



**Kentucky Public Health**

Prevent. Promote. Protect.

# END HIV KENTUCKY



## *Integrated Prevention and Care Plan,*

*including*

*the Statewide Coordinated Statement of Need  
and the Ending the HIV Epidemic Strategic Plan*

## **2022-2026**

Kentucky Department for Public Health

Division of Epidemiology and Health Planning

Infectious Disease Branch

HIV/AIDS Section

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## KENTUCKY DEPARTMENT FOR PUBLIC HEALTH HIV/AIDS USEFUL LINKS

**HIV Reporting:**

Fillable Adult HIV Confidential Case Report Form:

[https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/ACRF\\_Fillable.pdf](https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/ACRF_Fillable.pdf)

Fillable Pediatric HIV Confidential Case Report Form:

[https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/PCRF\\_Fillable.pdf](https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/PCRF_Fillable.pdf)

**HIV Prevention:**

Syringe Services Programs:

<https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/kyseps.aspx>

HIV Test Sites in Kentucky:

<https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/KYHIVTestSites.pdf>

**HIV Services:**

HIV Care Coordinator Regions and Contact Information:

<https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/KYHIVCCRs.pdf>

Ryan White Services Eligibility Application:

<https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/RWEligApp.pdf>

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## SECTION I: EXECUTIVE SUMMARY



### Background Information

The United States (US) government has put forth a bold vision for the US to be “a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance”.<sup>1</sup> To reach the national goals of reducing new HIV infections by 75 percent by 2025 and 90 percent by 2030, systems of HIV prevention and care must work together in unprecedented ways to address health inequities that remain. This includes providing equal access to all available tools so that no population or geographic area is left behind and efforts to end the HIV epidemic are accelerated. The Kentucky Department for Public Health (KDPH) aims to align HIV prevention and care services in Kentucky towards achieving this vision across the Commonwealth.

### Integrated Planning Guidance

In June 2021, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) released official guidance indicating support for integrated HIV prevention and care planning to further progress the goals of the National HIV/AIDS Strategy (NHAS) and the federal Ending the HIV Epidemic (EHE) initiative. KDPH has followed this guidance to bring together stakeholders across the Commonwealth in the development of an integrated plan to advance both HIV prevention and care services. Integrated planning reduces burden and duplicative planning efforts and promotes collaboration and coordination around data analysis. This *End HIV Kentucky Integrated Prevention and Care Plan* (“Integrated Plan”) outlined herein establishes the framework for HIV prevention and care during 2022-2026.

The Integrated Plan for CY 2022-2026 meets all programmatic and legislative requirements associated with both CDC and HRSA funding. Similar to the previous [2017-2021 Kentucky Integrated Prevention and Care Plan](#), this updated version serves as the Statewide Coordinated Statement of Need (SCSN) for 2022-2026. All required elements for the SCSN are noted throughout the document. This plan also contains Kentucky’s updated EHE Strategic Plan.

### NHAS

In January 2021, the US Department of Health and Human Services (HHS) released the *HIV National Strategic Plan: A Roadmap to End the Epidemic 2022-2025* which creates a collective vision for HIV service delivery across the nation. This national plan addresses the following four goals:

1. Prevent new HIV infections

2. Improve HIV-related health outcomes for people with HIV
3. Reduce HIV-related disparities and health inequities
4. Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

These goals helped to guide the development of the Integrated Plan, which seeks to advance Kentucky’s efforts in these four areas. In August 2022, HHS released the accompanying *NHAS Federal Implementation Plan 2022-2025*, which lays out a plan to track progress on activities and action steps to achieve each goal. The formatting of these two documents inspired the format for Sections V and VI of Kentucky’s Integrated Plan. The same design was used to best align efforts in Kentucky with national expertise. However, the content of the plan more closely follows the four pillars of the EHE initiative.

### **EHE Initiative**

The Integrated Plan is organized using the same overarching goals put forward in the EHE initiative to end the HIV epidemic through a comprehensive approach centered on four science-based strategies or “pillars”, including:



The Diagnose pillar focuses on utilizing the latest systems and technology to make HIV testing simple, accessible, and routine in all settings, including sexually transmitted infection (STI) clinics, which serve a high volume of racial, ethnic, sexual, and gender minority groups. The Treat pillar ensures that people who receive a positive HIV test result are quickly linked to care and treatment as soon as possible after diagnosis; and to help expand local programs that identify and follow up with people who have stopped receiving HIV care and treatment. The Prevent pillar focuses on scaling up proven interventions, such as pre-exposure prophylaxis (PrEP) and comprehensive syringe services programs (SSP), designed to address communities’ unique needs. The Respond pillar focuses on ensuring that when an HIV cluster or outbreak is identified, public health agencies can engage with various interested parties, including health care providers, persons with HIV (PWH), HIV advocates and organizations, and other community leaders, and respond promptly. These groups can collaborate to identify existing prevention and care gaps and design tailored interventions that address their community’s specific needs.

## PrEP and PEP

PrEP and post-exposure prophylaxis (PEP) are both methods for preventing HIV that involve taking HIV medications. PrEP is a prevention method used by people who are HIV-negative and at high risk for being exposed to HIV through sexual contact or injection drug use. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing an infection. The US Food and Drug Administration (FDA) has approved three medications for use as PrEP. Two consist of a combination of drugs in a single oral tablet taken daily. The third medication is a medicine given by injection every 2 months. PEP refers to the use of antiretroviral drugs for people who are HIV-negative after a single high-risk exposure to stop HIV infection. PEP must be started as soon as possible to be effective – always within 72 hours of a possible exposure – and continued for 4 weeks.<sup>35</sup>

## HIV Continuum of Care Model and Status Neutral Approach

The Integrated Plan utilizes the HIV Care Continuum Model and the Status Neutral Approach. The HIV Care Continuum, illustrated in Figure 1, depicts the stages a PWH engages in from initial diagnosis through their successful treatment with HIV medication to reach viral suppression. Supporting PWH to reach viral suppression not only increases their own quality of life and lifespan, but also prevents transmission to an HIV-negative partner, thus providing an additional strategy to prevent new HIV infections.

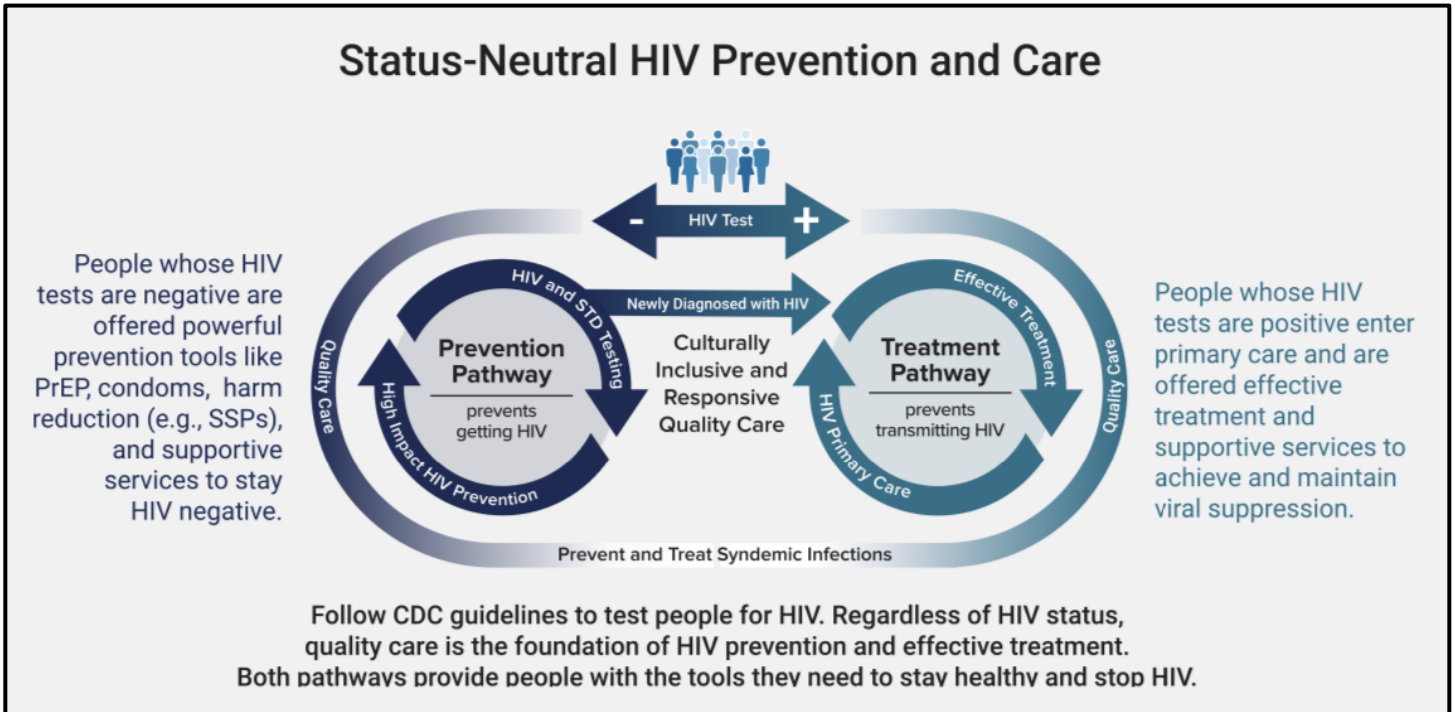
Figure 1. HIV Care Continuum



Source: Minority HIV/AIDS Fund. The HIV Care Continuum. Accessed June 2022, <https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum>

A Status Neutral Approach, illustrated in Figure 2, means that all people, regardless of HIV status are treated the same way.<sup>3</sup> Under this approach, persons with positive test results are linked to HIV care, treatment, and other social support services. Conversely persons testing negative are linked, as needed, to biomedical HIV prevention services, such as PrEP and other social support services.

**Figure 2. Status-Neutral HIV Prevention and Care**



Source: CDC. Status-Neutral Approach HIV Prevention and Care. Accessed June 2022, <https://www.cdc.gov/hiv/policies/data/status-neutral-issue-brief.html>

**a. APPROACH**

The Integrated Plan is a culmination of over three years of work with entities across the state of Kentucky to develop a shared vision for integrative HIV prevention and care. The Integrated Plan builds off Kentucky’s 2020 EHE planning process and is aligned with the updated NHAS. The document brings into the fold a situational analysis that includes considerations and changes made in response to the COVID-19 pandemic. A complete list all acronyms and definitions of terms used throughout the document can be found in Appendix A.

**Jurisdictional Planning Process**

Section II provides a complete description of the integrated process that led to this plan. Community engagement involves the collaboration of key stakeholders and broad-based communities who work together to identify strategies to increase coordination of HIV programming throughout the state. PWH who reflect the local demographics of the epidemic with lived experience were integral to this process and were invited to participate to help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations.

Like EHE, the Integrated Plan was developed in partnership with stakeholders across Kentucky, including the Kentucky HIV Planning and Advisory Council (KHPAC), community-based organizations (CBO), university partners, community members, and others across the state. Stakeholders were also engaged through a needs assessment process utilizing quantitative and qualitative methods to determine Kentucky residents' barriers

and challenges. Through this needs assessment and ongoing collaboration with the stakeholders mentioned above, shared goals and objectives were established for the state of Kentucky.

### **Understanding the Needs of Kentucky**

Sections III and IV aim to provide a complete picture of the contributing data sets and situational analysis that has been studied to understand the needs of Kentucky. The contributing data sets presented include an epidemiological snapshot; an HIV Prevention, Care and Treatment Resource Inventory; and a review of needs assessment data. The situational analysis explores the social determinants of health, as well as a detailed breakdown of each EHE pillar, including gaps, challenges, needs, barriers, strengths, and current resources.

### **A “Living Document” for Sustainability of Efforts**

Section V lays out the goals, objectives, and strategies to make progress across each pillar during 2022-2026, while Section VI details a complete implementation plan of proposed activities. Section VI also describes how progress will be monitored, evaluated, and communicated during the years of implementation. As a “living document”, developments will be regularly reported to the statewide planning group and improvements/changes will be discussed as needed.

### **Concurrence Process**

The planning process concluded with the complete concurrence process summarized in Section VII. Following the guidance presented, Section VII includes a signed letter from the planning body documenting concurrence with the Integrated Plan submission.

### **b. DOCUMENTS SUBMITTED TO MEET REQUIREMENTS**

Table 1 outlines where pre-existing documents were utilized to meet the submission requirements for the Integrated Plan, where new documents were created, and where a combination of the two were used. These documents include the previously submitted plans, epidemiological surveillance reports, and past and newly developed community needs assessments. Throughout the report, considerable focus was given to summarize what updates to other strategic plans, primarily the *2020-2025 EHE Strategic Plan*, were made to reflect current needs and priorities. Page numbers for each section can be found in the table of contents. A link to the *2020-2025 EHE Strategic Plan* can be found in Appendix I.



**Table 1. Checklist of Documents Submitted to Meet Requirements**

Requirement	New Material and/or Existing Material Used to Meet Requirement	Name of Existing Material Attached to Meet Requirement	Pages or Section in Existing Material Where Requirement is Addressed	Notes
<b>Section I: Executive Summary of Integrated Plan and SCSN</b>				
1. Executive Summary of Integrated Plan and SCSN	New Material			
a. Approach	New Material			
b. Documents Submitted to Meet Requirements	New Material			This chart aims to show where existing materials were utilized.
<b>Section II: Community Engagement and Planning Process</b>				
1. Jurisdiction Planning Process	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Community Engagement Section	The 2022 planning process built on the 2020 EHE planning process. Section II describes activities that took place 2020-2022.
a. Entities Involved in Process	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Community Engagement Section	This list was adapted from the original 2020 EHE list to include all 2022 integrated planning partners.
b. Role of Planning Bodies and Other Entities	New Material			
c. Collaboration with Ryan White HIV/AIDS Program (RWHAP) Parts – SCSN Requirement	New Material			
d. Engagement of PWH – SCSN Requirement	New Material			
e. Priorities	New Material			
f. Updates to Other Strategic	New Material			

Requirement	New Material and/or Existing Material Used to Meet Requirement	Name of Existing Material Attached to Meet Requirement	Pages or Section in Existing Material Where Requirement is Addressed	Notes
Plans Used to Meet Requirements				
<b>Section III: Contributing Data Sets and Assessments</b>				
1. Data Sharing and Use	New and Existing Material	<i>Kentucky Cluster and Outbreak Detection and Response Plan 2021</i>	4, 8, 10, 13-14	Information from this document was adapted to meet Integrated Plan requirements.
2. Epidemiologic Snapshot	New and Existing Material	KY HIV/AIDS Surveillance Report 2022	6-35	As new epidemiologic snapshots are created using newly released guidance they will be incorporated into the Integrated Plan.
3. HIV Prevention Care and Treatment Resource Inventory	New Material			
a. Strengths and Gaps	New Material			
b. Approaches and Partnerships	New Material			
4. Needs Assessment	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Needs Assessment Section	<i>Information from the 2020 EHE Needs Assessment Survey was used to create the 2022 End HIV Kentucky Statewide Needs Assessment Survey. Both are referenced in this Integrated Plan.</i>
a. Priorities	New Material			
b. Actions Taken	New Material			
c. Approach	New Material			
<b>Section IV: Situational Analysis</b>				

Requirement	New Material and/or Existing Material Used to Meet Requirement	Name of Existing Material Attached to Meet Requirement	Pages or Section in Existing Material Where Requirement is Addressed	Notes
1. Situational Analysis	Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Situational Analysis Section	The 2020 Situational Analysis was used for this plan. Data and resources were updated for 2022.
a. Priority Populations	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Situational Analysis Section	Section IV was covered in the existing EHE document and is still relevant for 2022.
<b>Section V: 2022-2026 Goals and Objectives</b>				
Goals and Objectives Description	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Goals and Activities Section	The EHE Plan served as the foundation for the new Integrated Plan. However, several changes were made to the format, and additional objectives and strategies were added to meet current needs.
a. Updates to Other Strategic Plans used to Meet Requirements	New Material			Section V describes all the changes made to the EHE plan to meet new requirements for integrated planning.
<b>Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up</b>				
1. 2022-2026 Integrated Planning Implementation Approach	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Goals and Activities Section	The vast majority of EHE Plan activities have been incorporated into the Integrated Plan. Additional new activities were added where relevant.
a. Implementation	New and Existing Material	<i>EHE Strategic Plan 2020-2025</i>	Goals and Activities Section	Activities have been put into chart format to assist with monitoring and evaluation.

Requirement	New Material and/or Existing Material Used to Meet Requirement	Name of Existing Material Attached to Meet Requirement	Pages or Section in Existing Material Where Requirement is Addressed	Notes
b. Monitoring	New Material			
c. Evaluation	New Material			
d. Improvement	New Material			
e. Reporting and Dissemination	New Material			
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material			Section VI describes all the changes made to the EHE plan to meet new requirements for integrated planning.
<b>Section VII: Letters of Concurrence</b>				
1. Statewide Planning Body	New Material			

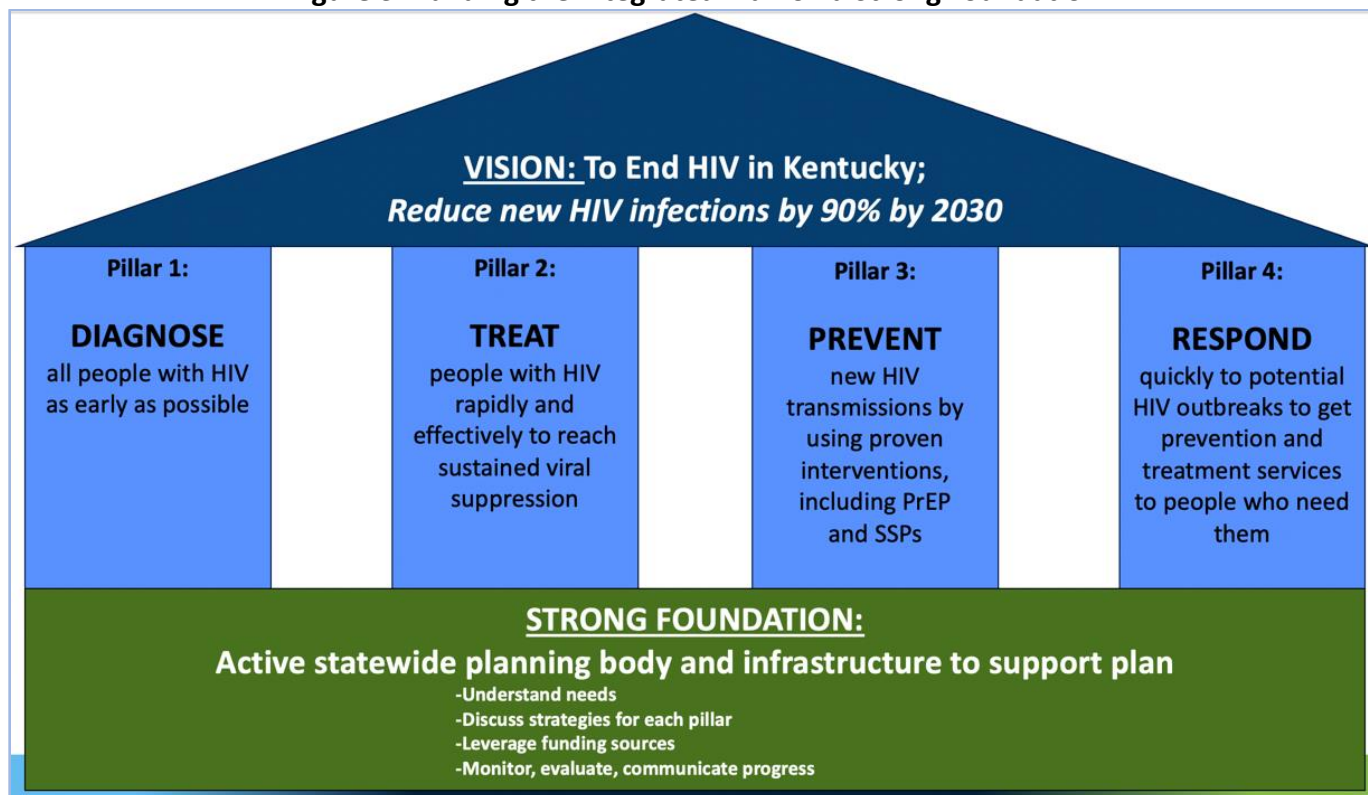
## SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

### JURISDICTIONAL PLANNING PROCESS

Following legislative and programmatic requirements, Kentucky's community engagement and planning process reflected local demographics and involved a wide variety of community members and local partners. The integrated planning process built heavily on the EHE planning process. Throughout the planning process a priority was to strengthen collaborations among systems of prevention and care relevant to HIV, including harm reduction programs and housing services.

A focus has been made to create a strong foundation with which to support the Integrated Plan development and implementation. This foundation includes an active statewide planning body and the infrastructure to support the plan. This will allow for long-term success and sustainability of efforts. Figure 3 depicts Kentucky's Integrated Planning Model, which was used throughout the 2022 planning process to clearly communicate the process to all stakeholders. Throughout the planning process, intentional efforts were made to build collaborations among systems of prevention and care relevant to HIV. This included inviting all entities to be part of the statewide planning group and/or to participate in planning activities.

Figure 3. Building the Integrated Plan on a Strong Foundation



Source: Kentucky's Integrated Planning Model, 2022

## **a. ENTITIES INVOLVED IN PROCESS**

Engaging local level partners in the integrated planning has been a top priority; increasing buy-in and stakeholder participation has guided communication strategies. Local partners include all recipients and subrecipients of CDC and HRSA funding streams (including RWHAP Parts B, C, D and F; EHE; Prevention and Surveillance), as well as US Department of Housing and Urban Development (HUD) and Substance Abuse and Mental Health Services Administration (SAMHSA) federal funding. Statewide partners include the KDPH Harm Reduction Program (which collaborates closely with SSPs), the KADAP (Kentucky) Income Reinvestment Program (KIRP), and the Kentucky AIDS Education and Training Center (KY AETC). Additional partners include the Kentucky Opioid Response Effort (KORE), the Homeless Shelter of Frankfort, and the Kentucky Housing Corporation. Meetings and listening sessions were held with collaborators throughout Kentucky.

The following is a list of the types of populations and organizations who have been engaged in at least one aspect of Kentucky's EHE and/or integrated planning processes (listed alphabetically).

- **Affected Populations, including:**
  - PWH
  - Persons who inject drugs (PWID)
  - Men who have sex with men (MSM)
  - Persons of color
  - LGBTQ (lesbian, gay, bisexual, transgender, and queer [or questioning]) community
  - Parents and Friends of the LGBTQ community (PFLAG)
  - Allies of the LGBTQ community
- **AIDS Service Organizations (ASO)**
- **Clinics/Hospitals/Pharmacies**
- **Community Advocacy Organizations**
- **Corrections, Law Enforcement, Emergency Agencies**
- **Faith-Based Organizations**
- **HIV/AIDS CBOs**
- **HOPWA-Funded Housing Service Providers**
- **Local Health Departments (LHD)**
- **Local and/or State Education Agencies**
- **Mental Health/Behavioral Health Centers**
- **Non-Governmental Organizations**
- **Organizations Serving the Homeless and Unstably Housed**
- **RWHAP-Funded Service Providers**
- **Statewide Public Health Entities**
- **State Government Entities**
- **SSPs and Harm Reduction Program**

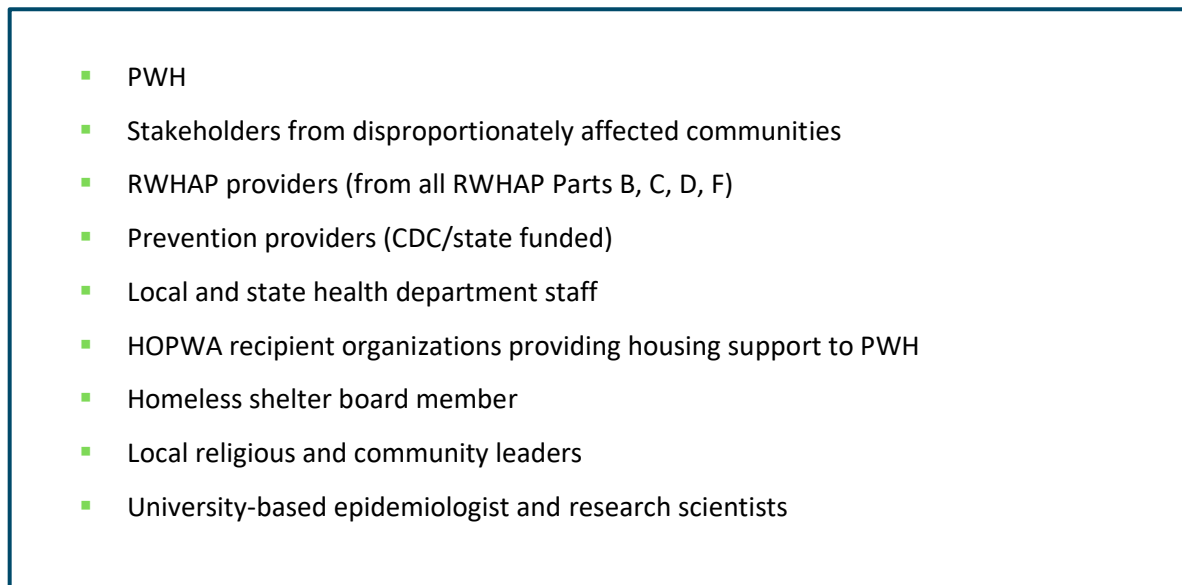
## b. ROLE OF PLANNING BODY

### Statewide Planning Body

KHPAC is the primary planning body for HIV in Kentucky. Since February 2022, KHPAC membership has increased by approximately 200%. The number of official voting members initially increased during summer 2022 from eight members to 24 members. Membership as of November 2022 has dropped slightly and is currently at 18 voting members. Participation from non-voting meeting attendees has also increased throughout this period as more local voices have joined meetings. Concerted efforts have been made to create a diverse planning body and invite everyone “to the planning table”, in alignment with national planning body guidelines and recommendations.

The Commonwealth’s planning council model is based on statewide representation from a variety of roles within the public and private sector. KHPAC draws its membership from key stakeholders, consumers, and interested parties from every region in the state. See Figure 4 for current KHPAC membership profile.

**Figure 4. KHPAC Membership Profile – November 2022**



Source: KHPAC, 2022

Throughout the integrated planning process, KHPAC members were engaged at monthly meetings. Members supported the development and distribution of the *End HIV Kentucky Statewide Needs Assessment Survey*, discussed how to ensure that all stakeholders were invited to participate in planning activities (including planning bodies), and explored the objectives, strategies, and activities detailed in this plan to meet Kentucky’s goals across the four EHE pillars. A variety of communication methods have been utilized to build trust and open communication channels with all KHPAC members. These have included focused group discussions at all meetings, email communications, and resource sharing, as well as virtual feedback surveys using the Qualtrics platform to allow for anonymous feedback.

KHPAC is a collaborative planning group, representing both the CDC Prevention Program and the Kentucky RWHAP Part B Program. Members provide input on the CDC/HRSA HIV Integrated Prevention and Care Plan, as well as the EHE Strategic Plan, and perform an array of other planning and advisory duties. All KHPAC activities are open to the public, thus any other planning groups’ input is welcome and applied to conversation and planning efforts. All current meetings are set in virtual formats due to pandemic conditions though strategies have been initiated to prepare for future sessions utilizing in-person means in various regional geographical settings. Additionally, discussions are currently taking place to determine the best way to mobilize regional and local planning groups and increase local community engagement. KHPAC serves a central component in the Respond pillar. KHPAC is one of the means by which entities throughout the state can share data and establish data sharing policies to better address HIV outbreaks and clusters.

A concurrence process for approval of this Integrated Plan was completed by KHPAC membership in November 2022. See Section VII for the Letter of Concurrence, signed by the two current KHPAC co-chairs and representing a vote of all current KHPAC members. A unanimous vote of concurrence by all active members approved this submission.

Moving forward, KHPAC will organize into four subcommittees. In doing so, this will allow more focused discussion and action on the most urgent planning needs. The four subcommittees (and relevant topics covered by each) will include:

1. Executive Subcommittee - to include material review
2. Care and Prevention Subcommittee - to include PrEP coordination
3. Policy and Promotion Subcommittee - to include community engagement, partnerships, and representation
4. EHE Subcommittee - to include needs assessment and strategic plan review and updates

**c. COLLABORATION WITH RYAN WHITE HIV/AIDS PROGRAM PARTS**

All RWHAP entities in Kentucky have been invited to maintain active membership on KHPAC and to participate in the integrated planning process. The following list summarizes all Ryan White programs in Kentucky. All entities participated in the 2022 integrated planning process.

**Table 2. Ryan White Entities in Kentucky**

<b>Program Part</b>	<b>Grant Recipients</b>	<b>Funding Purpose</b>	<b>Kentucky Directly Funded Entities (* indicates involvement in integrated planning process)</b>
Part A	Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA)	Provide medical and support services to cities and counties most severely affected by HIV	Not applicable
Part B	All 50 states, District of Columbia, Puerto Rico, US Virgin Islands, and six US territories	Improve the quality of and access to HIV health care and support in the US	KDPH *



		Provide medications to low-income PWH through AIDS Drug Assistance Program	
Part C	Local community-based groups	Provide outpatient ambulatory health services and support for PWH  Strengthen capacity to deliver high-quality HIV care	LivWell *  Matthew 25 *  University of Kentucky (UK) *  University of Louisville (UofL) *
Part D	Local CBOs	Provide medical care for low-income women, infants, children, and youth with HIV  Offer support services for PWH and their family members	Matthew 25 *  UK *  UofL *
Part F	<p><u>AIDS Education and Training Center (AETC) and Special Projects of National Significance (SPNS)</u> Domestic public or private, non-profit organizations, schools, academic health science centers, faith-based organizations, tribes, and tribal organizations</p> <p><u>Dental Programs</u> Dental schools, hospitals with postdoctoral dental residency programs, community colleges with dental hygiene programs</p> <p><u>Minority AIDS Initiative</u> RWHAP recipients</p>	<p><u>AETC</u> Provide training and technical assistance to providers treating patients with or at-risk for HIV</p> <p><u>SPNS</u> Develop innovative models of HIV care and treatment to respond to RWHAP client needs</p> <p><u>Dental Programs</u> Provide oral health care for PWH and education about HIV for dental care providers</p> <p><u>Minority AIDS Initiative</u> Help RWHAP recipients improve access to HIV care and health outcomes for minorities</p>	<p>UK KY AETC * (Part of the Southeast AETC region)</p> <p>UofL * (Dental Partnership Program)</p> <p>UK * (Dental Reimbursement Program)</p>

#### d. ENGAGING PWH

Building upon the regional planning group process conducted in 2020 for the EHE Strategic Plan, community engagement with PWH has been a primary focus of this process. All community members, including PWH and people at-risk for HIV have been invited to participate and share their opinions, experiences, and ideas. There have been a variety of different methods to participate in this process, including virtual and paper needs assessment surveys, attendance at a statewide or regional planning group meetings, RWHAP consumer meetings, community engagement sessions to review and discuss the Integrated Plan, and individual key informant discussions and semi-structured interviews.

## **Regional Planning Groups**

The *2020-2025 EHE Strategic Plan*, which has served as a baseline for this Integrated Plan, was developed in collaboration with six regional planning groups and one statewide group during 2020. Through a combination of interest expressed from the *2020 EHE Needs Assessment Survey* and reaching out to targeted stakeholders, the six regional planning groups were created. Effort was made to reach a profile in each planning group of 50% institutional stakeholders and 50% community members. Institutional stakeholders included local service provider partners, local prevention and education providers, and integrated community planning bodies. Community members included PWH and persons at-risk for acquiring HIV. Efforts were taken to ensure “new voices” were able to come to the table and participate in the planning process. In the end, 51 people participated across six regional planning groups. Of these, two institutional stakeholders and two community members from each regional group were invited to participate in the statewide planning group for a total of 12 statewide group members. All regional and statewide planning meetings occurred during 2020. Each meeting was two hours long and focused on one of the four EHE pillars. These virtual meetings were skillfully moderated by a coordinator from KDPH to ensure everyone had equal opportunity to be heard and express their opinions. Attendance was strong, with the majority of participants attending all four meetings.

Ideas are currently being explored with KHPAC about how to revitalize these regional planning groups moving forward. Discussions include how to best organize and support local planning groups to be part of the upcoming Integrated Plan implementation and evaluation strategies. Both KHPAC and KDPH recognize the necessity of collaborating with these groups to understanding needs and barriers to prevention and care services, and successfully implement activities to meet the needs of priority populations.

## **Ryan White Consumer Meetings**

During 2020, RWHAP consumer meetings were organized to better understand the consumer perspective and evaluate services offered at RWHAP clinics across the Commonwealth. Four meetings were held with a total of 26 participants (24 males and 2 females). All participants were PWH who were currently receiving treatment and care. Representation included people of color and PWID. Feedback and recommendations were discussed. The consensus of the group was that the care and services provided are excellent. The clients emphasized the quality of their clinical care, access to oral health services, and the support of their medical case managers. Additionally, they commented on the need for increased services in rural areas.

## **Community Engagement Sessions**

Two community engagement sessions were organized in October 2022 to provide an opportunity for all community members and stakeholders to discuss the Integrated Plan goals, objectives, strategies, and activities planned to reach priority populations across the four EHE pillars. These sessions were led by KHPAC’s Community Co-chair. A PowerPoint presentation provided an overview of the integrated planning process and assisted in focusing the discussion to cover each pillar’s goals and objectives. Group discussion notes were taken by an external evaluator. In total, 29 community members attended the sessions. Participants included PWH, community members, and staff serving the following organizations: LHDs, hospitals, linkage navigator

programs, CBOs, state entities, advocacy organizations, and a shelter serving the homeless. Participants asked questions and gave comments on the proposed Integrated Plan draft goals, objectives, and strategies. Themes that arose are included below in the priorities discussion of this section. Participants also expressed interest in future community engagement activities.

### **Key Informant Discussions/Semi-Structured Interviews**

Throughout the summer months of 2022, KHPAC members and local stakeholders were invited to share their ideas and perspectives during individual key informant discussions, also known as semi-structured interviews. These took place virtually via Zoom. In total, 10 people participated in the process, including partners from prevention organizations, RWHAP clinics, community leaders, and PWH. Topics discussed included local and organizational efforts across the four pillars, barriers to prevention and care, reaching priority populations, strategic planning efforts at the local level, how statewide integrated planning efforts can support local organizations/agencies, and ideas to build trust and engage more community members in planning efforts to end the HIV epidemic across the Commonwealth.

### **e. PRIORITIES**

Key priorities which arose out of the community engagement and planning process include:

- Systems to support the expansion of and participation in PrEP services
- Increased training support to expand certified community testers statewide
- Continuing efforts to reduce stigma and discrimination
- Serving priority populations, including persons of color, homeless population, PWH who are living longer
- Addressing transportation barriers
- Concurrent diagnosis and late testers
- Training medical providers to increase HIV screening in medical care settings

A complete situational analysis can be found in Section IV.

### **f. UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENT**

The 2022 integrated planning process built off the 2020 EHE strategic planning process. Discussion topics that began at the 2020 regional group meetings were continued for integrated planning. The *2020 EHE Needs Assessment Survey* was supplemented and supported by a new *2022 End HIV Kentucky Statewide Needs Assessment Survey*, which was developed and implemented with support from the statewide planning group.

## SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

### DATA SHARING AND USE

KDPH utilizes all available data to determine the services needed by clients to access and maintain HIV prevention, care, and treatment services across the Commonwealth; to identify barriers clients face when accessing services; and to assess gaps in the service delivery system. On December 1, 2018, KDPH reorganized branches in the Division of Epidemiology and Health Planning and transferred the HIV/AIDS Branch into a section under the Infectious Disease Branch (IDB). The IDB now includes the following sections under its umbrella:

- HIV/AIDS
- Viral Hepatitis
- Sexually Transmitted Disease (STD) Prevention and Control
- Healthcare-Associated Infection/Antibiotic Resistance
- Tuberculosis Prevention and Control
- Reportable Diseases

The integration of the HIV/AIDS Section within the IDB has improved collaboration for case surveillance and prevention activities among these programs. HIV Surveillance, HIV Prevention, HIV Services (RWHAP), and EHE are the four subsections of the KDPH HIV/AIDS Section and share data as needed. The HIV/AIDS Section has a data sharing agreement in place with all the other programs under IDB and share data as needed.

LHD are considered part of KDPH and do not need a specific data sharing agreement to share information. KDPH staff educate LHD staff about the importance of managing HIV data, including cluster data, consistent with guidance outlined in the *KDPH Division of Epidemiology and Health Planning HIV/AIDS Section Security and Confidentiality Policy*. KDPH uses MoveIT, a secure file transfer protocol, to share data with partners securely. HIV Surveillance staff are responsible for establishing MoveIT accounts and training as needed.

KDPH standard practices for sharing HIV data are outlined below. A complete review of all data sharing and use practices can be found in the *Kentucky HIV Cluster and Outbreak Detection and Response Plan 2021*, last updated in June 2021 (see Appendix J).

#### **HIV/AIDS Surveillance Annual Report**

Kentucky HIV/AIDS Surveillance data is distributed to stakeholders in the form of the “HIV/AIDS Surveillance Report” annually. The report is a comprehensive description of how the HIV epidemic has impacted Kentucky and includes detailed information about cumulative cases, prevalence, concurrent diagnosis, and latest trends in HIV disease across the Commonwealth. The report is printed and mailed to stakeholders across the state and is available online at <https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/reportsstats.aspx>.

## **Data Requests**

An integral part of public health surveillance is the dissemination of health data to public health agencies, medical providers, HIV Section partners, and the public. Surveillance data are needed to analyze trends in occurrence and prevalence, as well as to effectively plan and evaluate prevention and services programs.

Restrictions on data released must be established to ensure confidentiality of cases. A strict data release policy is necessary because release of certain types of data, even without names, could be utilized to identify a case. All data requests follow the data protocol outlined in the *KDPH Division of Epidemiology and Health Planning HIV/AIDS Section Security and Confidentiality Policy*, available upon request from the HIV Section Surveillance Coordinator. Data requests are honored, as much as possible, as long as the privacy of cases is ensured.

## **Quarterly Data Reports**

Quarterly data reports include the most recent HIV data, such as total of newly diagnosed cases for a defined region, sex at birth, category of transmission, and age category at the time of HIV diagnosis. No personally identifiable information (PII) is shared in these reports. KDPH regularly shares quarterly data reports with the three health departments (Jefferson County, Fayette County, and Northern Kentucky) that constitute the highest HIV burden areas in Kentucky.

## **Data Trends Report**

The Data Trends Report contains aggregate trends data for the Commonwealth, and the following area development districts: Kentuckiana Regional Planning and Development Agency (KIPDA), Bluegrass, and Northern Kentucky Area Development District (ADD). The report contains trend data on race and ethnicity, sex at birth, category of transmission, and age at HIV diagnosis. The report is regularly posted on the KDPH website <https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/reportsstats.aspx> for all interested stakeholders.

## **Data Presentations**

HIV data is shared with stakeholders across the state in the form of data presentations during HIV Prevention and HIV Ryan White Services quarterly meetings, and other HIV- related events across the state.

## **Cluster Data**

In the event of a cluster investigation, a specific data sharing agreement will be enacted with identified stakeholders based on the needs of the investigation following guidelines in the KDPH security and confidentiality policy.

## EPIDEMIOLOGIC SNAPSHOT

This section presents data from the *2022 Kentucky HIV/AIDS Surveillance Annual Report* (see Appendix H for a link to the full report). An updated Kentucky Integrated Epidemiological Profile is currently being developed, based on new guidance released by CDC and HRSA. This updated Kentucky Integrated Epidemiological Profile will be available during early 2023 and will include detailed information about Kentucky's population demographics, social determinants of health, epidemiology of HIV in Kentucky, and HIV prevention and Ryan White Services. Key terminology and acronyms used in this section are in Appendix A.

### Cumulative and Living HIV Infections Diagnosed as of December 31, 2021

**Table 3. Cumulative (1) HIV Disease Cases by Age at Diagnosis\*, Race/Ethnicity, and Sex as of December 31, 2021, Kentucky**

	Age Group	White, Not Hispanic		Black, Not Hispanic		Hispanic		Other/Unknown		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	%
<b>M A L E</b>	<13	26	<1	30	1	0	0	2	<1	58	1
	13-19	146	2	180	6	9	2	21	8	356	4
	20-29	1,743	29	1,022	36	200	40	139	40	3,104	32
	30-39	2,152	35	822	29	185	37	90	26	3,249	33
	40-49	1,370	22	544	19	72	14	56	17	2,042	21
	50+	663	11	251	9	40	8	25	9	979	10
	<b>TOTAL</b>	<b>6,100</b>	<b>100</b>	<b>2,849</b>	<b>100</b>	<b>506</b>	<b>100</b>	<b>333</b>	<b>100</b>	<b>9,788</b>	<b>100</b>
<b>F E M A L E</b>	<13	12	1	20	2	3	3	2	2	37	2
	13-19	47	5	57	6	5	6	3	3	112	5
	20-29	267	28	262	29	39	43	30	29	598	29
	30-39	315	33	286	32	20	22	33	32	654	32
	40-49	184	19	174	19	16	18	24	24	398	19
	50+	120	13	108	12	7	8	10	10	245	12
	<b>TOTAL</b>	<b>945</b>	<b>100</b>	<b>907</b>	<b>100</b>	<b>90</b>	<b>100</b>	<b>102</b>	<b>100</b>	<b>2,044</b>	<b>100</b>

(1) Includes HIV disease cases diagnosed from the beginning of the epidemic as of December 31, 2021.

\*Age at initial HIV diagnosis. Percentages may not total 100% due to rounding.

Since the beginning of the HIV epidemic in 1982, the majority (83%) of HIV cases diagnosed among Kentuckians have been reported among males (9,788 cases). In terms of age at time of diagnosis, more male HIV cases were diagnosed at ages 30-39 (3,249 or 33%) than any other age grouping. Among white males, the highest percentage of cumulative cases was aged 30-39 years at the time of diagnosis (35%). Among black males, 36% of cases were aged 20-29 years and 29% were aged 30-39 years at time of diagnosis. The percentage of Hispanic males aged 20-29 at time of diagnosis (40%) was higher when compared to black (36%) and white (29%) males. Conversely, Hispanic males had the lowest percentage of cases diagnosed at ages 40-49 years (14%) as compared to black males and white males (19% and 22% respectively).

Similar patterns exist among females with HIV disease. More females were diagnosed with HIV disease at ages 30-39 (654 or 32%) than in any other age category. For female cases, age at identification was nearly identical across age groups for black and white females, while Hispanic females were most often identified in the 20–29-year age group (43%).

**Table 4. Cumulative (1) Adult/Adolescent\* HIV Disease Cases by Transmission Route, Race/Ethnicity, and Sex as of December 31, 2021, Kentucky**

	Transmission Category	White, Not Hispanic		Black, Not Hispanic		Hispanic		Other/Unknown		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	%
<b>M A L E</b>	MMSC <sup>(2)</sup>	4,341	71	1,616	57	316	62	222	67	6,495	67
	IDU <sup>(3)</sup>	420	7	342	12	35	7	19	6	816	8
	MMSC/IDU	513	8	175	6	18	4	19	6	725	7
	Heterosexual <sup>(4)</sup>	217	4	225	8	46	9	22	7	510	5
	Other <sup>(5)</sup>	87	1	15	1	0	0	0	0	102	1
	Undetermined <sup>(6)</sup>	496	8	446	16	91	18	49	15	1,082	11
	<b>TOTAL<sup>(7)</sup></b>	<b>6,074</b>	<b>100</b>	<b>2,819</b>	<b>100</b>	<b>506</b>	<b>100</b>	<b>331</b>	<b>100</b>	<b>9,730</b>	<b>100</b>
<b>F E M A L E</b>	IDU <sup>(3)</sup>	287	31	167	19	12	14	14	14	480	24
	Heterosexual <sup>(4)</sup>	419	45	421	47	50	57	54	54	944	47
	Female Heterosexual <sup>(8)</sup>	159	17	242	27	21	24	27	27	449	22
	Other <sup>(5)</sup>	12	1	4	<1	0	0	1	1	17	1
	Undetermined <sup>(6)</sup>	56	6	53	6	4	5	4	4	117	6
	<b>TOTAL<sup>(7)</sup></b>	<b>933</b>	<b>100</b>	<b>887</b>	<b>100</b>	<b>87</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>2,007</b>	<b>100</b>

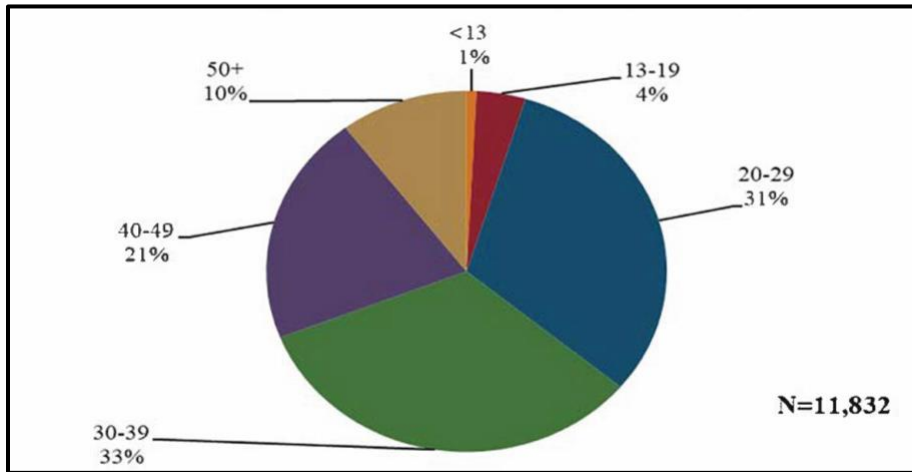
\*Cases are classified as adult/adolescent if they were 13 years of age or older at time of HIV diagnosis.

- 1) Includes HIV disease cases diagnosed from the beginning of the epidemic as of December 31, 2021.
- 2) MMSC = male-to-male sexual contact.
- 3) IDU = injection drug use.
- 4) Heterosexual includes persons who have had heterosexual contact with a PWH or at-risk for HIV.
- 5) Other includes persons who had a transfusion/transplant, hemophilia/coagulation disorder, or pediatric cases diagnosed as adults.
- 6) Undetermined refers to persons whose route of exposure to HIV is unknown. This includes persons who are under investigation, dead, lost to investigation, refused interview, and persons whose mode of exposure remains undetermined after investigation.
- 7) Percentages may not total 100% due to rounding.
- 8) Female heterosexual refers to female not reporting drug use but reporting sex with male.

Among adult/adolescent males, the majority of cumulative HIV cases reported the primary route of exposure as male-to-male sexual contact (MMSC, 67%), while among adult/adolescent women, most (47%) were exposed through heterosexual contact with a PWH or at high-risk for HIV infection (e.g., a PWID).

Adult/adolescent black males (12%) reported higher percentages of injection drug use (IDU) as the route of HIV transmission in comparison to adult/adolescents white (7%) and Hispanic males (7%). Conversely, a higher percentage of adult/adolescent white males (71%) reported MMSC as the primary route of transmission as compared to 57% of all adult/adolescent black males and 62% of all adult/adolescent Hispanic males. The most reported risk factor for adult/adolescent female cases in each racial/ethnic group was heterosexual contact. Risk factor information forms the basis for program planning, service provision, and guides resource allocation.

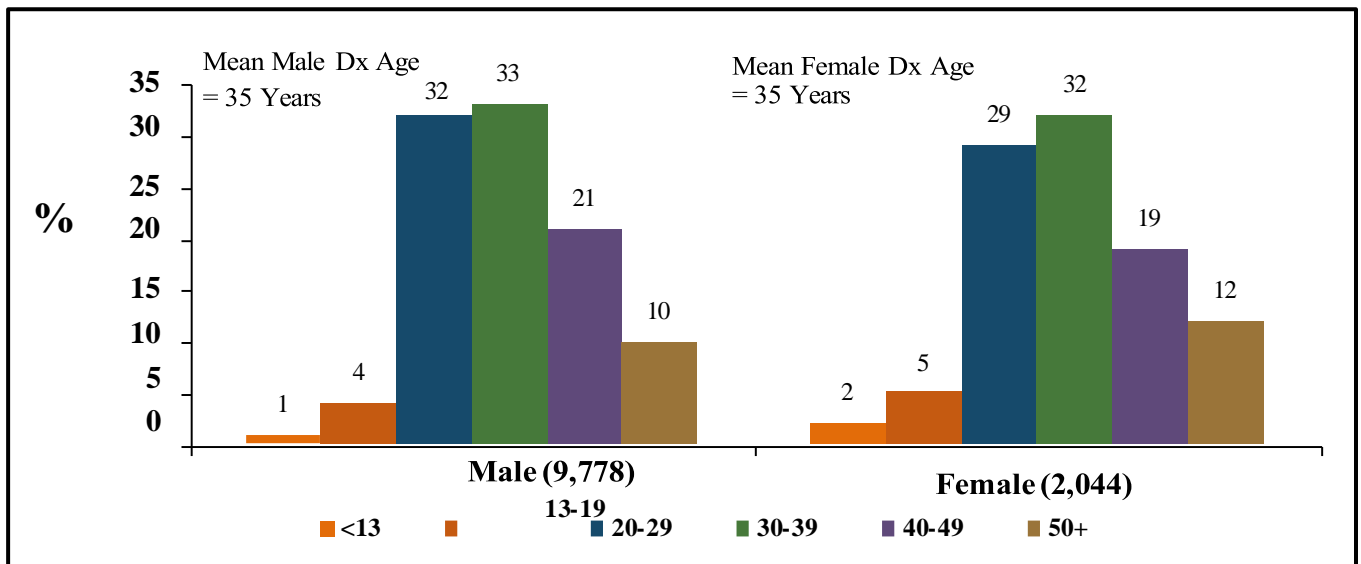
**Figure 5. Percentage of Cumulative HIV Disease Cases by Age at HIV Diagnosis As of December 31, 2021, Kentucky\***



\* Percentages may not total 100% due to rounding.

Figure 5 shows the distribution of cumulative Kentucky HIV cases by age at diagnosis. One-third (33%) of cumulative HIV cases in Kentucky were aged 30-39 years at time of diagnosis. Persons aged 20-29 years also account for almost a third of cumulative cases (31%). Children (aged <13 years at diagnosis) and teenagers (aged 13-19 years) account for the smallest percentages of cases at less than 5% each.

**Figure 6. Percentage of Cumulative HIV Disease Cases by Sex and Age at HIV Diagnosis (Dx) as of December 31, 2021, Kentucky\***

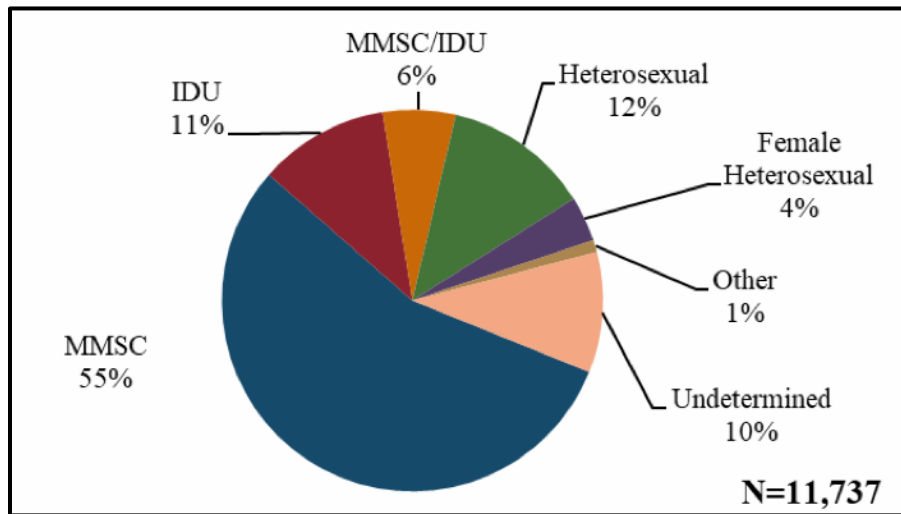


\* Percentages may not total 100% due to rounding.

Figure 6 shows the percentage of HIV cases by age group and sex. Cumulatively, 9,788 male HIV cases have been diagnosed, of which 33% were aged 30-39 years at time of diagnosis. Similarly, females aged 30-39 years at time of diagnosis accounted for the highest percentage of cumulative HIV cases by age group among females (32%). The mean age at diagnosis for both males and females is 35 years of age.



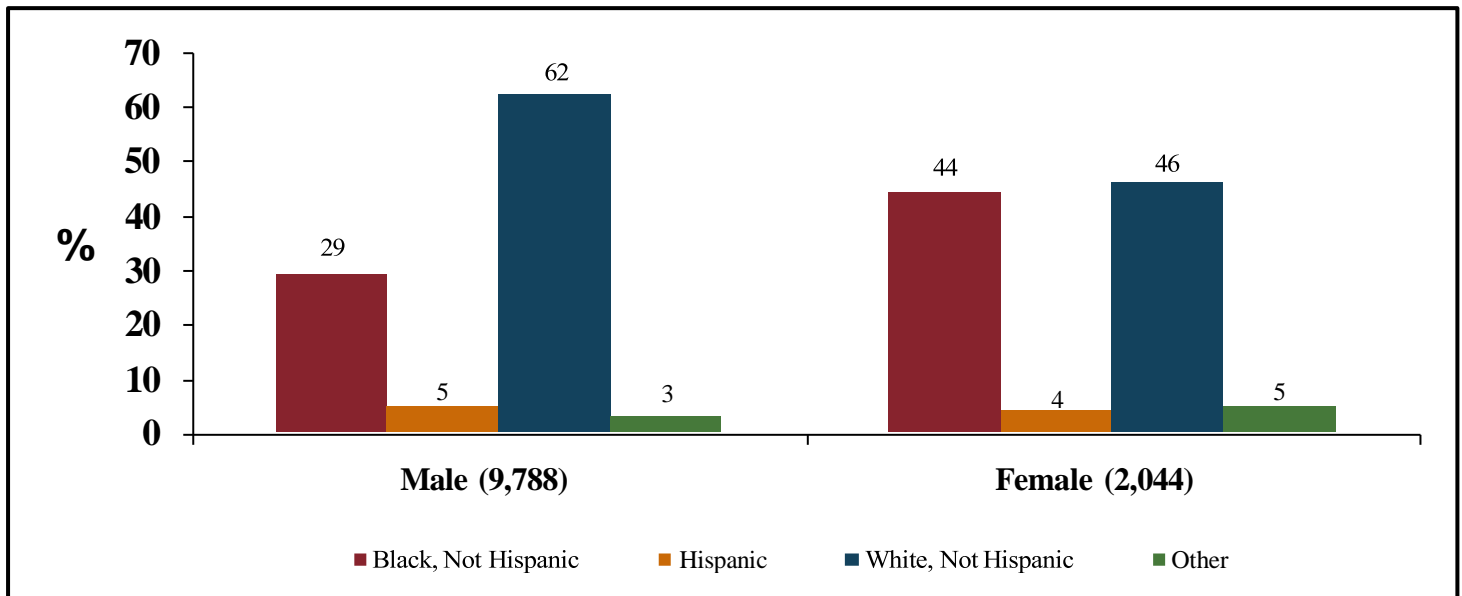
**Figure 7. Percentage of Cumulative Adult/Adolescent HIV Disease Cases by Transmission Route, As of December 31, 2021, Kentucky\***



\* Percentages may not total 100% due to rounding.

Figure 7 shows that 59% of cumulative HIV cases diagnosed in Kentucky are among white populations, 32% are in black populations, and 5% are in Hispanic populations.

**Figure 8. Percentage of Cumulative HIV Disease Cases by Race/Ethnicity and Sex As of December 31, 2021, Kentucky\***

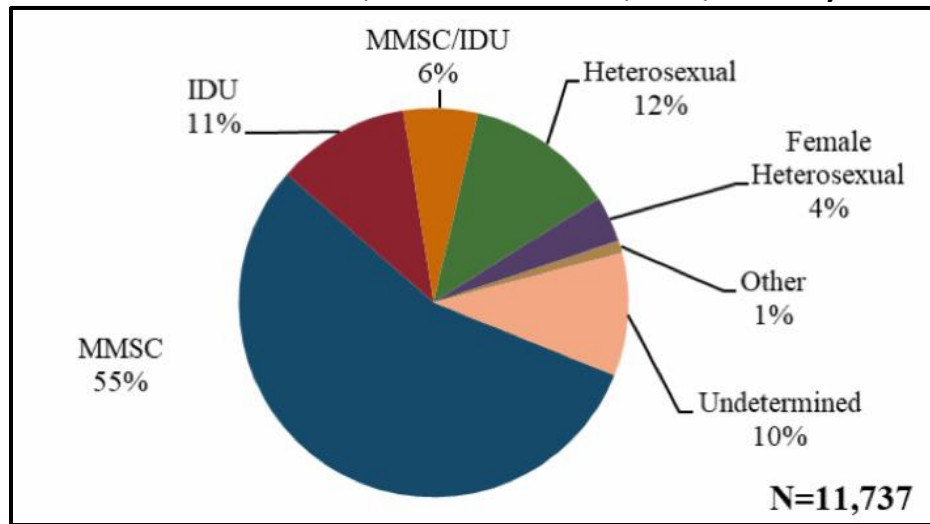


\* Percentages may not total 100% due to rounding.

Figure 8 shows the percentages of cumulative HIV cases within each sex group by race/ethnicity. Among males, the majority are white males (62%) with black males accounting for 29% of cumulative cases. The distribution among females by racial/ethnic grouping differs from males with both black females, as well as white females accounting for almost equal percentage of cases at 44% and 46% respectively.

## Cumulative Adult/Adolescent HIV Diagnoses by Transmission Route

**Figure 9. Percentage of Cumulative Adult/Adolescent HIV Disease Cases by Transmission Route, As of December 31, 2021, Kentucky\***



\* Percentages may not total 100% due to rounding.

**Table 5. Cumulative Adult/Adolescent HIV Disease Cases by Transmission Route as of December 31, 2021, Kentucky**

Transmission Route	No.	%
MSM	6,495	55
IDU	1,296	11
MSM/IDU	725	6
Heterosexual	1,454	12
Female Heterosexual*	449	4
Other†	119	1
Undetermined	1,199	10
Total**	11,737	100

\*Female heterosexual = a female not reporting drug use but reporting sex with male.

\*\*Percentages may not total 100% due to rounding.

† Other includes persons with transfusion/transplant or hemophilia/coagulation listed as mode of transmission. Also includes persons with perinatal exposure, but who were diagnosed as an adult.

In Kentucky, 55% of cumulative adult/adolescent HIV cases identified their primary transmission route as MSM as shown in Figure 9. Twelve percent of adult/adolescent HIV cases reported heterosexual contact as their primary transmission route, 11% IDU, and 6% reported both MSM and IDU. Ten percent of cumulative adult/adolescent HIV cases were reported without a risk factor identified. Cumulative adult/adolescent HIV case frequencies for each route of exposure are displayed in Table 5.

Cumulative HIV Diagnoses by Residential Area Development District (ADD) and County at Time of Diagnosis

**Table 6. Cumulative and Living HIV Disease Cases by Residential ADD and County at Time of Diagnosis as of December 31, 2021, Kentucky (1)**

ADD/County	Total HIV Disease Cases (2)	Total Living with HIV Disease (3)	ADD/County	Total HIV Disease Cases (2)	Total Living with HIV Disease (3)
<b>Barren River</b>	<b>418</b>	<b>265</b>	<b>Buffalo Trace</b>	<b>63</b>	<b>39</b>
Allen	23	13	Bracken, Fleming and Robert son*	17	10
Barren	49	28	Lewis	16	7
Butler	15	13	Mason	30	22
Edmonson and Metcalfe*	19	12			
Hart	13	5			
Logan	30	18			
Monroe	16	9	<b>Cumberland Valley</b>	<b>233</b>	<b>144</b>
Simpson	26	17	Bell	26	18
Warren	227	150	Clay	34	24
			Harlan	24	11
			Jackson	17	11
<b>Big Sandy</b>	<b>95</b>	<b>59</b>	Knox	24	17
Floyd	28	19	Laurel	50	30
Johnson and Magoffin*	17	8	Rockcastle	12	7
Martin	11	10	Whitley	46	26
Pike	39	22			
			<b>FIVCO</b>	<b>164</b>	<b>98</b>
			Boyd	97	58
<b>Bluegrass</b>	<b>2,265</b>	<b>1,606</b>	Carter	23	16
Anderson	35	22	Elliott and Lawrence*	18	7
Bourbon	34	25	Greenup	26	17
Boyle	41	29			
Clark	58	41	<b>Gateway</b>	<b>119</b>	<b>81</b>
Estill	11	7	Bath	15	11
Fayette	1,551	1,094	Menifee	12	11
Franklin	115	82	Montgomery	29	21
Garrard	14	9	Morgan	34	16
Harrison	13	9	Rowan	29	22
Jessamine	87	67			
Lincoln	16	9	<b>Green River</b>	<b>331</b>	<b>203</b>
Madison	129	101	Daviess	162	94
Mercer	37	19	Hancock and Webster*	19	12
Nicholas	7	6	Henderson	69	39
Powell	12	7	McLean	11	8
Scott	65	50	Ohio	14	9
Woodford	40	29	Union	56	41
(1) One case was missing residential county at time of diagnosis.					
(2) Total cases with HIV disease regardless of progression to AIDS, both living and deceased.					
(3) Living cases regardless of current residence.					

(Continued on page 12)

\* Cases combined due to confidentiality guidelines.

**Table 6 (continued). Cumulative and Living HIV Disease Cases by Residential ADD and County at Time of Diagnosis as of December 31, 2021, Kentucky (1)**

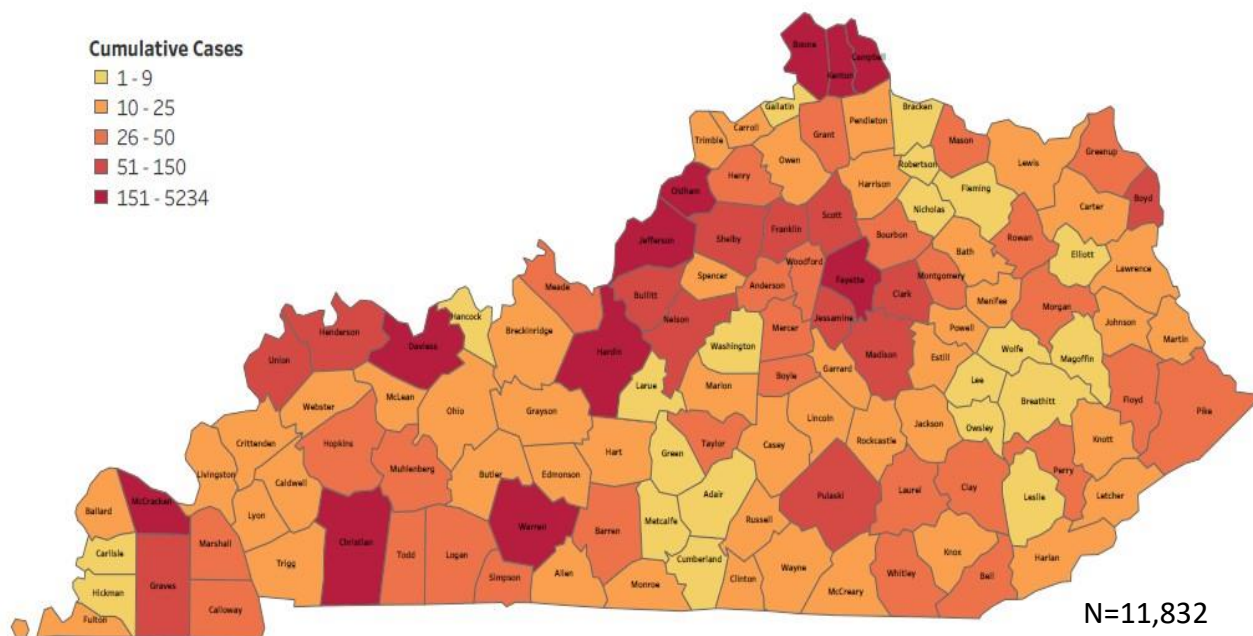
ADD/County	Total HIV Disease Cases	Total Living with HIV Disease	ADD/County	Total HIV Disease Cases	Total Living with HIV Disease
<b>Kentucky River</b>	<b>100</b>	<b>61</b>	<b>Northern Kentucky</b>	<b>1027</b>	<b>700</b>
Breathitt and Owsley*	9	5	Boone	171	122
Knott	17	13	Campbell	213	149
Lee, Leslie and Wolfe*	17	9	Carroll	18	13
Letcher	23	10	Gallatin and Owen*	14	11
Perry	34	24	Grant	40	27
			Kenton	561	370
			Pendleton	10	8
<b>KIPDA/North Central</b>	<b>5,697</b>	<b>3,693</b>	<b>Pennyrile</b>	<b>377</b>	<b>215</b>
Bullitt	114	87	Caldwell	25	14
Henry	32	23	Christian	177	118
Jefferson	5,234	3,404	Crittenden and Lyon*	28	8
Oldham	200	94	Hopkins	49	26
Shelby	93	72	Livingston	15	7
Spencer and Trimble*	24	13	Muhlenberg	39	21
			Todd	28	13
			Trigg	16	8
<b>Lake Cumberland</b>	<b>194</b>	<b>135</b>	<b>Purchase</b>	<b>356</b>	<b>212</b>
Adair and Cumberland*	12	7	Ballard and Carlisle*	15	8
Casey	11	7	Calloway	42	24
Clinton	14	11	Fulton	12	9
Green	8	6	Graves	60	35
McCreary	22	20	Hickman	9	7
Pulaski	70	45	Marshall	31	19
Russell	15	9	McCracken	187	110
Taylor	27	22			
Wayne	15	8			

ADD/County	Total HIV Disease Cases	Total Living with HIV Disease
<b>Lincoln Trail</b>	<b>392</b>	<b>266</b>
Breckinridge	19	8
Grayson	19	10
Hardin	235	167
Larue	9	8
Marion	22	13
Meade	27	18
Nelson	52	36
Washington	9	6

- (1) One case was missing residential county at time of diagnosis.
- (2) Total cases with HIV disease regardless of progression to AIDS, both living and deceased.
- (3) Living cases regardless of current residence.

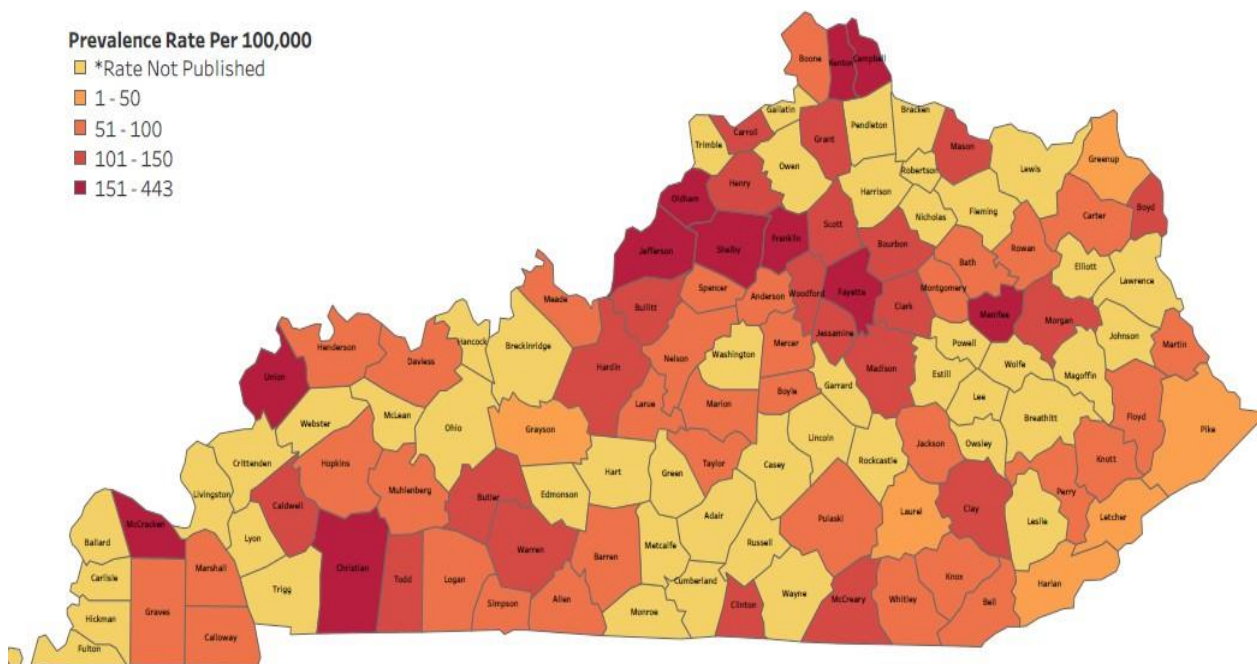
\* Cases combined due to confidentiality guidelines.

**Figure 10. Cumulative HIV Disease Cases Diagnosed by Residential County at Time of Diagnosis, As of December 31, 2021, Kentucky\***



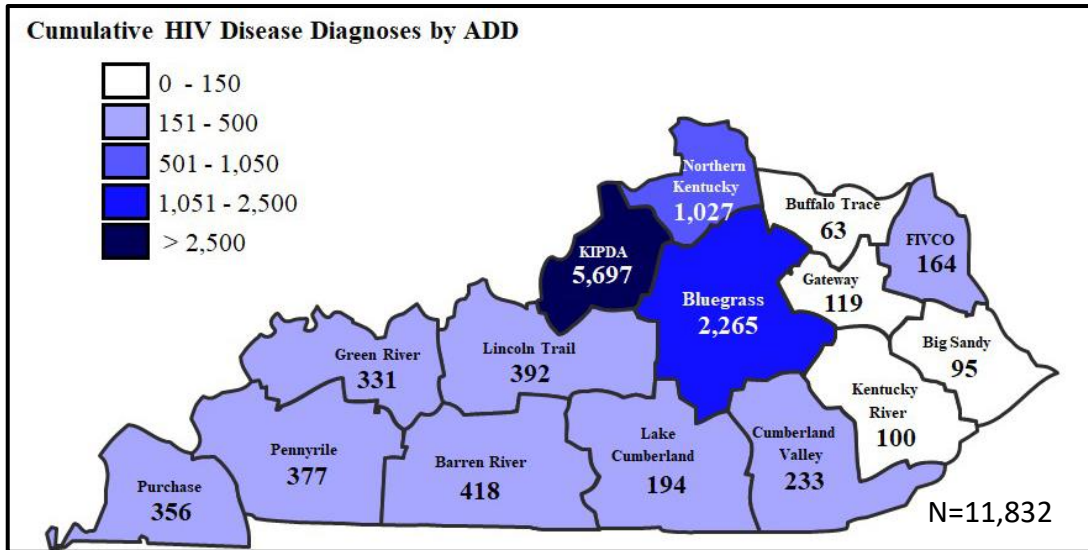
\* One case was missing residential county at time of diagnosis.

**Figure 11. HIV Disease Prevalence Rates by Residential County at Time of Diagnosis, As Of December 31, 2021, Kentucky**



\* Rates not published when cell size is less than 10.

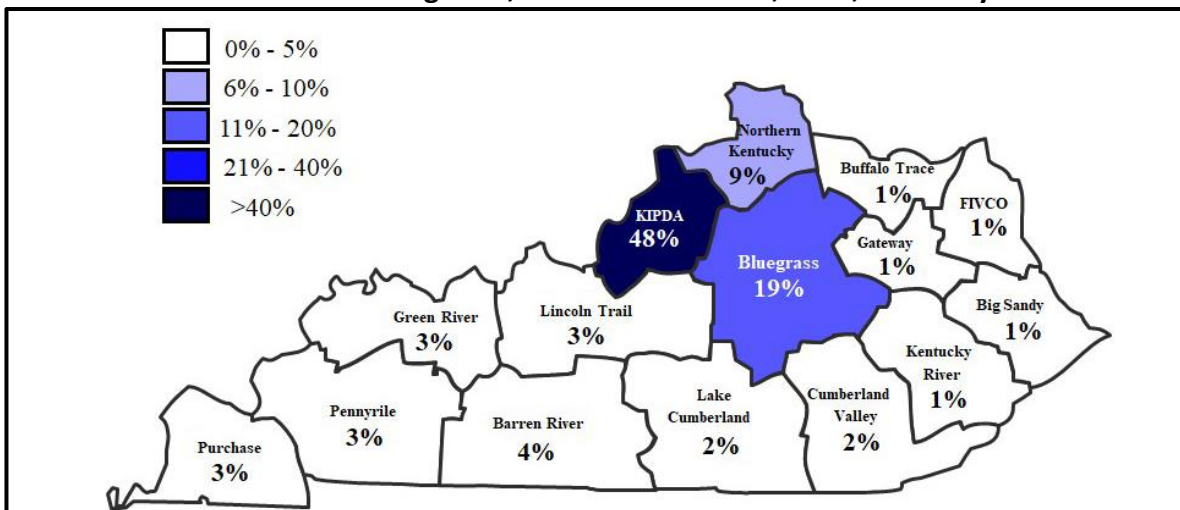
**Figure 12. Cumulative HIV Disease Diagnoses by ADD of Residence at Time of HIV Diagnosis, As of December 31, 2021, Kentucky\***



\* One case was missing residential county information at time of diagnosis.

Figure 12 indicates that the highest number of cumulative HIV cases, 5,697 (48%), resided in the KIPDA ADD at the time of diagnosis, which includes the city of Louisville. The Bluegrass ADD, which includes the city of Lexington, had the second highest number of HIV cases diagnosed, 2,265 (19%), followed by the Northern Kentucky ADD, including a portion of the Cincinnati metropolitan area, with 1,027 (9%) of cumulative cases.

**Figure 12. Percentage of Cumulative HIV Disease Diagnoses by ADD of Residence at Time of HIV Diagnosis, As of December 31, 2021, Kentucky\***



\* One case was missing residential county information at time of diagnosis.

Figure 13 shows the percentage of the cumulative 11,832 HIV cases statewide that were diagnosed within each ADD. The percentage of diagnoses by ADD ranged from 1% of total statewide cases residing in each of Buffalo Trace, Gateway, FIVCO, Big Sandy, and Kentucky River ADDs to almost half (48%) residing in the KIPDA ADD at time of diagnosis.

**Table 7. Living HIV Disease Diagnoses by Transmission Route, Race/Ethnicity, and Sex as of December 31, 2021, Kentucky (1)**

	Transmission Category	White, Not Hispanic		Black, Not Hispanic		Hispanic		Other/Unknown		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	%
<b>M A L E</b>	MMSC <sup>(2)</sup>	2,733	72	1,161	62	288	64	205	69	4,387	69
	IDU <sup>(3)</sup>	234	6	135	7	22	5	12	4	403	6
	MMSC/IDU	333	9	85	5	15	3	15	5	448	7
	Heterosexual <sup>(4)</sup>	117	3	131	7	42	9	21	7	311	5
	Perinatal	13	<1	22	1	0	0	2	1	37	1
	Other <sup>(5)</sup>	14	<1	3	<1	0	0	0	0	17	<1
	Undetermined <sup>(6)</sup>	338	9	310	17	80	18	44	15	772	12
	<b>Male Subtotal<sup>(7)</sup></b>	<b>3,782</b>	<b>100</b>	<b>1,847</b>	<b>100</b>	<b>447</b>	<b>100</b>	<b>227</b>	<b>100</b>	<b>6,375</b>	<b>100</b>
<b>F E M A L E</b>	IDU <sup>(3)</sup>	197	31	74	12	7	9	11	13	289	21
	Heterosexual <sup>(4)</sup>	282	44	287	48	47	60	42	49	658	47
	Female Heterosexual <sup>(8)</sup>	117	18	196	33	18	23	26	30	357	25
	Perinatal	8	1	14	2	3	4	2	2	27	2
	Other <sup>(5)</sup>	0	0	1	<1	0	0	1	1	2	<1
	Undetermined <sup>(6)</sup>	33	5	30	5	3	4	4	5	70	5
	<b>Female Subtotal<sup>(7)</sup></b>	<b>637</b>	<b>100</b>	<b>602</b>	<b>100</b>	<b>78</b>	<b>100</b>	<b>86</b>	<b>100</b>	<b>1,403</b>	<b>100</b>
<b>A L L L I V I N G</b>	MMSC <sup>(2)</sup>	2,733	62	1,161	47	288	55	205	53	4,387	56
	IDU <sup>(3)</sup>	431	10	209	9	29	6	23	6	692	9
	MMSC/IDU	333	8	85	4	15	3	15	4	448	6
	Heterosexual <sup>(4)</sup>	399	9	418	17	89	17	63	16	969	12
	Female Heterosexual <sup>(8)</sup>	117	3	196	8	18	3	26	7	357	5
	Perinatal	21	<1	36	1	3	1	4	1	64	1
	Other <sup>(5)</sup>	14	<1	4	<1	0	0	1	<1	19	<1
	Undetermined <sup>(6)</sup>	371	8	340	14	83	16	48	12	842	11
	<b>TOTAL<sup>(7)</sup></b>	<b>4,419</b>	<b>100</b>	<b>2,449</b>	<b>100</b>	<b>525</b>	<b>100</b>	<b>385</b>	<b>100</b>	<b>7,778</b>	<b>100</b>

- (1) Includes living HIV disease cases diagnosed from beginning of the epidemic as of December 31, 2021.
- (2) MMSC = male-to-male sexual contact.
- (3) IDU = injection drug use.
- (4) Heterosexual includes persons who have had heterosexual contact with a PWH or at-risk for HIV.
- (5) Other includes persons who had exposure through hemophilia/coagulation disorder, transfusion/transplant or pediatric cases diagnosed as adults.
- (6) Undetermined refers to persons whose route of exposure to HIV is unknown. This includes persons who are under investigation, dead, lost to investigation, refused interview, and persons whose route of exposure remains undetermined after investigation.
- (7) Percentages may not total 100% due to rounding.
- (8) Female heterosexual includes a female who does not report drug use as an exposure but does report sex with male.

Table 7 shows living HIV cases diagnosed through December 31, 2021, by demographic and behavioral characteristics. There are 7,778 Kentuckians reported to be living with HIV (prevalence rate: 173.7 cases per 100,000). The distribution of behavioral characteristics varied by race/ethnicity and sex, but the majority of Kentucky males living with HIV contracted the disease through MMSC (69%), whereas the majority of Kentucky females contracted HIV through heterosexual contact (47%). An additional 25% of females reported female heterosexual contact (FHC) which is different than heterosexual contact in that the behavioral risk or sero-status of the male partner is unknown.

### New HIV Infections Diagnosed among Kentuckians, as of December 31, 2021

A total of 11,832 cumulative HIV infections among Kentuckians have been reported to the KDPH HIV/AIDS Surveillance Program since AIDS reporting started in 1982. Of these infections, 60% have progressed to AIDS. The number of new HIV infections diagnosed since 2011 are presented in Table 8 along with the percentage from each year that have progressed to AIDS. Of the 3,794 HIV infections diagnosed since 2011, 1,208 (32%) had progressed to AIDS.

**Table 8. Number of HIV Infections per Year of Diagnosis (2011-2021†) and Percentage that Progressed to AIDS in the Course of Illness as of December 31, 2021, Kentucky**

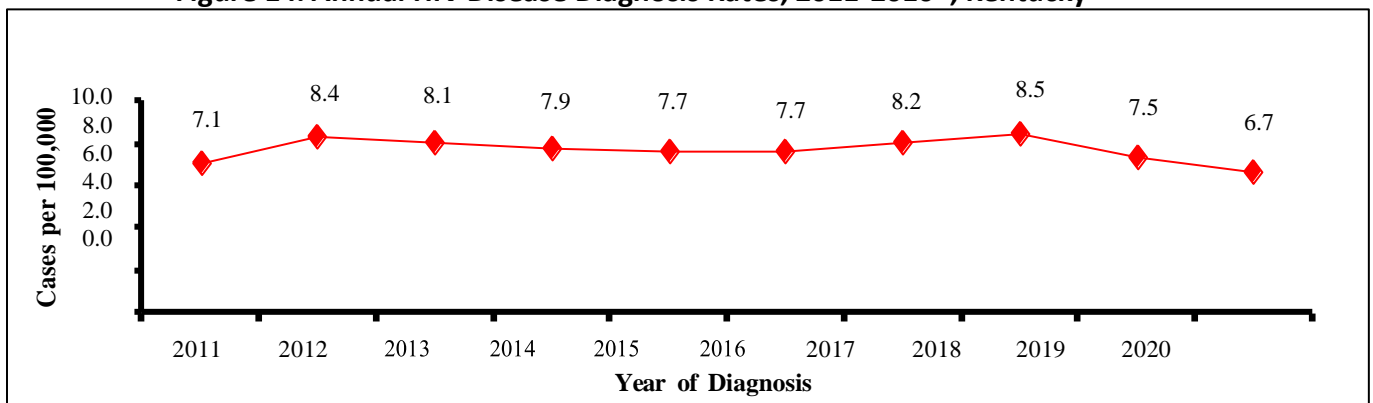
Year of HIV Diagnosis	TOTAL HIV/AIDS*	Percentage that Progressed to AIDS†
	No.	%
2011	312	48%
2012	368	39%
2013	357	37%
2014	349	35%
2015	339	32%
2016	341	38%
2017	364	29%
2018	379	25%
2019	334	25%
2020	301	24%
2021†	350	19%
<b>TOTAL</b>	<b>3794</b>	<b>32%</b>

\*Total HIV infections regardless of disease progression.

†Data reported as of December 31, 2021.

### Estimated Annual HIV Disease Diagnosis Rates Per 100,000

**Figure 14. Annual HIV Disease Diagnosis Rates, 2011-2010\*, Kentucky**



\*Data are current as of December 31, 2021. Data from 2021 are considered preliminary due to reporting delays and not included in trend analysis.

Figure 14 displays annual HIV diagnosis rates among Kentuckians. The annual HIV diagnosis rate has remained steady from 2011 to 2020 with slight fluctuations between 6.7 to 8.5 cases per 100,000 populations.



## Adult/Adolescent HIV Diagnoses Regardless of Progression to AIDS†

**Table 8. Adult/Adolescent (1) HIV Diagnoses by Year of Diagnosis, Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Route, Kentucky**

Characteristics	1982-15		2016		2017		2018		2019		2020		2021 <sup>(2)</sup>		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<b>SEX</b>																
Male	8,021	83	288	85	296	82	310	82	275	82	256	85	284	81	9,730	83
Female	1,652	17	51	15	67	18	69	18	58	18	44	15	66	19	2,007	17
<b>TOTAL<sup>(3)</sup></b>	<b>9,673</b>	<b>100</b>	<b>339</b>	<b>100</b>	<b>363</b>	<b>100</b>	<b>379</b>	<b>100</b>	<b>333</b>	<b>100</b>	<b>300</b>	<b>100</b>	<b>350</b>	<b>100</b>	<b>11,737</b>	<b>100</b>
<b>AGE AT DIAGNOSIS* 13-19</b>																
13-19	372	4	13	4	13	4	28	7	23	7	9	3	10	3	468	4
20-29	2,954	31	125	37	134	37	138	36	128	38	109	36	114	33	3,702	32
30-39	3,315	34	98	29	98	27	108	28	81	24	86	29	117	33	3,903	33
40-49	2,098	22	57	17	57	16	54	14	56	17	58	19	60	17	2,440	21
50+	934	10	46	14	61	17	51	13	45	14	38	13	49	14	1,224	10
<b>TOTAL<sup>(3)</sup></b>	<b>9,673</b>	<b>100</b>	<b>339</b>	<b>100</b>	<b>363</b>	<b>100</b>	<b>379</b>	<b>100</b>	<b>333</b>	<b>100</b>	<b>300</b>	<b>100</b>	<b>350</b>	<b>100</b>	<b>11,737</b>	<b>100</b>
<b>RACE/ETHNICITY</b>																
White, Not Hispanic	5,821	60	174	51	217	60	216	57	195	59	184	61	200	57	7,007	60
Black, Not Hispanic	3,114	32	115	34	105	29	110	29	90	27	68	23	104	29	3,706	32
Hispanic	418	4	36	11	26	7	25	7	32	10	28	10	28	8	593	5
Other/Unknown	320	3	14	4	15	4	28	7	16	5	20	7	18	5	431	4
<b>TOTAL<sup>(3)</sup></b>	<b>9,673</b>	<b>100</b>	<b>339</b>	<b>100</b>	<b>363</b>	<b>100</b>	<b>379</b>	<b>100</b>	<b>333</b>	<b>100</b>	<b>300</b>	<b>100</b>	<b>350</b>	<b>100</b>	<b>11,737</b>	<b>100</b>
<b>TRANSMISSION ROUTE</b>																
MMSC <sup>(4)</sup>	5,419	56	199	59	192	53	204	54	181	54	151	50	149	43	6,495	55
IDU <sup>(5)</sup>	1,012	10	20	6	49	14	52	14	50	15	47	16	66	19	1,296	11
MMSC/IDU	571	6	20	6	39	11	23	6	31	9	20	7	21	6	725	6
Heterosexual <sup>(6)</sup>	1,327	14	23	7	15	4	26	7	22	7	26	9	15	4	1,454	12
Female Heterosexual <sup>(7)</sup>	320	3	26	8	27	7	22	6	19	6	15	5	20	6	449	4
Other <sup>(8)</sup>	119	1	0	0	0	0	0	0	0	0	0	0	0	0	119	1
Undetermined <sup>(9)</sup>	905	9	51	15	41	11	52	14	30	9	41	14	79	23	1,199	10
<b>TOTAL<sup>(3)</sup></b>	<b>9,673</b>	<b>100</b>	<b>339</b>	<b>100</b>	<b>363</b>	<b>100</b>	<b>379</b>	<b>100</b>	<b>333</b>	<b>100</b>	<b>300</b>	<b>100</b>	<b>350</b>	<b>100</b>	<b>11,737</b>	<b>100</b>

†HIV disease cases include both PWH alone and those who have progressed to AIDS.

\*Age at time of initial HIV diagnosis.

- 1) Cases are classified as Adult/Adolescent if they were 13 years of age or older at time of diagnosis.
- 2) Data reported as of December 31, 2021. Data from 2021 are not used in trend analyses due to reporting delays.
- 3) Percentages may not total 100% due to rounding.
- 4) MMSC = male-to-male sexual contact.
- 5) IDU = injection drug use.
- 6) Heterosexual includes persons who have had heterosexual contact with a PWH or at-risk for HIV.
- 7) Female heterosexual refers to female not reporting drug use but reporting sex with male.
- 8) Other includes persons who had exposure through hemophilia/coagulation disorder, transfusion/transplant, or perinatal diagnosed as an adult.
- 9) Undetermined refers to persons whose route of exposure to HIV is unknown. This includes persons who are under investigation, deceased, lost to investigation, refused interview, and persons whose route of exposure remains undetermined after investigation.

Table 8 shows a breakdown of new adult/adolescent HIV diagnoses by year of diagnosis and demographic characteristics. Cumulative data are presented through December 31, 2021. New diagnoses over the most recent years for which data are complete, 2016-2020, have been predominantly among males, white populations, and males reporting MMSC. New HIV cases over the five-year period (2016-2020) were also highest among those aged 20-29 years in comparison to other age groups.

**Table 9. Adult/Adolescent (1) HIV Disease Cases with AIDS by Year of Initial HIV Diagnosis, Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Route, Kentucky**

Characteristics	1982-15		2016		2017		2018		2019		2020		2021 <sup>(2)</sup>		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<b>SEX</b>																
Male	5,416	84	111	85	91	85	81	84	67	82	56	77	54	83	5,876	84
Female	1,058	16	20	15	16	15	15	16	15	18	17	23	11	17	1,152	16
<b>TOTAL<sup>(3)</sup></b>	<b>6,474</b>	<b>100</b>	<b>131</b>	<b>100</b>	<b>107</b>	<b>100</b>	<b>96</b>	<b>100</b>	<b>82</b>	<b>100</b>	<b>73</b>	<b>100</b>	<b>65</b>	<b>100</b>	<b>7,028</b>	<b>100</b>
<b>AGE AT DIAGNOSIS* 13-19</b>	191	3	4	3	1	1	5	5	3	4	0	0	0	0	204	3
20-29	1,784	28	27	21	23	22	26	27	19	23	14	19	10	15	1,903	27
30-39	2,407	37	43	33	30	28	25	26	21	26	27	37	15	23	2,568	37
40-49	1,440	22	28	21	28	26	19	20	18	22	15	21	23	35	1,571	22
50+	652	10	29	22	25	23	21	22	21	26	17	23	17	26	782	11
<b>TOTAL<sup>(3)</sup></b>	<b>6,474</b>	<b>100</b>	<b>131</b>	<b>100</b>	<b>107</b>	<b>100</b>	<b>96</b>	<b>100</b>	<b>82</b>	<b>100</b>	<b>73</b>	<b>100</b>	<b>65</b>	<b>100</b>	<b>7,028</b>	<b>100</b>
<b>RACE/ETHNICITY</b>																
White, Not Hispanic	3,969	61	70	53	69	64	58	60	50	61	46	63	38	58	4,300	61
Black, Not Hispanic	2,028	31	46	35	22	21	23	24	13	16	14	19	16	25	2,162	31
Hispanic	286	5	12	9	9	8	6	6	9	11	7	10	10	15	339	5
Other/Unknown	191	3	3	2	7	7	9	9	10	12	6	8	1	2	191	3
<b>TOTAL<sup>(3)</sup></b>	<b>6,474</b>	<b>100</b>	<b>131</b>	<b>100</b>	<b>107</b>	<b>100</b>	<b>96</b>	<b>100</b>	<b>82</b>	<b>100</b>	<b>73</b>	<b>100</b>	<b>65</b>	<b>100</b>	<b>7,028</b>	<b>100</b>
<b>TRANSMISSION ROUTE</b>																
MMSC <sup>(4)</sup>	3,578	55	64	49	48	45	49	51	36	44	30	41	23	35	3,828	55
IDU <sup>(5)</sup>	804	12	9	7	10	9	13	14	8	10	14	19	4	6	862	12
MMSC/IDU	415	6	4	3	13	12	3	3	6	7	4	5	4	6	415	6
Heterosexual <sup>(6)</sup>	966	15	10	8	5	5	3	3	11	13	10	14	4	6	1,009	14
Female Heterosexual <sup>(7)</sup>	150	2	10	8	10	9	7	7	4	5	4	5	7	11	192	3
Other <sup>(8)</sup>	114	2	0	0	0	0	0	0	0	0	0	0	0	0	114	2
Undetermined <sup>(9)</sup>	447	7	34	26	21	20	21	22	17	21	11	15	23	35	574	8
<b>TOTAL<sup>(3)</sup></b>	<b>6,474</b>	<b>100</b>	<b>131</b>	<b>100</b>	<b>107</b>	<b>100</b>	<b>96</b>	<b>100</b>	<b>82</b>	<b>100</b>	<b>73</b>	<b>100</b>	<b>65</b>	<b>100</b>	<b>7,028</b>	<b>100</b>

†HIV disease cases that have progressed to AIDS include only persons reported with an AIDS diagnosis as of December 31, 2021.

\*Age at time of initial HIV diagnosis.

- 1) Cases are classified as Adult/Adolescent if they were 13 years of age or older at time of diagnosis.
- 2) Data reported as of December 31, 2021. Data from 2021 are not used in trend analyses due to reporting delays.
- 3) Percentages may not total 100% due to rounding.
- 4) MMSC = male-to-male sexual contact.
- 5) IDU = injection drug use.
- 6) Heterosexual includes persons who have had heterosexual contact with a PWH or at-risk for HIV.
- 7) Female heterosexual refers to female not reporting drug use but reporting sex with male.
- 8) Other includes persons who had exposure through hemophilia/coagulation disorder, transfusion/transplant, or perinatal diagnosed as an adult.
- 9) Undetermined refers to persons whose route of exposure to HIV is unknown. This includes persons who are under investigation, deceased, lost to investigation, refused interview, and persons whose route of exposure remains undetermined after investigation.

Table 9 shows a breakdown of adult/adolescent HIV diagnoses that have progressed to AIDS by year of initial HIV diagnosis and demographic characteristics. Newly diagnosed cases that had progressed to AIDS as of December 31, 2021, were predominantly male, white, and males reporting MMSC.

**Table 10. Number and Percentage of Cumulative Pediatric (1) HIV Disease Cases by Transmission Route and Race/Ethnicity as of December 31, 2021, Kentucky**

Transmission Route	White, Not Hispanic		Black, Not Hispanic		Other <sup>(2)</sup> Unknown		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Pediatric Hemophilia/Coagulation Disorder	10	26	1	2	0	0	11	11
Perinatal Exposure, Mother with HIV	25	66	43	86	7	100	75	79
Pediatric Transfusion/Transplant	2	5	0	0	0	0	2	2
Pediatric risk not identified or reported	1	3	6	12	0	0	7	7
<b>TOTAL<sup>(3)</sup></b>	<b>38</b>	<b>100</b>	<b>50</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>95</b>	<b>100</b>

- 1) Cases are classified as pediatric if they are less than 13 years of age at time of diagnosis.
- 2) Other includes Hispanics and persons of other races.
- 3) Percentages may not total 100% due to rounding.

**Table 11. Number and Percentage of Cumulative Pediatric (1) HIV Disease Cases by Disease Status and Year of Diagnosis, Kentucky**

Disease Status	1982-2015		2016		2017		2018		2019		2020		2021 <sup>(2)</sup>		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<b>HIV infections without AIDS</b>	40	44	2	100	1	100	0	0	0	0	1	100	0	0	44	46
<b>HIV infections with AIDS</b>	50	56	0	0	0	0	0	0	1	100	0	0	0	0	51	54
<b>Total<sup>(3)</sup></b>	<b>90</b>	<b>100</b>	<b>2</b>	<b>100</b>	<b>1</b>	<b>100</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>100</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>95</b>	<b>100</b>

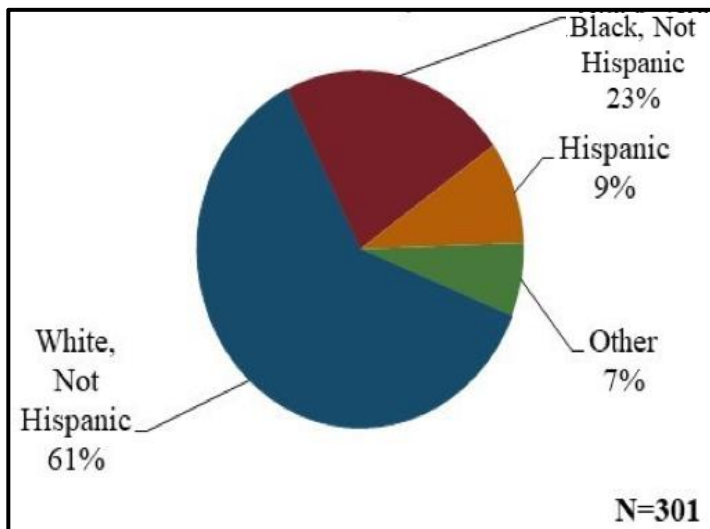
- 1) Cases are classified as pediatric if they are less than 13 years of age at time of diagnosis.
- 2) Data reported as of December 31, 2021.
- 3) Percentages may not total 100% due to rounding.

There have been 95 pediatric HIV cases reported to the Kentucky HIV/AIDS Surveillance Program (Table 10 and Table 11) since reporting began in 1982. The majority of reported pediatric cases (79%) were due to perinatal transmission through an HIV-infected mother, 11 cases were reported with a primary exposure route of pediatric hemophilia or coagulation disorders, and two cases were due to pediatric transfusion or transplant (Table 10). Since 1991, there have been no pediatric HIV cases with hemophilia or coagulation disorders reported as the route of exposure. The two pediatric cases reported with pediatric transfusion or transplant as the risk factor were diagnosed in 1987 or earlier. Eighty-six percent of the 50 pediatric HIV cases among black populations were due to perinatal exposure as compared to 66% of the 38 pediatric HIV cases among white populations. The majority (57%) of the 75 cumulative perinatal exposures from a mother with HIV were in black populations.

Table 11 shows disease progression to AIDS as of December 31, 2021. Ninety (95%) of the cumulative 95 pediatric cases in Kentucky were diagnosed prior to 2016. Two or fewer new pediatric HIV cases have been reported during each of the most recent five years.

## New HIV Disease Cases by Race/Ethnicity

**Figure 15. Percentage of Newly Diagnosed HIV Cases by Race/Ethnicity, 2020, Kentucky\***



\*Percentages may not total 100% due to rounding.

**Figure 16. Percentage of Population by Race/Ethnicity, As of July 1, 2020, Kentucky\***

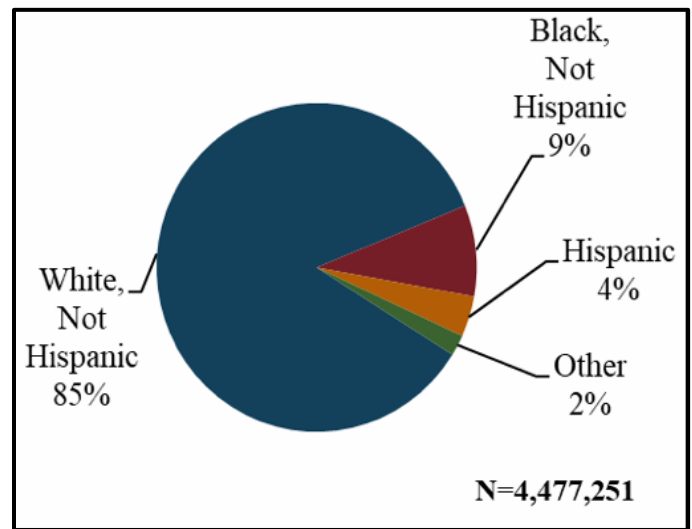


Figure 15 shows the race/ethnicity percentage distribution for newly diagnosed HIV cases among Kentuckians in 2020, the latest year data are considered complete. The majority of cases diagnosed in 2020 were among white populations (61%), followed by black populations (23%).

Figure 16 shows the percentage race/ethnicity distribution of Kentucky's population based on the 2020 population estimates. The majority of Kentuckians are white, non-Hispanic. Persons who identify with multiple races were grouped under the "other" category.

HIV racial disparities are highlighted by these two graphs, showing higher percentages of new cases among black and Hispanic populations in relation to their representation in the general population. Black populations accounted for 23% of new HIV cases diagnosed in 2020 yet comprised just 9% of Kentucky's population in 2020. Similarly, Hispanic populations accounted for 9% of newly diagnosed HIV cases in 2020 yet comprised only 4% of Kentucky's population in that same year. Rates of new diagnoses by race/ethnicity and sex are presented in Table 12, further highlighting racial disparities.

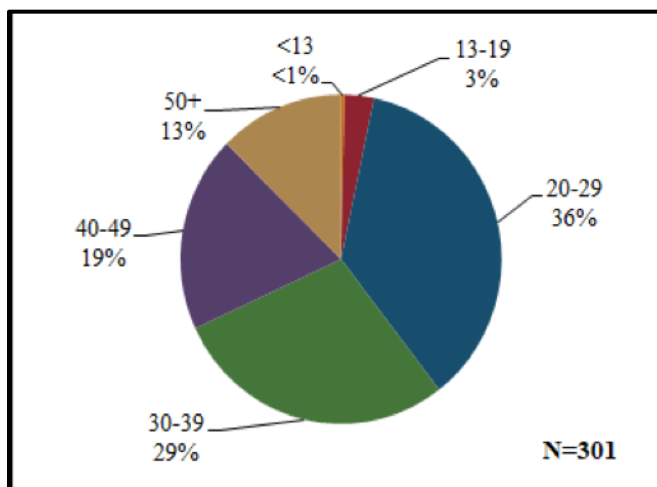
**Table 12. Number and Rate of New HIV Diagnoses by Race/Ethnicity and Sex, Kentucky, 2020**

Race/Ethnicity	Male		Female		Total No. of Cases	Total Rate
	No. of Cases	Rate*	No. of Cases	Rate*		
Hispanic	24	25.0	4	†	28	15.6
Black, not Hispanic	57	28.5	11	5.5	68	16.9
White, not Hispanic	157	8.4	28	1.4	185	4.9
Other	18	40.3	2	†	20	21.8
<b>Total</b>	<b>256</b>	<b>11.6</b>	<b>45</b>	<b>2.0</b>	<b>301</b>	<b>6.7</b>

\*Rate per 100,000 based on census data estimates for racial and gender distribution for Kentucky in 2020.

## New HIV Disease Cases by Age at Diagnosis

**Figure 17. Percentage of Newly Diagnosed HIV Cases by Age in Years at Diagnosis, 2020, Kentucky\***



\* Percentages may not total 100% due to rounding.

**Figure 18. Percentage of Population by Age in Years, As of July 1, 2020, Kentucky\***

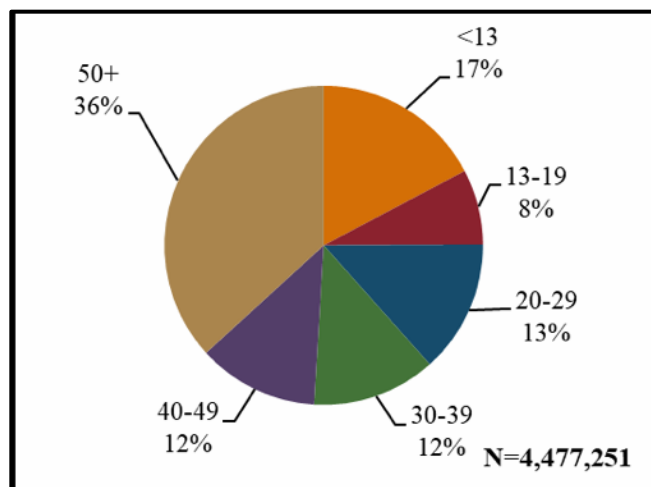


Figure 17 shows the percentage age distribution of newly diagnosed HIV cases among Kentuckians in 2020 at time of HIV diagnosis. The highest percentage of new diagnoses was reported among Kentuckians aged 20-29 years (36%). Kentuckians aged 30-39 and 40-49 years accounted for 29% and 19% of new cases, respectively. Kentuckians aged 50+ years accounted for 13% of new cases diagnosed in 2020.

Figure 18 shows the distribution of Kentucky's population based on 2020 estimates, which can be directly compared to the percentages in each age group that were newly diagnosed in 2020. HIV-related disparities by age are highlighted by these two graphs. Higher percentages of new diagnoses occurred among persons in age groups 20-29, 30-39, and 40-49 years in comparison to these groups in the general population.

**Table 13. Number and Rate of New HIV Diagnoses by Age at Diagnosis and Race/Ethnicity, Kentucky, 2020**

Age at Diagnosis	Black not Hispanic		White not Hispanic	
	No. of Cases	Rate*	No. of Cases	Rate*
20-29	31	45.6	60	12.2
30-39	18	34.3	54	11.5
40-49	7	†	39	8.3
50+	7	†	28	1.9

§Rates among pediatric cases (<13 years), teens and Hispanic populations by age at diagnosis not published due to small numbers.

\*Rate per 100,000 based on census data estimates for racial and age distribution for Kentucky in 2020.

†Rates not published when cell size is less than 10.

Rates of new diagnoses in 2020 (Table 13) were higher among black populations across all age groups in comparison to white populations. These relative rates were highest among 20-year-olds at the time of diagnosis. However, the rates among black populations in all age groups were at least about two times higher than the rates among their white counterparts of the same age group. Rates among Hispanic populations are not presented due to small numbers.

**Table 14. HIV Disease Cases and Diagnosis Rates by Year of HIV Diagnosis and ADD of Residence at Time of HIV Diagnosis, 1982-2021(2), Kentucky**

AREA DEVELOPMENT DISTRICT	CASES & RATES (1)	1982-2015*	2016	2017	2018	2019	2020	2021(2)	TOTAL CASES (3)	% Of Total
1. Barren River	Cases	345	15	13	14	13	9	9	418	4%
	Rate per 100,000		5.0	4.3	4.6	4.2				
2. Big Sandy	Cases	70	5	5	6	4	2	3	95	1%
	Rate per 100,000									
3. Bluegrass	Cases	1,898	65	66	79	47	50	60	2,265	19%
	Rate per 100,000		8.0	8.0	9.6	5.7	6.0			
4. Buffalo Trace	Cases	53	3	0	4	1	2	0	63	1%
	Rate per 100,000									
5. Cumberland Valley	Cases	186	10	10	6	6	5	10	233	2%
	Rate per 100,000		4.3	4.3						
6. FIVCO	Cases	134	5	8	4	8	3	2	164	1%
	Rate per 100,000									
7. Gateway	Cases	97	3	4	5	5	0	5	119	1%
	Rate per 100,000									
8. Green River	Cases	290	3	8	7	8	8	7	331	3%
	Rate per 100,000									
9. Kentucky River	Cases	83	1	5	1	3	2	5	100	1%
	Rate per 100,000									
10. KIPDA/ North Central	Cases	4,713	164	159	168	155	149	189	5,697	48%
	Rate per 100,000		16.4	15.8	16.7	15.4	14.7			
11. Lake Cumberland	Cases	165	3	11	3	5	3	4	194	2%
	Rate per 100,000			5.3						
12. Lincoln Trail	Cases	301	16	11	23	13	14	14	392	3%
	Rate per 100,000		5.9	4.0	8.3	4.7	5.0			
13. Northern KY	Cases	805	25	46	49	42	38	22	1,027	9%
	Rate per 100,000		5.5	10.0	10.6	9.0	8.1			
14. Pennyrile	Cases	311	18	12	4	13	8	11	377	3%
	Rate per 100,000		8.4	5.6		6.1				
15. Purchase	Cases	311	5	6	6	11	8	9	356	3%
	Rate per 100,000					5.6				
<b>TOTAL CASES<sup>(3)</sup></b>		<b>9,762</b>	<b>341</b>	<b>364</b>	<b>379</b>	<b>334</b>	<b>301</b>	<b>350</b>	<b>11,831</b>	<b>100%</b>

Rates are only listed for years of diagnosis 2016-2020. Data for 2021 are provisional due to reporting delays and are subject to change. Due to the small numbers of HIV cases reported in some ADDs, please interpret the corresponding rates with caution. Rates are not published when cell size is less than 10.

Data reported as of December 31, 2021. Rates are not published for 2021 because data are not complete.

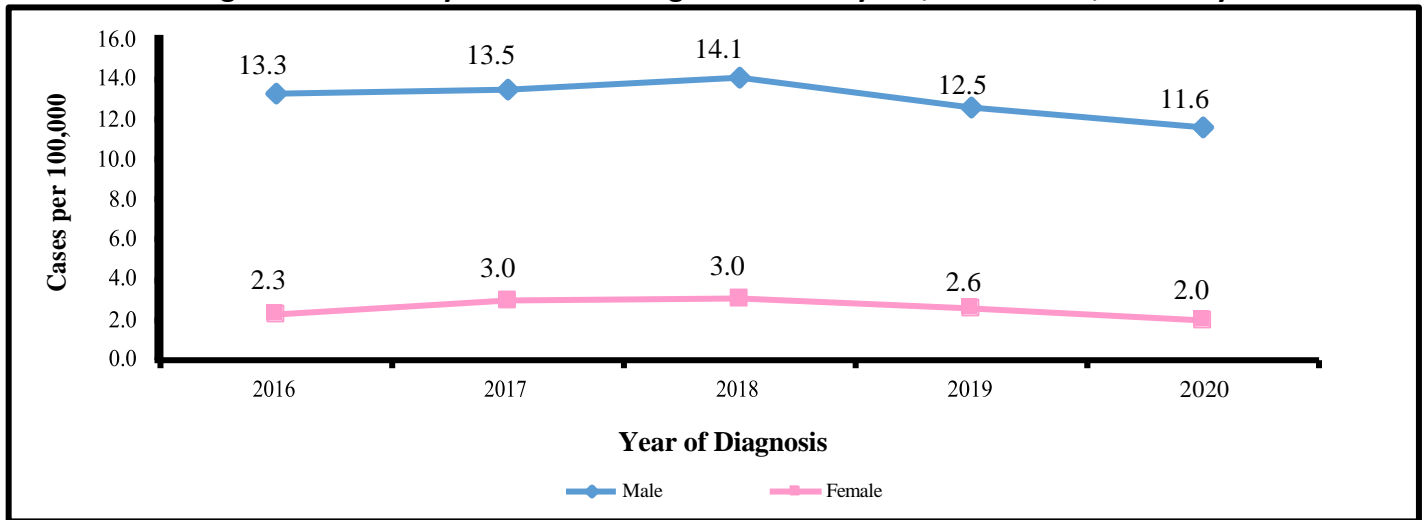
(3) Total HIV disease cases both living and deceased, regardless of progression to AIDS. Total HIV cases reported are 11,832— 1 HIV case had unknown residential information.

\*Rates are not published due to multi-year aggregation of data.

Table 14 shows the HIV disease cases and diagnosis rates by year of HIV diagnosis and ADD of residence at time of HIV diagnosis. The majority of cases can be accounted for by the three urban ADDs, i.e., KIPDA, Bluegrass, and Northern Kentucky ADDs. The rates are higher in general for KIPDA ADD followed by Bluegrass ADD, which includes the cities of Louisville and Lexington respectively. The Northern Kentucky ADD showed a distinct increase since 2017, which on separate investigation was found to be mainly associated with PWID.

**Trends in HIV Disease Diagnosis Rates, 2016-2020**

**Figure 19. Kentucky HIV Disease Diagnosis Rates by Sex, 2016-2020\*, Kentucky**

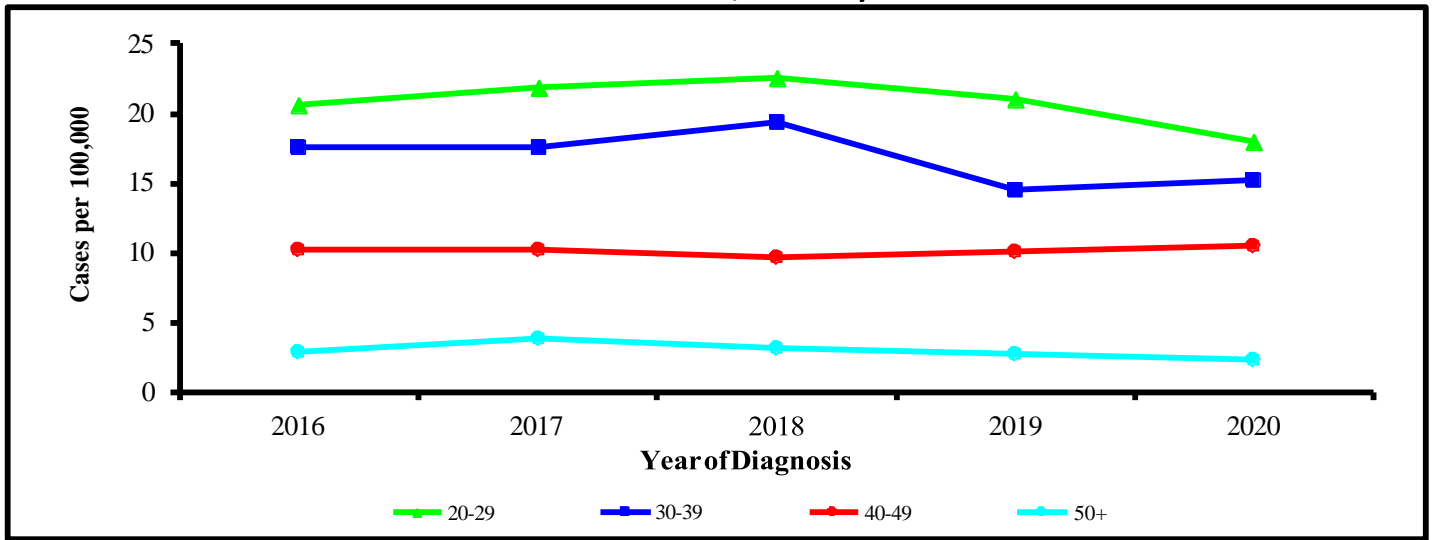


\*Data for 2021 are not included in trend analyses since they are considered provisional due to reporting delays.

Males represent the majority (83%) of cumulative HIV cases diagnosed among Kentuckians. The yearly diagnosis rates among males have remained almost stable over the five-year period shown, with slight decrease in 2019 and 2020. From 2016 to 2020, the HIV diagnosis rates among males fluctuated between 4.7 to 5.8 times higher than the rate for females (Figure 19).

The female HIV diagnosis rates have remained stable over the most recent five years, between 2.0 to 3.0 cases per 100,000 females. The highest HIV diagnosis rate among females within the most recent five years was in 2017 and 2018 at 3.0 newly diagnosed cases per 100,000 females.

**Figure 20. HIV Disease Diagnosis Rates by Age\* and Year of HIV Diagnosis, 2016-2020\*\*, Kentucky**



\* Due to the small numbers of HIV cases reported, rates are not presented for age groups 0-12 and 13-19 years old.  
 \*\*Data for 2021 are not included in trend analyses since they are considered provisional due to reporting delays.

Figure 20 shows HIV diagnosis rates by age category over the most recent five years (2016-2020) with complete data. The diagnosis rates among Kentuckians in the 20-29 and 50+ year age groups reveal an upward trend from 2016 to 2017. Between 2017 and 2018, the rate increased among the 20-29- and 30-39-year age groups, while rate in the 40-49 and 50+ year age groups stayed almost stable. Between 2018 and 2019 the rates in 20-29- and 30-39-year age group decreased, while the rates remained almost stable for 40-49 and 50+ year age group. Between 2019 and 2020 the rate for 20–29-year age group shows major decrease, while there was a slight increase for 30–39-year age group. The yearly diagnosis rates among those 40-49 and 50 years and over remained almost stable over the five-year period.

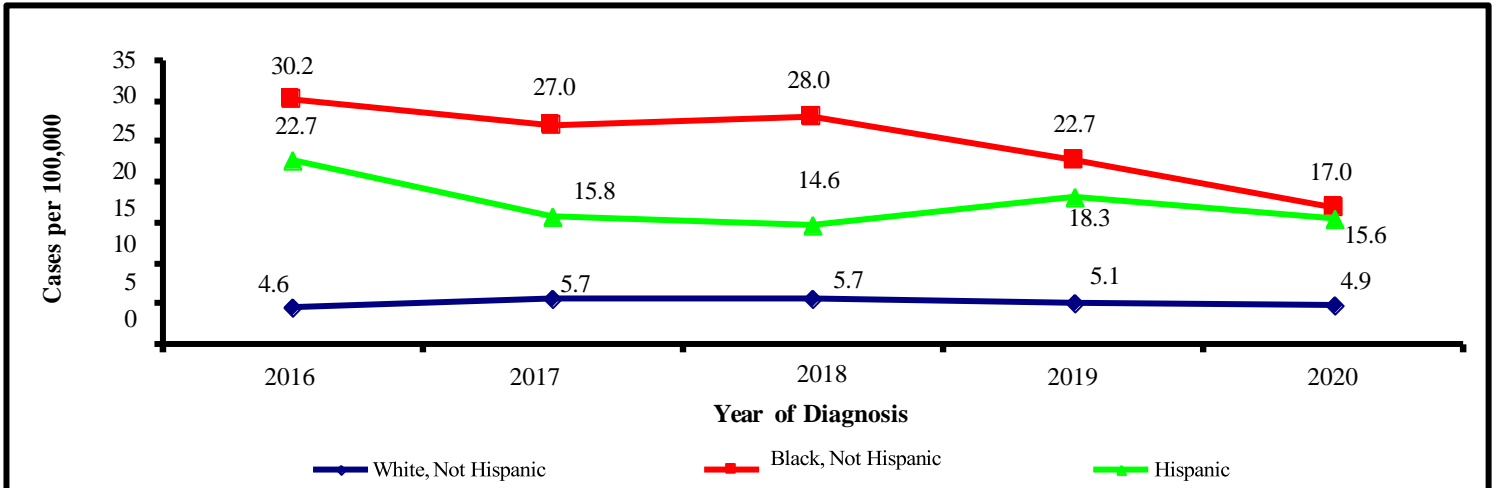
**Table 15. Mean Age at Time of HIV Diagnosis, 2016-2020, Kentucky**

HIV Diagnosis Year	Mean Age	Age Range
2016	34.6	1-71
2017	35.6	0-70
2018	34.1	15-84
2019	34.3	0-73
2020	35.0	0-77

Table 15 shows the mean ages and actual age ranges at time of HIV diagnosis from 2016-2020. The mean ages of Kentuckians at time of HIV diagnosis in the five-year period ranged between 34.1-35.6 years (age range 0-84 years).



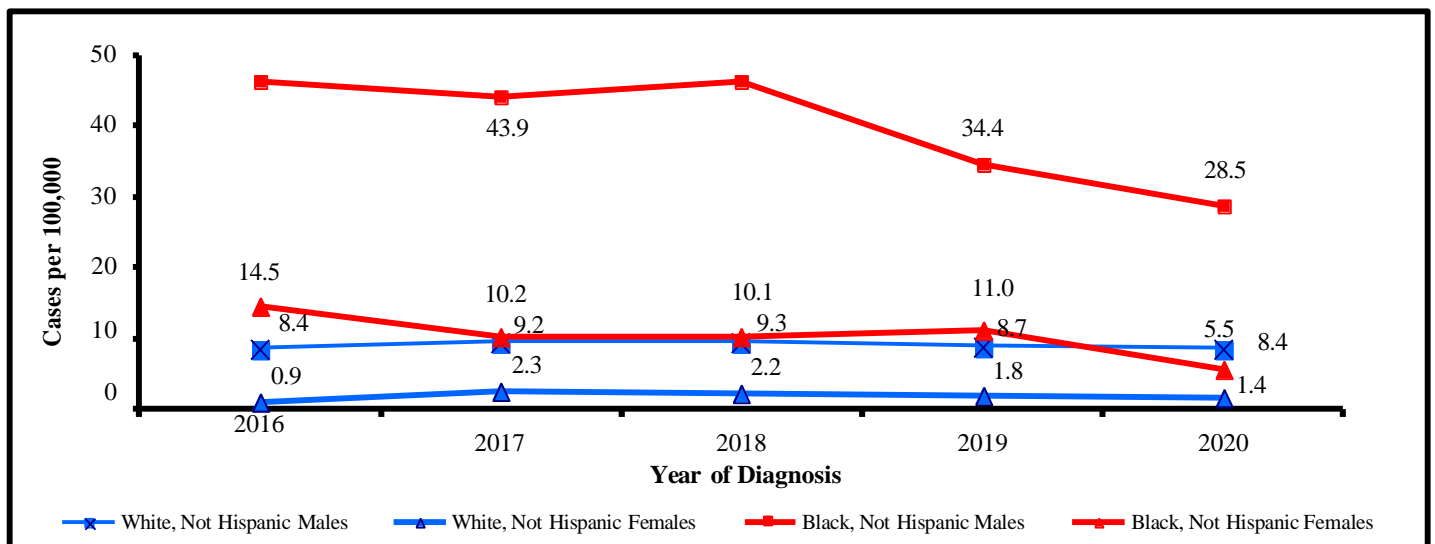
**Figure 21. HIV Disease Diagnosis Rates by Race/Ethnicity and Year of Diagnosis, 2016-2020\*, Kentucky**



\*Data for 2021 are not included in trend analyses since they are considered provisional due to reporting delays.

Figure 21 shows that between 2016 and 2020, the HIV diagnosis rates for black populations fluctuated between 3.5 to 6.6 times higher than white populations. The diagnosis rates for Hispanic populations were between 2.7 to 4.9 times higher than white populations over the same five-year period. The trends among white populations have remained almost steady. The rates for black populations decreased between 2016 and 2017, then slightly increased between 2017 and 2018, with again a decrease between 2018 and 2020. The rates for Hispanic populations decreased between 2016 and 2018 to the lowest level of 14.6, then increased between 2018 and 2019, but again decreased between 2019 and 2020.

**Figure 22. Annual HIV Disease Diagnosis Rates by Race/Ethnicity, Sex, and Year of Diagnosis, 2016-2020\*, Kentucky**



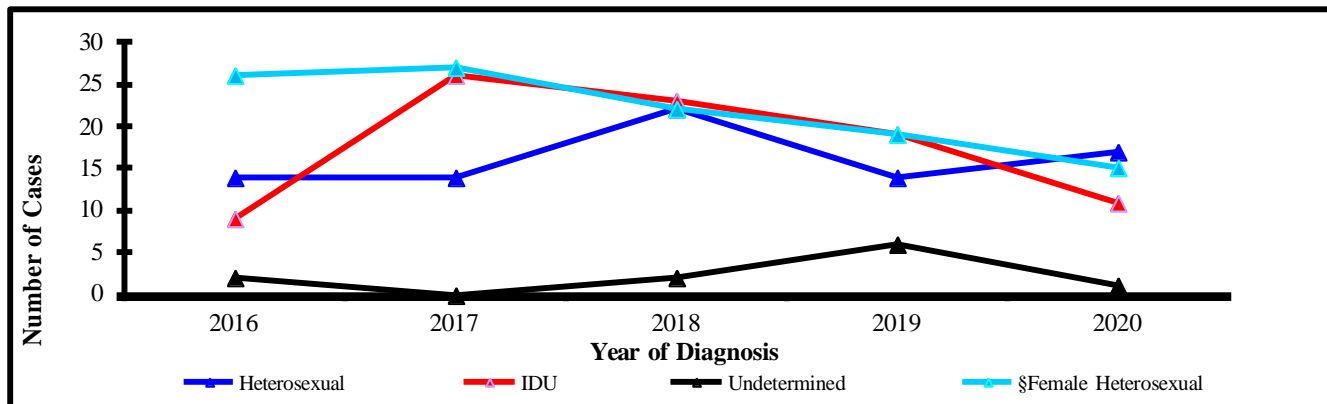
\* Data for 2020 are not included in trend analyses since they are considered provisional due to reporting delays.

<sup>a</sup> Rates for Hispanic cases by sex are not presented due to the small number of cases reported.

Figure 22 presents diagnosis rates from 2016 through 2020 for black and white populations by sex. Black males and black females had consistently higher rates of new diagnoses in comparison to their white

counterparts. The HIV diagnosis rates among black males fluctuated between 3.4 to 5.5 times higher than that of white males. The rates among black females were 3.9 to 16.1 times higher than those of white females over the five-year period

**Figure 23. Adult/Adolescent HIV Disease Cases by Transmission Route and Year of Diagnosis, FEMALES, 2016-2020\*, Kentucky**

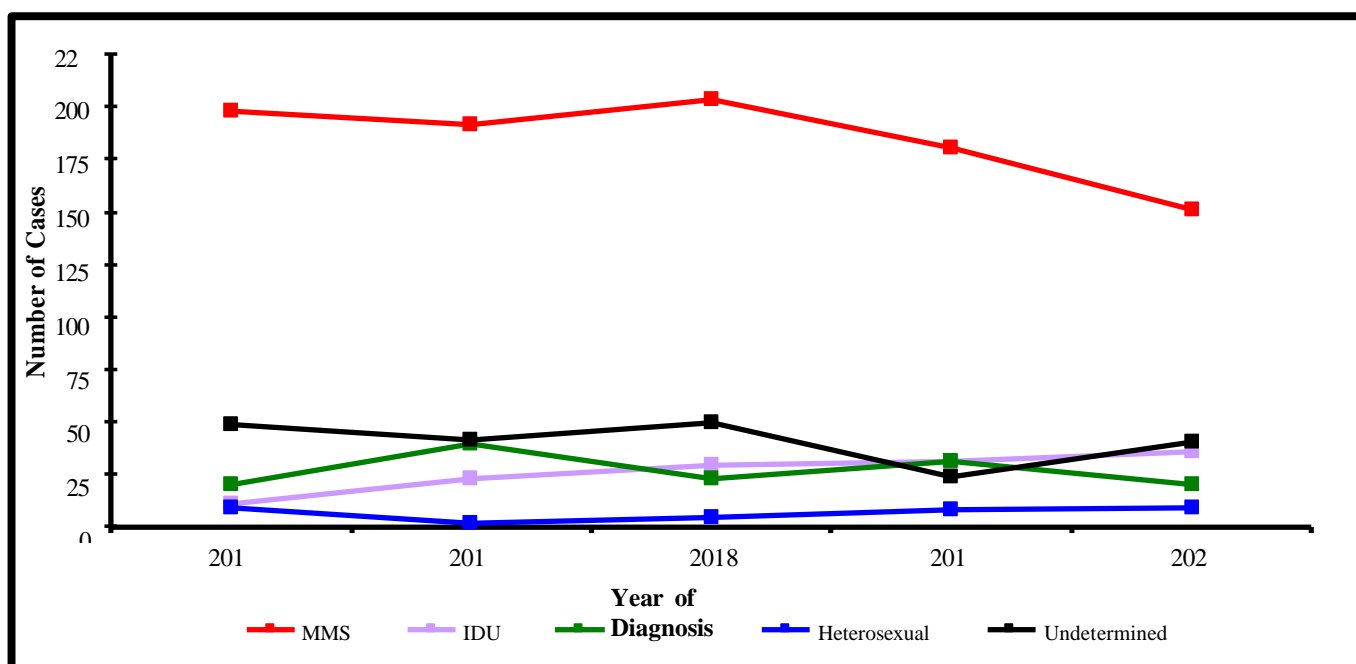


\*Data for 2021 are not included in trend analyses since they are considered provisional due to reporting delays.

§Female heterosexual contact = a female not reporting drug use but reporting sex with male with unknown HIV status or risk.

Figure 23 shows Kentucky’s adult/adolescent female HIV cases by transmission route and year of diagnosis. The largest number of new female cases reported FHC as their primary route of transmission followed by heterosexual contact over the five-year period. This change was applied to all the years shown. The number of new female cases reporting IDU as the primary route of transmission varied from 17.6% in 2016 to 38.8% in 2017. IDU as route of transmission among females decreased between 2017 and 2020.

**Figure 24. Adult/Adolescent HIV Disease Cases by Transmission Route and Year of Diagnosis MALES, 2016-2020\*, Kentucky**



\*Data for 2020 are not included in trend analyses since they are considered provisional due to reporting delays.

In Figure 24, which depicts trends for adult/adolescent males by transmission route, the largest number of cases diagnosed each year from 2016 to 2020 reported MMSC as their primary risk factor. The second largest number of cases were those with an undetermined risk. The number of males reporting IDU as a risk factor increased consistently between 2016 and 2020.

### HIV Infections Diagnosed Concurrently with AIDS Among Kentuckians, as of December 31, 2021

During the most recent 10-year period for which data are available (January 1, 2012 to December 31, 2021), a total of 3,482 HIV disease cases were diagnosed among Kentuckians. Of these, 1,059 (30%) had progressed to AIDS as of December 31, 2021.

**Table 16. AIDS Cases Diagnosed within the 10 Year Period January 1, 2012-December 31, 2021, by Time (in days) from HIV Diagnosis to AIDS Diagnosis, Kentucky**

<b>Time to AIDS Diagnosis (Days)</b>	<b>No.</b>	<b>%</b>
≤30 Days †	737	69.6
31-60 Days	66	6.2
61-90 Days	35	3.3
91-365 Days	90	8.5
>365 Days	131	12.4
<b>Total</b>	<b>1,059</b>	<b>100</b>

†Cases diagnosed with AIDS within 30 days of initial HIV diagnosis are considered concurrent diagnoses.

Note: 2,423 HIV-only cases diagnosed in the same timeframe are not included in the table as they had not progressed to AIDS as of December 31, 2021.

During the most recent 10-year period, 737 (21.2%) of the 3,482 newly diagnosed HIV cases were diagnosed with AIDS within 30 days of the initial HIV diagnosis - also known as a “concurrent diagnosis”. The distribution of progression to AIDS (in days) for the 1,059 AIDS cases is shown in Table 16. About 70% of the 1,059 AIDS cases diagnosed in the most recent 10 years were diagnosed with AIDS within 30 days of the initial HIV diagnosis. According to the CDC, late testers are those who have an AIDS diagnosis within one year of initial HIV diagnosis. During the presented period, 928 (26.7%) of the 3,482 Kentuckians diagnosed with HIV disease were late testers.

Table 17 examines the distribution of HIV cases among Kentuckians diagnosed between January 1, 2012 and December 31, 2021, by sex, age at diagnosis, race/ethnicity, and transmission route. Data are presented for cases diagnosed concurrently with AIDS, cases without a concurrent HIV/AIDS diagnosis (anyone who did not have an AIDS diagnosis within 30 days of the initial HIV diagnosis, whether they developed AIDS or not), and for all cases diagnosed with HIV (regardless of AIDS diagnosis status) within the 10-year period. Of the 3,482 Kentuckians diagnosed with HIV disease during the 10-year period, about a quarter (737 or 21.2%) were diagnosed with HIV and AIDS concurrently (within 30 days)

## Concurrent Diagnoses by Selected Characteristics, 2012-2021\*

**Table 17. HIV Infections Diagnosed in the Most Recent 10 Year Period (January 1, 2012-December 31, 2021) that were Diagnosed Concurrently with AIDS (within 30 Days of HIV Diagnosis) and those without a Concurrent Diagnosis\*\* by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, Kentucky**

Characteristics	HIV with Concurrent AIDS Diagnosis*		HIV Without Concurrent AIDS Diagnosis**		Total HIV Disease Diagnoses***	
	No.	% <sup>(1)</sup>	No.	% <sup>(1)</sup>	No.	% <sup>(1)</sup>
<u>SEX</u>						
Male	608	83	2,277	83	2,885	83
Female	129	17	468	17	597	17
<u>AGE AT DIAGNOSIS</u>						
<13	1	<1	18	1	19	1
13-19	10	1	144	5	154	4
20-29	140	19	1,124	41	1,264	36
30-39	195	26	716	26	911	26
40-49	189	26	447	16	636	18
50+	202	27	296	11	498	14
<u>RACE/ETHNICITY-Female</u>						
White, Not Hispanic	58	45	255	54	313	52
Black, Not Hispanic	58	45	177	38	235	40
Hispanic	7	5	14	3	21	4
Other/Unknown	6	5	22	5	28	5
<u>RACE/ETHNICITY-Male</u>						
White, Not Hispanic	372	61	1,280	56	1,652	57
Black, Not Hispanic	136	22	690	30	826	29
Hispanic	66	11	175	8	241	8
Other/Unknown	34	6	132	6	166	6
<u>TRANSMISSION CATEGORY</u>						
MMSC <sup>(2)</sup>	347	47	1,564	57	1,911	55
IDU <sup>(3)</sup>	62	8	292	11	354	10
MMSC/IDU	28	4	198	7	226	6
Heterosexual <sup>(4)</sup>	67	9	178	6	245	7
Female Heterosexual <sup>(5)</sup>	66	9	172	6	238	7
Perinatal	1	<1	15	1	16	<1
Other <sup>(6)</sup>	1	<1	2	<1	3	<1
Undetermined <sup>(7)</sup>	165	23	324	12	489	14
<b>TOTAL</b>	<b>737</b>	<b>100</b>	<b>2,745</b>	<b>100</b>	<b>3,482</b>	<b>100</b>

\*Concurrent is defined as being diagnosed with both HIV and AIDS within a 30-day period.

\*\*Without AIDS diagnosis 30 days after initial HIV diagnosis. Includes both HIV (non-AIDS) cases and those with an AIDS diagnosis more than 30 days after initial HIV diagnosis.

\*\*\*Total diagnoses January 1, 2012, through December 31, 2021, with HIV, regardless of AIDS diagnosis status.

- 1) Percentages may not total to 100% due to rounding.
- 2) MMSC = male-to-male sexual contact.
- 3) IDU = injection drug use.
- 4) Heterosexual includes persons who have had heterosexual contact with a PWH or at-risk for HIV.
- 5) Female heterosexual refers to a female not reporting drug use but reporting sex with male.
- 6) Other includes persons who had exposure through hemophilia, transfusion/transplant, or perinatal diagnosed as an adult.
- 7) Undetermined refers to persons whose route of exposure to HIV is unknown. This includes persons who are under investigation, deceased, lost to investigation, refused interview, and persons whose route of exposure remains undetermined after investigation.

**HIV Diagnoses by Area ADD January 1, 2012-December 31, 2021**

**Figure 25. Number of HIV Disease Diagnoses by ADD of Residence at Time of HIV Diagnosis, For Most Recent 10 Years, January 1, 2012 – December 31, 2021, Kentucky**

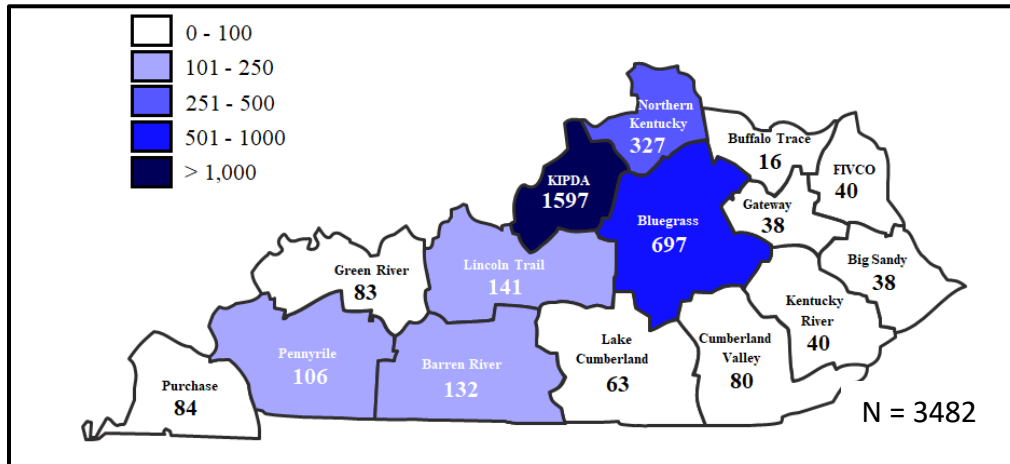
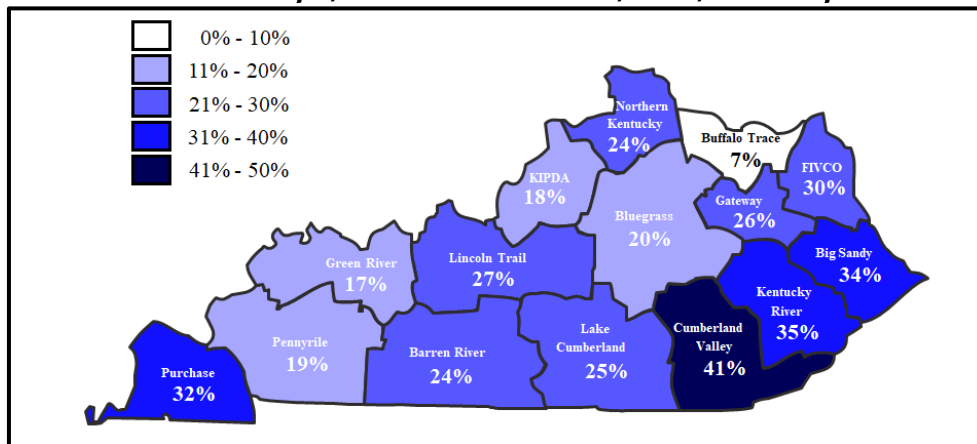


Figure 25 displays the total number of HIV infections (3,482) diagnosed between January 1, 2012, and December 31, 2021, by ADD of residence at time of HIV diagnosis. Data represent the total number of HIV cases in each ADD, regardless of disease progression status. The highest number of cases (1,597 or 46%) diagnosed during this period were among residents of the KIPDA ADD, which includes the city of Louisville. The second highest number of cases (697 or 20%) resided in the Bluegrass ADD, which includes the city of Lexington.

**Figure 26. Percentage of All HIV Disease Diagnoses within each ADD of Residence at Time of HIV Diagnosis, who have a Concurrent Diagnosis of AIDS, For Most Recent 10 Years, January 1, 2012 – December 31, 2021, Kentucky**



Note: The percentages presented in Figure 26 represent the proportion of concurrent diagnoses out of the total for each ADD. Totals for each ADD are presented in Figure 25.

Figure 26 shows the percentage of total HIV cases within each ADD that were concurrently diagnosed with AIDS (within 30 days of initial HIV diagnosis), between January 1, 2012 and December 31, 2021. The percentage of concurrent HIV and AIDS diagnoses within each ADD ranged from 7% to 41%. Cumberland Valley ADD (41%) had the highest proportion of concurrent HIV and AIDS cases, followed by Kentucky River ADD.

**Figure 27. Number of New HIV Disease Diagnoses within each Care Coordinator Region of Residence at Time of HIV Diagnosis, For Most Recent 10 Years, January 1, 2012 – December 31, 2021, Kentucky**

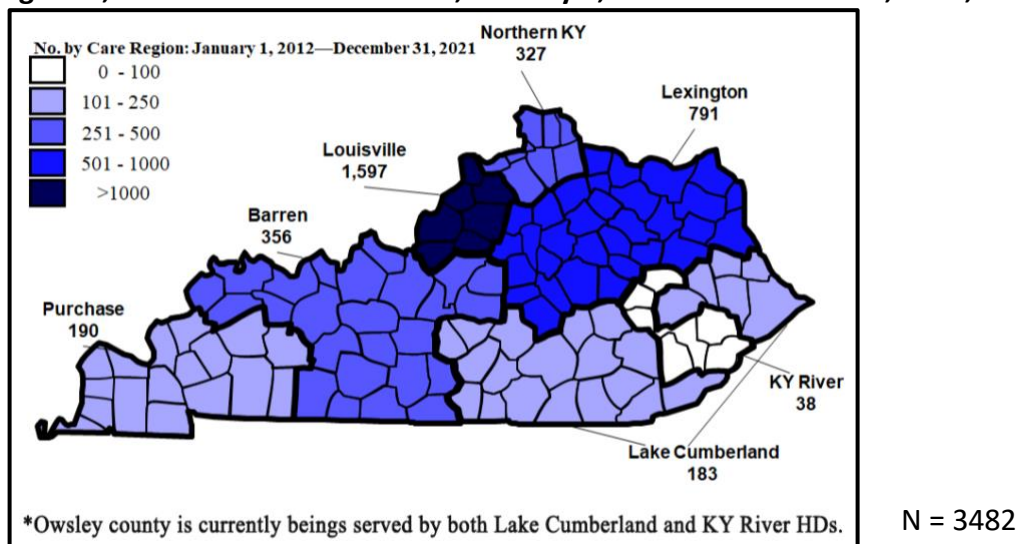
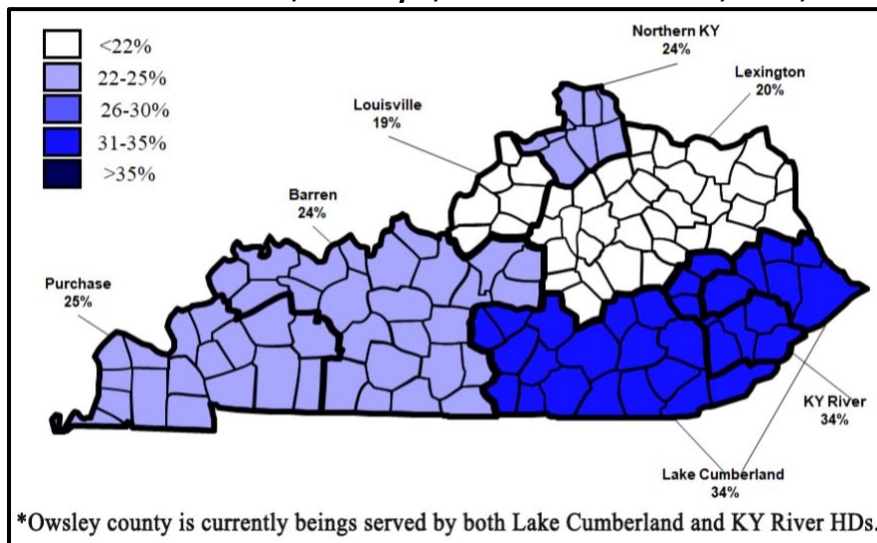


Figure 27 shows the total number of new HIV infections (regardless of disease progression status) diagnosed between January 1, 2012, and December 31, 2021, by Care Coordinator Region based on place of residence at time of HIV diagnosis. The highest number of cases (1,597 or 46%) diagnosed in this period occurred among residents of the Louisville Region. The second highest number of diagnoses (791 or 23%) occurred in residents of the Lexington Region.

**Figure 28. Percentage of New HIV Cases with Concurrent Diagnosis within each Care Coordinator Region of Residence at Time of HIV Diagnosis, For Most Recent 10 Years, January 1, 2012 – December 31, 2021, Kentucky**



Note: The percentages presented in Figure 28 represent the proportion of concurrent diagnoses out of the total for each individual region. Totals for each region are presented in Figure 27.

Figure 28 shows the percentage of total HIV cases within each Care Coordinator Region that were concurrently diagnosed with AIDS (within 30 days of an initial HIV diagnosis) between January 1, 2012 and December 31, 2021. In all regions, approximately one-fifth or more of cases diagnosed within each jurisdiction were concurrent diagnoses with the highest proportions of concurrent HIV and AIDS cases residing in the Lake Cumberland and Kentucky River Region (34%), and Purchase Region (25%).

## HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

The following inventory provides an overview of the HIV prevention and care resources in Kentucky. Table 18 details all organizations and agencies providing HIV prevention and care services, including services provided, funding sources, and populations served. Table 19 details the funding streams for these organization and agencies, including federal funding from CDC and HRSA. The total yearly Kentucky HIV budget accounted for in this table is approximately \$88 million dollars. Jurisdictional planning activities to gather this information were coordinated through KHPAC. All organizations described in this section have been invited to participate in KHPAC membership to support a synchronized effort in providing prevention and care services to all areas of the state.

### a. STRENGTHS AND GAPS

The situational analysis in Section IV provides a full discussion of strengths and gaps arranged by EHE pillar and describes how reducing gaps and barriers will contribute to the quality of services available to people at-risk for or with HIV. Section IV further details strengths and gaps related to health equity, social determinants of health, and legislative barriers.

As it relates to resources, Kentucky has many strengths along the path to ending the HIV epidemic across the Commonwealth. The spotlight here would be the champions who are working at every level and in every corner of the state to ensure prevention, care, and treatment resources are reaching the people who need them. These champions include case workers, infectious disease and medical care providers, health educators, community health workers, social workers, public health specialists, social services providers, and so many others who work in this field. These dedicated professionals are using the financial and programmatic resources available to provide outstanding care and services. Additional resource capacity strengths to highlight include:

- Kentucky has an extensive and well-developed network of SSPs.
- The extensive network of local organizations and health departments offering free and confidential testing across the state.
- Statewide prevention and services meetings are gathering all subrecipients in regular discussions regarding statewide progress, barriers, best practices, and data.
- The Kentucky HIV/AIDS Care Coordinator Program (KHCCP), funded by RWHAP Part B, is geographically covering all regions of the state with care services.
- PWH have commented on being satisfied and grateful for the quality of services provided, including housing support services and comprehensive dental services.
- The majority of local jails are being engaged through the Ryan White Program to provide treatment to incarcerated PWH. However, a gap still exists in improving testing coverage in these settings.

Also emerging from this resource inventory are some gaps that must be filled in order to achieve the resolute goals set forth in this plan. These gaps include:

- The need for stronger systems and networks to promote the expansion of and participation in PrEP. This is a focus of the Pillar 3 goals, objectives, and strategies laid out in Section V.
- Continued expansion of regional planning efforts. As statewide planning activities continue to be strengthened through KHPAC, conversations about revitalizing regional planning groups are being explored to engage more local stakeholders.
- Coverage and access to resources is still varied geographically, especially in rural areas. Also included in this plan are continued efforts to serve rural areas and better distribute resources.
- Lastly, there is a continued need to ensure that areas of past and potential future cluster outbreaks are adequately served with prevention and care resources. In this effort, partnerships with four emergent community partners are being fostered to serve Louisville and surrounding areas.

## b. APPROACH AND PARTNERSHIPS

In order to complete this resource inventory, all direct recipients of funding sources were contacted. Meetings and discussions were arranged to ensure that all resources were included. Additionally, federal websites were reviewed to ensure accuracy and amounts of funding sources. KHPAC members were also consulted in these planning efforts. Many KHPAC members represent organizations and agencies providing HIV prevention and care services. These members assisted with essential information in the process of completing this resource inventory.

Additionally, partnerships have been strengthened to coordinate the provision of substance use prevention and treatment services with HIV prevention and care services. Within KDPH, the HIV/AIDS Section and the Harm Reduction Program have partnered to ensure that HIV prevention and treatment services are available to participants at SSPs. Training is provided to all SSP staff members to ensure they are equipped with the correct information regarding HIV prevention and treatment resources available to the populations they serve. Additionally, the same training efforts have taken place for HIV prevention staff at CBOs to understand the harm reduction and substance use resources available to their populations. Partnerships are being established to ensure priority populations can access the services available to them.

## c. DESCRIPTIVE LIST OF ALL PREVENTION, CARE AND TREATMENT RESOURCES



### STATEWIDE HIV ENTITIES

- 1) **KDPH HIV/AIDS Section** - The KDPH HIV/AIDS Section, located in the Division of Epidemiology and Health Planning, assesses the current and future impact of HIV in Kentucky. The HIV/AIDS Section is composed of surveillance, prevention, services, and EHE programs. The HIV/AIDS Section is committed to:
  - Ensuring that HIV/AIDS surveillance is a quality, secure system.
  - Ensuring that all people at-risk for HIV infection know their sero-status.
  - Ensuring that persons not infected with HIV remain uninfected.



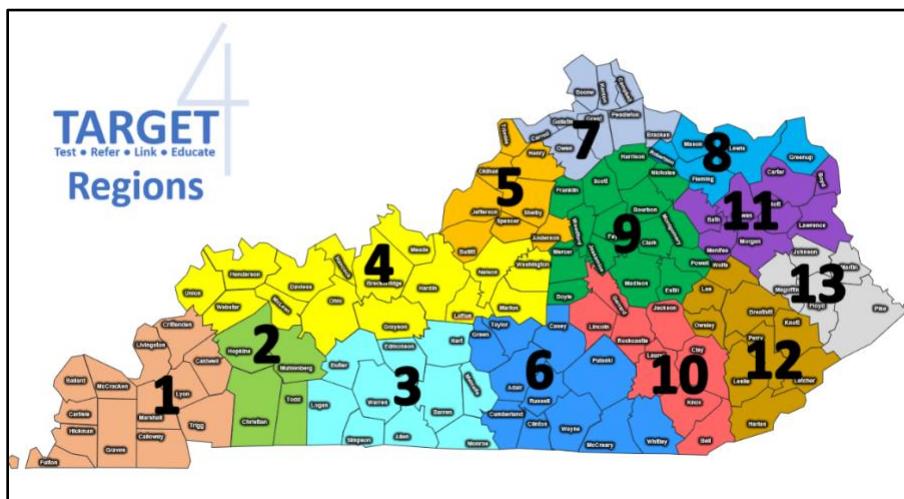
- Ensuring that PWH do not transmit HIV to others.
- Ensuring that PWH have access to the most effective therapies possible.
- Ensuring a quality professional education program includes the most current HIV/AIDS information.

2) **KHPAC** - KHPAC is responsible for planning priority interventions for target populations across the state, advising the Cabinet for Health and Family Services regarding HIV/AIDS activity in the Commonwealth, informing EHE efforts, and providing guidance to the Title II Services Program. Much effort is made to assure the membership of KHPAC reflects representation from all targeted populations and service providers, as well as dedicated community members and local interest groups.

3) **KIRP** - KIRP is a RWHAP funded initiative that is a collaborative effort between the University of Kentucky (UK) and KDPH. The university serves as the contract pharmacy for KADAP which is funded by federal RWHAP Part B funds. UK supplies medications, on the approved KADAP formulary, to enrolled PWH across the Commonwealth of Kentucky. Income generated from insurance payments for KADAP approved medications is identified as RWHAP program income. UK and KDPH have signed a Memorandum of Understanding (MOU), collectively called KIRP, whereby UK facilitates KIRP and invests program income in statewide initiatives in coordination with KDPH. The two entities work cooperatively, administering three initiatives, to improve health care delivery to citizens of the Commonwealth of Kentucky through disease education, prevention, treatment, and the provision of professional services intended to benefit PWH.

- **The Target4 Project** - The Target4 Project embeds Early Intervention Services (EIS) Health Education Coordinators, EIS Health Education Coordinator Associates, and EIS Peer Prevention Specialists into harm reduction programs (HRP), CBOs, and ASOs across the Commonwealth of Kentucky. KIRP is divided into 13 regions (Figure 29) and is structured to include a regional team lead and field staff.

**Figure 29. KIRP Target4 Regions**



Regional Team Leads provide oversight and organize efforts within the specified region. The Target4 Project regional teams work with designated programs throughout the region (LHDs, HRPs, CBOs, and ASOs) to provide services, including HIV testing and linkage to care, at regularly designated intervals

(quarterly, monthly, weekly). Target4 staff provide screening, comprehensive education, and linkage to care for persons at highest risk for contracting and transmitting HIV and hepatitis C; distribute prevention and harm reduction supplies, education materials, and naloxone to at-risk persons visiting the HRPs and accessing services through targeted outreach activities; and connect participants to programs providing services for HIV, PrEP, PEP, and hepatitis C medical care, as well as mental health and substance abuse counseling.

- **KY AETC Expansion** - Nationally, the AETC Program is funded by HRSA and serves as the education component of the RWHAP consisting of a national network of leading HIV experts who provide locally based tailored education, clinical consultation and technical assistance to health care professionals and health care organizations to integrate high quality, comprehensive care for those living with or affected by HIV. The AETC Program offers comprehensive, collaborative educational opportunities designed to increase the size and strength of the HIV clinical workforce. The program works to empower providers to improve outcomes along the HIV Care Continuum, with the ultimate goal of reducing the rate of new HIV infections. RWHAP programs must demonstrate collaboration with each state's local performance site (KY AETC) to ensure clinical care and supportive services for PWH are provided in accordance with national standards of care. At the intersection of the Kentucky RWHAP Part B program and the KY AETC program is the expansion collaboration with a goal to support capacity building, technical assistance, assessment, and evaluation needs to ensure recipients across Kentucky develop and improve their systems of care and adhere to established HIV clinical practice standards and HHS Guidelines, which is demonstrated by the improved health of PWH.
- **Innovative Pilot Programs** - This initiative is an investment of funds in pilot programs for innovative projects throughout the Commonwealth to address access to care and supportive services for PWH and those at highest risk. These programs are identified as priorities of KDPH and must comply with the federal RWHAP legislative program guidance. Initiatives must engage low-income PWH and/or those that are at-risk for contracting/transmitting HIV/AIDS. As part of the Innovative Pilot Program Initiative, KIRP funds an Emergency Department (ED) Pilot Program that integrates universal HIV testing for persons utilizing the ED at UK's two affiliated hospitals (UK Chandler Hospital and Good Samaritan).

- 4) **KY AETC** - Kentucky AETC educates, trains, and provides information on HIV/AIDS to medical professionals throughout Kentucky via live and virtual didactic trainings, preceptorships, and Community of Practice sessions. AETC is supported through both KIRP funding and RWHAP Part F subrecipient funding from the Southeast AETC Region.



## HIV PREVENTION SERVICES ACROSS KENTUCKY

- 1) **HIV Testing Locations Across Kentucky** - The HIV Prevention Program at KDPH sponsors HIV counseling and testing sites in each of the 120 counties across the state. In addition, KIRP offers targeted testing through

scheduled outreach events. Sponsored non-clinical agencies and programs offer rapid-rapid HIV-1/2 antibody testing and can provide results within 1 to 20 minutes. Those with reactive results from an initial rapid test can be tested immediately with a different brand of rapid test than the initial rapid test. Clients receiving reactive results from both rapid tests are almost certainly infected with HIV and can be promptly linked to an HIV care provider without waiting days or weeks for a confirmatory test. Sponsored clinical agencies offer both rapid fingerstick HIV 1/2 antibody tests and blood tests. All state sponsored testing sites offer anonymous or confidential HIV testing at free or minimal cost by appointment and/or on a walk-in basis. Pre-test and post-test counseling are offered at all agencies. A list of testing sites can be found via the following links:

- <https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/prevention.aspx>
- <https://kirpky.com/hiv-testing-outreach-events-calendar/>
- <http://www.aidsvu.org>

- 2) **LHDs** - LHDs offer local HIV interventions, provide HIV testing and counseling, and can use funding provided for targeted HIV projects. Several LHDs partner with KIRP to provide HIV testing through their community SSP activities. LHDs can also use funding to expand access to PrEP but does not cover medication or co-pays. LHDs offer safe sex kits and prevention strategies for people at high-risk of becoming infected. KDPH supplies HIV test kits to the LHDs.
- 3) **CBOs** - A CBO is defined as a public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs (HIV.gov). The following is a list of CBOs providing prevention services to those at-risk for HIV in Kentucky. See Table 18 for additional details on each CBO.
  - AVOL Kentucky, Inc. (formerly AIDS Volunteers of Lexington) - Lexington, KY
  - UK Bluegrass Care Clinic - Lexington, KY
  - LivWell Community Health Services - Paducah, KY
  - Matthew 25 AIDS Services, Inc. - Locations in Henderson, Owensboro, Evansville, and Bowling Green, KY
  - Music Center PrEP Clinic - Louisville, KY
  - Shawnee Christian Health Center - Louisville, KY
  - Volunteers of America (VOA) - Louisville, KY
- 4) **PrEP Providers** - As Kentucky moves forward to create more effective systems for PrEP use and delivery, a key partner in this expansion will be the network of PrEP providers. Implementation strategies involving more inclusive messaging and further integration of PrEP within health care have been laid out in this plan. PrEP providers are a key resource to reducing PrEP stigma and ultimately increasing the percentage of users among target populations. A website navigator of PrEP providers, as well as locations that offer testing and other services, can be found via the following links:

- <https://locator.hiv.gov>
- <Npin.cdc.gov/prelocator>



## HIV TREATMENT AND CARE SERVICES ACROSS KENTUCKY

1) **KHCCP** - The intent of this Ryan White Part B program is to help provide prompt, consistent, continuous quality care and services to HIV-infected individuals and their families. Care coordinators in seven regional sites assess needs and provide services. These regions ensure statewide access to local services. KHCCP also is an umbrella program for other client assistance programs described below, including KADAP, the Kentucky Health Insurance Continuation Program (KHICP), and the Linkage Navigation Program. The traditional KHCCP service network consists of nine regional DPH subrecipients. The subrecipients are responsible for providing HIV medical care, including all laboratory testing. Four of the agencies provide HIV clinical care directly and five agencies work with area clinical providers experienced in treating HIV. All nine subrecipients provide an array of other core medical and support services to meet the needs of PWH in their service areas. See Table 18 for additional details regarding each subrecipient.

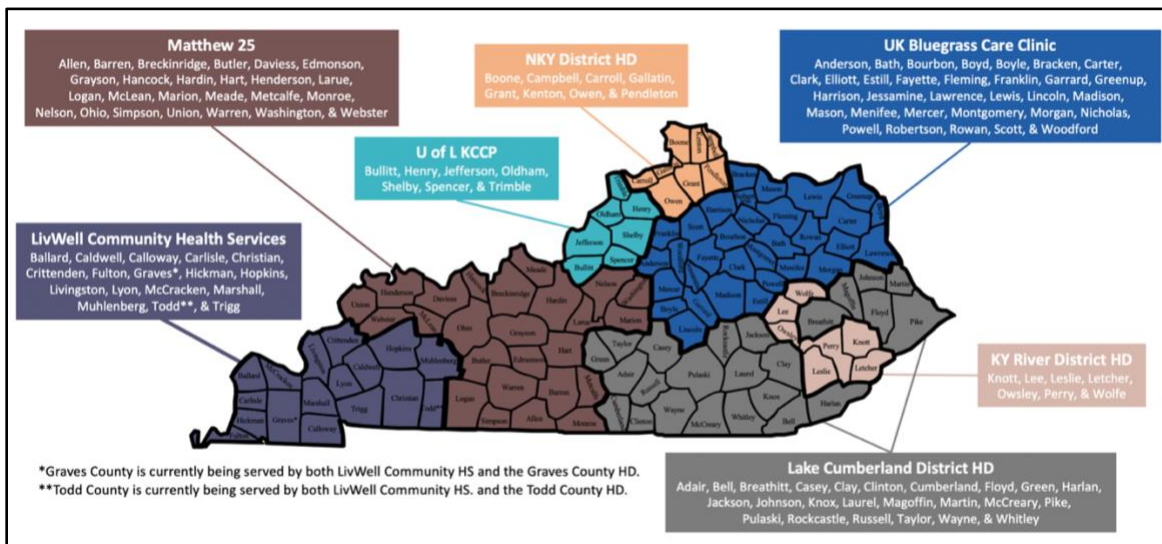
- Graves County Health Department - Mayfield, KY
- Kentucky River District Health Department - Hazard, KY
- Lake Cumberland District Health Department - Somerset, KY
- LivWell Community Health Services - Paducah, KY
- Matthew 25 - locations in Henderson, Owensboro, Evansville, and Bowling Green, KY
- Northern Kentucky District Health Department - Florence, KY
- Todd County Health Department - Elkton, KY
- UK Bluegrass Care Clinic - Lexington, KY
- University of Louisville School of Dentistry KY Care Coordinator Program (ULSD KCCP) - Louisville, KY

KHCCP programs:

- **KADAP** - This program helps eligible low-income Kentuckians purchase AIDS-related, FDA-approved medications. Participants receive formulary medications through mail-order service provided by the Kentucky Clinic Pharmacy at UK in Lexington. With the addition of the EHE grant the income eligibility requirement has been removed for any HIV+ clients.
- **KHICP** - This program provides payment to continue health insurance coverage for eligible individuals at risk of losing employee health benefits or private-pay health insurance because of HIV-related disease.
- **Linkage Navigation Program** - The Kentucky Ryan White Part B Program began implementing the Linkage Navigation program in 2017. There are currently 11 linkage navigator (LN) positions (of which one is vacant) within KHCCP and four additional combined LN/Disease Investigation Specialist (DIS)/Cluster Response positions. The KHCCP Administrator oversees the program. Each LN has a

region of counties they cover. The navigators work in two roles: (1) linking Ryan White Part B clients who have been newly diagnosed or have been lost to care into the program and (2) working with the Data to Care (DTC/D2C) Program to engage people who have tested positive for HIV but do not show any labs for the preceding 12+ months.

**Figure 30. Kentucky HIV Care Coordinator Regions with Counties**



**\*Update on planned clinical expansion through Federally Qualified Health Centers (FQHC)** - Over the last several years, it has become apparent that a system of nine regional providers does not provide sufficient coverage for the entire state of Kentucky. The need for more clinical partners created a goal of adding additional clinical subrecipients in rural and urban areas. After two years of development with the Kentucky Primary Care Association (KPCA) new clinical providers have been recruited. Two new agencies are located in rural Western Kentucky (Pennyroyal Center and Health First Community Health Center), a third is in rural Eastern Kentucky (Little Flower Clinic), and a fourth provider is located in the West-End of Louisville (Park DuValle Community Health Center), the most populous area of Kentucky. Through the Practice Transformation Expansion, the KY AETC program is partnering with identified FQHCs in Kentucky to expand services to PWH and those at highest risk. In addition, the UK is working with Kings Daughters in Ashland, Kentucky to expand services in an area that is adjacent to recent /suspected HIV outbreaks in Huntington, West Virginia and Ironton, Ohio.

2) **University-Affiliated HIV Care Clinics** - There are two university-affiliated HIV care clinics in Kentucky who are direct recipients of RWHAP funding. These clinical providers operate in partnership with the traditional KHCCP. The UK Bluegrass Care Clinic receives both direct funding and Part B KHCCP funding. This list includes:

- UK Bluegrass Care Clinic - Lexington, KY
- UofL 550 Clinic - Louisville, KY

3) **HUD Housing Opportunities for Persons With AIDS (HOPWA) Program Services** - The HOPWA Program is the only federal program dedicated to the housing needs of PWH. Under the HOPWA Program, HUD makes funding available to local communities, states, and nonprofit organizations for projects which benefit low-income PWH and their families. HOPWA grants are funded statewide from HUD to Kentucky Housing Corporation and to Lexington-Fayette Urban County Government. Subrecipients include:

- AVOL - Lexington, KY
- House of Ruth - Louisville, KY
- LivWell Community Health Services - Paducah, KY
- Matthew 25 - locations in Henderson, Owensboro, Evansville, and Bowling Green, KY
- VOA - Louisville, KY

Research shows that a stable home is critical to the well-being of PWH, and results in better health outcomes and reduced transmission of HIV. In addition to housing assistance, these local programs will provide access to supportive services such as case management, mental health services, substance abuse services, and employment training. The combination of housing assistance and supportive services are critical in sustaining housing stability, promoting better health outcomes, and increasing quality of life, which promotes self-sufficiency efforts for those able to transition to the private housing market.<sup>3</sup> HOPWA funding provides (1) short-term housing assistance for PWH, (2) long-term housing subsidies for PWH, (3) supportive services, (4) utility assistance, and (5) case management.

4) **Dental Services** - All RWHAP Parts may support oral health services. Additionally, Part F dental grants include the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The following dental entities focus on providing dental care to PWH in Kentucky:

- UK Dental Program (RWHAP Part F recipient)
- UofL School of Dentistry (RWHAP Part B subrecipient)

5) **FQHCs** - FQHCs provide health care services to some of the most resource limited populations and geographical areas in Kentucky. Regardless of someone's ability to pay, FQHC services range from routine and preventive care to substance abuse, mental health, and oral health care services which allows the care focus to be on the patients. There are more than 200 FQHC locations throughout the state of Kentucky. All of which provide primary and preventive health care to eliminate health disparities to the medically underinsured. FQHCs receiving HIV-focused funding include:

- Kentucky Mountain Health Alliance, Inc – Little Flower Clinic - Hazard, KY
- Mountain Comprehensive Care Center, Inc. - locations in Prestonsburg, Salyersville, and Pikeville, KY
- Park DuValle Community Health Center -locations in Louisville, Taylorsville, and New Castle, KY
- Pennyroyal Center - locations in Hopkinsville, Central City, Greenville, Princeton, and Madisonville, KY

- Regional Health Care Affiliates DBA (doing business as) Health First Community Health Center - locations in Henderson, Calhoun, Clay, Earlington, Morganfield, Owensboro, Princeton, and Providence, KY
- Shawnee Christian Health Center - Louisville, KY

6) **Emergent Community Partners** – Louisville, KY has been an area of previous cluster outbreaks. In an effort to reduce future outbreaks, while also ensuring that the area is adequately served with prevention and care resources, partnerships with four community partners have been fostered. These partnerships serve the Metropolitan Statistical Area (MSA), which includes Louisville and five counties in Indiana. Services at these entities include housing support, legal services, emergency financial assistance, transportation, food bank, case management, and health insurance cost sharing. These RWHAP Part B funded subrecipient emergent community partners include:

- Hoosier Hills AIDS Coalition - Jeffersonville, IN
- House of Ruth - Louisville, KY
- Kentuckiana AIDS Alliance - Louisville, KY
- Legal Aid Society, Inc. - Louisville, KY



## HARM REDUCTION SERVICES ACROSS KENTUCKY

1) **KDPH Harm Reduction Program** - Harm reduction is a set of ideas aimed at reducing negative consequences associated with substance misuse for individuals, their families, and communities by meeting people where they are. The practice extends to many services including disease prevention, syringe exchange, safer use practices, and linking people to housing, food access, insurance, medical care, substance use treatment and behavioral health services. The KDPH Harm Reduction Program is positioned under the Preparedness Branch in the Division of Public Health Protection and Safety.

Harm reduction services are provided at many LHDs in Kentucky. Services are available free of cost to any person who uses drugs, regardless of method. These programs are a great resource to obtain harm reduction supplies such as sterile syringes, naloxone, wound care kits, and fentanyl test strips. Additionally, these programs provide linkages to critical services and programs, including substance use treatment, HIV and viral hepatitis screening, vaccinations, social and behavioral health services, employment opportunities and other clinical and social programs.

2) **Substance Use Prevention and Treatment Services** - PWH are likely to experience a range of mental health issues, which can often accompany adverse life events. Additionally, mental health problems usually predate substance use activity, both of which can interfere with HIV/AIDS treatment adherence. Mental illness contributes to an inadequate knowledge and understanding of risk factors and difficulty





**Table 18: All Organizations and Agencies Providing HIV Care and Prevention Services in Kentucky (Listed Alphabetically)**

Name of Organization or Agency	Services and/or Activities Delivered	Funding Source(s)	Priority Population(s) served
<a href="#">AIDS Education Training Center (KY AETC)</a>	Educates, trains, and provides information on HIV/AIDS to medical professionals throughout Kentucky via live and virtual didactic trainings, preceptorships, and Community of Practice sessions	KIRP, HRSA RWHAP Part F Subrecipient	Medical professionals
<a href="#">AVOL (formerly AIDS Volunteers of Lexington)</a>	HIV, hepatitis, and STI testing; PrEP navigation; 340B pharmacy access; financial assistance; case management; supportive services; short- and long-term rental assistance; utility assistance for PWH; community-based housing for seven PWH with extensive medical issues; direct-managed permanent housing units (26) with on-site supportive services.	CDC Subrecipient, HOPWA, Low-income Housing Tax Credit, Affordable Housing Trust Fund, and local fundraising	All populations
<a href="#">Christian County Health Department</a>	HIV/STI testing, linkage to care, condom distribution, medical care, PrEP, health screenings, and medical case management	CDC EHE Subrecipient	All Populations
<a href="#">Graves County Health Department</a>	HIV/STI testing, linkage to care, SSP, condom distribution, medical care, PrEP, health screenings, and medical case management	CDC Subrecipient, HRSA RWHAP Part B Subrecipient	All populations
<a href="#">Hoosier Hills AIDS Coalition</a>	Health insurance premium/cost sharing, emergency financial assistance, food bank home delivered meals, and transportation	HRSA RWHAP Part B Subrecipient	5 Indiana counties and Louisville area PWH
<a href="#">House of Ruth</a>	Case management, emergency and family services, financial assistance, food pantry, and emergency housing	HOPWA, HRSA RWHAP Part B Subrecipient	Homeless PWH
<a href="#">Kentuckiana AIDS Alliance</a>	Housing and case management	HRSA RWHAP Part B Subrecipient	PWH with housing/eviction issues
<a href="#">Kentucky Department for Health (KDPH)</a>	HIV/AIDS Section, HRP, KHPAC, KADAP, KHCCP, and KHICP	CDC, HRSA	All populations
<a href="#">Kentucky Mountain Health Alliance, Inc. – Little Flower Clinic</a>	HIV/STI testing, linkage to care, medical care, health screenings, medical care management, behavioral health, substance abuse, social services, dental services, and transportation	HRSA EHE Subrecipient	Underinsured and socially vulnerable groups
<a href="#">Kentucky River District Health Department</a>	HIV/STI testing, linkage to care, SSP, condom distribution, medical care, PrEP, health screenings, and medical case management	RWHAP Part B Subrecipient	All populations

Name of Organization or Agency	Services and/or Activities Delivered	Funding Source(s)	Priority Population(s) served
<a href="#">KIRP (KY Income Reinvestment Program)</a>	Comprehensive education, screening, and testing services for those at high-risk for HIV infection; linkage to care for PWH to medical care and supportive services; educate health care providers and students on substance abuse disorders and mental health issues that affect effective HIV and hepatitis C medical care through KY AETC partnership	RWHAP Part B Program Income, CDC EHE Subrecipient, Gilead FOCUS	PWH, Populations at high-risk for HIV
<a href="#">Lake Cumberland District Health Department</a>	HIV/STI testing, linkage to care, SSP, condom distribution, medical care, PrEP, health screenings, and medical case management	RWHAP Part B Subrecipient	All populations
<a href="#">Legal Aid Society, Inc.</a>	Represents individuals and families whose incomes are at or below 125 to 200 percent of the poverty guidelines	HRSA RWHAP Part B Subrecipient	PWH
<a href="#">LivWell Community Health Services (Formerly Heartland Cares, Inc.)</a>	HIV/STI testing, linkage to care, condom distribution, housing, medical care, PrEP, health screenings, prevention medication, social support, and medical case management	CDC direct recipient and subrecipient, HRSA RWHAP Part B Subrecipient and Part C Recipient, HOPWA	PWH, Populations at high risk for HIV
<a href="#">Louisville Metro Department of Public Health and Wellness</a>	SSP, wound care, HIV/hepatitis C screening, STI testing and treatment, condom distribution, prevention education, and treatment navigation	CDC Subrecipient, Gilead, KIRP	All populations, PWID/persons who use drugs (PWUD)
<a href="#">Matthew 25</a>	HIV/STI testing, linkage to care, health insurance, condom distribution, medication assistance, food pantry, housing, medical care, PrEP, health screenings, primary care, transportation assistance, medical case management, and social support services	HOPWA, CDC EHE Subrecipient, HRSA RWHAP Part B Subrecipient and Parts C/D Recipient	PWH, Populations at high risk for HIV
<a href="#">Mountain Comprehensive Care Center, Inc.</a>	Addiction services, adult and children’s behavioral health, crisis services, developmental/intellectual disability services, and housing	HRSA EHE Primary Care Award direct recipient	Underinsured and socially vulnerable groups
<a href="#">Music City PrEP Clinic</a>	PrEP, PEP, HIV/STI testing, linkage to care, condom distribution, and medical care	340B Funding	All populations
<a href="#">Northern Kentucky District Health Department</a>	HIV/STI testing, linkage to care, SSP, condom distribution, medical care, PrEP, health screenings, and medical case management	HRSA RWHAP Part B Subrecipient, HRSA EHE Subrecipient	All populations
<a href="#">Park DuValle Community Health Center</a>	HIV/STI testing, linkage to care, dental care, women’s health, family planning, transportation services, medical care, PrEP, behavioral health services, social services, laboratory, primary care, and medical case management	HRSA EHE Subrecipient	Underinsured and socially vulnerable groups

Name of Organization or Agency	Services and/or Activities Delivered	Funding Source(s)	Priority Population(s) served
<a href="#">Pennyroyal Center</a>	HIV/STI testing, residential treatment with 3 different facilities, crisis services, behavioral health services, substance abuse services, linkage to care, social services, and medical case management	HRSA EHE Subrecipient	Underinsured and socially vulnerable groups
<a href="#">Regional Health Care Affiliates</a> <a href="#">DBA Health First Community Health Center</a>	HIV/STI testing, linkage to care, medical care, health screenings, medical case management, behavioral health, laboratory, and primary care	HRSA EHE Subrecipient	All populations
<a href="#">Shawnee Christian Healthcare Center</a>	Medical and mental health services, pharmacy, dental clinic, pediatric care, women’s health, behavioral health, substance abuse, preventative health care, HIV/STI testing, and PrEP	CDC EHE Subrecipient	All populations
<a href="#">Todd County Health Department</a>	HIV/STI testing, linkage to care, SSP, condom distribution, medical care, PrEP, health screenings, and medical case management	HRSA RWHAP Part B Subrecipient	All populations
<a href="#">University of Kentucky Bluegrass Care Clinic</a>	HIV/STI testing, primary care for PWH, medical and non-medical case management, mental health program, nutritional services, psychosocial support, support groups for PWH, oral health, food bank, housing program, emergency financial assistance, access to clinical trials, condom distribution, prevention services, PrEP outreach, linkage services for inmates at jails, adherence services, linkage to care, expedited antiretroviral therapy (ART), injectable ART, injectable PrEP, pharmacy, financial eligibility services, and vaccine services	HRSA RWHAP Part B Subrecipient and Parts C/D Recipient, CDC direct recipient and CDC EHE Subrecipient	PWH, All populations
<a href="#">University of Kentucky Dental Program</a>	Comprehensive dental care	HRSA RWHAP Part F Recipient	PWH
<a href="#">University of Louisville School of Dentistry</a>	Comprehensive dental care	HRSA RWHAP Part B Subrecipient	PWH
University of Louisville School of Dentistry KY Care Coordination Program (ULSD KCCP) -Note: no current website to link	Case management, emergency financial assistance, and transportation	HRSA RWHAP Part B Subrecipient	PWH, Minority clients
<a href="#">University of Louisville 550 Clinic</a>	HIV/STI testing; PrEP; rapid ART; primary care; HIV medical services; client advocacy/financial eligibility services; mental health screening, assessment, treatment, referral and case management; substance abuse screening,	HRSA RWHAP Part C, CDC EHE Subrecipient	PWH, All populations

Name of Organization or Agency	Services and/or Activities Delivered	Funding Source(s)	Priority Population(s) served
	assessment, treatment, and referral; nutritional assessment and referral; oral health care referrals; social support; and access to clinical trials		
<a href="#">Volunteers of America (VOA) Louisville</a>	HIV/STI testing, linkage to care, condom distribution, housing, medical care, support for PrEP, social support, and medical case management	CDC Subrecipient, HOPWA	PWH, Populations at high risk for HIV

**Table 19: Leveraged Funding Sources for HIV Prevention, Care, and Treatment in Kentucky**

Funder and Funding Source Name	Organization Receiving Funding	Annual Award Amount (based on 2022 funding)	Subrecipients	Services Delivered	EHE Pillar(s)
CDC <b>PS18-1802</b> Integrated HIV Surveillance and Prevention Programs for Health Departments	KDPH	\$2,565,658	AVOL, LivWell, Matthew 25, VOA	Surveillance and Prevention	Diagnose Prevent
CDC <b>PS20-2010</b> <b>Component A</b> Integrating HIV Programs to Support EHE	KDPH	\$1,988,268	Shawnee Christian Health Center, Bluegrass Care Clinic, UofL 550 Clinic, KIRP, Matthew 25, Christian County Health Department	Surveillance and Prevention	Diagnose Treat Prevent Respond
CDC <b>PS20-2102</b> Comprehensive High-Impact HIV Programs for Community-Based Organizations	LivWell	\$441,625	Not applicable	HIV testing events, Expanded STI testing services to include hepatitis C	Diagnose Treat Prevent Respond

<b>Funder and Funding Source Name</b>	<b>Organization Receiving Funding</b>	<b>Annual Award Amount (based on 2022 funding)</b>	<b>Subrecipients</b>	<b>Services Delivered</b>	<b>EHE Pillar(s)</b>
HRSA RWHAP Part B	KDPH	\$9,983,312	LivWell, Matthew 25, UofL KCCP, Northern KY District Health Department, Bluegrass Care Clinic, Lake Cumberland District Health Department, KY River District Health Department, Graves County Health Department, Todd County Health Department, UofL School of Dentistry	KHCCP, Medical case management, Care and treatment services	Diagnose Treat Prevent Respond
HRSA RWHAP Part C	LivWell	\$601,023	Not applicable	Care and treatment services	Diagnose Treat Prevent
HRSA RWHAP Part C	Matthew 25	\$430,085	Not applicable	Care and treatment services	Diagnose Treat Prevent
HRSA RWHAP Part C	UK	\$654,268	Not applicable	Care and treatment services	Diagnose Treat Prevent
HRSA RWHAP Part C	UofL	\$650,345	Not applicable	Care and treatment services via local community-based groups	Diagnose Treat Prevent
HRSA RWHAP Part D	Matthew 25	\$327,093	Not applicable	Medical care for Women, Infants, Children, and Youth (WICY)	Treat
HRSA RWHAP Part D	UK	\$477,806	Not applicable	Medical care for WICY	Treat
HRSA RWHAP Part D	UofL	\$459,086	Not applicable	Medical care for WICY	Treat
HRSA RWHAP Part F	Southeast Region AETC	\$276,819	KY AETC	Education for medical providers	Diagnose Treat Prevent Respond

Funder and Funding Source Name	Organization Receiving Funding	Annual Award Amount (based on 2022 funding)	Subrecipients	Services Delivered	EHE Pillar(s)
HRSA RWHAP Part F	UK Dental Program	\$166,136	Not applicable	Dental Services	Treat
HRSA Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B	KDPH	\$1,269,630	Park DuValle Community Health Center, Pennyroyal Center, Regional Health Care Affiliates DBA Health First Community Health Center, Little Flower Clinic, LivWell, Matthew 25, Bluegrass Care Clinic, Northern KY District Health Department, Todd County Health Department, ULSD KCCP, Lake Cumberland Health Department	Testing, EIS, Care and treatment services	Diagnose Treat Prevent Respond
Rebate dollars from Gilead Sciences, Inc.	KDPH	~\$8-10 million	LivWell, Matthew 25, UofL KCCP, Northern KY District Health Department, Bluegrass Care Clinic, Lake Cumberland District Health Department, KY River District Health Department, Graves County Health Department, Todd County Health Department, UofL School of Dentistry and KCCP	Aids Drug Assistance Program, EIS, Emergency financial assistance, Food bank, Health education/risk reduction, Health insurance premium/cost sharing, Housing, Legal services, Linguistics, Medical and non-medical case management, Medical nutrition therapy, Transportation, Mental health, Oral health services, Outpatient ambulatory health services, Outreach services, Rehabilitation, Substance abuse outpatient and residential	Diagnose Treat
RWHAP Part B Program Income dollars generated from contracted pharmacy	KDPH	~\$32 million	KIRP, LivWell, Matthew 25, UofL KCCP, Northern KY District Health Department, Bluegrass Care Clinic, Lake Cumberland District Health Department, KY River District Health Department, Graves County Health Department, Todd County Health Department, UofL School of Dentistry and KCCP	Aids Drug Assistance Program, EIS, Emergency financial assistance, Food bank, Health education/risk reduction, Health insurance premium/cost sharing, Housing, Legal services, Linguistics, Medical and non-medical case management, Medical nutrition therapy, Transportation, Mental health, Oral health services, Outpatient ambulatory health services, Outreach	Diagnose Treat Response

Funder and Funding Source Name	Organization Receiving Funding	Annual Award Amount (based on 2022 funding)	Subrecipients	Services Delivered	EHE Pillar(s)
				services, Rehabilitation, Substance abuse outpatient and residential	
SAMHSA State Opioid Response (SOR)	Kentucky Opioid Response Effort	\$750,000	KDPH	Expansion of SSP and harm reduction related programs in 40 LHDs throughout the state; Can include expenses related to HIV such as rapid HIV testing kits and personnel costs for PrEP Coordinators	Diagnose Prevent
HUD HOPWA	Kentucky Housing Corporation	\$1,001,179	AVOL	Housing assistance (short- and long-term), Supportive services, Utility assistance, Case management	Treat
HUD HOPWA	Louisville-Jefferson County Metropolitan Government	\$1,082,719	VOA, House of Ruth, LivWell, Matthew 25	Housing assistance (short and long term), supportive services, utility assistance, case management.	Treat
HUD HOPWA	Lexington-Fayette Urban County Government	\$450,000	AVOL	Short- and long-term housing assistance	Treat
Lexington-Fayette Urban County Government Extended Social Services	AVOL	\$100,000	Persons at high-risk for HIV infections	HIV, STI, and hepatitis C testing, connectivity to medical care, neighborhood outreach in Fayette County	Prevent Diagnose

<b>Funder and Funding Source Name</b>	<b>Organization Receiving Funding</b>	<b>Annual Award Amount (based on 2022 funding)</b>	<b>Subrecipients</b>	<b>Services Delivered</b>	<b>EHE Pillar(s)</b>
HUD Low-income Housing Tax Credit	AVOL	\$6,500,000	Permanent housing, Persons at-risk for HIV, PWH, medically vulnerable persons	Construction of 26 permanent housing one-bedroom apartments, Diversity inclusive – stigma free living, Onsite support services	Treat
Lexington-Fayette County Government Affordable Housing Trust Fund	AVOL	\$500,000	Permanent housing, Persons at-risk for HIV, PWH, medically vulnerable persons	Construction of 26 permanent housing one-bedroom apartments, Diversity inclusive – stigma free living, Onsite support services	Treat
Kentucky Housing Corporation Affordable Housing Trust Fund	AVOL	\$500,000	Permanent housing, Persons at-risk for HIV, PWH, medically vulnerable persons	Construction of 26 permanent housing one-bedroom apartments, Diversity inclusive – stigma free living, Onsite support services	Treat
Other Local Fundraising	AVOL	\$30,000	PWH, Persons at-risk for HIV	Emergency housing assistance, Utility assistance, Temporary shelter, Hepatitis C tests, Prevention supplies	Diagnose Treat Prevent
<b>Estimated Total Yearly Budget (Based on 2022 funding):</b>		<b>\$87,703,520</b>			

Note: Additional HRSA funding was awarded in 2022 as EHE Primary Care HIV Prevention Awards. Seven sites were awarded sums of \$325,000 each. These new awardees will be invited to participate in integrated planning efforts starting in 2023.

Awardees include the following:

1. Juniper Health, Inc. - Beattyville, KY
2. Cumberland Family Medical Center, Inc. - Burkesville, KY
3. Kentucky Mountain Health Alliance, Inc. - Hazard, KY
4. Healthfirst Bluegrass, Inc. - Lexington, KY
5. Health Help, Inc. - McKee, KY
6. Audubon Area Community Care Clinic, Inc. - Owensboro, KY
7. Mountain Comprehensive Health Corporation - Whiteburg, KY



## NEEDS ASSESSMENT

Following the Status Neutral Approach to HIV prevention and treatment, the needs assessment for integrated planning was designed to establish, inform, and shape the objectives, strategies, and activities to address the needs of both PWH and people at-risk for HIV in the state of Kentucky. Through a public health lens that uses the social determinates of health, the process considered the needs, gaps, and barriers to services at the individual and structural level. The needs assessment was compiled using both qualitative and quantitative methods including surveys, focus groups, key informant interviews, and listening sessions. The needs assessment detailed here consists of data accumulated both during and after the height of the COVID-19 pandemic. Specifically, pulling from the findings of the *2020 EHE Needs Assessment Survey*, and the *2022 End HIV Kentucky Statewide Needs Assessment Survey*.

### a. APPROACH

The *2022 End HIV Kentucky Statewide Needs Assessment Survey* was conducted as part of the statewide integrated planning process to provide consumer driven data regarding needs, use, barriers, and gaps in HIV prevention and treatment within the state of Kentucky. This 2022 statewide needs assessment was completed by 329 respondents of which 59 (19.80%) indicated they were living with HIV, and 238 (79.87%) indicated they were living without HIV, with one person indicating they were unsure of their HIV status. The assessment was informed by, and supplements, the findings from the *2020 EHE Needs Assessment Survey*. The 2022 assessment was designed to gauge the knowledge and experiences of Kentuckians both with and without HIV. Developed in partnership with KDPH and KHPAC, the assessment details findings in the following six areas: **(1) knowledge of HIV prevention, (2) HIV testing and prevention services, (3) perceptions of HIV prevention services, (4) knowledge of HIV treatment services, (5) perceptions of HIV treatment services, and (6) barriers to HIV care and treatment.** The needs assessment was disseminated through KHPAC by members who represent citizens, universities, LHDs, and CBOs. The needs assessment was distributed in both English and Spanish. The needs assessment used a convenience sample, through the placement of QR codes and hyperlinks in KHPAC member facilities, and through dissemination on social media. Results of the needs assessment are to be interpreted as indicative of the needs, assets, and barriers in the state of Kentucky, but are not designed to provide definitive statements, nor conclusions. See Appendices B and C for a copy of the survey questions and a complete summary of survey data.

The *2022 End HIV Kentucky Statewide Needs Assessment Survey* served the following functions:

- Ability to integrate planning based on the results of *2022 End HIV Kentucky Statewide Needs Assessment Survey* for PWH.
- Supplementing the results of the *2020 EHE Needs Assessment Survey*.
- Assessing impact of COVID-19 on the delivery of prevention and treatment services.
- Using the data to update KHPAC on the needs and barriers of Kentuckians to inform priority setting and resource allocation.
- Using the data for policy decision makers to identify the continued/new role for Ryan White services.

- Using the data to inform HIV Prevention based on findings from survey respondents.

During the 2020 EHE planning process, the KDPH team developed a community engagement survey (*2020 EHE Needs Assessment Survey*) to gather data from both stakeholders and community members. Data was collected through questions covering the availability, and perceived availability, of resources and programs from across the four pillars, as well as barriers to community access to these services. The data collected was used in addition to the project’s epidemiologic profile, situational analysis, and needs assessment to provide planning group members with a clear profile of the HIV epidemic in Kentucky. The community member version of survey was the survey had 1,738 respondents. The stakeholder portion of the survey had 379 respondents. The stakeholder section included a prompt to assess interest in participating in a regional planning group to support the development of the statewide EHE strategic plan. The findings from this survey influenced the *2022 End HIV Kentucky Statewide Needs Assessment Survey*. Together they help paint a picture of HIV prevention and care needs across the Commonwealth.

### **Limitations**

Both needs assessments had their limitations. The *2020 EHE Needs Assessment Survey* was far reaching and helped to gain perspective from both community stakeholders and the community at large, but it didn’t specifically target PWH. The 2022 needs assessment, while smaller in scale did specifically target PWH. Additionally, the *2022 End HIV Kentucky Statewide Needs Assessment Survey* was the first attempt to develop and distribute a needs assessment through KHPAC. These limitations likely had an impact on the representation of both PWH and higher risk persons without HIV who are harder to reach, including those experiencing unstable housing, transgender youth, and undocumented individuals.

Furthermore, the following limitations should be considered when interpreting the results from the needs assessments:

- Survey data were based on a convenience sample, and therefore may not accurately reflect the general population of Kentuckians. A “convenience sample” is a group of people under study who have been assembled based on the ease of interviewing them or on accessibility to their records, etc. While this type of sampling can help produce good information about a topic, its major disadvantage is that there is no way of knowing if the group is representative of the population as a whole.
- Although methods were used to encourage a random sample (fliers posted throughout the community, Facebook/Instagram posts, etc.), the respondents were generally referred to the survey through a convenience sampling method.

### **b. PRIORITIES**

The needs assessment supports an approach that builds off the four pillars for EHE and that aligns with NHAS. Several priorities arose from the needs assessment process which was used to develop the goals, strategies, and activities for the Integrated Plan. For a full list of goals, strategies and activities see Section V. The following is a list of key priorities that arose from the needs assessment process.

### **Services People Need to Access HIV Testing**

The ability to diagnose HIV is the first Pillar of the Integrated Plan and is a necessary component to ending the HIV epidemic. In the *2020 EHE Needs Assessment Survey*, when asked, “do you know where someone can get tested for HIV, in your area?” Seventeen-point four percent (17.4%) of respondents indicated “no”. Of the 82.6% that answered “yes”, the most understood locations for HIV testing included: LHDs (78.0%), primary care (39%), CBOs (31.7%), and emergency room (31.3%). These findings were further explored in the *2022 Statewide Needs Assessment Survey* which asked respondents about their level of comfort in getting an HIV test at various venues and about the barriers that exist to receiving an HIV test. More than 75% of respondents indicated that they strongly agree or agree with the statement, “I feel comfortable going for an HIV test at a local health department (81%), doctors office (82%), or mobile testing van (78%)”.

### **Services People at Risk for HIV Need to Stay HIV Negative**

The conditions in which people live, work and play have a profound impact on their ability to access services to reduce their risk to HIV. The following represents needs assessment finds specifically related to these known protective services/resources PrEP, PEP, and SSPs.

- **PrEP** - In the *2020 EHE Needs Assessment Survey* 50.6% of respondents reported hearing of PrEP. However, knowledge varied significantly across regions with 78.7% of respondents in Western Kentucky reporting knowledge, and only 38.1% in the Bluegrass region reporting knowledge. These data stand in contrast to the *2022 End HIV Kentucky Statewide Needs Assessment Survey* in which 100% of men who identified as gay or bisexual indicated knowledge of PrEP, with 85% of participants who identified as black/African American reporting knowledge of PrEP, and 88% of those age 51 and older reporting knowledge of PrEP. Furthermore, only 36.7% of respondents in the *2020 EHE Needs Assessment Survey* who heard of PrEP knew where to go to receive that service.
- **PEP** - In the *2022 End HIV Kentucky Statewide Needs Assessment Survey* 24.2% of respondents indicated that they were unaware that PEP medication exists, and of its uses. Among the population of gay/bisexual men in the 2022 assessment, 83% overall reported knowledge of PEP, 85% of black/African Americans reported knowledge of PEP, and 72% of respondents over the age of 51 reported knowledge of PEP.
- **SSPs** - In the *2022 End HIV Kentucky Statewide Needs Assessment Survey* 94% of respondents reported knowledge of SSPs. In the *2020 EHE Needs Assessment* 68.7% of respondents reported having access to SSPs. However, knowledge varied significantly across region with only 20.8% of respondents in Western Kentucky reporting knowledge, and nearly twice as many (48.0%) in the Bluegrass region reporting knowledge.

### **Services People Need to Rapidly Link to HIV Medical Care and Treatment**

Treatment as Prevention (TasP) refers to taking HIV medicine to prevent the transmission of HIV. It is one of the most highly effective options for preventing HIV transmission. For the purpose of integrated planning, developers sought to understand the experience of Kentuckians with HIV and their ability to access treatment

services soon after diagnosis. First, the needs assessment sought to gauge respondent's knowledge of Ryan White prior to their HIV diagnosis. Results indicated that respondents were largely aware of Ryan White Services, with 74.6% of respondents with HIV indicating that they knew about the program before taking the needs assessment. When asked about "treatment as prevention" 83.26% of respondents without HIV indicated that they knew of this method of HIV prevention. The *2020 EHE Needs Assessment Survey* also details an important insight into the perceptions of community stakeholders regarding their knowledge of where to refer an HIV positive person for HIV treatment. Thirteen-point three percent (13.3%) indicated that they had poor knowledge in this area.

### **Services PWH Need to Stay in HIV Care and Treatment and Achieve Viral Suppression**

In the *2022 End HIV Kentucky Statewide Needs Assessment Survey*, respondents with HIV were asked to describe their level of access with regards to receiving HIV treatment and care services at various venues and their perceptions of these services. These core services identified through key informant interview and regional planning groups were noted as being critical for individuals with HIV to be retained in care. Identified services include HIV/infectious disease providers, pharmacy, housing, dental, addiction and case management services. The 2022 respondents with HIV were overwhelmingly viral suppressed with 96.61% of respondents indicating that they had been told by their HIV provider that they are viral suppressed. These respondents in-care reported having positive experience and ease of access to their HIV providers, case managers, labs/bloodwork, and medication.

### **Barriers to Prevention and Treatment Services**

Several themes emerged throughout the needs assessment process with regards to barriers to HIV prevention and treatment. These include structural barriers (state laws and regulations), health care access, and societal influences (stigma). The following are summary findings of prevention and treatment service barriers that emerged from the needs assessment.

- **HIV Fear and Stigma** - Survey results from 2020 and 2022 all pointed to fear and stigma as being the main deterrents to getting an HIV test for the population that believed themselves at risk for HIV. With the results of the *2020 EHE Needs Assessment Survey* pointing to fear or stigma being the top three reasons respondents refused an HIV test, with 17.5% indicating fear of HIV disease, 15.9% indicating fear someone would find out, and 9.7% indicating stigma (negative belief about group of persons). These findings are consistent with the results of the *2022 End HIV Kentucky Statewide Needs Assessment Survey*, in which 21% of respondents indicated that they strongly agree or agree with the statement that, "stigma around HIV, and what other people think, stops me from getting an HIV test". Fear and stigma emerged as significant barriers not only for HIV testing, but also for HIV treatment. Results from 2020 demonstrate that as a community barrier, fear and stigma were selected as the two biggest issues, with 36.0% of respondents selecting "fear someone would find out/confidentiality" as a barrier and 27% reporting stigma as a barrier to HIV treatment.
- **Income** - In 2022, when respondents were asked if they had adequate income to cover essential monthly expenses the majority (42.37%) responded that they were mostly able to cover expenses each

month, 30.51% indicated that they were able to cover all their expenses, and 25.42% indicated that they were not able to cover essential monthly expenses. By race, 24.14% of white populations and 20% of black populations reported not being able to cover essential expenses each month.

- **Location and Transportation** - In 2022, when respondents were asked if they had transportation to get to HIV appointments, 89.83% reported having a car or having access to borrow or use a car, whereas 6.79% reported not having reliable access to transportation. While PWH may have access to a car, many rely on gas cards and transportation assistance to attend medical appointments. Significant RWHAP funds are spent to address this barrier of transportation to accessing HIV care. The results of the 2020 show 22.2% of respondents viewing transportation as a community barrier to HIV treatment. This measure varied widely by region with as many as 35% reporting transportation as a community barrier in Lake Cumberland, and as few as 17.6% in the Bluegrass region.

### c. ACTIONS TAKEN

In addition to shaping the goals, strategies, and activities listed in Section V, the needs assessment process led to a more revitalized and functional KHPAC and established priorities for the formation of regional planning councils to better address needs and barriers. For a complete list of proposed action items informed by the needs assessment and situational analysis see Section V.

## SECTION IV: SITUATIONAL ANALYSIS



The following section provides a complete situational analysis used to guide planning decisions regarding the goals, objectives, and strategies outlined in Section V. This section begins with a review of priority populations in Kentucky and continues with an analysis summary by pillar, including gaps, challenges, needs, barriers, strengths, and resources. This situational analysis was informed by the Epidemiological Profile Snapshot, Appalachian Regional Commission data, 2021 Kentucky HIV/AIDS Annual Surveillance Report, and the 2017 Kentucky Minority Health Status Report. Data from both the 2020 and 2022 statewide needs assessment surveys also supported the development and revision of this situational analysis.

### a. PRIORITY POPULATIONS

Kentucky has been identified by the *Ending the HIV Epidemic (EHE) Initiative: A Plan for America* as one of seven states with a substantial rural burden. The highest percentage of persons unaware of their HIV status (undiagnosed HIV infection) occurred in the South as compared with other US regions at year-end 2016 and second highest at year-end 2019.<sup>3-5</sup> Roughly 31% of Kentuckians diagnosed with HIV have not received care.<sup>6</sup> Approximately 85% of Kentuckians diagnosed with HIV in 2020 were linked to medical care within 12 months of diagnosis compared to 79% within one month of diagnosis, indicating delay in treatment and viral suppression.<sup>5</sup> Approximately, 22% of HIV cases over the last 10 years received a concurrent diagnosis (diagnosis with AIDS within 30 days of the initial HIV diagnosis), with the majority (47%) of concurrent diagnoses in the Cumberland Valley ADD in Southeastern Kentucky.<sup>6</sup> Approximately, 28% of Kentuckians diagnosed with HIV were late testers (diagnosed with AIDS within one year of initial HIV diagnosis). Twenty-two percent of concurrently diagnosed HIV and AIDS cases have an undetermined transmission route, which creates challenges for prevention initiatives aimed at increasing early testing and engagement in care.

Kentucky has two predominant HIV disease patterns: urban and rural. Fifty-four of the 220 identified counties as most vulnerable to an HIV and/or hepatitis C virus (HCV) outbreak in the United States are in Kentucky, with most located in Appalachian Kentucky.<sup>7,8</sup> Appalachian Kentucky is isolated with limited employment opportunities, low educational attainment, limited access to care, low wages, and other barriers to seeking care, such as transportation. In Kentucky, for example, 45 of the state's 120 counties are designated as "Health Professional Shortage Areas" (HPSAs) for primary care, as of July 2021. The state also has 105 designated "Medically Underserved Areas/Populations" (MUA/P). When it comes to health care positions, Kentucky has large gaps to fill.<sup>9</sup> The greatest HIV burden for the state as a whole is in urban areas, with 48% of known cases in Jefferson County (including Louisville) and 19% in Fayette County (including Lexington).<sup>10</sup> Louisville and Lexington both have more diverse populations than the rest of the state.

## **Social Determinants of Health**

Looking through the social determinants of health (SDOH) lens, many Kentuckians have been disadvantaged in multiple areas as compared to the US and are even more disadvantaged and distressed in Appalachia, as supported by 2017 data. For example, Appalachian Kentucky's median household income was 40% less than the national median, and 31% less than the median income in non-Appalachian Kentucky.<sup>10</sup> Appalachian Kentucky had a 26% lower supply of primary care physicians (PCP) per 100,000 population and a 59% lower supply of specialty providers compared to non-Appalachian Kentucky with 21% lower PCPs and 60% lower specialty providers than the national average. Long-term poverty and geographic isolation have created vulnerability and a disproportionate impact by the opioid epidemic in Appalachian Kentucky.<sup>11</sup> Appalachian Kentucky comprised a large majority of the drug overdose death rate through 2020, with three of the top five counties (Carter, Clark, and Knott Counties).<sup>11</sup> Nationally, Kentucky ranked very low for educational attainment. Kentucky ranked fifth in the nation for the percent of population 25 years and older with no high school diploma (or equivalent).<sup>12</sup> The two major urban areas are also affected by SDOH. For instance, Fayette County reported 19.1% persons living in poverty compared to 18.5% in Kentucky and 13.5% in the US.<sup>13</sup> Adults aged 18-64 with health insurance decreased by 14% in Fayette County from 2010 to 2016 indicating a need for better access to health care. Louisville Metro identified 136 languages spoken, while almost 12% of Lexington-Fayette County residents spoke non-English languages at home (compared to approximately 5% in Kentucky and 21% in the US).<sup>14-15</sup> In 2020, Jefferson County ranked first in the state with the most overdose deaths of any county (417), an increase from 319 in 2019, while Fayette County ranked second for fentanyl-related, heroin-related, and methamphetamine-related overdose deaths.<sup>11</sup>

PWH and persons at risk for HIV also face stigma, discrimination, homophobia, and transphobia. In Kentucky, there is a greater burden of HIV disease among certain populations, such as persons of color and young MSM.<sup>16</sup>

## **SDOH and Kentucky HIV Resources**

KHCCP helps provide prompt, consistent, and continued quality care and services to PWH and their families. There are no income requirements for KHCCP and their financial assistance resources. Over 70 care coordinators in 9 regional sites assess the needs and provide services for PWH. KHCCP assistance includes helping clients locate and access a system of referrals to medical care, emergency financial assistance for utilities, food bank home delivered meals, health education/risk reduction/prevention, health insurance, home and community-based health, hospice, housing, insurance assistance, legal services, linguistics, Medicaid, medical and non-medical case management, oral health care, outpatient/ambulatory health, medication assistance, mental health, medical nutrition therapy, psychosocial services, Social Security Disability, substance abuse outpatient/residential treatment, and transportation. KHCCP also provides clients with educational information regarding disease transmission and health maintenance, encouraging good health habits, and supporting secondary prevention through continued case management. KHCCP is also an umbrella program for other client assistance programs such as the KHICP, outpatient health care and support services, and state support service programs.

**Table 19. SDOH Indicators in Kentucky**

National Rates Compared to Appalachian Kentucky and Non-Appalachian Kentucky, % <sup>8, 12</sup>					
	Median Household Income, 2010-2014	Household Poverty Rate	Post-Secondary Education, 25-44 Years	Disability Benefits	Uninsured Population <65 Years
Appalachian Kentucky	\$33,840	26.7	48.4	14.3	18.6
Non-Appalachian Kentucky	\$48,889	16.3	61.8	6.8	16.2
National	\$56,135	15.6	63.6	5.1	16.8

**PILLAR #1: DIAGNOSE**

Early diagnosis of all individuals with HIV is imperative to ending the HIV epidemic. From 2010 to 2019, the annual Kentucky HIV diagnosis rate has remained fairly stable with slight fluctuations between 7.1 to 8.5 cases per 100,000 population.<sup>6</sup> According to the CDC 2019 estimated annual HIV disease diagnosis rates per 100,000, Kentucky ranked twenty-third with a rate of 7.3 compared to the national rate of 11.1. From 2012 through 2021, a total of 3,482 HIV cases were diagnosed among Kentuckians. Of these total HIV cases, 30% had progressed to AIDS as of December 31, 2021.<sup>6</sup>

Racial disparities exist among Kentuckians diagnosed with HIV. There are higher percentages of new cases among black non-Hispanic and Hispanic populations. In 2020, black populations accounted for 23% of newly diagnosed HIV cases compared to nine 9% of Kentucky’s population, whereas Hispanic populations accounted for 9% of new HIV cases while comprising only 4% of Kentucky’s population.<sup>6</sup> Black/African American females and males had consistently higher rates of new diagnoses compared to their white counterparts from 2015 through 2019.<sup>6</sup>

Seven hundred thirty seven of the 3,482 HIV disease cases diagnosed in the most recent 10 years were diagnosed with AIDS within 30 days of the initial HIV diagnosis—also known as a concurrent diagnosis.<sup>6</sup> During the presented period, 928 Kentuckians diagnosed with HIV disease were late testers (or those who have an AIDS diagnosis within one year of initial HIV diagnosis).

The HIV Prevention Program at KDPH supports HIV counseling and testing activities in each of the 120 counties across the state.<sup>15</sup> Sponsored non-clinical agencies offer rapid-rapid HIV-1/2 antibody testing and can provide results in minutes. Those with reactive results from an initial rapid test can be tested immediately with a different brand of test that is less sensitive than the initial test. Clients receiving reactive results from both rapid tests are almost certainly infected with HIV and can be promptly linked to an HIV care provider without waiting days or weeks for a confirmatory test. Sponsored clinical agencies offer both rapid fingerstick HIV 1/2 antibody tests and blood tests. All state sponsored testing sites offer anonymous or confidential HIV testing at free or minimal cost by appointment and/or on a walk-in basis. Pre-test and post-test counseling are offered at all agencies.



**Gaps** - Limited routine and universal HIV testing occurs in acute care, emergency care settings, outpatient medical encounters, and in the criminal justice system resulting in missed opportunities. Data compiled from multiple surveys suggested that HIV testing did not increase at physician office visits, increased at community health center (CHC) physician visits, and increased slightly at ED visits, indicating missed opportunities for routine HIV testing with an additional finding that HIV testing was performed more often at visits for preventive care and visits with venipuncture.<sup>17,18</sup> As of October 2022, there are three hospital systems in Kentucky which are currently participating in opt-out testing, despite CDC recommending routine opt-out HIV testing since 2006. These include Norton in Louisville, St. Elizabeth in Northern Kentucky, and UK in Lexington. Notably, these all serve largely metropolitan areas. Efforts still need to be increased to promote opt-out testing in rural areas. Additionally, there is limited targeted testing happening in high-risk communities, such as rural communities. Hoover et al. identified higher HIV testing rates at visits to physician offices, CHCs, and EDs in more urban areas compared to less urban (rural) areas.<sup>18</sup>

Approximately 2,149 Kentuckians were unaware of their HIV status as of December 31, 2019.<sup>6</sup> HIV prevalence is five times higher in state and federal US correctional systems than in the general population and the confirmed AIDS case rate in prisons is 2.5 times greater than the non-incarcerated population. The incarcerated population is among the most challenging to diagnose and treat for HIV. Incarcerated persons are most likely to benefit from HIV prevention interventions due to related HIV risk behaviors including high rates of substance dependence.<sup>19</sup>

Additional missed opportunities include lack of utilization of pharmacies for HIV testing and Kentucky legislation not allowing for the use and distribution of self-administered in-home HIV test kits. However, as part of DIS investigation and targeted outreach, some in-home testing options have started to become available through certified HIV testers who will go to people's home and provide testing in the privacy of their home. Local advocacy groups have started to pursue lobbying for legislative changes to allow for the use of in-home test kits.

**Challenges** - Challenges in this area are multiple as evidenced by high rates of concurrent diagnosis for HIV and AIDS among MSM transmission, undetermined transmission, and rural populations. There are limited funding sources and resources at the state level to coordinate and expand collaborations across health care settings with only one full-time position focused on creating collaboration across all stakeholders. Buy-in from EDs and urgent care can be difficult to obtain. There is no existing collaboration with pharmacies and state programs (KDPH) for HIV testing. Strides for HIV testing in the criminal justice system due to the recently changed RWHAP policy (PCN 18-02) which allows for the use of RWHAP funds for PWH who are locally incarcerated, and justice involved, will take time to implement.<sup>20</sup> Hard to reach populations, such as PWID, have unique barriers/challenges to implement testing. Limited awareness and stigma continue to be a challenge, as discussed in the Needs Assessment Section.

**Needs (resources, infrastructure, service delivery)** - The following needs were identified: increased testing

in both high-risk populations and in general populations based on universal screening protocols; comprehensive list of urgent care facilities; data to assess which providers, agencies, and organizations are already implementing routine HIV testing in acute, emergency, and outpatient settings; outreach materials for persons at high-risk for HIV identified in health care settings; referral process and protocols for PWH who are newly diagnosed and/or lost to care; referral process and protocols to connect persons who are HIV negative and identified as high-risk to PrEP; and culturally sensitive outreach materials translated into non-English languages.

**Barriers** - Multiple barriers have been identified regarding HIV diagnosis in multiple health care settings. Providers are not routinely ordering HIV tests in acute, emergency, and outpatient settings; providers have not widely adopted routine HIV screening as part of medical care. Staffing availability to implement testing and counseling in acute care settings may not be a top priority. Additionally, the rapid-rapid testing algorithm is not used in EDs in Kentucky. Stronger relationships with pharmacies are needed. The new policy for PWH who are in the correctional system is still being adapted with a need for more knowledge and awareness. Insensitive or un/undertrained staff and lack of cultural competence has been identified as a barrier. Limited application of HIV and HCV screening recommendations has been identified. It is difficult to engage providers in education for HIV and HCV, and the HIV continuing medical education (CME) requirement for providers was removed from Kentucky law.

**Strengths** - Kentucky has several identified strengths in health care systems. Positive relationships exist between KDPH and health care systems and professional societies. In the past, lack of access to ED HIV testing was limited significantly by a Kentucky law which required the testing provider be responsible for informing the patient of the test results. Recent change in state legislation now allows for a designee, such as a nurse or social worker, to give HIV results and necessary counseling, rather than the testing provider.<sup>21,22</sup> Three hospital systems are performing opt-out testing in their EDs rather than opt-in. Kentucky is home to a large number of chain and independently owned pharmacies who could be utilized for HIV testing. Norton Prompt Care has partnered with Walgreen at five Louisville locations to offer rapid HIV testing.<sup>23</sup>

More strengths exist in the community setting. Treatment is covered by RWHAP services in local and county jails in eligible patients (PCN 18-02).<sup>20</sup> Kentucky currently leads the nation with SSPs, providing participants with access to critical services and programs including screening, care, and treatment for HIV and viral hepatitis. As of August 3, 2022, Kentucky had 82 SSPs operating in 63 counties.<sup>20</sup> Increased targeted outreach and testing is provided by KIRP through EIS Health Education Coordinators (HEC) embedded in SSPs in both urban and rural settings. The majority of LHDs in Kentucky offer free rapid screening for HIV with results available in 15-20 minutes, free HIV confirmatory testing, referrals for HIV positive individuals, safer sex counseling, and free condoms. Several CBOs and health centers also offer rapid HIV testing.<sup>15</sup> KDPH has employees who work specifically on social justice issues, implicit bias, and health equity. HIV Prevention promotes the “Know Your Status” Campaign focused on Eastern Kentucky and testing, as well as a faith-based HIV/AIDS initiative focused on African American women.

## PILLAR #2: TREAT

Linkage to and retention in care are key to treating PWH rapidly and effectively with the goal of achieving sustained viral suppression. Roughly 21% of Kentuckians diagnosed with HIV do not receive care and approximately 46% are not virally suppressed.<sup>5</sup> Approximately 85% of Kentuckians diagnosed with HIV in 2020 were linked to medical care within 12 months of diagnosis. In 2020, cumulative viral suppression among PWH in Kentucky increased if you received care (79% virally suppressed) or were retained in care (84% virally suppressed). Among RWHAP clients, viral suppression was 87%, supporting the importance of retention in care.<sup>6</sup>

As of June 2020, there were 2,673 PWH identified as Not in Care (NIC).<sup>25</sup> Kentucky defines NIC as absence of an HIV care indicator for over 365 days. NIC PWH were identified by EHE Region: Louisville (45.4%, Northern Kentucky 17%, Bluegrass 16.3%, Western Kentucky 9.5%, Lake Cumberland 6.8%, and Kentucky River 3.7%. Kentucky's NIC demographics differed slightly from the new HIV case distribution from 2018 indicating disparities in care retention.

**Gaps** - A gap was identified in the care received among those not in the RWHAP program. Among the 7,719 Kentuckians living with HIV in 2018, 69% had a care marker, 52% were retained in continuous care, and 54% achieved viral suppression.<sup>5</sup> Viral suppression increased for persons who received care in 2018, 76% being retained in continuous care and 79% achieving viral suppression. Of note, among those retained in care in 2018, 84% achieved viral suppression. This data indicates the importance to link PWH to care, as this greatly improves their retention and viral load suppression rates (with adherence to ART) which can ultimately reduce forward infections.

**Challenges** - Several challenges have been identified. Kentucky needs to increase linkage to care for rural and urban populations and the same process for both may not be ideal. Many new staff are working in outreach and linkage to care, and training is ongoing. Limited funding for salaries results in high turnover for DIS, resulting in DIS leaving these positions for higher paying positions within health departments. The DTC Initiative in Kentucky is in early stages of implementation, limiting the reduction of those NIC. There are limited infectious disease specialists in rural areas, specifically Lake Cumberland, Kentucky River, Todd County, and Graves County. Additionally, there is a lack of available transportation, particularly in rural areas.

**Needs (resources, infrastructure, service delivery)** - The following needs were identified: increased numbers of DIS, more transportation options and/or medical care options in rural areas, increased awareness of available resources, identification of barriers to HIV prevention services for at-risk populations and communities, increased access to telemedicine and ECHO models of medical care, and exploration of cultural competency of agencies providing services.

**Barriers** - Several barriers have been identified. Limited/developing relationships exist between LNs, DIS,

social workers, and case managers. Some LNs identified lack of resources as barriers, further challenging linkage to care efforts. Kentucky has limited access to HIV medical care in rural areas: Appalachian Kentucky had a 26% lower supply of primary care providers per 100,000 population and a 59% lower supply of specialty providers.<sup>8</sup> Limited public transportation exists in rural areas as identified in several community needs assessments.<sup>13-14</sup> Also, there is limited HIV knowledge and awareness of RWHAP services in minority communities (African American and Latina(o)).<sup>16</sup> The intersection of religion and HIV and associated stigma and discrimination may result in PWH not seeking treatment.

Transportation and access to services continues to be one of Kentucky's most significant barriers to services.<sup>18</sup> SSPs are an effective strategy to reduce blood-borne infections of HIV and HCV in PWID; serving as an access point for services including, HIV and HCV testing, health education and risk reduction, prevention supplies, and referrals to community services.<sup>23-25</sup> KIRP and KDPH reviewed three years of SSP data to determine the frequency and risk factors for loss to follow-up in PWID enrolled at SSPs in Kentucky. The analysis included 5,742 PWID. Lost to follow-up (LTFU) by year of enrollment was 287/770 (37.3%) in 2017; 796/1,874 (42.5%) in 2018; and 1,479/3,098 (47.7%) in 2019. LTFU was significantly associated with distance to SSP from home of more than five miles (RR 1.25; 95%CI 1.09–1.43; p = 0.002) and SSPs housed in rural counties (RR 1.22; 95%CI 1.06–1.40; p = 0.004), adjusted by age, sex, and race.<sup>23</sup> As a follow-up from this study, KIRP conducted a LTFU survey to identify specific barriers to accessing services. The LTFU survey assessment was distributed from August 18, 2021 to October 7, 2021, and was a bi-directional survey shared with LHDs and distributed to staff who work with harm reduction programs and participants who utilize program services. Nearly half of the 388 participants that participated in the survey (46.7%) said they had experienced a long period of time (three months or more) where they were unable to regularly access the needle exchange program; with more than half (53.4%) of respondents stating transportation was the main barrier to program access in the past.

**Strengths** - Kentucky has a large number of staff across the state. Regional LN and DIS are a strength with 89 out of every 100 Kentuckians diagnosed with HIV in 2018 linked to medical care within two months of diagnosis. There are currently 10 LNs and there will be 12 DIS when all vacancies are filled serving across the Commonwealth. The Target4 Project utilizes EIS HECs to target testing and education to focus on hard-to-reach populations and assure linkage to care for PWH NIC and persons newly diagnosed with HIV. RWHAP Part B Case Managers are located across the state in regional access points. RWHAP Part B Programs provide care and support services for eligible individuals. Four RWHAP Part C and/or Part D Programs provide comprehensive medical care and supportive services to PWH: UofL 550 Clinic, UK Bluegrass Care Clinic, Matthew 25 (Owensboro and Bowling Green Offices), and LivWell. RWHAP resources are available for transportation to HIV medical care, housing, and many other needs in both urban and remote rural areas. Furthermore, as has been demonstrated throughout the country, Kentucky's clients in the Ryan White program have better outcomes due to the services they are eligible to receive from Ryan White.<sup>26,27</sup> Consistently, clients in the program have higher viral suppression rates than PWH not in the program.

## PILLAR #3: PREVENT

Since 2000, drug overdose rates in Kentucky have seen an upward trend. In response to Senate Bill 192 enacted in 2015, KDPH publishes guidelines for LHDs implementing harm reduction programs and SSPs. In November 2016, KDPH mobilized the Harm Reduction Program.<sup>11</sup> The opioid epidemic has contributed to an increase in HIV and HCV cases and a need for increased prevention efforts. In 2018, 15% of new HIV cases were transmitted by PWID and 5% by MSM/PWID—higher than the estimated US rates of 7% and 3%, respectively.<sup>6</sup> Strategies to prevent new HIV transmissions include PrEP and SSPs (see Pillar One Strengths). About a quarter of counties deemed vulnerable by the CDC across the US for HIV and HCV outbreaks are in Kentucky indicating a need for PrEP and SSPs.<sup>7</sup>

While HIV incidence is increasing in the South, disproportionately fewer people use PrEP (only 30% in 2017).<sup>26</sup> In 2018, Kentucky had a low PrEP-to-Need Ratio (PNR) of 3.46, but higher (better) than the PNR of 2.97 for the Southern US and lower (worse) than the US PNR of 4.89.<sup>26-29</sup> Targeted prevention efforts are needed to improve Kentucky's use of PrEP and address the inequalities in PrEP use relative to need.

KDPH is working in minority communities ensuring those at greatest risk for HIV infection know their serostatus and have access to the most effective treatments, coordinated health care, transportation, social services, and evidence-based programming regarding risky behaviors. Community engagement and HIV/AIDS champions are important partners in reducing the transmission of HIV/AIDS and reducing the stigma associated with the disease.<sup>10</sup>

**Gaps** - There is inadequate awareness of PrEP among providers and those at risk. A deficient number of providers prescribe PrEP. Additionally, persons are unaware of where to find PrEP services.<sup>16</sup> PrEP materials need to be available in Spanish and other languages and very few Latina(o) staff are available throughout Kentucky rural areas, as identified in several needs assessments.<sup>13-14,28</sup> Gaps were also identified in SSPs. SSPs are not located in all communities. Some SSPs have limitations on services available and one-for-one exchanges, despite best practice recommendations. Even in communities with SSPs only a minority of PWID participate in SSPs.

**Challenges** - There are challenges for PrEP and SSPs. A limited number of providers are prescribing PrEP. PrEP awareness continues to be a challenge among providers and at-risk populations. Funding for both PrEP and SSPs is limited. SSPs are locally driven, resulting in many variations in structure, services provided, and community support. PWID are often reluctant to use preventive services in SSPs due to time needed, loss of anonymity, or other barriers.

**Needs (resources, infrastructure, service delivery)** - The following needs were identified: increased number of providers trained to prescribe PrEP, increased education for at-risk populations and providers on PrEP, champions and local experts for PrEP, PrEP media campaign, and linkage to PrEP for persons that

are identified as at-risk and test negative.

**Barriers** - SSP barriers include many SSPs are one-for-one exchanges, despite best practice recommendations due to community acceptance. Support in communities for SSPs varies across the state. For PrEP a lack of payment options exists for uninsured and underinsured. Kentucky needs more PrEP clinics and PrEP prescribing providers. For both SSPs and PrEP, there can be insensitive staff and lack of cultural competency, lack of social support (family, faith-based, etc.), and language barriers.[13-14,28](#)

**Strengths** - Kentucky currently leads the nation with the largest number of SSPs. The Target4 Project embeds EIS HECs in SSPs throughout the state to provide screening, testing, comprehensive education, and care for persons at highest risk for contracting and transmitting HIV and HCV. SSPs have increased PrEP education through the Target4 Project team.

In 2018, there were an estimated 1,209 PrEP users in Kentucky (rate of 32 PrEP users per 100,000 population compared to 57 in the Southern US and 68 in the US).[29-32](#) One LHD has an operating PrEP clinic. HIV Prevention has ongoing PrEP marketing efforts in areas with the highest burden of HIV.

Additional strengths include health education resources offered in both English and Spanish by LHDs, as well as translators. KRS 214.650 states “The Cabinet for Health Services shall urge access to Spanish speaking interpreters to provide prevention, treatment, and service efforts in relation to HIV/AIDS.” Condom distribution by the HIV Prevention team focuses on high-risk areas, providing education on the importance of condom use while providing over 400,000 condoms in 2019.

#### **PILLAR #4: RESPOND**

Kentucky has a well-developed cluster detection and response (CDR) plan (see Appendix J). Due to cluster outbreaks, Kentucky has experienced and demonstrated effectiveness working across state jurisdictions and working with PWID. The overall goal of CDR is to identify early potential HIV outbreaks and to get needed prevention and treatment services to people who need them.

**Gaps** - Lack of capacity to respond to cluster investigations at the LHD level.

**Challenges** - Several challenges have been identified, such as Kentucky’s shared border with seven other states creating some disruption for data sharing. Depending on the location of the cluster, there may be limited staff to respond to investigations or existing staff must be reassigned from regular duties. Finally, 54 counties have been designated by CDC as vulnerable to an HIV and/or HCV outbreak among PWID in Kentucky.

**Needs (resources, infrastructure, service delivery)** - The following needs were identified: training for new LN/DIS/Outbreak response staff in responding to cases of HIV outbreak and retention of KDPH HIV Surveillance staff to conduct all required activities.

**Barriers** - Multiple health care systems with different laboratory reporting protocols results in difficulty to satisfy complete reporting, contiguous state reporting requirements are unique, and multiple data systems which do not communicate with each other.

**Strengths** - KDPH has an existing collaboration with the Kentucky Health Information Exchange (KHIE) and an established network of DIS, LNs, community testers, case managers, regional epidemiologists, and medical providers. These partnerships strengthen the surveillance capacity to identify and respond to clusters that may arise.

## SECTION V: 2022-2026 GOALS AND OBJECTIVES



### END HIV KENTUCKY INTEGRATED PREVENTION AND CARE PLAN 2022-2026

#### Overarching Goal

To reduce new HIV infections by 75% by 2025, by 90% by 2030, from an estimated baseline of 453.

#### Goals, Objectives and Strategies

The *End HIV Kentucky Integrated Prevention and Care Plan* (“Integrated Plan”) has four overarching, ambitious, and quantifiable goals which directly correspond to the national EHE pillars. Each goal has three to four objectives and corresponding key strategies, designed **to be met by December 31, 2026**, in order to achieve the associated goal. Several key activities/action steps encompass each strategy and are described in the implementation plan detailed in Section VI.

#### Format

The format of this section is based on definitions from the *National HIV/AIDS Strategy 2022-2026*, as described in Table 20. See Appendices D and E for links to the NHAS and NHAS Implementation Plan.

**Table 20. Definition of NHAS Elements**

National HIV/AIDS Strategy	Federal Implementation Plan
<p><b>Goals:</b> Broad aspirations that enable a plan’s vision to be realized</p> <p><b>Objectives:</b> Changes, outcomes, and impact a plan is trying to achieve</p> <p><b>Strategies:</b> Choices about how best to accomplish objectives</p>	<p><b>Action Steps:</b> Specific activities that will be performed to implement the strategies and achieve the goals of the plan</p> <p><b>Progress Reports:</b> Reports on progress, successes, and challenges</p>

<sup>a</sup> Adapted from the HHS Office of the Assistant Secretary for Planning and Evaluation.

Source: NHAS, 2022-2025.

#### At-a-Glance and Detailed Overview

The At-a-Glance page in Section V is an easy to read, condensed version of the 2022-26 goals, objectives, and strategies. What follows is a more detailed review of each pillar, including key partners, potential funding resources, estimated funding allocation, outcomes (reported annually, locally monitored more frequently), monitoring data source, and expected impact on the Status Neutral Approach.



## Implementation, Monitoring and Evaluation Plan

A detailed implementation, monitoring, and evaluation plan is outlined in Section VI. Activities directly related to the EHE Strategic Plan are identified with an asterisk (\*) for EHE HRSA funding and a caret (^) for EHE CDC funding.

### Core Indicators

A set of core indicators, aligned with national indicators for the EHE initiative, have been selected to track the progress and impact of the efforts contained in the Integrated Plan.

## INTEGRATED PLAN AT-A-GLANCE

### PILLAR #1: DIAGNOSE

GOAL 1: TO DIAGNOSE ALL PWH AS SOON AS POSSIBLE

- **Objective 1.1: Advance HIV-related communications to improve uptake of HIV testing (including knowledge of the status-neutral approach and strategies to reduce stigma and discrimination)**
  - Strategy 1.1.1: Ensure that health care professionals and front-line staff are educated and trained on stigma, discrimination, and unrecognized bias toward priority populations
  - Strategy 1.1.2: Increase public awareness for HIV across the Commonwealth to reach all Kentuckians, including specifically targeted populations
- **Objective 1.2: Increase HIV testing within clinical settings**
  - Strategy 1.2.1: Initiate routine opt-out testing in acute care settings (i.e., EDs, urgent care)
  - Strategy 1.2.2: Increase HIV screening tests in routine medical encounters, including primary care, dental care visits, prenatal care, elective admissions, mental health visits, substance use disorder clinics, medication-assisted treatment (MAT) clinics, university health services, FQHCs, and LHDs
- **Objective 1.3: Improve targeted HIV testing efforts within CBOs**
  - Strategy 1.3.1: Train and certify community-based HIV testers
  - Strategy 1.3.2: Host quarterly prevention meetings to highlight best practices
  - Strategy 1.3.3: Advocate for legislative changes to allow for home HIV testing
- **Objective 1.4: Increase targeted outreach testing efforts in populations at higher risk for HIV**
  - Strategy 1.4.1: Promote and increase testing in the criminal justice system
  - Strategy 1.4.2: Promote and increase testing in SSPs
  - Strategy 1.4.3: Promote and increase outreach testing efforts in rural areas and hard-to-reach populations
  - Strategy 1.4.4: Promote and increase outreach testing efforts with Ryan White discordant partners
  - Strategy 1.4.5: Establish a Prevention Screening Services Program

## PILLAR #2: TREAT

GOAL 2: TO TREAT PWH RAPIDLY AND EFFECTIVELY TO REACH SUSTAINED VIRAL SUPPRESSION

- **Objective 2.1: Increase the percentage of newly diagnosed PWH linked to care within 1 week of diagnosis**
  - Strategy 2.1.1: Increase capacity to provide linkage to care for newly diagnosed PWH
  
- **Objective 2.2: Re-engage PWH who are out of care**
  - Strategy 2.2.1: Increase linkage to care activities for targeted populations
  - Strategy 2.2.2: Increase public awareness focused on getting PWH living in Kentucky into care
  
- **Objective 2.3: Reduce barriers to retain PWH in care**
  - Strategy 2.3.1: Reduce transportation barriers
  - Strategy 2.3.2: Reduce housing barriers
  - Strategy 2.3.3: Reduce stigma barriers
  
- **Objective 2.4: Increase the capacity of the public health and health care workforce to effectively provide holistic care and treatment for PWH**
  - Strategy 2.4.1: Increase provider education on the treatment and quality of care for HIV, and of HCV and Hepatitis B (HBV) co-infection(s)

## PILLAR #3: PREVENT

GOAL 3: TO PREVENT NEW HIV TRANSMISSIONS BY USING PROVEN INTERVENTIONS, INCLUDING PREP AND SSPs

- **Objective 3.1: Promote full access to, and the expansion of, PrEP**
  - Strategy 3.1.1: Expand PrEP resources at the state level, including systems to navigate PrEP access
  - Strategy 3.1.2: Build a cohesive statewide network of PrEP coordinators to coordinate PrEP initiatives
  - Strategy 3.1.3: Increase the number of providers who are aware of, and trained to prescribe, PrEP
  - Strategy 3.1.4: Increase awareness of, and participation in, PrEP services among priority populations
  
- **Objective 3.2: Promote full access to, and the expansion of, substance use-related harm reduction**
  - Strategy 3.2.1: Partner with the recently established DPH Harm Reduction Program, under the Preparedness Branch in the Division of Public Health Protection and Safety, to support local communities in approval of and implementation of SSPs and expand available HIV prevention services at SSPs
  - Strategy 3.2.2: Provide data on SSPs

- **Objective 3.3: Increase prevention strategies in priority populations**
  - Strategy 3.3.1: Increase awareness of treatment as prevention (Undetectable = Untransmittable [U=U])
  - Strategy 3.3.2: Increase participation in support groups for those at risk for HIV, such as PWID
  - Strategy 3.3.3: Increase youth awareness of HIV prevention
  - Strategy 3.3.4: Increase the availability of safe sex kits, including condoms

## PILLAR #4: RESPOND

GOAL 4: TO RESPOND QUICKLY TO POTENTIAL HIV OUTBREAKS AND TREATMENT SERVICES TO PEOPLE WHO NEED THEM

- **Objective 4.1: Improve surveillance capacity for rapid detection of active HIV transmission clusters**
  - Strategy 4.1.1: Improve HIV surveillance lab collection system to decrease delay in importing labs into eHARS, thereby boosting cluster detection and response activities with more timely data
- **Objective 4.2: Increase workforce capacity to respond to outbreaks in the field**
  - Strategy 4.2.1: Hiring and maintaining positions in the KDPH HIV Section to provide appropriate services to address cluster demands
- **Objective 4.3: Increase community engagement and input in cluster detection and response**
  - Strategy 4.3.1: Creating and maintaining surveillance products
  - Strategy 4.3.2: Increase partnership activities to engage and maintain stakeholders in HIV cluster detection and response

### ADDITIONAL INFORMATION BY PILLAR

#### **PILLAR #1:**

- **Key Partners** - Diagnosing providers, Matthew 25, LivWell, Bluegrass Care Clinic, 550 Clinic, Shawnee Christian Health Center, Ryan White Case Management program staff, LHDs, AVOL, KIRP/Target 4, Louisville Youth Group, regional community planning groups, universities, LGBTQ organizations, faith-based organizations, organizations serving Appalachia, African American and Latina(o) communities, SSPs
- **Potential Funding Resources** - CDC, HRSA, RWHAP Rebate funds, RWHAP Program Income
- **Estimated Total Yearly Statewide Funding Allocation** - ~\$10,000,00
- **Outcomes** - (1) Increase the percentage of PWH who know their status, (2) increase the number of persons newly diagnosed with HIV, (3) decrease concurrent and late tester diagnoses
- **Monitoring Data Source** - EvaluationWeb, HIV Surveillance data, potentially payer data
- **Expected Impact on Status Neutral Approach** - Kentucky and its CBOs have been practicing a Status Neutral Approach for the last four to five years with the advent of PrEP and U=U. KDPH is currently in the process of writing a policy brief formalizing the Status Neutral Approach.

## **PILLAR #2:**

- **Key Partners** - FQHCs, health care providers, public health organizations, hospitals, CBOs especially LGBTQ organizations, various professional health care associations, correctional systems, judicial systems, federal agencies including HRSA/ HIV/AIDS Bureau (HAB) and CDC
- **Potential Funding Resources** - RWHAP Part B, CDC, state and local funding, SAMSHA, HUD/HOPWA, Medicaid expenditures, Administration for Children and Families, other public and private funding sources, Kentucky RWHAP (all parts), HRSA Bureau of Primary Health Care (BPHC) – over 20 funded FQHCs in Kentucky with over 75 clinical sites, KIRP/Target4 Project
- **Estimated Total Yearly Statewide Funding Allocation** - ~\$65,000,000
- **Outcomes** - Any Kentucky Resident diagnosed with HIV disease and not in care: (1) increasing numbers of PWH participating in and retained in care, (2) increasing numbers of PWH who are virally suppressed, (3) increasing numbers of providers who provide quality HIV care and support services
- **Monitoring Data Source** - Data from the DTC initiative, CAREWare, HIV Surveillance data
- **Expected Impact on Status Neutral Approach** - Patients in RWHAP case management care will have the opportunity to learn about PrEP and HIV testing options for their partners who do not know their status.

## **PILLAR #3:**

- **Key Partners** - Diagnosing providers, Bluegrass Care Clinic, 550 Clinic, Ryan White Case Management program staff, KHIE, LHDs, AVOL, KIRP/Target 4, schools/universities, LGBTQ organizations, faith-based organizations, organizations serving - African American/Latina(o)/Appalachian communities, SSPs, substance abuse agencies, homeless shelters
- **Potential Funding Resources** - CDC, HRSA, RWHAP Program Income
- **Estimated Total Yearly Statewide Funding Allocation** - ~\$10,000,000
- **Outcomes** - (1) Increase in PrEP/PEP awareness, access, and utilization; (2) increase access to and use of comprehensive SSPs; (3) increased prevention of HIV among priority populations
- **Monitoring Data Source** - CBO reports, HIV Surveillance data, REDCap SSP data, Target4 Project Outreach data
- **Expected Impact on Status Neutral Approach** - All prevention activities will be developed, delivered, and maintained with the concept of Status Neutral as an expected outcome. This should result in more persons at risk of HIV acquisition participating in activities that will reduce their risk.

## **PILLAR # 4:**

- **Key Partners** - Diagnosing providers including Bluegrass Care Clinic, 550 Clinic, Ryan White Case Management program staff, KHIE, regional epidemiologists, AVOL KY, KIRP/Target 4
- **Potential Funding Resources** - CDC, RWHAP Rebate funds, RWHAP Program Income
- **Estimated Total Yearly Statewide Funding Allocation** - ~\$200,000

- **Outcomes** - (1) Completed CDR plan, (2) increased capacity to effectively respond to identified clusters
- **Monitoring Data Source** - KDPH Annual Reports, RWHAP Services Annual Reports, Surveillance Standard Evaluation Report, SSP data, Target4 Project outreach database, STD data
- **Expected Impact on Status Neutral Approach** - HIV Surveillance has adopted the Status Neutral Approach and will begin incorporating appropriate language in all surveillance products. The Status Neutral Approach, when successfully delivered, aims to reduce HIV and STD associated stigma, improve outcomes for persons who have tested negative for HIV infection and are at increased risk of HIV acquisition, and provide hope for ending the HIV epidemic.

#### a. UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

The *2021-2026 EHE Strategic Plan* (see Appendix I) prepared under the PS19-1906 funding opportunity served as the foundation for this Integrated Plan. Updates were made to the original EHE plan to reflect the priorities that arose from the statewide needs assessment, epidemiological data analysis, resource inventory information, and community engagement efforts. Additionally, the new Integrated Plan reflects the successful implementation of several critical components of the EHE plan and establishes new strategies based on those developments. Lastly, the new Integrated Plan formatting creates SMART goals and objectives corresponding to a more robust tool for monitoring and evaluation. The following is a list of the most significant additions and removals made to the updated *2022-2026 EHE Strategic Plan* during the integrated planning process:

#### **Additions, Updates, and Accomplishments**

- Formatting was adjusted from the original document to comply with the new integrated planning guidance. This included selecting a new format which aligns with the layout of NHAS. Specifically, the new Integrated Plan uses goals, objectives, strategies, and activities/action steps. These changes were made to enable the Integrated Plan to be used as a guiding document for subrecipients and health service entities seeking to align their goals and objectives with Kentucky and the nation.
- Objectives were added to clearly define goals. At least three objectives were defined per pillar, as required in the federal guidance.
- The Respond Pillar was expanded by adding new strategies. This will enable more entities across Kentucky to participate in response activities.
- A notable accomplishment from the EHE Strategic Plan was the addition of a new statewide PrEP Coordinator position. This position will provide leadership for statewide PrEP initiatives and strengthen the coordination of pathways and systems for PrEP delivery. Several new PrEP strategies were edited to encompass expanded efforts moving forward with the Integrated Plan and Pillar 3.
- Having successfully added several new LN positions across the state, new strategies were added to encompass expanded linkage navigation efforts.
- Under the Diagnose Pillar, activities were organized under a separate strategy around awareness. This will make the activities in this domain monitorable and aligned with NHAS. Two strategies were added: (1) ensuring health care professionals and front-line staff are educated and trained on stigma, discrimination,

and unrecognized bias toward priority populations and (2) increasing public awareness for HIV across the Commonwealth to reach all Kentuckians, including specifically targeted populations. Also, under the Diagnose Pillar, three strategies were added to improve targeted HIV testing efforts within CBOs.

- Under the Treat Pillar, the following were added: a statewide Let's Stop HIV Together campaign, clinical quality management education, and an action to explore the inclusion of hormone treatment in the KADAP formulary.
- Under the Prevent Pillar, several activities to expand PrEP access and participation were added.
- Under the Response Pillar, another accomplishment during the first years of the EHE Strategic Plan was the hiring of LN/DIS/Outbreak response staff positions. This success will improve response efforts across the state.
- Objectives, strategies, and actions were edited to ensure the Integrated Plan reflects all efforts planned over the course of implementation, across all entities. Partners were invited to ensure their actions and activities were included in the plan. This was done to ensure the plan reflects everyone's joint commitment to ending the HIV epidemic together. This plan is designed to reflect all efforts occurring across the Commonwealth. As noted, the Integrated Plan will continue to be a "living document" throughout the course of implementation. As new activities and programs arise, the plan will be updated to ensure that everyone's hard work is reflected.

### **Removed Items**

- To reflect more achievable outcomes, a pilot rapid-rapid testing algorithm in three selected EDs in high-risk populations in two years was removed. However, strategy 1.2.1 was enhanced to continue to improve opt-out testing in all acute care settings, including EDs. KIRP continues to fund and support the promotion of this strategy.
- Given certain funding and capacity restraints under outreach testing efforts, transportation access, i.e., vans/buses to get to testing sites, was removed. However, a new strategy 2.3.1 was created to reduce transportation barriers in other ways.
- Given certain procedural and legal barriers, an activity related to educating boards of health and executive judges on HIV was removed under increasing public awareness of getting PWH into care. However, strategy 2.2.2 continues to be robust in activities to increase public awareness of getting PWH into care.
- Anything that was already accomplished over the first two years of the EHE Strategic Plan implementation was removed from the new Integrated Plan. Accomplishments included the following: a new ELR Manager, a statewide PrEP Coordinator, and four LN/DIS/Outbreak response staff who were hired in the first years of implementation.

## SECTION VI: IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

### a. IMPLEMENTATION

Outlined below is the implementation plan for activities across the four pillars' goals, objectives, and strategies. This format follows the NHAS Implementation Plan released in August 2022. Activities are included from all funding sources, including HRSA, CDC, and HOPWA grants. This section encompasses the EHE Strategic Plan. Activities directly related to EHE funding are identified with an asterisk (\*) for EHE HRSA funding and a caret (^) for EHE CDC funding.

The tables that follow list specific actions by all participating partner entities and organizations across the Integrated Plan's goals, objectives, and strategies. The timeframe indicates the fiscal years in which the action begins and ends within the context of the Integrated Plan (2022–2026). Actions that started before fiscal year 2022 or extend beyond fiscal year 2025 only list the years within this timeframe. The actions are described as succinctly as possible. While many actions support more than one strategy, they are listed under that with which they most closely align.

KDPH and KHPAC will lead the coordination of statewide HIV partners and stakeholders in the implementation of the Integrated Plan. An evaluation team will be organized (with membership still to-be-determined) to ensure that all activities are monitored, and process is tracked, throughout the 2022-2026 implementation period. All HIV prevention and care entities have been invited to be a part of KHPAC. In this way, this is a shared responsibility in achieving the goals of the Integrated Plan.

### b. MONITORING

The implementation plan will assist in monitoring progress across the goals, objectives, and strategies proposed. Success in accomplishing the proposed activities/action steps will support the overarching goal of the Integrated Plan to reduce new HIV infections in Kentucky by 75% by 2025 and 90% by 2030. The plan will also serve as a process evaluation measurement tool over the implementation years 2022-2026 to track yearly progress.

The Integrated Plan evaluation team will monitor progress, using the charts contained in the implementation plan, on a quarterly basis. This team will compile quarterly progress reports to share at regular prevention and RWHAP meetings. A complete reporting and dissemination plan is described below.

## IMPLEMENTATION PLAN 2022-2026

### PILLAR #1: DIAGNOSE

GOAL 1: TO DIAGNOSE ALL PWH AS SOON AS POSSIBLE

Objective 1.1: Advance HIV-related communications to improve uptake of HIV testing (including knowledge of the status-neutral approach and strategies to reduce stigma and discrimination)

**Strategy 1.1.1: Ensure that health care professionals and front-line staff are educated and trained on stigma, discrimination, and unrecognized bias toward priority populations**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Increase health care professionals' awareness of KY AETC and KYTRAIN.org educational offerings	AETC	2022-2026
Connect providers to KY AETC educational events through community-based services and partnerships	KIRP	2022-2026
Ensure up-to-date HIV information is available from KDPH	KDPH	2022-2026
Provide education for providers and multi-disciplinary care teams on topics of cultural competency, counselling patients about sexuality and sexual behaviors, drug use, faith-based issues, how to address LGBTQ specific health needs, and how to address sex workers' health needs	AETC	2022-2026
Educate KY AETC intra-professional student cohort and fellows through scheduled didactics, shadowing, and Community of Practice trainings and at least one session of the annual conference will be dedicated to stigma reduction	AETC	2022-2026
Provide education for SSP/Harm Reduction Staff via the Bi-Monthly SSP Trainings	KDPH Harm Reduction Program	2022-2026

**Strategy 1.1.2: Increase public awareness for HIV across the Commonwealth to reach all Kentuckians, including specifically targeted populations**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Partner with community leaders and champions to discuss appropriate and sensitive outreach efforts ^*	KDPH, KHPAC, CBOs, RWHAP Partners	2022-2026
Approach prominent community influencers to explore innovative strategies to promote screenings ^*	KDPH, KHPAC, CBOs	2022-2026
Partner with local HIV CBOs and LHDs to increase HIV/AIDS basic education, dispel myths, and encourage testing ^*	KDPH, CBOs, LHDs	2022-2026
Coordinate HIV risk reduction workshops for priority population communities to help reduce concerns of stigma and disclosure ^	KDPH, CBOs	2023-2026



Increase HIV awareness for higher education institutions through social media outlets and testing events ^	KDPH, Higher Education Institutions	2022-2023
Explore providing funding to partners for awareness campaigns through dating apps and other social media ^	KDPH	2023-2026
Partner with LHDs, diverse CBOs, community health worker organizations, faith-based facilities, educational institutions, and various cultural groups to implement appropriate outreach, testing, and educational programming ^*	KDPH, CBOs, LHDs	2022-2026
Consult communities to help develop appropriate HIV testing messages for billboards, posters, fliers, bus wraps, public service announcements, and branded materials ^	KDPH, KHPAC, HIV Program Review Panel	2022-2026
Partner with national and regional community planning groups for community resources and expertise ^*	KDPH, AETC, CBOs	2022-2026
Increase awareness of free, HIV testing available at LHDs and CBOs ^*	KDPH, CBOs, LHDs	2022-2026
Provide routine HIV screening, testing, and education in partnership with collaborating agencies providing services to vulnerable populations that are at highest risk for HIV *	KIRP, AVOL	2022-2026

**Objective 1.2:** Increase HIV testing within clinical settings

**Strategy 1.2.1:** Initiate routine opt-out testing in acute care settings (i.e., EDs, urgent care)

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Partner with EDs through Innovative Pilot Program Initiatives to provide resources to implement opt-out testing initiatives	KIRP	2022-2026
Gather opt-out resources, including exploring development of an opt-out testing toolkit ^*	KDPH	2022-2026
Research number of existing EDs, urgent care, other acute care settings presently offering testing services and inquire about process and protocols ^	KDPH	2022-2026
Research statewide and national resource opportunities (funding, staffing) for EDs, urgent care, other acute care settings needing assistance to offer testing ^	KDPH	2022-2026
Develop and implement provider detailing on universal screening based on CDC screening recommendations for HIV ^*	KDPH, Shawnee Christian Health Center	2022-2026
Develop and implement statewide campaign targeting providers to increase HIV screening ^*	KDPH, AETC	2022-2026
Identify and/or develop outreach materials for distribution to health care facilities and providers to share with identified high risk populations ^*	KDPH, AETC	2022-2026
Develop protocols for referral process to HIV services in newly diagnosed and lost to care HIV+ persons ^*	KDPH	2022-2026

**Strategy 1.2.2: Increase HIV screening tests in routine medical encounters, including primary care, dental care visits, prenatal care, elective admissions, mental health visits, substance use disorder clinics, MAT clinics, university health services, FQHCs, and LHDs**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Pilot HIV testing and LN position within a FQHC to increase routine HIV testing and enhance linkage to care for PWH ^*	KDPH, Shawnee Christian Health Center	2022-2026
Develop and implement provider detailing on universal screening based on CDC screening recommendations for HIV ^*	KDPH	2022-2026
Identify and/or develop prevention and treatment outreach materials for distribution to health care facilities and providers regarding universal screening guidelines ^*	KDPH	2022-2026
Develop protocols for referral process to HIV Services in newly diagnosed and lost to care HIV+ persons ^*	KDPH	2022-2026
Recommend opt-out HIV testing as part of routine screening ^*	KDPH	2022-2026
Recommend health care providers to incorporate HIV testing with wellness testing, such as same day as flu shots, diabetes screening, blood pressure screening ^*	KDPH, KPCA, AETC	2022-2026
Provide access to HIV testing through partnerships with substance use disorder clinics, MAT clinics, university health services, and LHDs ^*	KDPH, KIRP, AVOL	2022-2026

**Objective 1.3: Improve targeted HIV testing efforts within CBOs**

**Strategy 1.3.1: Train and certify community-based HIV testers**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Offer scheduled training to CBOs and maintain contact information on how to schedule training ^*	KDPH	2022-2026
Annual review of tester training to ensure information is accurate and current, based off of CDC guidance ^*	KDPH	2022-2026
Maintain tester training information on KDPH HIV Prevention webpage ^*	KDPH	2022-2026
Provide HIV testing in non-clinical settings training for all newly hired EIS HECs and perform annual skills check of all staff to ensure testing procedures are in line with manufacturers guidelines and in accordance with the approved state training	KIRP	2022-2026

**Strategy 1.3.2: Host quarterly prevention meetings to highlight best practices**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
CBOs share testing activities scheduled	KDPH, CBOs	2022-2026
CBOs share barriers they have encountered	KDPH, CBOs	2022-2026
Open discussion of best practices ^	KDPH, CBOs	2022-2026

**Strategy 1.3.3: Advocate for legislative changes to allow for home HIV testing**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Local advocacy organizations and HIV CBOs will coordinate efforts to advocate for legislative change	Local Advocacy Groups	2022-2023

**Objective 1.4:** Increase targeted outreach testing efforts in populations at higher risk for HIV

**Strategy 1.4.1: Promote and increase testing in the criminal justice system**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Continue to increase awareness of new policy for RWHAP Services for local and county jails for PWH *	KDPH	2022-2026
Build on existing relationships between CBOs and local detention centers that are currently performing HIV and HCV testing ^*	KDPH, CBOs	2022-2026
Establish regular meetings with representatives from the Kentucky Jailers Association, Department of Corrections, Administrative Office of the Courts, and KDPH *	KDPH	2022-2026
Support and develop collaborations between LHDs, Target4 Project, RWHAP service centers, detention centers, probation officers, drug courts, and local/county jails for increased testing, access to treatment, and promotion of the LN support available *	KDPH, LHDs, KIRP, CBOs	2022-2026
Identify and explore HIV screening barriers in the criminal justice system, such as need for testers, education of criminal justice system staff ^*	KDPH	2022-2026
Provide HIV screening, testing, and education in collaboration with detention centers, probation and parole, drug courts, and local/county jails *	KIRP, CBOs	2022-2026

**Strategy 1.4.2: Promote and increase testing in SSPs**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Explore incentives to encourage HIV testing in SSPs ^	KDPH, KIRP	2022-2026
Build partnership between HIV Section and Harm Reduction Unit ^	KDPH	2022-2026
Provide HIV screening, testing, and education in partnership with LHDs/SSPs	KIRP	2022-2026
Annually monitor percentage of SSP participants tested for HIV, and strategize and facilitate methods to engage participants in routine testing	KIRP	2022-2026

**Strategy 1.4.3: Promote and increase outreach testing efforts in rural areas and hard-to-reach populations**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Partner with nontraditional sites to increase testing in homeless shelters, LGBTQ offices in colleges/universities, and other nontraditional sites ^	KDPH, KIRP	2022-2026
Increase participation in mobile units and satellite testing locations, including exploring drive-through/drive-up testing ^*	KDPH, CBOs	2022-2026
Explore best practices in incentive use for testing and update current policy as appropriate ^*	KDPH	2022-2026
Expand HIV outreach through targeted testing efforts of KIRP/Target 4 ^*	KDPH, KIRP	2022-2026

**Strategy 1.4.4: Promote and increase outreach testing efforts with Ryan White discordant partners**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Provide partner testing for persons who test positive through SSP and targeted outreach efforts *	KIRP, SSPs, CBOs	2022-2026
Provide partner testing for persons engaged in on-going medical care and supportive services through RWHAP funded programs *	RWHAP Funded Clinics, HOPWA Entities	2022-2026
Assess what current efforts are focused on this population and what, if any, materials are specifically designed to reach this target population *	KDPH	2022-2026
Create new information materials to share with PWH to share with their partners *	KDPH	2022-2026
Share newly created materials with prevention and care partners to distribute *	KDPH	2022-2026

**Strategy 1.4.5: Establish a Prevention Screening Services Program**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Maintain a DIS focused on follow up testing for persons at elevated risk for contracting HIV who have been identified as contacts during investigations and have initially tested negative for HIV ^	KDPH	2022-2026
Provide routine HIV screening, testing, and linkage to care for participants at SSPs to monitor HIV status and linkage to care needs	KIRP	2022-2026

**PILLAR #2: TREAT**

GOAL 2: TO TREAT PWH RAPIDLY AND EFFECTIVELY TO REACH SUSTAINED VIRAL SUPPRESSION

Objective 2.1: Increase the percentage of newly diagnosed PWH linked to care within 1 week of diagnosis

**Strategy 2.1.1: Increase capacity to provide linkage to care for newly diagnosed PWH**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Expand linkage navigation capacity by maintaining four LN/DIS/Outbreak response staff ^*	KDPH	2022-2026
Engage and increase collaboration across LNs, DIS, EIS HECs, social workers, and case managers to enhance linkage to care ^*	KDPH	2022-2026
Partner HIV testing efforts with RWHAP providers to provide seamless linkage to care *	KIRP, RWHAP Funded Clinics, HOPWA Entities	2002-2026
Monitor linkage to care for persons newly diagnosed with HIV through SSPs and targeted outreach testing efforts *	KIRP, CBOs	2022-2026

Objective 2.2: Re-engage PWH who are out of care

**Strategy 2.2.1: Increase linkage to care activities for targeted populations**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Continue to implement the DTC/D2C initiative to identify PWH who are not in care and link to re-engage them in care ^*	KDPH, RHWAP Funded Clinics, HOPWA Entities	2022-2026
Expand Linkage to care activities by LNs engaging directly with HIV care providers in their region to follow up on patients who miss appointments, are not getting HIV bloodwork completed in a consistent fashion, or other actions suggesting the patient has fallen out of care *	KDPH, RHWAP Funded Clinics	2022-2026
Increase awareness about RWHAP services *	KDPH, RHWAP Funded Clinics, KIRP, HOPWA Entities	2022-2026
Rural: Work with LHDs, health care delivery systems, pharmacies, and community partners to find and engage PWH into care *	KDPH, KIRP, RHWAP Funded Clinics, HOPWA Entities	2022-2026
Urban: Work with LHDs, health care delivery systems, pharmacies, and community partners serving identified targeted populations to find and engage clients, such as testing at events (such as LGBTQ Pride Festivals) and working at SSPs ^*	KDPH, KIRP, RHWAP Funded Clinics, CBOs	2022-2026
<p>PWH that live in rural areas and have issues accessing quality care and services, and fear of disclosure of status *</p> <ul style="list-style-type: none"> <li>a. Work with LHDs and local health care delivery systems to engage more health care providers in the area to provide HIV care including PrEP for discordant partners and treatment</li> <li>b. Increase community and provider awareness of existing services and support that are available, including Linkage Navigation, transportation, housing, and financial resources</li> </ul>	AETC, KDPH, LHDs, RHWAP Funded Clinics, HOPWA Entities	2022-2026
<p>PWID</p> <ul style="list-style-type: none"> <li>a. Increase collaboration with and across SSPs</li> <li>b. Explore “Swarming Syringe Services Programs” in the event of outbreaks and times of increased need for services</li> <li>c. Increase collaboration with substance use disorder treatment programs, such as methadone programs, continuing therapy programs, housing assistance programs, recovery community organizations, and behavioral health</li> <li>d. Explore and develop partnerships with law enforcement agencies</li> <li>e. Monitor percentage of SSP participants tested for HIV and address barriers to increase testing rates ^</li> </ul>	KDPH, KIRP, SSPs, CBOs	2022-2026

<p>Persons of color especially HIV+ women *</p> <ul style="list-style-type: none"> <li>a. Continue to expand partnerships with professional associations, faith-based communities, academic institutions, and other organizations</li> <li>b. Develop and expand partnerships with social justice and health equity associations</li> <li>c. Provide HIV screening, testing, and education through targeted outreach efforts ^</li> </ul>	KDPH, KIRP, RHWAP Funded Clinics, CBOs	2022-2026
<p>Transgender persons</p> <ul style="list-style-type: none"> <li>a. Develop partnerships with transgender communities, organizations, and academic institutions</li> <li>b. Increase collaboration with health centers that work with transgender persons to address stigma</li> <li>c. Provide HIV screening, testing, and education through targeted outreach efforts</li> <li>d. Explore including hormone treatment in KADAP formulary</li> <li>e. Revised KADAP application to be gender neutral ^</li> </ul>	AETC, KIRP, RHWAP Funded Clinics, CBOs	2022-2026
<p>Young gay men and MSM</p> <ul style="list-style-type: none"> <li>a. Continue and expand community conversations to target interventions for youth</li> <li>b. Develop social media outreach</li> <li>c. Expand partnerships with academic institutions, including fraternities</li> <li>d. Provide HIV screening, testing, and education through targeted outreach efforts ^</li> </ul>	KDPH, KIRP, RHWAP Funded Clinics, CBOs	2022-2026
<p>Kentuckians with undiagnosed HIV who are unaware of their status</p> <ul style="list-style-type: none"> <li>a. Awareness events in highly visible nontraditional settings, such as sporting events, festivals, academic informational events, and state and county fairs</li> <li>b. Implement screening tools to facilitate education and to ensure testing efforts are targeted and effective ^</li> </ul>	KDPH, KIRP, RHWAP Funded Clinics, CBOs	2022-2026
<p>Incarcerated persons *</p> <ul style="list-style-type: none"> <li>a. Collaborate with the criminal justice system to increase treatment for PWH through Ryan White Services</li> <li>b. Review linkage to care and case management process and increase efficiency and timeliness where able</li> <li>c. Ensure linkage navigation for pre-released, local and state prisons to keep PWH in the treatment system</li> <li>d. Provide HIV screening, testing, and education through collaborations with corrections institutions ^</li> </ul>	KDPH, KIRP, RHWAP Funded Clinics, CBOs	2022-2026

**Strategy 2.2.2: Increase public awareness focused on getting PWH living in Kentucky into care**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Working with local communities, health centers, LHDs, community health workers, and correctional systems ^*	KDPH, RHWAP Funded Clinics, CBOs	2022-2026
Statewide Let's Stop HIV Together campaign ^	KDPH, RHWAP Funded Clinics, CBOs	2022-2026

Working with organizations that work with at-risk populations ^*	KDPH, RHWAP Funded Clinics, CBOs	2022-2026
Working with SSPs ^	KDPH, RHWAP Funded Clinics, CBOs	2022-2026
Working with DTC/D2C program and Linkage Navigator Program to reach more PWH and get them into care ^*	KDPH, RHWAP Funded Clinics, CBOs	2022-2026
Community programming, such as summits and conferences on harm reduction, to include education on current updated HIV evidence-based messaging ^	KDPH, RHWAP Funded Clinics, CBOs	2022-2026
Provide HIV screening, testing, and education through collaborations with local communities, health centers, LHDs, community health workers, and correctional systems *	KIRP, RHWAP Funded Clinics, CBOs	2022-2026

**Objective 2.3:** Reduce barriers to retain PWH in care

**Strategy 2.3.1: Reduce transportation barriers**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Explore processes, policies, and strategies to address identified transportation barriers in communities *	KDPH, RHWAP Funded Clinics, HOPWA Entities	2022-2026
Enhance transportation options, especially in rural areas, such as incentives and mobile units ^*	KDPH, RHWAP Funded Clinics, HOPWA Entities	2022-2026
Community conversations to identify transportation barriers to receiving care and support services *	KHPAC, RHWAP Funded Clinics, HOPWA Entities	2022-2026
Provide assistance through RWHAP funding for PWH that face transportation barriers *	RWHAP Funded Clinics, HOPWA Entities	2022-2026
Investigate/pursue satellite clinics, as appropriate *	RWHAP Funded Clinics, HOPWA Entities	2022-2026

**Strategy 2.3.2: Reduce housing barriers**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Provide assistance through RWHAP funding for PWH that face housing instability *	RWHAP Funded Clinics	2022-2026

Outreach and re-engagement of persons out-of-care to reduce housing barriers *	HOPWA Funded Entities	2022-2026
Provide the following for stable housing assistance, based-on-need, to support on-going medical treatment compliance * a. Short-term housing assistance for PWH b. Long-term housing subsidies for PWH c. Supportive services d. Utility assistance e. Case management	HOPWA Funded Entities	2022-2026
Increase awareness of available support resources for PWH who are houseless or in unstable housing *	KDPH, HOPWA Funded Entities	2022-2026

**Strategy 2.3.3: Reduce stigma barriers**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Community conversations to identify stigma barriers to receiving care and support services *	KHPAC	2022-2026
Explore processes, policies, and strategies to address identified stigma barriers in communities *	KDPH	2022-2026
Provide programming to address and reduce HIV stigma *	KDPH, CBOs	2022-2026
Explore telemedicine options, rapid start, and ECHO (Extension for Community Healthcare Outcomes) model to address stigma and provider shortages ^*	KDPH, AETC (ECHO)	2022-2026
Increase access to mental health counselors to address life issues (e.g., anxiety, fear, stigma, medication side effects) *	CBOs, KHCCP, FindHelpNow.com	2022-2026
Expand access to HIV screening, testing, and education to normalize access to services and increase health literacy around risk and access to services *	KIRP, CBOs	2022-2026

**Objective 2.4:** Increase the capacity of the public health and health care workforce to effectively provide holistic care and treatment for PWH

**Strategy 2.4.1: Increase provider education on the treatment and quality of care for HIV, and of HCV and HBV co-infection(s)**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Expand outreach and educational services to community providers regarding clinical quality management	AETC	2022-2026
Partner with the Weitzman Institute at the Community Health Center, Inc. to facilitate ECHO model of education	AETC, KIRP	2022-2026
Increase health care professionals’ awareness of KY AETC educational offerings	AETC	2022-2026



Provide continuing education units (CEU) for topics of cultural competency, cultural humility, counselling patients about sexuality and sexual behaviors, drug use, faith-based issues, LGBTQ specific health needs, and how to address sex workers' needs	AETC	2022-2026
KY AETC to host didactic trainings and partner with multi-disciplinary endocarditis team (MDET) at UK to provide education around the needs of HIV patients that are co-infected with hepatitis	AETC	2022-2026

**PILLAR #3: PREVENT**

GOAL 3: TO PREVENT NEW HIV TRANSMISSIONS BY USING PROVEN INTERVENTIONS, INCLUDING PREP AND SSPS

Objective 3.1: Promote full access to, and the expansion of, PrEP

**Strategy 3.1.1: Expand PrEP resources at the state level, including systems to navigate PrEP access**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
KDPH PrEP Coordinator will coordinate PrEP initiatives across the Commonwealth ^	KDPH	2022-2023
Increase collaboration with HIV Prevention staff, KDPH Community Liaison Consultant, and the newly established PrEP Coordinators at the Universities of Kentucky and Louisville, and Matthew 25 ^	KDPH, KHPAC, AVOL, Network of PrEP Coordinators	2022-2026
KDPH PrEP Coordinator will establish and maintain PrEP policy ^	KDPH	2022-2026

**Strategy 3.1.2: Build a cohesive statewide network of PrEP coordinators to coordinate PrEP initiatives**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Newly established PrEP Coordinators at the Universities of Kentucky and Louisville, and Matthew 25 will identify barriers and opportunities to increase awareness and prescriptions among targeted populations ^	KDPH, KHPAC, AVOL, Network of PrEP Coordinators	2022-2026
Offer capacity building/technical assistance for new PrEP coordinators ^	KDPH	2022-2026

**Strategy 3.1.3: Increase the number of providers who are aware of, and trained to prescribe, PrEP**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Collaborate with LHDs to identify providers who are willing to learn about and provide PrEP; leverage experience of Christian County Health Department (HD) PrEP Clinic ^	AETC, KDPH, Christian County HD, KIRP	2022-2026

Integrate introduction to PrEP trainings into professional conferences throughout the state to identify potential providers for PrEP delivery ^	AETC, KDPH	2022-2026
Coordinate PrEP trainings for providers including clinicians, pharmacists, physician assistants, and nurses at locations such as medical associations, nursing associations, pharmacy associations, professional conferences, and physician assistant associations ^	AETC, KDPH, KPCA	2022-2026
Promote PrEP educational opportunities to medical, pharmacy, and nursing faculty, staff, and students ^	AETC, KDPH	2022-2026
Identify community providers that are interested in learning more about PrEP and offering this service through their medical practice and connect them to KY AETC resources	AETC, KIRP, AVOL	2022-2026
Partner with federal entities to provide capacity building assistance	AETC, KDPH	2023-2026
KY AETC provides monthly PrEP series, supports on-site trainings to three clinics who participate in the Practice Transformation project to build PrEP prescription comfort, and provide these clinics with support materials such as posters to increase awareness and participation for patients serviced	AETC	2022-2026

**Strategy 3.1.4: Increase awareness of, and participation in, PrEP services among priority populations**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Coordinate regional PrEP activities that would reach diverse communities such as LHDs, diverse CBOs, faith-based organizations, academic settings, and various social/civic cultural groups for community conversations about PrEP ^	KDPH, Network of PrEP Coordinators	2022-2026
With community input, as funding available, develop appropriate and culturally sensitive branded materials/incentives, billboards, posters, church fans, bus wraps, and educational materials at non-traditional sites (such as rest stops, pizza box stickers, adult entertainment, LGBTQ bars), ads to be shown before movies, advertise on social media apps, and posting on social media sites. ^	KDPH, HIV Program Review Panel	2022-2026
Partner with regional community planning groups, faith-based organizations, and CBOs for community resources, expertise, and increased reach ^	KDPH, KHPAC, CBOs	2022-2026
Partner with PrEP champions in communities for promotion ^	AETC, KDPH, CBOs, Network of PrEP Coordinators	2022-2026
Implement PrEP education in HIV testing settings	AETC, KDPH, KIRP, CBOs	2023-2026
Refer persons that test negative for HIV to network of PrEP providers throughout the state ^	KIRP, CBOs	2022-2026
Assess use of PrEP through data collection at SSPs and through targeted outreach	KIRP	2022-2026

Objective 3.2: Promote full access to, and the expansion of, substance use-related harm reduction

**Strategy 3.2.1: Partner with the recently established DPH Harm Reduction Program, under the Preparedness Branch in the Division of Public Health Protection and Safety, to support local communities in approval of and implementation of SSPs and expand available HIV prevention services at SSPs**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Provide documentation and in-person presentations to local governing bodies to support creation of new SSPs and adoption of best practices in new and existing SSPs	KDPH (HIV/AIDS Section and Harm Reduction Program)	2022-2026
Refine existing data sources of HIV prevention services available, such as Harm Reduction Program Best Practice Evaluation Tool and REDCap ^	KDPH (HIV/AIDS Section and Harm Reduction Program), KIRP	2022-2026
Promote HIV testing, linkage to care, PrEP, cultural competency, and harm reduction strategies in SSPs ^	KDPH (HIV/AIDS Section and Harm Reduction Program), KIRP	2022-2026
Increase use of and access to SSP services among PWID through targeted outreach efforts (such as participating in established PWID support groups through Louisville Metro Health Department and through KORE)	KDPH, LHDs	2022-2026
Encourage flexible hours for late evening/night/weekend hours to increase accessibility as allowable per local ordinance and utilize mobile vans or offsite buildings as available	KDPH, KIRP	2022-2026
Explore existing transportation access to get to SSPs	KDPH, LHDs, SSPs	2022-2026
Monitor percentage of participants tested for HIV and address barriers to testing	KIRP	2022-2026

**Strategy 3.2.2: Provide data on SSPs**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Expand network of LHDs participating in REDCap for SSP data entry	KDPH, LHDs, SSPs	2022-2026
Create Internal SSP Data Dashboard	KDPH, KIRP, LHDs, SSPs	2022-2026
Provide educational and statistical information as requested at local level to support the operation of SSPs	KDPH, KIRP, LHDs, SSPs	2022-2026

Objective 3.3: Increase prevention strategies in priority populations

**Strategy 3.3.1: Increase awareness of treatment as prevention (U=U)**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
With community input, as funding available, explore existing campaigns and/or develop appropriate and culturally sensitive incentives, billboards, posters, church fans, bus wraps, educational materials at nontraditional sites (such as rest stops, pizza box stickers, adult entertainment) that emphasize U=U ^	KDPH, KHPAC, HIV Program Review Panel	2022-2026
Provide U=U education to participants at SSPs and through targeted outreach activities	KIRP	2022-2026

**Strategy 3.3.2: Increase participation in support groups for those at risk for HIV, such as PWID**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Explore availability of online support groups ^	KDPH	2023-2026
Offer financial support/incentives to participants ^	KDPH	2023-2026

**Strategy 3.3.3: Increase youth awareness of HIV prevention**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Collaborate with schools for age-appropriate education and information	KDPH, KIRP	2022-2026
Participation in youth focused community events, such as tabling fairs, to increase youth awareness and engagement	KDPH, KIRP	2022-2026
Seek opportunities on the local level to engage with school nurses and family resource centers	CBOs	2022-2026
Provide HIV screening, testing, and education through partnerships with local colleges and universities	KIRP	2022-2026

**Strategy 3.3.4: Increase the availability of safe sex kits, including condoms**

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Increase network of sites that will display/offer safe sex kits in communities ^	KDPH, LHDs, CBOs	2022-2026
Explore the potential of including safe sex kits in naloxone/harm reduction kiosks (vending machines)	KDPH Harm Reduction	2022-2026

**PILLAR #4: RESPOND**

GOAL 4: TO RESPOND QUICKLY TO POTENTIAL HIV OUTBREAKS AND TREATMENT SERVICES TO PEOPLE WHO NEED THEM

**Objective 4.1:** Improve surveillance capacity for rapid detection of active HIV transmission clusters

**Strategy 4.1.1:** Improve HIV surveillance lab collection system to decrease delay in importing labs into eHARS, thereby boosting cluster detection and response activities with more timely data

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Build partnership with KHIE to allow for more complete and timelier laboratory reporting ^	KDPH	2022-2026
Complete onboarding of major commercial laboratories to report HIV viral sequences to KDPH ^	KDPH	2023
Continue enhanced surveillance, whereby the data reports for HIV diagnosis for each county of Kentucky are created and reviewed on a biweekly basis to monitor for time-space clusters ^	KDPH	2022-2026
Continue to regularly share data with regions of largest HIV burden in Kentucky, such as Louisville metro, Lexington, and Northern Kentucky ^	KDPH	2022-2026
Continue to share data with LHDs as needed, dependent on changes in data at the county level ^	KDPH	2022-2026
Further develop interstate partnerships to enhance data sharing and earlier detection of clusters ^	KDPH	2022-2026

**Objective 4.2:** Increase workforce capacity to respond to outbreaks in the field

**Strategy 4.2.1:** Hiring and maintaining positions in the KDPH HIV Section to provide appropriate services to address cluster demands

ACTION /ACTIVITY	ENTITY/ ORGANIZATION	TIMEFRAME
Maintain positions of LN/DIS/Outbreak response staff who will provide surge capacity to be deployed in cluster response ^	KDPH	2022-2026
Maintain an epidemiology position responsible for coordinating with National Electronic Disease Surveillance System (NEDSS), Office of Application Technology Services (OATS), and KHIE to ensure efficient and secure transfer of ELRs to HIV surveillance platform for investigation; promote timely and complete reporting of HIV electronic lab reporting (ELR) from providers; and develop and deliver report cards on lab reporting to identified facilities ^	KDPH	2022-2026
Explore training for regional epidemiologists and Target4 Project staff in HIV prevention and cluster response activities to increase capacity for HIV cluster response in every region of Kentucky ^	KDPH, KIRP	2023
Review and revise current Surveillance Standard Operating Procedures (SOP) to increase efficiency and completeness of reporting ^	KDPH	2022-2026
Staff participation in different national level learning collaboratives to enhance current response activities ^	KDPH	2022-2026

**Objective 4.3:** Increase community engagement and input in cluster detection and response

**Strategy 4.3.1:** Creating and maintaining surveillance products

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Create and maintain the annual report, trends data report, HIV continuum of care report, fact sheets, and other shared data ^	KDPH	2022-2026
Customize data requests from stakeholders	KDPH	2022-2026
Follow updated guidance from national partners to create up-to-date products	KDPH	2022-2026

**Strategy 4.3.2: Increase partnership activities to engage and maintain stakeholders in HIV cluster detection and response**

<b>ACTION /ACTIVITY</b>	<b>ENTITY/ ORGANIZATION</b>	<b>TIMEFRAME</b>
Continue to share data with LHDs as needed, dependent on changes in data at the county level ^*	KDPH	2022-2026
Maintain relationship with STD Section to encourage partner services staff to be vigilant of potential clusters in communities served ^*	KDPH	2022-2026
Continue to link response activities to current surveillance data and use to inform STD and Viral Hepatitis Sections, HIV Prevention, and linkage to care ^*	KDPH	2022-2026
Notify KDPH of differences in trends recognized in the field through SSPs and targeted outreach testing *	KIRP	2022-2026
Educate diagnosing providers how to report following 902 Kentucky Administrative Regulations (KAR) Disease Reporting Surveillance	KDPH	2022-2026
Report any presumed newly diagnosed case of HIV infection to KDPH, following 902 KAR Disease Reporting Surveillance	Testing Partners	2022-2026
Expand community outreach to include local stakeholders to enhance and incorporate community involvement in local cluster response activities ^	KDPH	2023
Educate community stakeholders on different aspects of cluster detection and response activities, such as quarterly HIV Prevention and Ryan White meetings, and other HIV conferences to reach stakeholders ^*	KDPH, Community Partners	2022-2026
Establish and build collaborative relationships with clinicians and other providers across Kentucky; educate on reporting HIV labs and cases to HIV Surveillance ^ *	KDPH, Community Partners	2022-2026
Promote adoption of rapid ART initiation with medical providers to enhance viral suppression and decrease forward transmission ^	KDPH	2024
Improve participation in HIV targeted testing and DIS investigations, provide resources to community partners for incentives such as gift cards, food, hygiene needs, and transportation ^*	KDPH, Community Partners	2022-2026
As available, KDPH will allocate funds to identified cluster areas to support community efforts in tailoring outreach activities and testing for specific populations through non-traditional means ^*	KDPH, Community Partners	2022-2026
Partner with existing facilities providing HIV care, services, and education to engage affected community members to participate in KHPAC *	KDPH	2022-2026

## c. EVALUATION

In addition to the quarterly monitoring and progress reports, the evaluation team will also compile a yearly evaluation report to be shared with stakeholder groups. This focus on process and impact evaluation will help paint a clear picture of yearly progress across the objectives and strategies, and impact on the broader goals of the plan. The evaluation plan will utilize data collected across five core indicators, described below. These have been chosen to align Kentucky's Integrated Plan evaluation strategy with national NHAS and EHE indicators. While showing impact across the Commonwealth, these indicators will also provide a comparison between other states and national data.

### Evaluation Questions

#### Process Evaluation

- 1) To what extent have prevention and care partners been engaged in the planning, implementation, and evaluation of the *Integrated Plan 2022-2026*?
- 2) To what extent have community members been engaged in the planning, implementation, and evaluation of the *Integrated Plan 2022-2026*?
- 3) To what extent have planning and advisory efforts within KHPAC increased over the course of 2022-2026?
- 4) To what extent have the Integrated Plan strategies and activities been implemented as planned over the course of 2022-2026?

#### Impact Evaluation

- 5) To what extent have the increased testing efforts impacted the percentage of Kentuckians who know their HIV status?
- 6) To what extent have linkage to care activities impacted the percentage of newly diagnosed PWH who are linked to care within one week of diagnosis? One month of diagnosis?
- 7) To what extent have linkage to care activities re-engaged PWH who have been out of care back into care?
- 8) To what extent have the efforts to remove barriers to care impacted the percentage of PWH who have been maintained in care? And who have achieved viral suppression?
- 9) To what extent has PrEP access and participation increased?
- 10) To what extent has SSP access and participation increased?
- 11) What impact have Pillar 4 response activities had on Kentucky's ability to respond to clusters and outbreaks rapidly and effectively?

### EHE Core Indicators

Data on the following EHE core indicators will be collected annually during the implementation of the Integrated Plan. The actions detailed in the implementation plan are ultimately intended to help move the Core Indicators of Progress in the right direction. Note: baseline has been determined by calculating an average for years, 2018, 2019, 2020, 2021.

- KY Indicator 1: Reduce new HIV infections by 75% from an estimated baseline of 453(#).
- KY Indicator 2: Reduce new HIV diagnosis by 75% from a baseline of 351(#).
- KY Indicator 3: Increase knowledge of status to 95% from an estimated baseline of 77%.
- KY Indicator 4: Increase linkage to care within one month of diagnosis to 95% from a baseline of 79%.

- **KY Indicator 5:** Increase viral suppression among people with diagnosed HIV to 75% from a baseline of 55%. \*
- \* *Adjusted for KY to 75% from federal goal of 95%.*

The federal government defines these six EHE indicators as the following:

- **HIV incidence:** Incidence is the estimated number of new HIV infections in a given year.
- **HIV diagnoses:** Diagnoses is the number of PWH diagnosed in a given year confirmed by laboratory or clinical evidence.
- **Knowledge of HIV status:** Knowledge of status is the estimated percentage of PWH who have received an HIV diagnosis.
- **Linkage to HIV medical care:** Linkage to HIV medical care is the percentage of PWH diagnosed in a given year who have received medical care for their HIV infection within one month of diagnosis.
- **Viral suppression:** Viral suppression is the percentage of people living with diagnosed HIV infection in a given year who have an amount of HIV that is less than 200 copies per milliliter of blood.
- **PrEP coverage:** PrEP coverage is the estimated percentage of individuals with indications for PrEP classified as having been prescribed PrEP. \*\*

*\*\*Kentucky is not currently collecting data on estimated PrEP coverage. Kentucky is current exploring potential indicators and data markers to track progress for Pillar 3 Prevent objectives. New aggregate data will be collected in 2023 under CDC PS20-2010 EHE Funding.*

**d. IMPROVEMENT**

As a “living document”, progress will be regularly reported to the statewide planning group and improvements will be discussed at least annually and as needed. Following the dissemination of a yearly evaluation report, findings and necessary changes will be discussed in collaboration with planning groups, prevention and care partners, and stakeholders. The evaluation team will be organized at the state level to support monitoring, evaluation, and improvement activities, such as collecting stakeholder feedback, revising goals and objectives as needed, evaluating planning and engagement activities, and evaluating progress related to the evaluation questions and core indicators.

**e. REPORTING AND DISSEMINATION**

As discussed in the above monitoring and evaluation sections, the following chart summarizes the reporting and dissemination plan.

**Table 21. Reporting and Dissemination Plan**

Reporting Materials and Structure	Stakeholders Involved	Timeline
<u>Quarterly Updates</u> - A presentation will be prepared to share a process evaluation summary on the implementation plan strategies and activities.	Prevention, care partners, and subrecipients  KHPAC, including community members and PWH	Follow the Quarterly meeting schedule for HIV Prevention and Ryan White partner meetings



<p><u>Annual Evaluation Report</u> - A formal written evaluation report will be compiled to evaluate process and impact evaluation questions, as well as progress following the core indicators.</p>	<p>Prevention, care partners, and subrecipients</p> <p>KHPAC, including community members and PWH</p> <p>KDPH stakeholders and partners</p> <p>CDC and HRSA project officers</p>	<p>Compile annually, utilize data from the annual KY Continuum of Care Report and KY Annual HIV Report</p>
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**f. UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS**

While the implementation plan format is newly created, many of the activities were included in the *2021-2026 EHE Strategic Plan*. Additional activities were added to ensure success in reaching all Integrated Plan goals and to account for efforts across all prevention and planning entities in Kentucky.

Throughout 2020-2022, efforts have been made to implement the *2021-2026 EHE Strategic Plan*. These efforts will now continue as the EHE Strategic Plan is integrated fully into the *2022-2026 Integrated Plan*. A challenge during the initial years of the EHE Strategic Plan has been the limited workforce capacity to implement and evaluate the plan. In order to overcome this limitation moving forward, stronger ties with community members and KHPAC have been established to coordinate local efforts. Additionally, this new Integrated Plan includes tailored efforts to monitor progress across core indicators and evaluate impact across specific evaluation questions. Lastly, the new Integrated Plan includes a reporting strategy to communicate evaluation findings regularly to all evaluation stakeholders. This will help ensure collective collaboration in staying focused on the vision to end HIV in Kentucky, and across the United States.

## SECTION VII: LETTERS OF CONCURRENCE

### HIV Statewide Planning Group and Kentucky Department for Public Health November 2022

Centers for Disease Control and Prevention (CDC)  
Atlanta, GA 30341-4146

Health Resources and Services Administration (HRSA)  
Rockville, MD 20857

Dear CDC and HRSA Officers,

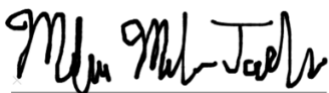
The Kentucky HIV Statewide Planning Group, also known as the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC), concurs with the following submission by the Kentucky Department for Public Health in response to the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need and the Ending the HIV Epidemic Strategic Plan, CY 2022-2026.

The Statewide Planning Group has reviewed the End HIV Kentucky Integrated Prevention and Care Plan (“Integrated Plan”) that is to be submitted to the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) and concurs that this statewide Integrated Plan demonstrates a collaborative and coordinated approach for HIV prevention, care, and treatment and ensures that services and resources are directed to the areas with the greatest HIV disease burden.

The Statewide Planning Group provided input into the development of the Integrated Plan. This process involved receiving feedback from KHPAC members, representing organizations and regions from across the state. These representatives reflected an effort to ensure that the voices of the local communities and key stakeholders were heard. There are currently 18 KHPAC voting members from across all regions of Kentucky.

The format of both the meetings and the Integrated Plan have followed the recommended four pillars of the national EHE initiative to diagnose, treat, prevent, and respond to HIV in Kentucky. Suggestions and feedback for each pillar were collected and considered for the final Integrated Plan. The Integrated Plan also supports the achievement of the National HIV/AIDS Strategy (NHAS) goals and advances the strategies set out in the NHAS.

Sincerely,



Melvin “Miles” Jackson



John Martin

Co-Chairs  
Kentucky HIV/AIDS Planning and Advisory Council

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## Appendices Attached:

- A. Acronyms and Definitions of Terms Used Throughout Document
- B. End HIV Kentucky Statewide Needs Assessment Survey Questions, 2022
- C. End HIV Kentucky Statewide Needs Assessment Data Report, 2022

## Additional Appendices Available via Hyperlink:

*D. National HIV/AIDS Strategy 2022-2025*

<https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf>

*E. National HIV/AIDS Strategy Federal Implementation Plan 2022-2025*

[https://files.hiv.gov/s3fs-public/2022-09/NHAS\\_Federal\\_Implementation\\_Plan.pdf](https://files.hiv.gov/s3fs-public/2022-09/NHAS_Federal_Implementation_Plan.pdf)

F. Ending the HIV Epidemic, America's HIV Epidemic Analysis Dashboard (AHEAD)

<https://ahead.hiv.gov/about-ehe>

G. Integrated Prevention and Care Plan Guidance, CDC/HRSA, 2022

<https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-Integrated-HIV-Prevention-Guidance.pdf>

*H. Kentucky HIV/AIDS Surveillance Report, 2022*

<https://www.chfs.ky.gov/agencies/dph/dehp/hab/Documents/AnnualReport2022.pdf>

*I. Kentucky Ending the HIV Epidemic Strategic Plan, 2021-2026*

<https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/EHEStrategicPlanKY.pdf>

## Additional Appendices Available by Request from KDPH:

*J. Kentucky Cluster and Outbreak Detection and Response Plan, 2022*

*K. EHE Summary of Community Engagement and Needs Assessment Report, 2020*

## Appendix A: Acronyms and Definitions of Terms Used Throughout Document

<b>ACRONYM</b>	<b>MEANING</b>
ADD	Area Development District
AIDS	Acquired immunodeficiency syndrome
AETC	AIDS Education Training Center
ASO	AIDS Service Organization
ART	Antiretroviral therapy
BPHC	Bureau of Primary Health Care (HRSA)
CBO	Community-based organization
CBDDP	Community-based dental partnership program
CDC	Centers for Disease Control and Prevention (HHS)
CDR	Cluster detection and response
COPHI	Cases of Public Health Importance
DBA	Doing business as
DIS	Disease Investigation Specialist
DTC or D2C	Data to Care
DRP	Dental Reimbursement Program
ED	Emergency Department
EFA	Emergency Financial Assistance
FHC	Female heterosexual contact
EHE	Ending the HIV Epidemic in the US
EIS	Early Intervention Services
EMA	Eligible Metropolitan Areas
FDA	US Food and Drug Administration
FQHC	Federally Qualified Health Center
HAB	HIV/AIDS Bureau (HRSA)
HHS	US Department of Health and Human Services
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration (HHS)
HOPWA	Housing Opportunities for Persons With AIDS
HRP	Harm reduction programs

HUD	Housing and Urban Development
IDU	Injection drug use
KADAP	Kentucky AIDS Drug Assistance Program
KHCCP	Kentucky HIV/AIDS Care Coordinator Program
KHICP	Kentucky Health Insurance Continuation Program
KDPH	Kentucky Department for Public Health
KHPAC	Kentucky HIV/AIDS Planning and Advisory Council
KPCA	Kentucky Primary Care Association
KIRP	Kentucky (KADAP) Income Reinvestment Program
KORE	Kentucky Opioid Response Effort
KY	Kentucky
LGBTQ	Lesbian, gay, bisexual, transgender, and queer (or questioning)
LHD	Local health department
LN	Linkage navigator
MMSC	Male-to-male sexual contact
MSA	Metropolitan Statistical Area
MSM	Men who have sex with men
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
NIR	No identified risk
PEP	Post-exposure prophylaxis
PFLAG	Parents and Friends of the LGBTQ community
PII	Personally identifiable information
PrEP	Pre-exposure prophylaxis
PWH	Persons with HIV
PWID	Person who injects drugs
RWHAP	Ryan White HIV/AIDS Program (HRSA)
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SCSN	Statewide Coordinated Statement of Need
SOR	State Opioid Response
SPNS	Special Projects of National Significance
SSP	Syringe Services Program
STI	Sexually transmitted infection
TasP	Treatment as prevention

TGA	Transitional Grant Areas
UK	University of Kentucky
UofL	University of Louisville
ULSC KCCP	University of Louisville School of Dentistry Kentucky Care Coordination Program
US	United States
U=U	Undetectable = Untransmittable
VOA	Volunteers of America
WICY	Women, Infants, Children, and Youth

TERM	DEFINITION
Current Age	An individual's age or age group as of December 31, 2021.
Age at Diagnosis	An individual's age or age group at the time of initial HIV disease diagnosis. Adults and adolescents: An individual aged 13 years and older.
Pediatric	An individual aged less than 13 years.
AIDS	Advanced stage of HIV infection characterized by severe immune deficiency and diagnosed by the presence of at least one of 26 opportunistic illnesses or a CD4 T-lymphocyte count of less than 200 cells/ml of blood. The CD4 T-lymphocyte count takes precedence over the CD4 T-lymphocyte percentage, and a percentage of less than 14% is considered only if the count is missing.
Concurrent Diagnosis	Concurrent diagnosis: Both HIV and AIDS are diagnosed within a 30-day period. Date of diagnosis: The date of an individual's initial HIV disease diagnosis.
HIV	A retrovirus that infects the helper T cells of the immune system resulting in immunodeficiency. HIV is diagnosed by a positive confirmatory antibody test or positive/detectable viral detection test.
HIV Disease	Persons with a diagnosis of HIV infection regardless of stage of disease. This includes persons with HIV (non-AIDS), as well as those who have advanced stages of the disease (AIDS).
Race and Ethnicity	Ethnicity categories include Hispanic and not Hispanic. Data for all not Hispanic persons are displayed in combination with their racial groupings, which include: <ul style="list-style-type: none"> <li>• White</li> <li>• Black or African American</li> <li>• Asian</li> <li>• Native Hawaiian or other Pacific Islander</li> <li>• American Indian or Alaska Native</li> </ul>
Sex	Sex designations in this report are based on a person's sex assignment at birth. In May 2012, CDC issued guidance to state and local programs on methods for collecting data on transgender persons and working with transgender-specific data. However, characterization of HIV infection among transgender persons in Kentucky would



	require supplemental data from special studies.
Transmission Category (Classification used to summarize the behavior or event most likely responsible for disease transmission. Each case is only included in a single transmission route.)	<ul style="list-style-type: none"> <li>• Male-to-male sexual contact (MMSC): Men who report having sexual contact with other men.</li> <li>• Injection drug use (IDU): Individuals who report injecting nonprescription drugs.</li> <li>• MMSC/IDU: Men who report having sex with other men and also inject nonprescription drugs.</li> <li>• Heterosexual contact: A person reporting specific heterosexual contact with a person known to have, or to be at high risk for HIV infection, such as an injection drug user, a bisexual male (females only), or a person with hemophilia/coagulation disorder.</li> <li>• Female heterosexual contact (FHC): A female who does not fit in the heterosexual contact category above, with no reported injection drug use, but reported sexual contact with a male and no additional information about the male's HIV status or behaviors.</li> </ul>
Hemophilia	Individuals receiving clotting factor for hemophilia/coagulation disorder.
Perinatal	Individuals born to a mother with HIV or a mother with an exposure history listed in the transmission category hierarchy.
Blood Transfusion/Organ Transplant	Individuals who received blood transfusions or organ transplants. Individuals with a transfusion date listed after March 1985 are considered Cases of Public Health Importance (COPHI) and are followed to verify the mode of transmission.
Undetermined/No Identified Risk (NIR)	Individuals reporting no exposure history to HIV through any of the modes listed in the transmission category hierarchy above.

**Note:** The terminology used in this report is in a format consistent with CDC's technical guidelines for HIV surveillance grantees in the United States, and also consistent with the National HIV Surveillance Report, available online at: <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>.

**Appendix B:**  
***End HIV Kentucky Statewide Needs Assessment Survey***  
**Questions, 2022**

**What is the End HIV Kentucky Statewide Needs Assessment Survey?**

The End HIV Kentucky Statewide Needs Assessment is a survey conducted for the Kentucky Department for Public Health (KDPH). It is an opportunity for individuals to share their thoughts about HIV-related prevention, services, and treatment in Kentucky. Everyone is welcome to take this survey- regardless of HIV status.

**THIS SURVEY IS ANONYMOUS. Your name and identity will NOT BE COLLECTED.**

The questions take approximately 5-10 minutes to answer. Your responses will help us towards our goal to End HIV in Kentucky.

**Thank you for your participation!**

DEMOGRAPHICS- PLEASE TELL US ABOUT YOURSELF

- 1.) In what county do you live? (Drop down menu)  
(Also include "N/A; I do not live in Kentucky. Please indicate in what state you live\_\_\_\_\_")
  
- 2.) Which best describes your race?
  - a. American Indian/Alaska Native
  - b. Asian
  - c. Black/African American
  - d. Native Hawaiian/Other Pacific Islander
  - e. White / Caucasian
  - f. More than one race
  - g. I prefer not to respond
  
- 3.) Are you of Hispanic or Latino origin?
  - a. Yes
  - b. No
  - c. I prefer not to respond
  
- 4.) In which age group are you?
  - a. Under 18 years
  - b. 19-30
  - c. 31-40
  - d. 41-50
  - e. 51 or older
  - f. I prefer not to respond
  
- 5.) Which best describes your identified gender?
  - a. Female
  - b. Male
  - c. Transgender
  - d. Genderqueer/gender nonconforming
  - e. Other; please specify \_\_\_\_\_

f. I prefer not to respond

6.) Which best describes how you think of yourself?

- a. Straight or heterosexual
- b. Lesbian or gay
- c. Bisexual
- d. Queer, pansexual, and/or questioning
- e. Something else; please specify \_\_\_\_\_
- f. Don't know
- g. I prefer not to respond

**HIV STATUS**

7.) Are you a person living with HIV?

- a. Yes
- b. No
- c. Unsure

**Needs Assessment Version #1-**  
**For people with HIV (PWH)**

Based on your response to Question 7 above, the following questions will be about your experiences and opinions as someone **WHO HAS TESTED POSITIVE** for HIV. Your responses are completely ANONYMOUS and will NOT be linked to your identity.

8.) When you first found out about your positive HIV status, did you know how to get into Ryan White care?

- a. Yes
- b. No
- c. Unsure

9.) Has your doctor told you that your HIV viral load is “undetectable”?

- a. Yes
- b. No
- c. Unsure
- d. N/A; I told my doctor I don't want to know my HIV viral load

**ACCESSING TREATMENT AND MEDICATION**

10.) To what extent do you agree or disagree with the following statements about your **Infectious Disease (ID) or HIV DOCTOR** who you see most often for HIV treatment?

Statement about your <b><u>ID/HIV DOCTOR:</u></b>	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to respond
A. It is easy to schedule an appointment with my ID/HIV doctor.					
B. My ID/HIV doctor explains my treatment in a way I can easily understand.					
C. My ID/HIV doctor treats me with respect.					

D. I feel comfortable discussing my sexual health with my ID/HIV doctor.					
E. I feel comfortable asking my ID/HIV doctor any questions I have.					

11.) To what extent do you agree or disagree with the following statements about your **HIV MEDICATION AND LABWORK?**

Statement about your <b>HIV MEDICATION AND LABWORK:</b>	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to respond
A. I take my HIV medication regularly as prescribed.					
B. I know how to get my prescriptions refilled.					
C. I remember to get my lab work (bloodwork) done when the doctor tells me to.					

12.) Does your ID/HIV doctor offer telehealth (virtual or online) appointments?

- a. Yes
- b. No
- c. Unsure

**ACCESSING SERVICES AND SUPPORT**

13.) To what extent do you agree or disagree with the following statements about your **HIV CASE MANAGER?**

Statements about your <b>HIV CASE MANAGER:</b>	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to respond
A. It is easy to schedule an appointment with my HIV Case Manager when needed.					
B. My HIV Case Manager helps me understand and access the services that are available to support me.					
C. My HIV Case Manager treats me with respect.					
D. I feel comfortable discussing my needs with my HIV Case Manager					

14.) Is your income enough to cover your essential monthly expenses (Including housing, medication, food, etc.)?

- a. Yes, I am able to cover ALL of my essential expenses each month
- b. Mostly, I am able to cover MOST of my expenses each month
- c. No, I am n able to cover my essential expenses each month
- d. I don't know

- 15.) Which of the following best describes your transportation to get to your HIV appointments and pick-up your medication?
- I have my own car
  - I borrow someone else's car, or they drive me
  - I use a bus
  - I call a taxi or Uber
  - I walk or use a bike
  - I do NOT have reliable access to transportation

16.) To what extent do you agree or disagree with the following statements about **YOUR ACCESS TO SUPPORT SERVICES?**

Statements about <b><u>YOUR ACCESS TO SUPPORT SERVICES:</u></b>	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to respond
A. I have somewhere safe to sleep every night.					
B. I have access to visit a dentist when I need to.					
C. I have access to see a therapist if needed.					
D. I have access to services to address addiction if needed.					

**PREVENTING TRANSMISSION TO OTHERS**

- 17.) Which of the following prevention methods can help reduce the risk of a person with HIV transmitting it to another person?
- By taking their HIV medications correctly, a person with HIV greatly reduces risk of transmission of HIV to their sexual or needle sharing partners
  - By using a syringe services program to exchange used needles for clean ones and not sharing needles
  - By using condoms the right way every time they have sex
  - By the person without HIV taking a medication called PrEP to prevent transmission
  - All of these are correct

- 18.) How confident are you in your ability to talk about your HIV status with new sexual or needle sharing partners?
- Very confident
  - Confident
  - Somewhat confident
  - Not confident at all

**ADDITIONAL QUESTIONS**

- 19.) Did the questions on this survey make sense to you?
- Yes
  - No

20.) What would keep you from getting an HIV test regularly? (open-ended)

Needs Assessment Version #2-  
For the general population, including high-risk priority groups

Based on your response to the previous question, the following questions will be about your experiences and opinions related to prevention of HIV. Your responses are completely anonymous and will not be linked to your identity.

GENERAL HIV KNOWLEDGE

- 7.) Which of the following is NOT a way someone can get HIV?
- a. From having unprotected vaginal sex with someone who has HIV
  - b. From sharing a toilet with someone who has HIV
  - c. From sharing needles with someone who has HIV
  - d. From having unprotected anal sex with someone who has HIV
- 8.) Which of the following can help reduce your risk of getting HIV?
- a. By using condoms the right way every time you have sex
  - b. By not sharing needles
  - c. By taking a medication called PrEP to prevent transmission
  - d. All of these are correct

HIV TESTING

- 9.) Do you know where to go for an HIV test when you need one?
- a. Yes
  - b. No

10.) To what extent do you agree or disagree with the following statements about HIV TESTING?

Statements about <u>HIV TESTING:</u>	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to respond
A. I feel comfortable going to the local health department for an HIV test.					
B. I feel comfortable requesting an HIV test from my doctor.					
C. I feel comfortable getting an HIV test from a mobile testing van.					
D. I have transportation to go get an HIV test when I need one.					
E. Stigma around HIV, and what other people may think, stops me from getting an HIV test.					
F. Lack of health insurance keeps me from getting an HIV test.					
G. I do NOT want to know my HIV status.					
H. I don't need an HIV test because I have no risk of getting HIV.					

## HIV PREVENTION

- 11.) Do you know that there is a **medication, called PrEP**, that a person who is at risk for HIV can take to prevent getting HIV from condom-less sex, or sharing needles and/or works?
- Yes, I know about PrEP
  - No, I didn't know about PrEP until reading this
- 12.) Do you know that there is also another **medication, called PEP**, which can be used in emergency cases for people who have possibly been exposed to HIV? People must start taking this pill within 72 hours of exposure.
- Yes, I know about PEP
  - No, I didn't know about PEP until reading this
- 13.) Do you know that Kentucky has many **Syringe Services Programs (SSPs)**, also known as needle exchange programs, which provide clean needles in exchange of used needles, in order to reduce the spread of HIV?
- Yes, I know about SSPs
  - No, I didn't know about SSPs until reading this
- 14.) Do you know about the prevention method called "**treatment as prevention**"?
- Treatment as Prevention is a highly effective prevention method in which people with HIV take HIV medication daily as prescribed to get and keep an undetectable viral load. As a result, they have effectively no risk of sexually transmitting HIV to their HIV-negative partners. This is often referred to as U=U or "undetectable = untransmittable."
- Yes, I know about this prevention method
  - No, I didn't know about this prevention method until reading this
- 15.) Did you know that using **condoms** the right way every time you have sex can help prevent HIV?
- Yes, I know condoms can prevent HIV
  - No, I didn't know condoms can prevent HIV
- 16.) Did you know there is a free program called **Ryan White** that helps people with HIV get the medication and services they need to prevent transmitting HIV to others?
- Yes, I know about the Ryan White program
  - No, I didn't know about Ryan White before reading this.
- 17.) How confident are you in your ability to discuss HIV status and testing with new sexual partners?
- Very confident
  - Confident
  - Somewhat confident
  - Not confident at all

## ADDITIONAL QUESTIONS

- 18.) Did the questions on this survey make sense to you?
- Yes
  - No
- 19.) What would keep you from getting an HIV test regularly? (open-ended)

## Appendix C: *End HIV Kentucky Statewide Needs Assessment Survey* Data Report, 2022

### **Summary**

The *2022 Kentucky Statewide Needs Assessment Survey* was conducted as part of the statewide integrated planning to provide consumer driven data regarding needs, use, barriers, and gaps in HIV prevention and treatment within the state of Kentucky. The assessment was informed by, and supplements, the findings from the *2020 Ending the Epidemic Needs Assessment Survey*. The assessment was designed to gauge the knowledge and experiences of Kentuckians both with and without HIV. Developed in partnership with the Kentucky Department for Public Health (KDPH) and the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) the assessment details findings in the following six areas: **(1) Knowledge of HIV Prevention, (2) HIV Testing and Prevention Services, (3) Perceptions of HIV Prevention Services, (4) Knowledge of HIV Treatment Services, (5) Perceptions of HIV Treatment Services, and (6) Barriers to HIV Care and Treatment.**

### **Survey Limitations**

This was the first attempt to develop and distribute a needs assessment through KHPAC. The survey was largely distributed electronically through social media, and in the waiting rooms of KHPAC members and affiliates. These limitations likely had an impact on the representation of both people with HIV and higher risk people without HIV who are harder to reach, including those experiencing homelessness, transgender youth, and undocumented individuals.

Furthermore, the following limitations should be considered when interpreting the results from the needs assessment survey.

**Sampling Method:** Survey data were based on a convenience sample, and therefore may not accurately reflect the general population of Kentuckians. A “**convenience sample**” is a group of people under study who have been assembled based on the ease of interviewing them or on accessibility to their records, etc. While this type of sampling can help produce good information about a topic, its major disadvantage is that there is no way of knowing if the group is representative of the population as a whole. Although methods were used to encourage a random sample (fliers posted throughout the community, Facebook/Instagram posts, etc.), the respondents were generally referred to the survey through a convenience sampling method.

**Literacy:** There may have been differences in understanding survey items based on the literacy levels of respondents.



## **Section I - Demographics**

The statewide needs assessment was completed by 329 respondents of which 59 (19.80%) indicated they were living with HIV, and 238 (79.87%) indicated they were living without HIV, with one person indicating there were unsure of their HIV status.

Respondents were distributed across the state of Kentucky, counties with most representation came from large metro areas including Fayette (15.74%), Jefferson (8.85%), McCracken (5.90%), Henderson (5.90%), and Franklin (4.26%) County.

### **Race and Ethnicity**

By race and ethnicity total respondents largely reflected the population of Kentucky with 85% reported as white/Caucasian, 8.75% black/African American, and 5.3% indicating Hispanic/Latina(o) origin. When examined across HIV status the distribution by race remains relatively the same among those that indicated not living with HIV, but there was a notable increase in representation of black/African Americans in the proportion of respondents that reported living with HIV. In total there was one respondent (.34%) who reported being American Indian/Alaskan Native, two respondents (.67%) who reported being Asian, five respondents (1.68%) who reported being of more than one race, and nine respondents (3.03%) who preferred not to respond to the race question.

When analyzed across ethnicity the proportion of respondents with HIV who indicated being Hispanic/Latina(o) was notably greater than the proportion of respondents without HIV who reported being Hispanic/Latina(o) (16.95% compared to 2.10%).

### **Age**

With HIV 45.76% of respondents were 51 years of age or older, 15.25% of respondents were 41-50 years old, 18.64% of respondents were 31-40 years old, 13.56% of respondents were 19-30 years old, and 6.78% were 18 years of age or younger. Without HIV 28.15% of respondents were 51 years of age or older, 31.09% of respondents were 41-50 years old, 23.11% of respondents were 31-40 years old, 14.29% of respondents were 19-30 years old, and 2.94% were 18 years of age or younger.

### **Gender**

By gender there was a notable asymmetry between distribution of respondents. Respondents living with HIV were majority male (66.10%), while respondents without HIV were overwhelming female (84.03%). There were five respondents (8.47%) that identified as transgender in the populations of those with HIV, and one that indicated that they preferred not to answer. Among the population without HIV there were two that indicated they were genderqueer/nonconforming, one that selected other, and five who indicated they preferred not to answer.

## Sexual Orientation

Across sexual orientation by HIV status, among those with HIV 57.63% indicated they were lesbian or gay, 27.12% indicate they were heterosexual, and 8.47% were bisexual. Among those who reported not having HIV, 84% were heterosexual and 8.4% were lesbian or gay.

## Priority Populations

The National HIV/AIDS Strategy emphasizes communities of color, those aging with HIV, adolescent girls and young women, and those in the LGBTQ community. Among other objectives, it aims to address the needs of “priority populations” or those who have been disproportionately affected by HIV. This includes gay and bisexual men of all races, transgender individuals, and African Americans. Additionally, according to the Centers for Disease Control and Prevention (CDC), in 2018, over half (51%) of people in the United States and dependent areas with diagnosed HIV were aged 50 and older. In addition, people aged 50 and older accounted for 17% of the 37,968 new HIV diagnoses in 2018 in the United States and dependent areas.<sup>1</sup> Though new HIV diagnoses are declining among people aged 50 and older, around one in six HIV diagnoses in 2018 were in this group. The following section provides an overview of finds relevant to these groups.

## Gay and Bisexual Men

In total, 19.6% of needs assessment respondents (n=47) self-identified as men who are either gay or bisexual. Thirty-nine respondents reported being male, gay/bisexual, and with HIV. There were 33 white men (84.62%), five black men (12.82%), and one mixed race man (2.56%) in the pool of respondents that were gay/bisexual and with HIV. By ethnicity, 89.74% of gay/bisexual men with HIV were non-Hispanic and 10.25% were Hispanic/Latino gay/bisexual men. By age, there was a notable difference in the distribution of gay/bisexual participants by HIV status, with majority 56.41% of gay/bisexual respondents with HIV being 51 year of age or older, while in the group of gay/bisexual men without HIV the majority (31.03%) indicated that they were between 41-50 years old, and 20.69% indicated they were 19-30 years old.

The following findings relate to gay/bisexual men without HIV:

- 100% answered correctly to questions regarding HIV prevention knowledge
- 32% strongly agreed or agreed that stigma surrounding HIV was a barrier to them getting tested
- 100% reported knowledge of pre-exposure prophylaxis (PrEP)
- 83% reported knowledge of post-exposure prophylaxis (PEP)
- 91% reported knowledge of Treatment as Prevention
- 83% reported being very confident in discussing their HIV status

The following findings relate to gay/bisexual men with HIV:

- 97% had been told by a provider that they were undetectable

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<sup>1</sup> Centers for Disease Control and Prevention. (2022, 09 29). CDC. Retrieved from HIV in the United States by Age: <https://www.cdc.gov/hiv/group/age/index.html>

- 8.6% reported that it was difficult to schedule an appointment
- 5.7% reported feeling uncomfortable discussing their sexual health or asking questions
- 34% reported feeling uncomfortable discussion their HIV status with a potential sex partner

### **Black/African Americans**

In total there were 26 black/African Americans who responded to the needs Assessment (7.9%). Seventeen were without HIV and nine were with HIV. By gender there were twenty females, five males, and one transgender woman.

The following findings relate to black/African Americans without HIV:

- 100% answered correctly to questions regarding HIV prevention knowledge
- 20% strongly agreed or agreed that stigma surrounding HIV was a barrier to them getting tested
- 85% reported knowledge of PrEP and PEP
- 92% reported knowledge of syringe services programs (SSP)
- 85% reported knowledge of Treatment as Prevention
- 100% reported being very confident or confident in discussing their HIV status

The following findings relate to black/African Americans with HIV:

- 89% had been told by a provider that they were undetectable
- 100% strongly agreed or agreed that their ID/HIV doctor treats them with respect; and that they feel comfortable discussing their sexual health and any questions they may have with their ID/HIV doctor.
- 22% reported not being able to cover essential expenses
- 11% reported feeling uncomfortable discussing their HIV status with a potential sex partner

### **Population Over the Age of 51**

Just under half (45.7%) of respondents (n=27) with HIV were over the age of 51. This group was 81.48% male and 18.52% female. The majority were white/Caucasian (81.48%), followed by 14.81% black/African American, and one respondent in this age group with HIV identifying being of more than one race.

The following findings relate to people over the age of 51 without HIV:

- 100% answered correctly to questions regarding HIV prevention knowledge
- 95% reported knowing where to get an HIV test
- 20% reported not feeling comfortable getting an HIV test at a health department, doctors office, or mobile testing van
- 20% reported that stigma around HIV stops them from getting tested
- 88% reported knowledge of PrEP
- 72% reported knowledge of PEP
- 96% reported knowledge of SSPs

- 81% reported knowledge of Treatment as Prevention
- 80% reported being very confident or confident in discussing their HIV status with a potential sex partner

The following findings relate to people over the age of 51 with HIV:

- 100% had been told by a provider that they were undetectable
- 100% strongly agreed or agreed that their ID/HIV doctor treats them with respect; and that they feel comfortable discussing their sexual health and any questions they may have with their ID/HIV doctor.
- 18.5% reported not being able to cover essential expenses
- 14% reported feeling uncomfortable discussing their HIV status with a potential sex partner

### **Transgender Population**

The population of people that identify as transgender or gender non-conforming were underrepresented in the needs assessment. In total there were five individuals who identified as transgender men, and all reported that they were living with HIV. Two were between 19-30 years old and the other three were between 31-40 years old. Four were white/Caucasian and one was black/African American. Four had been told at one point that they were HIV undetectable. Eighty percent (80%) strongly agreed or agreed that their ID/HIV doctor treats them with respect; and that they feel comfortable discussing their sexual health and any questions they may have with their ID/HIV doctor. Three out of the five reported not being able to afford monthly expenses.

### **Section II - Prevention**

For the purpose of integrated planning, developers sought to understand the knowledge of Kentuckians without HIV, in regard to their thinking of their risks of acquiring HIV, the steps that can be taken to stop HIV transmission, and their knowledge of where to get testing to learn their HIV status. Furthermore, respondents were asked about their general awareness regarding pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Three questions were asked of respondents to gauge their HIV knowledge. In the response to all three questions, respondents overwhelmingly demonstrated their accurate understanding of the risks, steps that can be taken to stop the spread of HIV, and where they can go to learn their status. Responses to the two questions that were asked to assess respondent's knowledge regarding PrEP and PEP indicated widespread knowledge of these preventive medications.

### **Knowledge of HIV Testing and Prevention Services**

Respondents were also asked to describe their level of comfort in getting an HIV test at various venues and about the barriers that exist to receive an HIV test. More than 75% of respondents indicated that they strongly agreed or agreed with the statement, "I feel comfortable going for an HIV test at a local health department (81%), doctors office (82%), or mobile testing van (78%)".

### **Perceptions of HIV Prevention Services**

Respondents were asked about their beliefs and attitudes towards HIV. First, participants were asked about whether they believed that had any risk to contracting HIV, and next they were asked about their level of confidence in their ability to discuss their HIV status with a potential sex partner. The majority of respondents indicated that they strongly agreed or agreed with the statement, “I believe I have no risk of getting HIV”. When asked about their level of confidence in discussing their HIV status, 83% of respondents indicated that they were very confident or confident in their ability to discuss this matter with a potential sex partner.

### **Section III - Treatment**

For the purpose of integrated planning, developers sought to understand the knowledge of Kentuckians with HIV, in regard to their knowledge of HIV prevention, and their ability to discuss their HIV status. To the multiple-choice question “Which of the following prevention methods can help reduce the risk of a person with HIV transmitting it to another person?” 79.66% selected the correct answer of all of these are correct. When asked about their level of confidence in discussing their HIV status, 71% of respondents indicated that they were very confident or confident in their ability to discuss this matter with a potential sex partner.

### **Knowledge of HIV Treatment Services**

For the purpose of integrated planning, developers sought to understand the experience of Kentuckians with HIV and their ability to access treatment services. First, the needs assessment sought to gauge respondents’ knowledge of Ryan White prior to their HIV diagnosis, and if they had ever been told by a provider that their viral load was suppressed. The majority (74.58%) of respondent that were living with HIV indicated that they were unaware of the Ryan White Program at the time of their diagnosis. When asked if their HIV medical provider had told them that their viral load was undetectable 96.61% of respondents indicated yes.

### **Perceptions of HIV Treatment Services**

Respondents with HIV were also asked to describe their level of access with regards to receiving HIV treatment and care services at various venues and their perceptions of these services. Overwhelmingly, respondents indicated they strongly agreed or agreed with statements about their medical providers and case managers. When those with HIV were asked if their medical provider provides telehealth (virtual or online) appointments 61.2% indicated yes, 28.81% indicated they were unsure, and 10.17% indicated no.

### **Barriers to HIV Care and Treatment**

Respondents were asked a series of questions regarding known barriers to HIV care and treatment. This included questions related to income, transportation, and access to supplemental services (housing, mental health, and addiction services). Respondents overwhelmingly indicated they strongly agree or agree that they have adequate access supplemental services. Finds for income and transportation are presented below.

**Income**

When asked if respondents had adequate income to cover essential monthly expenses, 42.37% responded that they were mostly able to cover expenses each month, 30.51% indicated that they were able to cover all their expenses, and 25.42% indicated that they were not able to cover essential monthly expenses. By race, 24.14% of white respondents and 20% of black respondents reported not being to cover essential expenses each month.

**Transportation**

When asked if respondents had transportation to get to HIV appointments, 89.83% reported having a car or having access to borrow or use a care, whereas 6.79% reported not having reliable access to transportation.