Development Authority (IHCDA) • Indiana Legislative Black Caucus • Interagency State Council on Black and Minority Health (ISCBMH) • Marion County Metropolitan Development Commission • Walgreens Community Clinics • Willowbrook Family Planning Clinic	• Almost 4 Minds • Indy Bag Ladies • Central Indiana Community Foundation • Exodus Refugee Immigration • HIV Modernization Movement - Indiana • Ignite Indy Youth • Immigrant Welcome Center • Indiana Health Disparities Task Force • Luna Language Services • Marion County Re-Entry Coalition • Mental Health America of Indiana (MHAI) • NAMI - National Alliance on Mental Illness • PACE - Public Advocates in Community Re-entry	

This Marion County EHE Plan is a result of contributions of hundreds of people, including people living with HIV, service providers, and representatives of community organizations and local and state government. Thanks are due to all partners who contributed time and effort to the creation of this plan and for their collective decades of work in addressing the HIV epidemic in Marion County and Indiana.

Our Process

Table 4. Marion County EHE Plan – Process of Plan Development	Timing
Notification of CDC PS19-1906 planning award	October 2019
Development of planning process and timeline	October-November
Development and submission of an initial draft Marion County EHE Plan to the CDC as required under the PS19-1906 award	December
Recruitment and formation of Marion County EHE Task Force *(47 participating from over 27 organizations and coalitions)*	December-February 2020
Stakeholder engagement and needs assessment	
Task Force discussions with four other US jurisdictions about EHE Plans and related innovations, successes and challenges	March-May
Interviews with local stakeholders (52 completed)	March-August
Survey of service provider capacity (37 responses)	May-June
Survey of individuals in EHE priority populations (880 responses)	June-August
Focus groups (26 constituency groups; 120 participants)	June-August
Review of literature and related planning documents	July-August
Task Force discussions to determine EHE Plan priorities	
Epidemiology review and discussion	June
Review and discussions of programming by each EHE Pillar	July-August
Small group discussions of Situational Analysis and findings of all interviews, surveys and focus groups	August
Task Force review of plan and concurrence process	
Review of a first full draft of the EHE Plan	September
Review by IDOH Advisory Council, Ryan White Planning Council and other HIV-related planning bodies and coalitions	October
EHE Plan final concurrence, finalization, approval and launch	November-December

The Challenges Ahead

Epidemiologic Profile

The following is a snapshot summary of current HIV-related epidemiology in Marion County. This draws from and summarizes detailed epidemiological and service utilization data available from the Marion County Department of Public Health at http://ryanwhiteindytga.org/Resources

1. Summary

Marion County, home to the city of Indianapolis and approximately 965,000 people, is the center of the 26th most populous metropolitan area of the United States and one of the ten largest metro areas of the Midwestern US and the Great Lakes region.

In 2019, an estimated 5,575 people were living with HIV in Marion County.[1] A total of 4,850 people living with HIV (PLHIV) have been diagnosed and informed of their status, and another 725 people are estimated to be HIV-positive but are as-yet undiagnosed and likely unaware that they have HIV. In 2019, 218 people were newly diagnosed with HIV in Marion County, continuing a five-year range of approximately 200-225 people being newly diagnosed every year in the county.

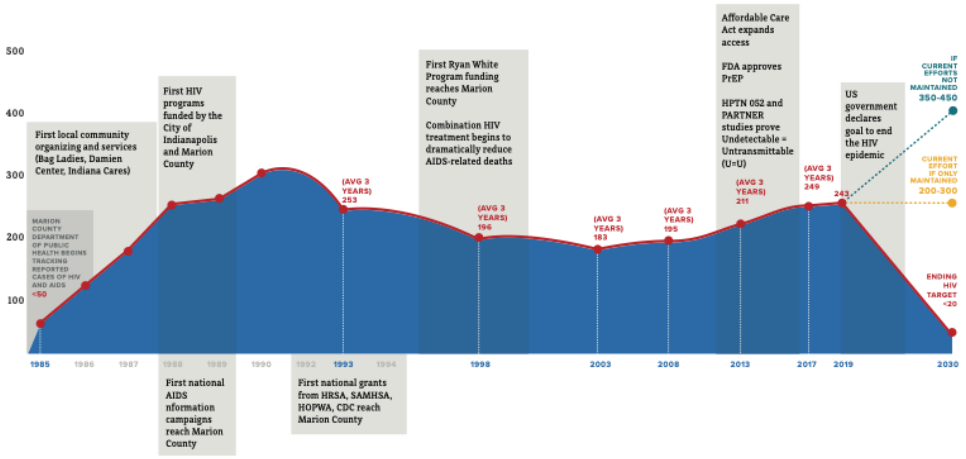
Marion County's HIV epidemic is the largest in the Indianapolis metropolitan region, constituting 84% of all people living with HIV and 80% of all people newly diagnosed in the 10-county Ryan White Transitional Grant Area (TGA). Marion County's HIV epidemic is also the largest in the state of Indiana, amounting to 38% of all people living with HIV and 42% of all new HIV diagnoses in the state. Marion County's HIV prevalence is more than four times, and incidence more than three times, the corresponding rates of the remainder of the state.

The historical trajectory of new HIV diagnoses in Marion County and the surrounding TGA shows promise that the HIV epidemic can be ended with sufficient investment and effort. From a peak of new HIV diagnoses in the late 1980s and early 1990s, the local HIV epidemic likely slowed and then plateaued in the 1990s with the scale-up of HIV programming funded by the county, state and federal governments and with the introduction of effective combination HIV treatment, with a slow increase seen only during the past two decades (see Figure 1).

With new commitments to scale up and intensify HIV-related testing, treatment and prevention along with other services, Marion County can reduce new HIV transmissions by 90% so that fewer than 25 people are newly diagnosed with HIV each year. This reduction in new HIV cases each year would not be the end of the HIV effort – testing, prevention, treatment and care efforts will need to be maintained for decades to come – but halting the relentless increase in the HIV epidemic would control a major health threat to people in Marion County and prevent illness, early loss of life, and significant health costs.

[1] All data in this epidemiologic summary comes from Marion County Public Health Department unless otherwise noted. Further detailed epidemiological data and analyses are available at http://ryanwhiteindytga.org/Resources and may be requested from the Marion County Public Health Department by contacting Maguette Diop, Epidemiologist at MDiop@marionhealth.org.

Table 5. Trajectory of the HIV epidemic in Marion County and greater Indianapolis
[Total HIV/AIDS diagnoses per year 1985-2019, with EHE goals to 2030]



2. HIV incidence and prevalence in Marion County

The HIV epidemic in Marion County has persisted at a mostly steady rate since the early 1990s, with slow increases in incidence seen during the past two decades.

- A total of 218 people were newly diagnosed with HIV in Marion County in 2019, translating to an HIV incidence rate of 22.7 people per 100,000 population in 2018, which is double the national US rate of 11.4.
- Marion County has seen between 150-250 new HIV diagnoses each year since 1992, with fewer than one in four people diagnosed late in the course of infection (i.e., with an AIDS diagnosis within 90 days of the HIV diagnosis – all indicating that the local HIV epidemic continues to spread).
- An estimated 5,575 people were living with HIV in Marion County as of 2019. A total of 4,850 (87%) PLHIV have been diagnosed and informed that they have HIV. An estimated 725 (13%) PLHIV are as-yet undiagnosed and therefore are likely not aware of their status and not accessing the HIV treatment and prevention options that could protect their health and prevent further HIV transmissions.

The HIV epidemic in Marion County is also concentrated in specific networks.

Among the 218 people newly diagnosed in 2019 in Marion County, most attributed their likely exposure to a known risk category (see Table 6). A total of 109 (50%) new HIV diagnoses were men reporting their likely exposure as sex with another man (MSM) or a dual transmission risk of sex between men and sharing of drug injection equipment. A total of 58 (27%) were women or men reporting their likely exposure as heterosexual sex. A remaining 14 (6%) were women or men reporting their likely risk as sharing of drug injection equipment (PWID).

Additional demographic characteristics of the 218 people newly diagnosed in 2019 show patterns associated with broader health disparities and lower access and utilization of health services. A total of 77% of the newly diagnosed self-identified as Black (134) or Hispanic (35), 20% (44) were under the age of 25, 17% (42) were born outside of the United States, and 2% (<5) self-identified as transgender.

Table 6. Priority populations for the Marion County Ending the HIV Epidemic plan

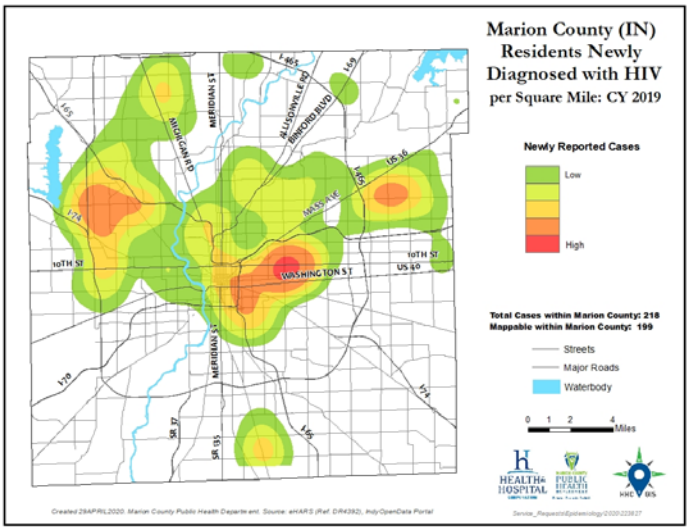
Priority populations *(Overlapping behavioral or demographic categories)*	Number of people newly diagnosed with HIV in 2019	Number of people living with HIV in 2019	Number of people at elevated risk for HIV (100-150 x incidence)
People living with HIV (PLHIV)	218	5,575	20,000-30,000
Black / African Americans	134	2,441	13,000-20,000
Gay men and other MSM	109	2,663	10,000-15,000
Heterosexual women and men	58	1,136	5,000-7,500
Young people age <25	44	250	4,000-7,000
People born outside the US	42	900	4,000-7,000
Hispanic / Latinx	35	471	3,000-5,000
People who inject drugs	14	443	1,500-2,000
People who are transgender	<5	83	500-750

The networks of people most affected by HIV intersect with other population categories (See Table 8).

Compared with the general population of Marion County, people newly diagnosed with HIV during the past five years (2015-2019) have been more likely to be low-income. Over half of all newly diagnosed PLHIV in Marion County live with incomes less than 300% of the Federal Poverty Level (FPL) and one in four living at below 100% FPL. This economic adversity faced by most people living with HIV and people at high risk for HIV is linked with other structural challenges, including unstable housing and employment; minimal economic savings and resilience; minimal access to legal services and adverse histories with policing and the criminal justice system; and lack of quality health insurance, a regular healthcare provider or routine access to health services. Similar sub-analyses of people newly diagnosed during the past five years who were late in their stage of infection (AIDS <91 days) show an even deeper correlation of HIV with social, economic and health disparities.

The geographic distribution of HIV incidence and HIV prevalence aligns with data showing concentration of the local HIV epidemic in Marion County (See Table 7). The highest HIV incidence and prevalence in Marion County are seen in the central urban neighborhoods of Indianapolis, such as in the eastside zip code of 46201, the north-central and northeast zip codes of 46205, 46208, 46218, 46226, and 46235, and the westside zip codes of 46222, 46224, and 46254. All of these zip codes were classified as having majority-minority populations in the 2010 census, and all contain neighborhoods classified as economically distressed by the 2017 Indianapolis Neighborhood Investment Strategy and Marion County Metropolitan Development Commission.

Table 7. Geographic concentration of the HIV epidemic in Marion County



People living with and at risk for HIV in Marion County and the surrounding TGA also experience a heavy burden of sexually transmitted infections (STIs). Bacterial STIs such as chlamydia, gonorrhea, and syphilis are an important indicator of concurrent risk for HIV infection and can increase likelihood of HIV transmission.

- At least 326 PLHIV were diagnosed with a case of chlamydia in 2018, out of a total of 12,254 cases reported in the TGA. The chlamydia rate among PLHIV was 5,301 per 100,000, a rate 7-8 times higher than that of HIV-negative residents and twice the rate for all of Indiana.
- At least 236 PLHIV were diagnosed with gonorrhea in 2018, of a total of 4,367 cases reported in the TGA. The gonorrhea rate among PLHIV was 3,838 per 100,000, a rate 13-16 times higher than that of HIV-negative residents.
- At least 110 PLHIV were diagnosed with early syphilis (primary, secondary, and early latent) in 2018, among a total of 363 cases reported in the TGA. The rate of early syphilis among PLHIV was 1,789 per 100,000, a rate at about 76 times higher than that of HIV-negative residents.
- These statistics suggest a population of over 12,000 people who are uninfected by HIV but at high risk due to sexual risk who should be assessed, counseled and potentially referred for the use of nPEP and PrEP.

Viral hepatitis is also highly prevalent among people living with and at risk for HIV in the TGA.

- Approximately 25% (1,538) PLHIV are thought to be co-infected with hepatitis C based on estimates of the National Alliance of State and Territorial AIDS Directors (NASTAD). Hepatitis C is curable through the use of antiviral treatment and preventable with safe injection practices. Its high prevalence among PLHIV triples people's risk for liver disease, the leading cause of non-AIDS related death among PLHIV.
- Approximately 10% (615) PLHIV are thought to be co-infected with hepatitis B based on estimates of the US Department of Health and Human Services (DHHS).

Behavioral health issues affect a significant number of people living with and at risk for HIV in Marion County and the surrounding ten-county region. Marion County is an underserved area for mental health services; its population-to-provider ratio is approximately two-thirds the average mental health staffing capacity in Indiana.

- Approximately 50% (2,787) PLHIV in Marion County and the surrounding TGA experience mental health issues according to estimates cited in the National HIV/AIDS Strategy. Approximately 40% (2,230) of PLHIV in Marion County and the surrounding TGA are estimated to have addiction-related health issues. Approximately 13% (725) are thought to experience both substance abuse and mental health issues.
- An estimated 8.5% (at least 85,000) of the total population of Marion County and the surrounding TGA experience dependence on alcohol (6.7% of the population) or drugs (2.8%), and an estimated 4.5% (at least 43,000) experience serious mental health conditions such as schizophrenia, bipolar disorder, and major depression, contributing to people's behavioral risks for HIV and creating barriers to access to services.
- Approximately 5,000 people are thought to be actively injecting drugs in Marion County and the surrounding TGA, based on estimates from the National Survey on Drug Use and Health (NSDUH). A significant number of these PWID are young, insecurely housed, and with limited access to behavioral health services and harm reduction programs, placing them at risk for HIV, hepatitis C and overdose.
- In summary, the statistics cited above suggest a population of over 5,000 people who are uninfected by HIV but at high risk for HIV transmission through unsafe injection drug use who should be assessed, counseled and potentially referred for the use of nPEP, PrEP and syringe services programs.

Other chronic health conditions are prevalent among people living with and at risk for HIV, conditions that must be managed alongside HIV and may be the priority or presenting issue that brings people into contact with health service providers. These health conditions include asthma, cardiovascular disease, and diabetes, especially among the 29% (1,587) of PLHIV who are older than 55 years, and among African Americans and other populations experiencing disparately high burdens of chronic health issues.

Table 8. Intersectional populations for the Marion County Ending the HIV Epidemic plan

Additional intersecting priority populations *(Population categories that intersect with the EHE priority behavioral or demographic populations)*	
People facing poverty and lack of economic opportunity	Poverty is a known risk factor for HIV infection and decreases access and use of prevention, treatment and care services. Most people living with incomes less than 300% of the Federal Poverty Level (FPL) face concurrent structural barriers to health, including unstable housing and employment, minimal economic savings and resilience, minimal access to legal services and adverse histories with policing and the criminal justice system, and lack of quality health insurance, a regular healthcare provider or routine access to health services.
People seeking STI testing and treatment	Bacterial STIs such as chlamydia, gonorrhea, and syphilis are an important indicator of concurrent risk for HIV infection and can increase likelihood of HIV transmission.

People living with chronic health conditions, including mental health and substance use issues	Behavioral health issues affect a significant number of people living with and at risk for HIV in Marion County and the surrounding ten-county region. Marion County is an underserved area for mental health services; its population-to-provider ratio is only about two-thirds the average mental health staffing capacity in Indiana.
People interacting with law enforcement and criminal justice systems	An estimated 10% of PLHIV in Marion County have been recently incarcerated. A substantial number of these individuals are younger, Black or Hispanic, and gay men or other MSM or transgender. Often with limited employment and housing options, PLHIV with recent incarceration histories have special needs for mental health and substance use services and support for access to and retention in clinical care and HIV-specific services.

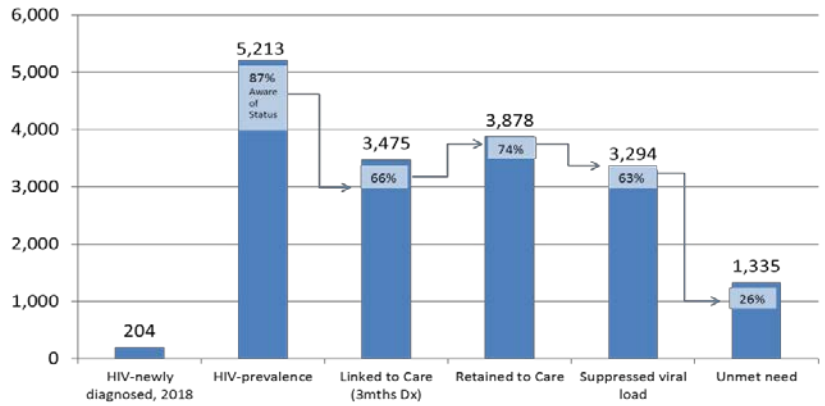
3. Engagement in HIV-related treatment

In 2019, of the estimated 5,575 people living with HIV in Marion County, a total of 4,850 people have been diagnosed and informed of their status. Among people newly diagnosed with HIV in Marion County and the surrounding TGA during 2019, 61% were linked to care within 90 days of their diagnosis. A subset of those (46%) were linked to care within 30 days. A substantial number were linked within 7 days or less, mostly notably people who were diagnosed at one of the large hospitals or Marion County public health programs such as the Bell Flower Clinic and linked to services in the same day.

Of the 4,850 people diagnosed with HIV, 2,834 (over 50%) are enrolled in services funded by the Ryan White HIV/AIDS Program and an additional 1,163 (24%) were accessing care funded through other insurance or programs. Among all people linked to care, 74% (3,878) received at least one CD4/viral load (VL) test in 2019, and 43.2% (2484) received at least two CD4/viral load tests performed at least three months apart during the year.

More than half (57.6%; or 3,310) of PLHIV in the TGA reached viral suppression, with viral load suppression among Marion County residents slightly higher at 63% (N=3,294). HIV viral suppression – a reduction of a person's viral load to less than 200 copies of HIV per milliliter of blood – sustained over time, reduces risk of acquired immune deficiency over time, and minimizes likelihood of onward HIV transmission. Successful HIV treatment and subsequent sustained viral suppression in a network or community can thus reduce illness and reduce rates of HIV transmission, a concept known by the acronyms TasP (Treatment as Prevention) and U=U (Undetectable=Untransmissible).

Table 9. The Continuum of HIV Treatment and Care, Marion County, December 31, 2019



Successes in linkage to care, HIV treatment and viral suppression vary in alignment with broader health disparities. Viral suppression rates are worse among people self-identified as Black (50% reaching VL suppression) or Hispanic (39.7%), young adults aged under 25 (46%), people born outside of the United States, and people self-identified as transgender. Viral suppression rates were also lower among people with unstable housing, with a recent history of incarceration, and with concurrent mental health or substance use issues. Geographically, average community viral load counts are highest in majority-minority zip codes such as 46218, 46224 and 46226. Viral load suppression rates are significantly higher among people enrolled all year in Ryan White services as compared with people accessing care through other means, indicating the importance of working to enroll people who are eligible into this program. As noted previously, average community HIV viral load rates are important both for the health of people living with HIV and for prevention of HIV transmission in a concept known by the acronyms TasP (Treatment as Prevention) and U=U (Undetectable=Untransmissible).

4. Engagement in prevention services

Based on the statistics above, approximately 20,000-30,000 people in Marion County are at heightened vulnerability for HIV transmission and should be offered and provided regular screenings for sexual health and behavioral health needs, including access to nPEP, PrEP and other HIV prevention services.

During 2019, more than 30,000 HIV tests were provided to people in Marion County by leading hospital emergency departments and infectious disease departments, smaller clinics and health centers, community organizations, and public health programs and health services operated by Marion County, including Bell Flower Clinic, Ryan White HIV Services, the Adolescent Action Health Center, Refugee Health Program, the Safe Syringe Access and Support Program (SSAS), Substance Use and Outreach Services (SUOS), and the Marion County Jail.

Of the more than 20,000 people testing for HIV in 2019, nearly all were screened for STIs, viral hepatitis, and other sexual and behavioral health needs. Several thousand are likely to have tested more than once during the year through programs that encourage regular HIV testing, including through mobile van and outreach testing programs provided by the Marion County Bell Flower Clinic, Safe Syringe Access and Support Program and Substance Use and Outreach Services. A total of 725 people were prescribed PrEP and approximately 300 people were provided with syringe access.

The following is a snapshot summary of existing local HIV-related programs and related needs in efforts to end the HIV epidemic. This summarizes findings from the EHE stakeholder engagement and needs assessment process (summarized on page 7) and a review of data and publications from the Marion County Public Health Department (MCPHD), Indiana Department of Health (IDOH) and other local, state and national sources.

EHE Pillar 1. DIAGNOSE

To end the HIV epidemic in Marion County, all HIV-positive people should learn of their status as early as possible. To achieve this, IDOH, MCPHD and other EHE partners seek to ensure that regular routine HIV testing and other health screenings, including screenings for STIs and hepatitis C, are offered and provided to all people in high-incidence neighborhoods and demographics.

> The goals of the Marion County EHE Plan: Reach the 600-900 people who are HIV-positive but as-yet undiagnosed with offers of testing and services, so that:
> - At least 90% of people living with HIV are diagnoses early in the course of infection (i.e., <1 year from an AIDS diagnosis), and
> - All people have improved access to, and reduced disparities in accessing, health screenings and linkage to care.

In Marion County, several of the largest health service providers routinely encourage, offer and provide routine testing for HIV and other health issues to people who may be at risk. As a result in 2019, 218 people were newly diagnosed with HIV, with 175 (80%) identified through testing in clinical care settings, including from hospital emergency departments (15% of total diagnoses), health department programs such as the publicly run Bell Flower STI clinic (15% of total), and clinics and health centers (32% of total). (see Table 11)

In addition, approximately 40 people (20% of newly HIV diagnosed in 2019) learned of their status through testing in community settings. These settings included mobile health vans run by MCPHD Bell Flower Clinic, MCPHD SSAS Program and BU Wellness, and at offices of numerous community organizations, social and commercial venues specific to priority populations, and self-testing conducted in people's homes. (see Table 10)

Leading hospitals and clinics in Marion County are working with IDOH and other EHE partners to improve the extent and consistency of healthcare provider-initiated offers of testing. Notably:

- Marion County's largest hospital networks—Eskenazi Health, IU Health, and Community Health Network—already conduct routine HIV testing each year, identifying 60-80 (a quarter to a third of total) newly diagnosed PLHIV in Marion County each year. At each hospital network, HIV testing is encouraged through trained staff and automated electronic medical record (EMR) prompts (Eskenazi Health and Community Health hospital networks use Epic; IU Health uses Cerner), with a resulting 1% positive case rate from HIV testing efforts.
- During 2018 and 2019, the two largest hospital emergency departments in Marion County—Eskenazi Health and IU Health—have been piloting routine opt-out testing for HIV and HCV for all

patients as part of the Gilead FOCUS (Frontlines of Communities in the United States) program. The aim of this pilot has been to demonstrate the feasibility of routine emergency room testing and to generate evidence about where and how routine testing might be cost-effective in identifying previously undiagnosed cases of HIV and HCV.

To build on these efforts, IDOH and MCPHD are working with the leading hospitals and clinics in Marion County to pilot and roll out combination testing for HIV, HCV and STIs, support further improvements in EMR reminders and prompts, and support use of clinic champions to help each hospital network to routinize health screenings as part of essential clinical practice. Each hospital network is also being encouraged to roll out routine combination testing to urgent care locations and other affiliated clinics and health centers where there is likelihood of a <.5% (1 in 200) case detection rate for HIV screening.

Table 10: Where people living with HIV (PLHIV) received their diagnosis in 2019

Source of new HIV diagnoses in 2019	Number of new HIV diagnoses in 2019	Examples of leading providers of HIV testing and other health screening in Marion County
Clinics and health centers	88	Alivio Medical Center, Aspire Indiana Health, Damien Cares, Shalom Health Care Center, and 20 clinics and health centers affiliated with or part of Eskenazi Health, HealthNet, IU Health, and Community Health Network
Hospitals	44	Eskenazi Health (Emergency Department, Infectious Disease Department); Indiana University Health (Emergency Department, LifeCare Clinic); Community Health Network (Emergency Departments at Community East, South and North Hospitals)
Health departments	43	MCPHD Bell Flower Clinic, Refugee Health Program, Safe Syringe Access Services (SSAS), Substance Use Outreach Services (SUOS), Adolescent Action Health Center
Prison / jail	5	Marion County Jail; Indiana Women's Prison
Community organizations	27	BU Wellness, Damien Center Indianapolis Urban League, Step Up, Women in Motion
Other	11	(e.g., unaffiliated primary care providers, blood plasma screening)

HIV testing and other health screenings are also offered to EHE priority populations in community settings. For example:

- Mobile health vans run by MCPHD Bell Flower Clinic, MCPHD SSAS Program and BU Wellness collectively reach people who are not otherwise engaged in regular healthcare with an offer of testing and related health counseling and referrals at multiple regular locations throughout central Indianapolis.
- Community health outreach workers at organizations such as BU Wellness, Damien Center and Step Up offer people the opportunity to test for HIV, STIs and viral hepatitis at their fixed locations, at social and commercial venues specific to priority populations, and through social network organizing, dating apps, social media and person-to-person referrals. Collectively these community-based testing programs identified 27 (12% of total) newly diagnosed PLHIV in Marion County in 2019.

- Four HIV self-testing campaigns are being piloted or proposed in Marion County to offer people an alternative opportunity to test themselves for HIV and STIs in a location of their choice, with accompanying offers of counseling and follow-up linkage to services. The leading efforts are Damien Center and Step Up, which have facilitated self-testing for HIV by more than 50 people during the first six months of 2020, IU Health Positive Link in Bloomington, which is piloting an HIV self-testing campaign offered throughout central Indiana, and Bell Flower Clinic, which is developing a partnership with TakeMeHome.com to promote self-testing for HIV along with gonorrhea, chlamydia and syphilis.

EHE Pillar 2. TREAT

To end the HIV epidemic in Marion County, all people living with HIV should be retained in care and benefit from HIV treatment to reach viral suppression. Average community HIV viral load rates are important both for the health of people living with HIV and for prevention of HIV transmission in a concept known by the acronyms TasP (Treatment as Prevention) and U=U (Undetectable=Untransmissible).

The goals of the Marion County EHE Plan:

- At least 90% of the 200-250 people testing HIV-positive each year will be rapidly linked to medical care and HIV treatment (within 30 days of diagnosis),
- At least 90% of all PLHIV will be retained in regular care and treatment to maintain health, and
- At least 90% of people accessing HIV treatment will reach viral suppression.

Marion County has a strong network of healthcare providers, which has allowed steady progress toward EHE targets of linkage, treatment, retention in care, and viral suppression.

- In 2019, of the estimated 5,575 people living with HIV in Marion County, a total of 4,850 (87%) people have been diagnosed and informed of their status.
- Among people newly diagnosed with HIV in Marion County and the surrounding TGA during 2019, 61% were linked to care within 90 days of their diagnosis. A subset of those (46%) were linked to care within 30 days.
- Of the 4,850 people diagnosed with HIV, 2,834 (over 50%) are enrolled in regional Ryan White services and an additional 1,163 (24%) are accessing care through other insurance or programs.
- Among all people linked to care, 74% (3,878) received at least one CD4/viral load test in 2019, and 43.2% (2,484) received at least two CD4/viral load tests performed at least three months apart during the year.
- More than half (57.6%; 3310) of PLHIV in the 10-county Transitional Grant Area (TGA) reached viral suppression, with viral load suppression among Marion County residents at 63% (N=3,294) and viral suppression among PLHIV enrolled in Ryan White services in the TGA at 67%.

Linkage to HIV-related care is fastest when people are diagnosed and referred from within one of the large hospitals and clinic networks, such as Eskenazi Health, IU Health, Community Health Network,

and HealthNet, or within centrally located Marion County public health programs such as the Bell Flower Clinic. In those settings, protocols and experienced staff allow for a streamlined process in which the newly diagnosed person is immediately offered care management, linkage and accompaniment to needed follow up services, and an offer of rapid start of HIV treatment. As a result, most people newly diagnosed with HIV within an Eskenazi Health, IU Health, Community Health Network, or HealthNet site are linked to case management and follow-up medical care within 7 days, and some are linked to services in the same day, leading to decreased time to treatment initiation and viral suppression.

A total of 12 organizations are providers of medical and non-medical care for PLHIV with funding from the Ryan White program (See Table 11). Ryan White funding allows providers to offer clients a comprehensive range of medical and non-medical supportive services, including intensive case management and support for mental health and substance use issues. Data show that viral suppression rates are significantly higher, at 71%, among the >50% of PLHIV enrolled all year in Ryan White services as compared to people accessing care through other means, indicating the importance of working to enroll people into this program.

In addition, MCPHD disease intervention specialists (DIS) work alongside Ryan White funded case managers and early intervention specialists (EIS) to identify individuals who are likely not in medical care (as evidenced by a lack of CD4 and viral load testing or contact with a clinician or case manager) and to contact and link those individuals to health care and related services as needed. During 2019, this effort linked 37 people who were otherwise not in HIV-related care.

To intensify linkage and re-engagement efforts, as of August 2020, MCPHD has hired three community EHE engagement liaison officers and a data analyst to work with medical providers and community partners to improve data sharing and use of information technology to identify PLHIV who are not receiving medical care and to link and re-engage those individuals. The goal of this effort is to increase rates of linkage within 30 days of diagnosis, retention in care with regular viral load testing, and achievement of viral suppression. A particular focus is on populations that are not benefitting as extensively from these interventions, notably Black and Hispanic men and women, young adults under the age of 25, recent migrants and immigrants, people self-identified as transgender, and people needing supportive services for housing, mental health and addiction issues.

Table 11. Current providers of Ryan White funded services, with client totals as of 2019

Type of Ryan White funded care or service	Providers
Core medical services: • Primary medical care – outpatient ambulatory • Medical case management • Pharmaceutical assistance • Health insurance / cost assistance • Mental health services • Substance use services • Medical nutrition • Oral health	• Eskenazi Health (ID Clinic) • IU Health LifeCare • Indiana University (Schools of Dentistry and Optometry) • Community Physician Network • Damien Cares
Early intervention services and supportive services, e.g.:	• Eskenazi Health (Emergency Department, Sandra Eskenazi Mental Health Center)

• Non-medical case management • Medical transport • Emergency financial assistance • Short-term housing assistance • Legal assistance • Vocational and employment support	• IU Health (LifeCare) • MCPHD Substance Use Outreach Services • BU Wellness Network, Concord Neighborhood Center, Damien Center, Meals on Wheels, Minority Health Coalition, Shalom Health Care Center, Step Up, Women in Motion

EHE Pillar 3. PREVENT

To end the HIV epidemic, 80% of people in priority populations should be offered and provided regular screenings and referrals for sexual health and behavioral health needs, including access to nPEP, PrEP and other HIV prevention services.

The goals of the Marion County EHE Plan:

- At least 20,000 people in Marion County will access sexual health and behavioral health screenings each year, with
- At least 3,000 people referred to and enrolled in PrEP services, and
- At least 500 people referred to and enrolled in syringe access or other harm reduction programs, resulting in
- 90% reductions in annual incidence of HIV, and 90% reductions in annual incidence of STIs, acute viral hepatitis and overdose among people living with HIV.

As of 2020, approximately 20,000 people are tested each year for HIV in Marion County by leading hospital emergency departments and infectious disease departments, smaller clinics and health centers, community organizations, and public health programs and health services operated by MCPHD. Of this total, several thousand people in EHE priority populations are screened at least annually for STIs, viral hepatitis, and other sexual and behavioral health needs. Health care and community service providers are also highly aware of injection drug use practices and networks, and routinely screen and refer people for services related to substance use, mental health and harm reduction. Examples of leading providers include Eskenazi Health, IU Health Lifecare, the MCPHD Bell Flower Clinic, the Substance Use Outreach Services (SUOS), the Marion County Jail, Aspire, Damien Center, Shalom, Step Up, BU Wellness, Indiana Youth Group, and the Indianapolis Urban League. (See Table 12)

More than 20 locations throughout Marion County offer access to nPEP and/or PrEP, providing screening, counseling, starter packs and linkage to ongoing medical care and support services. Pharmacies, including CVS Minute Clinics and Walgreens clinics, are among the providers. A 2016 study of 284 pharmacists across Indiana found that 16% of pharmacies statewide, and a higher percentage in Marion County, had dispensed PrEP, and most believed that they are important resources for HIV and HCV information and were comfortable counseling patients about PrEP. Four hospital emergency departments (Eskenazi Health, IU Health, Community Hospital East and Community Hospital North) offer 24-hour access to PEP. More than ten local organizations are actively promoting nPEP and PrEP in EHE priority communities and this is complemented by advertising by the Federal Ready, Set, PrEP

initiative and the CDC PrEP Daily campaigns. In addition, IDOH provides funding for a PrEP Medication Assistance Program (PrEP MAP) that defrays costs of PrEP and related testing and services. As a result, a total of 725 people were prescribed PrEP in Marion County in 2019.

To prevent HIV transmissions through unsafe injection practices, the MCPHD funds the Safe Syringe Access and Support Program (SSAS), which served approximately 300 individuals in 2019 with sterile syringes, harm-reduction kits, HIV and hepatitis C screening, naloxone, immunizations, peer recovery coaching, and referrals for substance use disorder treatment. Launched in 2018 with support from the Richard M. Fairbanks Foundation, the Health Foundation of Greater Indianapolis (THFGI), and the MCPHD, SSAS has a fixed location on the west side of Indianapolis and a mobile clinic with regular hours at two east side locations (Damien Center and Brookside Community Church).

Pharmacies in Indiana may also have a role in HIV prevention and harm reduction. Pharmacies in Indiana are allowed to sell syringes without a prescription, and research in 2016 found that many pharmacies in Marion County sell syringes to people who may use them to inject drugs. In 2018, more than 100 pharmacists in Marion County were successfully enrolled in a PharmNet harm reduction intervention pilot in which they provided naloxone, syringes, and related counseling and service referrals.

Table 12: Examples of HIV prevention service providers, with client numbers as of 2019

Type of prevention service	Providers
Community outreach and health promotion, including information, education, communications, and peer support and accompaniment to increase awareness and link people to services.	• Marion County public health programs: Bell Flower Clinic, Safe Syringe (SSAS), Substance Use Outreach Services (SUOS), Adolescent Action Health Center • Clinics and health centers: Aspire Indiana Health, Damien Cares, Shalom Health Care Center • Community organizations: BU Wellness, Damien Center, Indianapolis Urban League, Minority Health Coalition of Marion County, Step Up, Women in Motion
Screenings and referrals for HIV, STIs, and other sexual health and behavioral health needs	• MCPHD public health programs: Bell Flower Clinic, Safe Syringe (SSAS), Substance Use Outreach Services (SUOS), Adolescent Action Health Center, Refugee Health Program • Hospitals: Eskenazi Health (Emergency Department, Infectious Disease Department); Indiana University Health (Emergency Department, LifeCare Clinic); Community Health Network (Emergency Departments at Community East, South and North Hospitals) • Clinics and health centers: Alivio Medical Center, Aspire Indiana Health, Damien Cares, Shalom Health Care Center • Community organizations: BU Wellness, Damien Center, Indianapolis Urban League, Minority Health Coalition of Marion County, Step Up, Women in Motion
PrEP and nPEP services	• MCPHD public health programs: Bell Flower Clinic • Eskenazi Health – Emergency Department, Infectious Disease Department, Forest Manor Health Center, West 38th Street Health Center

	• IU Health – Emergency Department and LifeCare Clinic • Community Health Network (Community Hospital East, Community Hospital North, affiliated MedCheck and Walgreens Clinics) • Other clinics and health centers: Aspire Indiana Health, CVS Minute Clinics, Damien Cares, Planned Parenthood, Shalom Health Care Center
Syringe access and harm reduction services	• MCPHD Safe Syringe Access and Support (SSAS) Program • Aspire Indiana Health (offering behavioral health, not syringe access)

EHE Pillar 4. SUPPORT, ORGANIZE AND RESPOND

To end the HIV epidemic in any jurisdiction, community organizations, service providers and the county and state health departments need to collaborate to document and respond to entrenched and emergent health needs and barriers in the HIV response in priority populations and quickly identify, prevent and stop HIV outbreaks.

Effective documentation and response to people's needs requires an interlinked and interdependent combination of supportive services, community organizing, and health monitoring and reporting systems.

The goals of the Marion County EHE Plan:

- Supportive services: An increasing percentage of people living with HIV and people vulnerable to HIV will receive supportive services from HIV service providers to overcome poverty-related barriers to HIV prevention and treatment, connect with social support, and overcome social isolation, stigma, discrimination and criminalization.
- Community organizing: Community coalitions and networks will document entrenched and emergent health needs and barriers to HIV programming, mobilize community-led responses, and work with IDOH and MCPHD to quickly identify and stop HIV outbreaks.
- Health surveillance and reporting: IDOH and MCPHD will work with other governmental agencies and non-governmental service providers to improve data systems and digital technology for improved health surveillance and reporting, with the aim of using data to (re)direct resources and services to identified priority needs.

Indiana health officials, health providers and communities have valuable experience in responding to a range of recent local epidemics, including the 2015 Scott County outbreak of HIV and viral hepatitis, the ongoing statewide epidemics of STIs and opioid-related overdoses and viral hepatitis infections, and most recently the outbreak of SARS-CoV-2 and Covid-19. Local experience shows that an effective epidemic response requires accurate real-time data from, and collaboration among, service providers and public health agencies, and also community-generated evidence that describes the realities of people's health and needs outside of the clinic.

Accordingly, in Marion County, all partners in the Marion County EHE Task Force are working in some way to fund and deploy a combination of supportive services, community organizing, and health

monitoring and reporting systems to help people overcome structural barriers to health and to ensure effective and rapid detection of and response to outbreaks of HIV and other health issues.

In supportive services, over 40 organizations work with people in EHE priority populations to help them overcome poverty-related barriers to HIV prevention and treatment, to connect people to social support, and to overcome social isolation, stigma, discrimination and criminalization (see Table 13). Most of these supportive service providers are based (not coincidentally) in relatively lower-income high HIV prevalence Indianapolis neighborhoods (such as in eastside zip code of 46201, the north-central and northeast zip codes of 46205, 46208, 46218, 46226, and 46235, and the westside zip codes of 46222, 46224, and 46254)—neighborhoods that are home to large communities of African Americans, Hispanics, LGBT people, and recent immigrants.

Table 13: Supportive services: Examples of supportive services currently provided alongside HIV testing, prevention and treatment in 2019

Supportive services	**Examples of leading HIV-funded providers** *(e.g., Ryan White, HOPWA and IDOH SPSP)*
• Non-medical case management, including navigation of insurance coverage and other benefits • Housing services o Rental and utility assistance (TBRA, STRMU) and facilitated access to housing choice voucher program, permanent supportive housing, etc. o Supportive case management o Behavioral health (residential treatment, group homes, halfway houses) • Food and nutrition services (including emergency assistance for food) • Health insurance assistance program • Other support and assistance (including social engagement opportunities, emergency financial assistance, transportation assistance, vocational and employment support)	• Eskenazi Health Emergency Department • IU Health (LifeCare) • MCPHD Substance Use Outreach Services (SUOS) • Almost4Minds • BU Wellness Network • Concord Neighborhood Center • Damien Center • Indiana Youth Group and Trinity Haven • Indianapolis Urban League • Meals on Wheels • Minority Health Coalition • Shalom Health Care Center • Step Up • Women in Motion
Population-specific supportive services	
Young people < age 25	Indiana Youth Group, Trinity Haven, BU Wellness, Damien Center, Indianapolis Urban League, Step Up, IU Health Riley Clinic, Eskenazi Health Trans Health Program, Eskenazi Adolescent Health Program (7 locations), HealthNet (school clinics), MCPHD Substance Use Outreach Services (SUOS), MCPHD Action Health Center (including a school health clinic at Crispus Attucks High School)

Women at risk for HIV	Women in Motion, Center of Wellness for Urban Women, Planned Parenthood
Trans and gender non-conforming people	GenderNexus, IYG, Trinity Haven, BU Wellness, Damien Center, Step Up (RealTime), and Eskenazi Health Trans Health Program
People needing addiction-related services	MCPHD Substance Use Outreach Services (SUOS), MCPHD Safe Syringe Access & Support Program (SSAS), Indianapolis Urban League (IDOH SPSP), Damien Center
Re-entry, diversion and other services for people interacting with the criminal justice system	Step-Up, Public Advocates in Community Re-Entry (PACE), Indianapolis Urban League, Indiana Re-entry Coalition, The Bail Project, Volunteers of America Brandon Hall (Men's Program) and Theodora House (Women's program)
Recent migrants and immigrants at risk for HIV	IDOH Refugee and Immigrant Outreach (RIO), MCPHD Refugee Health Program, Immigrant Welcome Center, Indiana Undocumented Youth Alliance (IUYA), Catholic Charities Refugee and Immigrant Services, Exodus Refugee Immigration, Luna Language Services, Concord Neighborhood Center, Damien Center

Additionally, a diverse range of organizations, networks and coalitions are working in Marion County to monitor, document and communicate about EHE priority population health needs and mobilize community-led responses. These groups are therefore strong partners in the EHE efforts to identify and stop emergent HIV outbreaks (see Table 14).

Table 14: Community organizing and advocacy: Examples of recent reports and communications that document and publicize health needs among EHE priority populations and related actions that could help to prevent future and ongoing HIV outbreaks

- Coalition for Homelessness Intervention & Prevention (CHIP). Indianapolis Community Plan to End Homelessness: Priorities and Progress 2019-2020.
- Central Indiana Community Foundation (CICF). Strategic Plan for Marion County. 2019.
- HIV Modernization Movement-Indiana. Outdated Indiana HIV-related punitive codes. 2020.
- Immigrant Welcome Center. Indianapolis Immigrant Integration Plan. 2017.
- Indiana Coalition Against Domestic Violence (ICADV). Re-centering Indiana's movement to ground domestic violence programs in survivor-defined success. 2019.
- Indiana Health Disparities Task Force. Corrective Action Plan Deliverables Report. July 2020.
- Indiana Housing and Community Development Authority (IHCDA). State of Indiana 2020-2024 Consolidated Plan and 2020 Action Plan. 2020.
- Indiana Legislative Black Caucus. Racism and low wages make Blacks more susceptible to Covid-19. WIBC interview with State Representative Robin Shackleford. April 2020.
- Indianapolis Urban League, in partnership with IDOH, BTAN, BU Wellness Network, THFGI, IDOH, Minority Health Coalition of Marion County, Women in Motion, and MCPHD. World AIDS Day event. November 2019.

- Marion County Metropolitan Development Commission. Thrive Indianapolis – Comprehensive Plan. 2019.
- National Black HIV/AIDS Awareness Day Citywide Festival. Watkins Park. February 2020. Co-sponsored by BU Wellness, Indianapolis Urban League, Women In Motion, Marion County Public Health Department, Indiana Department of Health, The Health Foundation of Greater Indianapolis, and with participation by Flanner House, Indiana University – Purdue University Indianapolis (IUPUI), Indy Pride, Ivy Tech, National LINKS Inc., Minority Health Coalition of Marion County, Reggie Aliveness Project, Shalom Health Care Center, several Black sororities and fraternities, and other community partners.
- Interagency State Council on Black and Minority Health (ISCBMH). 2019 Annual Report. November 2019.
- Mental Health America of Indiana (MHAI). Public Policy Agenda 2019-2020.
- Taylor M, Nowaskie DZ, Witchey A. LGBTQ Community Needs 2020: and LGBT HIV+ in Indy supplemental report. Damien Center 2020.

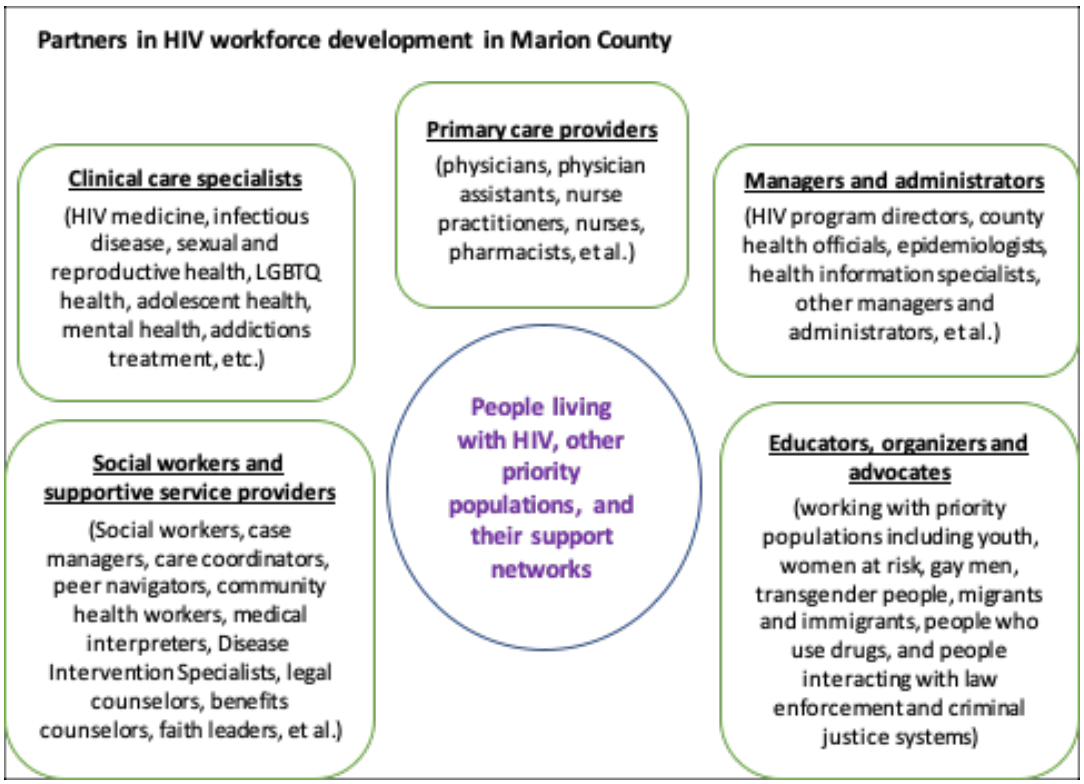
Regarding HIV-related health surveillance and reporting, IDOH and MCPHD and other EHE partners have been investing in improved data systems and data reporting to accurately track HIV diagnoses, treatment, prevention, and service utilization. For example:

- EHE partners are working to adopt and expand use of new data systems (Aphirm® / Luther Consulting) that is linked with eHARS and NBS systems to compile data and reporting about HIV, STI and HCV testing, PrEP utilization, and related prevention outreach and client engagement in prevention interventions.
- EHE partners are updating and improving CareWare HIV service tracking software to version CareWare 6 to replace the RISE system and reduce redundancy.
- Both IDOH and MCPHD are working with other government agencies and with laboratories, pharmacies, and community providers to develop new data sharing and data reporting agreements for Data to Care (D2C) metrics and approaches across the HIV care continuum. Two goals of this effort are to improve tracking of time between HIV diagnoses and linkage to care, and to potentially track HIV treatment and PrEP prescription refills along with HIV viral load and STI testing, as indicators of retention in treatment and prevention.
- Each of Marion County's hospital and healthcare systems is working to improve Electronic Medical Record (EMR) / EPIC systems to prompt providers to offer or intensify services based on client history and data.

INVEST IN WORKFORCE AND MANAGEMENT

Achievement of the EHE goals and targets requires investment in diversity, competency and related management and accountability of a workforce of hundreds of people working across dozens of organizations.

Table 15. Partners in workforce development in Marion County



The EHE needs assessment process conducted during March-August 2020 highlighted several strengths and ongoing challenges and needs, including the following:

Diversity and linguistic and cultural competency: Analyses by the Midwest AIDS Training and Education Center (MATEC) suggest that leading HIV service providers in Marion County continue to struggle to attract, hire and retain a workforce that is experienced with the structural issues faced by HIV priority populations, including issues of poverty and stigma or discrimination based on race, ethnicity, national origin, primary language, gender, gender identity, sexual orientation and age. Stakeholder interviews and focus groups echo this finding, noting that engaging people in health screenings, treatment and care, and ongoing health promotion requires that people have trust and a sense of interpersonal connection with service providers, and that the providers' backgrounds, experience and language and communications skills are important factors in establishing trust.

Trainings, residencies, mentorships, fellowships, and scholarships: Marion County has strong universities, healthcare providers, supportive service providers and community organizations, all of which provide trainings for their employees, contract workers and volunteers. This is supplemented by HIV-related trainings offered by MATEC, the Fairbanks School of Public Health Project ECHO (Extension for Community Healthcare Outcomes), and fellowships offered by national and local programs such as The Health Foundation of Greater Indianapolis and AmeriCorps. However, in the EHE needs assessment process, stakeholder interviews and focus groups described many training needs for the HIV workforce in Marion County, stating that the local HIV effort would be strengthened with expanded trainings and "medical detailing" for clinicians, supportive service providers and community-based leaders about the following:

- Routine sexual health histories and related counseling and referrals
- Routine mental health and substance use disorder assessments and related counseling and referrals
- Assessments and referrals for PEP and PrEP
- Improvements in rapid interagency linkages to HIV care and supportive services
- Competency in working with specific populations, including adolescents, gay men, transgender people, people who inject drugs, and people with recent histories of violence, trauma, and/or interactions with law enforcement and criminal justice systems

Work expectations, remuneration and retention: In the EHE needs assessment process, stakeholders stated that recruitment and retention of care coordinators, case managers and other community health workers is being harmed by unrealistic workloads, insufficient pay, and lack of opportunities for professional growth and advancement. Extremely high caseloads of 50 or more clients per case worker, along with administrative requirements, forces care coordinators and case workers to be reactive rather than proactive in helping clients, which undermines quality, effectiveness and trust. This situation, along with limited pay and benefits and limited opportunities for professional advancement, has led to challenges in recruiting and retaining experienced people, which also undermines quality, effectiveness and trust.

Management, coordination and accountability: In the EHE needs assessment process, stakeholders also described challenges in coordination among service providers and between county and state government agencies, resulting in duplication and overlap of programs and services. Stakeholders also described policy barriers and administrative barriers to effective and efficient use of resources. Stakeholders recommended that IDOH and MCPHD consider additional working groups and reinforcement of strong leadership to foster coordination and shared accountability by all agency leaders, service providers and frontline workers toward collective impact.

Goals and Strategies

Table 16. Marion County EHE Plan – Goals and Strategies at a Glance
DIAGNOSE
Goal: All HIV-positive people will learn of their status as early as possible.
Strategy 1.1: Expand health provider-initiated testing. **Strategy 1.2:** Expand community-based testing.
TREAT
Goal: All people living with HIV will be retained in care and benefit from HIV treatment to reach viral suppression (U=U).
Strategy 2.1: Further streamline linkage to care. **Strategy 2.2**: Retain and reengage people in HIV treatment and care. **Strategy 2.3:** Reduce stigma associated with HIV treatment, STIs, mental health and addictions.
PREVENT

Goal: All people in priority populations will be offered regular screenings and referrals for sexual health and behavioral health needs, including access to nPEP, PrEP and other HIV prevention services.
Strategy 3.1: Promote sexual health and behavioral health **Strategy 3.2:** Increase access to, and provision and use of, PrEP **Strategy 3.3:** Increase access to syringe access and harm reduction services
SUPPORT, ORGANIZE AND RESPOND
Goal: Community organizations, service providers and the county and state health departments will collaborate to document and respond to entrenched and emergent health needs and barriers to the HIV response in priority populations and quickly identify, prevent and stop HIV outbreaks.
Strategy 4.1: Increase access to supportive services. **Strategy 4.2:** Support community organizing to document health needs and barriers to HIV programming, mobilize community-led responses, and work with IDOH and MCPHD to quickly identify and stop HIV outbreaks. **Strategy 4.3:** Improve data systems and digital technology for improved health surveillance.
INVEST IN WORKFORCE AND MANAGEMENT
Goal: IDOH, MCPHD and all HIV providers will invest in workforce diversity and competency, and related management and accountability of the HIV workforce across dozens of organizations.
Strategy 5.1: Invest in diversity and linguistic and cultural competency of the HIV workforce and improve recruitment and retention of community-facing frontline health workers. **Strategy 5.2:** Invest in technical competency of medical providers, supportive service providers and community health workers through trainings, residencies, mentorships, fellowships and scholarships. **Strategy 5.3:** Engage with a diverse range of provider and community networks to foster innovation, coordination and shared accountability by all agency leaders, service providers and frontline workers toward collective impact.

EHE Pillar 1. DIAGNOSE

Goal: All HIV-positive people should learn of their status as early as possible.

Strategy 1.1: Health provider-initiated testing: Expand routine offer of HIV testing and other health screening in emergency departments, urgent care centers, or other clinics and health centers where people go as a first point of contact for health care.

Strategy 1.2: Community-based testing: Offer HIV testing along with HIV prevention services and linkage to supportive services in community settings to reach people who do not regularly access health services, and develop and assess self-testing campaigns to provide people with an additional option for testing.

DIAGNOSE **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*

Health provider-initiated testing: • Support healthcare providers to expand provider-initiated HIV testing to additional clinical care locations and continue to improve the quality and consistency of routine health screening in all major emergency departments, health centers and clinics. • Establish organizational policies to support HIV testing and other routine health screening (including three-site STI screening, sexual health histories, assessment of mental health and substance use issues, and assessment for PrEP, especially for any patient with a recent STI and for each EHE priority population such as gay men and other MSM, transgender people, and people who inject drugs). • Establish options for rapid testing so that patients may receive results and referrals, including for nPEP, in the same visit • Train staff on how to offer, conduct and talk about HIV testing and other health screening. • Develop tools to support staff to offer, conduct and talk to patients about HIV testing. • Adapt clinic flows to facilitate HIV testing. • Adapt electronic medical record (EMR) system to prompt staff to offer HIV testing. • Identify a champion to lead and support HIV testing practice change. • Monitor and evaluate the HIV testing program. • Establish strong linkage arrangements to HIV-specific clinical services and other health and social services.	• By 2025, all people who are HIV-positive but as-yet undiagnosed (currently 600-900 people) will be reached with offers of testing and services. • At least 90% of people living with HIV are diagnosed early in the course of infection (i.e., <1 year from an AIDS diagnosis). • All people have improved access to, and reduced disparities in accessing, health screenings and linkage to care.
Community-based testing • Invest in mobile health vans, venue-based testing, fixed location testing and self-testing campaigns; target efforts to locations and networks where people are most in need of rapid testing; and tailor and adjust locations, staffing and incentives according to evidence of relative costs and yield. • Hire and retain outreach staff and health service providers who are effective and trusted resources for HIV testing and other health screening in priority population venues and communities. • Incorporate rapid linkage to care and related patient navigation and accompaniment into HIV testing services where possible. • Maximize use of digital technology for increased awareness about testing options, reduction of stigma about testing, anonymous partner notification, sexual and social network outreach, and increasing use of mobile clinics, venue-based testing and fixed location testing. • Work with the Department of Corrections to assess and develop a way for health and social service providers to offer people health screenings and supportive service linkage	

immediately after release from the Marion County Jail and the Indiana Women's Prison. • Work with Indiana state legislators to modernize state laws to align with current HIV science, remove penalties based on a person's disease status, and improve access and use of HIV prevention and harm reduction supplies.	

EHE Pillar 2. TREAT

Goal: All people living with HIV should be retained in care and benefit from HIV treatment to reach viral suppression (U=U).

Strategy 2.1: Further streamline linkage to care.
Strategy 2.2: Retain and reengage people in HIV treatment and care.
Strategy 2.3: Reduce stigma associated with HIV, STIs, mental health and addictions.

TREAT **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
<u>Streamline linkage to care</u>: • Increase the percentages of newly diagnosed individuals who enroll in the Ryan White HIV/AIDS Program by strengthening linkages with primary care providers in health centers, community health clinics, and private practices that serve EHE priority populations. • Reduce and streamline patient data and document requirements, and ensure provider protocols and financial reserves, so that people can be enrolled in care and treatment while eligibility is pending. • Continue to improve inter-organizational linkage arrangements for "red carpet" enrollment of new patients into medical care and supportive services. • Invest in frontline staff recruitment, retention, training, and inter-organizational coordination so that people living with HIV have the benefit of continuity with trusted and competent community health workers and care coordinators. • Invest in community organizing, peer support, coaching and mentoring, and related supportive services to facilitate people's readiness to access treatment and care and follow-up screenings and support. <u>Retain and reengage people in HIV treatment and care</u>. • Reduce caseloads of Ryan White case managers and explore differentiated care and targeted care approaches so that case managers can allocate more time, attention and resources to people most at risk of falling out of care.	• At least 90% of people testing HIV-positive each year will be rapidly linked to medical care and HIV treatment (within 30 days of diagnosis), • At least 90% of all 5575 PLHIV will be retained in regular care and treatment to maintain health, and • At least 90% of people accessing HIV treatment will reach viral suppression.

• Invest in frontline community workers and PLHIV peer groups and peer mentorships to reinforce people's interpersonal connection and trust with service providers. • Continue to strengthen and scale up Data to Care systems so that Ryan White case managers, medical providers and supportive service providers can work efficiently with Disease Intervention Specialists and Early Intervention Specialists to help PLHIV access the support and resources they might need. <u>Reduce stigma associated with HIV, STIs, mental health and addictions.</u> • Promote the U=U (Undetectable=Untransmissible) message to the public and to primary care providers to convey that HIV is and can be a well-managed long-term health issue for everyone living with the virus and that average community HIV viral load rates are important both for the health of people living with HIV and for prevention of HIV transmission. • Train primary care providers to routinely screen for HIV, STIs, viral hepatitis, and sexual health and behavioral health needs as a regular part of health care. • Work with Indiana state legislators to modernize state laws to align with current HIV science, remove penalties based on a person's disease status, and improve access and use of HIV prevention and harm reduction supplies.. • Connect people living with HIV (PLHIV) with each other through support groups, meetings, planning councils, and social venues.	

EHE Pillar 3. PREVENT

Goal: Offer and provide all people in priority populations regular screenings and referrals for sexual health and behavioral health needs, including access to nPEP, PrEP and other HIV prevention services.

Strategy 3.1: Promote sexual health and behavioral health
Strategy 3.2: Increase access to, and provision and use of, PrEP
Strategy 3.3: Increase access to syringe access and harm reduction services

PREVENT **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
<u>Promote sexual health and behavioral health</u> • Work with faith-based leaders, such as at Concerned Clergy, Broadway United Methodist Church, Eastern Star Church, Indianapolis Black Ministerial Alliance, and Purpose of Life Ministries to identify the right messengers and getting the messages out about nPEP and PrEP, and about sexual health	• A steady increase in the numbers of people in Marion County who are provided sexual health and behavioral health screenings each year.

and behavioral health, to overcome misinformation, fear and stigma. • Increase support to high school clinics, working with the MCPHD Adolescent Health Action Center, the Riley Clinic, LifeSmart Youth, and their partnerships to increase young people's access to health education and health services. • Work with the Indiana Primary Health Care Association, MATEC, and the Fairbanks School of Public Health Project ECHO to inform and educate primary care providers about nPEP and PrEP and screening for sexual health and behavioral health needs. • Use digital technology to reach people in social networks and dating / hook-up networks to increase awareness about PrEP, reduce stigma about PrEP, target PrEP promotion, allow people to fill out a self-assessment, and then rapidly access PrEP information and related counseling and referrals to sexual health and behavioral health services. Center PrEP promotion and services around what people need and want, alongside the public health goals of reducing infections. • Work with the Department of Corrections to assess and develop a way for health and social service providers to offer people health screenings and supportive service linkages, including related to PrEP, immediately after release from the Marion County Jail and the Indiana Women's Prison.	• At least 3,000 people referred to and enrolled in PrEP services. • At least 500 people referred to and enrolled in syringe access or other harm reduction programs • The aim: a 90% reduction in annual incidence of HIV, and a 90% reduction in annual incidence of STIs, acute viral hepatitis and overdose among people living with HIV.
<u>Increase access to, and provision and use of, PrEP</u> • Invest in PrEP peer navigators and related frontline prevention educators and counselors who can be effective and trusted resources in the priority networks and neighborhoods to help engage people in EHE priority populations in screening for PrEP, especially young adults <25, transgender people, people who inject drugs, and people of color. • Integrate PrEP into routine health screenings and counseling by providing trainings and small grants to clinics and health centers serving EHE priority populations. • Engage smaller retail pharmacies in high-prevalence zip codes to ensure they are able to offer PrEP counseling to customers. • Increase easy rapid access options for nPEP and PrEP at emergency departments and urgent care centers, including same-day starts for PrEP as long as initial laboratory results will be received and acted upon within seven days. • Reduce barriers to PrEP maintenance, including medication assistance, online self-risk assessments and rapid self-referrals and linkage, and telePrEP initiatives, and through offering voucher incentives, free rapid STI testing and treatment, and access to mental health or substance use services, access to drug treatment, and other supportive services such as food pantry and emergency financial assistance.	

Increase access to syringe access and harm reduction services • Invest in harm reduction peer navigators. • Enhance provider capacity to assess and refer people for syringe services and harm reduction. • Expand locations and hours of mobile syringe services and of fixed site services, including syringe access, testing, PrEP, and other services in pop-up health events or at large supportive service locations. • Expand harm reduction coalitions and working groups to advise on public education campaigns about harm reduction and to work with law enforcement and criminal justice system to refer people to addictions treatment and behavioral health services pre-arraignment, post-arraignment (but pre-sentencing), post-sentencing, or probation/parole stages. • Work with elected officials, prosecutors, law enforcement and the media to increase understanding and support for evidence-based harm reduction, and to remove legal and law enforcement barriers to people's access to and use of PrEP and sterile syringes.	

EHE Pillar 4. SUPPORT, ORGANIZE AND RESPOND

Goal: Community organizations, service providers and the county and state health departments will collaborate to document and respond to entrenched and emergent health needs and barriers to the HIV response in priority populations and quickly identify, prevent and stop HIV outbreaks.

Strategy 4.1: Increase access to supportive services to help people connect with healthcare and to help providers to document and respond to entrenched and emergent health needs in priority populations.

SUPPORT **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
• Continue to invest in Ryan White HIV/AIDS Program supportive services for PLHIV and for people at risk of HIV in need of early intervention services. • Provide resources to vulnerable and economically distressed communities for education, organizing and mobilization about structural disparities and barriers in health. • Train providers to ensure service coordination and effective linkage across multiple supportive services. • Increase the availability of safe, stable and affordable housing and related housing services to reduce homelessness and increase housing stability in all communities. • Improve economic opportunities and reduce economic disparities through emergency financial assistance and access	• An increasing percentage of people living with HIV and people vulnerable to HIV will receive supportive services from HIV service providers to overcome poverty-related barriers to HIV prevention and treatment, connect with social support and overcome social isolation, self-stigma and discrimination and criminalization.

to training, education, and employment with adequate remuneration, benefits and accommodation. • Provide legal services to help people overcome barriers to services. • Provide opportunities for social engagement, along with support groups, assessment and linkage for behavioral health services, and support for individual empowerment and leadership development. • Collect data to track and act on disparities, including collection of data that tracks service utilization and client experience by client demographics.	

Strategy 4.2: Support community organizing so that community coalitions and networks will document entrenched and emergent health needs and barriers to HIV programming, mobilize community-led responses, and work with IDOH and MCPHD to quickly identify and stop HIV outbreaks.

ORGANIZE **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
• Coordinate with local community and practitioners to reinforce community development efforts, and to tap into community-specific knowledge that facilitates locating difficult-to-find individuals, identifies individuals' distinct needs, and reinforces word of mouth, driven by social networks and trust, to engage people in health screenings, prevention and treatment. • Invest in community-centered "one-stop shop" services that address a full array of service needs. • Conduct public education to increase awareness, reduce stigma and foster community support for individuals at risk, such as through sharing individual stories to profile actions for health, individual strengths and resilience. • Promote health and health screening through trusted community voices, including African American media (including print, radio and social media) and through minority businesses and educational partners such as Martin University and Black sororities and fraternities. • Train frontline workers, including community outreach workers, pharmacists and first responders to provide consistent high-quality patient counseling and follow up on priority health issues. • Work with elected officials, prosecutors, law enforcement and the media to increase understanding and support for evidence-based harm reduction and non-punitive approaches to public health issues, and to remove legal and law enforcement barriers to people's access to and use of PrEP, sterile syringes, and other HIV services.	• Community coalitions and networks will document entrenched and emergent health needs and barriers to HIV programming, mobilize community-led responses, and work with IDOH and MCPHD to quickly identify and stop HIV outbreaks.

• Work with Indiana state legislators to modernize state laws to align with current HIV science and remove penalties based on a person's disease status and access and use of HIV prevention and harm reduction supplies.	

Strategy 4.3: Improve data systems and digital technology for improved health surveillance and reporting to document and respond to entrenched and emergent health needs and barriers to the HIV response in priority populations and quickly identify, prevent and stop HIV outbreaks.

RESPOND **Short-term objectives** *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
• Invest in data systems that can quickly and accurately link data from multiple sources, including eHARS, Regenstrief Institute, Indiana Health Information Exchange, and NBS (NEDSS Based System) surveillance systems, Ryan White CAREWare, AIDS Drug Assistance Program (ADAP) databases, client-specific Electronic Health Records (EHR) systems such as EPIC, pharmacies and insurers. • Invest in staffing and training in clinical settings to support complete and accurate data. • Invest in health data security and privacy to protect individuals and communities from potential harms, including harms due to HIV-related stigma, discrimination and criminalization, due to sharing and use of health data, and maximize the potential benefit gained from collection and use of data. • Invest in data reporting and EMR prompts that allows health providers and health departments to use the information to direct extra attention and offers testing and services to people in most need, rapidly respond to emergent population health needs, reduce inefficient or ineffective health practices and expenditures, and improve patient experience and health outcomes.	• >75% of new diagnoses and other key laboratory results (e.g., CD4 and VL) will be entered within 14 days. • Monthly service utilization data will be reported to providers to improve intervention targeting and delivery. • Interagency meetings about specific priority populations will be held regularly to review epidemiology and service data and identify and respond to service gaps. • Entrenched and emergent health needs in priority populations, including HIV outbreaks, will be quickly identified, prevented and addressed.

Implementing the Plan

INVEST IN WORKFORCE AND MANAGEMENT

Goal: Invest in workforce diversity and competency, and related management and accountability of a workforce of hundreds of people working across dozens of organizations.

Strategy 5.1: Invest in diversity and linguistic and cultural competency of the HIV workforce, and improve recruitment and retention of care coordinators, case managers and other community-facing frontline health workers by analyzing and improving workloads, pay scales, and opportunities for professional growth and advancement.

Short-term objectives *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
<u>Attract a diverse workforce</u> • For community-facing positions, including community outreach and education, peer support, patient navigation, and contact tracing and assisted partner notification, fund competitive remuneration levels and opportunities for training, cross-learning, cross-placement and professional networking to attract highly qualified candidates from diverse backgrounds, especially with lived experience of the structural issues faced by HIV priority populations, including issues of poverty and stigma or discrimination based on race, ethnicity, national origin, primary language, gender, gender identity, sexual orientation and age. <u>Recognize, reward and retain competency</u> • Across the entire EHE partner workforce, create ways to recognize and reward people who demonstrate competency in engaging with clients and who make extra effort to establish trust and ensure positive health outcomes. Invest in long-term retention of those individuals with opportunities for professional networking and growth and/or with appropriate workplace accommodations and other support.	• Workforce diversity and linguistic competency will improve. • Retention of highly rated care coordinators, case managers and other community-facing frontline health workers • Client surveys and client data will show improved trust, engagement and retention in healthcare and supportive services.

Strategy 5.2: Invest in technical competency of medical providers, supportive service providers and community health workers through trainings, residencies, mentorships, fellowships, and scholarships.

Short-term objectives *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
<u>Invest in training opportunities</u> • Create training opportunities, including residencies, mentorships, fellowships and scholarships to help people across the HIV effort and at all practice levels gain new knowledge, skills and confidence related to working with people who may face barriers to care due to poverty, behavioral health issues, language or stigma or discrimination based on age, gender, race, ethnicity or sexual orientation. • Specifically invest in and build on existing training programs, such as the Midwest AIDS Education + Training Center (MAETC) and the Fairbanks School of Public Health Project ECHO (Extension for Community Healthcare Outcomes), and trainings offered by Marion County universities, healthcare	• Client surveys and client data will show improved trust, engagement and retention in healthcare and supportive services.

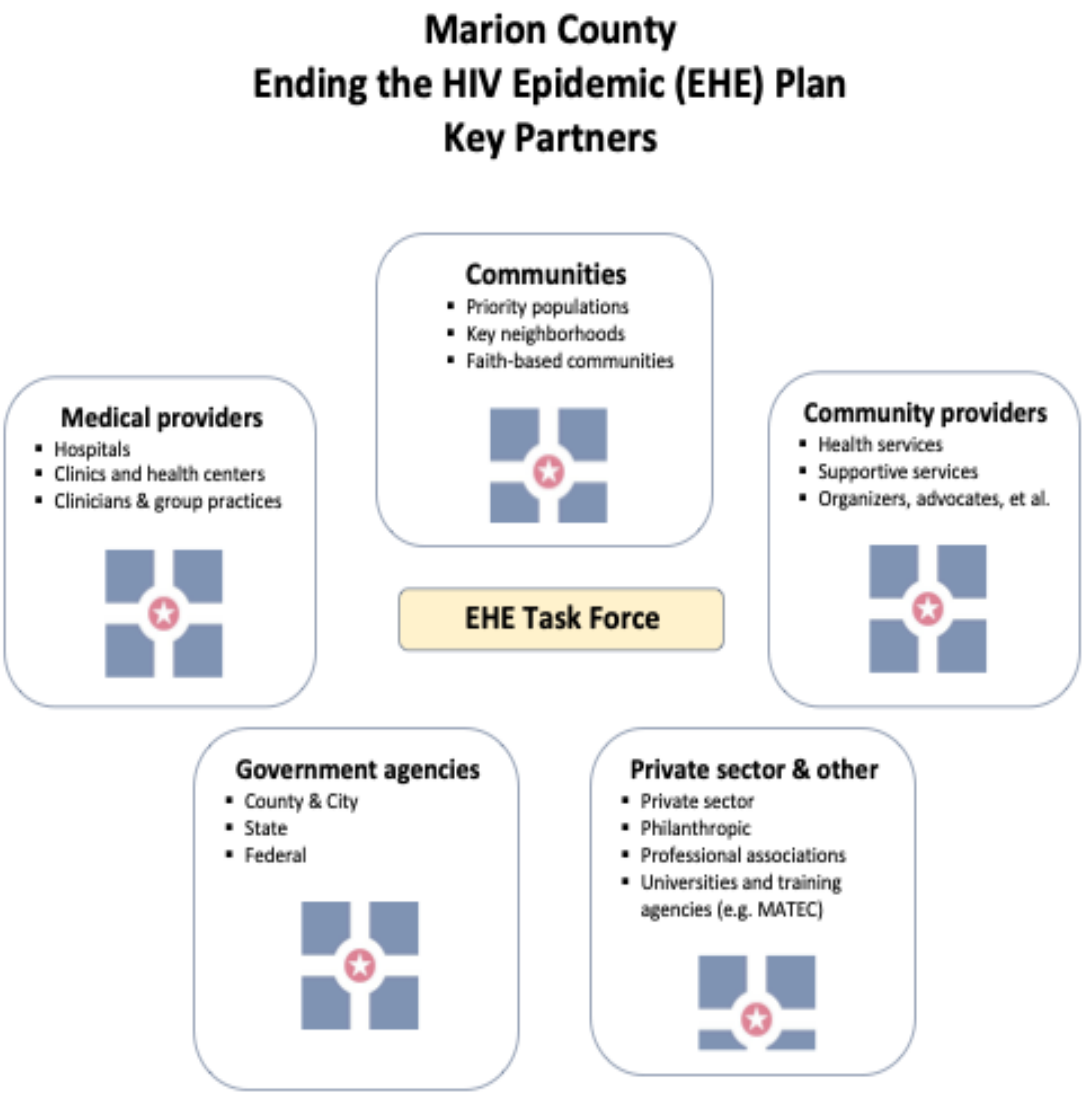
providers, supportive service providers and community organizations. • Consider "medical detailing" visits for primary care providers, supportive service providers and community-based leaders about five themes: o Routine sexual health histories and related counseling and referrals o Routine mental health and substance use disorder assessments and related counseling and referrals o Assessments and referrals for PEP and PrEP o Improvements in rapid interagency linkages to HIV care and supportive services o Competency in working with specific populations, including adolescents, gay men, transgender people, people who inject drugs and people with recent histories of violence, trauma, and/or interactions with law enforcement and criminal justice systems.	

Strategy 5.3: Engage with a diverse range of provider and community networks to foster innovation, coordination and shared accountability by all agency leaders, service providers and frontline workers toward collective impact.

Short-term objectives *(outputs; annual deliverables; sphere of control)*	**Outcome objectives** *(intermediate outcome; 3-5-year deliverable; sphere of influence)*
• To ensure that the HIV workforce remains updated about new information and evolving approaches to address the needs of people living with or vulnerable to HIV, work with local and national networks and coalitions to present evidence and best practices. These networks and coalitions should include those organized by: o Health provider networks, such as the Indiana Primary Health Care Association, the ID Society of Indiana, the Central Indiana Association of Nurses in AIDS Care, Indiana Association of School Nurses, Central Indiana Association of Black Social Workers, Indiana Pharmacists Alliance, the Indiana Recovery Alliance and Mental Health America of Indiana (MHAI). o Supportive service provider networks, such as the Coalition for Homelessness Intervention and Prevention (CHIP), Indiana Health Disparities Task Force, Concerned Clergy of Indianapolis, Indiana Addictions Issues Coalition, Indiana Recovery Alliance, the Marion County Re-Entry Coalition, and Public Advocates in Community Re-entry (PACE). o Population and geographic networks, such as the Minority Health Coalition, Indiana Urban League, the African American Coalition of Indianapolis (AACI), Central Indiana Community Foundation (CICF), the Indiana Health Disparities Task Force, the Indiana Legislative Black Caucus,	• Coalitions and networks will recommend innovations and opportunities for coordination and collective impact in efforts to end the HIV epidemic and achieve progress in health and equity in Marion County.

	the Interagency State Council on Black and Minority Health (ISCBMH), Indy10 Black Lives Matter, GenderNexus, BU Wellness Network, Indiana Youth Group, Indiana Undocumented Youth Alliance (IUYA), and the HIV Modernization Movement-Indiana.	

Key Partners

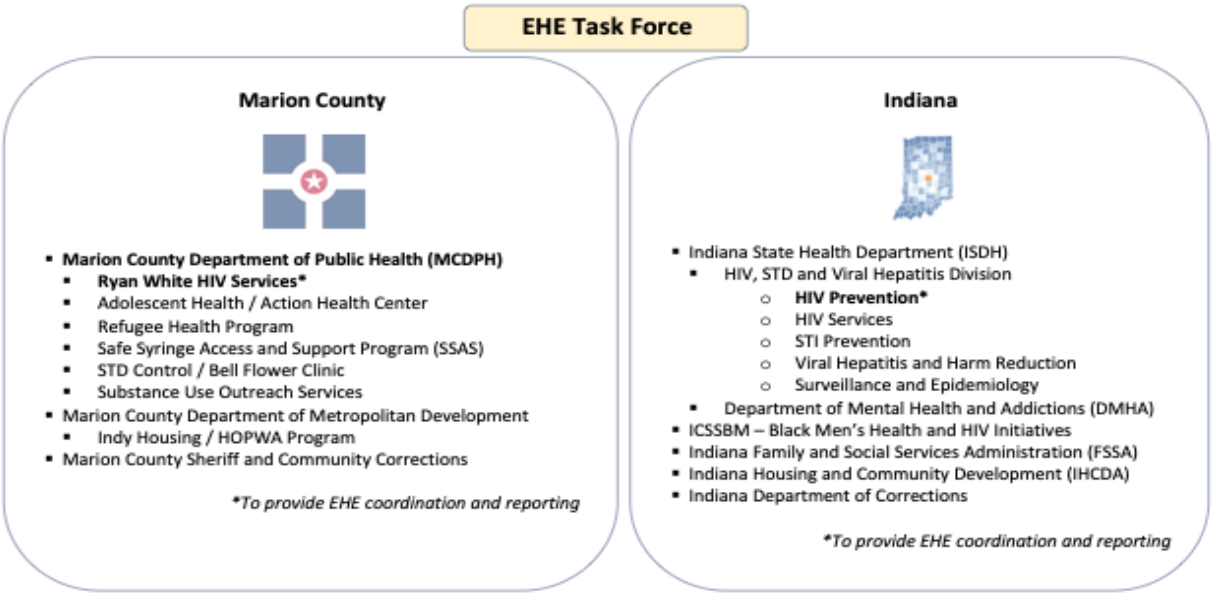


County and State Coordination

Ending the HIV Epidemic

Marion County
Ending the HIV Epidemic (EHE) Plan

County and State Coordination



Join us!

Please, join this effort to end the HIV epidemic in Marion County and greater Indianapolis!
https://thfgi.org/marion-county-hiv-ending-the-epidemic-ete/

New partners are welcome to join the work of this Ending the HIV Epidemic plan:

- **If you're a funder**, join us or partner with us in supporting local organizations.
- **If you're a government official**, let us work together to ensure public and private sector programs complement each other to meet the needs of people most affected by HIV.
- **If you're a company representative**, work with us to find a way to express and expand your corporate social responsibility to advance health and equity in specific neighborhoods and communities and achieve an end to the HIV epidemic.
- **If you work with a service provider or community organization**, contact us to let us know about your work.

Contact us to learn more:

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Organization abbreviations

340b	340B Drug Pricing Program within HRSA
A4M	Almost 4 Minds
BUMC	Broadway United Methodist Church
CDC	US Centers for Disease Control and Prevention
CHIP	Coalition for Homelessness Intervention & Prevention
CHN	Community Hospital Network
CHOICE	Community and Home Options to Institutional Care for the Elderly and Disabled
CICF	Central Indiana Community Foundation
CICOA	Central Indiana Center on Aging
DHHS	US Department of Health and Human Services
DMHA	Indiana Department of Mental Health and Addictions
DOC	Indiana Department of Corrections
ECHO	Extension for Community Healthcare Outcomes Training Project
EHE	Ending the HIV Epidemic Initiative
eHARS	Enhanced HIV/AIDS Reporting System
FSSA	Indiana Family and Social Services Administration
HOPWA	Housing for People Living with HIV/AIDS
HRSA	US Health Resources and Services Administration
HUD	US Department of Housing and Urban Development
ICSSBM	Indiana Commission on the Social Status of Black Males
IHCDA	Indiana Housing and Community Development Authority
IPHCA	Indiana Primary Health Care Association
ISCBMH	Interagency State Council on Black and Minority Health
IDOH	Indiana Department of Health
IU	Indiana University
IUPUI	Indiana University – Purdue University Indianapolis
IUL	Indianapolis Urban League
MATEC	Midwest AIDS Training and Education Center
MDC	Marion County Metropolitan Development Commission
MCPHD	Marion County Public Health Department
MHAI	Mental Health America of Indiana
MHCMC	Minority Health Coalition of Marion County
MMP	Medical Monitoring Project
NACCHO	National Association of County and City Health Officials
NASEM	National Academies of Sciences, Engineering, and Medicine
NASTAD	National Association of State and Territorial AIDS Directors
NCSD	National Coalition of STD Directors
PACE	Public Advocates in Community Re-entry
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	US Substance Abuse and Mental Health Services Administration
SSAS	MCPHD Safe Syringe Access and Support Program
SUOS	MCPHD Substance Use and Outreach Services
THFGI	The Health Foundation of Greater Indianapolis
USPSTF	US Preventive Services Task Force
VA	US Veterans Administration
VOA	Volunteers of America

Acronyms

5As	Availability, Affordability, Accessibility, Accommodation, Acceptability
5Ps	Sexual health history (Partners, Practices, Protection, Past, Pregnancy prevention)
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
API	Asian and Pacific Islander
ARTAS	Antiretroviral Treatment and Access to Services
CHC	Community Health Center
D2C	Data to Care
DIS	Disease Intervention Specialist
ED	Emergency Department
EIS	Early Intervention Specialist
EHE	Ending the HIV Epidemic
HER	Electronic health record
EMR	Electronic medical record
FQHC	Federally Qualified Health Center
GNC	Gender Non-Conforming
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HPV	Human Papillomavirus
HEEADSS	Social history acronym (Home, Employment, Eating, Activity Drugs, Sex, Safety)
HIPAA	Health Insurance Portability and Accountability Act
IPV	Intimate Partner Violence
LGBT	Lesbian, Gay, Bisexual and Transgender
LEAD	Law Enforcement Assisted Diversion
LTC	Linkage to Care
MEL	Monitoring Evaluation and Learning
MOUD	Medication for Opioid Use Disorder
MSM	Men who have sex with men
NBS	NEDSS Based System
NEDSS	National Electronic Disease Surveillance System
nPEP	Non-occupational Post-Exposure Prophylaxis
PHC	Primary Health Care
PHR	Personal Health Records
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PrEP MAP	PrEP Medication Assistance Program
PTSD	Post Traumatic Stress Disorder
PWID	People who inject drugs
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TGA	Transitional Grant Area
U=U	Undetectable Equals Untransmittable
VCT	Voluntary Counseling and Testing
VL	Viral Load
VPN	Voluntary Partner Notification
YRBS	Youth Risk Behavior Surveillance Survey

Terminology and definitions

Geographic terms:

The scope of this EHE Plan is **Marion County**, which is one of the jurisdictions named by the Department of Health and Human Services (DHHS) for initial Ending the HIV Epidemic investments. Marion County encompasses the city of Indianapolis and is at the center of a larger multicounty greater Indianapolis, a 10-county Indianapolis Transitional Grant Area (TGA), and the state of Indiana.

Geographically the highest HIV incidence and prevalence in Marion County are seen in the central urban neighborhoods of Indianapolis, such as in the eastside zip code of 46201, the north-central and northeast zip codes of 46205, 46208, 46218, 46226, and 46235, and the westside zip codes of 46222, 46224, and 46254. All of these zip codes were classified as having majority-minority populations in the 2010 census, and all contain neighborhoods classified as economically distressed by the 2017 Indianapolis Neighborhood Investment Strategy and Marion County Metropolitan Development Commission.

Epidemic terms:

An **epidemic** is a widespread occurrence of a health issue in a population, with that occurrence expanding (as opposed to an endemic health issue, which is regularly occurring in a stable, predictable or baseline pattern). Epidemics typically have infectious disease as their cause (e.g., influenza, SARS-CoV-2, measles) but can have other causes (e.g., overdoses due to fentanyl, women's loss of life due to lack of safe abortion services). An **outbreak** is an increase in cases, typically in a small defined geography or population. A **cluster** is an aggregation of cases grouped in place and time that are suspected to be greater than the number expected

"Ending the HIV Epidemic" is defined by the Department of Health and Human Services (DHHS) Ending the HIV Epidemic (EHE) initiative as reducing HIV transmissions by 90% by 2030. In general terms, ending the HIV epidemic would mean a situation where both HIV transmissions and cases of AIDS are rare, where people living with HIV have treatment and services to support health and prevention and few people are vulnerable or exposed to the virus.

If and when a 90% reduction in HIV transmissions is achieved, the HIV response can then shift to a long-term effort to sustain treatment, prevention and outbreak response efforts until HIV is no longer a public health threat. An analogy is the US polio epidemic, in which effective polio vaccines and public health efforts reduced poliovirus transmissions by 90% by 1960 and yet, as of 2020, over 125,000 Americans continue to live with post-polio syndrome and remain important to health services and public health, including as activists for equal access and rights of disabled people and for global polio eradication efforts still underway in Africa and Asia.

Population terms:

Populations, communities or social or sexual networks can be defined and self-defined by a myriad of geographic, demographic, behavioral or other characteristics or terminology.

The EHE Plan has defined "**priority populations"** based on epidemiology of the HIV epidemic, relative burden of other health issues, and relative service access, use and benefit. These populations are "key" to ending the HIV epidemic not only because of their needs but because of their direct experience, expertise, commitment and leadership in the response. In some cases. but not all, these populations are underserved, marginalized, disadvantaged, vulnerable, or historically or currently neglected. (see Tables 6 and 8 In the EHE Plan)

Social and structural determinants of health: Conditions in the environment in which people are born, grow, live, work and age that affect a wide range of health, functioning and quality of life outcomes and risks. They include factors such as social and economic status, legal environment, education, physical environment, employment and social support networks, as well as access to health care.

Organizational terms:

Medical care and medical providers refer to hospitals, clinics and health centers (such as Federally Qualified Health Centers and Community Health Centers), laboratories, pharmacies and health professionals such as physicians, nurses, pharmacists, psychiatrists and dentists.

Primary care providers serve as a first and primary point of contact for medical care, including non-specialized care in emergency departments, urgent care centers, other clinics and health centers, pharmacies and private doctor offices.

Supportive service providers include providers of non-medical case management, early intervention services, patient navigation, health insurance navigation, housing services, social engagement opportunities, emergency financial assistance, transportation assistance, vocational and employment support, food and nutrition and health insurance assistance.

Community service organization and community organization refers to any non-governmental not-for-profit organization providing services, and thus includes educational, social and faith-based organizations, and also not-for-profit organizations providing HIV testing, non-medical case management, early intervention services and other supportive services.

HIV-related service terms:

Routine provider-initiated counseling and testing refers to a provider recommending and offering a test to a patient based on protocols and assessment of patient need. **Opt-out testing** refers to testing after a patient is informed and consents to broader care that includes testing as a routine part of that care, frequently with prompts to allow the patient to decline or defer any part of the offered care. **Self-testing**: Preferred term vs home-testing. Refers to rapid testing that can be done via oral swab or finger prick, and also to sample collection that can be done in any setting and sent to a lab by a patient.

Linkage to care: A process that leads a patient to enter care after diagnosis. In HIV, it refers to the initiation of HIV outpatient care. The standard and goal of the Department of Health and Human Services (DHHS) Ending the HIV Epidemic (EHE) initiative is that at least 90% of newly diagnosed PLHIV will be linked to care within 30 days of their diagnosis. Rapid linkage to care can mean linkage within 10 days or even within 48 hours of a diagnosis.

HIV treatment refers to the combination antiviral medicines that suppress HIV. **HIV viral suppression** refers to a viral load of less than 200 copies of HIV per milliliter of blood, sustained over time, indicating reduced viremia and associated risk of acquired immune deficiency over time, and minimal likelihood of onward HIV transmission. **Treatment as Prevention (TasP) and Undetectable=Untransmissible (U=U**) refer to the proven evidence that sustained viral suppression prevents HIV transmission to others.

Retention and reengagement in HIV treatment and care means that a person living with HIV is taking daily medications to achieve viral suppression and accessing medical care at least annually and as needed. In states where prescription refills are monitored, these can indicate patient retention in HIV treatment. Otherwise retention can be measured by regular viral load and CD4 testing and visits to a medical provider.

HIV care continuum refers to a model of stages of HIV medical care for people living with HIV, from initial screening and diagnosis to achieving the goal of viral suppression and regular health screening for viral suppression, CD4 counts and other health issues, showing the proportion of individuals living with HIV who are engaged at each stage. A similar **HIV prevention continuum** refers to stages of HIV prevention services for people who are vulnerable to HIV, including regular screening for HIV and related health issues, provision of prevention options such as PrEP, harm reduction, behavioral health services and supportive services and return to regular screening for HIV and related health issues.

HIV criminalization refers to laws and policies that are used to criminalize the alleged or actual transmission of, or exposure to HIV, or to enhance sentencing because a person has HIV. These laws and policies put people living with HIV at risk for prosecution. Most laws do not account for the actual scientifically based level of risk engaged in, or risk reduction measures undertaken by, persons living with HIV or persons exposed to HIV. They also do not reflect best practices in criminal law. HIV Criminalization works against public health by increasing stigma and discrimination, deterring HIV testing, and disincentives participation in proven HIV related public health efforts like partner services and cluster response.

Harm reduction or **risk reduction** are broad preventive approaches to help people reduce potential harms of behavior without prohibiting, punishing or judging the behavior. Harm reduction encompasses social and structural interventions such as seat belts, bicycle helmets, and face masks. Harm reduction or risk reduction related to drug use or sex provides the individual with easily accessible options to reduce harms and risks, including abstinence if and when they choose it. **Syringe access** is a harm reduction approach for people who inject drugs that allows injection drug users (IDUs) to obtain clean syringes and associated supplies and services at little or no cost. **Medication for opioid use disorders (MOUD)** encompasses opioid agonist therapy (OAT) and opioid substitution therapy (OST) to help people to reduce dependence on opioid drugs.

Sexual health services are services that include taking a sexual health history; providing sexual health education; counseling, testing and treatment for HIV and STIs; counseling, testing and care related to pregnancy and reproductive options; provision of condoms, PrEP and other prevention and health supplies and support for physical, emotional, mental and social well-being in relation to sexuality and sexual activity.

Behavioral health services are services that assess, counsel, refer and treat mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms and behaviors that may affect health and medical conditions.

Attachment 2: **References and additional reading**

The following documents provide additional evidence base for the Marion County Ending the HIV Epidemic Plan and can be sent to Marion County EHE Task Force participants on request.

EHE PILLAR: DIAGNOSE

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Attachment 3: **Marion County EHE Needs Assessment and Consultation Methodology**

This Marion County EHE Plan is a result of contributions of hundreds of people, including people living with HIV, service providers, and representatives of community organizations and local and state government. The following is a summary of the needs assessment and consultation approaches.

Marion County EHE Plan – Process of Needs Assessment and Consultation	**Timing**
Notification of CDC PS19-1906 planning award	October 2019
Development of planning process and timeline	October-November
Development and submission of an initial draft Marion County EHE Plan to the CDC as required under the PS19-1906 award	December
Recruitment and formation of Marion County EHE Task Force *(47 participating from over 27 organizations and coalitions)*	December-February 2020
Stakeholder engagement and needs assessment	
Task Force discussions with four other US jurisdictions about EHE Plans and related innovations, successes and challenges	March-May
Interviews with local stakeholders (52 completed)	March-August
Survey of service provider capacity (37 responses)	May-June
Survey of individuals in EHE priority populations (880 responses)	June-August
Focus groups (26 constituency groups; 120 participants)	June-August
Review of literature and related planning documents	July-August
Task Force discussions to determine EHE Plan priorities	
Epidemiology review and discussion	June

Review and discussions of programming by each EHE Pillar	July-August
Small group discussions of Situational Analysis and findings to date	August
Task Force review of plan and concurrence process	
Review of a first full draft of the EHE Plan	September
Review by IDOH Advisory Council, Ryan White Planning Council and other HIV-related planning bodies and coalitions	October
EHE Plan final concurrence, finalization, approval and launch	November-December

About the facilitators of the 2020 EHE needs assessment and consultation process

In early 2020, the Indiana Department of Health (IDOH) in consultation with the Marion County Public Health Department (MCPHD) contracted with The Health Foundation of Greater Indianapolis (THFGI) and through THFGI the consulting firm Johnson, Grossnickle and Associates (JGA) to lead and facilitate the EHE needs assessment and consultation process for Marion County.

The Health Foundation of Greater Indianapolis (THFGI) is a private foundation that supports health-related projects and organizations that serve the community's most vulnerable citizens. The Health Foundation is a trusted independent community-centered grant maker with a long commitment to funding programs focused on HIV prevention and emergency financial assistance for people in need. The Health Foundation began making grants for HIV/AIDS in 1990 and to date has granted more than $21.5 million to AIDS service organizations and community health providers across Indiana.

Johnson, Grossnickle and Associates (JGA) is a consultant team dedicated to strengthening and empowering not-for-profit organizations and philanthropic grant making initiatives to make the world a better place. The JGA team has extensive experience in strategic planning, research and community engagement in greater Indianapolis and a strong commitment to community engagement, pluralism and advancement of health and social and economic opportunity.

The Marion County EHE needs assessment and consultation approach

The EHE needs assessment and consultation process in Marion County was developed with input from the newly formed 47-member EHE Task Force and from the Indiana Department of Health (IDOH) in consultation with the Marion County Public Health Department (MCPHD).

The first step in the needs assessment process was to compile and review existing documents, including the 2016 Integrated HIV Plan for the State of Indiana, the 2019 HIV epidemiology data for the Indianapolis Transitional Grant Area (TGA) the 2019 IDOH PLHIV Needs Assessment, and other relevant state and county plans and documents. The Health Foundation and JGA then worked together and with the Task Force, IDOH and MCPHD to identify an extensive list of stakeholders and informants to contact and involve in the 2020 needs assessment and consultation process.

JGA then designed and implemented a three-tiered data collection protocol to include both qualitative and quantitative information gathering. The protocol included individual interviews, focus groups, and

two separate survey instruments. An important part of the methodology for the data collection included regular convening of the EHE Task Force to provide guidance and input throughout the process.

Individual Interviews

On the qualitative side, JGA conducted individual interviews with 52 stakeholders within Marion County. The interviewees included those traditionally included in the HIV services arena as well as others who work in support services, faith-based communities, and organizations that address social determinants of health. This group intentionally included several stakeholders who are considered potential new partners in the EHE effort.

JGA used a semi-structured appreciative inquiry approach, which ensured that a consistent set of questions was used in each meeting, while still focusing on topics and themes relevant to the interest and expertise of individual interviewees. The interviews were conducted by two consultants who then synthesized the notes to compile and document common themes.

Focus Groups

JGA then conducted 26 focus groups with 120 participants, with a broad cross-section of provider groups, people with lived experience, and people in at-risk populations. The focus groups provided opportunities for an in-person, interactive group dynamic, resulting in important discussions, observations and insights.

Participants were intentionally recruited across 26 defined networks in a variety of roles, organizational affiliations, neighborhoods and communities and demographics, through leading providers and community organizations, as well as independent outreach.

Facilitators were matched with each group based on its composition, yet there was one single PhD researcher who took the notes for all of the focus groups in order to provide continuity and to synthesize all of the input.

Summary of EHE Planning Focus Groups

Focus Group Type	***# of Participants***	***Type of Meeting***	***Protocol Type***
Front Line Workers	9	Virtual	TYPE 1
Subject Matter Experts (English)	3	Virtual	
Subject Matter Experts (Spanish)	6	Virtual	TYPE 1
Julian Center	1	Virtual	TYPE 1
HIV Treaters	8	Virtual	TYPE 1
Providers	7	Virtual	TYPE 1
Community Centers	8	Virtual	TYPE 1
Homeless Centers	5	Virtual	TYPE 1
STD Providers	5	Virtual	TYPE 1
Hospitals	6	Virtual	TYPE 1
Nutrition	3	Virtual	TYPE 1
Marion County Trustees	1	Virtual	TYPE 1
Mental Health	2	Virtual	TYPE 1
Re-Entry	6	Virtual	TYPE 1
White MSM	3	In Person	TYPE 2

Black MSM	19	In Person	TYPE 2
Latinx	3	In Person	TYPE 2
Youth	3	In Person	TYPE 2
Substance Abuse Workers	6	Virtual	TYPE 1
People Over 55	4	In Person	TYPE 2
Transgender	3	In Person	TYPE 2
Faith Based	5	In Person	TYPE 2
Parents	5	In Person	TYPE 2
Foreign Born	1	In Person	TYPE 2
Black Women	3	In Person	TYPE 2
Parents	5	In Person	TYPE 2
Total	130		

Provider Survey

JGA then conducted a survey of 37 organizations in Marion County receiving HIV-related funding, with a significant outreach aiming to engage nearly all providers, including several potential new providers. Questions were related to the four EHE pillars and intersectional issues, encouraging expression of thoughts and opinions, which resulted in a good affirmation and mapping of providers engaged in the HIV effort.

Consumer and Expert Survey

To round out the data collection, JGA completed the largest HIV survey in the known history of HIV work in Marion County. This anonymous survey was completed by 880 individuals in EHE priority populations, recruited through electronic distribution through social media channels and in-person distribution through service providers and faith communities. The survey was notable for engaging significant numbers of people self-identifying as Black (40% of 880 respondents), Hispanic or Latinx (18%), gay or lesbian (28%), transgender (7%), adolescent (5%), and/or living in majority-minority zip codes (14%).

An extensive recruiting effort employed digital technology, with significant incentives offered, yielding a far-reaching response that intentionally bridged into populations and networks not currently reached by the HIV effort.

To maximize the opportunity for participation and accessibility, the anonymous survey was:

- offered in both Spanish and English;
- conducted over a six-week period;
- provided in online and paper options; and
- offered a financial incentive as well as information about services and related referral and linkage support.

Task Force Engagement Group discussions

A 47-member Task Force was convened to guide the planning process and provide input throughout the process. As a part of its role, four small engagement groups, organized by EHE Pillar and comprised of ten or fewer task force members in each group, were called together during late August to encourage interactive in-person discussion on the four EHE pillars and related issues. This elicited helpful observations and insights.

Open review and discussion of the full draft EHE Plan

Finally, a full compiled draft of the Marion County EHE Plan was developed, distributed and publicly posted to invite review and discussion. Successive drafts of the EHE Plan were presented to the Task Force in early September and October, and then the draft EHE Plan was presented to the Ryan White Part A Planning Council and to the Indiana Department of Health (IDOH) HIV Prevention Advisory Council. This process ensured that all stakeholders had an opportunity during the two months of September and October to access the plan, share it widely, provide comments and ultimately confirm that the EHE Plan is acceptable and inclusive of, reflective of and aligned with priority needs and work in Marion County for ending the HIV epidemic.

Attachment 5: **Summary of 2019 HIV funding in Marion County**

2019 HIV Funding
Marion County, Indiana

Organization	RW Part A	RW Part B	RW Part C	IDOH Prevention	MAI	IAFI	THFGI	HOPWA	Total
Almost4Minds		$190,000.00				$342,780.00			$532,780.00
Bell Flower Clinic	$236,969.00			$35,677.00			$49,046.00		$321,692.00
Bookkeeping Plus		$238,156.00							$238,156.00
BU Wellness Network	$13,728.00	$446,607.00		$287,019.00	$35,101.00	$139,650.00	$131,225.00		$1,053,330.00
Community Health Network	$144,938.00	$460,500.00		$100,000.00			$5,000.00		$710,438.00
Concord Center	$67,265.00	$60,050.00					$6,000.00		$133,315.00
Damien Center	$349,800.00	$736,392.00	$98,400.00	$337,468.00		$408,117.00	$95,350.00	$824,431.00	$2,849,958.00
Damien Cares	$299,131.00	$1,531,724.00	$60,346.00	$224,749.00		$315,000.00			$2,430,950.00
Eskenazi ED	$102,192.00		$39,000.00	$127,140.00					$268,332.00
Eskenazi IDC	$614,417.00	$449,123.00	$119,779.00		$41,195.00		$17,500.00		$1,242,014.00
Indiana Legal Services		$124,586.00				$145,350.00			$269,936.00
Indianapolis Urban League				$65,000.00					$65,000.00
IU Health – LifeCare	$1,211,485.00	$508,036.00	$113,989.00	$42,477.00	$46,674.00		$78,000.00		$2,000,661.00
IU School of Dentistry	$70,465.00	$44,000.00							$114,465.00
IU School of Optometry			$5,485.00						$5,485.00
Luna Language	$15,000.00								$15,000.00
MCPHD Dental	$1,500.00								$1,500.00
Meals on Wheels	$14,300.00								$14,300.00
Midtown Mental Health	$20,473.00						$65,000.00		$85,473.00
Minority Health Coalition of Marion County	$8,580.00								$8,580.00
Shalom	$7,736.00				$38,682.00		$500.00		$46,918.00
Step-Up	$510,940.00	$535,469.00	$55,950.00	$454,000.00		$160,000.00	$15,000.00		$1,731,359.00
Substance Use Outreach Service	$49,830.00				$80,819.00				$130,649.00
Women in Motion	$31,977.00						$2,000.00		$33,977.00
Total Funding:	$3,770,726.00	$5,324,643.00	$492,949.00	$1,673,530.00	$242,471.00	$1,510,897.00	$464,621.00	$824,431.00	$14,304,268.00

DIAGNOSE

EHE Strategy	**What might be measured, monitored and reported**	**Funding and lead responsibility**: Current or likely funding sources and agency responsible for securing and administering funds and confirming guidelines and plans for M&E and reporting
1.1: Expand health provider-initiated testing.	Across each of the ~20 hospital emergency departments and urgent care locations, and ~ 30 other clinics and health centers in Marion County, document: • The locations providing routine opt-out HIV screening, and the volume, demographics, and quality indicators (e.g., org policies, EMR prompts, trainings, STI/hep/TB testing integration) of testing at each of those locations. • The locations at which people can seek on-demand HIV testing, and the accessibility of that testing (especially costs, hours, locations) • Correlation of locations and testing volumes with diagnosis rates and HIV correlates such as zip codes that are majority-minority or average income is <300% FPL.	CDC funding through IDOH
1.2: Expand community-based testing.	Document how the community testing is being targeted, i.e., • The locations where people are being tested and the volume, demographics, and quality indicators (e.g. org policies, trainings, rapid testing, STI/hep/TB testing integration) of testing at each of those locations. and • The number of people at elevated risk regularly (at least annually) re-screened for HIV and STIs • The number of people at elevated risk formally screened and informed about PrEP • The number of people referred to PrEP and other services • The number of people newly diagnosed (and efficiency - case detection rate per cost of effort)	CDC funding through IDOH

TREAT

EHE Strategy	**What might be measured, monitored and reported**	**Funding and lead responsibility**: Current or likely funding sources and agency responsible for securing and administering funds and confirming guidelines and plans for M&E and reporting

2.1: Further streamline linkage to care.	Document: • The percentage of newly diagnosed linked to HIV-related care (as evidenced by an initial CD4 and viral load) and to HIV treatment (as evidenced by a prescription fulfillment and/or a subsequent viral load) within seven days, within 30 days, within 90 days or not at all. • The number and percentage of people eligible for Ryan White HIV AIDS Program services who are enrolled. • Assessment of whether providers have the ability to start someone on treatment before they are determined eligible, and actions planned to overcome barriers to this. • The FTEs and analysis (job descriptions, locations, etc.) of the workforce responsible for working with newly diagnosed PLHIV to link them with care, and actions planned to optimize the cost effectiveness of this workforce.	HRSA CHC funding to Shalom and Bell Flower HRSA funding through MCPHD
2.2: Retain and reengage people in HIV treatment and care.	Document: • The percentage of PLHIV retained in HIV-related care (as evidenced by at least annual CD4 and viral load). • The percentage of PLHIV retained in HIV treatment (as evidenced by a prescription fulfillment and/or suppressed viral load). • The number and percentage of people eligible for Ryan White HIV AIDS Program services who are enrolled. • Assessment of actions taken to prevent loss to care. • The FTEs and analysis (job descriptions, locations, etc.) of the workforce responsible for retaining and reengaging PLHIV care, and actions planned to optimize the cost effectiveness of this workforce. • Efforts to address disparities (racial, gender, age, location, economic) in treatment access and retention (e.g., telemedicine, multi-month medication refills, improved options for providers and provider locations/hours, additional case management services, access to supportive services, etc.).	HRSA CHC funding to Shalom and Bell Flower HRSA funding through MCPHD
2.3: Reduce stigma associated with HIV treatment, STIs, mental health and addictions.	Document: • Trainings (content, # and demographics of participants) for primary care providers to reduce stigma and increase confidence and competence regarding testing and treatment for HIV, STIs, sexual health issues and behavioral health issues. • Public and social media campaigns to increase awareness and reduce stigma regarding testing and treatment for HIV (including U=U), STIs, sexual health issues and behavioral health issues. • The number, and demographics, of people living with HIV charged or prosecuted under Indiana's HIV criminal laws. • The number, and demographics, of people living with HIV participating in public speaking, advocacy, meetings, advisory boards, planning councils, or other similar events or meetings.	CDC and HRSA funding through MCPHD HRSA AETC funding through MATEC ECHO funding through IUPUI

PREVENT

EHE Strategy	What might be measured, monitored and reported	Funding and lead responsibility: Current or likely funding sources and agency responsible for securing and administering funds and confirming guidelines and plans for M&E and reporting
3.1: Promote sexual health and behavioral health.	Document: • The total number of people in Marion County receiving sexual health services and behavioral health services, including "evidence-based risk-reduction behavioral interventions" and "essential supportive services." • The number of people at elevated risk regularly (at least annually) re-screened for HIV and STIs. • The number of people at elevated risk formally screened and informed about PrEP. • Indicators of condom availability (numbers and locations of distribution; surveys indicating people have access).	CDC through IDOH
3.2: Increase access to and provision and use of PrEP.	Document: • The number of PrEP prescriptions fulfilled in Marion County. • Efforts to address disparities (racial, gender, age, location, economic) in PrEP access and PrEP retention (e.g., telemedicine, multi-month medication refills, improved options for providers and provider locations/hours, additional case management services, access to supportive services etc.). • Availability and accessibility of nPEP.	CDC through IDOH
3.3: Increase access to syringe access and harm reduction services.	Document: • The number and demographics of people accessing harm reduction services, and syringe access services • Efforts to address disparities (racial, gender, age, location, economic) in access and retention in those services (e.g., improved options for providers and provider locations/hours, additional case management services, access to supportive services, etc.). • Efforts to improve political awareness and acceptance of harm reduction approaches, as well as acceptance by faith-based leaders, primary care providers, criminal justice and law enforcement, legislators, and other stakeholders.	MCPHD with funding from THFGI, Fairbanks Foundation, (and CDC via IDOH)?

RESPOND

EHE Strategy	What might be measured, monitored and reported	**Funding and lead responsibility**: Current or likely funding sources and agency responsible for securing and administering funds and confirming guidelines and plans for M&E and reporting
4.1: Increase access to supportive services.	Document: • Investments from HIV funding into supportive services, including housing services, emergency financial assistance, legal services, employment support, and social supports (funded via Ryan White, HOPWA, THFGI, CICF, etc.) • Provision of resources to vulnerable and economically distressed communities for education, organizing and mobilization about structural disparities and barriers in health.	HRSA and HOPWA funding through MCPHD DEFA funding through THFGI Other – CICF, state and city initiatives, IDOH CHII, etc.
4.2: Support community organizing and mobilize community-led responses.	Document: • HIV provider participation in, contributions to, and investments in the coalitions that define and propel intersectional plans and actions – such as about health care access, racial disparities, criminal justice, migrant rights, housing, gender equality, sexual health and rights, mental health, harm reduction and youth empowerment. • Evidence of integration of HIV-related services in community settings, and work by and in communities in engaging people in HIV testing, treatment and prevention. • Evidence of increased community engagement in cluster detection and response. • Efforts to provide public health leadership and education to elected officials, prosecutors, law enforcement, and the media on HIV science and the dangers of punitive HIV related responses to public health EHE efforts. • The number, and demographics, of people living with HIV charged or prosecuted under Indiana's HIV criminal laws, and or provided supportive legal or counseling services to that directly relates to HIV criminalization.	Funding from IDOH, THFGI, CICF, other city and state initiatives
4.3: Improve data systems and digital technology.	Document: • Investments in data systems and related staffing, training, data security, and data reporting. • Evidence of how improved data is used to better structure and target prevention and supportive services, and facilitating access to care, identifying and reducing barriers to care. • Number of times public health HIV data is requested by criminal justice and law enforcement entities and outcome, e.g., provided, not provided, only deidentified data provided. • Evidence of increased health department capacity for cluster detection and response.	CDC through IDOH HRSA through MCPHD

INVEST IN WORKFORCE AND MANAGEMENT

EHE Strategy	**What might be measured, monitored and reported**	**Funding and lead responsibility**: Current main funding source or potential and agency that will be responsible for securing and administering
5.1: Invest in diversity and linguistic and cultural competency of the HIV workforce.	Document: • Agency reporting on workforce diversity and linguistic competency, including diversity and competency related to the lived experience of the structural issues faced by HIV priority populations. • Agency reporting on retention of highly rated community-facing frontline workers. • Client surveys and client data documenting levels of trust, engagement and retention in services.	Should be integrated into all funded programs
5.2: Invest in technical competency of medical providers, supportive service providers and community health workers.	Document: • Client surveys and client data documenting levels of trust, engagement and retention in services.	Should be integrated into all funded programs
5.3: Engage with a diverse range of provider and community networks to foster innovation, coordination and shared accountability.	Document: • Evidence of ongoing dialogue and recommendations about innovations and opportunities for coordination and collective impact in efforts to end the HIV epidemic and achieve progress in health and equity in Marion County.	Integrated into all funded programs

Attachment 7: **Process and affirmations of concurrence**

The Ending the HIV Epidemic in Marion County, Indiana – Plan 2021-2025 was presented to three community advisory/planning groups for discussion and feedback. The plan was provided at least a week before the meetings to allow for review and discussion preparation.

- **Ryan White, Part A, Planning Council – Thursday, October 1st, 2020**
  The Ryan White Part A Planning Council and the ten county Transitional Grant Area (TGA), which includes Marion County (Indianapolis), thanked the EHE TaskForce for providing the Planning Council with a copy of the final draft of the Marion County Ending the HIV Epidemic (EHE) Plan and for providing the Planning Council with a presentation of the EHE Plan with an opportunity for review, input, and discussion.

  After the meeting, Ryan White Part A Planning Council acknowledged the robust discussion on October 1, 2020 about the EHE Plan and appreciated the responsiveness of the EHE Task Force and writers to rapidly respond and incorporate suggestions from the Planning Council about PrEP and PEP, the concept and approach of U=U, the promotion of peer coaching, HIV stigma, racial disparities and structural barriers, and importance of community leadership and community-centered responses. The two co-chairs, Ryan McConnell and Dayon Burnett, confirmed the Council's concurrence via a letter of concurrence included in the Plan submission.

- **Indiana Department of Health HIV/STD Advisory Committee – Thursday, October 15th, 2020**
  The Indiana Department of Health HIV/STD Advisory Committee, made up of agency representatives and invested individuals from around Indiana, thank EHE TaskForce for providing the Advisory Committee with a copy of the final draft of the Marion County Ending the HIV Epidemic (EHE) Plan and for providing the Advisory Committee with a presentation of the EHE Plan, with an opportunity for review, input, and discussion.

  After the meeting, the HIV/STD Advisory Committee noted the robust discussion on October 15, 2020 about the EHE Plan, and appreciated the responsiveness of the EHE Task Force and writers to rapidly respond and incorporate suggestions from the HIV/STD Advisory Committee about alignment with national and state STI strategies and hepatitis elimination plans and emphasis on racial disparities and structural barriers to health services. The two Advisory Committee co-chairs, Cat Kibiger and Nick Melloan-Ruiz, confirmed the Committee's concurrence via a letter of concurrence included in the Plan submission.

- **Marion County Ending the HIV Epidemic TaskForce – Thursday, November 12th, 2020**
  The Marion County EHE Task Force was provided a copy of the final draft of the Marion County Ending the HIV Epidemic (EHE) Plan and received a detailed presentation of the final EHE Plan, with an opportunity for review, input, and discussion.

  The Task Force noted the efforts made to convene an open, transparent, and consultative EHE planning process starting in February 2020, with eight monthly Task Force meetings and numerous working group and focus group meetings held during the year, with all due precautions, in the midst of the COVID-19 epidemic. All materials were shared online and in a transparent manner. The four TaskForce co-chairs, Jarnell Burks-Craig, Paula French, Darrin Johnson, PhD, and Gloria King, EhD, confirmed the TaskForce's concurrence via a letter of concurrence included in the Plan submission.