2022–2026

Wisconsin Integrated HIV Prevention and Care Plan

Wisconsin Department of Health Services, Division of Public Health
Bureau of Communicable Disease: HIV Program
P-03516 (09/2023)

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Acknowledgements and Thank You!

The development of the *Wisconsin HIV Integrated Prevention and Care Plan for 2022–2026* was a major undertaking that drew upon the knowledge and experience of many dedicated individuals, including people living with HIV, people from communities impacted by HIV, health and human service providers, community leaders and advocates, academic staff and researchers, staff from public and private sectors, and the general public.

Throughout 2022, the Wisconsin Statewide Action Planning Group (SAPG), the state's integrated HIV community planning body, worked closely with the Wisconsin HIV Program to develop the plan.

Sincerest gratitude and many thanks to the individuals who contributed to this vitally important resource for Wisconsin, including:

Natalie Bachmeier – Project Design and Editing

Molly Bieber – Project Design and Editing

Allison Budzinski – Goal 4 Workgroup Lead

Jacob Dougherty – Goal 1 Workgroup Lead

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Yi Ou – Epi Snapshot

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Acronyms

ACS	American Community Survey
ADAP	AIDS/HIV Drug Assistance Program
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
BHCW	Black Health Coalition of Wisconsin
BIPOC	Black, indigenous, and people of color
BRFS	Behavior Risk Factor Survey
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CTR	Counseling, testing, and referral
D2C	Data to Care
DGB	Data Governance Board
DHS	Department of Health Services
DIS	Disease Intervention Specialist
DMS	Division of Medicaid Services
DOA	Department of Administration
DOC	Department of Corrections
DPH	Division of Public Health
DPI	Department of Public Instruction
DUA	Data Use Agreement
eHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV epidemic
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resources and Services Administration
IDU	Injection drug use
IHAP TAC	Integrated HIV/AIDS Planning Technical Assistance Center
LGBTQ+	Lesbian, gay, bisexual, transgender, and queer
LTHD	Local and Tribal health departments
MATEC	Midwest AIDS Training and Education Center
MFSC	Male-female sexual contact

MMSC	Male-male sexual contact
MSM	Men who have sex with men
NASTAD	National Alliance of State and Territorial AIDS Directors
NHAS	National HIV/AIDS Strategy
NMAC	National Minority AIDS Council
OCI	Office of the Commissioner of Insurance
PEP	Post-exposure prophylaxis
PLWH	People living with HIV
PrEP	Pre-exposure prophylaxis
PS	Partner Services
PWID	People who inject drugs
RFA	Request for application
RIDR	Routine Interstate Duplicative Review
SAPG	Statewide Action Planning Group
SCSN	Statewide Coordinated Statement of Need
SGL	Same-gender loving
SHIP	State Health Improvement Plan
SSA	Social Security Administration
SSP	Syringe Services Program
STI	Sexually transmitted infection
TasP	Treatment as prevention
TB	Tuberculosis
U=U	Undetectable = untransmittable
USPSTF	United States Preventive Services Task Force
WALHDAB	Wisconsin Association of Local Health Departments and Boards
WEDSS	Wisconsin Electronic Disease Surveillance System
WISH	Wisconsin Interactive Statistics on Health
WSLH	Wisconsin State Lab of Hygiene
YRBS	Youth Risk Behavior Survey

Section I: Executive Summary

The Wisconsin Integrated HIV Prevention and Care Plan for 2022–2026 serves as the strategic plan for the Wisconsin HIV Program and the Wisconsin Department of Health Services (DHS) to end the HIV epidemic in Wisconsin.

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

The Wisconsin HIV Program is responsible for coordinating and overseeing the implementation, monitoring and evaluation of the plan. The plan is consistent with the National HIV/AIDS Strategy (NHAS), and encompasses four primary goals:

- Prevent new HIV infections.
- Improve HIV-related health outcomes of people with HIV.
- Reduce HIV-related disparities and health inequities.
- Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and interested parties.

The plan is considered a living document that will be reviewed frequently and revised as needed. The plan covers the five-year time frame of 2022–2026 and has been informed by results from a statewide, comprehensive HIV prevention and care needs assessment, input and feedback from members of the Statewide Action Planning Group (SAPG), and input from external partners and members of communities most impacted by HIV in Wisconsin.

The plan recognizes the importance of addressing the co-occurring syndemics of sexually transmitted infections (STIs), viral hepatitis, substance use, and the role each plays in the transmission of HIV and the barriers to accessing needed services. The plan also acknowledges the importance of addressing social determents of health, such as housing, systemic racism, employment, and safety in the planning, implementation, and monitoring of prevention and care services. Furthermore, the plan prioritizes reducing stigma and promoting wellness for individuals and communities in Wisconsin who are most impacted by HIV.

Vision, Mission, and Values

The plan exemplifies the Wisconsin HIV Program's vision, mission, and values:

- **Vision:** Ending the epidemics of Hepatitis C (HCV), HIV, and sexually transmitted infections (STI).
- **Mission:** Improve quality of life, protect people, and reduce harm and health disparities associated with HCV, HIV, and STIs.
- **Values:**
    - Accountability
    - Collaboration and partnerships
    - Commitment
    - Compassion and empathy
    - Diversity
    - Empowerment
    - Equity
    - Excellence
    - Integrity and trust
    - Intentionality
    - Leadership and guidance
    - Respect

Approach

- The Wisconsin HIV Program, SAPG, and various other work groups used the 2017–2021 plan as a foundation to help guide discussion and updates to the goals, objectives, strategies, and activities for the 2022–2026 plan. In addition, the plan is consistent with the new 2022–2027 Wisconsin State Health Improvement Plan (SHIP).

This plan is designed to represent the strategic vision for the Wisconsin HIV Program, the input of the community, and the steps needed to achieve the objectives set forth.

Documents used to meet submission requirements include:

- 2017–2021 Integrated Plan
- Wisconsin State Health Improvement Plan (SHIP)
- National HIV Strategy
- National Viral Hepatitis Elimination Strategy
- STI National Strategic Plan

Language Disclaimer

The Wisconsin HIV Program honors the diversity of our communities and strives to use inclusive language to reflect that diversity. This document uses language based on partner input, and still we recognize that the language used may not resonate with every individual. We value and affirm each individual's identity and language used to communicate about themselves and their communities. As language evolves, so will we.

Section II: Community Engagement and Planning Process

Since the very beginning of the HIV epidemic, the Wisconsin HIV Program has coordinated Wisconsin's public health response. The program's response to the epidemic has emphasized the need for collaboration and coordination among service providers from multiple disciplines, public and private agencies, individuals and communities impacted by HIV, and people living with HIV (PLWH).

Collaborative partnerships are established with traditionally funded agencies, state agencies, local and Tribal health departments, and community-based agencies and organizations. Relationships among community partners, such as academic, governmental, and private nonprofit organizations, are maintained through ongoing collaboration, consultation, training, and financial support (including competitive grants and contractual agreements). In Wisconsin, there is a long and successful history of collaboration and support to build capacity among Black, Indigenous, and people of color (BIPOC), and sexual and gender minority groups to respond to the HIV epidemic directly in their communities.

Initial Planning Steps

The Wisconsin HIV Program began the integrated planning process in July 2021, following the release of the Integrated HIV Prevention and Care Plan Guidance in June 2021. Initial work included identifying key external partners, funding agencies, and community groups to provide input. The program worked with AIDS United to receive technical assistance on best practices for reaching out to communities to gather input on the integrated plan. Technical assistance was provided to Wisconsin HIV Program staff in February 2022. Elements of the technical assistance included identifying and implementing different communication styles and proven methods for reaching communities impacted by HIV.

Needs Assessment

The first step in the planning process was to begin the integrated HIV prevention and care needs assessment (outlined in Section III, Part 4: Needs Assessment). In order to reach the largest number of community members impacted by HIV, including priority populations and PLWH, the program decided to do a competitive request for applications process (Appendix I). The program used CDC

and HRSA funds to contract with a community-based organization experienced in conducting community-based needs assessments. Diverse & Resilient, located in Milwaukee, was chosen to conduct the needs assessment because of their trusted ties to communities most impacted by HIV in Wisconsin, and their experience providing HIV prevention services to those communities. They have offices in Milwaukee and Appleton, increasing access to people across the state. Diverse & Resilient conducted the needs assessment in two phases: a planning phase, which occurred during October to December, 2021, and an implementation phase, which occurred during January to April, 2022. They delivered their final report to the Wisconsin HIV Program in April, 2022, and the results of the needs assessment were used to inform goals, objectives, strategies, and activities set forth throughout the plan.

Needs Assessment Planning Phase

To kick off the planning phase, Diverse & Resilient conducted a thorough review of existing literature to identify qualitative data to drive the development of the needs assessment survey. Publications reviewed included, but were not limited to:

- Wisconsin's 2017-2021 HIV Prevention and Care Integrated Plan 2017-2021
- Diverse & Resilient's previous needs assessment with the transgender community and the Peer Navigator programs including the Peer Specialist
- The HIV National Strategy 2015-2021
- The previous Needs Assessment Qualitative Report
- Literature compiled by DHS
- Other peer reviewed articles published since 2017 focusing on HIV prevention and care in rural and

Diverse & Resilient drafted an initial survey instrument, following requirements set forth by CDC/ HRSA for the new Integrated Care Plan, and using information gleaned from literature and previous needs assessments. The initial survey instrument was distributed internally for review by Wisconsin HIV program staff.

The survey was also shared with Vivent Health's HIV Prevention program serving Outagamie and Brown counties. Vivent Health staff who work with PLWH, people impacted by HIV, and intravenous drug users reviewed the survey and provided critical feedback, specifically on language related to intravenous drug use. After initial edits were made, the survey was distributed to program participants through Diverse & Resilient's Milwaukee-based Counseling, Testing and Referral (CTR) program.

Demographics of Survey Reviewers

Age Range: 19 to 45 years old

Zip Codes of Residence: 54304, 53233, 53206, 53208, 53189, 54130, 54911, No response

Race and Ethnicity: White (4), Black (1), Black/White (1), Self-described/Middle Eastern (1), No response (1)

Sexual Orientation: Gay (5), Straight (3)

Gender Identity: Male/man (5), Female/woman (2), No response (1).

HIV Status: HIV negative (6), HIV positive (1), Don't know (1)

Once feedback was gathered, Diverse & Resilient incorporated all recommended changes, and sent HIV program staff a second draft for review. During this time, staff also began compiling lists of providers for recruitment and outreach for the implementation phase, including key members of Governor Tony Evers' Health Equity Group. Diverse & Resilient also completed a review of provider and partner input from both the Peer Navigator project and the most recent Integrated Plan.

Participant Survey Overview

The survey collected basic demographic information about participants including the following:

- Age
- County of residence/zip code
- Race
- Ethnicity
- Sex at birth
- Current gender identity
- Sexual orientation
- Education
- HIV status

The survey also included questions that assessed needs and sought input from participants across a wide array of domains including:

- Experience with and interest in at-home HIV tests
- Condom use
- Needle use (such as for injecting steroids and testosterone and for drug use)
- Employment
- Housing

- Health care experiences (including dental and telemedicine)
- Transportation
- Stress and emotional well-being (including coping with stress and mental health)
- General social support
- Experiences of oppression
- HIV-related services

Participant Survey Recruitment and Development Overview

Diverse & Resilient has recent experience conducting a transgender community needs assessment, Peer Navigator listening sessions, and protocol development. Feedback from PLWH and individuals impacted by HIV gathered through these experiences was incorporated into the development of the recruitment plan for the survey. Diverse & Resilient integrated this with feedback obtained during the survey review by community members in Milwaukee, Outagamie, and Brown counties. While survey distribution focused heavily on Brown, Dane, Milwaukee, and Outagamie counties, it was also distributed to rural areas, with distinct attention paid to organizations with Tribal affiliations. In counties with high rates of HIV, Diverse & Resilient incorporated social and sexual network style recruitment among priority populations to capture individuals not currently receiving services. Entities assisting with survey distribution included HIV prevention and care programs funded by DHS, Tribal health coordinators and programs, syringe service programs, federally qualified health centers, members of SAPG, and providers identified by members of the Governor's Health Equity Group.

The survey was created in Formstack to be completed via computer, laptop, or smartphone. A paper version of the survey was also distributed for any provider conducting in-person outreach with participants who may need assistance or support completing the survey. Survey links were unique to each organization and conducted in batches with limited windows of time for participation and completion. The survey was translated for Spanish-speaking participants.

Provider and Key Informant Survey Development Overview

The provider survey was developed after reviewing literature and applying past lessons learned from the participant survey and Peer Navigator Program development. The provider survey included the following questions/categories:

- Age
- County/zip code where they provide services
- Race
- Ethnicity

- Sex at birth
- Current gender identity
- Sexual orientation
- HIV status
- Role in HIV prevention and care
- Telehealth
- Education
- Populations served
- Knowledge of population barriers to service
- Training

In total, 83 providers completed the provider survey. Diverse & Resilient used a grounded theory approach to their analysis, systematically analyzing the data for thematic patterns. Their research design allowed for:

- The exploration and discovery of concepts and themes.
- Adding context and depth to the understanding of the qualitative data via focus groups.
- An interpretation of the data from the point of view of the community and key contributors.
- The use of lived experiences of community members to make specific programmatic recommendations.

Diverse & Resilient received approval to move forward with the community, provider, and key informant surveys in December, 2021. They submitted the following workplan for the implementation phase of the needs assessment project.

Implementation Phase December 1, 2021–April 15, 2022	
Timeline	**Activity**
December 15–31	Implement targeted recruitment strategies for providers and communities utilizing partnerships with community-based organizations identified in the planning phase of the project.
January 1–February 28	Facilitate the distribution and completion of 100 unduplicated surveys. Surveys will include Venmo or CashApp IDs to facilitate incentive distribution. Each person completing a survey will receive a $75 cash incentive.
March 1–18	Conduct quantitative and qualitative analysis of survey data. Extract themes.
March 19–31	Conduct focus groups with contributors to confirm or deny themes extracted from the surveys. A minimum of two focus groups with community members and a minimum of 35 participants for the focus groups. Focus groups will be conducted virtually via Zoom.

Needs Assessment Implementation Phase Overview

In total, 65 contacts at local and statewide community-based organizations and 30 members of the SAPG received the community survey in English and Spanish to distribute to eligible community members via direct recruitment of their program staff.

The survey was distributed in "waves" which grouped small organizations together but allowed for larger organizations to receive unique survey links. The survey links were open Monday to Friday of the same week to minimize the sharing of the survey link beyond individuals who were recruited directly by staff. Survey respondents received a $75 incentive via CashApp or a mailed gift card. In total, Diverse & Resilient received 184 completed surveys. Individuals with no risk factors for HIV transmission or no individual factors prioritized by federal guidance for HIV prevention programs were removed prior to survey analysis. This left 126 completed surveys by members of priority populations.

Once the survey period was completed, staff from Diverse & Resilient conducted analysis of the survey data and extracted themes. Themes were further analyzed through virtual and in-person focus groups with community members and key contributors in central and rural Wisconsin counties.

Focus group participants included PLWH and individuals who were not living with HIV. Participants identified as white, BIPOC, cisgender, and transgender. Additionally, participants were either current or previous consumers of harm reduction or HIV prevention services, or were currently engaged in care if they were living with HIV. One focus group included individuals in various states of substance use recovery, who due to stigma associated with PWID wanted their identities to remain anonymous. This focus group was virtual with cameras remaining off, and participants were called upon using only their initials. In total, 26 individuals participated in focus groups, including a subgroup of providers who were either current or previous consumers of harm reduction or HIV prevention and care services. Focus group participants received a $50 gift card for their participation.

Entities Involved in the Planning Process

In addition to individuals from communities impacted by HIV and HIV providers who were engaged in the needs assessment process, the Wisconsin HIV Program engaged several other important groups throughout the planning process.

Wisconsin HIV/HCV/STI Statewide Action Planning Group

In Wisconsin, community engagement is a major focus of statewide planning. The Wisconsin SAPG is the primary HIV planning body that advises the Wisconsin HIV Program on the development,

implementation, and prioritization of HIV prevention and care services in Wisconsin. The goal of the Wisconsin HIV community planning process is to plan for a continuum of high-quality and effective HIV prevention, care, and treatment services to meet the current and future needs of individuals and communities most impacted by HIV.

The SAPG is comprised of 25 to 30 members who broadly represent affected communities and key partners, characteristic of Wisconsin's HIV epidemic as it relates to geography, sexual orientation, age, gender, race/ethnicity, life experiences, and HIV status. The leadership team of the SAPG is composed of the Community Co-Chair, Health Department Co-Chairs, and Community Co-Chair Elect.

The Health Department Co-Chairs include one representative from the HIV Care Unit and one representative from the HIV Prevention Unit to ensure that planning is integrated. Staff from Wisconsin's ATEC (the Midwest AIDS Training and Education Center) also attend all meetings. SAPG members are chosen by the membership through a competitive application and selection process. The SAPG meets for day-long meetings five times per year, both in-person and virtually, to provide input to the HIV Program. SAPG members also facilitate communication and expanded engagement throughout the state.

2021 and 2022 meetings of the SAPG have been a major venue for facilitating community member involvement in the development of the Integrated HIV Plan. In preparing for this activity, Wisconsin HIV Program internal workgroups developed draft materials for review and discussion by the SAPG. Internal workgroups were formed based on the four goals in the National HIV/AIDS Strategy, which the program decided would be mirrored as our four goals for this integrated plan.

During three consecutive SAPG meetings in 2022, attendees formed small groups to discuss aspects of each goal in the integrated plan. Most of the groups met in-person with a smaller number of attendees meeting virtually. The discussions consisted of current tasks and potential areas for improvement. For the first time, SAPG members were also welcomed to our DHS goal-planning meetings and some members took advantage of this. Many members also participated in the needs assessment process. Diverse & Resilient presented the background and key findings from the needs assessment to SAPG in April, 2022.

Ryan White care providers

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

Local and Tribal health departments

Input was gathered from staff providing disease intervention and partner services at local and Tribal health departments in a series of regional partner services provider meetings and in regularly-held meetings of Tribal HIV coordinators.

Grant-funded agencies

Agencies funded to provide HIV care and prevention services through indirect CDC funding, state general purpose revenue funding, or HRSA funding were given overviews of the planning process and had an opportunity to provide input through regular meetings and site visits.

Black Health Coalition of Wisconsin (BHCW) HIV Task Force

This task force is comprised of 30 to 40 members of the Black community in Milwaukee and includes representatives from health care settings, faith leaders, PLWH, and people working in the HIV field. Feedback and input was gathered from task force members after HIV Program staff presented at their August 2022 meeting.

Community-based organizations

Each of the goals and their corresponding objectives, strategies, and activities were presented to a group of front-line staff at community-based organizations funded to provide HIV prevention and care services in Milwaukee for feedback at two meetings in 2022.

General public

The program posted a draft overview of the proposed goals, objectives, strategies, and activities for this integrated plan for public comment on the DHS website from September 6 through October 2, 2022. The public could provide feedback directly through the website and this feedback was taken into consideration in the updates that were made to the final submission of this plan.

Engagement of People with HIV

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

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

Community Engagement Through Community Planning

The SAPG promotes consumer engagement and provides a forum for community members and partners, including PLWH, to exchange information and ideas and provide input on the development and delivery of HIV prevention and care services.

Development of this plan was a major focus of SAPG meetings and deliberations throughout 2022. Group discussions and feedback from SAPG members helped shape and inform the development of objectives and priorities for the plan. Staff from the Wisconsin HIV Program directly disseminated updates about the development of the Integrated HIV Plan to local consumer advisory groups comprised of consumers at Ryan White-funded agencies.

SAPG membership would be enhanced and better reflect the HIV epidemic in Wisconsin when future recruiting of SAPG members focuses on the following groups:

1. PLWH who are not linked to or who are out of medical care.
2. People with HIV who live in areas that are less resource dense.
3. Community members and service providers not part of the planning process, specifically:
    - Indigenous people/Tribal members
    - Asian/Pacific Islander persons

- Hispanic/Latinx persons
- Youth
- Older adults
- Persons who inject drugs (PWID)

Community Engagement through the Implementation, Monitoring, Evaluation, and Improvement Process

The Wisconsin HIV Program plans to continue engaging PLWH and PLWH service providers throughout the life of this plan. Planned engagement activities include:

- Regular updates and presentations on progress toward the objectives in the plan to SAPG.
- Continuous requests for feedback and updates to the plan when new innovations in HIV prevention and care arise.
- Presentations and engagement on outcomes of the plan to key partner groups, including community-based organizations that serve PLWH and BHCW HIV Task Force.
- Organizing workgroups made up of state health department staff, funded providers, SAPG members, community partners, and PLWH to help monitor and provide input on plan outcomes. These workgroup will meet regularly throughout each year for the life of the plan.

Further activities related to implementation, monitoring, evaluation, and improvement are included in Section VI of this plan.

Community Engagement Priorities

Several key priorities emerged from the community engagement process, especially through the needs assessment and SAPG meetings. These priorities included:

Addressing barriers to care/social determinants of health

Many respondents to the needs assessment indicated that it is necessary to increase access to care for PLWH and improve prevention services, while also addressing social determinants of health in the communities most impacted by HIV, including housing, employment, safety, and experiences of stigma and oppression.

Applying a stigma-free, status-neutral approach to HIV prevention services

Community members indicated that it is critical to provide adequate linkage to other services, such as pre-exposure prophylaxis (PrEP) or STI testing, when someone seeks any HIV prevention service. Additionally, if they are diagnosed with HIV, they must be provided immediate linkage to stigma-free care.

At-home HIV testing

When considering ways to increase access to testing, several providers and community members indicated that the state should support an at-home testing service that allows community members to order HIV and STI tests online and have them delivered to their home. This was especially true of providers and community members in rural areas who experience challenges to accessing testing services in traditional clinical settings or at health departments.

Increasing access to PrEP

Community members expressed that there is inconsistent implementation of the United States Preventative Services Task Force (USPSTF) guidance that PrEP should be offered with no cost-sharing to a patient who is at risk for HIV, and that PrEP should be promoted more widely to the general public rather than only to gay/bisexual men.

Training and technical assistance for providers

Both providers and community members believe that more continuing education opportunities are needed for people working in the field to provide culturally responsive services to people from communities disproportionately impacted by HIV, especially BIPOC gay/bisexual men, transgender people, and people who use drugs. This education should come from members of the communities most impacted.

Section III: Contributing Data Sets and Assessments

Data Sharing and Use

Below are the internal and external data sources and systems that provide qualitative and quantitative data to inform program planning focused on HIV surveillance, prevention, and care service activities. These data sources are used to inform program activities and resource allocation. They were also used to guide the development of this plan.

Overview of Data Sources and Systems

2022 Wisconsin HIV Needs Assessment

The Wisconsin HIV Needs Assessment was completed in 2022. It consisted primarily of qualitative survey questions that collected input from participants, including PLWH. The questions centered around the impact of a wide array of social determinants of health.

Enhanced HIV/AIDS Reporting System

The enhanced HIV/AIDS Reporting System (eHARS) is the HIV surveillance database used by all jurisdictions that receive federal funding to conduct HIV surveillance activities. Data in eHARS are used to describe the trends associated with new and existing HIV cases. The following demographic information is available on people living with HIV:

- Race/ethnicity
- Age
- County of residence
- Transmission mode
- Sex at birth
- Gender identity
- Other HIV diagnosis-related information

eHARS also contains laboratory test results, including CD4 counts, viral load results, and HIV-1 viral sequences. These data are used to assess HIV care outcomes, including linkage and retention to care, and viral suppression. Laboratory data and demographic data are used together to identify health disparities.

HIV Care Continuum

Wisconsin's HIV Care Continuum is primarily based on HIV surveillance data stored in eHARS.

Wisconsin Electronic Disease Surveillance System

The Wisconsin Electronic Disease Surveillance System (WEDSS) is Wisconsin's communicable disease surveillance and case management system. Data include client demographics and location information for individuals diagnosed with communicable diseases. HIV case and laboratory data were integrated into WEDSS in 2017. In early 2020, HIV Partner Services (PS) program and Data to Care (D2C) data were also integrated into WEDSS.

The WEDSS integration reduced the number of systems used for HIV-related data, enhanced follow-up initiatives for PLWH, helped improve testing efforts and the identification of individuals with co-occurring conditions (for example, HIV-HCV, HIV-TB, syphilis-HIV), and provided access to additional data for HIV service providers who work with PLWH. WEDSS provides important information about client location, linkage to care, transmission mode, co-occurring conditions, and client needs.

EvaluationWeb

EvaluationWeb is a web-based system developed by Luther Consulting, LLC that collects and reports state-funded HIV testing and prevention activities. Wisconsin currently uses the CDC version of EvaluationWeb. The data are used to monitor prevention subrecipient performance and monitor testing activities in Wisconsin. EvaluationWeb is also an important source of transmission mode information for individuals newly diagnosed with HIV.

HIV Partner Services Program

The HIV PS Program is coordinated by the Wisconsin HIV Program. All PS case assignments and PS provider notes are managed within WEDSS and EvaluationWeb. PS outcomes include contact attempts, case notes, linkage to care, and partner elicitation and testing.

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) database contains information about clients currently or previously enrolled in ADAP, including demographic information, medical provider, income, and insurance status. The database is used to manage ADAP client eligibility but can also be used to locate out-of-care clients, identify new move-in clients, and monitor insurance status. The database also contains claims data that can serve as markers of HIV care.

Ryan White Services Report

The Ryan White Services Report is a de-identified client-level data report required by HRSA of all agencies that provide services to clients using Ryan White funds. Ryan White subrecipients make these reports available to the Wisconsin HIV Program to monitor service utilization, linkage and retention to care, viral suppression, and other client outcomes, such as insurance and housing status.

Subrecipient performance measures

Ryan White subrecipients that receive Part B funds from the HIV Program are required to submit quarterly performance measures. These measures are reviewed to identify best practices and areas for improvement.

Wisconsin Medicaid Program

The Wisconsin Medicaid Program maintains claims information on medical visits, laboratory visits, and pharmaceuticals for its recipients. The Wisconsin HIV Program receives data to monitor service utilization and medication prescription, including HIV testing among PLWH and uptake of PrEP among people without a HIV diagnosis.

Wisconsin Youth Risk Behavioral Survey

The Wisconsin Youth Risk Behavioral Survey (YRBS) is conducted at a national level by CDC to monitor health-risk behaviors of high school students in the U.S. The Wisconsin YRBS monitors behaviors including traffic safety, weapons and violence, suicide, tobacco use, alcohol and other drug use, sexual behavior, and exercise.

Wisconsin Behavioral Risk Factor Survey

The Wisconsin Behavioral Risk Factor Survey (BRFS) is part of national health survey system, the Behavioral Risk Factor Surveillance System. BRFS collects data about Wisconsin residents regarding their health-related risk behaviors (for example, smoking, alcohol use, and physical activity), prevalence of chronic health conditions, and the use of recommended cancer and cholesterol screening tests.

Wisconsin Interactive Statistics on Health

The Wisconsin Interactive Statistics on Health (WISH) is a site that provides information about measures of health, such as population, birth, and death information.

Birth and death ascertainments

All jurisdictions that receive funding from CDC conduct routine data matching between eHARS and birth and death records. These activities maintain the most current HIV surveillance data to guide program planning and implementation. Described below are the three sources routinely used by the Wisconsin HIV Program:

- Wisconsin Vital Records: This office provides birth and death data.
- National Death Index: This index provides death record information on file in the state vital statistics office.
- Social Security Master Death File: The file from the Social Security Administration is created from internal records of deceased persons possessing social security numbers and whose deaths were reported to the Social Security Administration.

U.S. Census and American Community Survey

Data from the U.S. Census and American Community Survey provide demographic information at the census tract that are not available in many of the Wisconsin DHS, Division of Public Health (DPH), and HIV Program's internal data systems, including income, employment status, housing, education, and other markers commonly associated with better or worse health. These data can be used to identify geographic areas where additional HIV prevention or care services may be needed.

National HIV surveillance data

Data published by CDC are used to compare the Wisconsin and national HIV epidemics.

Data Sharing and Data Use Agreements

Currently, there is an active data use agreement (DUA) between the DHS Wisconsin HIV Program and the Medical College of Wisconsin for perinatal HIV surveillance. Additional DUAs are in place with the Division of Medicaid Services, Diverse & Resilient, and UW-Madison. The Wisconsin HIV Program is part of a bureau-level DUA with the Wisconsin Vital Records Office. For the prevention and care funded subrecipients, program data reporting and sharing agreements, and confidentiality

guidelines are listed in the special provision section of the standard DHS contract template. The DHS DUA template provides flexibility to strengthen the template language around data use and data sharing between DHS and the data requestors. For internal data sharing within the DHS Communicable Disease Harm Reduction Section, HIV/STI/HCV epidemiologists and data staff have shared access to the surveillance databases. This has been further strengthened by HIV data integration into WEDSS, which houses all other reportable communicable diseases. There are restrictions on access to HIV laboratory, PS, and D2C data in WEDSS. Therefore, only a limited number of surveillance staff, epidemiologists, PS and D2C staff, and local health department PS providers/disease intervention specialists (DIS) are granted access to HIV data. The epidemiologists and staff who maintain the data for these programs can do database matching and data analysis for identification of trends, co-occurring conditions, clusters, and evaluation.

There is also an active data sharing agreement (DSA) between the Wisconsin HIV Program and Georgetown University for the PS 18-1805 Black Box Project funded by CDC. This project supports routine interstate duplicate review, cumulative interstate duplicate review, and D2C activities required by CDC. To share person-level surveillance, PS, and D2C data among inter-state jurisdictions (such as record searches) on a routine basis, the Wisconsin HIV Program staff and PS/D2C staff communicate by phone and use faxes to securely share reports.

State-to-state communication supports maintaining the HIV surveillance data in eHARS while ensuring the most up-to-date information. If inter-state exchange of person-level data is needed, a data agreement will be drafted and reviewed by the Data Governance Board and the Office of Legal Counsel for approval. The Wisconsin HIV Program will reference the National Alliance of State & Territorial Directors (NASTAD) source for guidance using their sample data sharing templates.

Epidemiologic Snapshot: Data Overview

This epidemiologic overview is based primarily on HIV surveillance data derived from the 2016 to 2020 epidemiologic profile. HIV case and laboratory-based reporting is required by Wis. Stat. §252.15. Laboratories perform confidential name-associated HIV confirmatory testing and routine monitoring of HIV. The laboratories then report to the Wisconsin HIV Program the laboratory results for confirmed or suspect HIV cases. Once collected, Wisconsin HIV Program staff use the surveillance data to define the current trends of HIV and affected populations. This information can help prevention staff plan and focus interventions, allocate resources, and provide essential data that determines program funding from the federal and state government.

In addition to the data presented in this section, data on HIV, HCV, STIs, and Tuberculosis in Wisconsin can be found on the DHS website.

Wisconsin Demographic Highlights

Population

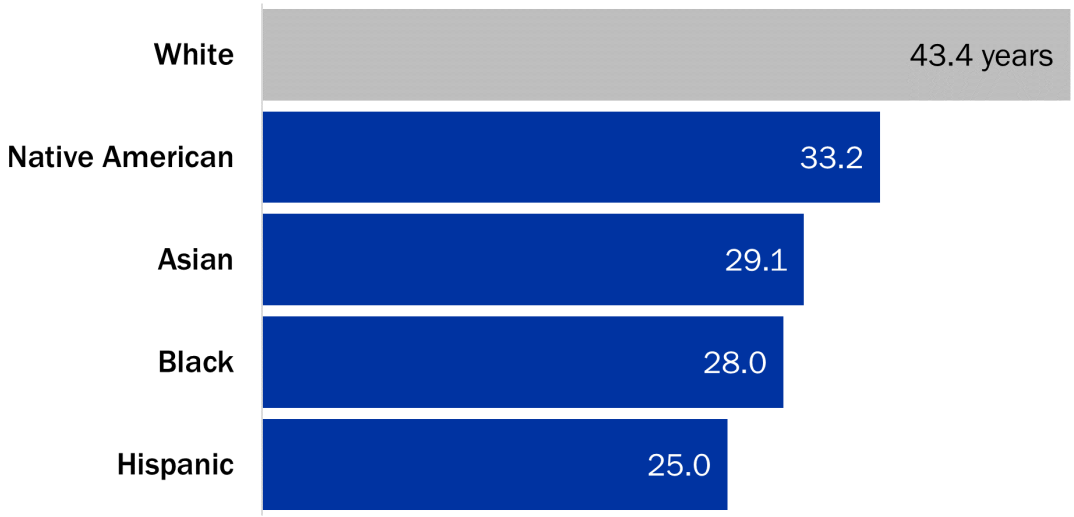
According to WISH (2022), Wisconsin's total population in 2020 was estimated to be 5.8 million. The state's 72 counties range in population from fewer than 5,000 in several rural counties to nearly one million in Milwaukee County. The southeastern region of the state is the most populous (36% of the total state population).

Race, ethnicity, and age

Wisconsin is predominantly non-Hispanic white (81%), followed by Hispanic (7.3%), Black (7.1%), Asian (3.3%), and Native American (1.0%) [Figure 1] (WISH, 2022). Wisconsin's Black population is concentrated in the southeastern counties. Hispanic and Asian residents live primarily in the southeastern, southern, and central parts of the state. Native American people live primarily in Milwaukee County, as well as the northeastern and northern counties of the state. People born outside of the United Sates make up 5% of all Wisconsin residents, comprising three of 10 Asian residents and four in 10 Hispanic residents (WISH, 2022). The median age of Wisconsin residents is 39.7 years old, with 38.8% of the residents being of reproductive age (15 to 44 years old). BIPOC, including Native American, Asian, Black, and Hispanic people, are 10 to 18 years younger (median age: 25 to 33.3 years old) compared to white people (median age 43.4 years old) (WISH, 2022).

FIGURE 1

The median ages of people of color are younger than white people.
Median age by race and ethnicity, Wisconsin, 2020



Socioeconomic status

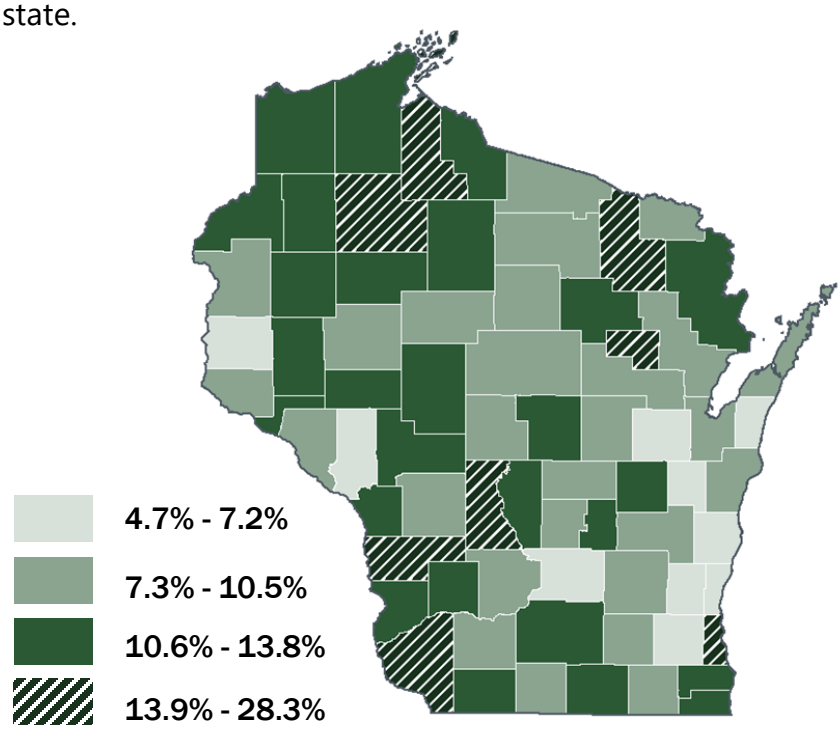
Wisconsin's median household income in 2020 was estimated at $63,293, closely behind the median income of the rest of the nation ($64,994). Median household income by county in 2020 varied from about $45,000 in some counties to more than twice that in the wealthiest counties [Figure 2].

During 2016-2020, 11% of Wisconsin residents were living in poverty compared to 12.8% nationally. Except for the three counties of Milwaukee, Menominee, and Grant, the counties with the largest percent (>15%) of residents living in poverty are found in the Western and Northern regions of the state.

FIGURE 2

The counties with the largest percent of residents living in poverty are found primarily in the western and northern regions of Wisconsin.

Percent living in poverty, Wisconsin, 2020



Sexual orientation

Sexual orientation is not routinely collected information. Data from 2018 and 2019 indicates that among Wisconsin youth, 9% of students in all Wisconsin public high schools and 16% of Milwaukee public school students identify as lesbian, gay, or bisexual (WI YRBS, 2019). Among adults, 7% of Wisconsin adults identify as lesbian, gay, or bisexual (WI BRFS, 2019). Same-sex couples make up one in 200 households in Wisconsin (WI BRFS, 2019).

Overview of HIV in Wisconsin

Newly diagnosed HIV

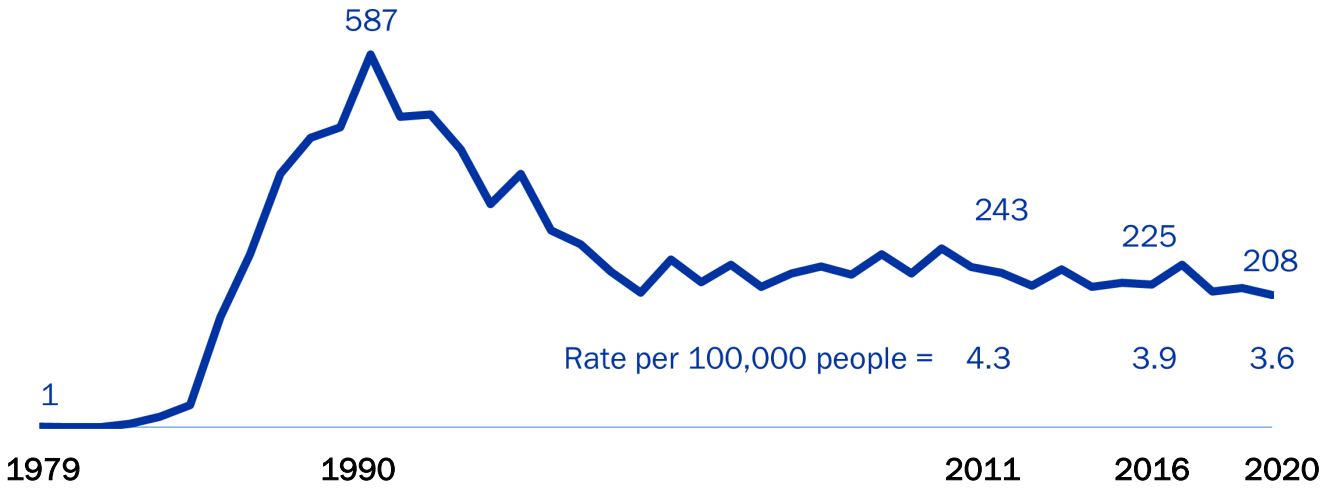
From 2011 to 2020, the number and rate of new HIV diagnoses reported each year in Wisconsin has slowly declined [Figure 3] (Wisconsin Annual HIV Surveillance Report, 2020). From 2016 to 2020, the 5-year average was 224 new HIV diagnoses per year. Most recently, 2020 reported the fewest cases

with 208 people who were newly diagnosed with HIV, for a rate of 3.6 per 100,000 people living in Wisconsin. However, all HIV data from 2020 should be interpreted with caution due to COVID-19 impacts (for example, decreased HIV testing and increased telehealth). It is unclear whether the declining data trends in 2020 are a true decrease in new HIV diagnoses.

FIGURE 3

The number and rate of new HIV diagnoses reported each year have slowly declined from 2011 to 2020.

Number and rate per 100,000 people of new HIV diagnoses, Wisconsin, 1979 to 2020



Sex and gender

Men typically account for most of new HIV diagnoses, with 94% of new diagnoses at state-funded CTR sites being men. From 2011 to 2020, 53 transgender individuals were newly diagnosed with HIV. The majority were from racial and ethnic minority groups (92%) and most cases were attributed to sexual contact (89%). Data from the WI YRBS indicates that transgender youth in Wisconsin experience worse mental health than cisgender peers and are three times more likely to report being forced into unwanted sexual activity or physically hurt by a dating partner.

Race and ethnicity

HIV disproportionately affects people of color. During 2020, racial and ethnic minorities made up just 19% of Wisconsin's population but accounted for 61% of new HIV diagnoses. For 2016 to 2020, the HIV diagnosis rate among racial and ethnic minorities compared to white males (by sex at birth) were the following:

- 14 times greater for Black males (43% of HIV diagnoses).

- 5 times greater for Hispanic males (15% of HIV diagnoses).
- 3 times greater for Asian and Native American males (2% of HIV diagnoses).

Age

From 2016 to 2020, youth ages 13 to 24 represented 1 in 4 new HIV diagnoses in Wisconsin. The intersection of race and young age shows that Black youth are 23 times more likely to be newly diagnosed with HIV than white youth, with male-male sexual contact being the main transmission mode among all youth (87%).

HIV transmission mode

From 2016 to 2020, most new diagnoses were attributed to an estimated transmission mode of male -male sexual contact (MMSC, n=813, 72%), which included 47 MMSC with injection drug use (MMSC/IDU). The remainder were attributed to male-female sexual contact (MFSC, n=191, 17%) and injection drug use (IDU, n=73, 6%). Of note for strategic planning among Native American communities, the transmission mode of injection drug use accounted for a higher percentage of HIV cases compared to other racial groups.

Geography and migration

From 2016 to 2020, there were 1,126 new HIV diagnoses throughout Wisconsin. Most people were diagnosed in Milwaukee county (52%). Compared to non-metropolitan counties, the HIV diagnoses in metropolitan areas of Milwaukee and Dane county are 8 and 1.5 times higher, respectively.

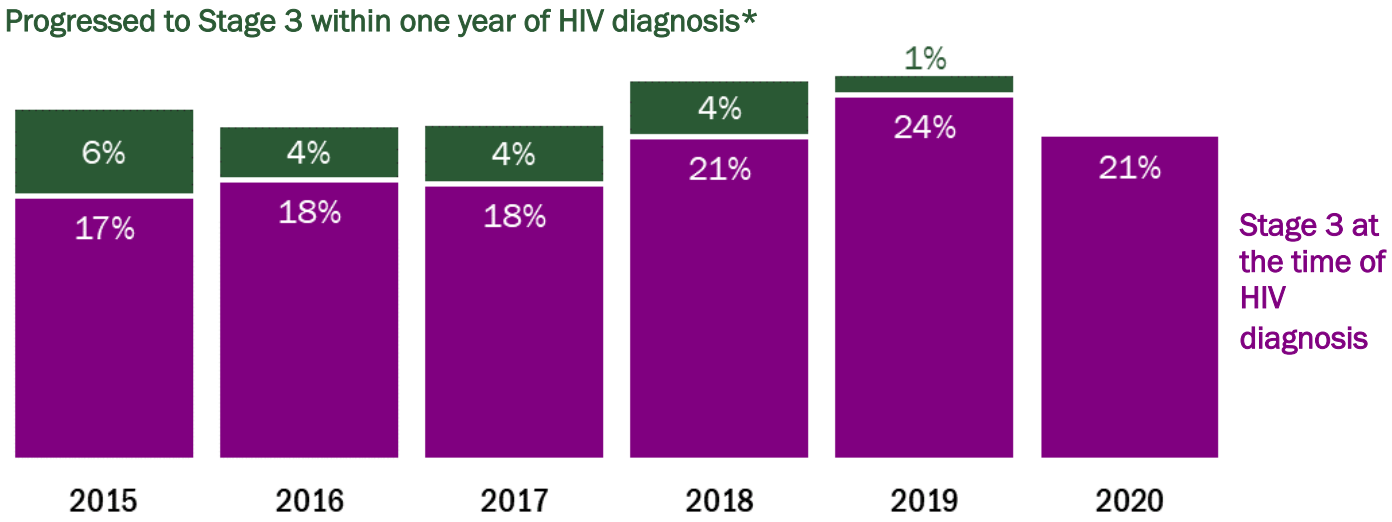
Disease status at diagnosis and late diagnosis

The proportion of individuals who progressed to Stage 3 (AIDS) within 12 months of HIV diagnosis declined from 6% in 2015 to 1% in 2019 [Figure 4]. The percentage of new HIV diagnoses that had progressed to Stage 3 by the time they were first identified increased from 17% in 2015 to 24% in 2019. These cases are late diagnoses and represent individuals living for several years with undiagnosed HIV, which may lead to poorer health outcomes and increased opportunities for disease transmission.

FIGURE 4

Indicators for HIV late diagnosis show a small decrease in progression to Stage 3 within 12 months and a small increase in being Stage 3 at time of diagnosis from 2015 to 2019.

Percentage of people who progressed to Stage 3 (AIDS) of HIV within one year of diagnosis, Wisconsin, 2015 to 2020



*Those diagnosed with HIV during 2020 have not had one full year to evaluate progression to Stage 3 and have been excluded.

Prevalent cases, HIV unaware, and deaths

In 2019, PLWH had the following characteristics:

- The majority (79%) were male.
- The majority were over age 30 (89%) and half (51%) were over age 50.
- Three out of seven (43%) were white, 38% were Black, and 14% were Hispanic.
- Three out of five (62%) had a transmission mode of male-male sexual contact, 21% had a transmission mode of male-female sexual contact, and 16% had a transmission mode of injection drug use or both injection drug use and male-male sexual contact.
- Nearly half (48%) of PLWH in Wisconsin resided in Milwaukee County, 12% lived in Dane County, and 4% each lived in Racine, Kenosha, and Brown counties.

PLWH are living longer and healthier lives. This has resulted in a shift in the average age of prevalent cases (median age= 50 years) compared to those being newly diagnosed (median age 32 years). Services for PLWH need to address health conditions associated with aging in addition to HIV, while prevention efforts need to target younger age groups.

Not everyone living with HIV is aware of their diagnosis. According to the CDC, awareness of HIV status may be substantially lower for younger people and slightly lower for some racial and ethnic minorities due to barriers to HIV testing. Using 2019 data, the estimated number of people unaware

of their HIV status is 1,126 people, making the total estimated prevalence of PLWH in Wisconsin approximately 8,035 people. PLWH who are unaware of their HIV status tend to be younger, with most people being 25-34 years of age (n=453) [Figure 5]. By race and ethnicity, Black and white PLWH (n=450 and n=375, respectively) are more likely to be unaware of HIV status, followed by Hispanic or Latinx people (n=190), Multi-racial people (n=30), Asian people (n=23) and Native American people (n=7) [Figure 6].

FIGURE 5

Younger people tend to be less aware of their HIV status.

Estimated number unaware of their HIV status, using CDC national estimates, by age (years), Wisconsin, 2020

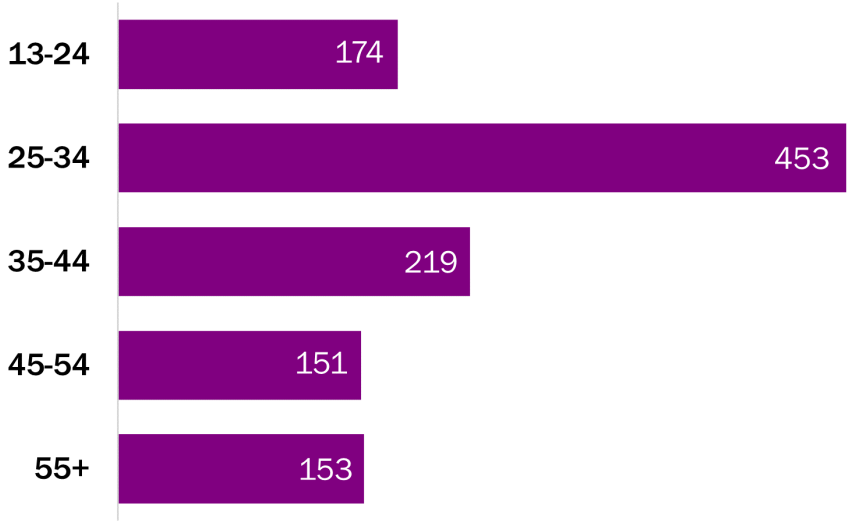
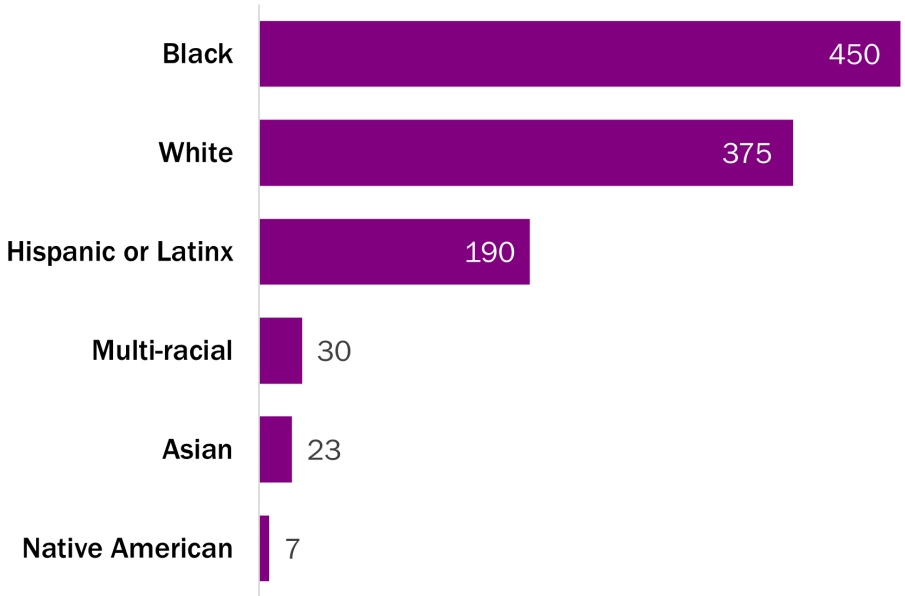


FIGURE 6

Black and white people living with HIV are more likely to be unaware of their HIV status.

Estimated number of people unaware of their HIV status, using CDC national estimates, by race or ethnicity, Wisconsin, 2020

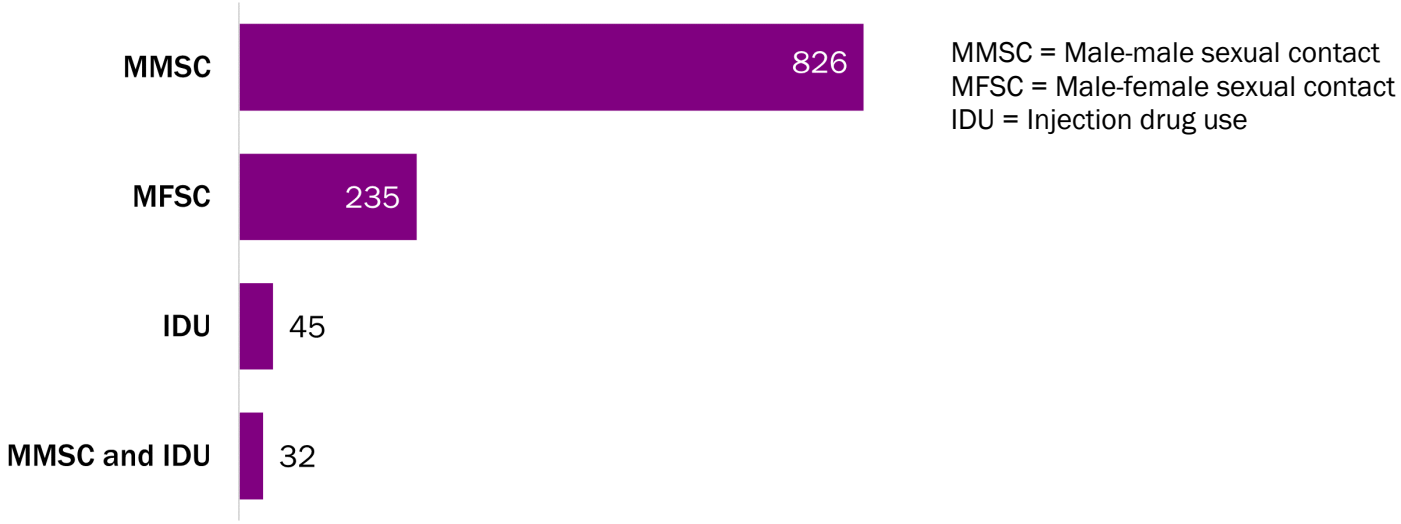


Male-male sexual contact is the primary mode of HIV transmission among PLWH who are unaware of their HIV status [Figure 7]. Once people become aware of their HIV status, they may reduce their risk behaviors, and they are more likely to receive medical care and achieve viral suppression. Viral suppression improves the health of PLWH and also prevents them from transmitting HIV sexually to partners.

FIGURE 7

Male-male sexual contact is the leading HIV transmission mode among the people living with HIV who are unaware of their HIV status.

Estimated number of people unaware of their HIV status, using CDC national estimates, by HIV transmission mode, Wisconsin, 2020

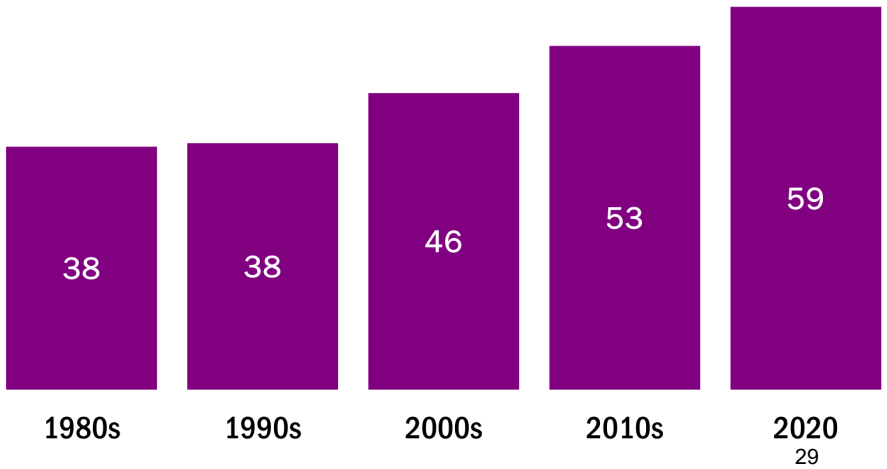


The 2019 migration data shows that more PLWH moved out of Wisconsin or were identified to be no longer residing in Wisconsin (n=310) compared to people moving into the state (n=181). During 2019, 79 deaths occurred among PLWH. Of these, 29% had HIV listed as the primary cause of death; 71% were due to causes other than HIV, which is in line with the national leading causes of death. The median age at death of PLWH in Wisconsin has increased substantially since 1982 from 38 years of age to 59 years of age in 2020 [Figure 8].

FIGURE 8

People living with HIV are living longer and healthier lives.

Median age at death of people living with HIV in Wisconsin by decade, 1982-2020



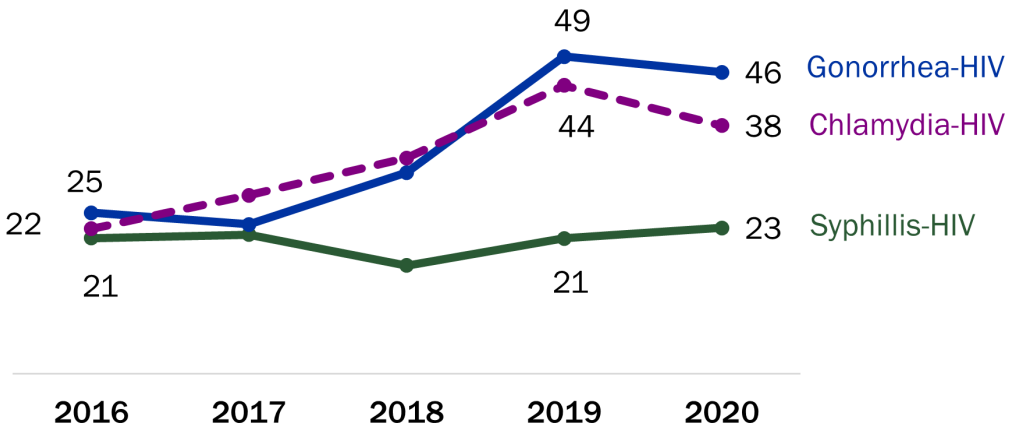
Co-occurring conditions (STIs, TB, HCV, mental health and substance use)

In this document, a co-occurring condition is defined as a sexually transmitted infection (STI), tuberculosis (TB), or Hepatitis C virus (HCV) report within 30 days of, or any time after, the date of HIV diagnosis. PLWH are more severely impacted by co-occurring conditions compared to the general population [Figure 9].

FIGURE 9

People living with HIV are likely to be impacted by STIs.

Rate of sexually transmitted infection per 1,000 people living with HIV, Wisconsin, 2016-2020



In 2019, STIs affected PLWH at a rate that was 8 to 210 times greater than the general population in Wisconsin for syphilis, chlamydia, and gonorrhea. Among all PLWH, rates of all three STIs have shown an increasing trend from 2016 to 2020. Most STI-HIV co-occurring conditions are reported by PLWH who reported male-male sexual contact at the time of HIV diagnosis (81-87%).

The rate of TB-HIV is low in Wisconsin (5%). From 2016 to 2020, 224 people in Wisconsin developed TB, but only 11 were diagnosed with both TB and HIV. HCV affects 8% of PLWH. Injection drug use was the most common risk factor for people with HCV-HIV co-occurring conditions (36%), followed by male-male sexual contact (27%). People with HCV-HIV were mostly men (75%) and older age 55+ (62%). By race, white (41%) or Black people (38%) were most affected.

Mental health and substance use are significant conditions impacting PLWH. According to the provider survey in the 2022 needs assessment, most HIV service providers (95%) responded that poor mental health is a barrier to seeking health care for their patients. Additionally, one in two respondents of the community member survey report stress or anxiety at least a couple days per week. Self-harm is a common, with 37% of community members surveyed reporting thoughts of suicide or self-harm and 25% having attempted suicide [Figure 10].

Substance use is also common among respondents of the community survey, with 59% reporting ever using drugs or medication to cope with stress. 32% said substance use impacted their ability to

carry out responsibilities such as work, child care, family, or social responsibilities. Additionally, respondents of the community survey reported using syringes to inject hormones or steroids (11% use, 21% ever shared needles) and recreational drugs (28% use, 66% ever shared needles) [Figure 11].

FIGURE 10

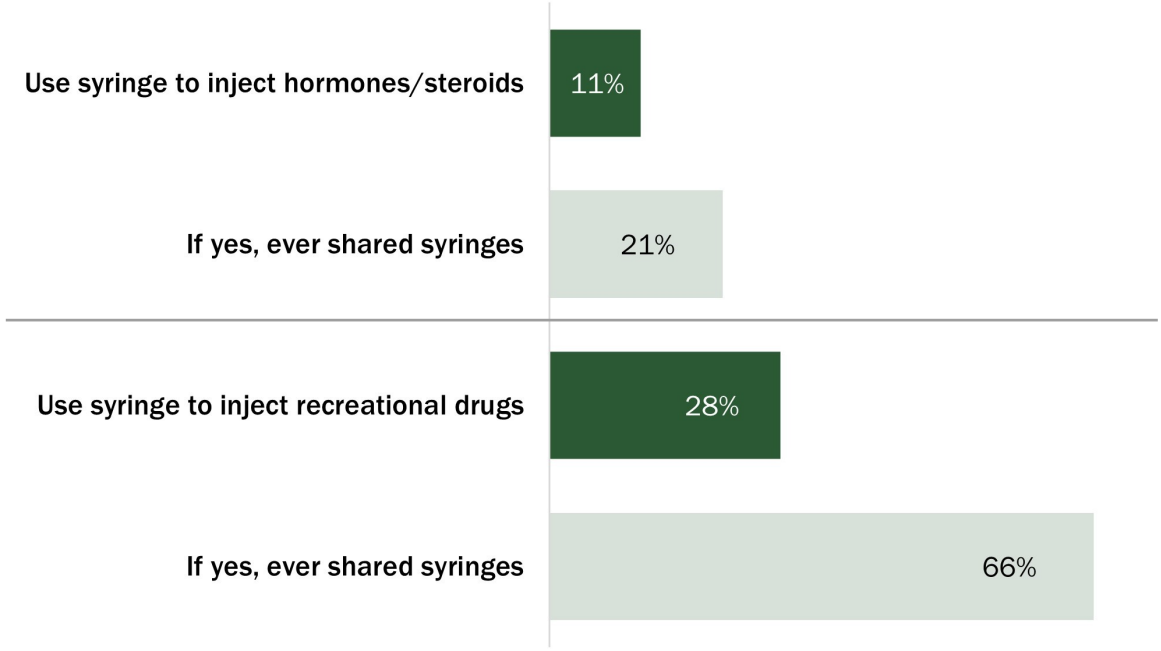
Survey respondents living with HIV or impacted by HIV report prevalent stress, anxiety, and depression.

Needs Assessment, Wisconsin, 2022

FIGURE 11

Survey respondents living with HIV or impacted by HIV report syringe use and sharing practices to inject hormones and recreational drugs.

Needs Assessment, Wisconsin, 2022



Social determinants

By census tract area, HIV diagnosis increases with an increasing percentage of those living below the federal poverty level (<6% below federal poverty level= 1.5% of new HIV diagnoses, ≥ 18% below federal poverty level=12.2% of new HIV diagnoses). The rate of HIV diagnosis also increases as the

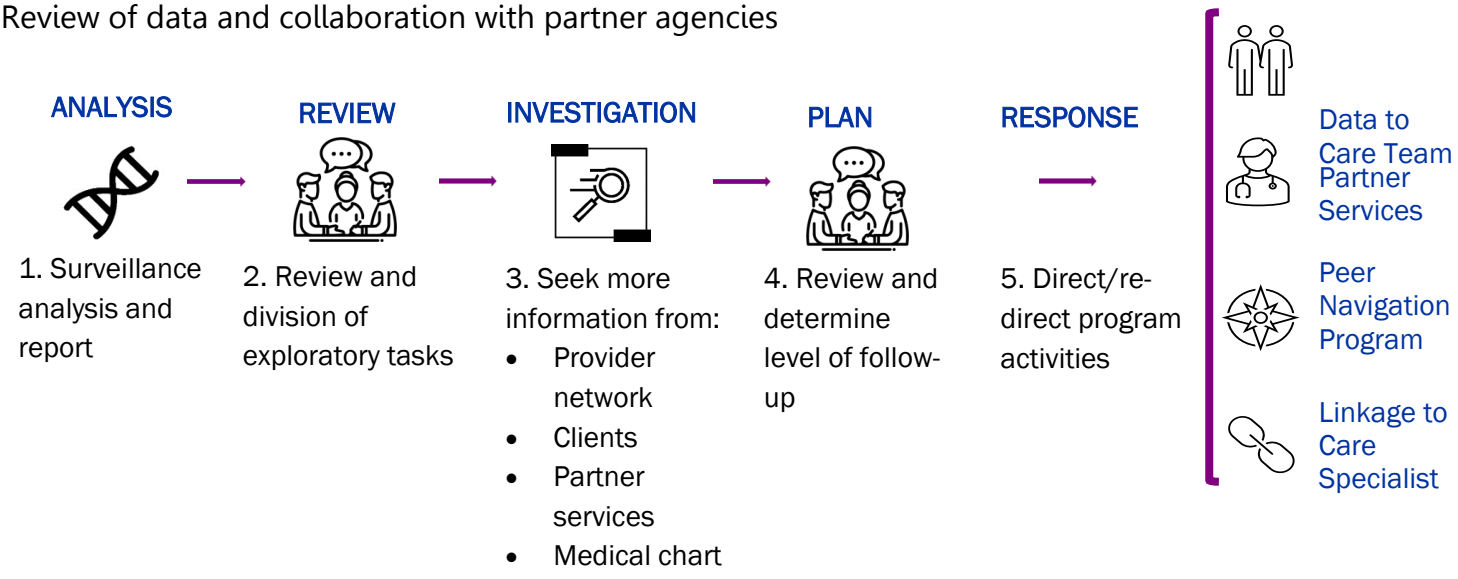
percentage of residents without health insurance coverage increases (<5% without health insurance=2.1%, ≥14% without health insurance=13.0%).

Cluster detection

There were no notable clusters detected from 2016 to 2020 that required response by the Wisconsin HIV Program. Detecting a cluster of related HIV cases indicates increased HIV transmission among a group of people in an area or in a sexual or social network. When an HIV cluster or outbreak is identified, public health agencies engage the network of health care providers, advocates, and other community leaders to address the community's specific needs [Figure 12].

FIGURE 12

Detecting and prioritizing HIV clusters is a dynamic and iterative process.



One way that clusters or outbreaks can be identified is when frontline health workers (such as medical providers, public health staff, or others in the community) report an increase in HIV diagnoses among a specific group of people in their community.

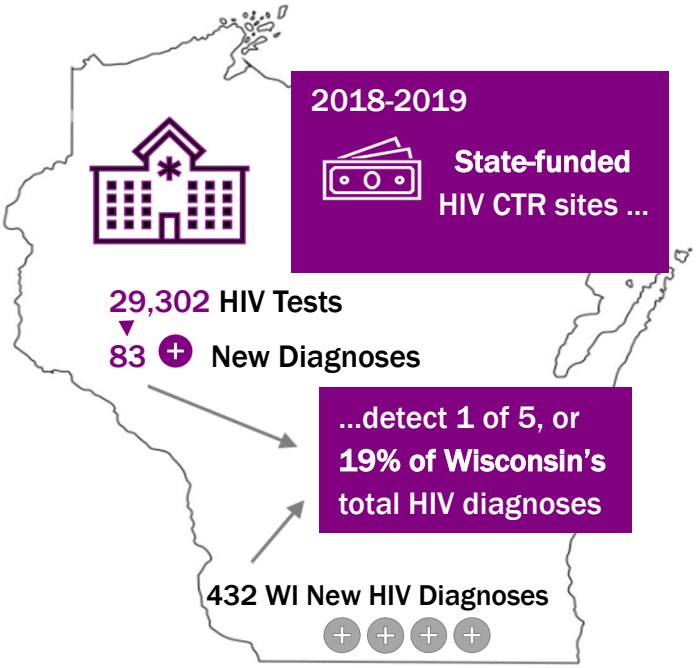
Another way that clusters or outbreaks are identified is by analyzing HIV surveillance data to identify areas where HIV diagnoses are increasing. Three methods used by the Wisconsin HIV Program are time -space analysis, molecular cluster detection, and monitoring of HCV-HIV co-occurring conditions.

Program Outcomes

During 2018 to 2019, publicly funded HIV CTR sites performed 29,302 HIV tests, of which 83 tests were reported as new HIV diagnoses [Figure 13]. These CTR sites detected 19%, or one-fifth of Wisconsin's total HIV diagnoses (n=432). By gender, men received the most testing (72%) and represented the majority new HIV diagnoses (94%). By exposure risk, people who reported male-female sexual contact received more HIV testing at HIV CTR sites (47%), but male-male sexual contact accounted for most new HIV diagnoses (31% of tests, and 84% of HIV diagnoses).

FIGURE 13

State-funded HIV CTR sites diagnose 1 in 5 of Wisconsin's new HIV cases in 2018-2019.



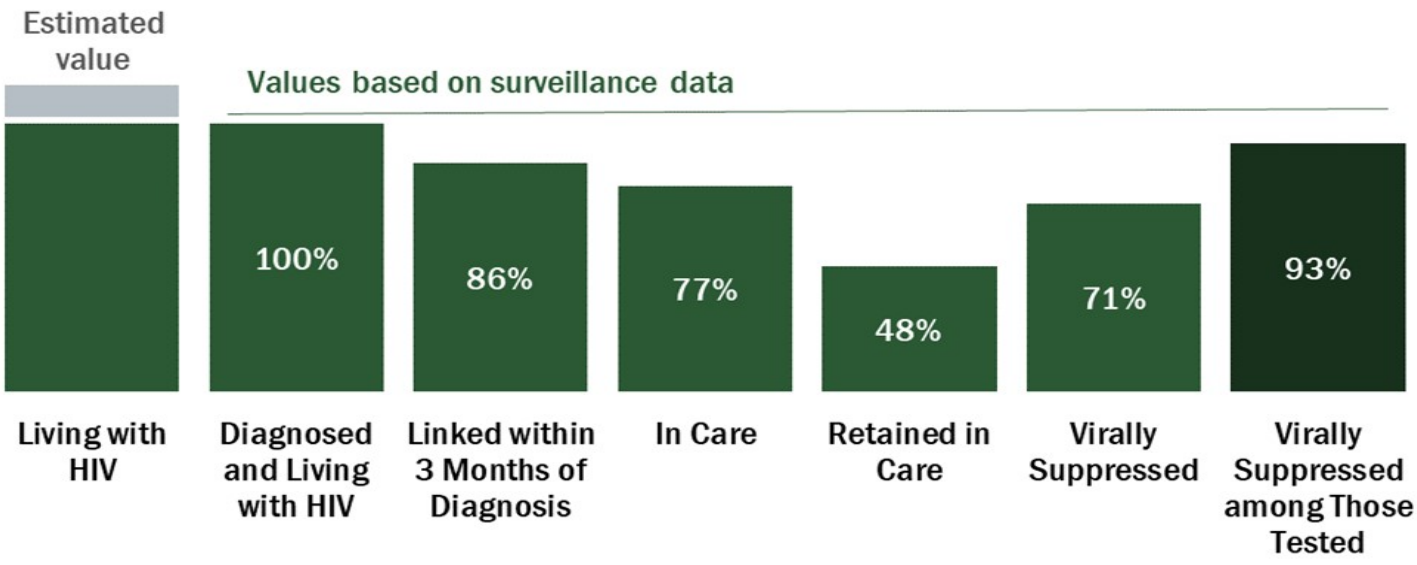
HIV Care Continuum

The HIV Care Continuum continues to be an important framework for understanding and assessing the status of HIV care and treatment in the United States as well as prevention efforts directed at early detection and prevention of transmission (treatment as prevention) [Figure 14]. The HIV care continuum illustrates the stages through which PLWH can progress in their HIV management.

FIGURE 14

Most people living with HIV who are engaged in care are virally suppressed.

HIV Care Continuum, Wisconsin, 2020



- Living with HIV: The CDC estimates that 13.8% of individuals living with HIV in the U.S. are unaware of their status. In Figure 14, this bar shows both those aware and diagnosed and those unaware of their HIV diagnosis.
- Diagnosed and living with HIV: All individuals living with HIV reported in Wisconsin by the end of 2019 who were still alive and living in Wisconsin by the end of 2020 (6,636 people).
- Linked within three months of diagnosis: Of 211 people diagnosed with HIV in Wisconsin during 2020, 90% (190 people) were linked to care within three months of diagnosis. Six out of seven (181/211 people or 85%) newly diagnosed individuals were linked to care within the one-month target described in the most recent National HIV/AIDS Strategy (National HIV/AIDS Strategy for the United States: Updated to 2020, 2015).
- In care: Of 6,636 PLWH HIV in Wisconsin during 2020, 78% had at least one medical visit that included one or more laboratory tests that were available in the HIV surveillance system as evidence of receiving care.
- Retained in care: Of 6,636 individuals diagnosed and living with HIV in Wisconsin during 2020, 3,145 (47%) had laboratory test results that suggested two or more medical visits occurred at least three months apart during the reporting period. This criterion for retention in care may underestimate the number of people who are routinely receiving HIV care, as people who have been treated for many years or who are uninsured may receive care once a year or less and may still be adherent to care and attaining viral suppression.
- Virally suppressed: Of 6,636 PLWH in Wisconsin, 71% had viral loads (number of virus copies in the blood) that were less than 200 copies/mL, indicating attainment of viral suppression. Individuals whose last viral load test was prior to 2020 or who did not have a viral load test recorded were considered to have unsuppressed viral loads.
- Virally suppressed among those tested: Of 5,100 people who had a viral load test during 2020, 4,759 (93%) were virally suppressed at their last measurement. This suggests that most individuals receiving some medical care are achieving viral suppression. Viral suppression improves the health of the person living with HIV and also prevents them from transmitting HIV sexually to partners.

The following differences in these important health indicators were observed:

- Males and females had equal success across the whole care continuum except for linkage to care where males linked to care faster than females (87% vs 81% linkage within one month).
- Transgender data are limited, and we are unable to make meaningful statistical inferences.
- Hispanic PLWH were the most likely to be linked to care within three months but were less likely to be in care or to be virally suppressed. Outcomes for white PLWH were better than Hispanic and Black PLWH.
- Younger PLWH (ages 13 to 29) were more likely than PLWH ages 30 and older to be in care but were less likely to be virally suppressed.
- Individuals with a history of injection drug use had among the lowest proportion at each stage of the continuum, except for linkage to care.

HIV Prevention, Care, and Treatment Resource Inventory and Needs Assessment

The Wisconsin HIV Program contracted with an independent consultant based in Milwaukee to assist with compiling the HIV prevention, care, and treatment resource inventory. Wisconsin HIV Program staff also developed a needs assessment.

HIV Prevention, Care, and Treatment Resource Inventory

The Wisconsin HIV Program contracted with an independent consultant based in Milwaukee to assist with the HIV prevention, care, and treatment resource inventory. Work on the resource inventory was done during February to August, 2022, with a survey on comprehensive HIV-related funding going out to clinical sites, non-clinical sites, federally qualified health centers, local and Tribal health departments, sexual health clinics, and funders. Using the results of this survey, the consultant and staff within the Wisconsin HIV Program used the 'Resource Inventory Compiler Tool' developed by the Integrated HIV/AIDS Planning Technical Assistance Center at John Snow, Inc. put together a final resource inventory table.

Needs Assessment

Development

During the early weeks of the planning phase, Diverse & Resilient conducted a thorough review of existing literature to identify qualitative data useful for the current needs assessment survey. Items reviewed include but are not limited to the:

- 2017-2021 HIV Prevention and Care Integrated Plan
- Previous Needs Assessment Qualitative Report
- HIV National Strategy 2015-2021
- Previous needs assessment with the trans community
- Peer Navigator programs including the Peer Specialist literature review compiled by Wisconsin HIV Program
- Other peer reviewed articles published since 2017 focusing on HIV prevention and care in rural and indigenous communities

The initial draft survey instrument was distributed for review by target community members, project staff from the HIV Prevention and Care programs, and the DHS DPH CDHR Section. Once finalized, the survey was translated into Spanish by a bilingual key collaborator with an understanding of common language used for all related issue areas of the survey.

Survey overview

The survey collected basic demographic information with questions that assessed needs and input from participants across a wide array of domains that included critical social determinants of health:

- Experience with and interest in “at-home” HIV tests
- Condom use
- Needle use (such as for injecting steroids and testosterone and for drug use)
- Employment
- Housing
- Health care experiences, including dental and telemedicine
- Transportation
- Stress and emotional well-being (including substance use questions to cope with stress and mental health)
- General social support
- Experiences of oppression
- HIV-related services

The surveys were created in an online survey platform and could be completed via computer, laptop, or smartphone. Survey distribution was supported by agencies across the state including HIV Prevention and Care programs funded by DHS, Tribal Health Coordinators and Programs, Syringe Service Programs, and some Federally Qualified Health Centers. Assistance was also provided by members of the SAPG. In total, 65 contacts at local and statewide community-based organizations and 30 members of the SAPG received the community survey in English and Spanish to distribute to eligible community members via direct recruitment of their program staff. The survey was distributed in "waves" which grouped small organizations together but allowed for larger organizations to receive unique survey links making it easier for communication and follow up. The survey links were open from a Monday to Friday of the same week to minimize the sharing of the survey link outside of individuals who were recruited directly by staff. Survey respondents received $75 incentives either directly via CashApp or a mailed gift card. In total we received 184 completed surveys. Individuals with no risk factors for HIV transmission or no individual factors targeted by federal guidance for HIV prevention programs were removed prior to survey analysis leaving 126 total surveys.

Once the survey period was completed, project staff conducted analysis of the survey data and extracted themes. Themes were further analyzed through virtual and in-person focus groups with community members and key contributors in central and rural Wisconsin counties. Focus group participants were included PLWH and individuals who were not living with HIV. Participants identified as white, BIPOC, cis and trans, with participants being either current or previous consumers of harm reduction or HIV prevention services or were currently engaged in care. Focus group participants received a $50 gift card for their participation.

The process also included a Provider survey. In preparation for the creation of the provider survey, we integrated what we learned in our literature review, research for the community survey, and information gleaned in our research for the development of the Peer Navigator program. Based on this knowledge, we developed a survey that included the following questions/categories: basic demographics, role in HIV prevention and care, experiences with telehealth, populations served, knowledge of population barriers to service, and training needs.

We used a grounded theory approach to our analysis, systematically analyzing the data for thematic patterns. Our research design allowed for:

1. The exploration and discovery of concepts and themes.
2. Added context and depth to the understanding of the qualitative data via focus groups.
3. Provided an interpretation of the data from the point of view of the community and key contributors.
4. Used lived experiences of community members to make specific programmatic recommendations.

Strengths of existing programming

- Condoms are widely available and accessible:
    - 95% of all survey respondents indicated they had easy access to condoms when they needed them.
    - 59% of survey respondents stated they get condoms from an HIV related program or agency.
- Some participant groups indicate fairly high/consistent condom use for anal/vaginal sex:
    - Trans women of color have the most consistent use of condoms across all groups, with 60% indicating that they use condoms most of the time to every time for anal/vaginal sex.
    - Hispanic/Latinx gay and bisexual men have the second most consistent condom use for anal/vaginal sex, with 53% indicating they use condoms most of the time to every time.
- Respondents are open to at-home HIV tests:
    - 86% of respondents who had never taken a test indicated they were interested or potentially interested in using one. Of these participants, their primary interest in an at-home HIV test was due to its privacy and discreteness, thereby avoiding any potential shame or stigma from a health care provider.
- Telehealth/telemedicine was widely used and accepted when available:
    - 83% of respondents indicated seeing a doctor virtually via telemedicine would be a good option or a potentially good option for them.
    - 73% of providers across 40 Wisconsin counties stated their programs offer telehealth options.
    - Focus group participants appreciated the telehealth option during the pandemic, and many indicated hope that telehealth options would continue to be offered and expanded.
- Community members showed high levels of awareness of both PrEP and PEP:
    - 86% of all participants have heard of PrEP:
        - 100% of trans women of color and Hispanic/Latinx gay and bisexual men, 97% of Black gay and bisexual men, 90% of white gay and bisexual men, and 60% of People Who Inject Drugs (PWID) were aware of PrEP.
    - 75% of all participants have heard of PEP.

- There are high levels of community knowledge of and comfort level with safe syringe services:
    - 94% of PWID knew where to get sterile or new supplies (such as needles and syringes) in their area.
    - 85% of respondents felt moderately to extremely comfortable utilizing safe syringe services.
- Providers surveyed expressed knowledge and recognition of systemic barriers to health care access.
    - 88% understood a fear of stigma as a barrier to health care for their clients/patients.
    - 80% understood barriers to health care could be attributed to experiences of oppression.
    - Providers noted mental health as a significant barrier to health care, with 95% of providers indicating their clients experience this.

Program gaps and barriers

- Though there was high awareness of where to get condoms, there was low usage across most groups for anal/vaginal sex:
    - When asked "How often do you use condoms for anal or vaginal sex," only 12% of respondents use them every time.
    - The lowest usage was among PWID at only 3%, with the highest usage among Hispanic/ Latinx gay and bisexual men with 27% using condoms every time for anal/vaginal sex.
    - 25% of participants indicated they never use condoms for anal or vaginal sex.
- There are high levels of needle sharing among PWID:
    - 66% of PWID respondents said they have ever shared needles.
    - 11% of PWID respondents are living with HIV, 25% of whom are not currently in care. 9% of survey respondents who are PWID did not know their status.
- Across participant groups, there were high levels of unemployment and underemployment. Employment instability contributes to missed appointments and inconsistent care, due to the impact on other social determinants of health, particularly housing, transportation, and mental well-being:
    - 56% of survey participants were currently employed.
    - 37% of employed participants had missed a medical appointment because they were unable to get off of work.

- 51% of respondents who said they were currently employed indicate that their income is not enough to consistently cover their regular expenses, with 25% indicating it covers expenses only sometimes. The remaining 26% stated that their pay is never enough.
- PWID, trans women of color, and PLWH have the highest income instability with 53% of PWID indicating their pay is not enough to cover their regular expenses.
- In the provider survey, respondents indicated that clinic hours can be a barrier for consumers who are employed and can't get time off to make their appointments. For PLWH this can include physician appointments twice a year (in addition to any specialty or other health related appointments) and lab appointments. One missed appointment can result in an individual waiting months for the rescheduled appointment, and prescriptions can go unfilled in the meantime.
- In participant focus groups, participants stated work time missed for appointments often means missed pay, which can mean missed rent payments. A missed appointment can often mean the patient had to choose between multiple basic needs, and rent money will be prioritized over a medical appointment most of the time.

- There were high levels of housing instability among participants:
  - 17% of survey respondents met the federal definition of homelessness either due to couch hopping or currently residing in a shelter.
  - 29% of respondents stated that they have a lease or are able to stay at their currently place as long as they need to.
  - 40% of respondents stated their home is mostly in good condition (little to no peeling paint or loose plaster).
  - 41% of respondents said they have their own room for sleeping.
  - 42% of respondents stated that their home has a bathroom with a shower or tub.
  - 43% of respondents said their home has heat in the winter.
  - 44% of respondents said their home has hot and cold water.
  - 44% of respondents said that to their knowledge, their home meets all building codes and is safe for me to live in.
  - The highest levels of housing instability were among trans women of color (70%), PWID (69%), and Black gay and bisexual men (60%).
  - Of all participants, 36% stated that their housing situation had caused them stress or anxiety, a lack of sleep, or other things that sometimes resulted in not being able to go to work or keep appointments. Many reported that it happened occasionally to always.
  - 90% of providers recognized housing instability as a barrier to health care for their patients/clients.

- Inconsistent or unreliable transportation is a barrier to regular and consistent health care for participants. In survey responses and throughout focus group conversations, transportation was the most mentioned barrier to health-related activities:
    - 39% of community survey respondents indicated transportation was an issue in getting to work or meeting other needs.
    - 46% of community survey respondents indicated that a lack of reliable transportation has caused them to miss work or health care-related appointments.
    - 94% of provider survey respondents indicated that transportation is a barrier to health care for their clients/patients.
    - Participants who rely on others for transportation are vulnerable to their friend/family member's schedule changing. Medical rides are often unreliable, can be late, and need to be scheduled in advance, so are not a last-minute solution.
    - Weather considerations are necessary for people who take public transportation. Excessive heat in summer and cold, snow, and freezing conditions in winter can prevent participants from keeping appointments.
    - Bus tickets given in advance are sometimes needed for other things, then when the appointment comes around that ticket is gone.
    - Late public transportation can lead to missed appointments, and a refusal to see the patient. Public transportation, in general, isn't safe for trans people due to harassment, discrimination, and violence that are based in systems of oppression.
    - Asking friends or family for a ride can strain relationships if that person also has to make sacrifices. In addition, depending on the location of the provider, the client may be outing themselves, and they may not be out as a person living with HIV to friends or family.
    - Participants may have their own vehicle, but due to other issues related to employment and housing, they may not always have the resources to keep gas in their car.
    - Many participants noted that in rural parts of the state, they are traveling sometimes over 40 miles to get to their provider. This raises issues related to cost, time away from employment.
- Fear of discrimination prevented 40% of participants from seeking health care when they needed it:
    - Most commonly participants were fearful of discrimination due to their drug or alcohol use (44%), their sexual orientation (34%), due to "previous bad experiences" (30%), and/or their race or ethnicity (18%).
    - 80% of providers acknowledged experiences of oppression (racist, homophobic, or transphobic harm from a provider or health care staff) were a barrier to care.

Opportunities and recommendations for program improvements

Focus group participants and community survey respondents provided recommendations to address the following areas.

- Increase use of at-home HIV tests:
    - A YouTube video link that could demonstrate how to use the test.
    - Different videos for different populations.
    - Videos made by providers who are known in the community or other community partners or subject matter experts.
    - The instructions can be intimidating, therefore someone to talk the consumer through the process over the phone would be welcomed and helpful to many.
    - A positive result could have an initial telehealth follow up prior to an in-person visit.
- Safe syringe services:
    - Participants indicated that there is a need for programs to provide sterile equipment services to participants who use needles for hormone injections, but these programs should not be confused with programs providing services to PWID.
    - 21% of community survey respondents who use needles to inject hormones indicated they have ever shared needles.
    - 66% of community survey respondents who use needles to inject recreational drugs indicated they have ever shared needles.
    - Having sterile equipment available for participants reduces risk of HIV transmission.
- Housing and employment barriers:
    - Housing barriers should not be seen as siloed from other areas of the clients' lives. Issues with employment and financial resources, mental health, and transportation, among others, all impact a client's housing situation.
    - Phone calls from provider offices the day prior to an appointment as a reminder help and can also be a problem-solving opportunity. Callers can ask if the patient has transportation and offer support and solutions (see section on transportation).
    - If a patient indicates they will not be able to make the appointment, alternatives could be offered such as telehealth, a home visit that can be scheduled sooner than a rescheduled office visit, mobile medical vans with lab techs, physician assistants, or outreach nurses.
    - Emergency appointments should be available for urgent needs but could also be used to reschedule missed appointments quickly.

- After-hour appointments can also be helpful. Many individuals experiencing housing instability also have financial and other related barriers such as transportation. The ability to see a provider outside of what are considered "normal" clinic hours is needed.
- Resources are needed that provide legal support to participants regarding prior evictions, legal histories that are a barrier to housing eligibility, outstanding energy payments, and more.
- Programs need funds available to assist individuals with other housing needs such as the purchase of appliances, energy bills, cleaning products, and other items not available through food pantries. Too many individuals try to make do without these things, impacting their overall well-being and health behaviors.
- Some participants are in the "middle," not fully eligible for supportive services, but are not able to do things on their own. There needs to be a tiered category for supportive services, not simply eligible or ineligible.

- Telehealth expansion:
  - 48% of participants would like to participate in telehealth/telemedicine appointments when needed.
  - Telehealth opened up avenues in terms of flexibility for participants with no child care or transportation. They maintained appointments that they might not have been able to otherwise.
  - All participants agreed that even though telehealth appointments might not be for everyone, or available for every type of appointment, they were good and increased the general likelihood of keeping their appointments.
  - If a participant needed to miss an in-person appointment, fewer individuals experienced rescheduling problems when telehealth was available.
  - If a patient calls to cancel an appointment, telehealth should be offered as a way to potentially maintain the appointment.
  - When calling to remind patients of an upcoming appointment, telehealth should be offered as an alternative to canceling if a patient is expressing difficulty in keeping the appointment.
  - Telehealth options should be discussed at every in-person appointment to increase patient awareness.
  - Provider offices and waiting areas should include posters, stickers, brochures, and other materials saying "ask your provider about telehealth."

- Issues to bear in mind when developing or expanding telehealth options:
  - Confidentiality becomes critical when using telehealth. Treatment and recovery groups may not be well suited for virtual sessions, unless there are guidelines in place that protect client confidentiality. The host of any meeting can use session settings so that cameras aren't turned on, for example.
  - Internet service costs money making telehealth tricky for people without sufficient income.
  - Having private spaces for virtual visits for those who use shelters can present challenges that need to be resolved through community partnerships with the organizations providing shelter services, and a system that coordinates care.

- Stigma or experiences of oppression as barriers to health care:
  - Providers who are non-judgmental, empathetic, and unbiased can greatly increase a patient's engagement in care and positively benefit their health behaviors. A participant stated, "My primary was very kind and welcoming. On our first visit he said, 'Thank you for choosing me to help you get healthy.' He was nonbiased, non-judgmental. And it was because of that that I stayed with him and got my health under control."
  - Participants indicated that having a provider who shares their identity and experience would be helpful in increasing their comfort with the provider, but identity can't be seen as equivalent to training and education.
  - Participants need to know their providers know more than they do, and they often find themselves in the position of having to educate their doctors about their health, identity, and the barriers they face.
  - Black focus group participants indicated that it can still be difficult to discuss their pain levels with a provider due to medical bias regarding opioid addiction.
  - When a patient identifies a barrier to care, the provider needs to accept that barrier as real. One participant stated, "My barriers shouldn't have to be seen as barriers by the provider in order for them to be acknowledged. If a person says it is a barrier, it is a barrier to them. Period. You don't walk in my shoes. How would you even know?"
  - Cultural competency trainings should include "peripheral" providers like receptionists, maintenance staff, assistants, or technical staff. All members of an organization interact with the community and should receive the same trainings that primary providers do. A bad experience with a receptionist can prevent an individual from returning for care that is critical to their well-being.

- Barriers to transportation:
    - In communities where it makes sense to do so, funds should be allocated for Uber and Lyft in the form of gift cards, or contracts for services.
    - Where relevant, taxi vouchers can also be utilized. One participant stated, "After an accident when I was actively using, the hospital gave me a taxi voucher to get home, and to return the next day. That was an example of help. I was homeless at the time and didn't have anyone in my life I could depend on. That cab voucher really helped me."
    - A phone call to check in on an individual can make the difference between someone dropping out or staying engaged in care, particularly when the individual may be struggling to prioritize their care. One individual stated, "When they reached out to say 'We miss you, are you okay?', that helped me stay connected."
    - Gas cards are needed. Many participants have cars, but no funds for gas.
    - Providers should be proactive regarding transportation to appointments with questions specific to transportation asked when the appointment is scheduled and again when calling to remind the patient of the appointment.
        - Participants indicated that transportation services are sometimes covered by insurance, but providers need to assist with the process.
    - Peer Specialists/Navigators/Case Managers can pick up participants for appointments and serve as their advocates throughout the process. This can be extremely supportive for our most marginalized clients and is a relationship that can impact other areas of their lives.
    - Telehealth was widely agreed upon to be a proactive measure for many participants in accessing appointments that don't require lab work or tests.
    - When labs are required, participants across all groups discussed the use of mobile medical units/vans that could offer in person medical exams, blood draws or other specimen collection, and medication delivery.
        - This is particularly needed in rural parts of the state.
        - Vans would need to be "unmarked," without markings that inadvertently "out" the person who is using it.
        - In-home appointments would be useful for individuals with other barriers that make it difficult for them to leave their homes:
            - Pharmacies already utilize home delivery services, with staff who are trained in packaging and explaining medications to patients.
            - Providers could offer rotated in-home care that allows for patients with transportation issues to schedule medical visits in their homes.

- Increasing use of PrEP:
    - Only 22% of participants who were not living with HIV were taking PrEP.
    - Although 86% of Hispanic/Latinx gay and bisexual men who responded to the community survey were interested in taking PrEP, only 50% were currently taking it.
    - Opportunities for improvement include developing group-specific programming to address fears and barriers to medication access and acceptance.

Section III References

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Section IV: Situational Analysis

This section will provide a summary of the strengths, challenges, and identified needs in Wisconsin with respect to each of the four "Ending the HIV Epidemic" (EHE) pillars: Diagnose, Treat, Prevent, and Respond. Supporting contextual data for the strengths, challenges, and identified needs can be found in Section II: Community Engagement and Planning Process and Section III: Contributing Data Sets, specifically the epidemiologic snapshot, needs assessment, and resource inventory.

Demographic Highlights

Wisconsin has 5.8 million residents living in 72 counties. The most populous county is Milwaukee County in the southeastern part of the state, with nearly 1 million residents. Approximately 81.3% of Wisconsin residents are non-Hispanic White, 7.3% are Hispanic/Latinx, 7.1% are Black, 3.3% are Asian, and 1% are American Indian. The median age among White people in Wisconsin is 43.4, while the median age among all other racial and ethnic groups is between 28 and 33. Recent population growth in the state is greatest in Asian and Hispanic/Latinx people and among people age 50 and older. 11% of Wisconsin residents live in poverty. According to the YRBS, 9% of students in Wisconsin high schools and 16% of Milwaukee public school students identify as lesbian, gay or bisexual. Comparatively, according to the Wisconsin BRFS, 7% of Wisconsin adults identify as lesbian, gay, or bisexual.

Overview of HIV in Wisconsin

Over the past 10 years, the number and rate of new HIV diagnoses have declined. Wisconsin has a relatively low diagnosis rate compared to other states. From 2016 to 2020, male to male sexual contact continued to be the most common mode of HIV transmission in Wisconsin. Approximately 813 (72%) of the 1,126 new HIV diagnoses in Wisconsin between 2016–2020 were among gay, bisexual, and other men who have sex with men, including 47 people who also injected drugs. Diagnosis trends varied by other population characteristics:

- **Age:** 28% of gay, bisexual, or other men who have sex with men who were diagnosed with HIV in Wisconsin between 2016 and 2020 were under the age of 25 at the time of their diagnosis. 37% were between the ages of 25 and 34. Gay, bisexual, and other men who have sex with men ages

15 to 24 accounted for 21% of new diagnoses of HIV in Wisconsin from 2016 to 2020. The median age of diagnosis during this timeframe was 29 years. White men who have sex with men were generally older at the time of HIV diagnosis compared to men of color who have sex with men.

- **Race:** Among gay, bisexual, and other men who have sex with men newly diagnosed with HIV in Wisconsin from 2016 to 2020, 37% were white and 63% were people of color. 41% of new diagnoses were among Black men who have sex with men. This is a notable disparity as Black residents make up only 7.1% of the population of Wisconsin.
- **Geographic location:** Over half of all HIV diagnoses among gay, bisexual, and other men who have sex with men between 2016 and 2020 were in Milwaukee County. Milwaukee County accounted for one in 12 white and Hispanic/Latinx men who have sex with men diagnoses and one in three Black men who have sex with men diagnoses.

A total of 6,926 people known to be living with HIV resided in Wisconsin at the end of 2020. An estimated 1,109 additional people may have been living with HIV in Wisconsin but were not aware of their diagnosis. The estimated HIV prevalence was 8,035 people when those who were not aware of their diagnosis were taken into account. 4,726 gay, bisexual and other men who have sex with men were living with HIV in Wisconsin at the end of 2020, and an estimated additional 690 gay, bisexual, and other men who have sex with men were living with HIV but were unaware of their status.

Situational Analysis: Based on Ending the HIV Epidemic Pillars

Pillar 1: Diagnose

Strengths

- Rapid HIV testing available at six community-based sites, 12 local health departments, and the statewide AIDS service organization, Vivent Health, in 10 locations.
- Most sites that offer rapid HIV testing also offer testing for syphilis, gonorrhea, chlamydia, and mpox.
- Funding sources for HIV testing include CDC's PS18-1802 grant, Wisconsin general purpose revenue, and program income from ADAP rebates.
- Froedtert/Medical College of Wisconsin in southeastern Wisconsin offers universal opt-out HIV testing in their emergency departments.

Challenges

- At-home HIV testing is not widely available statewide. Currently residents have to pay

for at-home testing through a third-party service or access the OraQuick rapid HIV test through Vivent Health's online store at no-cost.

- There are gaps in services in rural areas.
- Stigma remains a barrier to accessing testing.
- Misinformation about HIV is widespread in the general public.
- Implementation of CDC's recommendation that all people between the ages of 13 and 64 be tested for HIV at least once in their lifetime as part of routine care is not widespread.
- Too many people from communities disproportionately impacted by HIV are not aware of their HIV status.

Identified Needs

- At-home HIV testing that is free and available to residents throughout the state.
- Implementation of a dual-rapid testing algorithm to facilitate faster linkage to care.
- Expansion of routine HIV testing in clinical settings.

Pillar 2: Treat

Strengths

- Ryan White-funded care services are available in locations throughout most of the state.
- Most people who are newly diagnosed with HIV are linked to care services within one month of diagnosis (79%).
- Nine out of ten PLWH in Wisconsin were virally suppressed during 2020.

Challenges

- PLWH experience higher rates of health disparities and social determinants of health.
- Too many PLWH are unaware of their status (16%).
- Stigma, misinformation, and medical mistrust lead to too many people living with HIV not seeking or staying on treatment.

Identified Needs

- Access to affordable housing and housing supports remains a need among PLWH.
- There is a lack of HIV-specific services in rural areas of the state.
- Staff need training in cultural responsiveness to meet the needs of communities most impacted.

Pillar 3: Prevent

Strengths

- A network of PrEP navigators in community-based organizations, clinical sites, and Vivent Health.
- Most HIV counseling, testing, and referral sites funded by the Wisconsin HIV Program offer linkage to PrEP, condoms, STI testing, and other supportive services for people seeking HIV testing.
- 91% of PLWH are virally suppressed in Wisconsin.
- Several local health departments and all Vivent Health locations offer syringe services programs for PWID.

Challenges

- PrEP uptake in Wisconsin is still low overall. In 2020, it is estimated that 17.5% of the 12,980 people who could benefit from PrEP are using it.
- PEP is not widely available to people who could benefit from it in Wisconsin, especially in rural areas.
- Overall, condoms are not widely used by gay, bisexual, and other men who have sex with men.
- Stigma, misinformation, and medical mistrust lead to people who could benefit from PrEP and HIV treatment not seeking it.

Identified Needs

- More education for primary care and other non-infectious disease clinicians around PrEP and PEP.
- Widespread implementation of the USPSTF and CMS guidance that PrEP medication, labs, and ancillary services should be covered with no cost-sharing.
- Wider availability and accessibility of PEP statewide.
- Education to communities disproportionately impacted by HIV and the general public about biomedical HIV prevention interventions (PrEP, PEP, Treatment as Prevention).

Pillar 4: Respond

Strengths

- Wisconsin's HIV Cluster Detection and Response Plan has been in place since 2021.
- Wisconsin has a strong network of local health departments that provide PS.

- Several local health departments and all Vivent Health locations offer syringe services programs for PWID.
- Vivent Health has staff and locations throughout the state to offer assistance in the event of an HIV cluster.

Challenges

- Local and Tribal health departments in rural areas may have little or no experience in addressing sexual health or HIV.
- There is a lack of HIV-specific services in rural areas of the state.
- Most local and Tribal health departments have no experience addressing an HIV cluster.

Identified Needs

- Training and technical assistance for local and Tribal health departments regarding Wisconsin's HIV Cluster Detection and Response Plan.
- More HIV-specific services available in rural parts of the state.

Priority Populations

The priority populations identified for this plan are in line with the populations identified in the unmet need analysis conducted as part of Ryan White grant activities, and also recommended by community members through the community engagement process outlined in Section II of this plan. These populations are also reflective of communities experiencing health disparities and inequities related to HIV or co-occurring health conditions with HIV. They are also communities most impacted by HIV in Wisconsin. The priority populations for this plan are:

- Black and Latinx gay, bisexual, and other men who have sex with men (including people who identify as same-gender loving (SGL) men of color).
- Black women.
- Black and Latinx people of trans experience, including gender non-conforming people.
- Youth (people ages 15-29).
- People who use drugs.

Section V: Goals, Objectives, Strategies, and Activities

The next pages of this plan define the goals and objectives that we are committed to achieving by 2026, including specific indicators to measure success and demonstrate progress, and strategies and activities to inform our next steps and meet the needs of community.

It is important to note that while developing and seeking feedback on the objectives, strategies, and activities, there were four topics that had overwhelming support and significance. These four topics represent our four priorities for this plan. They highlight the need for intersectional perspectives and cross-cutting initiatives, and must be in the forefront of our minds throughout all steps moving forward.

Health equity

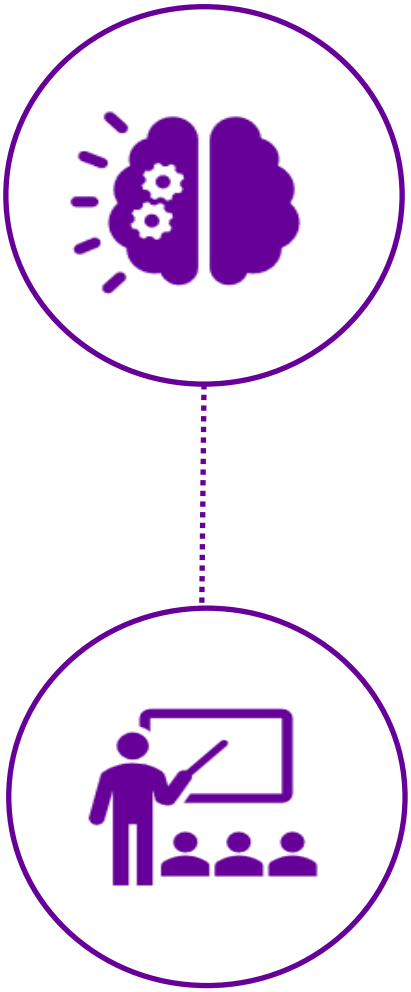
We must prioritize health equity and expand the genuine sharing of ideas and experiences to influence change. This means promoting wellness and development opportunities for populations disproportionately impacted by HIV, and ensuring service providers are responsive to the diverse cultural health beliefs, practices, preferred languages, and health literacy of those being served. Furthermore, racism is a public health crisis, and we must recognize and address the injustices caused by it through the strategies and activities within this plan. Racism shapes both opportunity and access to resources that support health, and contributes to health inequities and health disparities in communities across Wisconsin (APHA).

Status-neutral approaches

We must prioritize status-neutral approaches and support all people living with and/or impacted by HIV. Such approaches eliminate stigma and barriers by viewing people holistically and addressing their needs regardless of their HIV status. Embracing status-neutral approaches helps to improve health outcomes, prevent new infections, improve care and service delivery, and address social determinants of health that impact engagement in routine care and support. See Appendix II for a helpful figure to assist with implementation of a status-neutral approach.

Stigma reduction

We must prioritize reducing stigma, offer support and speak out against stereotypes and myths, and ensure intersectional experiences are valued and appreciated. HIV-related stigma creates unnecessary barriers and affects the health and wellbeing of PLWH. Misconceptions about HIV and lack of accurate and up-to-date knowledge contribute to stigma and can keep people from getting tested and accessing resources, treatment, and services. It is necessary to address the impact of stigma and work to reduce harm by providing safe and supportive environments for PLWH to share their experiences. Additionally, we must engage providers in training opportunities to learn more about HIV and correct misconceptions. This involves collaborating with communities to develop policies and messaging, ensuring communications use images and language that reflect diverse and accurate depictions of communities without reinforcing stereotypes or biases, and expanding the use of social media to reach communities most impacted.



Workforce development

We must prioritize workforce development and the impact of systemic and structural barriers put in place to organize power and resources, particularly on communities who are also disproportionately impacted by HIV. Workforce development includes expanding opportunities for hiring, capacity building, and advancement of staff who represent or are members of the communities they serve. Recruiting and retaining staff requires paying equitable and living wages, support from supervisors and colleagues, and opportunities for collaboration and learning.

The strategies and activities outlined in this section will build on these four priorities and focus on five populations disproportionately impacted by HIV:

- Black and Latinx men who are gay/bisexual, including SGL men of color
- Black women
- People of color of trans experience and non-binary/gender non-conforming persons
- People who use drugs
- Youth (people ages 15 to 29)

The people who make up or identify within or across these five priority populations share many similarities and also have significant differences. Their unique experiences and collective well-being must be valued and appreciated. While some strategies may work well for one group or individual, others might work better for another. Being aware of and responsive to the needs and voices of each and all community members will guide our strategy and inform our actions throughout and beyond this plan.

Lastly, while this plan outlines our goals and objectives through 2026, and the strategies and activities we plan to implement during the years covered in this plan, it is important to note that many of the details surrounding actual implementation are not present. This plan provides an outline for future internal and external workgroups to consider as they collaborate and develop next steps, and will guide strategic planning for HIV care and prevention activities moving forward.

Goal 1: Prevent new HIV infections.

Objective 1.1:

By the end of 2026, reduce the number of new HIV diagnoses by at least 40%. In 2021, there were 227 new diagnoses.

Objective 1.2:

Increase the percent of PLWH who know their status from 87% in 2019 to at least 95% by the end of 2026.

Objective 1.3:

Increase PrEP coverage from 19% in 2019 to at least 50% of all people who could benefit from the medication by the end 2026.

Target Populations	Responsible Parties	Timeline
• Gay/bisexual cisgender Black and Latinx men • Transgender people of color • Black women • People who use drugs	• Wisconsin HIV program • Local and Tribal health departments • Clinical and non-clinical community-based agencies funded to provide HIV prevention services • SAPG	Over the 5-year period during 2022 to 2026, and beyond

Strategy 1: Promote comprehensive HIV, STI, and HCV testing.

Knowing your HIV, STI, and HCV status is the surest way to take control of your health and be linked to care successfully. Based on data from 2016, 15% of PLWH didn't know their HIV status. This group accounted for 38% of all new HIV transmissions in the United States. Evidence shows that people who test positive for HIV, STIs, or HCV take steps to keep others from being exposed, while people who are unaware of their status miss out on the benefits of treatment and may unintentionally expose others to HIV, STIs, or HCV.

Conversations and feedback from communities most impacted by HIV tell us that for testing efforts to truly be effective, they must be:

- **Integrated:** A person seeking testing services should be able to receive HIV and HCV testing, as well as testing for STIs, all in one visit.
- **Comprehensive:** Multi-site gonorrhea and chlamydia testing should be offered, if relevant, and testing should be based on risks presented by the person seeking testing.
- **Efficient:** Rapid tests should be used whenever possible to reduce the wait time to receive results.
- **Community-based**: Testing services should be made available where communities are based to reduce the burden of traveling to receive services. At-home testing should be available.

Activity 1A: Ensure HIV testing is reaching focus populations where they are located and is accessible to them in a variety of settings. This includes creating partnerships and offering HIV testing in non-traditional settings, including:

- Bars and clubs
- Mobile units
- Shelters, day centers, and encampments for people experiencing homelessness
- Correctional facilities

Activity 1B: Develop new or implement existing effective, evidence-based or evidence-informed models for HIV testing that improve convenience and access.

- Expand availability of free at-home HIV and STI testing to all Wisconsin residents who are interested in getting tested.

- Implement a dual-rapid HIV testing algorithm at publicly-funded HIV testing sites, which would allow a person getting tested for HIV to have a confirmed positive result after two positive rapid tests instead of needing to wait for a lab to confirm a positive result. This will improve efficiency and linkage to care.

Activity 1C: Increase the availability of comprehensive HIV, STI, and HCV testing in both clinical and non-clinical settings.

- Increase capacity of HIV testing providers to screen for HCV and STIs, including three-site extragenital testing for gonorrhea and chlamydia.
- Increase testing for STIs among PLWH.
- Offer testing at festivals and other large gatherings.
- Increase availability of testing at treatment and recovery centers.
- Increase capacity of testing providers at university health services and college campuses.

Activity 1D: Expand routine HIV testing following the CDC recommendation that everyone ages 13 to 64 years get tested for HIV at least once as part of routine health care, and that people with specific risk factors be tested annually.

- Expand routine testing in emergency rooms and urgent care settings.
- Increase awareness among primary care clinicians of the benefits of routine testing.

Strategy 2: Raise awareness of HIV and dispel misinformation in communities most impacted by HIV and in the general public.

Despite four decades passing since the first cases of HIV were identified in Wisconsin, too many people are still unaware of how HIV is transmitted, who is at risk, and how it can be prevented. Advances in HIV prevention and care, such as PrEP and treatment as prevention (U=U), are mostly unknown to the general public and misinformation has led to a lack of trust in the science behind these advances within populations most impacted by HIV. The resulting misperception of self-risk and perpetuation of HIV-related stigma and misinformation can deter people from learning their status and from accessing PrEP or HIV treatment. Misinformation and stigma in the general public can also lead to a lack of support for PLWH among their friends and family members.

Misinformation and stigma among health care providers can also lead to missed opportunities for HIV testing and PrEP, or to patients being prescribed outdated or ineffective treatments. More must be done to increase HIV awareness among everyone, but especially within communities where HIV is most heavily concentrated. Messaging must be clear, specific, consistent, and culturally and linguistically relevant, and must reflect today's scientific knowledge of advances in HIV treatment and prevention. Crucially, messaging must be delivered from trusted sources in the communities most impacted by HIV, and any awareness campaigns must be reflective of the communities they are trying to reach.

Schools must also play a role in providing comprehensive, LGBTQ+-inclusive sex education to young people. Primary prevention should be a part of comprehensive sexual education, particularly for youth, including non-judgmental and affirming information about safer sexual activity for those who are sexually active.

Activity 2A: Partner with the Department of Public Instruction (DPI), school districts, and community-based organizations to promote ongoing, age-appropriate, LGBTQ+-inclusive, comprehensive sex education in schools and community-based settings for adolescents and young adults.

Activity 2B: Create and disseminate community-appropriate awareness campaigns that promote HIV facts, proven HIV prevention methods (PrEP, PEP), and HIV treatment (U=U).

Activity 2C: Integrate HIV messaging into existing campaigns and other activities pertaining to STIs, HCV, behavioral/mental health, and the health of people who use drugs.

Activity 2D: Work with the Midwest AIDS Training and Education Center (MATEC) and other partners to educate and increase capacity of primary care clinicians to provide HIV education, testing, PrEP, linkage to PEP, and treatment.

Activity 2E: Hold a Wisconsin HIV, STI, and Harm Reduction Summit.

Activity 2F: Organize a series of trainings for HIV providers regarding various topics beyond HIV.

Activity 2G: Facilitate HIV-specific trainings and development opportunities for students in medical and/or health professional schools and non-HIV care providers.

Strategy 3: Expand partnership between and capacity of CTR providers, PS providers, and DIS.

DIS and HIV partner services providers at local and Tribal health departments play a critical role in preventing HIV in Wisconsin. When new HIV diagnoses occur or PLWH move into Wisconsin, disease intervention specialists follow up to ensure that a person living with HIV is linked into appropriate medical care and able to access other essential support services like case management. They also offer the opportunity to anonymously contact potential sex or needle-sharing partners to ensure those individuals have access to testing and status-neutral services. D2C is a program that uses HIV surveillance data to identify PLWH who have fallen out of care, and offers the opportunity for disease intervention specialists or others to follow up with them to help provide them the support they need to get back into care. D2C offers a variety of opportunities, including the opportunity to expand a network of peer navigators to help PLWH re-engage with the health care system.

Activity 3A: Expand partner services to include partnerships with community-based settings and health care providers in clinical settings.

Activity 3B: Promote awareness of PS and DIS among health care providers in clinical settings.

Activity 3C: Incorporate the use of HIV and STI disease intervention specialists in D2C response activities.

Activity 3D: Incorporate D2C into Wisconsin's existing linkage to care model, including the use of peer navigators to perform D2C activities.

Activity 3E: Develop and diversify the workforce of partner services providers and disease intervention specialists.

Activity 3F: Facilitate cross-training opportunities for partner services providers.

Activity 3G: Explore at-home testing engagement strategies.

Activity 3H: Provide hybrid networking and collaboration opportunities.

Strategy 4: Expand and improve implementation of proven HIV prevention interventions including:

- **PrEP**
- **PEP**
- **U=U**
- **Condom distribution**
- **Syringe services and harm reduction programs**

Today, a range of highly effective prevention methods are available for use in combination or on their own. However, they do not reach everyone who needs them. In Wisconsin, the Integrated HIV Prevention and Care Needs Assessment indicated that a majority of people who could benefit from PrEP are aware of what PrEP is (85%) but only 12% are currently taking it. This number is lower among Black and Latinx gay and bisexual men. Similarly, 75% of respondents to the integrated needs assessment survey indicated that they have heard of PEP but only 58% said they were either "extremely likely" or "strongly likely" to ask for PEP in a health care setting.

Syringe services and harm reduction programs are strong in Wisconsin, with 89% of people who use drugs indicating that they know where to go to get sterile injection equipment or supplies in their area, and 73% are "extremely comfortable" or "quite comfortable" going to a syringe services program. It is crucial to maintain the accessibility of these programs to prevent any future outbreaks of HIV among people who use drugs in Wisconsin, and also to prevent Hepatitis C or overdoses.

Condom distribution is a proven method of HIV and STI prevention as well, and the needs assessment showed that 95% of people at risk for HIV say they have easy access to condoms when they need them. At the same time, only 12% of people at risk for HIV reported using condoms during vaginal or anal sex every time, and 25% reported never using condoms for vaginal or anal sex. This speaks to the need to maintain the easy accessibility of condoms while also increasing the accessibility of the other proven prevention methods like PrEP and PEP. These interventions must be available to people who need them in a variety of traditional health care and public health settings, as well as nontraditional settings.

Public health and health care settings can better meet the HIV prevention needs of the people they serve by developing or adopting culturally relevant, linguistically appropriate, and accessible approaches and policies for service design and delivery. It is also important for systems to be adaptable to new and emerging technologies for PrEP that are currently being developed and researched, as these could prove to be more acceptable to some people in communities disproportionately impacted by HIV than the current methods.

Activity 4A: Expand awareness of PrEP among primary care clinicians, including proper billing and coding procedures to ensure that patients are not charged for clinical services, labs, or PrEP medication.

Activity 4B: Increase implementation of alternative PrEP options, such as cabotegravir (long-acting injectable PrEP), "on-demand" PrEP dosing, and other PrEP options that are currently being researched and developed.

Activity 4C: Expand availability and accessibility of PEP by training providers on how to screen and prescribe PEP in clinical settings, and establish a PEP provider directory showing where a person could access PEP if they needed it.

Activity 4D: Support low- or no-barrier condom education and distribution in both clinical and non-clinical, community-based settings, including in schools and mobile units.

Activity 4E: Expand evidence-based harm reduction services for people who use drugs, including Syringe Services Programs (SSPs), and integrate them with HIV prevention services.

Activity 4F: Increase awareness of the role that medication adherence and viral suppression plays in preventing the spread of HIV in both the general public and among medical providers.

Goal 2: Improve HIV-related health outcomes of people with HIV.

Objective 2.1:

By the end of 2026, increase the percentage of newly diagnosed people linked to HIV medical care within one month of their diagnosis to 95% and provide low-barrier access to HIV treatment. In 2021, 75% of newly diagnosed people were linked within one month.

Objective 2.2:

By the end of 2026, increase the percentage of PLWH in care to 95% by identifying, engaging, or re-engaging people who are not in care. In 2021, 88% of PLWH were engaged in care.

Objective 2.3:

Increase retention in care and adherence to HIV treatment in order to achieve and maintain long-term viral suppression of 95%. In 2021, 90% of PLWH were virally suppressed.

Objective 2.4:

By the end of 2026, increase the capacity of public health, health care delivery systems, and the health care workforce in order to increase retention in care to 90%. In 2021, 60% of PLWH were considered "retained in care."

Strategy 1: Implement initiatives to identify PLWH who are out of care and promote linkage to care programs.

Achieving improved health outcomes for PLWH begins with ensuring that they are promptly linked to effective HIV care and treatment upon diagnosis. Linkage to HIV care and treatment immediately or as early as possible following HIV diagnosis leads to clients reaching viral suppression more quickly. It also helps clients to be retained in care and maintain viral suppression over time. We must continue to support and build capacity in Linkage To Care programs. This includes fostering relationships with community partners and sharing resources that ensure people can begin receiving care and treatment within hours or days of their diagnosis, regardless of where in Wisconsin they live. Access to and participation in HIV medical care is an essential component for helping PLWH to achieve viral suppression and overall positive health outcomes. Clients who are successfully linked and retained in medical care and achieve viral suppression are less likely to transmit HIV than PLWH who are not engaged in medical care. HIV medical care includes:

- Diagnostic testing
- Risk assessment
- Preventive care and screening
- Diagnosis of common physical and mental health conditions
- Education and counseling on health issues
- Continuing care and management of chronic conditions
- Prescribing and managing medication therapies including antiretroviral therapy

Pharmacies and pharmacists are an example of community partners with whom Linkage To Care programs and providers can connect to increase capacity. Pharmacists' knowledge and accessibility to both urban and rural communities throughout Wisconsin can be leveraged as part of a comprehensive HIV prevention and care strategy to expand access to care and improve

population health. As trusted health care professionals, pharmacists develop a strong rapport with patients and serve as essential liaisons between patients and other members of the multidisciplinary care team. In addition, studies have shown that engaging pharmacists as key players in a care team can increase retention in care, adherence to antiretroviral therapy, and maintain viral suppression.

Activity 1A: Increase capacity of Linkage To Care specialists across Wisconsin.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Linkage To Care Specialists • People newly diagnosed with HIV or out of care for HIV	• HIV Care Unit staff • HIV care providers	Over the 5-year period during 2022 to 2026, and beyond	• People linked to care by a Linkage To Care specialist • Median time between the first contact with a Linkage To Care specialist and the first medical appointment

Activity 1B: Develop and share Linkage To Care resources.

Target Populations	Responsible Parties	Timeline	Data Indicators
People newly diagnosed with HIV or out of care for HIV	• Wisconsin HIV Program • CTR workforce • PS workforce • HIV care workforce	Over the 5-year period during 2022 to 2026, and beyond	• People linked to care by a Linkage To Care specialist • Median time between the first contact with a Linkage To Care specialist and the first medical appointment • Number of new and newly shared resources

Activity 1C: Connect Linkage To Care specialists with pharmacies and pharmacists across Wisconsin..

Target Populations	Responsible Parties	Timeline	Data Indicators
• Linkage To Care specialists • Pharmacists and pharmacy staff	Wisconsin HIV Program	Over the 5-year period during 2022 to 2026, and beyond	Connections made between Linkage To Care specialists and pharmacies

Activity 1D: Advance and improve data sharing practices with partners to ensure appropriate access to data for care and prevention.

Target Populations	Responsible Parties	Timeline	Data Indicators
Subrecipient agencies and other community partners	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	Increase the number and scope of data sharing agreements with partners

Activity 1E: Increase outreach capacity across Wisconsin.

Target Populations	Responsible Parties	Timeline	Data Indicators
HIV Care Workforce	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	• Number of staff providing outreach services • Number of clients reached through outreach services • Completion of training and development opportunities for outreach staff

Activity 1F: Support routine opt-out HIV testing in emergency departments throughout Wisconsin.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Emergency Departments and urgent care settings who have implemented or seek to implement routine opt-out HIV testing • PLWH who are not aware of their status	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	• Number of sites providing routine opt-out testing across Wisconsin • Number of PLWH who are newly diagnosed through routine opt-out HIV testing

Strategy 2: Increase access to core and support services and promote existing resources.

There are many people across Wisconsin and the country that are in need of resources but have trouble finding or accessing what they need. There are many reasons for this, including but not limited to a lack of awareness of available resources, an unclear understanding or explanation of resources and steps to access them, lack of transportation or child care, information only presented in English, or burdensome paperwork and processes.

In order to meet such needs and decrease barriers, we must work to promote and improve resources that are already available. This includes using online platforms and social media to post about events and services. Providing educational materials and ensuring transparency for clients and consumers can greatly improve client experience and outcomes.

Within DHS, there are many assistance and support programs that aim to reach and serve many of the intersecting populations that are disproportionately impacted by HIV. In order to promote and improve services and resources that are already available, we must foster collaboration and build partnerships with these programs to take advantage of our shared resources.

Activity 2A: Increase social media presence.

Target Populations	Responsible Parties	Timeline	Data Indicators
General public	Wisconsin HIV Program	Over the 5-year period during 2022 to 2026, and beyond	• Increase in number of posts on social media or networking sites • Increase in number of people reached through social media or networking posts

Activity 2B: Provide consumer-facing transparency and education about medication access.

Target Populations	Responsible Parties	Timeline	Data Indicators
Clients using and/or seeking pharmacy services	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	• Client satisfaction surveys • Educational resources about medication access

Activity 2C: Foster partnership and collaboration between the Wisconsin HIV Program and other DHS programs.

Target Populations	Responsible Parties	Timeline	Data Indicators
DHS programs and staff	Wisconsin HIV Program	Over the 5-year period during 2022 to 2026, and beyond	Increase the number and scope of collaborative projects and initiatives between the Wisconsin HIV Program and other DHS programs

Activity 2D: Expand opportunities for telehealth.

Target Populations	Responsible Parties	Timeline	Data Indicators
All PLWH	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	Increase in telehealth usage

Activity 2E: Increase access to and awareness of housing resources.

Target Populations	Responsible Parties	Timeline	Data Indicators
People who do not have access to safe and stable housing	• HIV Care providers • Housing opportunities for Persons with AIDS	Over the 5-year period during 2022 to 2026, and beyond	• Increase in the number of housing services provided • Needs assessment survey, indicators of unstable housing • Needs assessment survey, indicators of unsafe housing

Activity 2F: Address barriers to accessing care for older adults living with HIV.

Target Populations	Responsible Parties	Timeline	Data Indicators
PLWH who are 65 years and older	• HIV Care unit staff • Contracted agencies	Over the 5-year period during 2022 to 2026, and beyond	• Increase enrollment in Medicare • Drugs added to ADAP formulary that are associated with priority populations • Increased care access for priority populations

Strategy 3: Promote participation in ADAP.

ADAP is a program that ensures eligible clients have access to medications and insurance. People who are living with HIV in Wisconsin with an income below 300% of the federal poverty level may be eligible for the program. Currently, ADAP covers 111 different medications, including all FDA-approved antiretrovirals. Enrolled pharmacies across the state bill ADAP for the cost of covered medications less than any portion paid by the client's health insurance, if applicable. Then, ADAP reimburses pharmacies at the Medicaid specialty pharmacy drug reimbursement rate. During calendar year 2021, ADAP in Wisconsin served 1,398 individuals. For more information, see the ADAP webpage on the DHS website.

Activity 3A: Develop and implement ADAP online portal.

Target Populations	Responsible Parties	Timeline	Data Indicators
• ADAP clients • HIV Care providers	• HIV Care Unit staff • Contracted vendors	Over the 5-year period during 2022 to 2026, and beyond	• Date of contract award • Date of go-live for portal • Once live, number applying • How many recertifying

Activity 3B: Establish an ADAP Advisory Committee.

Target Populations	Responsible Parties	Timeline	Data Indicators
• ADAP clients • HIV Care providers	• HIV Care Unit staff • Contracted vendors	Over the 5-year period during 2022 to 2026, and beyond	• Date of contract award • Date of go-live for portal • Once live, number applying • How many recertifying

Activity 3C: Improve ADAP webpages to include additional resources for people using ADAP.

Target Populations	Responsible Parties	Timeline	Data Indicators
• ADAP clients • HIV Care providers	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	Increased number of resources and links added to the ADAP webpage

Strategy 4: Encourage trauma-informed approaches that retain and sustain the HIV workforce.

The HIV workforce consists of highly dedicated individuals with a wealth of knowledge and a large capacity for compassion. It is important to encourage healthy work-life balance, foster reasonable flexibility, and promote personal well-being to ensure that staff can support clients and themselves. Implementing and promoting trauma-informed approaches and education will help to reduce burnout, compassion fatigue, and vicarious trauma experienced by providers.

Activity 4A: Explore innovative strategies to reduce burnout.

Target Populations	Responsible Parties	Timeline	Data Indicators
HIV, STI, and harm reduction providers	• Wisconsin HIV Program • UW HIV Training System	Over the 5-year period during 2022 to 2026, and beyond	• Turnover rates at agencies • Staff responses to climate surveys

Activity 4B: Create agency-specific plans to implement trauma-informed approaches.

Target Populations	Responsible Parties	Timeline	Data Indicators
HIV care program managers	HIV Care Unit staff	Over the 5-year period during 2022 to 2026, and beyond	• Status of plans • Updates on implementation of plans

Activity 4C: Offer routine training on trauma-informed approaches, trauma-informed care, and harm reduction strategies.

Target Populations	Responsible Parties	Timeline	Data Indicators
HIV, STI, and harm reduction providers	• CDHR Section • UW HIV Training System	Over the 5-year period during 2022 to 2026, and beyond	• Number of attendees at trainings • Post-training surveys and feedback forms

Goal 3: Reduce HIV-related disparities and health inequities.

Target Populations	Responsible Parties	Timeline
• Black and Brown people of trans experience and non-binary/gender non-conforming persons • Black women • People living in the southeastern region of Wisconsin • Same-gender loving men of color • Black, Brown, Latinx, and Indigenous people • People who use drugs	• Wisconsin HIV Program • Local and Tribal health departments • Clinical and non-clinical community-based agencies funded to provide HIV prevention services • SAPG	Over the 5-year period during 2022 to 2026, and beyond

Objective 3.1:

Reduce disparities in new HIV infections. Between 2017 and 2020, new diagnoses were more likely to occur amongst those with lower income compared to those with higher income, those with less than a high school diploma compared to those with a high school diploma or higher education, and those without health insurance compared to those with health insurance.

Objective 3.2:

Reduce disparities along the HIV Care Continuum. In 2017, there was a difference in retention in care between white men who have sex with men compared to Hispanic/Latinx men who have sex with men, and younger people compared to older people. Also, in 2017, there was a difference in viral suppression between Black men who have sex with men compared to white men who have sex with men, and younger people compared to older people.

Objective 3.3:

Address social determinants of health that impede access to HIV services and exacerbate HIV-related disparities. When PLWH face greater negative impact from social determinants of health, their engagement in care and viral suppression decreases. Additionally, as the negative impacts of social determinants of health increase, new HIV diagnoses increase.

Strategy 1: Engage peer programs and promote community-led and community-based initiatives.

While community engagement is a primary area of focus, engagement specifically with people who have relevant lived experiences plays an essential role in ending HIV in Wisconsin. Engaging those most impacted by HIV provides opportunities for them to describe their experiences in a way that makes them experts on their own experiences. People with lived experiences are context experts. When they are able to tell their stories, it allows us to gain a true perspective on the unique challenges surrounding their communities. It can also show what resources and services are needed to make more equitable opportunities available that would allow community members to educate, support, advocate, and link people who have been mistreated by public health and health care systems to care.

Activity 1A: Utilize community leaders and other models for paid peer engagement by people from communities most impacted to educate, support, advocate, and link people who have been mistreated by public health and health care systems to care.

Activity 1B: Support and strengthen peer programs.

Activity 1C: Explore community engagement strategies led by SAPG.

Activity 1D: Prioritize collaboration with community partners outside of HIV systems to provide holistic and comprehensive care.

Strategy 2: Improve health care access for all.

While we have made many advances, people continue to struggle with access to needed health care services and resources. Even people who can afford care often have a hard time accessing it. This may be because the person cannot find a primary care or specialty care provider accepting new patients. There may be long wait times for appointments or the provider may be too far away, leading to difficulties with transportation, child care or taking time off work. Additionally, the provider may not speak their language or understand cultural differences in care preferences.

During a listening session, trans people stated that they are constantly put in the position of educating providers about what it means to be trans and often field invasive questions that have little to do with the presenting medical issue or concern. Switching providers means having to begin this process all over again. This can be exhausting and ultimately prevent people from seeking care. In addition, they may have had negative experiences that make them not want to seek care except in emergencies. Reports of mistreatment in medical settings are especially common among BIPOC

individuals, people who use drugs, LGBTQ+ people, people who are unhoused, and people whose first language is not English. To ensure proper and supportive health care access for everyone living in Wisconsin, we must increase access by removing barriers to care, with a focus on serving people less likely to seek care in clinical settings.

Activity 2A: Coordinate trainings focused on addressing social determinants of health and other barriers that impede access to HIV services and exacerbate HIV-related disparities.

Activity 2B: Increase visibility and access to care statewide through telemedicine, mobile health care, and at-home testing programs.

Strategy 3: Prioritize economic justice.

Jha and Lavery (2004) stated that the greatest health hazard is in fact the economic gap between the rich and the poor. According to population health studies, the primary determinant of health within a country is societal structure, especially the degree of hierarchy as measured by income distribution. They also indicate that not only is the health of a population related to income, but at any given level of overall economic development for a country or a region within a country, the populations of countries and regions with smaller gaps between rich and poor are, in general, healthier than the populations of countries and regions where the gap is larger.

According to the Public Policy Institute, there are many reasons for these differences, including low-paying jobs, gaps in employment due to incarceration, disparities in education, limited job opportunities, and discrimination in the labor market.

Unfortunately, the COVID-19 pandemic and mpox outbreak has only made these disparities worse. These types of economic inequalities have direct implications for HIV, HCV, and STIs and become a barrier to accessing proper care and other services.

To ensure economic justice is at the forefront of the work that we do, we must increase access to care for people with low or no income. It will also require improving the economic well-being of all people living in Wisconsin so that they have equitable access to be healthy.

Activity 3A: Create pathways to employment for people from communities most impacted by HIV, HCV, and STIs, including but not limited to offering paid internships, reducing barriers like unnecessary educational requirements, and entry-level positions with clear opportunities for professional advancement.

Activity 3B: Prioritize funding for programs that employ people with lived experience in the communities served, programs that demonstrate frontline staff are paid a living wage, and/or programs that have BIPOC serving in meaningful leadership positions.

Activity 3C: Examine state and local health jurisdiction hiring practices to promote equity and inclusion, to remove barriers such as advanced degree requirements, to offer extra pay to people who speak languages other than English, or who have lived experience with HIV, HCV, STIs, substance use, mental health challenges, and/or housing insecurity.

Goal 4: Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and interested parties.

Objective 4.1:

Ensure voices of lived experience guide system-level improvements and inform best practice and decision making within HIV programs across governmental, public, private, faith-based, clinic-based, community-based, and academic spaces.

Objective 4.2:

Improve coordination of HIV services through cross-public health sector collaboration, elevate the HIV workforce through professional development and capacity-building strategies, and increase partner accountability through data collection and analysis.

Objective 4.3:

Improve mechanisms to measure, monitor, evaluate, report progress, and make changes in order to achieve the goals and objectives set forth.

Strategy 1: Achieve effective and holistic community engagement, leadership, and capacity building.

Incorporating community voices and community engagements are essential components of our plan to end HIV in Wisconsin. This can be achieved by:

- Increasing collaborative efforts among grantee and other community partners.
- Continuous listening sessions and focus groups that center the voices of communities disproportionately affected by HIV, STIs, HCV, and other social determinants of health.
- Building capacity and providing leadership positions for communities disproportionately affected by HIV, STIs, HCV, and other social determinants of health.

To achieve effective community engagement holistically, we must understand its importance and ability to enhance day-to-day realities of populations most impacted by HIV. This includes hosting on-going meetings and creating spaces for meaningful conversations on ways to uplift and elevate the voices of community. While doing so, we can start to identify effective ways to address barriers to accessing HIV prevention, care, and treatment. This also creates opportunities to unfold underlying social determinants of health and expand opportunities for personal and professional development.

Activity 1A: Recruit, retain, and support current and emerging leaders of disproportionately affected communities to apply for and serve as SAPG members, while simultaneously building public awareness of SAPG.

- Continue outreach efforts to raise awareness of SAPG member application opportunities and selection processes.
- Promote SAPG opportunities through statewide and local events, such as PrideFest, as well as social media and marketing campaigns.
- Identify passive education opportunities, such as newsletters, to build awareness and disseminate updates to partners.
- Engage youth leaders and elevate youth voices in new ways.
- Incorporate stigma-reduction strategies in awareness-building and engagement opportunities.
- Equip SAPG members with the data, resources, and tools they need to best serve and report-out to their communities.

Target Populations	Responsible Parties	Timeline	Data Indicators
• SAPG members • Potential SAPG members and other leaders in communities that are not formally engaged with SAPG efforts • Tribal partners • Youth leaders • Communities disproportionately impacted by HIV	• CDHR Section • Contacted agencies	Over the 5-year period during 2022 to 2026, and beyond	• Quarterly SAPG meeting report-outs • Annual discussions and updates on Integrated Plan progress

Activity 1B: Participate in external partnerships to bolster the professional development of SAPG Members and other community leaders.

- Identify external funding opportunities to support travel and conference registration for SAPG Members and other non-state staff.
- Promote involvement in NASTAD, AIDSUnited, National Minority AIDS Council (NMAC), and HealthHIV listservs to offer external training opportunities.
- Offer mental health resources, in conjunction with more traditional professional development, to SAPG members and community leaders.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Parallel public health fields and program areas • Contracted agencies • SAPG members • Tribal partners • Community organizations	• CDHR Section • Contracted agencies • National organization contacts and partners	Over the 5-year period during 2022 to 2026, and beyond	• Trainings conducted and participant evaluations • New training curricula developed and offered • Other events and webinars offered through national partners and platforms.

Activity 1C: Support and enhance collaborative efforts among community partners in addressing social determinants of health and factors that contribute to HIV-related disparities.

Activity 1D: Meaningfully and consistently involve PLWH, HCV, and/or STIs in local and statewide planning, decision-making, and service delivery.

Activity 1E: Collaborate and engage with faith-based organizations and initiatives to address disparities within communities of color.

Activity 1F: Continue momentum and engagement practices of the SAPG.

- Maintain the SAPG venue to actively engage with and collect input from HIV prevention and care experts across the state.
- Maintain strong representation of communities impacted by HIV that serve as SAPG members.
- Improve the process of reporting-out SAPG meeting minutes to a larger audience of state staff, specifically the Harm Reduction Section staff and Division of Public Health (DPH) leadership team.
- Streamline meeting notes and sharing to all SAPG Members that are unable to attend a meeting, ensuring their feedback is incorporated into all decision making.
- Restore SAPG subcommittees and work groups.

Activity 1G: Coordinate and integrate SAPG planning with other public health planning processes.

- Take advantage of the unique opportunity to merge planning SAPG planning processes with other coordinating bodies and strategic planning processes that include, but are not limited to:
    - ◊ Wisconsin DHS State Health Improvement Plan
    - ◊ Wisconsin DHS Hepatis Elimination Planning
    - ◊ Wisconsin DHS Drug User Health Plan
    - ◊ Wisconsin State Council on Alcohol and Other Drug Abuse
    - ◊ Wisconsin DHS National Sexually Transmitted Infection strategies
    - ◊ Wisconsin DHS Harm Reduction strategy development
    - ◊ Statewide Trauma-Informed Care planning
- Summarize parallel planning processes annually to SAPG Members and communities to raise awareness of the supporting strategic plans and resources that exist in Wisconsin.
- Actively invite and engage other public health partners, faith-based communities, and Tribal leaders to incorporate relatable topic area expertise into SAPG planning and vice versa.
- Monitor how public funding aligns with the larger strategic plans of multiple public health areas.

Activity 1H: Equip SAPG members with advocacy tools and communication channels that elevate the vision and mission within and outside SAPG spaces.

- Identify opportunities for SAPG members to extend the SAPG work into other professional spaces through sub-committee creation and access to larger public health communication channels.
- Foster relationships with non-SAPG allies across the HIV prevention and Care Continuum.
- Support SAPG to serve as a conduit of community voice, providing members with additional advocacy and media training.

Strategy 2: Support program integration and coordination.

Enhance program integration and coordination through information sharing and peer technical assistance across jurisdictions that dismantle silos and move effective interventions into practice more swiftly.

Activity 2A: Ensure coordinated service delivery through macro-system program and policy improvement.

- Elevate priority populations at the systemic level to have optimal impact and improved health outcomes.
- Develop and disseminate guidance for local and regional-level providers to abide by state, federal, and funding requirements, while following best-practice and evidence-based recommendations.
- Identify non-engaged partner agencies and target collaboration invitations to partners that have yet to be involved in HIV, HCV, STI, and other harm reduction planning efforts.
- Prioritize collaboration among macro-system policy makers within:
    - Wisconsin Department of Corrections (DOC)
    - Wisconsin DPI
    - Wisconsin DHS Division of Medicaid Services (DMS)
    - Wisconsin State Laboratory of Hygiene (WSLH)
    - Wisconsin Association of Local Health Departments (WALHDAB)
- Avoid repeating and/or competing efforts across units, sections, bureaus, and divisions within DHS, while supporting cross-state agency work to align programming that is negatively impacted by duplicative efforts.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Tribal partners • Community partners • Contracted agencies • Federal funders • State funders	• CDHR Section • SAPG members	Over the 5-year period during 2022 to 2026, and beyond	• Landscape assessment of current macro-system collaborations • Quality improvement plans • Training and technical assistance plans

Activity 2B: Foster public and private/non-profit/community partnerships across the HIV prevention and Care Continuum.

- Build upon momentum of pandemic-driven collaborations, working groups, and resource development to continue the acceleration of public and private partnerships.
- Maintain virtual meeting and collaboration opportunities, introduced over the course of the pandemic, to continue improved accessibility of engagement.
- Address organizational barriers, such as detrimental workplace culture or biases, that prevent open communication between an array of agencies.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Private, non-profit, and other community organizations • Tribal partners • Other state agencies	CDHR Section	Over the 5-year period during 2022 to 2026, and beyond	• Landscape assessment of current partnerships and annual follow-up of progress • Virtual meetings and meeting accessibility participant feedback

Activity 2C: Streamline the HIV prevention and care community member experience through accessible and clear processes, language, and triages.

- Target and eliminate the "run-around" that community members or professionals experience when attempting to access care and services through call centers or triages through improved crosswalks, referral directions, and broader education of staff that take calls or in-person questions.
- Train system partners on the crosswalk and referral process when working directly with clients to ensure accurate contact information and action steps are provided to callers or in-person questions.
- Identify crossover services, such as Naloxone and Narcan distribution and/or HCV medication, to expand services that HIV prevention and care service providers offer their communities.
- Enhance partnership with the Office of the Commissioner of Insurance (OCI) and Housing Opportunities for People with AIDS (HOPWA) through DOA.

Target Populations	Responsible Parties	Timeline	Data Indicators
• All community members and professionals accessing HIV prevention and care services • Service providers involved in triages for community members to access HIV prevention and care services	• CDHR Section • Contracted agencies • Tribal partners • SAPG members • OCI • HOPWA • DOA	Over the 5-year period during 2022 to 2026, and beyond	• Crosswalk and other resource development, completion, and dissemination • Implementation tracking of resources to improve and streamline the community member experience of accessing services and care

Strategy 3: Engage in research.

Research that evaluates the performance of HIV prevention and care programs must be monitored and integrated into policy and program improvements. Research projects must ensure that the results, tools, and products developed from the research are disseminated effectively to reach affected communities.

Activity 3A: Conduct frequent needs assessments to guide and update HIV prevention and care research priorities.

- Expand the feedback gathered beyond currently engaged partners (for example, SAPG members) and identify opportunities to survey impacted communities through avenues outside of SAPG.
- As pandemic priorities paused an array of research, updated needs assessments will be critical to direct funding and resource-development decisions through research.
- Ensure research projects support the goals, objectives, strategies, and activities of the Integrated HIV Prevention and Care Plan.
- Utilize the Vital Strategies position to conduct and evaluate needs assessments.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Community partners • Tribal partners • Contracted agencies • SAPG members	• CDHR Section • Academic and research partners	Over the 5-year period during 2022 to 2026, and beyond	• Needs assessment development, dissemination, and results • Research designs and findings • Implementation tracking of research findings recommendations and resources developed

Activity 3B: Maximize the system-change recommendations of research findings by integrating larger public health and social determinants of health data.

- Support research projects that evaluate and improve the performance of HIV prevention and care programs across the state on a large-scale level.
- Ensure research projects are culturally and linguistically appropriate.
- De-identify and summarize research results in conjunction with other public health data available and applicable.
- Present and re-introduce findings in relevant initiatives to promote system-level changes.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Other states • National organizations	• CDHR Section • SAPG members • Academic and research partners	Over the 5-year period during 2022 to 2026, and beyond	• National benchmarks • Cross-state program and data comparison

Strategy 4: Ensure accountability.

Project monitoring and improvement, in conjunction with strengthening the data infrastructure of Wisconsin, will be necessary to track progress, outcomes, and quality improvement recommendations for improving HIV prevention and care services across the state.

Activity 4A: Make program data accessible to influence positive change and quality assurance efforts.

- Ensure health disparity data is captured, summarized, and disseminated to contracted agencies and partners.
- Present data in interactive ways (for example, with Tableau) in comparison to traditional spreadsheet tracking.
- Include diverse experiences and representation in research designs and the process in which research is conducted.
- Enhance accessibility to data, in addition to more individualized data to bolster community partner abilities to prioritize special provisions in contracts.
- Ensure processes to allocate funding and resources are data-driven, equity-focused, and inclusive of input from members of communities most impacted by HIV.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Community partners • Contracted agencies	• CDHR Section • WEDSS • Academic and research partners • SAPG members	Over the 5-year period during 2022 to 2026, and beyond	• Introduction and implementation of WEDSS • Data reports analyzed and disseminated

Activity 4B: Report out the progress made toward the goals, objectives, strategies, and activities of the Wisconsin DHS Integrated Plan, in conjunction with course correction recommendations.

- Develop a system of contract monitoring that demonstrates the progress in meeting the Wisconsin DHS Integrated Plan goals and objectives.
- Ensure funded agencies have evaluation, quality assurance metrics, and quality improvement plans as part of their overall work plans.
- Provide SAPG Members and contracted agencies updates on progress, challenges, and emerging priorities.
- Incorporate client feedback and satisfaction surveys to improve accountability within the assessment and program improvement process.
- Offer training and technical assistance for contracted agencies to utilize epidemiological and program data to improve program design.
- Strive for consistency and integration within the HIV prevention and care units in regard to contracts, scopes of work, and other agreements with external organizations.

Target Populations	Responsible Parties	Timeline	Data Indicators
• Contracted agencies • Community partners • Federal funders • State funders	• CDHR Section • WEDSS • Contracted agencies • SAPG members	Over 5-year period during 2022 to 2026, and beyond	• Quality assurance and quality improvement plans and metrics • Training and technical assistance plans • Client satisfaction surveys

Section V References

American Public Health Association. (n.d.) Racial equity & public health. https://www.apha.org/-/media/Files/PDF/advocacy/SPEAK/210825_Racial_Equity_Fact_Sheet.ashx

Jha, P., & Lavery, J. V. (2004). Social and economic justice: the road to health. *CMAJ : Canadian Medical Association Journal*, *171*(9), 1021–1022. https://doi.org/10.1503/cmaj.1041238

Section VI: Implementation, Monitoring, and Jurisdictional Follow Up

Achieving the goals described in this plan requires engagement and commitment from partners and people across Wisconsin including:

- State agencies
- Local and Tribal health departments
- Health care systems and providers
- Schools and other academic institutions
- Community-based and faith-based organizations
- People living with and impacted by HIV, STIs, and viral hepatitis

This section outlines our commitment to implement the goals, objectives, strategies, and activities described earlier in this plan. Additionally, it outlines our plan to consistently monitor, evaluate, and share our progress. These activities are necessary in order to make sustainable impacts, improve the health outcomes and lives of PLWH, address health disparities, and ensure that programs and activities are promoting the health and wellbeing of communities that are disproportionately impacted.

By building on lessons learned and valuable input from partners, community members, and providers, we have the opportunity to end the HIV epidemic in Wisconsin. The information in this section outlines the ways that we intend to monitor, evaluate, and improve along the way.

Implementation

The Wisconsin HIV Program will be responsible for coordinating activities with partners and identifying opportunities to align and accelerate efforts. The Wisconsin HIV Program will apply lessons learned from contributing data, like the comprehensive needs assessment and input from the SAPG to ensure that actions reflect the knowledge gained and the needs of people most impacted by HIV. Additionally, the Wisconsin HIV Program will form an internal workgroup that meets quarterly to monitor implementation of the plan and chart progress towards goals and objectives.

External partners will also form a workgroup that includes people living with or impacted by HIV, members of the SAPG, staff and providers from HIV prevention and care subrecipient agencies, and LTHDs. The workgroup will meet regularly to monitor implementation of the plan and ensure the

activities, strategies, objectives, and goals outlined in the plan are being prioritized and progressing.

Furthermore, the upcoming request for application (RFA) process used to award prevention and care grant funding will be informed and guided by the plan. The RFA determines what organizations and services receive funding, what amounts of funding are awarded, and what requirements and restrictions are placed on those receiving the funding.

Evaluation

The activities detailed in the plan are ultimately intended to help meet the objectives set for each goal.

Goal 1: Prevent new infections.

- **Objective 1.1:** By the end of 2026, reduce the number of new HIV diagnoses by at least 40%.
- **Objective 1.2:** By the end of 2026, increase the percent of PLWH who know their status to at least 95%.
- **Objective 1.3:** By the end of 2026, increase PrEP coverage to at least 50% of all people who could benefit from the medication.

Goal 2: Improve HIV-related health outcomes of people with HIV.

- **Objective 2.1:** By the end of 2026, increase the percentage of newly diagnosed people linked to HIV medical care within one month of their diagnosis to 95% and provide low-barrier access to HIV treatment.
- **Objective 2.2:** By the end of 2026, increase the percentage of PLWH in care to 95% by identifying, engaging, or re-engaging people who are not in care.
- **Objective 2.3:** Increase retention in care and adherence to HIV treatment in order to achieve and maintain long-term viral suppression of 95%.
- **Objective 2.4:** By the end of 2026, increase the capacity of the public health, health care delivery systems, and health care workforce to help increase retention in care to 90%.

Goal 3: Reduce HIV-related disparities and health inequities.

- **Objective 3.1:** Reduce disparities in new HIV infections.
- **Objective 3.2:** Reduce disparities along HIV Care Continuum.
- **Objective 3.3:** Address social and structural determinants of health that impede access to HIV services and exacerbate HIV-related disparities.

Goal 4: Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and interested parties.

- **Objective 4.1:** Ensure voices of lived experience guide system-level improvements and inform best practice and decision making within HIV programs across governmental, public, private,

faith-based, clinic-based, community-based, and academic spaces.

- **Objective 4.2:** Improve coordination of HIV services through cross-public health sector collaboration, elevate the HIV workforce through professional development and capacity-building strategies, and increase partner accountability through data collection and analysis.
- **Objective 4.3:** Improve mechanisms to measure, monitor, evaluate, and report progress and make changes in order to achieve the goals and objectives set forth.

In addition to the objectives, every activity within each of the strategies has an associated data indicator, which will be used to document progress. Many of the indicators are process measures and therefore may more directly reflect the actual implementation of the plan's activities. These indicators will play a crucial role in documenting successes. Select indicators that best describe the work that has been done to implement the plan's activities will be included in the progress reports described in the monitoring section above.

The HIV Care Continuum is also a direct indicator of the success of the plan's implementation and the status of HIV care in Wisconsin. Wisconsin's HIV Care Continuum is updated annually, and is included in the annual HIV surveillance report and many other presentations each year. Not only will the HIV Care Continuum data be used to evaluate progress overall, but particularly when looking at improving access to care, improving health outcomes, and reducing health disparities.

Improvement

Data that is collected through plan monitoring and evaluation processes will be utilized to make revisions and improvements to the plan. The plan will be considered a "living document" and revisions can be made at any time throughout the years covered in the plan. The workgroup responsible for monitoring and evaluating the plan will determine what revisions will be made.

Furthermore, the Wisconsin HIV Program intends to complete routine needs assessments outside of the Integrated Planning cycle, to ensure the needs of communities most impacted are prioritized and the plan reflects activities and strategies that are relevant, trauma-informed, and culturally competent.

Reporting and Dissemination

The information collected during workgroup meetings described in the monitoring section will be distributed through widely shared progress reports. The reports will include progress towards goals and objectives, including indicators for activities that best describe the work that has be done to implement the plan's activities.

Workgroup participants will take the knowledge gained back to share with colleagues and consider improvements, innovative activities, and new partners to engage in efforts to meet the plan's goals and objectives.

Section VII: Letter from Wisconsin Statewide Action Planning Group

Tony Evers
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

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U.S. Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV Prevention, Program Development and Implementation Branch (PDIB) and HIV Surveillance Branch (HSB)
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Atlanta, GA 30329-4018

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

The SAPG has reviewed the Wisconsin Integrated HIV Prevention and Care Plan 2022-2026 submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The SAPG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV Program legislation and program guidance.

The SAPG collaborated closely with the Wisconsin HIV Program in the development of the Integrated HIV Plan. Meetings of the SAPG were a major venue for facilitating stakeholder and community member involvement in the development of the Integrated HIV Plan. During SAPG meetings in 2021 and 2022, content experts and others familiar with HIV prevention and care services in Wisconsin gave brief overviews of related services and activities. This was followed by group discussions facilitated by Wisconsin HIV Program staff who posed general questions to the groups to help frame discussions. Group discussions and feedback from SAPG members, as well as SAPG member involvement in needs assessment activities, helped shape and inform the development of objectives and priorities for the Wisconsin 2022-2026 Integrated Plan.

The signatures below confirm the concurrence of the planning body with the Wisconsin Integrated HIV Prevention and Care Plan 2022-2026.

Elle Halo & Justin Roby
Statewide Action Planning Group
Community Co-Chairs

Elle Halo

Syd Robinson & Rachel Welsh
Statewide Action Planning Group
Health Department Co-Chairs

Syd Robinson
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Funding Opportunity Announcement
HIV Prevention and Care Integrated Resource Inventory

Project Description

The Wisconsin HIV Program is requesting proposals to organize a written HIV Prevention, Care, and Treatment Resource Inventory for the State of Wisconsin. The Resource Inventory is a key component of the *Wisconsin Integrated HIV Prevention and Care Plan*, which is in the process of being developed for 2022-2026. You can find the previous *Wisconsin Integrated HIV Prevention and Care Plan: Envisioning and End to the HIV Epidemic* for 2017-2021, which includes an example of a Resource Inventory, here: https://www.dhs.wisconsin.gov/publications/p01582.pdf

Per the guidance and expectations received from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), the HIV Prevention, Care, and Treatment Resource Inventory must include the following information:

- Name and location(s) of all organizations and agencies providing HIV care and prevention services in Wisconsin
- Funding sources and amounts from each source dedicated to HIV prevention, care, and treatment services at each organization and agency identified that is providing these services. This includes, but is not limited to, CDC, HRSA, other public funds, private funds, foundation funds, SAMHSA, and Indian Health Service funds.
- Description of the strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services at organizations and agencies (if applicable)
- Names of services and activities provided by each organization and agency identified related to HIV prevention, care, and treatment (i.e. HIV testing, case management, etc.)
- Names of priority populations each organization or agency serves (i.e. gay and bisexual men of color, people who use drugs)
- Description of how each service will maximize the quality of health and support services for people at-risk for or living with HIV

The content can be organized in a table, diagram, or narrative format, or some combination of different formats. The information should be gathered by creating a questionnaire or survey that includes questions about each of the required items for the Resource Inventory. The project will be divided into two phases- the information-gathering phase and the assembling phase.

Project Timeline

Information-Gathering Phase: October 1, 2021 – December 31, 2021

During the information-gathering phase, the funded recipient must develop a questionnaire or survey tool they will use to gather the required information from organizations or agencies providing HIV prevention, care, or treatment services in Wisconsin. They must also research and identify contact information for each organization or agency providing services, and send out the questionnaire or survey tool. The recipient must then collect the questionnaire or survey responses by a designated deadline. During this phase, the recipient will be working closely with staff from the Wisconsin HIV Program in the Division of Public Health.

Assembling Phase: January 1, 2022 – April 1, 2022

During the assembling phase, the funded recipient will organize all the information they received from organizations or agencies providing HIV prevention, care, or treatment services in Wisconsin and conduct any follow-up with these organizations or agencies as needed to ensure information is complete and comprehensive. The funded recipient will assemble the information into a comprehensive report that includes all of the required information listed in the 'Project Description' section of this funding announcement. The report can include a table, diagram, narrative, or some combination of formats.

Maximum Award

Information-Gathering Phase: $25,000

Assembling Phase: $25,000

Required Deliverables

Information-Gathering Phase: By November 8, 2021, the funded recipient must provide staff from the Wisconsin HIV Program the survey or questionnaire they will use to gather information from organizations and agencies. Upon approval of the survey or questionnaire, the recipient must work with staff from the Wisconsin HIV Program to compile a list of contacts at each agency or organization they expect to complete the survey or questionnaire.

Implementation Phase: By April 1, 2022, the funded recipient must provide a detailed final resource inventory that addresses each of the six areas identified by CDC and HRSA for inclusion in the Wisconsin Integrated HIV Prevention and Care Plan, 2022-2026. The resource inventory must include all of the elements identified in the 'Project Description' section of this FOA and can be organized as a table, diagram, narrative, or some combination of formats.

Eligibility Criteria

In order to be eligible for this funding opportunity, applicants must meet the following criteria. Applicants must provide a detailed description of how they meet each criterion in their proposal.

- Understanding of HIV care, treatment, and prevention services provided in Wisconsin in both clinical and non-clinical settings
- Basic knowledge of agencies and community-based organizations serving people living with and impacted by HIV in Wisconsin
- Experience organizing surveys or questionnaires and putting together complex reports with multiple layers of information
- Ability to conduct research and gather information on sites statewide that provide services
- Ability to communicate effectively with different stakeholder groups (clinical sites, non-clinical community-based sites, state health department staff)

Submitting a Proposal

Proposals should be **no more than 10 pages** and must include the following components:

- **Project proposal narrative:** Narrative must include proposed methods to create the resource inventory, a description of how the applicant fulfills the eligibility criteria, and a timeline for completing the project.
- **Budgets:** Applicants must submit one budget that is inclusive of both the information-gathering phase and the implementation phase.
- **Budget narrative:** The budget narrative may be combined for both the information-gathering and implementation phases.
- **Letters of agreements/Memoranda of Understanding** (not counted toward the page limit): Only if the recipient is planning on working with a consultant or external team/agency.

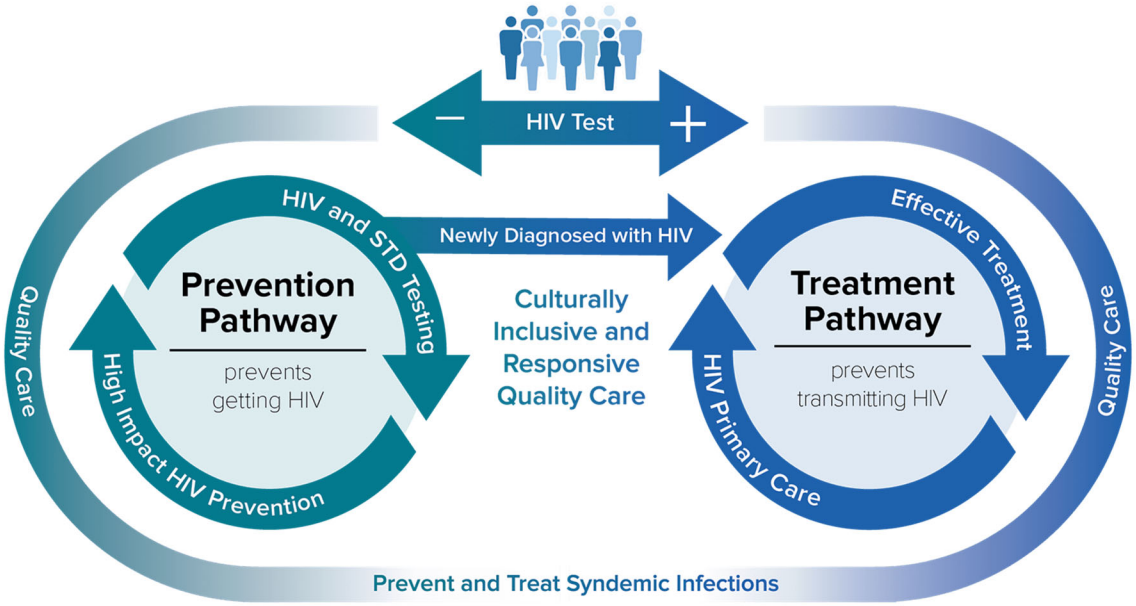
Deadline: Proposals are **due by September 20, 2021 at 11:59 PM CST.** Late applications will not be accepted. The successful applicant will be notified of their award by Tuesday, September 28, 2021.

Submit proposals via email to DHSGranteeHIV@dhs.wisconsin.gov. Questions may also be submitted to this email address.

Appendix II: Implementation of a Status-Neutral Approach

Status Neutral HIV Prevention and Care

People whose HIV tests are negative are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.



People whose HIV tests are positive enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

Source: https://www.cdc.gov/hiv/effective-interventions/prevent/status-neutral-hiv-prevention-and-care/index.html

Appendix III: HIV Prevention, Care and Treatment Resource Inventory

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	Diagnose	Treat	Prevent	Respond
State of Wisconsin	State General Purpose Revenue	Vivent Health	$4,000,000.00	-	Medical Case Management, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Legal Services		✓		
State of Wisconsin	State General Purpose Revenue	Wisconsin Department of Health Services	$1,306,200.00	-	AIDS/HIV Drug Assistance Program		✓		
HRSA	Ryan White HIV/AIDS Program Part B	Wisconsin Department of Health Services	$8,401,316.00	Legal Aid Society of Milwaukee, Medical College of Wisconsin, Sixteenth Street Community Health Centers, UW Hospitals and Clinics	AIDS/HIV Drug Assistance Program, Health Insurance Premium and Cost Sharing Assistance, Home and Community-Based Services, Medical Case Management, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Use Disorder Outpatient Care, Legal Services, Medical Transportation, Referral for Health Care and Support Services, Minority AIDS Initiative Outreach		✓		
340B Rebate	340B Rebate	Wisconsin Department of Health Services	$538,945.00	Medical College of Wisconsin, UW Hospitals and Clinics, Diverse and Resilient, Sixteenth Street Community Health Centers	Early Intervention Services, Mental Health Services, Emergency Financial Assistance, Housing, Medical Transportation		✓		✓
340B Rebate	340B Rebate	Wisconsin Department of Health Services	$4,217,893.00	Vivent Health, Milwaukee Health Services Inc.	Health Insurance Premium and Cost Sharing Assistance, Home and Community-Based Services, Medical Case Management, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Use Disorder Outpatient Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Legal Services, Medical Transportation, Non-Medical Case Management Services, Referral for Health Care and Support Services				
HRSA	Ryan White ADAP Carryover	Wisconsin Department of Health Services	$3,479,738.00	-	AIDS/HIV Drug Assistance Program		✓		✓
340B Rebate	340B Rebate	Wisconsin Department of Health Services	$11,348,001.00	-	AIDS/HIV Drug Assistance Program		✓		✓
HRSA	Ryan White Part B Supplemental	Wisconsin Department of Health Services	$739,686.00	Vivent Health	Oral Health Care, Outpatient/Ambulatory Health Services, Substance Use Disorder Outpatient Care		✓		✓
340B Rebate	340B Rebate	Wisconsin Department of Health Services	$200,000.00	Brown County HHSD, Eau Claire City/Co HD, Kenosha Count Div of Health, LaCrosse Co HD, Marathon Co HD, Price Co DHSS, Racine City HD, Rock Co pHD, Waukesha Co PHD CC, Winnebago CO HD	Partner services		✓	✓	
HRSA	Ryan White COVID-19 Funding	Wisconsin Department of Health Services	$478,980.00	Vivent Health, Medical College of Wisconsin, Sixteenth Street Community Health Centers, Diverse and Resilient, University of Wisconsin-Madison Department of Continuing Studies	Early Intervention Services, Medical Case Management, Mental Health Services, Outpatient/Ambulatory Health Services, Emergency Financial Assistance, Housing, Medical Transportation, Capacity Building/Technical Assistance		✓		
340B Rebate	340B Rebate	Wisconsin Department of Health Services	$377,101.00	BESTD Clinic, Diverse and Resilient, Holton Street Clinic, Sixteenth Street Community Health Centers, UMOS	Testing	✓		✓	
CDC	Integrated HIV Surveillance and Prevention Programs for Health Departments	Wisconsin DHS	$2,384,516.00	Benedict Center, Black Health Coalition of Wisconsin, Diverse and Resilient, Health Connections Inc, Holton Street Clinic, Medical College of Wisconsin, OutReach Inc, Planned Parenthood of Wisconsin, Sixteenth Street Community Health Centers, UMOS, UW Health, University of Wisconsin Madison Division of Continuing Studies, Tribal Health Departments, Milwaukee Health Department, PHMDC	Outreach Services, Capacity building/technical assistance, Community engagement, Community mobilization, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, PrEP delivery, Social media strategies, Surveillance, Syringe services programs	✓		✓	
State of Wisconsin	State General Purpose Revenue	Vivent Health	$825,780.00	-	Community engagement, Community mobilization, Condom distribution, PrEP delivery, Prevention for persons living with HIV, Social marketing campaigns, Social media strategies, Syringe services programs, Testing	✓		✓	
State of Wisconsin	State General Purpose Revenue	Wisconsin Department of Health Services	$113,000.00	-	Testing	✓			

Appendix IV: Detailed Objectives

Goal 1: Prevent new HIV infections.

Objective 1.1: By the end of 2026, reduce the number of new HIV diagnoses by at least 40%. In 2017, there were 235 new diagnoses.

Baseline Year: 2017

Numerator: The three-year average of the number of new HIV diagnoses among persons of all ages during the calendar year and two preceding years.

Denominator: None

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV diagnosis data may not be representative of all people living with HIV in Wisconsin, as not all people have been tested or diagnosed.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
235*	232*	230*	213*	227*	234	237	217	196	176

*actual value

Objective 1.2: By the end of 2026, increase the percent of people living with HIV who know their status from 85% in 2017 to at least 95%.

Baseline Year: 2017

Numerator: Number of persons ages 13 and older in Wisconsin diagnosed with HIV at the end of the calendar year.

Denominator: Estimated number of persons ages 13 and older in Wisconsin with HIV (diagnosed or undiagnosed) at the end of the calendar year.

Data Source: An HIV surveillance supplemental report including these data is released annually; data from prior years may be updated. The most recent can be found here: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Data Limitations: Data are estimates, based on diagnoses, severity of disease at diagnosis, and deaths, and are statistically adjusted for incomplete reporting, reporting delays, and missing data.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
84.9%*	85.7%*	86.8%*	88.0%	89.1%	90.3%	91.5%	92.7%	93.8%	95.0%

*actual value

Objective 1.3: By the end of 2026, increase PrEP coverage from 19% in 2019 to at least 50% of all people who could benefit from the medication.

Baseline Year: 2019

Numerator: Number of persons >16 who were classified as having been prescribed PrEP during the calendar year.

Denominator: Estimated number of persons with indications for PrEP in the calendar year.

Data Source: The numerator uses data from AIDSVu (https://aidsvu.org) and the denominator comes from the CDC HIV Surveillance Data Tables (https://www.cdc.gov/hiv/library/reports/surveillance-data-tables/vol-2-no-3/index.html)

Data Limitations: Data for the denominator is estimated using the National HIV Surveillance System, National Health and Nutrition Examination Survey, and the U.S. Census Bureau's American Community Survey. The data sources used to estimate the number of persons with indications for PrEP have different schedules of data availability. Consequently, the availability of a denominator may lag the availability of a numerator. The 2018 denominator was used to calculate the 2019 and 2020 PrEP coverage data.

Annual Targets:

2019	2020	2021	2022	2023	2024	2025	2026
18.6%*	17.5%	22.9%	28.3%	33.8%	39.2%	44.6%	50.0%

*actual value

Goal 2: Improve HIV-related health outcomes for people with HIV.

Objective 2.1: By the end of 2026, increase the percentage of newly diagnosed people linked to HIV medical care within one month of their diagnosis to 95% and provide low-barrier access to HIV treatment. In 2017, 75% of newly diagnosed people were linked within one month.

Baseline Year: 2017

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

Denominator: Number of persons newly diagnosed with HIV in Wisconsin during the calendar year.

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
74.5%*	81.0%*	80.4%*	78.8%*	75.2%*	79.2%	83.1%	87.1%	91.0%	95.0%

*actual value

Objective 2.2: By the end of 2026, increase the percentage of people living with HIV in care to 95% by identifying, engaging, or re-engaging people who are not in care. In 2017, 87% of people living with HIV were engaged in care.

Baseline Year: 2017

Numerator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period and had at least one medical visit that included one or more laboratory tests in the current calendar year that were available in the HIV surveillance system.

Denominator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period.

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
87.2%*	87.7%*	90.2%*	85.5%*	87.7%*	89.2%	90.6%	92.1%	93.5%	95.0%

*actual value

Objective 2.3: Increase retention in care and adherence to HIV treatment in order to achieve and maintain long term viral suppression of 95%. In 2017, 91% of people living with HIV were virally suppressed.

Baseline Year: 2017

Numerator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period and whose most recent viral load test in the past 12 months showed a result of less than 200 copies/mL. People without a viral load test within the past 12 months were considered unsuppressed.

Denominator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period.

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
91.2%*	89.7%*	90.9%*	90.3%*	90.2%*	91.2%	92.1%	93.1%	94.0%	95.0%

*actual value

Objective 2.4: By the end of 2026, increase the capacity of the public health, health care delivery systems, and health care workforce in order to increase retention in care to 90%. In 2017, 64% of people living with HIV were considered 'retained in care'.

Baseline Year: 2017

Numerator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period and that had two care visits at least 90 days apart during the calendar year (as measured by documented test results for CD4 count, viral load, or HIV genotype).

Denominator: Number of persons living with HIV in Wisconsin at the end of the calendar year (excluding persons newly diagnosed and persons who moved into Wisconsin in the calendar year) that had any HIV-related laboratory test in the most recent five calendar year period.

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data. With the inception of telehealth visits during the 2020 COVID-19 pandemic, the HIV program recognizes this data point is underreported since there is no access to telehealth data currently.

Annual Targets:

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
63.5%*	61.4%*	66.2%*	53.1%*	59.7%*	65.8%	71.8%	77.9%	83.9%	90.0%

*actual value

Goal 3: Reduce HIV-related disparities and health inequities.

Objective 3.1: Reduce disparities in new HIV diagnoses amongst each of the social determinants of health below by 10%. Between 2017-2020, new diagnoses were more likely to occur amongst:

Those with lower income compared to those with higher income

Those with less than a high school diploma compared to those with a high school diploma or higher education, and

Those without health insurance compared to those with health insurance.

Baseline Year: 2017-2020 (combined 3 year)

Definitions and Methods:

The social determinants of health (SDOH) variables were obtained from the ACS. They were categorized by using empirically derived quartiles, and each quartile cut-point was rounded to the nearest integer. The three SDOH focused used were:

Median household income: median income for a household within the census tract during the 12 months before the survey response

Education level: proportion of residents in the census tract with less than a high school diploma (individuals aged 18 and older)

Health insurance coverage: proportion of residents in the census tract without health insurance or health coverage plan (individuals aged 18 years and older)

Rates per 100,000 population were calculated for the numbers of new HIV diagnoses in Wisconsin from 2017-2020.

Value: The absolute rate difference (the difference between the SDOH quartile group with the lowest rate of new HIV diagnoses and the SDOH quartile group with the highest rate of new HIV diagnoses) for median household income, education level, and health insurance coverage.

Data Source: The American Community Survey (ACS) and the Wisconsin HIV Surveillance System

Data Limitations: Due to small numbers, years have been combined into three-year periods.

Annual Targets:

SDOH	2017-2020	2018-2021	2019-2022	2020-2023	2021-2024	2022-2025	2023-2026

Income	9.4*	9.2	9.1	8.9	8.7	8.6	8.4
Education	11.6*	11.4	11.3	11.1	10.9	10.8	10.6
Health Insurance	10.9*	10.7	10.6	10.4	10.2	10.1	9.9

*actual value

Objective 3.2: Reduce disparities along the HIV care continuum. Specifically:

Reduce the difference of Hispanic/Latinx men who have sex with men that are in care and white men who have sex with men that are in care by 75%.

Reduce the difference of youth (ages 15-29) who are in care and adults (ages 30 and older) who are in care by 33%.

Reduce the difference of Black men who have sex with men who are virally suppressed and white men who have sex with men who are virally suppressed by 70%.

Reduce the difference of youth (ages 15-29) who are virally suppressed and adults (ages 30 and older) who are virally suppressed by 66%.

Baseline Year: 2017

Value: The absolute difference for the percentage in care or virally suppressed for the populations listed above.

Data Source: Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data.

Annual Targets:

SDOH	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
In Care										
White MSM vs Hispanic/Latinx MSM	6.3*	5.6*	3.0*	4.8*	2.6*	2.4	2.2	2.0	1.8	1.6
Youth vs older adults	5.0*	4.7*	3.7*	3.4*	6.6*	6.0	5.3	4.7	4.0	3.4
Viral Suppression										
White MSM vs Black MSM	7.9*	9.0*	6.3*	6.1*	4.2*	3.9	3.6	3.3	3.0	2.7

Youth vs older adults	9.4*	7.8*	8.9*	5.8*	5.3*	4.9	4.5	4.0	3.6	3.2

*actual value

Objective 3.3: Address social determinants of health (SDOH) that impede access to HIV services and exacerbate HIV-related disparities. When people living with HIV face greater social determinants of health, their engagement in care and viral suppression decreases. Specifically:

Reduce the difference in the percentage engaged in care of people living with HIV who are living in census tracts with the highest levels of SDOH and people living with HIV who are living in census tracts with the lowest levels of SDOH by 25%.

Reduce the difference in the percentage virally suppressed of people living with HIV who are living in census tracts with the highest levels of SDOH and people living with HIV who are living in census tracts with the lowest levels of SDOH by 25%.

Baseline Years: 2019

Definitions and Methods:

The social determinants of health (SDOH) variables were obtained from the American Community Survey (ACS). They were categorized by using empirically derived quartiles, and each quartile cut-point was rounded to the nearest integer. Each quartile was scored one to four with one being the least amount of SDOH and four being the highest among of SDOH. The seven SDOH used were:

Median household income: median income for a household within the census tract during the 12 months before the survey response

Education level: proportion of residents in the census tract with less than a high school diploma (individuals aged 18 and older)

Health insurance coverage: proportion of residents in the census tract without health insurance or health coverage plan (individuals aged 18 years and older)

Federal poverty status: proportion of residents in the census tract who were living below the U.S. poverty level during the 12 months before the survey response (individuals aged 18 years and older)

Unemployment status: proportion of residents in the census tract who were classified as unemployed (individuals aged 16 and older)

Vacant housing status: proportion of housing units in the census tract that are designated as vacant

Minority status: the percentage of residents in a census tract that are racial or ethnic minorities

The quartile score of each of the seven SDOH were added together resulting in an overall SDOH score for each census tract. The scores were then categorized in groups of low (seven to 14 points), medium (15-21 points), or high (22-28 points) SDOH.

Value: The absolute difference between the percentage of people in care or virally suppressed in the low SDOH group and the high SDOH group.

Data Source: The American Community Survey (ACS) and the Wisconsin HIV Surveillance System

Data Limitations: HIV medical care data are dependent on comprehensive laboratory result reporting. Comprehensive CD4 and viral load reporting began in Wisconsin in 2011. While the HIV program is unaware of any labs in the state who are not reporting these results, it is possible that there are missing data.

Annual Targets:

SDOH	2019	2020	2021	2022	2023	2024	2025	2026
In Care	4.7*	4.5	4.4	4.2	4.0	3.8	3.7	3.5
Viral Suppression	7.7*	7.4	7.2	6.9	6.6	6.3	6.1	5.8

*actual values

Goal 4: Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and interested parties.

Objective 4.1: Ensure voices of lived experience guide system-level improvements and inform best practice and decision making within HIV programs across governmental, public, private, faith-based, clinic-based, community-based, and academic spaces.

Objective 4.2: Improve coordination of HIV services through cross-public health sector collaboration, elevate the HIV workforce through professional development and capacity-building strategies, and increase partner accountability through data collection and analysis.

Objective 4.3: Improve mechanisms to measure, monitor, evaluate, and report progress and make changes in order to achieve the goals and objectives set forth.