# Integrated HIV prevention and care plan

2022–2026

Utah Department of
Health & Human Services
Population Health

# Acknowledgements

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Utah Ryan White Part B Community Advisory Committee

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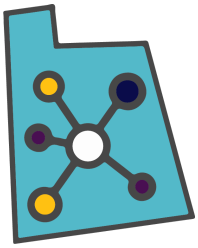
# Section I: Executive summary of integrated plan and statewide coordinated statement of need (SCSN)



## Executive summary

The DHHS Office of Communicable Diseases has taken an integrated approach to HIV prevention, treatment and care. In the fall of 2015 the Office underwent reorganization and all HIV related programs were integrated. In 2020, the HIV Prevention and Ryan White Part B programs were separated yet still worked closely together. Fortunately, another reorganization took place in July 2022 and the programs were once again integrated into the HIV/STD Elimination, Analysis, Response and Treatment (HEART) Program. HEART supports CDC's Program Collaboration and Service Integration (PCSI) initiative and is an integrative program that incorporates HIV Prevention, HIV Surveillance, Ryan White Part B, STD Prevention and Surveillance and Syringe Exchange. It is important to note that this restructure and integration follows the Integrated HIV Prevention and Care Plan guidance, making planning and integrated implementation of Utah's Integrated HIV Prevention and Care Plan seamless.

## Approach

Utah's Integrated HIV Prevention and Care Plan is a collaborative effort between the HEART Program and Utah's HIV Planning Group (UHPG), which includes representatives from local HIV prevention programs, service providers, stakeholders, and community members. Utah's Integrated HIV Prevention and Care Plan reflects the discussion and prioritization of the UHPG regarding HIV prevention and treatment strategies, resources, needs, and gaps for HIV prevention and treatment services throughout the state.

It is also important to note that the HEART Program recruited and hired an additional HIV epidemiologist (1 FTE) to ensure activities related to the Integrated HIV Prevention and Care Plan were completed in a timely manner and the UHPG was supported.

Documents submitted to meet requirements

- 2019 Utah Red Ribbon Survey and Community Health Survey Report Prepared by Deana Kepka, PHD MPH
- 2021 HIV Integrated Epidemiologic Profile and HIV Care Continuum (unpublished)
- Utah Getting to Zero Plan
- HIV Prevention, Care and Treatment Resource Inventory

# Section II: Community engagement and planning process

## Jurisdictional planning process

The DHHS, HIV/STD Elimination, Analysis, Response, and Treatment (HEART) Program focused on the planning process by first identifying internal program staff (Ryan White Part B Program, HIV Prevention, and Surveillance) who would be most appropriate to engage in the creating of the Getting to Zero (GTZ) initiative. The GTZ initiative is a multi-year, multi-agency collaboration that aims to reduce new HIV diagnoses and HIV-related stigma with the ultimate goal of zero HIV-related deaths in Utah. The GTZ plan focused on four key domains: Test, Treat, Prevent, and Respond. Each identified program staff oversees the applicable domain that they are assigned. The program staff work alongside the Utah HIV Planning Group (UHPG) to create goals, strategies, and actions to address the immediate and systemic factors affecting communities and individuals disproportionally impacted by HIV. The HEART Program implemented the GTZ strategic planning as part of Utah's Integrated HIV Prevention and Care Plan.

## Entities involved in process

Members of the UHPG, which includes representatives from DHHS, local HIV prevention programs, service providers, stakeholders, and community members were involved in the development and implementation of the GTZ plan. The UHPG members are passionate, knowledgeable, and motivated; all qualities that led to a high level of coordination and prioritization. The UHPG participated in all phases of the planning, such as discussion in providing feedback on goals, objectives, strategies, and actions related to the key domains. This process enabled members of the UHPG to understand data sources, and the limitations of the data, and encourage future collaboration in completing needs assessments.

Members of the Community Advisory Committee (CAC) include people who are diagnosed with HIV or their family/friends. CAC is facilitated by the Ryan White, Part B Program. The CAC members have been the voice of wisdom through their lived experiences. Their feedback has provided the lens for the HEART Program to identify areas that need improvement within services and programs and ensure needs for community resources are being addressed in the GTZ plan. The CAC members will continue to be involved in the HIV care continuum of the GTZ plan.

After the implementation of the GTZ, the UHPG and CAC members are involved in the formulation and review of the GTZ plan. The UHPG subcommittees work towards the GTZ goals, including expanding access to PrEP and PEP, and expedited initiation of ART treatment. The UHPG and CAC members review the progress and amendments to the GTZ plan. The Surveillance team in the HIV Prevention Program monitors the progress of the GTZ goals, including trends for viral suppression, linkage to care, and HIV testing.

Although there is valuable community members' participation, there is still a lack of representation from different cultural backgrounds among UHPG, CAC members, and agencies in the rural demographic. The HEART Program strives to improve community members' involvement by continuing recruitment during the quarterly UHPG meeting, social media, and CAC meeting.

## Role of planning bodies and other entities

The GTZ plan consists of different program representatives from the HEART Program, stakeholders, and community members to create a collaborative plan to end HIV in Utah. The GTZ plan included the four key domains (Test, Treat, Prevent, and Respond) that are the compass to guide in navigating the integrated planning process.

The HIV prevention team works to increase access to HIV testing, PrEP, and PEP throughout the state. This team uses the GTZ plan (Test and Prevent domains) to emphasize the importance of expanding access through creative solutions, including home testing and rapid testing for HIV. The HIV prevention team supports local community organizations that provide testing through contracts, including syringe service providers. The HIV prevention team also provides necessary education about HIV prevention to the community and providers.

In supporting the GTZ plan, The Ryan White Part B Program aims to focus on people diagnosed with HIV having access to the care they need, preventing new infections, and reducing HIV-related deaths. This will be measured through the GTZ plan under the Treat domain. The Ryan White Part B Program has created SMART goals related to engagement to care, core medical and support services, and early ART initiation. To see positive outcomes within the next five years, collaboration within the local health departments, contracted providers through the Utah AIDS Foundation (UAF) and the University of Utah Infectious Disease Clinic (IDC), peer navigator, AIDS Education Training Center (AETC), and CAC members. Another important aspect is the Ryan White Part B Program data management system (ClientTrack). ClientTrack will provide the program guidance and identify trends to better understand gaps in services and what specific program is working and what can we improve based on the GTZ plan.

The surveillance team within the HEART Program provides data support and maintains situational awareness of HIV-related trends. It ensures that cases are directed to the

appropriate local health districts in a timely manner, verifies that laboratory results are properly reported, performs de-duplication and other quality assurance activities, and collaborates with the prevention team to limit the burden of HIV in Utah. In contributing to the GTZ plan (Respond domain), the surveillance team analyzed data and made suggestions regarding priority populations, developed a cluster response plan to support the Respond domain, and determined SMART goals.

## Collaboration with RWHAP parts

Through the GTZ collaborative planning process, the Ryan White Parts C&D and F were a part of the initiative. Parts C&D and F were involved in the beginning of the GTZ initial discussion, preparation, and implementation. Their feedback guides the HEART Program to identify goals, objectives, and action steps that are geared toward the key domain (Test, Treat, Prevent, and Respond).

Before the implementation of the GTZ plan, parts C&D and F were included in the UHPG meeting along with other stakeholders, providers, and community members that had the opportunity to review and provide additional feedback on the goals and objectives. With the group's approval of the GTZ plan, the HEART Program started the implementation and provided updates quarterly during the UHPG meeting.

Ryan White Part B CAC Chair will coordinate with the Ryan White Part C CAB Program Chair to determine if there may be opportunities for collaboration between the two committees.

## Engagement of people with HIV

One of the GTZ strategies and actions is to improve community engagement. This has been the compass to develop the Integrated HIV Prevention and Care Plan. To improve community engagement among community members and stakeholders statewide. The HEART Program understands the benefit of increasing the use of social media (i.e., Instagram; @hivandmeut) as a tool and is diligently incorporating the Community Advisory Committee (CAC) members as part of the action to support the GTZ strategic plan. CAC member feedback and input is gathered during bi-monthly meetings and via email.

In July of 2021, the HEART Program created and hired an HIV Community Engagement Specialist position who is responsible for HIV-related social media efforts. Within their first three months navigating the role, there was a 214% increase in Instagram accounts engaged and a 1,934% increase in Instagram accounts reached compared to the three months directly preceding their time of hire. Additionally, in the timespan comparison noted prior, Instagram content interactions increased by 461%, post interactions increased by 302%, and the number of non-follower accounts engaged increased by 233%. Furthermore, the number of non-follower accounts reached increased by 2,391%, impressions increased by 562%, and profile visits increased by 273%.

The increase in social media engagement has been achieved and maintained by regularly releasing two Instagram posts per week minimum, with a target of three or more posts per week. The two-post minimum typically consists of one Instagram reel and one traditional Instagram image post. The posts (videos and graphics) are primarily educational and cover empirically-supported information about HIV and other illnesses that disproportionately impact people living with HIV or populations who are at the highest risk for HIV infection (e.g., monkeypox, hepatitis C).

Beyond social media, the HEART Program is focused on engaging community members and stakeholders in Utah by holding quarterly Utah HIV Planning Group (UHPG) meetings. UHPG members consist of community members and stakeholders, as well as medical and public health professionals. All are welcome to join and the regularly scheduled meetings provide opportunities for people living with HIV and their allies to network with one another, advocate for the needs of people living with HIV, and receive updates on the GTZ plan.

Additionally, the HEART Program held a two-day institute in November 2022 that covered PrEP and PEP for HIV prevention use. Attendance at the institute was free and open to the public and was held in person and via live stream. The information was delivered in a manner that was accessible to medical professionals, public health workers, community members, stakeholders, and laypersons alike. Over 80 participants from around the state and a few from out of state attended the event. Next steps include creating online resources and a Learning Collaborative to keep up the momentum of the information shared and the connections made at the Institute.

Specific learning objectives of the institute included: (1) reviewing Utah's plan to end the HIV epidemic and identify gaps in PrEP access among priority populations, (2) describing updates to the CDC PrEP guidelines, including eligibility criteria, safety monitoring, on-demand use, and long-acting formulations, (3) identifying strategies to facilitate PrEP uptake, including methods to finance PrEP care and deliver culturally responsive, trauma-informed services, and (4) devising organizational PrEP implementation action plans, including pharmacy-delivered PrEP.

Moving forward, the HEART Program will continue engaging with community members and stakeholders by ramping up its social media efforts and potentially expanding beyond Instagram and Facebook to platforms such as Twitter and TikTok. Furthermore, the HEART Program will work to recruit additional community members and stakeholders to join the UHPG. Finally, the HEART Program envisions sponsoring community events in the near future, such as communal HIV testing for World AIDS Day.

Another aspect of community engagement the HEART Program sees the benefit in is increasing the representation of members' participation and level of involvement within

the CAC. The Ryan White B Program Chair has worked with the CAC to develop stated goals for the Integrated Plan session. Community members of the CAC have offered input and guidance in developing these goals and objectives.

The Program's ClientTrack Administrator, who is a member of the QI team, has coordinated with the Quality Improvement Team and with CAC Program Chair to attend all scheduled CAC meetings to provide information to the community about the Program's current QI measures, as well as provide opportunities for the community to offer feedback, input, and guidance regarding the Program's QI initiatives and measures.

The CAC would like to help the Program work to address isolation among members of our community. The CAC will work on developing a "Community Engagement" casual interaction meeting to ensure that all members of our community have the opportunity to interface and engage. RWB Program Chair will engage the CAC in planning and coordinating to better determine the structure of these casual interaction meetings and how to best engage the community in the meetings. The CAC will participate in planning and coordinating discussions and activities for at least the first year of our Integrated Plan session and hopes to have a regular activity or meeting in place by the 2nd or 3rd year of the Plan cycle. The CAC is hopeful that these casual interaction meetings will offer an opportunity for Program and Community engagement on a larger scale, as well as potentially address the isolation that some experience in our community.

The CAC will coordinate with the Program's HIV Community Engagement Specialist to increase social media resources and build community connections. The CAC has identified a need and benefit to utilizing social media to increase our presence in the community. We believe that by utilizing a social media platform we will be able to more successfully share information with our community members and more actively seek their input and feedback regarding community needs, programming, and service provision. The HIV Community Engagement Specialist will be invited to all the CAC meetings and will attend when possible. The CAC will collaborate with the HIV Community Engagement Specialist to develop a plan for increasing the CAC's presence on social media. The CAC Program Chair will build time into the agenda to discuss, plan and develop how to best improve the CAC's social media resources and community connections.

The Program will work to coordinate time on a quarterly HOPWA meeting agenda to address integrated planning matters with contracted providers (Utah AIDS Foundation (UAF), University of Utah Infectious Disease (IDC), Housing Connect, Utah Community Action, and Housing Authority. The Program will also continue to work with the CAC quarterly to review and provide feedback on the integrated plan. Lastly, the Program will provide information and seek feedback on the integrated plan during the UHPG quarterly meeting.

## Priorities

Through the planning process, the HEART Program recognizes the need to have different backgrounds and cultures represented to obtain a broader perspective. Having a diverse representation within the CAC and UHPG can strengthen the system and provide an understanding of the needs of different paradigms to tailor the services appropriately.

To diversify representation within the different meetings, HEART Program acknowledges a need to increase the number of community members participating in the UHPG and CAC meetings and attempt to recruit members that may more broadly represent the populations that we serve. As the HEART Program continues to find ways to better the program and provide the necessary resources within the community, it is crucial to get perspective from the community as to what the needs are and what is working well.

The CAC identifies our goal of increasing our social media presence as a priority to improve communication between the Program and the community we serve. The CAC will begin coordinating with the Program's Community Engagement Specialist immediately to develop a solid plan for increasing our presence on social media and determining how to best utilize this resource to reach our other stated goals and priorities.

Through the planning process, HEART Program also recognized a need for stronger collaboration and coordination amongst the different parts of Ryan White. The Program identifies this need for closer collaboration and coordination as a priority. The Ryan White Part B Community Advisory Committee Program Chair will coordinate with the Program Chair for the Ryan White Part C Community Advisory Board (CAB) to determine how we may best work together to combine our community engagement efforts while still honoring the different needs of the two overlapping communities. The Ryan White White Part B CAC Program Chair will coordinate with the Part C CAB Program Chair to determine if one or two integrated meetings per year may be beneficial to our communities and, if so, we will collaborate to initiate the joined meetings within the first two years of the planning process.

## Updates to other strategic plans used to meet requirements:

The jurisdiction is using the Getting to Zero (GTZ) plan, outlined in other sections, to meet these requirements. The GTZ plan was created based on Utah-specific HIV prevention, treatment, and surveillance data. The goals in the GTZ plan are SMART goals, and progress is measured and monitored consistently by an evaluator in the HEART program. The plan has not yet been adapted to reflect changing trends in data, however, there is a strategy in place for discussing how the data trends in Utah may influence GTZ goals and progress at

UHPG meetings. Members of the UHPG and community stakeholders were involved in the formulation and review of the GTZ plan. Since the launch of the GTZ plan in December 2020, UHPG and community stakeholders have continued to be involved. The plan is discussed at UHPG meetings and is reviewed yearly in January. In January 2022, the plan was opened for public comment through an anonymous form to gather feedback from community groups, UHPG members, people in the community, and anyone else who wanted to give their opinion and feedback. The feedback was discussed at the February 2022 UHPG meeting and UHPG members voted on amendments to the plan based on community feedback and meeting discussion. The UHPG members voted to remove one activity of the plan relating to ART prescriptions being reported to the DHHS for evaluation. The GTZ plan will continue to change based on the monitoring of data and community feedback each year until the plan concludes in 2026.

# Section III: Contributing data sets and assessments

## Data sharing and use

The HIV Prevention, Ryan White Part B Program, and HIV Surveillance Programs are integrated under the same program known as the HIV/STD Elimination, Analysis, Response, and Treatment (HEART) program. Due to this integration, the HEART program has a limited need for data-sharing agreements.

Data to inform the creation of the Getting to Zero plan was collected from the state's epidemiological system EPITrax through the HIV surveillance program.

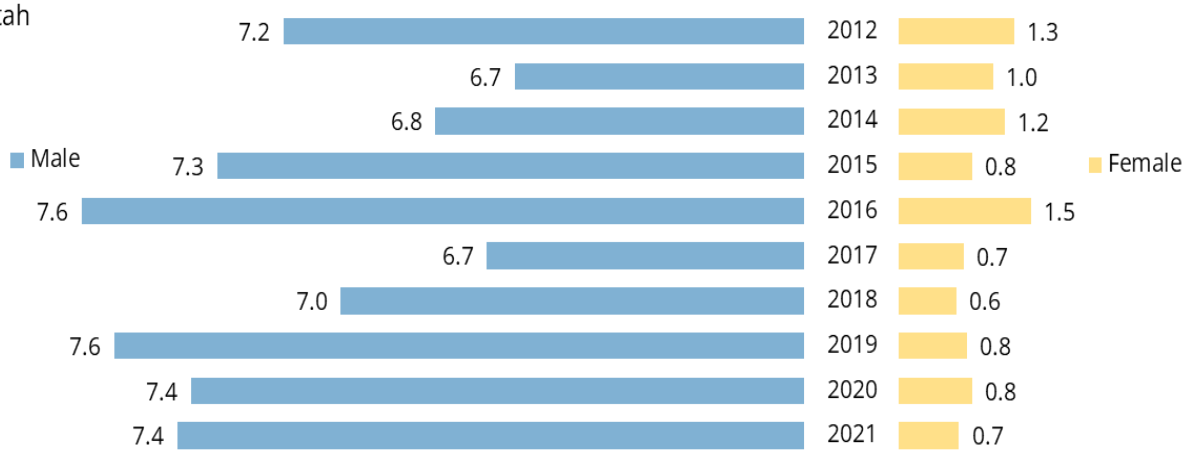
The program currently has two data-sharing agreements with the department's Office of Vital Records and Statistics to receive information on deaths, births, and fetal deaths. The agreement which covers deaths extends through the 2021 data year, and a new agreement covering the next five years is planned. Likewise, the agreement which covers live births and fetal deaths will need to be renewed within the year. These agreements allow the surveillance epidemiologists to monitor trends in HIV-related deaths as well as be alerted to any perinatal exposures which have not otherwise been reported.

## Epidemiologic snapshot

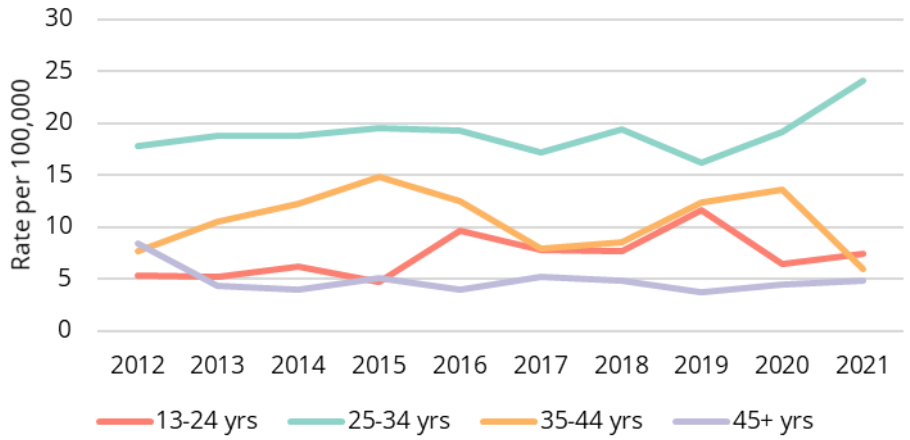
### New diagnoses

In 2021, Utah had 136 new diagnoses of HIV. Males consistently shoulder a much higher burden of HIV diagnosis than do females. Most new diagnoses consistently occur in young men between the ages of 25 and 34.

HIV rates are significantly higher among males than females in Utah

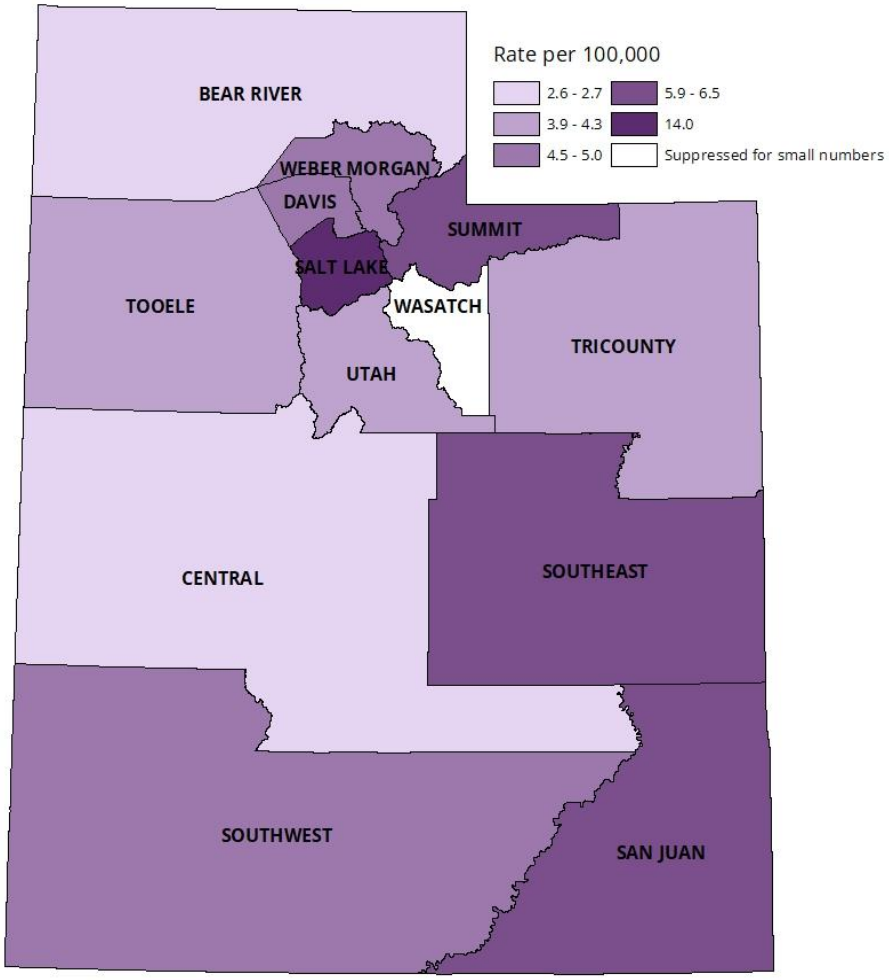



Most new HIV diagnoses are among younger men in Utah

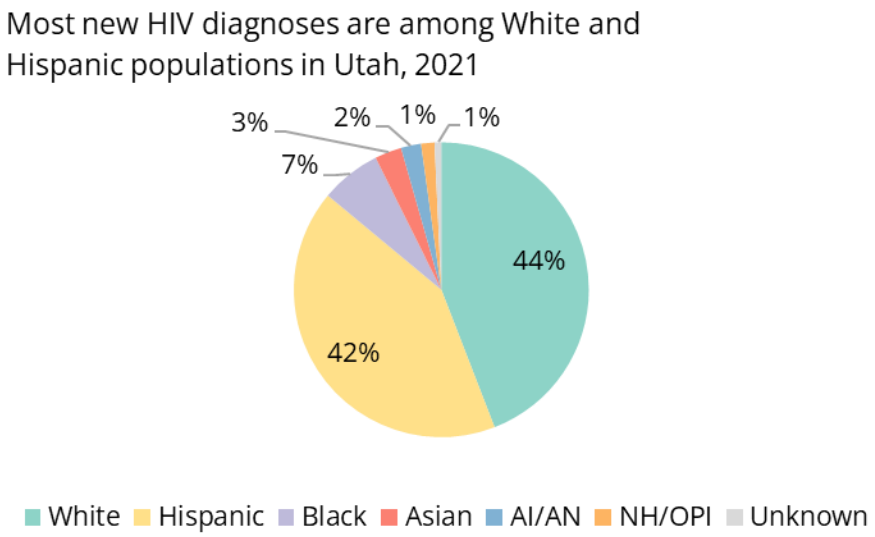



Geographically speaking, the highest number of diagnoses per capita over the last five years have been among Salt Lake county residents, but every local health district has had new diagnoses over the last five years. Some of the higher rates occur in frontier areas of the state due to small populations.

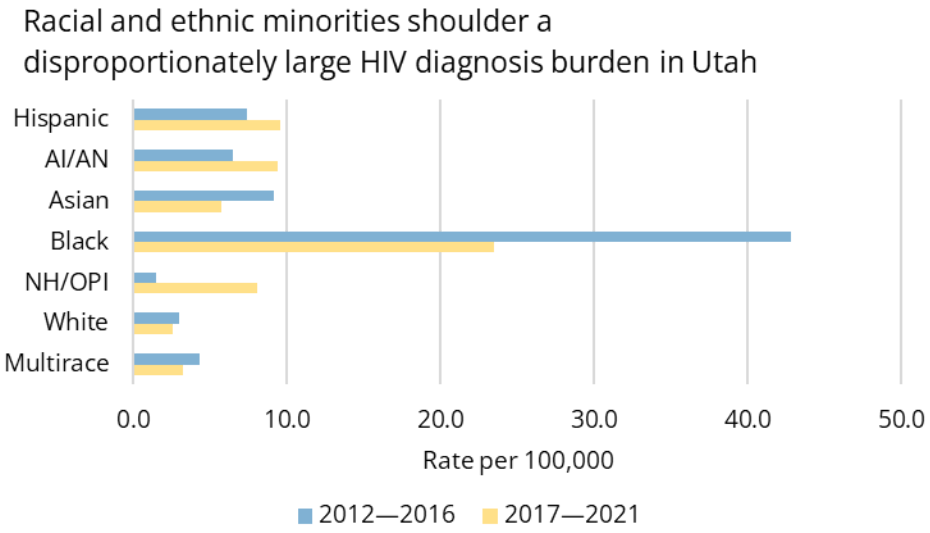
Most new cases live in Salt Lake county, but HIV affects all of Utah, 2017–2021




Utah's general population is overwhelmingly non-Hispanic White and Hispanic. This is reflected in the racial/ethinic makeup of new HIV diagnoses each year.

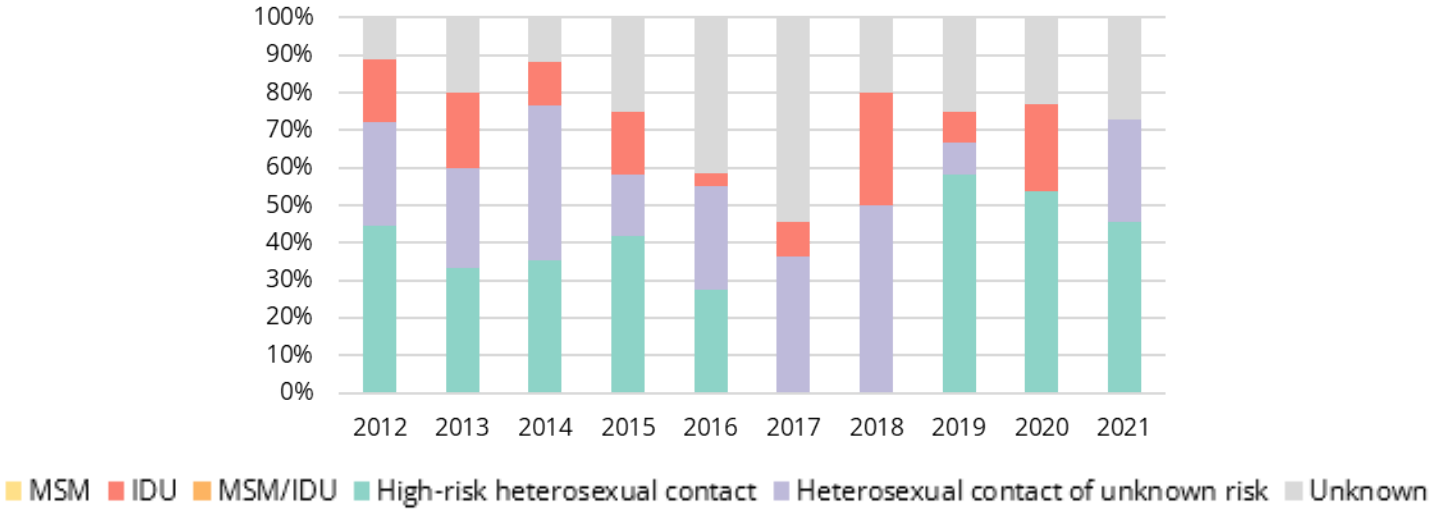



However, when the number of cases in each racial/ethnic category are compared to the relative size of those populations, it becomes clear that there is a disparity among many groups. In particular, rates among Hispanic, non-Hispanic Native American, and non-Hispanic Pacific Islander populations have increased over the past five years. The significant decrease in the non-Hispanic Black population is likely indicative of the successes of national and Utah-specific prevention strategies which consider this a priority population. Hispanic, and non-Hispanic Pacific Islanders should also be considered priority populations in Utah.



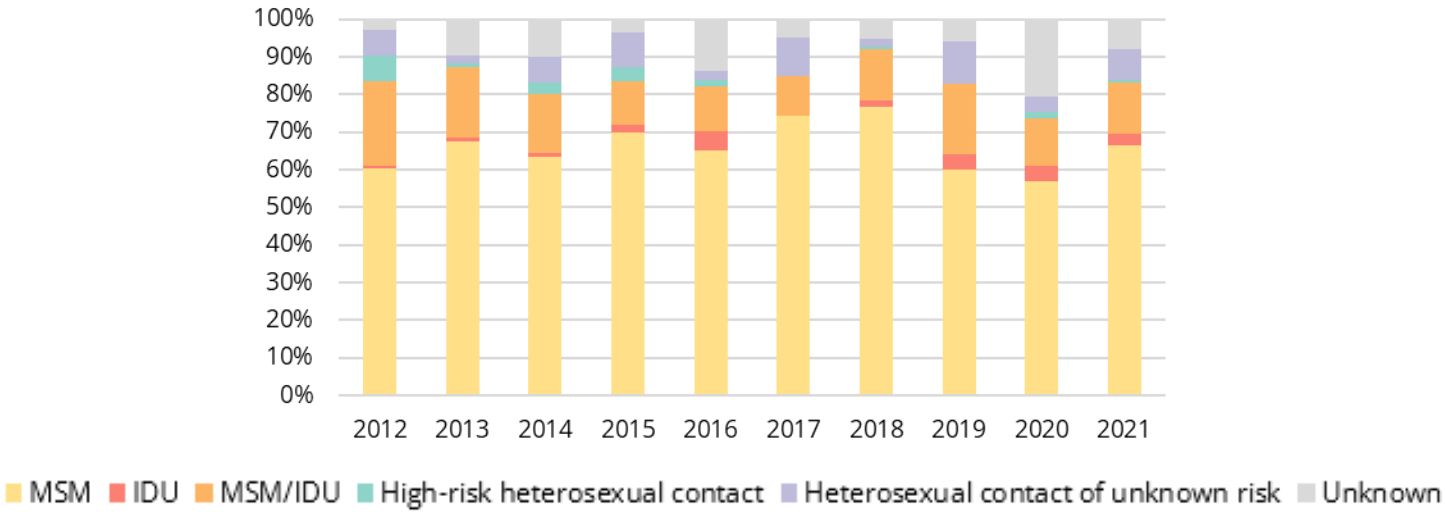

Among women, heterosexual contact is the dominant mode of transmission, although there is usually a small number of women who are believed to have acquired HIV through intravenous drug use (IDU). There were no diagnoses among females in 2021 attributed to IDU.

Heterosexual contact is the leading route of HIV transmission among Utah women



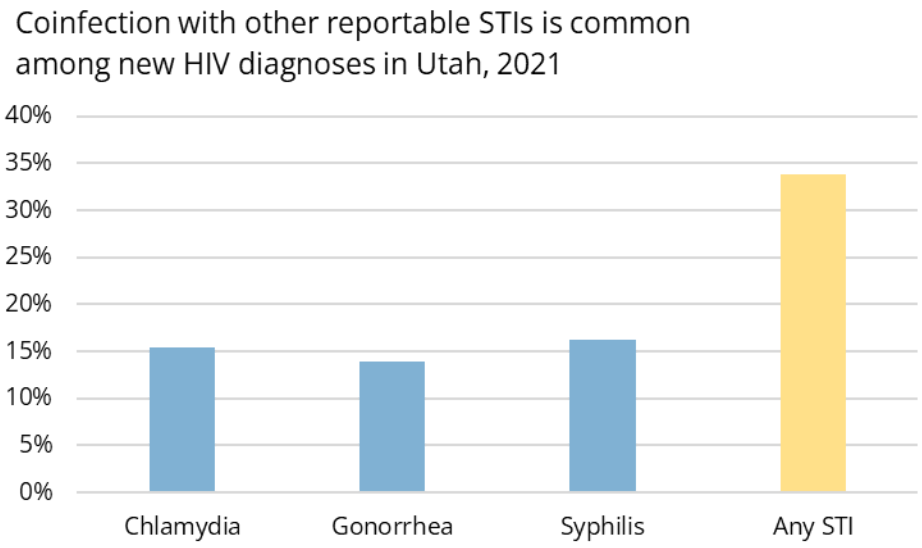

Among men, transmission occurs most often among those who have experienced male to male sexual contact (MSM). The second largest category is those who experience both male to male sexual contact and intravenous drug use (MSM/IDU). Overall, the percentage of new HIV diagnoses each year which are attributable to IDU alone is very small.

Male to male sexual contact is the leading route of HIV transmission among Utah men

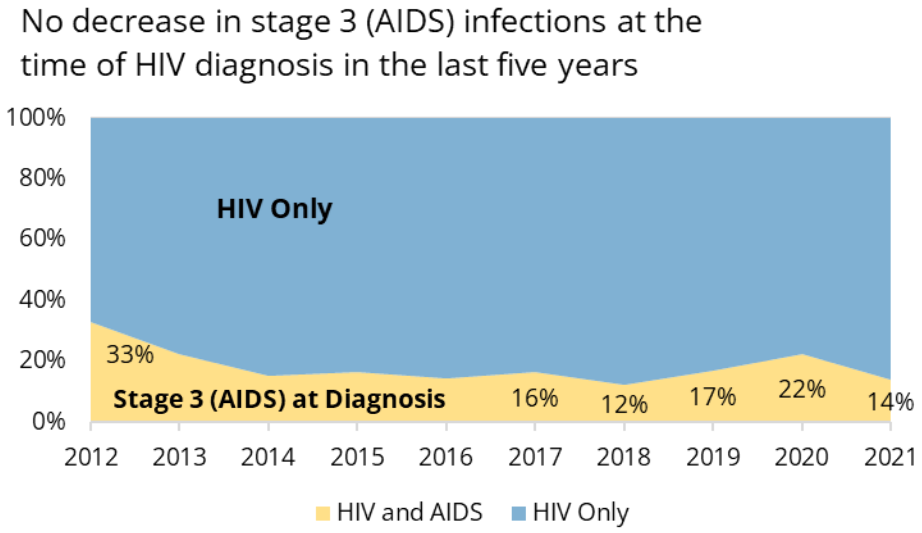



The previous charts demonstrate why gay, bisexual, and other men who have sex with men is a priority population both in Utah and in the nation. Although absolute numbers of cases attributed only to IDU are small, there are three counties in Utah which the CDC has identified as being at elevated risk of HIV and Hepatitis C transmission due to IDU. For this reason, Utah also considers people who inject drugs to be a priority population.

About 1 in 3 new HIV diagnoses in 2021 were also known to be co-infected with a reportable STI. This demonstrates the significant overlap in at-risk populations. It is also medically consistent, as STIs often create disruptions in the epithelium that act as portals of entry for HIV. The lower percentages in individual STIs indicate that many clients were co-infected with more than one STI.

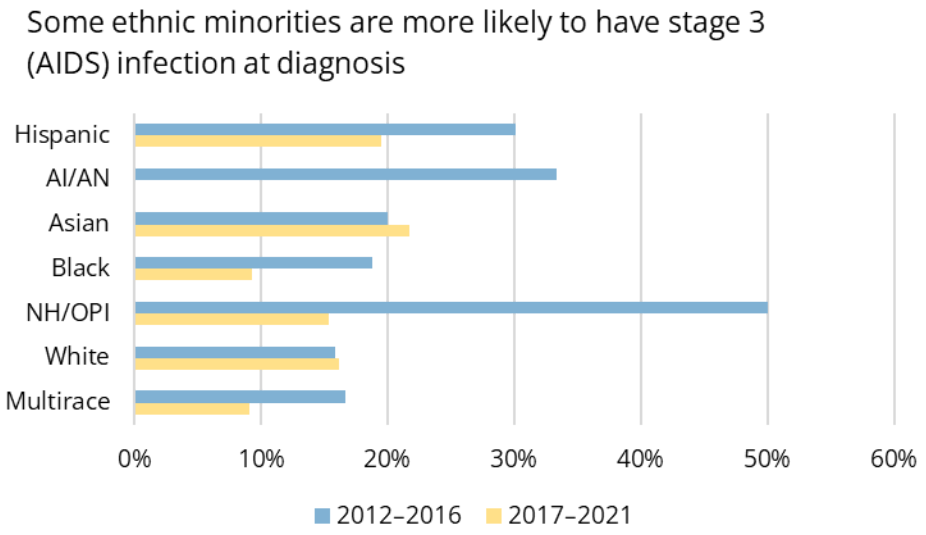



Significant reductions in stage 3 infections at time of diagnosis have been made since the start of the HIV epidemic. However, those reductions have plateaued and no reduction has been observed in Utah since 2014.

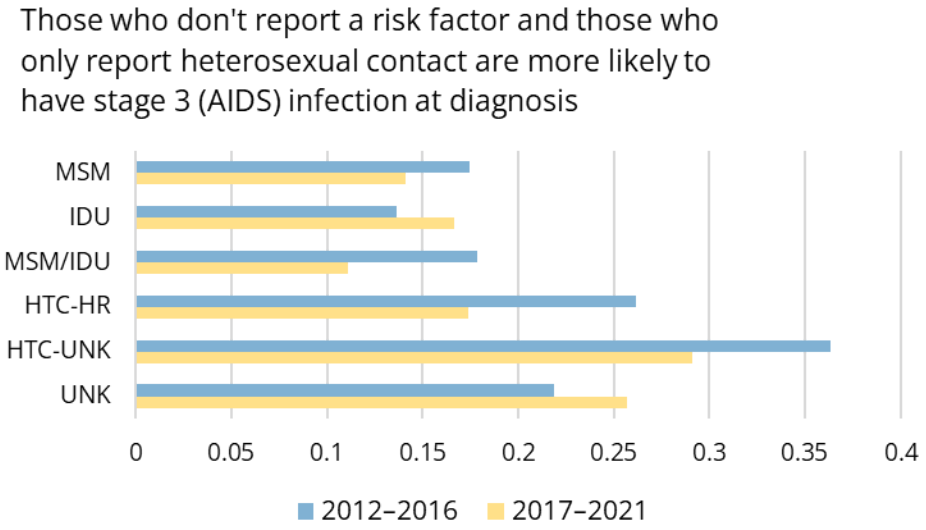


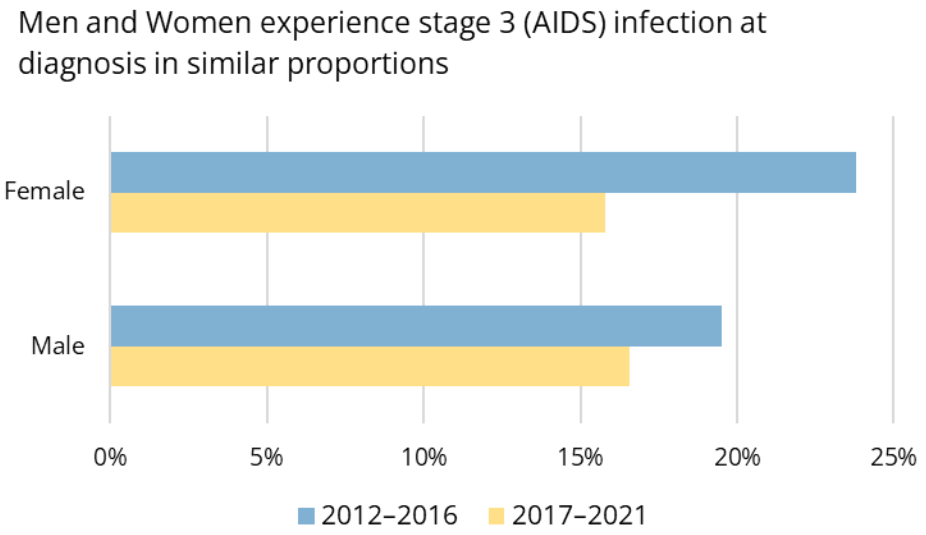

Although each racial/ethnic group has improved over the past 10 years, the chart below illustrates that Hispanic and non-Hispanic Asian clients are more likely than non-Hispanic White clients to have stage 3 infection at the time of their HIV diagnosis. Other groups, such as non-Hispanic Blacks are less likely to have progressed to stage 3 by the time they are

diagnosed, indicating that efforts to reduce late diagnosis in that population may have been successful and that more effort should be applied to Asian and Hispanic populations.

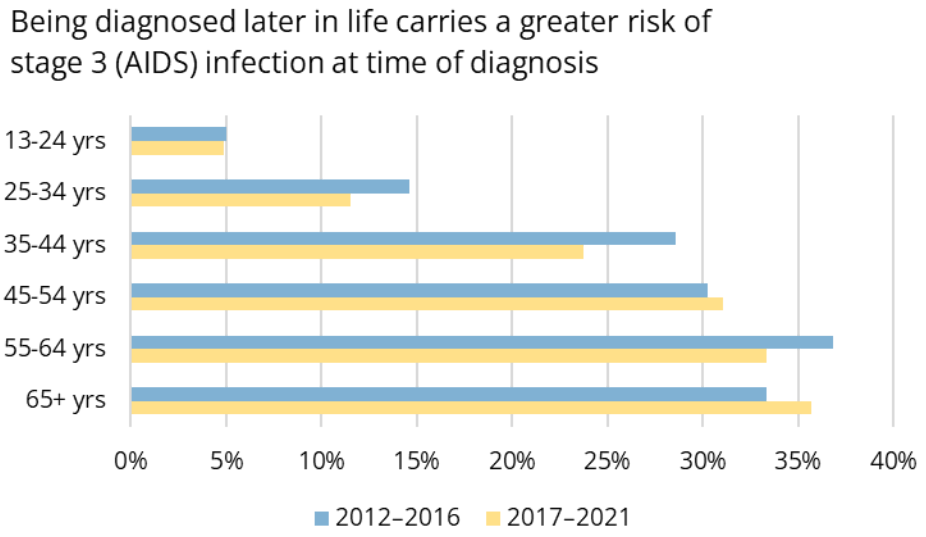



Failure to acknowledge a risk factor during client interview may be due to secretive sexual behavior, or denial. There is also a significant number of new cases each year who experience unstable housing or other situations which make them difficult to locate and some who are unwilling to be interviewed by a public health professional. Each of these conditions would contribute to the increased level of stage 3 infections at time of diagnosis illustrated below. It is also possible that there is under-recognition in the general population of the risk of HIV infection when sex occurs between anonymous heterosexual contacts, multiple partners, or sex workers. This under-recognition could lead to delayed HIV testing and increased stage 3 infection at diagnosis.

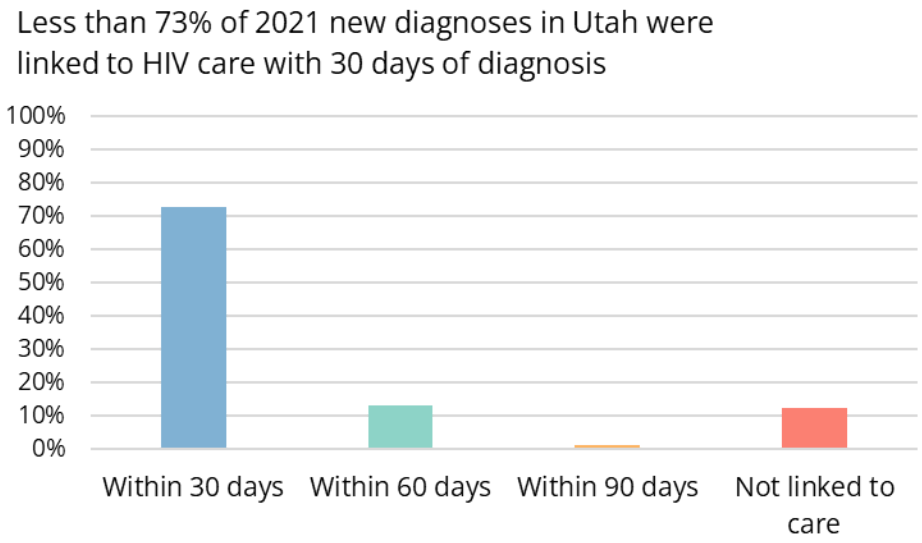





Since stage 3 infection at time of diagnosis is a proxy measure for late diagnosis due to a lack of HIV testing, it makes sense that the populations most likely to have progressed to stage 3 at time of diagnosis are also the oldest populations.

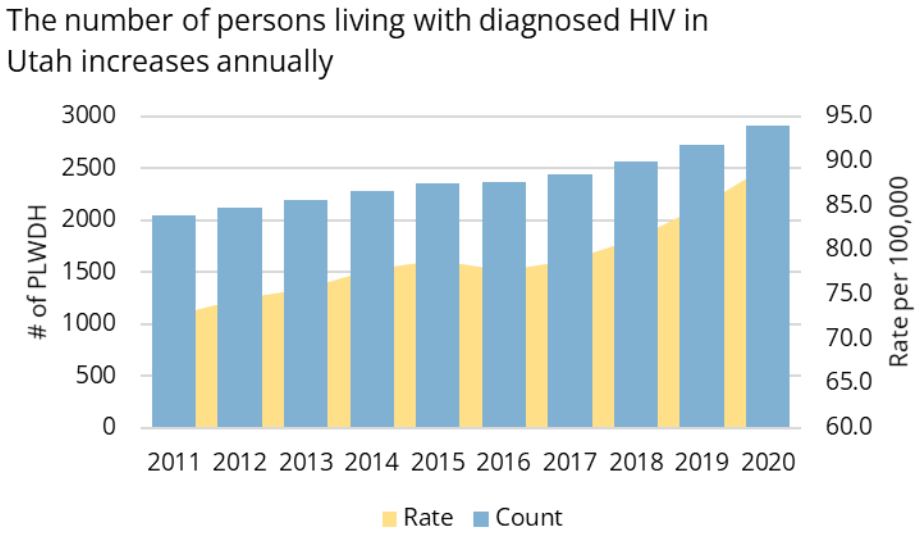



Since the advent of highly effective antiretroviral therapy and the discovery that such treatment drastically reduces one's risk of transmitting HIV to a sexual partner, prompt connection to HIV care for new diagnoses has become all the more important. The national standard for this linkage is that it should occur within 30 days of diagnosis for at least 85% of new cases. Failure to link a new case to care may result in continued unprotected sexual activity or it may contribute to unnecessary psychological distress as many clients do not have adequate support systems and may be unaware that persons with HIV can live a long and healthy life with treatment and support.



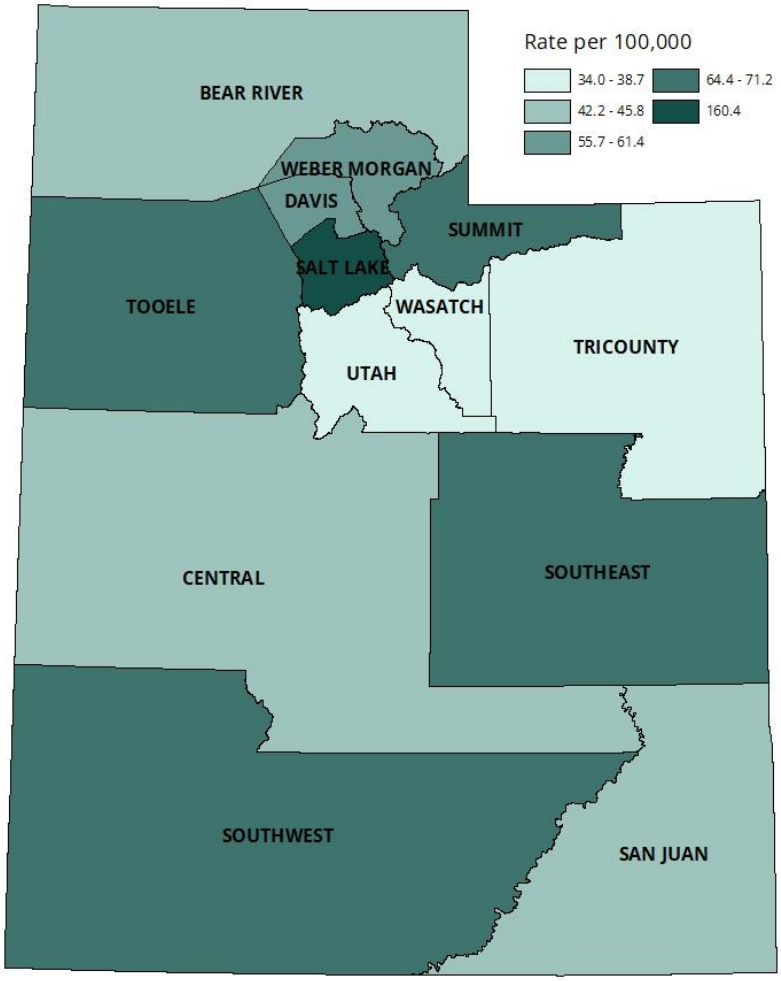

## Persons living with HIV

As of December 31, 2020, there were 2,908 people with diagnosed HIV known to be living in Utah. This number is lower than the CDC's estimate (3,275) since it discounts persons who have not had a laboratory result or an address reported to the department in more than five years. We believe that unreported deaths among the unhoused, name changes, and other situations likely account for the discrepancy.



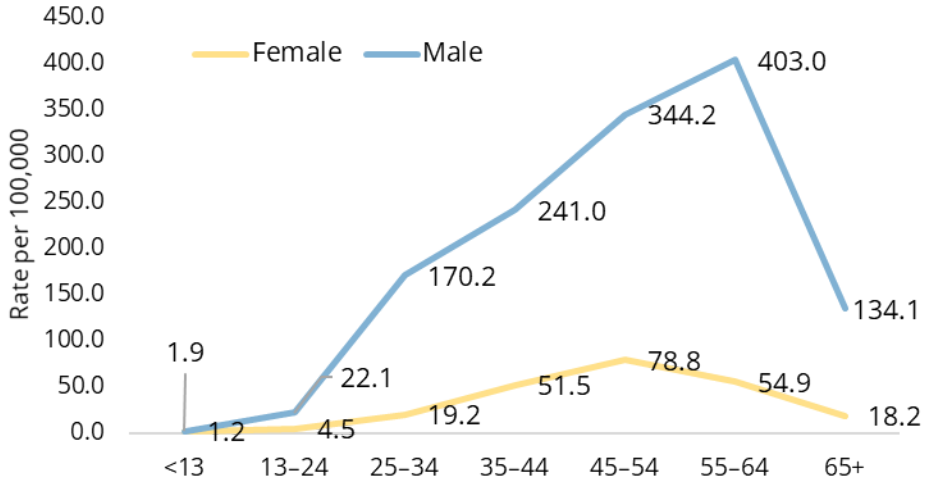

As with new cases, prevalent cases of HIV exist in every local health district. The rate in Salt Lake County, in 2020, was more than double the rate in the next most prevalent health district.

People living with diagnosed HIV reside in every part of Utah, 2020



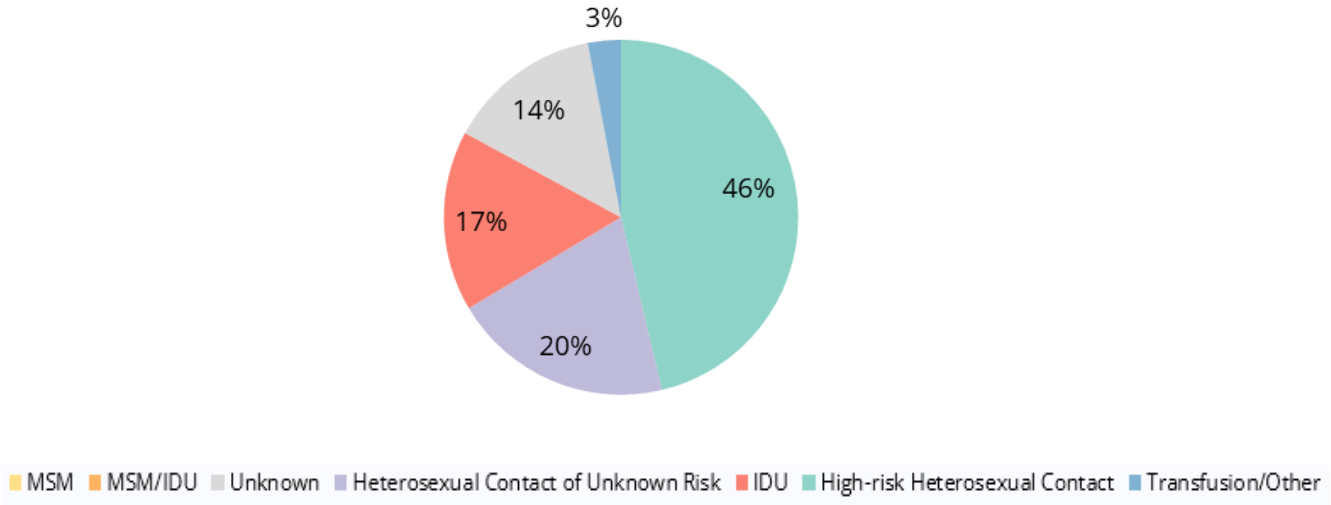
Improvements in HIV treatment regimens has translated to an aging population as HIV-related death becomes less common earlier in life.

The HIV+ population in Utah is aging, 2020

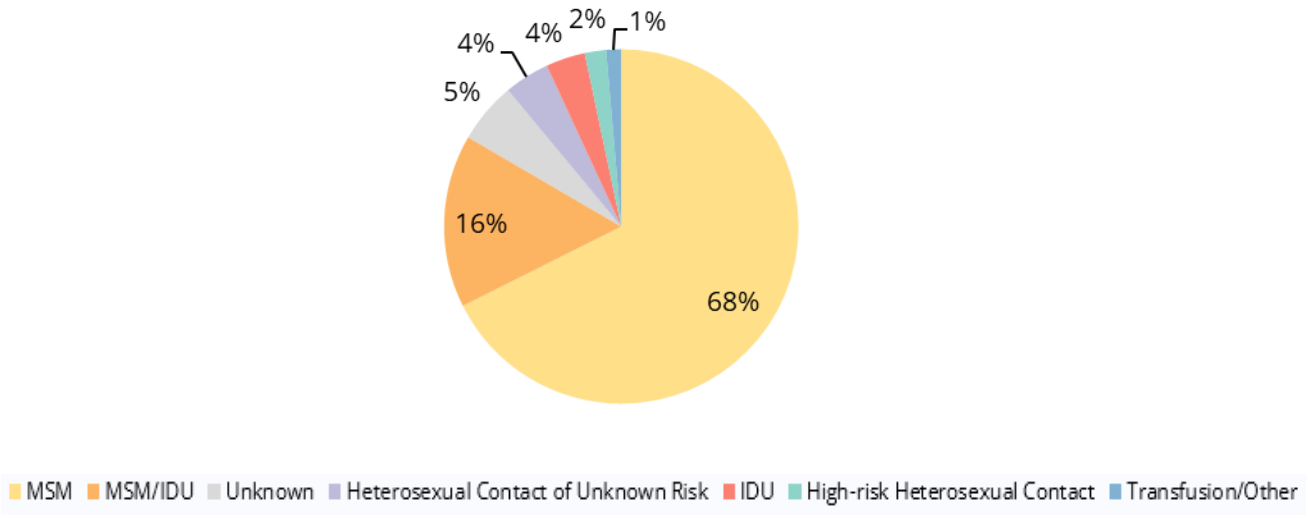



The percentages of infection attributable to different risks by birth sex mirror the trends seen in new diagnoses. Women become infected most often through sexual contact with a male partner who is at high risk of HIV infection themselves. It is worth noting the increased "unknown" category, which may indicate that women are less likely to identify a suitable transmission risk or may indicate that women who become infected in Utah are more likely to experience life situations that make complete disease investigations more difficult.

Most women living with HIV in Utah acquired it through heterosexual transmission, 2020

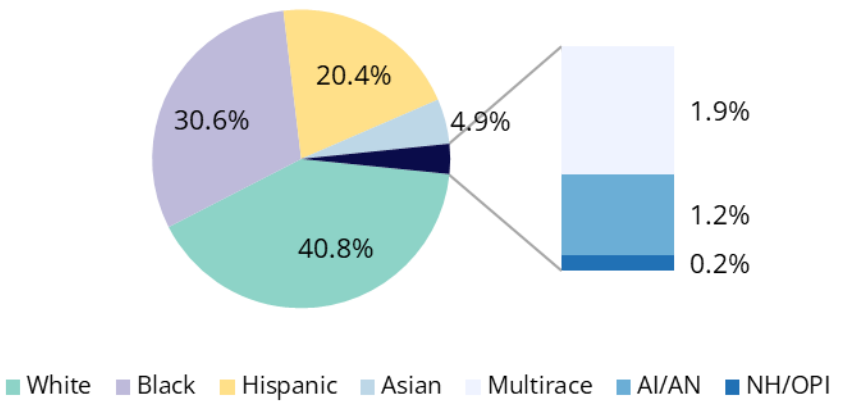


MSM is the most common transmission risk among men living with HIV in Utah, 2020



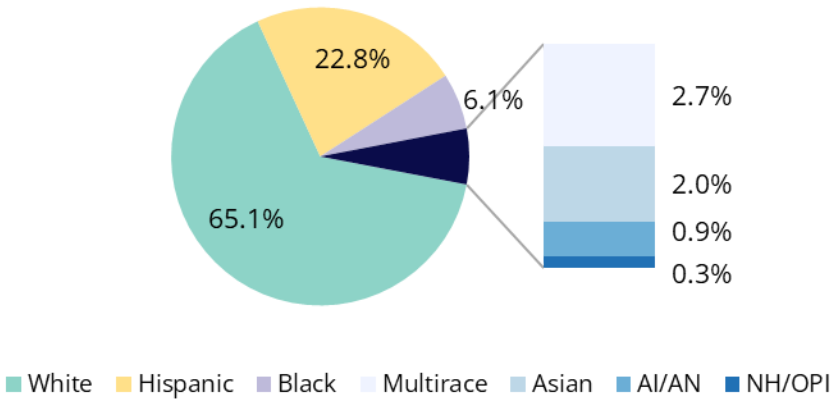

Among persons living with diagnosed HIV, over half of infected Utah women belong to a racial/ethnic minority group. Utah has a larger than average refugee population, but it is currently unknown how much of the minority burden in females is due to poor testing and prevention in home countries vs. becoming infected in Utah.

Racial/ethnic minorities comprise more than 50% of women living with HIV in Utah, 2020



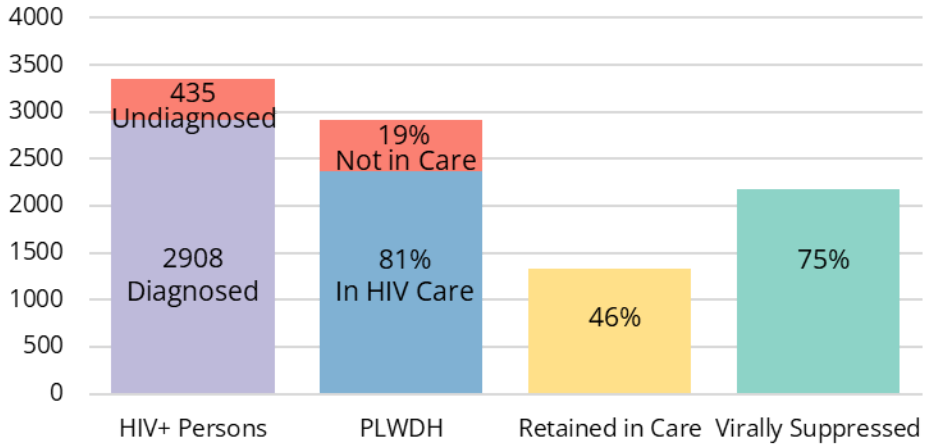

The racial/ethnic distribution among men is much closer to Utah's overall population, but still indicates a sizeable burden among minority populations, particularly Black/African American Utahns.

Racial/ethnic identities of men living with HIV resemble Utah's overall population, 2020

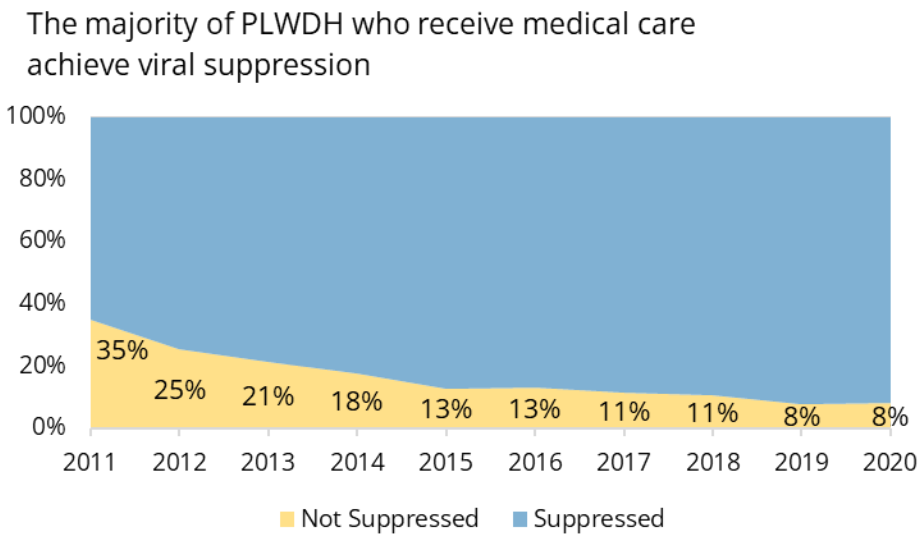



There were significant reductions in the quality of care among persons living with diagnosed HIV in 2020. Most of this is likely due to the COVID-19 pandemic, but exactly how much is unknown. Between 2019 and 2020, 5% more PLWDH fell out of care. More than 10% additional cases were not considered retained in care. The good news is that viral suppression only fell by about 4%, indicating that receiving any HIV care is the most important indicator of viral suppression rather than being retained in care.

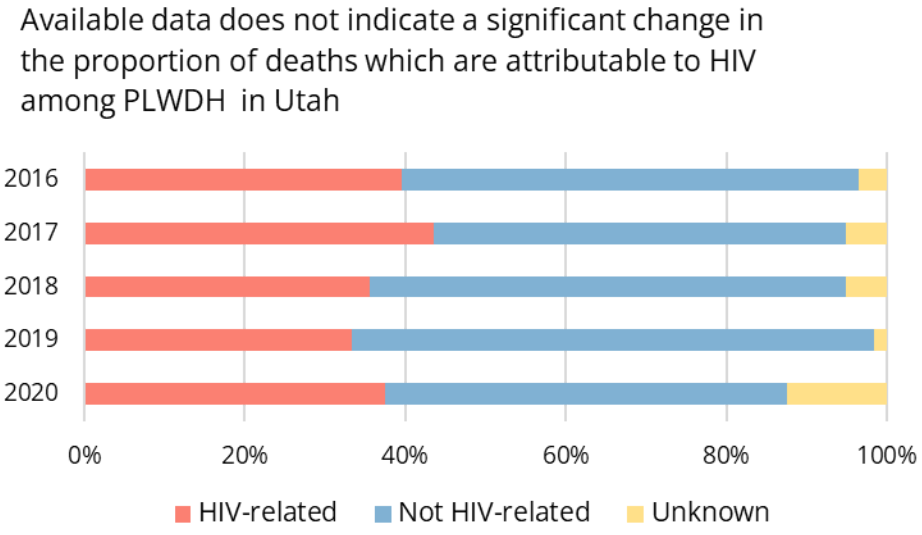
In 2020, 81% of PLWDH were in care and 75% were virally suppressed in Utah




As long as a PLWDH receives HIV care at least once during a year, they are very likely to achieve viral suppression.

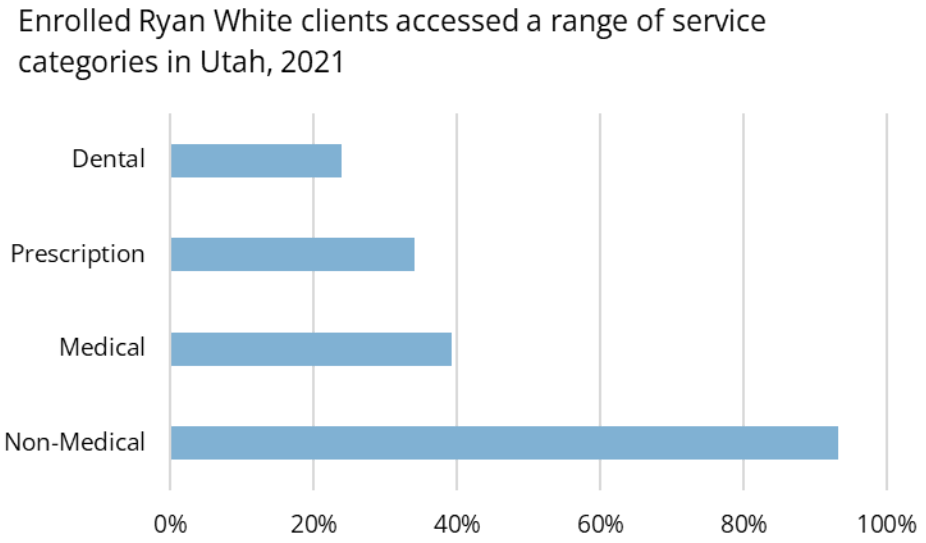



Small numbers and limited historical data make year-over-year analysis of death among PLWDH somewhat difficult, however, there do not appear to be large yearly fluctuations in the proportion of deaths attributable to HIV. Death ascertainment is not yet complete for 2020, and both the number and proportion of HIV deaths by cause are subject to change.




Estimation of education and economic factors among persons living with diagnosed HIV is very difficult since that information is not collected during a disease investigation and variation between individual households versus surrounding households can be high. What we do know is that in 2021, 1,045 PLWDH enrolled in Utah's Ryan White program. The Ryan White program is meant to be the "payer of last resort" for HIV+ people, meaning that enrollees must meet low income requirements. This means that nearly one third of Utah's total HIV prevalence is considered low enough income to qualify for Ryan White assistance. The number of PLWDH who do not enroll in Ryan White because they qualify for Medicaid

is currently unknown but represents another fraction of Utah's HIV prevalence that would be considered "low income."




### Persons at risk of HIV exposure

New case data from the past five to ten years offers us insight into who among Utah residents is most at risk for becoming infected with HIV. As is true for the national population, gay, bisexual, and other men who have sex with men experience the greatest risk. Rates of diagnosis among Hispanic individuals have been on the rise for the past several years. In Utah, the rate among native Hawaiian and other Pacific islanders has risen remarkably quickly. Young adults ages 25 to 34 are most likely to be diagnosed with HIV. Historically, those aged 35 to 44 have been the next most likely age group to be diagnosed with HIV. However, the gap between this age group and those aged 13 to 24 has been closing over the last ten years, and, in 2021, the 13 to 24 year old population had a higher rate of HIV diagnosis. This could be due to behavioral changes in the older population during the year previous, and it remains to be seen whether this trend will continue.

## HIV prevention, care, and treatment resource inventory

See Appendix D: HIV resource inventory.

Utah continues to meet with HIV stakeholder members of UHPG to ascertain the growing needs to help prevent HIV and care for PLWDH. Two local agencies provide wrap-around care for PLWDH, including benefits and eligibility specialists, case management, HIV medical providers and pharmacy services. These agencies create a one stop shop and these agencies are able to report back on the greatest needs to maximize the quality of health and support service for PLWDH. The jurisdiction has created a peer navigation

program to assist in linking those who have fallen out of care. Utah offers syringe service programs (SSPs) to assist People Who Use Drugs (PWUD) and link them to the care needed. This program continues to expand across the state. All services whether for PLWDH or those at risk for HIV have the ability to make referrals for both mental health and substance abuse services. The state continues to look at ways to improve accessibility to these services as well as housing, PrEP and HIV medical services.

## Strengths and gaps

One of the strengths of the HEART program is the size of the program and the ability for stakeholders in the jurisdiction to meet on a regular basis. The state is also contracted with a majority of stakeholders. Utah is able to offer a variety of services.

Utah is seeking to improve the current geographic disparities as many of the offered services are located along the Wasatch Front which consists of the northern urban areas of the state. Much of the rest of the state lacks the services needed to provide local comprehensive prevention, care and treatment. This continues to be a concern of stakeholders and continued efforts are being explored to expand all services so that people do not have to travel to the Wasatch Front for treatment or prevention. Another gap in services is the need for more diverse cultural services including language services to be available at care facilities. Utah's population is continuing to grow more diverse but hispanic and black populations are disproportionately affected by HIV.

Utah has been spared the difficulty of dealing with a large HIV outbreak despite a robust time-space cluster detection model and standard use of molecular surveillance tools. Each year, between 0 and 2 molecular clusters are identified and investigated. Epidemiologists at the state level analyze investigation information and report to the CDC quarterly. It has been difficult to develop formal data collection instruments and to keep the attention of local investigators, most of whom also investigate COVID, monkeypox, and other public health concerns. The roadblocks that have delayed development of investigation forms have been somewhat relieved and the program expects to have working forms in the first half of 2023. A renewed effort to communicate the importance and best practices of cluster investigation is also planned as well as Utah's participation in a joint NASTAD-CDC learning collaborative beginning in November of 2022.

## Approaches and partnerships

The HIV program is small in the state of Utah. The size of the program allows for an easy assessment of services offered to PLWDH and people who are at risk for HIV. Additionally, many service providers are stakeholders and members of UHPG and report on their services at quarterly UHPG meetings. The HEART Program has several contracted partners around the state for prevention, treatment and care services. The HIV prevention and Ryan White Part B program evaluated these contracts to create the inventory list as well as communicated with partners about the services offered.

## Needs assessment

- Services people need to access HIV testing, as well as the following status neutral services needed after testing:
    - The Community Health Survey ascertained that the majority of participants reported being tested for HIV but only one quarter of those participants reported being tested in the last year. Of those tested the majority of clients stated that they were tested due to a general health check-up with a physician. Those who decided not to be tested felt that they were at low risk. Historically, Utah has had low testing rates among its population. The majority of respondents felt that while it was important to discuss sexual health with a medical provider but felt it was uncomfortable to do so. Access to testing was not addressed in this needs assessment. The results from the Community Health Survey show the importance in provider education is making sure providers are properly trained in ascertaining HIV risks, providing the opportunity for testing, and starting the conversation about sexual health since this was the most commonly stated reason for a participant being tested.
- Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs).
    - Within the Community Health Survey a PrEP assessment was completed. While the majority of participants were familiar with PrEP the majority of respondents had not spoken to a provider in the last 12 months about PrEP. These findings suggest that an increased understanding is needed among healthcare providers around PrEP.
    - Among participants who responded to the Red Ribbon Survey the majority of Intravenous Drug Users (IDU) reported now knowing whether or not someone used their needles after their use. Syringe Service Programs have expanded and continue to expand since the results of this survey.
- Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis.
    - One of the main findings of the Red Ribbon survey was that 60% of those linked to care within 30 days of diagnosis worked with a Case Manager. Case Managers were able to assist those newly diagnosed with medical appointments and finding help for outpatient medical care. Fourteen percent of respondents were unaware of case management services. This shows the critical importance of Case Management in assisting in linkage to care activities as well as beyond the first 30 days of diagnosis.
- Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression
    - Case Management, as reported above, is important in assisting PLWDH to stay in care. Adherence programs are needed to help achieve viral suppression as one-fifth of respondents reported not taking their

medications as directed. Social determinants of health were a huge factor in PLWDH staying in care. Those who rent/own their housing were more likely to stay in care and reach viral suppression as well as those with higher education and more stable employment. Mental Healthcare was reported as a need due to high rates of stigma and discrimination that were reported.

- Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility
    - Twenty-four of Utah's twenty-nine counties have been classified as either rural or frontier counties. The majority of the population lives within the five urban counties and the majority of HIV care and treatment services are located within these counties. This has made it difficult for PLWDH who live outside of these urban counties to access the HIV treatment and care services they need. PLWDH have had to travel in excess of 5 hours to meet with an HIV provider. Along with the lack of HIV providers available to those living in rural counties, insurance plan availability is limited for several of the aforementioned rural and frontier counties. The lack of insurance plan availability often results in an HIV provider not being in network and HIV medications not available on the formulary. This can increase the out of pocket cost to PLWDH and create additional accessibility barriers.

# Priorities

- Test: Ending HIV infections and deaths starts with everyone getting tested and knowing their status
- Treat: By helping more people access care, we can prevent new infections and reduce HIV-related deaths
- Prevent: By increasing access to PrEP, nPEP, and other resources, many new HIV infections can be prevented
- Respond: With rapid access to care and cohesive efforts to identify potential exposures, we can prevent new HIV clusters and outbreaks.

# Actions taken

- Educate providers statewide on HIV testing guidelines and resources
- Get more hospitals to include HIV testing prompts in electronic medical records
- Implement at least one new testing method (at-home testing, pharmacy testing, etc.)
- Anyone with a positive HIV test will be linked to care within 30 days
- More testing sites throughout Utah will be able to initiate ARTs, often at initial diagnosis
- Ensure people living with HIV understand how to utilize support services like Ryan White
- Case management will be accessible to all Utahns through the Ryan White Part B Program and its contracted agencies

- Make PrEP and non-occupational post-exposure prophylaxis (nPEP) more affordable and accessible throughout Utah
- Increase outreach efforts to people who use drugs or participate in sex work
- Ensure anyone with a new HIV diagnosis is receiving care within 30 days
- Increase the number of contacts/partners who are tested and referred for PrEP

# Approach

In 2019 the Program contracted with the Huntsman Cancer Institute and College of Nursing to complete the Utah Red Ribbon Survey and Community Health Survey. This survey was distributed and collected in the latter half of 2019 and the final report was received at the end of 2019. The Utah Red Ribbon Survey's goal was to identify the needs for people living with HIV (PLWDH) while the Community Health Survey was intended to identify the needs of people at risk for HIV. Specifically, the goals of both surveys were to identify health disparities and inequalities, assess barriers to retaining care, identify barriers to HIV testing, ways to prevent HIV infections and enhance linkage to care.

The surveys used a self-administered cross sectional design. The Red Ribbon Survey consisted of 63 questions and the Community Health Survey consisted 58 questions. Both surveys used the 2015-2017 CDC HIV Medical Monitoring Project (MMP) and the 2012 and 2018 Behavioral Risk Factor Surveillance System questionnaires. Additional questions were informed by various other journal articles and the REACH questionnaire.

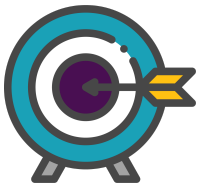
The team at the Huntsman Cancer Institute and College of Nursing completed a pilot testing of the survey in Reno, NV and also presented the Survey to Utah's HIV Planning Group (UHPG) three times to introduce the survey, seek feedback and dissemination of the survey. Both surveys were reviewed and approved by the appropriate Institutional Review Boards (IRB). Utah's HIV Planning Group includes various HIV stakeholders including HIV providers, HIV service organizations, HIV prevention groups, PrEP clinic providers, state health department programs including HIV Prevention and Ryan White Providers as well as various other HIV testing and service providers and community members living with HIV.

The Community Health survey was disseminated in both English and Spanish to several organizations that work with people at risk for HIV including the PrEP clinic, HIV testing sites, local health departments and Planned Parenthood Association of Utah. Initially, both surveys included a $10 incentive card to either Walmart or Amazon. The Red Ribbon Survey was mainly distributed to the Infectious Disease Clinic at the University of Utah, which sees the majority of PLWDH in the state of Utah. After some initial barriers in collecting the Red Ribbon survey the incentive was increased to $20 and a Smith's grocery store card.

The Red Ribbon survey included the analysis of 342 participants while the Community Health Survey included the analysis of 767 participants. The results from the Red Ribbon

survey were completed during the same time period that the UHPG was creating the statewide Getting to Zero plan. The results of the survey align with the goals made in the Getting to Zero plan and include all stakeholders involved in UHPG.

# Section IV: Situational analysis



## Diagnose

### Strengths

One strength of Utah's testing approach is the rapid tests and referral for testing that occurs in syringe service encounter outreach. People who use drugs are a priority population in Utah who are more likely to be affected by HIV. The syringe service program employs a harm reduction approach to prevent HIV transmission but also offers testing to people who may be less likely to seek medical care in conventional ways. Another strength is the new contract that the department of health is signing in with my lab box which will increase testing access in rural areas.

Utilization of ADAP rebate funding is finding more positives in populations that need testing most. Two organizations funded by ADAP rebate funding, Utah AIDS Foundation (UAF) and Salt Lake County Health Department (SLCoHD) provide home HIV testing options and targeted HIV outreach testing, respectively. Both organizations are local to Salt Lake City and provide services to the MSM population.

### Challenges

One challenge in Utah is that one local health department has not accepted state funds for HIV testing. There are community-based organizations to provide testing in that jurisdiction but it is a challenge to not have the health department actively providing HIV tests. Lack of sex education in schools is another challenge in Utah. Not providing comprehensive sex education in schools limits the ability to educate young adults about reducing harm and transmission of HIV and STDs in a population who will soon age into the 18-24 years of age population who are at an elevated risk for testing positive for HIV.

### Identified needs

Utah needs more testing access in rural areas. There are options for testing in rural areas, but expanding options for testing, especially free or low cost testing, will increase the number of people who are able to access a HIV test.

### Structural and systemic issues impacting HIV populations

Getting tested for HIV still carries a lot of stigma, especially in Utah which is a more religious state with religious influence in healthcare networks and policies. We know that conversations about HIV are not happening in a lot of primary care settings. We also know

that the array of people who are at risk for contracting HIV looks different today than it did 20 years ago and expanding the idea of who is at risk for HIV and who should be tested for HIV is an important educational component in our work to end HIV in Utah.

# Treat

## Strengths

One recent strength for treating HIV in Utah is the re-engagement to care initiative that is happening in the infectious disease clinic at the University of Utah. In this process, people who are identified on the not in care (NIC) list are reached out to by peer navigators and given options to return to treatment and receive medical care again.

Another strength in Utah is the decreased application time for Ryan White Part B applications. With faster application times, individuals are getting through the process of application and enrollment quicker than before, and decrease the time it takes to get into care. Ryan White clients are also now able to be co-treated for other health concerns. The ability of the Ryan White program in Utah to cover dental care and other health needs is an opportunity to provide the best treatment to those who need it most.

## Challenges

One challenge of HIV treatment is that treatment options can often be expensive and potentially differ in price with different insurance policy changes. There are great organizations and case workers in the state that support individuals in going through these changes, but we know that a barrier to staying in care and virally suppressed is having insurance changes, medication changes, or other gaps in care. Patients who lose insurance or have insurance changes also may not know they can access Ryan White.

In Utah there are a high number of dual diagnoses - people living with HIV who need care for mental health issues for substance use disorder - which can make adhering to treatment difficult.

Another challenge is that HOPWA vouchers have become more difficult to access and more scarce. Being in unstable housing is often a barrier to staying in care for people living with HIV. Housing prices in SLC metro areas are increasing, affordable housing opportunities are limited.

## Identified needs

Utah needs providers across the state who are educated in HIV care, specifically in rural areas of the state. Another need is access to low cost labs, so that every component of

getting into care and staying in care has reduced barriers.

### Structural and systemic issues impacting HIV populations

Many different organizations in Utah are siloed, and this can create gaps in care that makes it difficult to retain people in treatment. Utah lacks comprehensive mental health and substance use treatment(SUD) services, which can make it difficult for individuals to have all of their health needs addressed at one place of care or with one healthcare institution.

## Prevent

### Strengths

One major strength of Utah's HIV prevention approach is the free PrEP clinic. Anyone who is uninsured is able to get prep and have consistent medical treatment. Another anticipated opportunity for preventing HIV is a recent legislative initiative that allows pharmacists to prescribe prep. While regulations for this initiative are still in formulation, it is another opportunity for people to access prep/pep who need it.
Another strength is the Syringe Service Program (SSP), which provides rapid HIV testing or referrals to testing for people who use drugs (PWUDs). This program is able to access a population in need of HIV testing and provide resources at no cost to the individual. A general strength is the knowledge that treatment is prevention! U = U is an exciting new strategy for HIV prevention.

### Challenges

One challenge surrounding PrEP in Utah is that it is difficult to obtain a number of individuals who are on PrEP throughout the state. This is something that the surveillance team in HEART Program is working on, but without getting access to certain databases that have information about people who are insured this can be difficult. Utah is currently using the AIDSVu estimate for total PrEP users in Utah, but we would like to be able to calculate something that we are more confident in to measure progress.

### Identified needs

There is a need for general education about sexual health and HIV prevention in Utah, that includes the need to educate Utahns about PrEP, nPEP and U = U. Educating priority populations about access points and low cost options for PrEP and PEP is another need.

### Structural and systemic issues impacting HIV populations

Utah pharmacies are legally able to provide PrEP and PEP, but not every pharmacy chooses to provide these medications, or is able to. Funding structures have become another issue in providing HIV prevention and treatment. Great prevention strategies exist in Utah, but

will not continue without sustained funding. Different funding structures, including caps on funding certain prevention strategies or organizations, can sometimes be a challenge.

# Respond

## Strengths

Utah has a low number of new cases of HIV compared to other states. Being a low incidence state means that we have the capacity to investigate every new case of HIV within the state. Another strength is the DIS supplemental grant funding that has allowed the HEART Program to develop more training and monitoring of DIS staff throughout the state.

## Challenges

One challenge we face in responding to HIV cases in Utah is that not every HIV positive case that is investigated results in contacts elicited or those contacts being referred for PrEP or initiating PrEP. The surveillance team in HEART Program believes this is an opportunity to engage more people who are at risk for HIV, but local health departments are often overwhelmed with situational work, which has especially been the case during COVID-19, and we hope that we can work with local health departments to make this tracking more standard. As a low incidence state, some DIS staff may not be practiced or comfortable in HIV investigation. We hope that the DIS funding will aid in increasing the capacity of DIS staff for more thorough case investigations. Another challenge that is likely not specific only to Utah, is the increase in anonymous sex which makes eliciting contacts difficult.

## Identified needs

It is important that the HEART Program works with local health departments and DIS staff to develop strategies to elicit contacts and refer contacts to PrEP through active referrals. Another need is a practiced response to cluster outbreaks.

## Structural and systemic issues impacting HIV populations

COVID-19 and MPX have required focus from the DIS across the state. It is probable there will continue to be new disease investigations that will require DIS attention, making it difficult to prioritize HIV.

# Priority populations

| Tier 1 | Tier 2 |
|---|---|
| People who identify as MSM, gay, bisexual, or transgender | People who are aged 18-34 |

| | |
|---|---|
| People who have any type of sex with a known HIV-positive individual | People who engage in sex work |
| People who identify as Hispanic/Latino, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander | People who reside in one of the following Utah counties: Beaver, Box Elder, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Iron, Kane, Millard, Piute, Rich, Sanpete, San Juan, Sevier, Uintah, Wasatch, and/or Wayne |
| People who inject drugs | People who have insertive or receptive anal sex |
| | People who misuse substances |

Our identified priority populations are separated into two tiers. The first tier priority populations include: people who identify as men who have sex with men, gay, bisexual or transgender, people who have any type of sex with a known HIV-positive individual, people who identify as Hispanic/Latino, America Indian/Alaska Native, Asian, Black/African American,and/or Native Hawaiian/Pacific Islander, and people who inject drugs. The second tier priority populations include: people who are aged 18-34 years, people who engage in sex work, people who reside in one of the following Utah counties: Beaver, Box Elder, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Iron, Kane, Millard, Piute, Rich, Sanpete, San Juan, Sevier, Uintah, Wasatch, and/or Wayne, people who have insertive or receptive anal sex, and people who misuse substances. These priority populations were identified through surveillance data and statewide needs assessments outlined in prior sections.

Today we have the knowledge and technology to end the HIV epidemic. One of the key factors that is missing is access. The goals and objectives of the GTZ plan and the Integrated plan seek to increase access by increasing provider capacity, developing new strategies to meet the needs of those in rural areas, those experiencing stigma, transportation barriers, and negative consequences from other social determinants of health.

# Section V: 2022–2026 goals and objectives

A link to a PDF of the Getting to Zero (GTZ) plan is available in Appendix E.

## Diagnose

Goal 1: By 2026, 30% of Utahns know their HIV status
Goal 2: By 2026, 90% of people living with HIV have received a diagnosis

Key activities and strategies

- Implement one new technology that will aid in increased HIV testing (technology)
- Increase the number of providers reached by educational activities (provider capacity)
- Enact two systematic changes to promote HIV testing (provider capacity)
- Increase HIV screening among priority populations (HIV testing strategy)
- Promote one non-traditional HIV testing mechanism (HIV testing strategy)

| Utah state government associated programs | University of Utah associated programs | Community-based organizations |
|---|---|---|
| • DHHS Programs: HEART Program, Utah HIV Planning Group (UHPG)<br>• Local Health Departments (LHDs) | • AIDS Education Training Center (AETC)<br>• Utah Naloxone<br>• Infectious Disease Clinic | • Utah AIDS Foundation (UAF)<br>• Syringe Service Programs |

Potential funding resources:

- CDC - HIV Prevention Grant Funding (PS18-1802), STD PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PHCD)
  HRSA - Ryan White Part B Base Grant Funding and ADAP rebate funds,
- SAMHSA - Syringe Services Funding (State Opioid Response funding),

Estimated funding allocation:

- UAF - $110,000 (ADAP rebate)

- Salt Lake County Health Department (SLCO) - $70,000 (ADAP rebate)
- AETC - $110,000 (HIV PS18-1802 and STD PS19-1901)
- SSPs - $100,000 (SOR funding)
- LHDs - $250,000 (PS18-1802), $1,611,706 (PS19-1901 PHCD including DIS Workforce)

Outcomes (reported annually, locally monitored more frequently):

- Percentage of Utahns who have been tested for HIV
- Percentage of people living with HIV who are diagnosed

Monitoring data:

- Surveillance data
- BRFSS data

Expected impact on the HIV care continuum:

- Increase the number of people who know their HIV status. Increase the number of people living with HIV who are aware they have HIV so they can be linked to care.

Expected impact on status neutral approach:

- Further integration of HIV testing into primary care increases overall health and well-being of all individuals. Normalizing testing decreases stigma. Targeting priority populations provides health equity and linkage to both medical and support services.

# Treat

- Goal 1: By 2026, 95% of people living with diagnosed HIV are in care and on antiretrovirals (ARTs)
- Goal 2: By 2026, 90% of people living with diagnosed HIV are virally suppressed

Key activities and strategies

1. 90% of people with diagnosed HIV are linked to care within 30 days by end of year 2023 (engagement to care)
    a. DHHS and Infectious Disease Clinic will train peer navigators in holistic case management, and to work with all groups vulnerable to HIV, including commercial and situational sex workers, trans individuals, women, and people who use drugs(PWUD)
    b. Ensure a peer navigator is available in all jurisdictions to assist in linking people to care
    c. Case management will be accessible to all Utahns through the Ryan White Part B Program and its contracted agencies.
2. 90 % of people living with HIV are prescribed appropriate ARTs by end of year 2024 (engagement to care)
    a. AETC will educate providers on Department of Health and Human Services

(DHHS) guidelines for HIV care

3. 95% of people enrolled in the Ryan White Program utilize services within each calendar year, by end of year 2023 (core medication and supportive services)
    a. DHHS will assess education & enrollment needs to guide staff that assist people living with HIV
    b. DHHS will convene focus groups to better understand challenges associated with educating and enrolling clients in appropriate services
    c. Peer navigators will be identified and receive appropriate training to work with HIV clients
    d. DHHS will identify non-utilizing clients and refer them for peer navigation services
    e. DHHS will support systems and services to ensure people living with HIV can access medication and medical care
4. By mid-year 2023, medical care and support services will be available via technology, or within 50 miles of all Utah cities. (core medication and supportive services)
    a. AETC will provide outreach education on engagement and retention for two providers identified as potential HIV service providers
    b. DHHS will facilitate an in-service on best practices for engagement & re-engagement to core medical and support services
    c. DHHS and AETC will partner with at least three new healthcare systems or clinics to explore and implement new care models such as telemedicine
5. 80% of all Utahns living with HIV (and 95% of Utahns enrolled in Ryan White Part B) are virally suppressed by the end of year 2023. (core medication and supportive services)
    a. UAF and other Community-Based Organizations (CBOs) will implement advocacy and education efforts surrounding policies that inhibit retention and engagement to care
    b. Clinicians, UT AIDS Drug Assistance Program (ADAP), and community partners will develop and implement adherence strategies
    c. DHHS staff will coordinate with regulators to ensure proper lab reporting, and utilize quality improvement strategies where necessary
    d. Conduct interdisciplinary case review of Ryan White Part B clients with viral load > 200 copies, to identify barriers and establish treatment adherence plans.
6. By mid-year 2023, existing HIV providers will be able to initiate ARTs at diagnosis.
    a. Prevention, Treatment, and Care provider workgroup will develop clinical protocols for day-of-diagnosis appointments
    b. AETC will increase educational efforts to inform providers of early ART initiation resources
    c. Utah ADAP will determine eligibility during medical visits occurring within business hours
7. 95% of people newly diagnosed with HIV will start ARTs the same day by end of year 2024. (early ART initiation)

a. AETC will educate providers on DHHS guidelines for HIV care
b. AETC will identify and builds capacity of new providers for people living with HIV
c. Prevention, Treatment, and Care provider workgroup will develop same-day ART initiation protocols for Utah, including standing orders

| Utah state government associated programs | University of Utah associated programs | Community-based organizations |
|---|---|---|
| • Utah Division of Occupational and Professional Licensing (DOPL)<br>• DHHS Programs: HEART Program, UHPG<br>• LHDs | • University of Utah Infectious Disease Clinic<br>• AIDS Education Training Center (AETC) | • Utah AIDS Foundation (UAF)<br>• Syringe Service Programs |

Potential funding resources:

- CDC - HIV Prevention Grant Funding (PS18-1802), STD PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PHCD)
  HRSA - Ryan White Part B Base Grant Funding and ADAP rebate funds
- SAMHSA - Syringe Services Funding (State Opioid Response funding)

Estimated funding allocation:

- UAF - $110,000 (ADAP rebate), $285,000 (Part B Base)
- University of Utah IDC - $1,100,000.00
- AETC - $110,000 (HIV PS18-1802 and STD PS19-1901)
- SSPs - $100,000 (SOR funding)
- SLCO - $70,000 (ADAP rebate)
- LHDs - $250,000 (PS18-1802, includes lab allocations), $1,611,706 (PS19-1901 PHCD including DIS Workforce)

Outcomes (reported annually, locally monitored more frequently):

- Percentage of people living with diagnosed HIV are in care and on antiretrovirals (ARTs)
- Percentage of people living with diagnosed HIV are virally suppressed

Monitoring data:

- Surveillance data
- Clientrack

Expected impact on the HIV care continuum:

- Increasing the number of people with HIV who are linked to care and in tx on ARTs,

decreasing transmission through more people LWH being virally suppressed.

Expected impact on status neutral approach:

- Increasing access to care increases the overall health and well-being of PLWDH. Increasing access of PLWDH to Ryan White services increases access to support services such as housing, food, and transportation.

# Prevent

- Goal 1: By 2026, increase the number of pre-exposure prophylaxis (PrEP) users in Utah by 50%.
- Goal 2: By 2026, increase the availability of data-driven sexual health and harm reduction programming.

Key activities and strategies

1. Increase funding mechanisms that support PrEP and increase access to PrEP education (prep access)
2. Increase non-occupational post-exposure prophylaxis (nPEP) resources and education statewide (nPEP access)
3. Increase number of providers in Utah prescribing PrEP (provider capacity)
4. Increase the quality and availability of sexual health data and publish a report on PrEP and nPEP utilization and usage barriers (data utilization)
5. Increase representation of impacted communities in the Utah HIV Planning Group and increase representation in DHHS educational materials and training (community engagement)
6. Increase the quality and availability of sexual health data
    a. Release a report on the state of sexual health in Utah
    b. DHHS will increase data collection related to sexual orientation and gender identity
    c. Include sexual health questions in Utah Behavioral Risk Factor Surveillance System (BRFSS)
7. Develop two new sexual health initiatives
    a. Revise statewide HIV Prevention Testing and Counseling Training to be more client focused and sex-positive
    b. Participate in Leadership Exchange for Adolescent Health Promotion
8. Increase harm reduction programming for PLWDH who use drugs
    a. Better integrate DHHS systems by participating in Workgroup for Integrated Substance User Health (WISH)

| Utah state government associated programs | University of Utah associated programs | Community-based organizations |
|---|---|---|

| | | |
|---|---|---|
| • DHHS Programs: HEART Program, Utah HIV Planning Group (UHPG), WISH (VIPP, OSUMH, OME, Public Safety, Marijuana)<br>• DOPL<br>• LHDs | • AIDS Education Training Center (AETC)<br>• Infectious Disease Clinic (IDC)<br>• Utah Naloxone | • Utah AIDS Foundation (UAF), Salt Lake Harm Reduction Project (SHRP), Soap 2 Hope (S2H) |

Potential funding resources:

- CDC - HIV Prevention Grant Funding (PS18-1802), STD PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PHCD)
  HRSA - Ryan White Part B Base Grant Funding and ADAP rebate funds,
- SAMHSA - Syringe Services Funding (State Opioid Response funding,

Estimated funding allocation:

- UAF - $110,000 (ADAP rebate)
- University of Utah -Infectious Disease Clinic- $25,000 (HIV PS18-1802)
- SSPs - $100,000 (SOR funding)
- AETC - $110,000 (HIV PS18-1802 and STD PS19-1901)

Outcomes (reported annually, locally monitored more frequently):

- Percentage of PrEP users in Utah

Monitoring data:

- AIDSvu (using estimate for PrEP)
- AHEAD Dashboard

Expected impact on the HIV care continuum:

- Increasing the number of people on PrEP will decrease new HIV infections.

Expected impact on status neutral approach:

- Increasing access to PrEP also increases access to other medical services including STD testing. Fewer STDs and more PrEP reduces overall health wellness and reduces transmission. Better utilizing sexual health data gives us an idea of how overall health is in our population and how we can better our programming.

# Respond

- Goal 1: By 2026, 95% of people living with HIV are in care and on antiretrovirals (ARTs)
- Goal 2: By 2026, 90% of people living with HIV have received a diagnosis

Key activities and strategies

1. Provide linkage to care services for all people newly diagnosed with HIV and conduct a quarterly cohort review of new diagnoses
2. Increase contacts elicited from new HIV diagnoses by interviewing all people newly diagnosed with HIV and providing partner notification services.
3. Utilize case managers and peer navigators to contact individuals identified as not in care (NIC) and re-engage them in core medical and support services
4. Establish an Outbreak and Cluster Response Plan and utilize that plan to Identify and respond to outbreaks and clusters with appropriate materials to be shared with providers and people living with diagnosed HIV
5. Investigate 100% of perinatal exposures in Utah by developing pregnancy and perinatal HIV report forms and issuing State guidance on perinatal exposure investigation best practices

| Utah state government associated programs | University of Utah associated programs |
|---|---|
| • DHHS (UDOH) Programs: HIV and STD Program, Utah HIV Planning Group (UHPG)<br>• LHDs | • Infectious Disease Clinic<br>• AIDS Education Training Center (AETC) |

Potential funding resources:

- CDC - HIV Prevention Grant Funding (PS18-1802), STD PS19-1901 Strengthening STD Prevention and Control for Health Departments (STD PHCD)
  HRSA - Ryan White Part B Base Grant Funding and ADAP rebate funds
- SAMHSA - Syringe Services Funding (State Opioid Response funding

Estimated funding allocation:

- LHDs - $250,000 (PS18-1802), $1,611,706 (PS19-1901 PHCD including DIS Workforce)

Outcomes (reported annually, locally monitored more frequently):

- Percentage of PLWDH in care
- Percentage of PLWDH who are diagnosed

Monitoring data:

- All Payer Claims Database
- Surveillance data

Expected impact on the HIV care continuum:

- Increasing the number of people aware of their HIV status and number of people in care (linked to care).

Expected impact on status neutral approach:

- Increasing access to care increases the overall health and well-being of PLWDH. Increasing number of contacts elicited provides opportunities for referrals to health screening and support services

# Section VI: 2022-2026 Integrated planning implementation, monitoring, and jurisdictional follow-up

## 2022-2026 Integrated planning implementation approach

### Implementation

The GTZ plan began in December 2020 but planning began in 2017. During the planning process members of the Prevention, Treatment and Care program reached out to community partners to have meetings and discussions about what efforts they thought were important to include in the plan and what feedback they had on strategic plans that had been used by the DOH before. The UHPG is comprised of members of community organizations both funded and not funded by the department HIV providers, outreach groups that provide HIV testing, local health departments, people living with HIV and people with lived experience in the community that provide unique perspectives. UHPG also includes members of the HEART Program program. Because UHPG is composed of diverse stakeholders and community members, it was used in the formulation of this plan and in the dissemination of information about tracking goals and updates to the plan.

### Monitoring

When the plan was drafted in 2020 the evaluator of the GTZ plan in the HEART Program and other members of the HEART Program program worked together to meet with the key stakeholders and UHPG to ask for feedback on the draft of the plan. Considering that this would be the strategic plan for Utah for the next five years, it was decided that funding that the department had to offer contractors would be spent in a way that would support plan goals. This included funding for syringe service programs and other streams of funding that were not limited to HIV prevention or treatment only but provided multiple services to individuals who were at risk for HIV.

### Evaluation

In January 2020 an evaluator was hired to monitor the goals for the GTZ plan. The goals in the GTZ plan are SMART goals and were created using data specific to Utah. In monitoring the plan the valuator tracks what activities are being completed and what steps are being

taken to work towards goals. The long-term and short-term goals of the GTZ plan will not be completed until 2023 but progress is continually tracked and measured. There are goals in the GTZ plan that pertain to the percentage of people living with HIV who are virally suppressed and other similar surveillance trends. The valuator works closely with the HIV surveillance team to gather this data and report when necessary. The COVID-19 pandemic delayed some opportunities for reporting based on availability of surveillance data. The evaluator reports on the goals of the GTZ plan and any information about monitoring that has changed quarterly at each UHPG meeting. The GTZ plan is being used as the framework for the Integrated Plan so that both plans can make progress on similar efforts to end HIV in Utah.

## Improvement

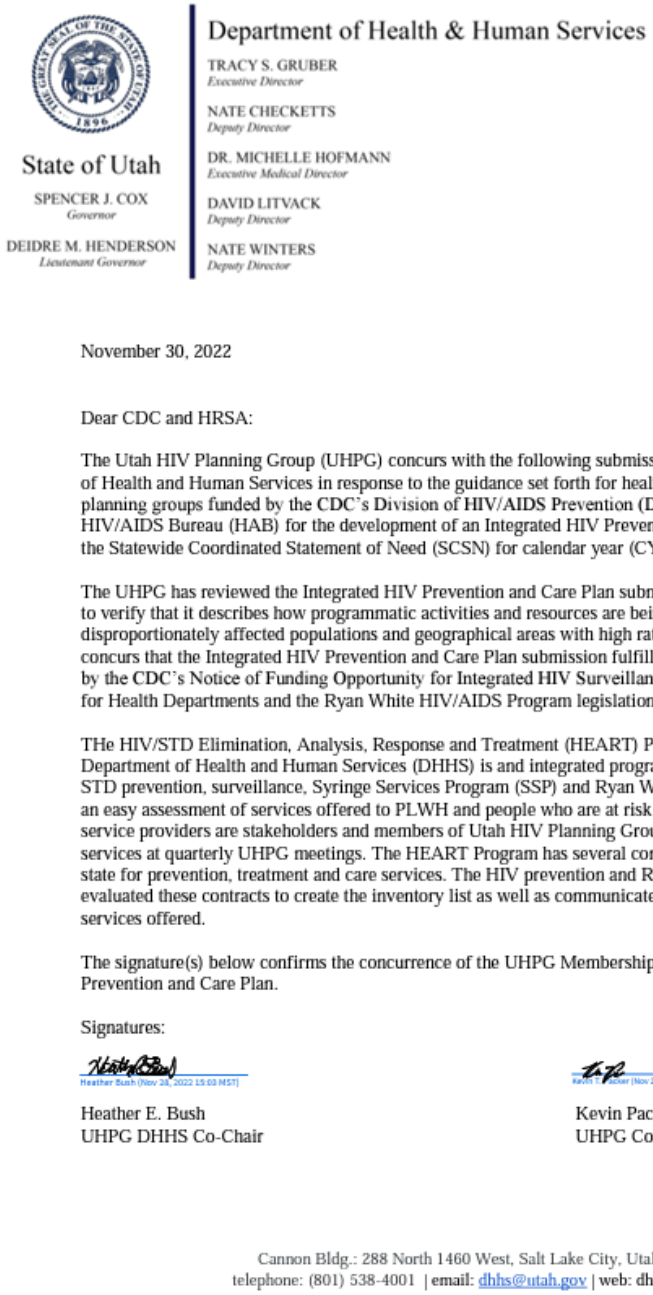
The GTZ plan is monitored internally and performance measures or successes are reported annually at UHPG meetings. The GTZ plan activities are performed by members of the HEART Program staff and community organizations contracted through DHHS, and also not contracted organizations. Organizations and individuals who contribute to plan efforts are asked to report activity progress quarterly to the GTZ evaluator. HEART Program staff is also asked to report activity progress quarterly. The evaluator will create a yearly report to show progress on performance measures using surveillance data from Utah, and reporting from different agencies and community organizations. The evaluator will publish a GTZ report in the remaining months of 2022.

## Reporting and dissemination

The GTZ plan will be open for feedback annually in January. In January 2022 the plan was open for feedback and the evaluator gathered anonymous feedback through a REDCap survey. The survey was distributed to members of UHPG and other stakeholders. The survey was available to anyone, so community organizations and partners were encouraged to share with people with lived experience or anyone they thought might be interested to look at the plan and provide feedback. The evaluator then gathered the feedback and presented that to UHPG. After the discussion of feedback and solutions, the members of the planning group were asked to vote on proposed changes to the plan including wording updates and addition/elimination of certain activities. When voting concluded the evaluator updated the plan.

# Section VII: Letter of concurrence

For the complete letter of concurrence, please go to Appendix F, or click on the screenshot of the letter below to be taken there automatically.



State of Utah
SPENCER J. COX
*Governor*
DEIDRE M. HENDERSON
*Lieutenant Governor*

Department of Health & Human Services
TRACY S. GRUBER
*Executive Director*
NATE CHECKETTS
*Deputy Director*
DR. MICHELLE HOFMANN
*Executive Medical Director*
DAVID LITVACK
*Deputy Director*
NATE WINTERS
*Deputy Director*

November 30, 2022

Dear CDC and HRSA:

The Utah HIV Planning Group (UHPG) concurs with the following submission by the Utah Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The UHPG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body 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/AIDS Program legislation and program guidance.

THe HIV/STD Elimination, Analysis, Response and Treatment (HEART) Program at the Utah Department of Health and Human Services (DHHS) is and integrated program encompassing HIV and STD prevention, surveillance, Syringe Services Program (SSP) and Ryan White Part B. This allows for an easy assessment of services offered to PLWH and people who are at risk for HIV. Additionally, many service providers are stakeholders and members of Utah HIV Planning Group (UHPG) and report on their services at quarterly UHPG meetings. The HEART Program has several contracted partners around the state for prevention, treatment and care services. The HIV prevention and Ryan White Part B program evaluated these contracts to create the inventory list as well as communicated with partners about the services offered.

The signature(s) below confirms the concurrence of the UHPG Membership with the Integrated HIV Prevention and Care Plan.

Signatures:

Heather E. Bush
UHPG DHHS Co-Chair

Kevin Packer
UHPG Community Co-Chair

Cannon Bldg.: 288 North 1460 West, Salt Lake City, Utah 84116
telephone: (801) 538-4001 | email: dhhs@utah.gov | web: dhhs.utah.gov

# Appendix A: CY 2022 – 2026 CDC DHAP and HRSA HAB integrated prevention and care plan guidance checklist

Please proceed to the next page to view the CY 2022 – 2026 CDC DHAP and HRSA HAB integrated prevention and care plan guidance checklist.

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| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| **Section I: Executive Summary of Integrated Plan and SCSN** | *Purpose:* To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission<br>Tips for meeting this requirement<br>1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements.<br>2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other. | | |
| **1.** Executive Summary of Integrated Plan and SCSN | Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below. | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished)<br>• Appendix D: HIV resource inventory | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | | • Appendix E: Utah Getting to Zero plan | |
| **a.** Approach | Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.). | • Appendix E: Utah Getting to Zero plan | |
| **b.** Documents submitted to meet requirements | List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement. | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished)<br>• Appendix D: HIV resource inventory<br>• Appendix E: Utah Getting to Zero plan | 7 |
| **Section II: Community Engagement and Planning Process** | *Purpose:* To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | programmatic requirements including:<br>1. SCSN<br>2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV<br>3. CDC planning requirements<br>Tips for meeting this requirement<br>1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released.<br>2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906.<br>3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.<br>4. The community engagement process should reflect the local demographics.<br>5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | especially new stakeholders, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of stakeholders to be included.<br>6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services).<br>7. Include community engagement related to "Respond" and support of cluster detection activities. | | |
| **1.** Jurisdiction Planning Process | Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans such as the EHE plan. Please be sure to address the items below in your description | • Appendix D: HIV resource inventory | 8 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| **a.** Entities involved in process | List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities such as HOPWA funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for list of required and suggested stakeholders | • Appendix D: HIV resource inventory | 8-9 |
| **b.** Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans) | Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan. | N/A. Don't receive RWHAP Part A funds | N/A. Don't receive RWHAP Part A funds |
| **c.** Role of Planning Bodies and Other Entities | Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement occurred. EHE | • Appendix D: HIV resource inventory | 9-10 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| | planning may be submitted as long as it includes updates that describe ongoing activities. | | |
| **d.** Collaboration with RWHAP Parts – SCSN requirement | Describe how the jurisdiction incorporated RWHAP Parts A D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system. | • Appendix D: HIV resource inventory | 10 |
| **e.** Engagement of people with HIV – SCSN requirement | Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan. | • Appendix D: HIV resource inventory | 10-12 |
| **f.** Priorities | List key priorities that arose out of the planning and community engagement process. | • Appendix E: Utah Getting to Zero plan | 13 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| **g.** Updates to Other Strategic Plans Used to Meet Requirements | If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe:<br>1. How the jurisdiction uses annual needs assessment data to adjust priorities.<br>2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders.<br>3. Any changes to the plan as a result of updates assessments and community input.<br>4. Any changes made to the planning process as a result of evaluating the planning process. | • Appendix E: Utah Getting to Zero plan | 13-14 |
| **Section III: Contributing Data Sets and Assessments** | *Purpose:* To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | 1. SCSN<br>2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV<br>3. CDC planning requirements<br>Tips for meeting this requirement<br>1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county*.<br>2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.<br>3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters.<br>4. The data used in this section should inform both the situational analysis and the goals established | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| | by the jurisdiction.<br>5. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot. | | |
| **1.** Data Sharing and Use | Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose. | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished) | 15 |
| **2.** Epidemiologic Snapshot | Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years). The snapshot should highlight key descriptors of people diagnosed with HIV and at-risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at-risk for exposure to HIV. This snapshot should | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished) | 15-29 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| | also describe any HIV clusters identified and outline key characteristics of clusters and cases linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction. | | |
| **3.** HIV Prevention, Care and Treatment Resource Inventory | Create an HIV Prevention, Care and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive:<br>● Organizations and agencies providing HIV care and prevention services in the jurisdiction.<br>● HRSA (must include all RWHAP parts) and CDC funding sources.<br>● Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding.<br>● Describe the jurisdiction's strategy for | ● Appendix D: HIV resource inventory | 29-34 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| | coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services. • Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves.<br>• Describe how services will maximize the quality of health and support services available to people at-risk for or with HIV. | | |
| **a.** Strengths and Gaps | Please describe strengths and gaps in the HIV prevention, care and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts. | • Appendix D: HIV resource inventory | 30 |
| **b.** Approaches and partnerships | Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area. | • Appendix D: HIV resource inventory | 30 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| **4.** Needs Assessment | Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including:<br>1. Services people need to access HIV testing, as well as the following status neutral services needed after testing:<br>a. Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs<br>b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs<br>2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression – Needs<br>3. Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished) | 31-34 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| **a.** Priorities | List the key priorities arising from the needs assessment process. | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished) | 32 |
| **b.** Actions Taken | List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process. | • Appendix E: Utah Getting to Zero plan | 32-33 |
| **c.** Approach | Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3.* | • Appendix G: 2019 Utah Red Ribbon Survey and Community Health Survey report | 33-34 |
| **Section IV: Situational Analysis** | Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
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| | Tips<br>1. New or existing material may be used; however, existing material will need to be updated if used.<br>2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN.<br>3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using EHE plans to fulfill this requirement, be sure to include updates as noted below. | | |
| **1.** Situational Analysis | Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV care continuum (unpublished)<br>• Appendix D: HIV resource inventory | 35-39 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas:<br>A. Diagnose all people with HIV as early as possible<br>B. Treat people with HIV rapidly and effectively to reach sustained viral suppression<br>C. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)<br>D. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them<br>*Please note jurisdictions may submit other plans to satisfy this requirement, if applicable to the entire HIV prevention and care service system across the jurisdiction.* | • Appendix E: Utah Getting to Zero plan | |
| **a.** Priority Populations | Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction. | • Appendix C: 2021 HIV integrated epidemiologic profile and HIV | 38-39 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | | • care continuum (unpublished)<br>• Appendix E: Utah Getting to Zero plan | |
| **Section V: 2022-2026 Goals and Objectives** | *Purpose:* To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding.<br>Tips for meeting this requirement:<br>1. *Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area.*<br>2. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following:<br>a. Diagnose all people with HIV as early as possible<br>b. Treat people with HIV rapidly and effectively to reach sustained viral | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | suppression<br>c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis<br>3. (PEP) and syringe services programs (SSPs)<br>a. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.<br>4. The plan should include goals that address both HIV prevention and care needs and health equity. | | |
| **1.** Goals and Objectives Description | List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least 3 goals and objectives for each of these four areas. See *Appendix 2* for suggested format for Goals and Objectives. | • Appendix E: Utah Getting to Zero plan | 40-47 |
| **a.** Updates to Other Strategic Plans Used to Meet Requirements | If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of | | N/A |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | data. | | |
| **Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up** | *Purpose:* To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases:<br>1. Implementation<br>2. Monitoring<br>3. Evaluation<br>4. Improvement<br>5. Reporting and Dissemination<br>Tips for meeting this requirement<br>1. This requirement may require the recipient to create some new material or expand upon existing materials.<br>2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process.<br>3. If you are submitting portions of a different jurisdictional plan to meet this requirement, | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases. | | |
| **1.** 2022-2026 Integrated Planning Implementation Approach | 1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met | • Appendix E: Utah Getting to Zero plan | 48-49 |
| **a.** Implementation | 2. Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams including but not limited to HAB and CDC funding. | • Appendix E: Utah Getting to Zero plan | 48 |
| **b.** Monitoring | 3. Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding | • Appendix E: Utah Getting to Zero plan | 48 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.* | | |
| **c.** Evaluation | 4. Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group. | • Appendix E: Utah Getting to Zero plan | 48-49 |
| **d.** Improvement | 5. Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how | • Appendix E: Utah Getting to Zero plan | 49 |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | those decisions will be made. | | |
| **e.** Reporting and Dissemination | 6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan. | • Appendix E: Utah Getting to Zero plan | 49 |
| **f.** Updates to Other Strategic Plans Used to Meet Requirements | If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe:<br>1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities.<br>2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes.<br>3. Revisions made based on work completed. | • Appendix E: Utah Getting to Zero plan | N/A |
| **Section VII: Letters of Concurrence** | Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See *Appendix 6* for a | | |

| Requirement | Requirement Detail | Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement | Page(s) Where Requirement is Addressed |
|---|---|---|---|
| | sample Letter of concurrence. | | |
| **1.** CDC Prevention Program Planning Body Chair(s) or Representative(s) | | • Appendix F: Letter of concurrence | Appendix F: Letter of concurrence |
| **2.** RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s) | | N/A. Don't receive RWHAP Part A funds | N/A. Don't receive RWHAP Part A funds |
| **3.** RWHAP Part B Planning Body Chair or Representative | | • Appendix F: Letter of concurrence | Appendix F: Letter of concurrence |
| **4.** Integrated Planning Body | If submitting an EHE plan, please ensure that the EHE planning body concurs. | • Appendix F: Letter of concurrence | Appendix F: Letter of concurrence |
| **5.** EHE Planning Body | If submitting an EHE plan, please ensure that the EHE planning body concurs. | N/A. Don't receive EHE funds | N/A. Don't receive EHE funds |

# Appendix B: Glossary

## Alphabetical

**ADAP**: AIDS Drug Assistance Program
**AETC**: AIDS Education Training Center
**AIDSVu**: is an interactive online mapping tool that visualizes the impact of the HIV epidemic on communities across the United States.
**APCD**: All-payer claims database
**ART**: Antiretroviral therapy. The standard treatment consists of a combination of drugs that suppress HIV replication. The combination of drugs is used in order to increase potency and reduce the likelihood of the virus developing resistance.
**AUCH**: Association of Community Health Centers
**BRFSS**: Behavioral Risk Factor Surveillance System
**CAPTC**: California AIDS Prevention Training Center
**CBOs**: Community-Based Organizations
**CD4**: is an indicator of immune function in patients living with HIV and one of the key determinants for the need of opportunistic infection (OI) prophylaxis.
**CDC**: Centers for Disease Control and Prevention
**DHAP**: Disaster Housing Assistance Program
**DHHS**: Department of Health and Human Services
**DIS**: Disease Intervention Specialist
**eHARS**: Enhanced HIV/AIDS Reporting System
**EHE**: Ending the HIV Epidemic
**EPITrax**: is an open source, highly configurable, comprehensive surveillance and outbreak management application designed for public health.
**FQHCs**: Federally qualified health centers
**GTZ**: Getting to Zero initiative
**HAB**: HIV/AIDS Bureau
**HEART**: HIV/STD Elimination, Analysis, Respond, and Treatment
**HOPWA**: Housing Opportunities for Persons With AIDS
**HRSA**: Health Resources and Services Administration
**IBIS-PH**: Utah's Public Health Indicator Based Information System
**IDC**: Infectious Disease Clinic
**IDU**: Intravenous drug use
**IHS**: Indian Health Service
**IRB**: Institutional Review Boards
**LHD**: Local Health Department
**MMP**: Medical Monitoring Project
**MPX**: Monkeypox
**MSM**: Male to male sexual contact
**NASTAD**: National Alliance of State and Territorial AIDS Directors

**NIC**: Individuals not in care
**nPEP**: Nonoccupational HIV Postexposure Prophylaxis
**OME**: Office of the Medical Examiner
**OSUMH**: Office of Substance Use and Mental Health
**PCSI**: Program Collaboration and Service Integration
**PEP**: Post-exposure prophylaxis
**PLWDH**: People living with diagnosed HIV
**PPAU**: Planned Parenthood Association of Utah
**PrEP**: Pre-exposure prophylaxis
**PWUD**: People Who Use Drugs
**QI**: Quality Improvement
**RWB**: Ryan White Part B
**RWHAP**: Ryan White HIV/AIDS Program
**S2H**: Soap 2 Hope
**SAMHSA**: Substance Abuse and Mental Health Services Administration
**SCSN**: Statewide Coordinated Statement of Need
**SHRP**: Salt Lake Harm Reduction Project
**SLCoHD**: Salt Lake County Health Department
**SMART**: Specific, Measurable, Achievable, Relevant, and Time-Bound
**SOR**: State Opioid Response
**SSP**: Syringe Services Programs
**U = U**: Undetectable = Untransmittable
**UAF**: Utah AIDS Foundation
**UHPG**: Utah's HIV Planning Group
**UMA**: Utah Medical Association
**VIPP**: Violence, Injury, and Prevention Program
**WISH**: Workgroup for Integrated Substance User Health

# Chronological

**HEART**: HIV/STD Elimination, Analysis, Respond, and Treatment
**SCSN**: Statewide Coordinated Statement of Need
**RWHAP**: Ryan White HIV/AIDS Program
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**UMA**: Utah Medical Association
**FQHCs**: Federally qualified health centers
**CD4**: is an indicator of immune function in patients living with HIV and one of the key determinants for the need of opportunistic infection (OI) prophylaxis.
**APCD**: All-payer claims database

# Appendix C: HIV integrated epidemiologic profile and HIV care continuum (unpublished)

Please proceed to the next page to view the HIV integrated epidemiologic profile and HIV care continuum (unpublished).

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Utah Department of
Health & Human Services
Population Health

HIV/STD Elimination, Analysis, Response, and Treatment (HEART) Program

# 2021: HIV epidemiological profile

# Acknowledgements

The Utah Department of Health & Human Services (UDHHS) recognizes the efforts of local health department (LHD) personnel throughout the state who play a critical role in data collection and case investigation and ensure accurate and timely reporting of communicable disease data.

The UDHHS also recognizes the efforts of other reporting partners including laboratories, healthcare facilities, healthcare providers, and the public in providing communicable disease data which contributed to this report.

The UDHHS 's HIV surveillance epidemiologists, Luke Edvalson, MPH and Jake Ortega, MPH compiled this report with the support of their colleagues in the UDHHS HIV/STD, Elimination, Analysis, Response, and Treatment (HEART) program. HIV/AIDS and other reportable communicable disease data for Utah are published by the UDHHS Population Health Division.

The UDHHS acknowledges long standing social, economic, and environmental inequities have resulted in adverse health outcomes for many populations. The effects they have on communities vary and often have a greater influence on health outcomes than either individual choices or one's ability to access health care. Health disparity reduction through policies, practices, and organizational systems can help improve opportunities for all Utahns.

# Data notes

Data from multiple data systems was utilized to compile this report, including: HIV surveillance data from the enhanced HIV/AIDS Reporting System (eHARS), UT-NEDSS (EpiTrax), Ryan White Part B's Client Track, and population data from IBIS-PH (Utah's Indicator Based Information System for Public Health).

Please direct questions or comments to:
UDHHS Population Health Division
PO Box 142104
Salt Lake City, Utah 84114
Phone: (801) 538-6191
Email: epi@utah.gov
Websites: https://ptc.health.utah.gov/
http://www.hivandme.com/

# New HIV diagnoses in Utah

In 2021, 136 newly diagnosed HIV infections were identified for a rate of 4.1 new diagnoses per 100,000 residents. Although rates have declined significantly since the height of the epidemic, little progress has been made over the past 10 years.

Fig.1 The rate of new HIV diagnoses in Utah has not decreased in the last 10 years

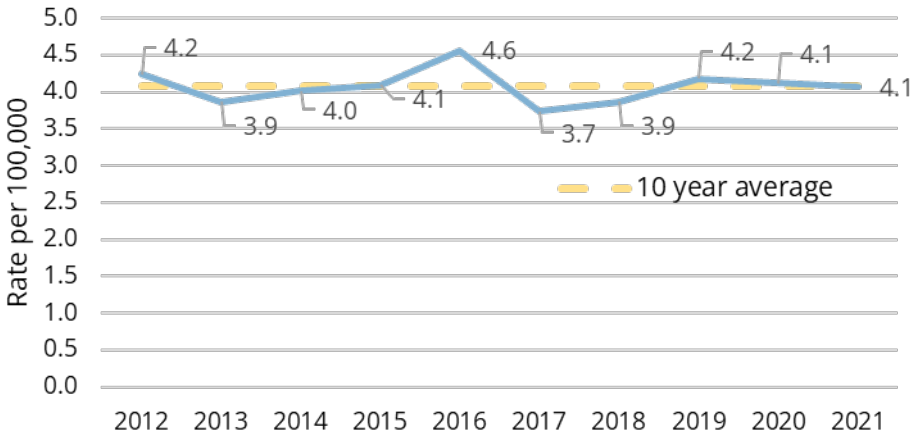
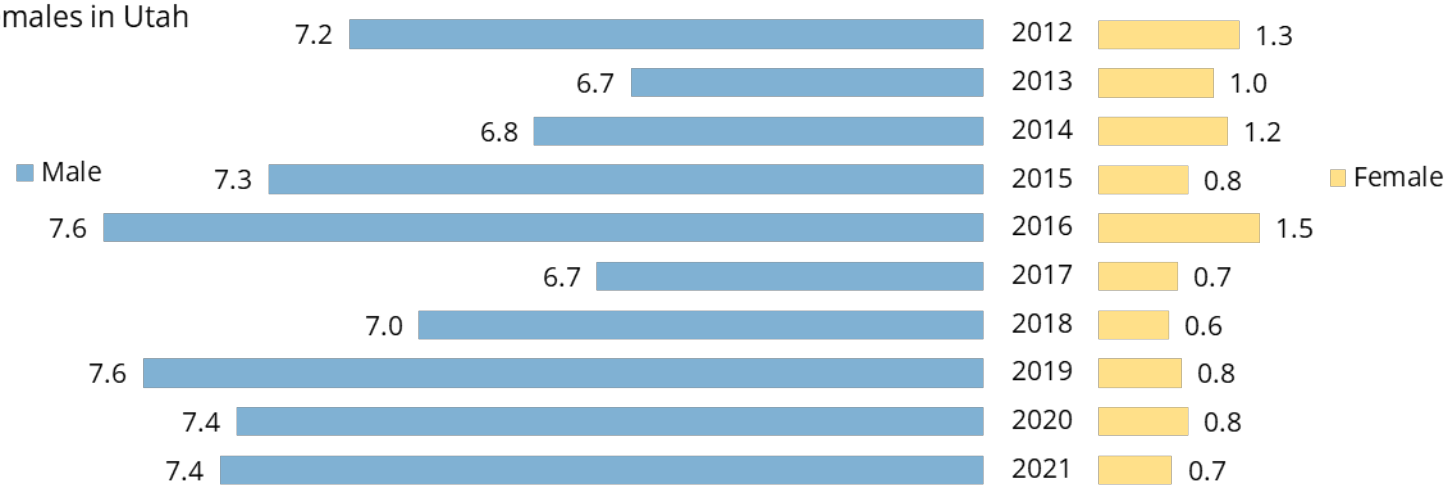
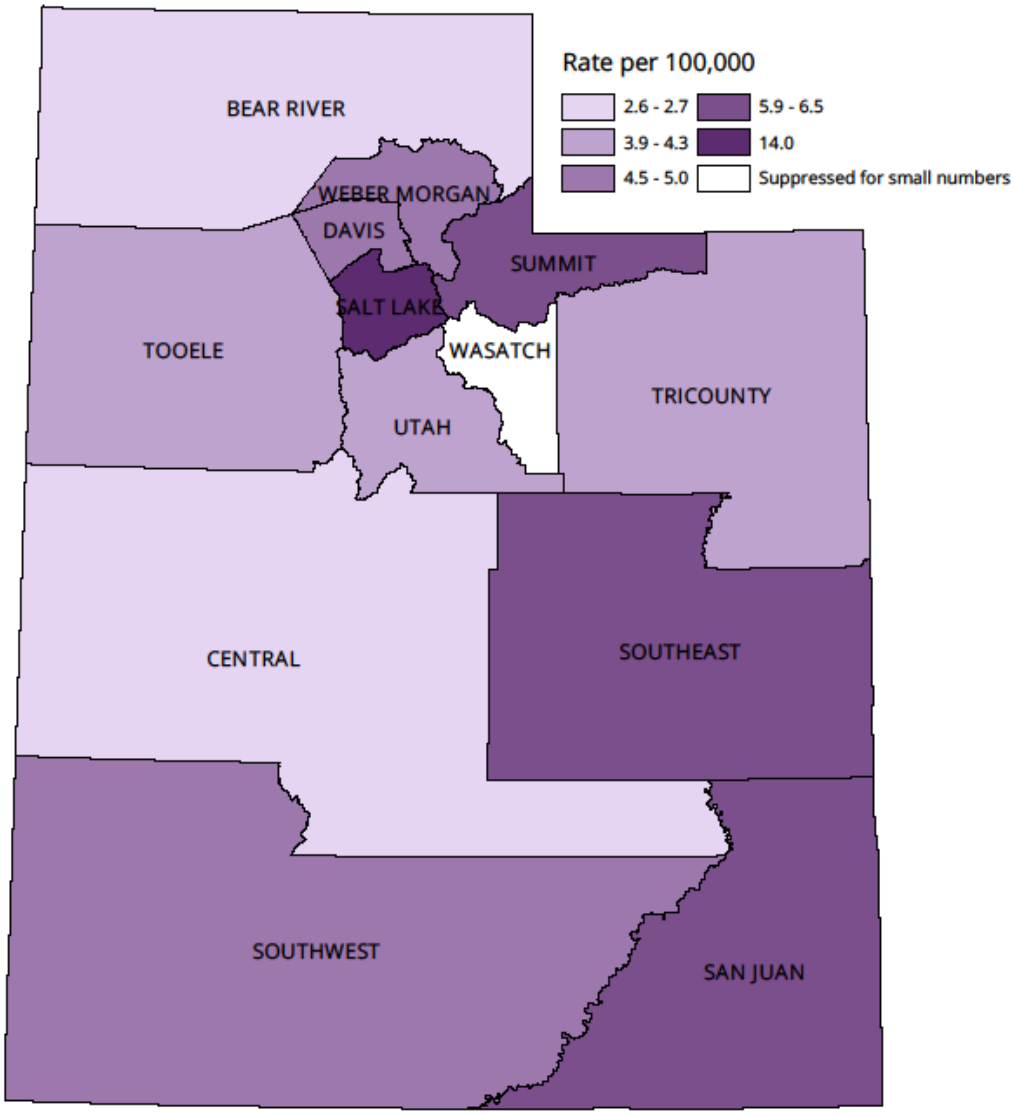



Fig 2. HIV rates are significantly higher among males than females in Utah



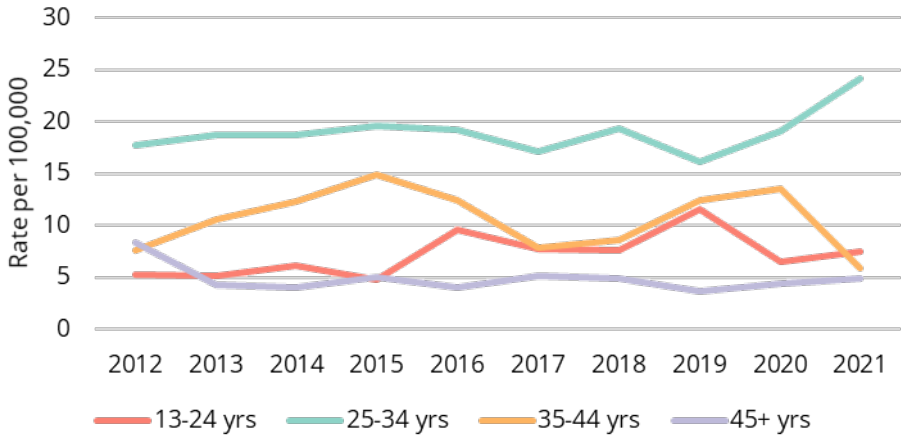
In 2021, 91% of newly diagnosed HIV infections were reported along the Wasatch Front; 63% were reported in Salt Lake County alone. Outside of Utah's largest population centers, most Utah counties and local health districts experience low numbers of new diagnoses without consistent trends. Low numbers result in large differences in rates from year-to-year. Epidemiologists get around these issues by combining multiple years of data into a single statistic.

Fig 3. Most new cases live in Salt Lake county, but HIV affects all of Utah, 2017–2021



Utah's numbers of new HIV diagnoses among women, when broken down by age group, are too small to produce rates usable for comparison or trend analysis. The same is true for males younger than 13 years of age. The difference in rates among men ages 45 and older is insignificant, so those categories have been combined for the figure below. For case counts, please see Table 3 at the end of this report.

Fig 4. Most new HIV diagnoses are among younger men in Utah




## Transmission category

The "transmission category" presented in this report is the most likely way that person acquired HIV. Determining the HIV risk of heterosexual partners during an investigation can be difficult. This frequently results in high numbers of cases (especially among females) being assigned a transmission risk which translates to "unknown" in CDC reports. To better illustrate information on transmission risk, this report includes an additional transmission category: heterosexual contact of unknown risk (previously referred to as "low-risk heterosexual contact"). This transmission category is defined by Utah as heterosexual contact with a person at low or unknown risk for HIV infection.

In Figure 6, the number of cases in each category is labeled to emphasize that larger percentages in each category are the result of small case numbers and the absence of MSM and MSM/IDU categories. It does not indicate that Utah women with HIV are more likely than men to engage in injection drug use.

Fig 5. Male to male sexual contact is the leading route of HIV transmission among Utah men

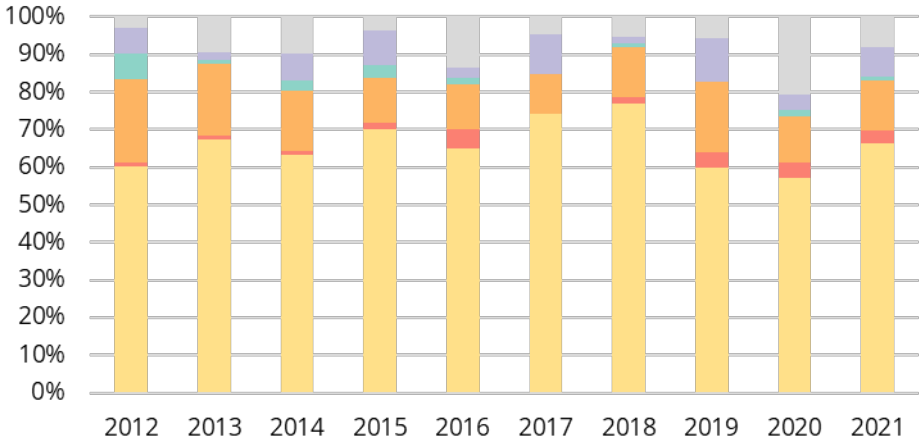
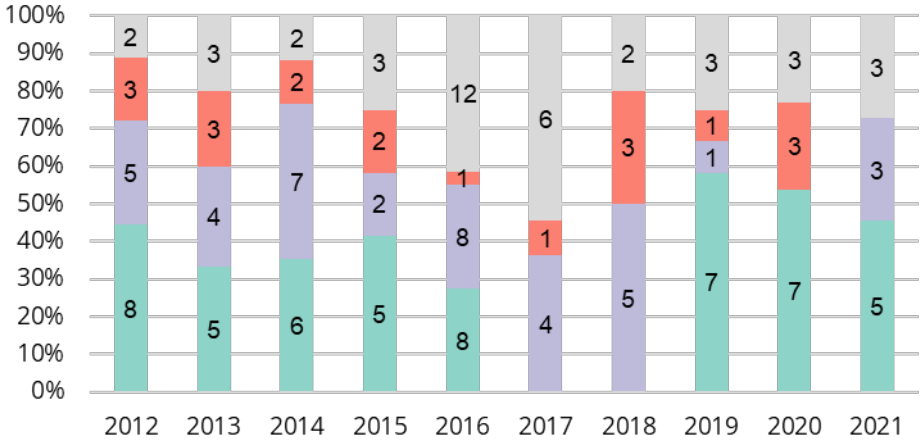



Fig 6. Heterosexual contact is the leading route of HIV transmission among Utah women

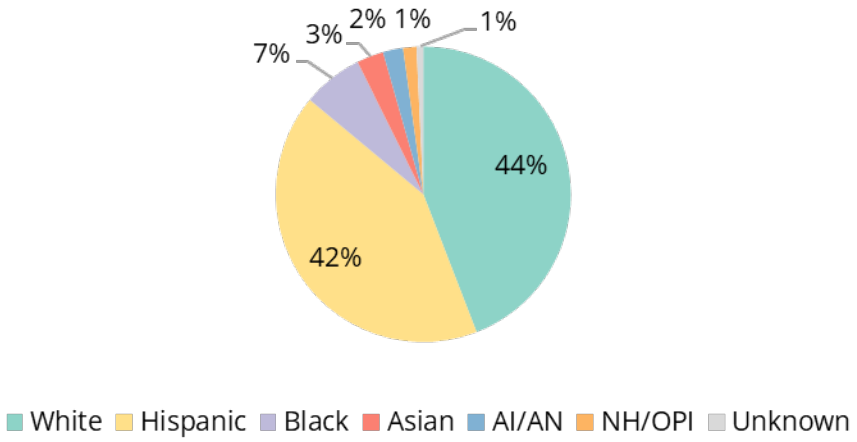



## Race and ethnicity

For the purposes of HIV surveillance, racial/ethnic categories are divided into major racial categories and one ethnic category. References to persons who are of Hispanic origin are shown as “Hispanic” regardless of other racial identities. Other racial categories refer only to persons who are non-Hispanic. Among females, a disproportionately large percentage of new infections was among women who are Black. As there were only 11 new diagnoses among females, this percentage is not

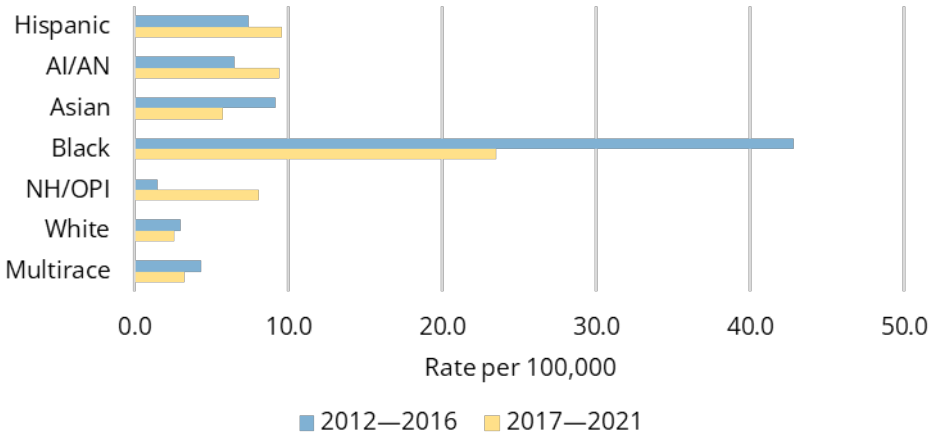
statistically stable; however, it is important to note this pattern repeats every year. Some of this may be due to persons immigrating to Utah from countries where heterosexual transmission of HIV is more common.

Fig 7. Most new HIV diagnoses are among White and Hispanic populations in Utah, 2021




When the number of new HIV diagnoses in each racial/ethnic category is compared with the overall size of Utah's racial/ethnic populations, it is evident that racial/ethnic minorities are disproportionately burdened by HIV. In Figure 8, the five-year cumulative rates for the first half of the 10-year period are compared with the cumulative rates for the last half for each race/ethnicity. Of particular note is the increase in the Native Hawaiian and Other Pacific Islander population in recent years.

Fig 8. Racial and ethnic minorities shoulder a disproportionately large HIV diagnosis burden in Utah

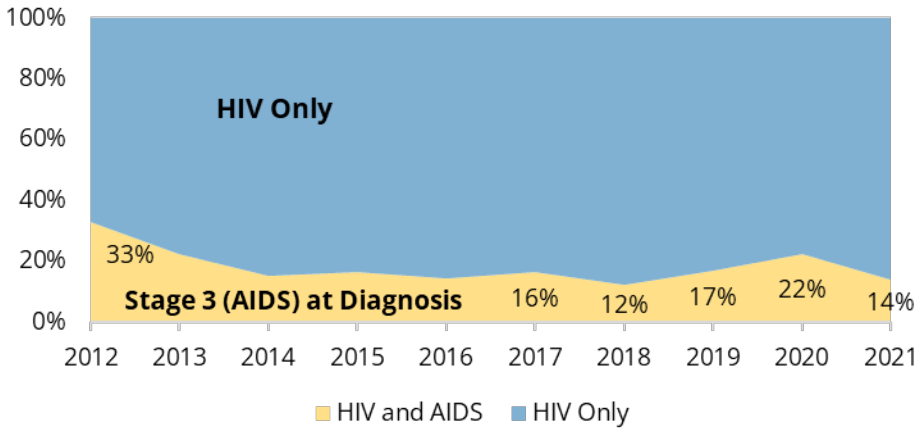


# New HIV diagnoses – clinical characteristics

## Stage 3 (AIDS) at diagnosis

People who meet the criteria for AIDS may improve with treatment and no longer meet the AIDS criteria. In addition, people living with diagnosed HIV may be inconsistent with their treatment and can meet (or not meet) the criteria for AIDS depending on their adherence to treatment. To solve this ambiguity, the term "stage 3 infection" is now used to refer to persons who have ever met the criteria for AIDS regardless of their current immune status. People who progress to stage 3 infection prior to HIV diagnosis have nearly always been infected for many years without being tested for HIV. People who are unaware they have HIV are much more likely to continue to transmit HIV and to have poor health outcomes.

Fig 9. No decrease in stage 3 (AIDS) infections at the time of HIV diagnosis in the last five years




The small number of new HIV diagnoses among each race/ethnicity does not allow for a standard time trend to be displayed in this report. Instead, Figure 10 displays the sum total of new HIV diagnoses for the past five years as well as the percentage of those cases with stage 3 infection at time of diagnosis for each race/ethnicity. The same analysis by birth sex, transmission risk, and age is presented in Figures 11–13. Although each racial/ethnic group has improved over the past 10 years, the chart below illustrates that Hispanic and non-Hispanic Asian clients are more likely than non-Hispanic White clients to have stage 3 infection at the time of their HIV

diagnosis. Other groups, such as Non-Hispanic Blacks are less likely to have progressed to stage 3 by the time they are diagnosed, indicating that efforts to reduce late diagnosis in that population may have been successful and that more effort should be applied to Asian and Hispanic populations.

Fig 10. Some ethnic minorities are more likely to have stage 3 (AIDS) infection at diagnosis

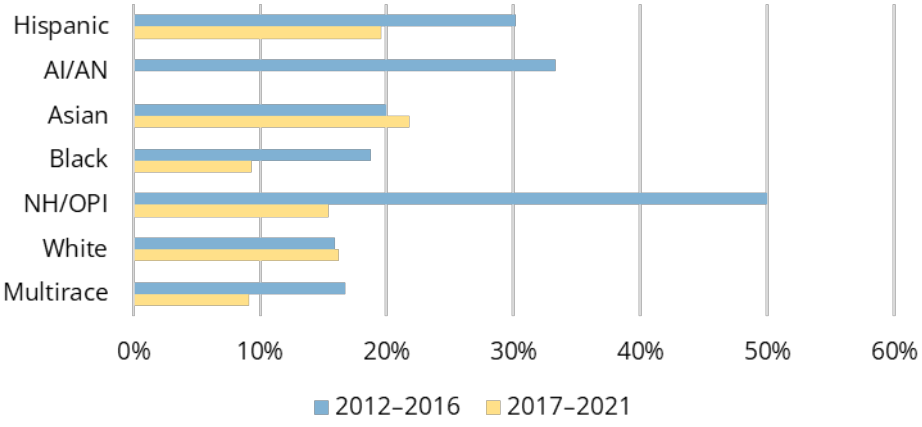
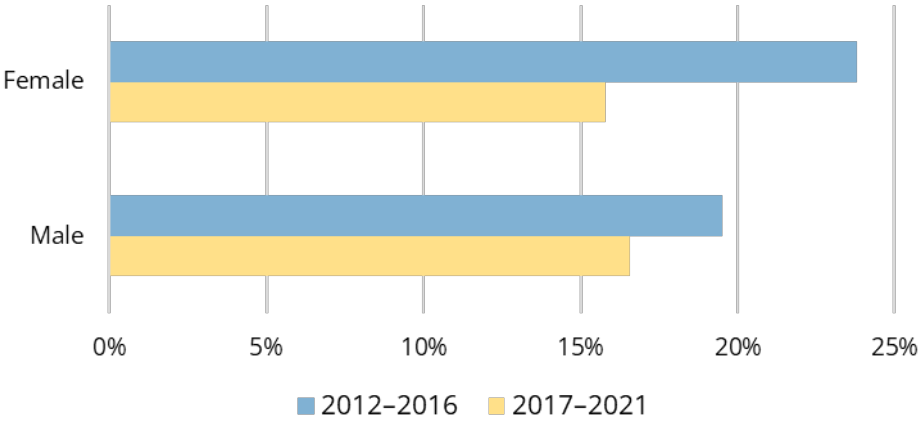



Fig 11. Men and Women experience stage 3 (AIDS) infection at diagnosis in similar proportions




Failure to acknowledge a risk factor during client interview may be due to secretive sexual behavior, or denial. There is also a significant number of new cases each year who experience unstable housing or other situations which make them difficult to locate and some who are unwilling to be interviewed by a public health professional. Each of these conditions would contribute to the increased level of stage 3 infections at time of diagnosis illustrated below. It is also possible that there

is under-recognition in the general population of the risk of HIV infection when sex occurs between anonymous heterosexual contacts, multiple partners, or sex workers. This under-recognition could lead to delayed HIV testing and increased stage 3 infection at diagnosis.

Fig 12. Those who don't report a risk factor and those who only report heterosexual contact are more likely to have stage 3 (AIDS) infection at diagnosis

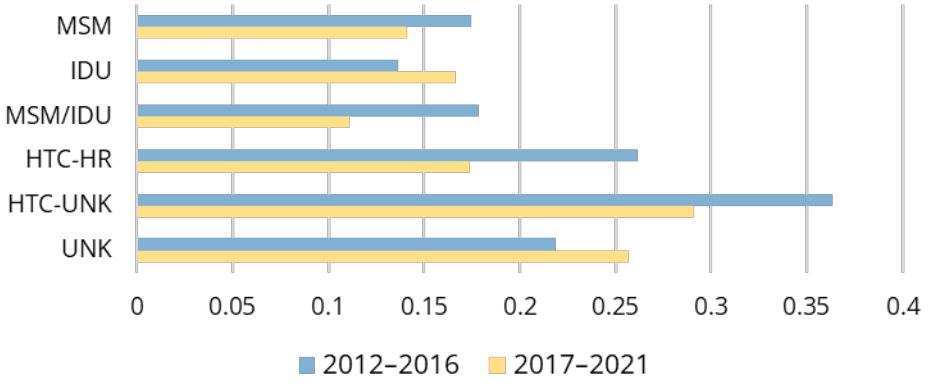
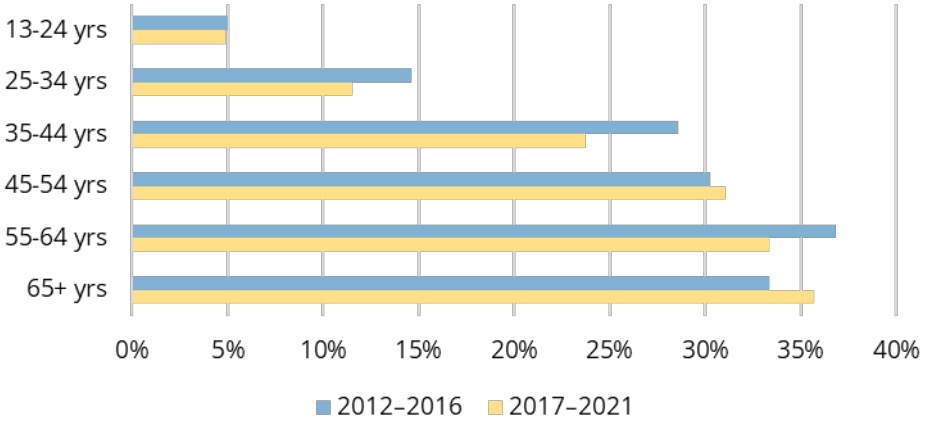


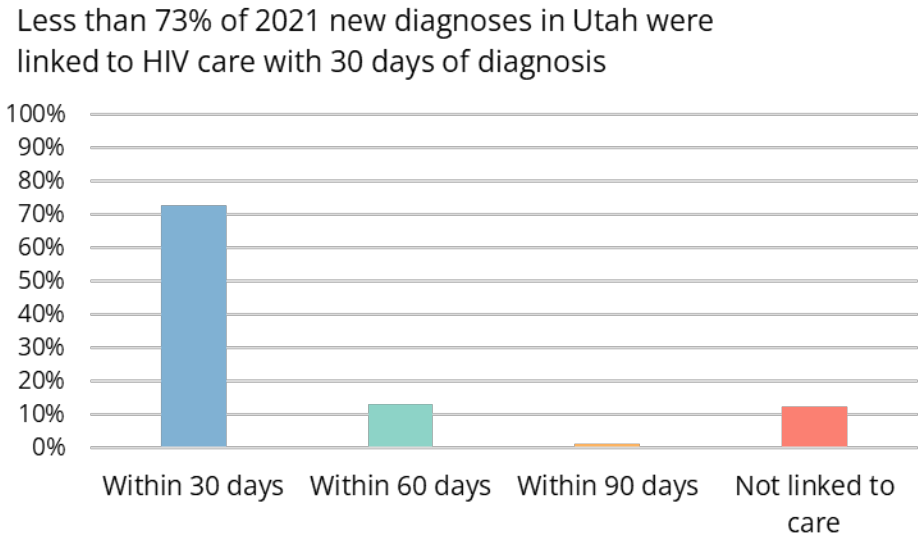

Fig 13. Being diagnosed later in life carries a greater risk of stage 3 (AIDS) infection at time of diagnosis




## Linkage to care

Since the development of highly effective antiretroviral therapy and the discovery that such treatment drastically reduces one's risk of transmitting HIV to a sexual partner, prompt connection to HIV care for new diagnoses has become all the more important. The national standard for this linkage is that it should occur within 30

days of diagnosis for at least 85% of new cases. Failure to link a new case to care may result in continued unprotected sexual activity or it may contribute to unnecessary psychological distress as many clients do not have adequate support systems and may be unaware that persons with HIV can live a long and healthy life with treatment and support. In 2021, 99 out of 136 new diagnoses (72.8%) were linked to care within 30 days and 17 (12.5%) were never linked to care.

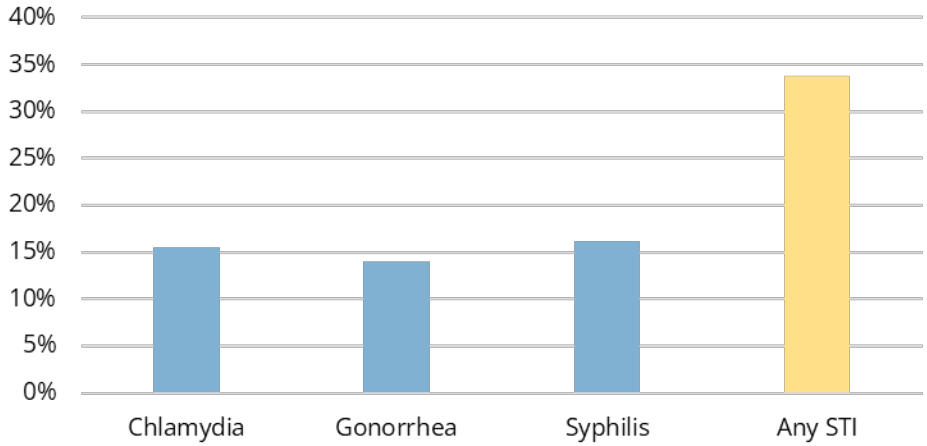



## Syndemics

A syndemic is an epidemic that occurs either close to or simultaneously with another epidemic, usually among populations that share characteristics which are relevant to both diseases.  Rises in the rates of diagnosis for chlamydia, gonorrhea, and (especially) syphilis both in Utah and nationwide are considered syndemic to HIV.

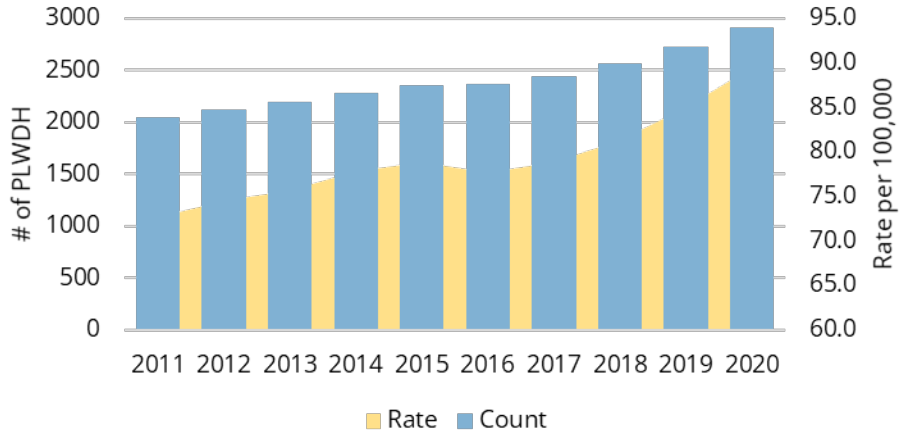
About 1 in 3 new HIV diagnoses in 2021 were known to be co-infected with a reportable sexually transmitted infection (STI) at the time of their HIV diagnosis. This demonstrates the significant overlap in at-risk populations. It is also medically consistent, as STIs often create disruptions in the epithelium that act as portals of entry for HIV. The lower percentages in individual STIs in figure 15 indicate that many clients were co-infected with more than one STI.

Fig 15. Coinfection with other reportable STIs is common among new HIV diagnoses in Utah, 2021

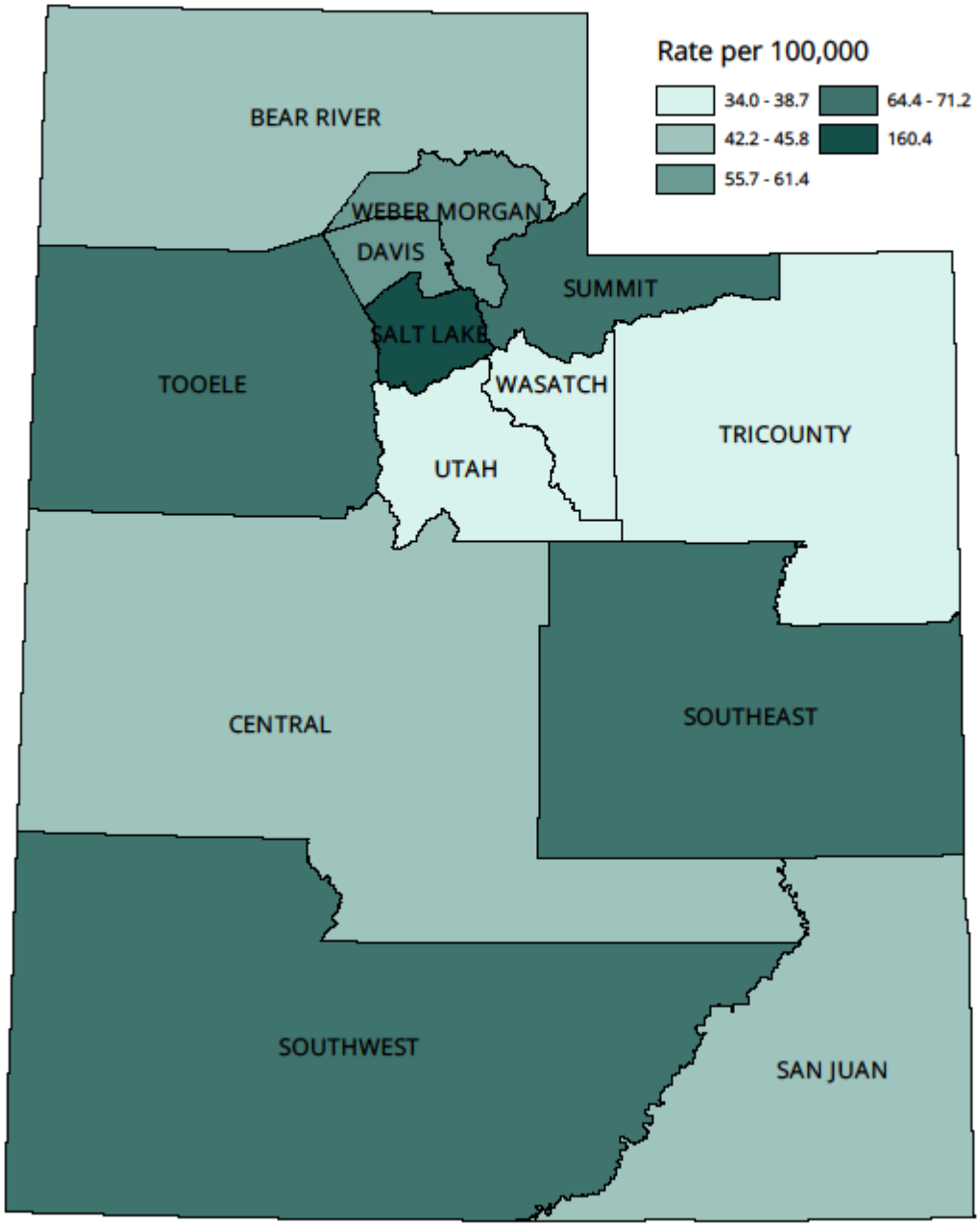



# Persons living with diagnosed HIV

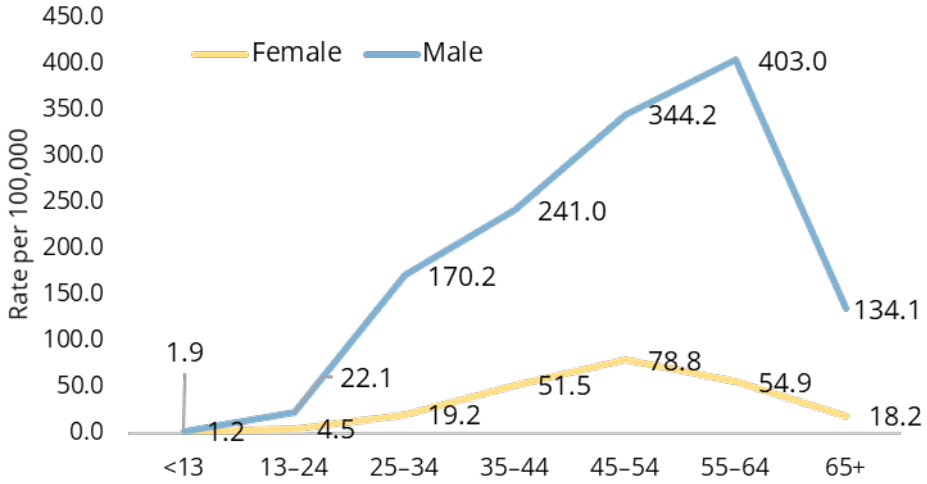
The number of persons living with diagnosed HIV in Utah increases annually



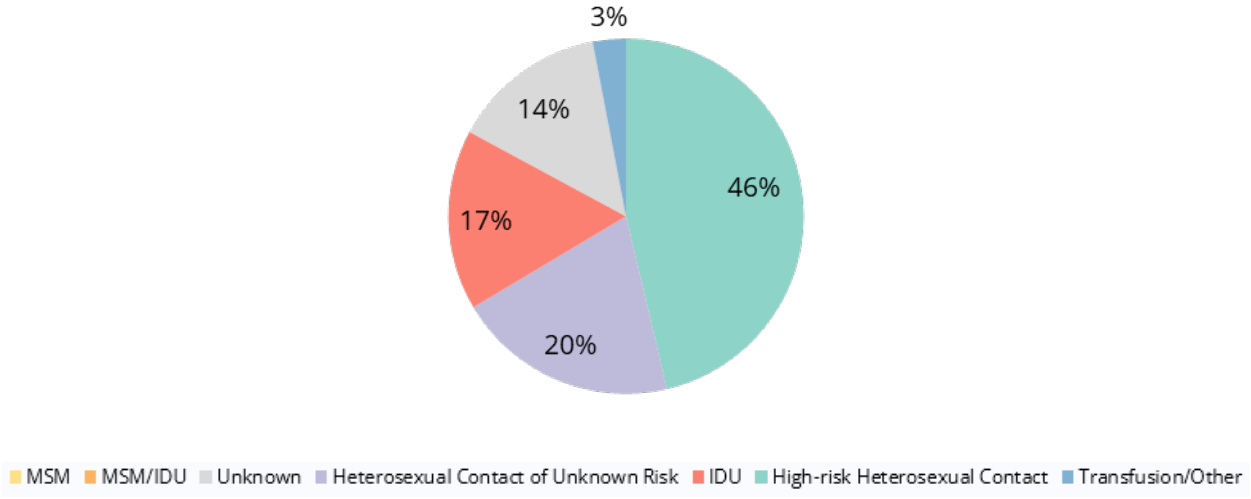
People living with diagnosed HIV reside in every part of Utah, 2020



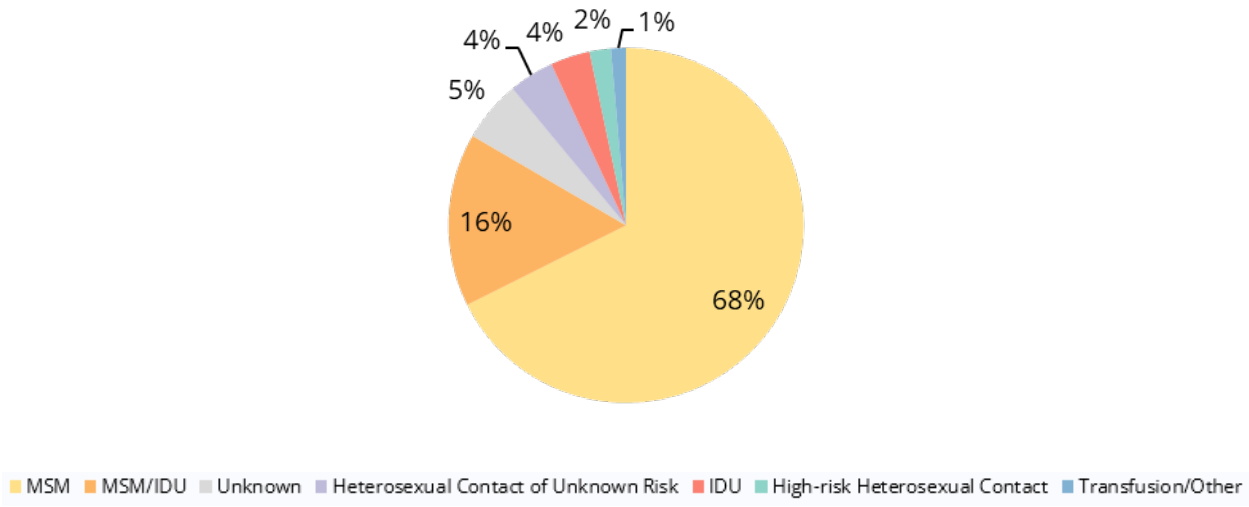
The HIV+ population in Utah is aging, 2020



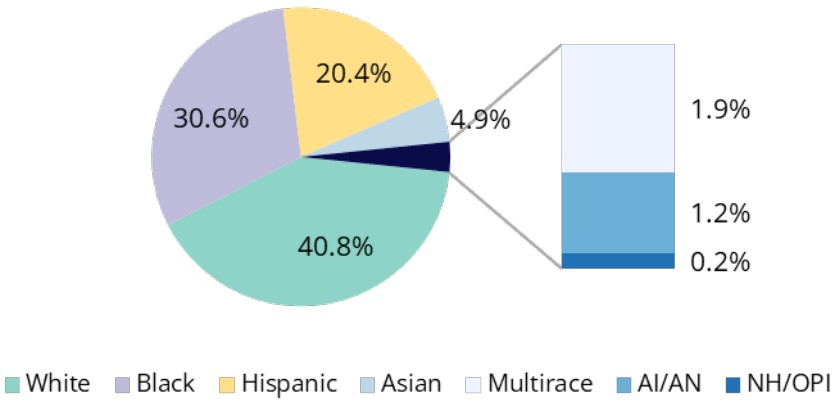

Most women living with HIV in Utah acquired it through heterosexual transmission, 2020



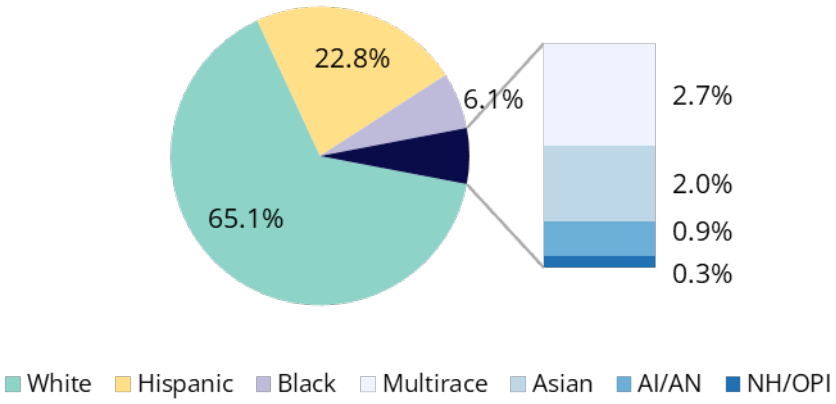
MSM is the most common transmission risk among men living with HIV in Utah, 2020



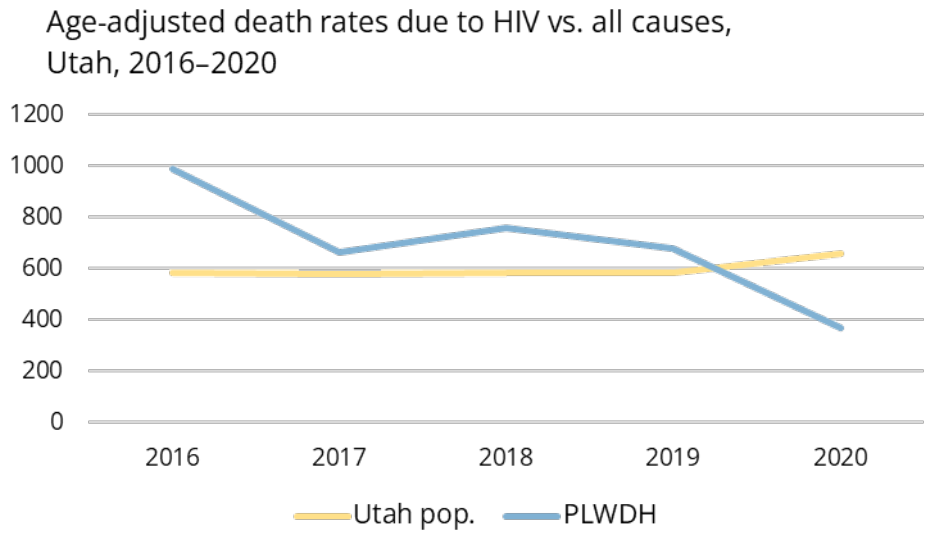

Racial/ethnic minorities comprise more than 50% of women living with HIV in Utah, 2020



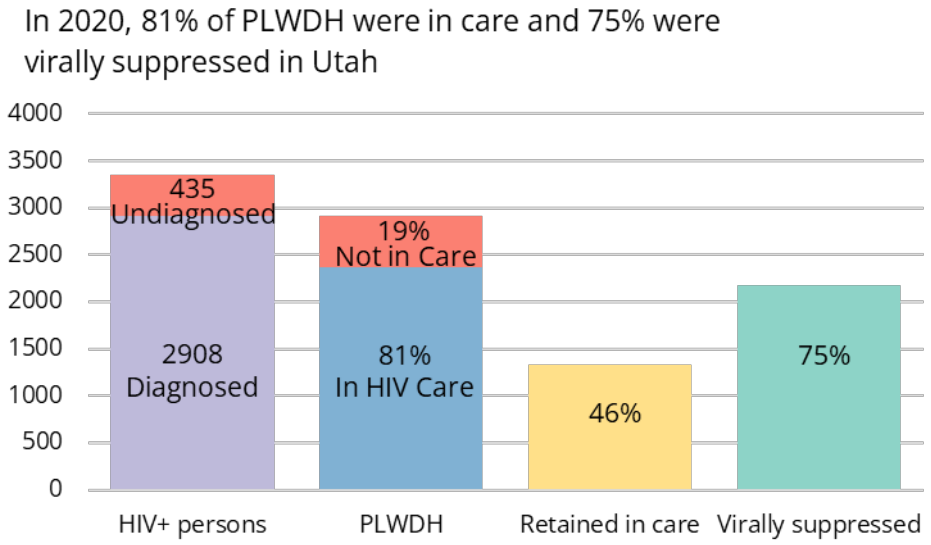
Racial/ethnic identities of men living with HIV resemble Utah's overall population, 2020



# Persons living with diagnosed HIV – clinical characteristics

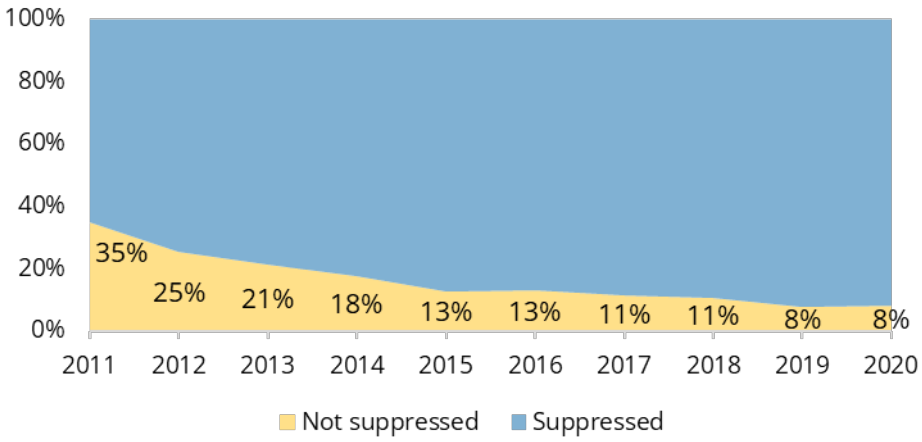



This graph represents the main reason why this report is unpublished. Either about half of deaths among PLWDH in 2020 are still unreported, or PLWDH were much more careful regarding their health than the average Utah resident during 2020. The department is currently waiting to receive results from a search with the National Death Index which will answer this question.

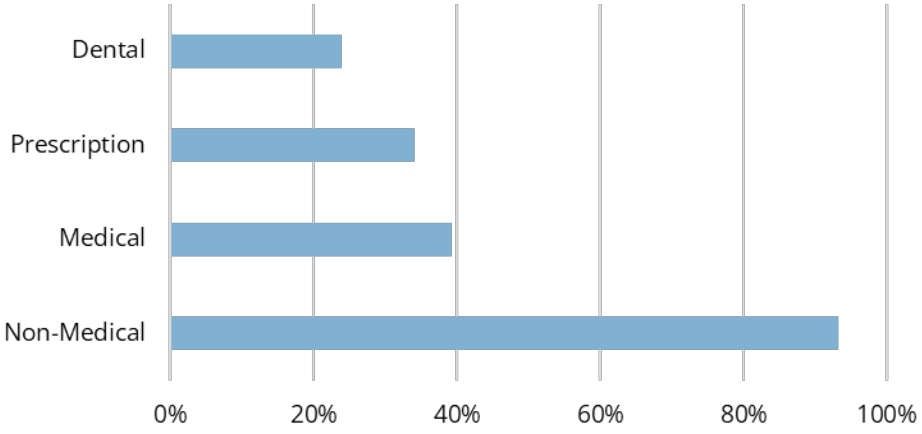



This is Utah's HIV care continuum for the year 2020.

The majority of PLWDH who receive medical care achieve viral suppression




Enrolled Ryan White clients accessed a range of service categories in Utah, 2021



# Appendix D: HIV resource inventory

Please proceed to the next page to view the HIV resource inventory.

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# Utah HIV Prevention and Care Resource Inventory

| Organization | Public Funding Sources Used for HIV Prevention/Care/Treatment (if applicable) | Member of Utah's HIV Planning Group | Offers HIV Prevention Services | Offers HIV Testing | Offers HIV Care Services | Offers HIV Case Management Services | Offers Syringe Services | Offers Substance Abuse Disorder Treatment | Offers Mental Health Services | Offers Housing Services |
|---|---|---|---|---|---|---|---|---|---|---|
| Utah Department of Health and Human Services | | | | | | | | | | |
| · Ryan White Part B Program | Ryan White Part B -HRSA | X | | | X | X | | | | X |
| · HIV Prevention Program | HIV Prevention Grant-CDC | X | X | X | | | | | | |
| Utah AIDS Foundation | | X | X | X | X* | X | X | | X | |
| University of Utah Infectious Disease Clinic | Ryan White Part C,D-HRSA | X | | | X | X | | | X | X |
| Intermountain Hospital Network | | | | | X* | | | | | |
| Utah Pride Center | | X* | X | X* | | | | | | |
| Local Health Departments | | | | | | | | | | |
| · Bear River | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Central | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Davis | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Salt Lake | HIV Prevention Grant-CDC | X | X | X | | | | | | |
| · Summit | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Southeast | HIV Prevention Grant-CDC | | X | X | | | X | | | |
| · Tooele | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · TriCounty | HIV Prevention Grant-CDC | | X | X | | | X | | | |
| · Wasatch | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Weber/Morgan | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · San Juan | HIV Prevention Grant-CDC | | X | X | | | | | | |
| · Utah | HIV Prevention Grant-CDC | | X | X | | | | | | |
| Utah Harm Reduction Coalition | SAMHSA - SOR | X | X | X | | | X | X | X | |
| Salt Lake Harm Reduction Project | SAMHSA - SOR | X | X | X | | | X | | | |
| Martindale Clinic | SAMHSA - SOR | X | X | X | | | X | X | | |
| Odessey House | SAMHSA - SOR | | X | | | | X | X | | |
| Utah Naloxone | | X | X | | | | X | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Soap2Hope | | | X | | | | X | | | |
| Hand in Hand | SAMHSA - SOR | X | X | X | | | X | | | |
| VA Hopsital | | | X | X | | | X | | | |
| UofU- Free PrEP Clinic | HIV Prevention Grant-CDC | X | X | X | | | | | | |
| AIDS Education Training Center | Part F-HRSA | X | X | | | | | | | |
| Comunidades Unidas | STD Prevention - CDC | | X | X | | | | | | |
| Eastern Utah Womens's Healthcare | STD Prevention - CDC | | X | X | | | | | | |
| Moab Free Health Clinic | HIV Prevention Grant-CDC | | X | X | | | | | | |
| Hope on Ttapp | Hepatitis C Prevention - CDC | X | X | X | | | | | | |
| First Step House | | | | | | | | X | | |
| Project Reality | | | | | | | | X | | |
| Apothecary Shoppe | | X | X | | X | | | | | |
| Walgreens Community Pharmacy | | X | X | | X | | | | | |
| Utah Office of Homeless Services | HOPWA | | | | | | | | | X |
| Salt Lake City Corporation | HOPWA | | | | | | | | | X |
| Utah Community Action | | | | | | | | | | X |
| Salt Lake Community College | | | | | | | | | | |
| University of Utah | | | X | X | | | | | | |
| Westminster College | | | X | | | | | | | |
| Weber State University | | | X | | | | | | | |
| Maliheh Free Clinic | | | | X | | | | | | |
| Fourth Street Clinic-Wasatch Homeless Health Care | | | | X | | | | | | |
| Homeless Resource Centers-VOA | | | | | | | | | | |
| Midtown Clinics | | | | X | | | | | | |
| Wasatch Pharmacy | | | | X | | | | | | |
| Family Healthcare-St. George | | | | X | | | | | | |
| Health Clinics of Utah | | | | X | | | | | | |
| Planned Parenthood Association of Utah | | | | X | | | | | | |
| Doctors Free Health Clinic-St. George | | | | X | | | | | | |
| Delta Dental | | | | | X | | | | | |
| Lyft | | | | | X | | | | | |

*Planned for in 2023

# Appendix E: Utah Getting to Zero plan

Please click on the screenshot of the plan cover below to view the full plan, or copy and paste the following URL into your web browser.

URL:
https://hivandme.com/wp-content/uploads/2021/01/GTZ_Full-Plan.pdf

# Appendix F: Letter of concurrence

Please proceed to the next page to view the letter of concurrence.

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State of Utah

SPENCER J. COX
*Governor*

DEIDRE M. HENDERSON
*Lieutenant Governor*

Department of Health & Human Services

TRACY S. GRUBER
*Executive Director*

NATE CHECKETTS
*Deputy Director*

DR. MICHELLE HOFMANN
*Executive Medical Director*

DAVID LITVACK
*Deputy Director*

NATE WINTERS
*Deputy Director*

November 30, 2022

Dear CDC and HRSA:

The Utah HIV Planning Group (UHPG) concurs with the following submission by the Utah Department of Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The UHPG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body 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/AIDS Program legislation and program guidance.

THe HIV/STD Elimination, Analysis, Response and Treatment (HEART) Program at the Utah Department of Health and Human Services (DHHS) is and integrated program encompassing HIV and STD prevention, surveillance, Syringe Services Program (SSP) and Ryan White Part B. This allows for an easy assessment of services offered to PLWH and people who are at risk for HIV. Additionally, many service providers are stakeholders and members of Utah HIV Planning Group (UHPG) and report on their services at quarterly UHPG meetings. The HEART Program has several contracted partners around the state for prevention, treatment and care services. The HIV prevention and Ryan White Part B program evaluated these contracts to create the inventory list as well as communicated with partners about the services offered.

The signature(s) below confirms the concurrence of the UHPG Membership with the Integrated HIV Prevention and Care Plan.

Signatures:

Heather Bush (Nov 28, 2022 15:03 MST)

Heather E. Bush
UHPG DHHS Co-Chair

Kevin T. Packer (Nov 28, 2022 15:57 MST)

Kevin Packer
UHPG Community Co-Chair

# Appendix G: 2019 Utah Red Ribbon Survey and Community Health Survey report

Please click on the screenshot of the report cover below to view the full report, or copy and paste the following URL into your web browser.

URL:
https://ptc.health.utah.gov/wp-content/uploads/2022/12/Kepka_Red-Ribbon_Community-Health_Final-Report_12.31.2019_Submission.pdf