Oklahoma HIV Integrated Prevention & Care Plan With Statewide Coordinated Statement of Need

Oklahoma State Department of Health | Sexual Health & Harm Reduction Service

2022-2026

OKLAHOMA State Department of Health

SEXUAL HEALTH & HARM REDUCTION SERVICE

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Definitions

The following terms used in this document will, unless the context suggests otherwise, have the meaning set forth below:

Comanche County Service area: Comanche, Caddo, Grady, Stephens, Jefferson, Carter, Love, Cotton, Tillman, Jackson, Kiowa, Washita, Greer, Beckham and Harmon Counties.
Dental Services: provision of diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care suppliers.
Eastern Oklahoma Service area: includes Osage, Pawnee, Washington, Craig, Nowata, Rogers, Mayes, Delaware, Tulsa, Creek, Okfuskee, Okmulgee, LeFlore, Haskell, Ottawa, Cherokee, Adair, Muskogee, Sequoyah, McIntosh, Pittsburg, and Latimer Counties.
MSA: Metropolitan Statistical Area, refers to the geographic areas defined in OMB BULLETIN NO. 20 – 01, dated March 2020 and available at the following URL: https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf

- **Oklahoma City MSA:** Principal City - Oklahoma City, includes - Canadian County, Cleveland County, Grady County, Lincoln County, Logan County, McClain County, and Oklahoma County.
- **Lawton MSA:** Principal City – Lawton, includes Comanche County and Cotton County
- **Tulsa MSA:** Principal City – Tulsa, includes Creek County, Okmulgee County, Osage County, Pawnee County, Rogers County, Tulsa County, and Wagoner County

OHHPC: Oklahoma HIV and Hepatitis Planning Council
Part B-Eligible Oklahomans: HIV-positive individuals residing in the state of Oklahoma, who are at or below 400% of the Federal Poverty Level, and have no other means to access case management or mental health services.
Social Services Case Management: provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Social Services case management does not involve coordination and follow-up of medical treatments.
Western Oklahoma Service Area: Cimarron, Texas, Beaver, Harper, Woods, Alfalfa, Grant, Kay, Ellis, Woodward, Major, Garfield, Noble, Roger Mills, Dewey, Blaine, Kingfisher, Logan, Payne, Lincoln, Custer, Canadian, Oklahoma, Cleveland, Pottawatomie, Seminole, Hughes, Beckham, Washita, Caddo, Grady, McClain, Greer, Kiowa, Comanche, Stephens, Garvin, Pontotoc, Coal, Harmon, Jackson, Tillman, Cotton, Jefferson, Carter, Murray, Johnston, Atoka, Pushmataha, Love, Marshall, Bryan, Choctaw, and McCurtain Counties.

Section I. Executive Summary

This HIV Integrated Prevention and Care Plan for Oklahoma builds on the first iteration of the Integrated Plan including the Statewide Coordinated Statement of Need developed and implemented in 2017 ending in 2021. This first iteration served as the vehicle by which Oklahoma identified HIV prevention and care needs, existing resources, barriers and gaps, and outlined strategies to address them. Its intent was to increase efficiencies in the use of planning resources and contribute to resultant improvements in program effectiveness and health outcomes of Oklahomans living with HIV, as well as those highly vulnerable to contracting the virus. The integrated plan, including the SCSN from 2017, also articulated the existing and needed collaboration among PLWH, service providers, funded program implementers, and other stakeholders (OSDH, Oklahoma HIV Integrated Prevention and Care Plan, 2017).

This new integrated plan allows Oklahoma to develop new goals and objectives that align public and private sectors to leverage strengths from the last five years and to add or revise services to address local health inequities that may remain. In particular, to allow Oklahoma's Integrated HIV Prevention and Care Plan to align with the goals for Oklahoma's Ending the HIV Epidemic (EHE) Plan and the HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025, published in 2021.

During 2015–2019, the annual number and rate of diagnoses of HIV decreased in both the United States and six dependent areas. Although numbers and rates decreased overall, diagnoses of HIV increased in some subgroups and decreased in others. Oklahoma reflected the same trend but numbers were increased in 2019 and 2020. Oklahoma's plan will address the four goals established in the National Strategic Plan and the EHE plan submitted to CDC in 2020 along with the four pillars of the EHE strategy. The four goals are:

- Prevent new HIV infections
- Improve HIV-related health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders

The four EHE Pillars are:

- Diagnose all people with HIV as early as possible.
- Treat HIV rapidly after diagnosis, and effectively, in all people with HIV to help them get and stay virally suppressed.
- Prevent people at risk for using proven prevention interventions, including Pre-Exposure Prophylaxis (PrEP) and syringe service programs (SSPs).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

The approach utilized for the preparation of the Integrated Plan submission was to review and utilize pertinent information from the existing EHE plan submitted to CDC in 2020 and previous Integrated Plan submitted in 2016. The resulting document for this Integrated Plan submission is an entirely new plan with new materials. Oklahoma State Department of Health (OSDH) Sexual Health and Harm Reduction Service (SHHRS) HIV care and prevention staff will illustrate in this plan the involvement and collaborative efforts of all entities involved in HIV care and prevention across the state of Oklahoma to produce and support the goals, objectives and implementation of activities outlined in this plan.

Section II. Community Engagement & Planning Process

Community Engagement

Community engagement is a key component of Oklahoma's Integrated Prevention and Care Plan. This involves the collaboration of key stakeholders and broad-based communities that work together to identify strategies to increase coordination of HIV programs throughout the state. Community engagement activities were achieved via the Oklahoma HIV and Hepatitis Planning Council (OHHPC).

The OHHPC convenes for two-hour meetings on a bi-monthly basis. Since the start of the COVID-19 pandemic, these meetings have been virtual. The meetings for 2022 occurred in March, June, September and November. The OHHPC is comprised of 30 voting members: five persons living with HIV, five representatives from the HIV prevention community, five representatives from the HIV treatment and care community, and 15 members at large. The OHHPC has over 50 non-voting members from diverse cultures and communities.

Key Stakeholders in the OHHPC Integrated Planning Body:

- **AIDS Walk:** non-profit fundraising organization which distributes funds to HIV/AIDS nonprofit organizations serving the greater Oklahoma City community, through direct health services, HIV/AIDS education and prevention, and community awareness.
- **ASP Cares Pharmacy:** local specialty pharmacy.
- **Cherokee County Health Services Council:** quasi-governmental agency formed to improve public health and coordinate health agency cooperation.
- **Chickasaw Nation Tribal Health:** assists tribal citizens with unmet medical services, dental services and durable medical equipment.
- **Community Health Centers of Oklahoma:** federally qualified health center providing primary health care and other health-related services in central Oklahoma on a sliding scale income basis.
- **Diversity Family Health:** provides primary and comprehensive care services specific to the gender diverse and LGBTQ+ community.
- **Expressions Community Center:** provides free HIV testing and other resources, located in the LGBTQ+ district in Oklahoma City.
- **Food and Shelter, Inc.:** non-profit organization providing food; short term, long-term, and supportive housing; as well as rent/utility assistance for individuals and families.
- **Freedom Oklahoma:** advocates within 39 sovereign tribal nations for Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, and full spectrum of people whose sexuality, gender, or romantic identity exists beyond a heteronormative, binary framework (2SLGBTQ+).
- **Gilead Sciences, Inc.:** biopharmaceutical company focusing on researching and developing antiviral drugs used in the treatment of HIV/AIDS, hepatitis B, hepatitis C, influenza, and COVID-19.
- **Guiding Right, Inc./New Hope Wellness Clinic:** a social justice-oriented, Black-focused, community-based organization providing health care and supportive services to improve the quality of life among Black and other marginalized populations in Oklahoma. Receives HRSA Ryan White EHE, CDC Prevention, and CDC EHE subrecipient funding through OSDH SHHRS to provide HIV

counseling/testing, transportation assistance, outpatient ambulatory care, and case management for target populations.

- **Health Outreach Prevention and Education (HOPE):** provides health services for hepatitis C, HIV, and other sexually transmitted infections (STIs) through outreach across Oklahoma, focused on the most at-risk. Receives CDC Prevention subrecipient funding through OSDH SHHRS to provide HIV counseling and testing.
- **Indian Health Services (IHS):** operating division within the U.S. Department of Health and Human Services responsible for providing direct medical and public health services to members of federally recognized Native American Tribes and Alaska Native people.
- **Latino Community Development Agency:** comprehensive, community-based, non-profit organization working to enhance the quality of life in the Latino community through education, leadership, services, and advocacy. Receives CDC Prevention subrecipient funding through OSDH SHHRS to provide HIV counseling and testing.
- **Oklahoma Department of Human Services (OK DHS):** statutory authority responsible for providing help to individuals and families in need, through public assistance programs and managing services for seniors and people with disabilities. DHS AIDS Coordination and Information Services (ACIS) receives HRSA Ryan White Part B subrecipient funding through OSDH SHHRS to provide case management services to PLWH.
- **Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS):** statutory authority responsible for prevention, treatment, and recovery from mental illness, substance abuse and addictive disorders.
- **Oklahoma Harm Reduction Alliance:** a grassroot harm-reduction organization that meets Oklahomans who use drugs where they are, through evidence-based education, advocacy, policy reform, and low barrier health services.
- **Oklahoma Health Care Authority (OHCA):** statutory authority responsible for administering Oklahoma's Medicaid program, commonly known as SoonerCare.
- **Oklahoma Primary Care Association (OKPCA):** partners with community health centers, safety-net providers, and the patients they serve to strengthen and simplify health care access to underserved communities.
- **Oklahoma State Department of Health (OSDH):** statutory authority responsible for protecting and improving public health with strategies that focus on preventing disease in Oklahoma. Sexual Health and Harm Reduction Service (SHHRS) program area is HRSA Ryan White Part B/EHE and CDC Prevention/EHE funding recipient.
- **Oklahoma State University (OSU) Internal Medicine Specialty Services:** State academic institution, EIS/IDI clinic, providing outpatient ambulatory health care, case management, dental services, mental health, and transportation assistance for PLWHA. Receives HRSA Ryan White Part B subrecipient funding through OSDH SHHRS and direct HRSA Part C recipient funding.
- **Oklahoma Turning Point:** independent, statewide consortium focused on policy issues aimed at improving Oklahoma's health, by partnering with communities across Oklahoma.
- **Osage Nation:** federally-recognized Native American tribal government.
- **Other Options, Inc.:** non-profit organization providing food, resources, and education to at-risk individuals and families with a focus on those affected by HIV and AIDS.
- **Persons Living With HIV/AIDS (PLWH):** consumers and other local community members with lived experience.
- **RAIN Oklahoma:** non-profit HIV community-based organization serving PLWH in western and central Oklahoma. Receives HRSA Ryan White Part B subrecipient funding through OSDH SHHRS to

provide case management, outreach, as well as dental and transportation assistance. Also funded to provide HOPWA assistance and Health Insurance Marketplace navigation.

- **Red Rock Behavioral Health Services:** nonprofit community mental health organization providing integrated behavioral health and physical health care coordination services to indigent Oklahomans.
- **Remerge Oklahoma:** serves mothers of minor children who are facing non-violent felony charges in Oklahoma County with the goals of achieving safe and stable housing, re-unification with minor children, sobriety, and stable employment.
- **Revan, Inc.:** provides welcoming, respectful family medicine and specialized care for the LGBTQ+ community of Oklahoma City.
- **Sage Associates:** provides non-profit management consulting services, including community-based research, strategic planning, program evaluations, and grant writing.
- **South Central AIDS Education and Training Center (SCAETC):** provides training on prevention and care as well as rural outreach.
- **Southern Plains Tribal Health Board:** non-profit organization established to provide a unified voice on tribal public health needs and policy for the 43 federally recognized tribes located in the states of Kansas, Oklahoma, and Texas.
- **Stop Harm on Tulsa Streets (SHOTS):** a non-profit harm reduction/syringe service program for individuals dealing with substance use disorder.
- **The Health and Wellness Center, Inc.:** community health center in rural Oklahoma.
- **Thrive Oklahoma:** backbone organization for the Central Oklahoma Teen Pregnancy Prevention Collaboration to convene and connect partners and change agents, engage and mobilize the community, evaluate and share data, and advocate for youth to have access to resources, services and medically accurate information about sexual health.
- **Tulsa Cares:** community-based organization providing comprehensive prevention and care programs to low-income individuals living with HIV/AIDS and Hepatitis C in eastern Oklahoma. Receives HRSA Ryan White Part B, CDC Prevention, and CDC EHE subrecipient funding through OSDH SHHRS to provide HIV counseling and testing, case management, mental health, food pantry, and transportation assistance to PLWH. Also provides HOPWA assistance, Health Insurance Marketplace navigation, and treatment for HIV.
- **Turnkey Health:** contracted provider of comprehensive health care services to incarcerated populations throughout Oklahoma.
- **University of Oklahoma, Center for Health Sciences (OU HSC):** state academic institution, EIS/IDI clinic, providing outpatient ambulatory health care, case management, dental services, and mental health services for PLWHA. Receives HRSA Ryan White Part B subrecipient funding through OSDH SHHRS and direct HRSA Part C and Part D recipient funding.
- **Variety Care:** non-profit community health center providing care to all persons, regardless of income, residency status, employment, health insurance coverage or ability to pay for services.
- **ViiV Healthcare:** pharmaceutical company specializing in the development of HIV treatment.
- **Walgreens:** national chain pharmacy/store.
- **1893 Pharmacy:** Oklahoma Ryan White HIV/AIDS Drug Assistance Program (ADAP) 340B contracted pharmacy. Receives Ryan White Part B subrecipient funding for drugs and medication adherence counseling.

Integrated Prevention and Care Planning Process

The Integrated Prevention and Care Planning Committee is comprised of seven staff members from each area of SHHRS: SHHRS Director, Ryan White Care Administrative Program Manager, HIV Prevention Administrative Program Manager, HIV/STI Surveillance and Analysis Administrative Program Manager, Ryan White Data and Evaluation Manager, Ryan White Clinical Quality Manager, and HIV Surveillance Manager. This committee meets monthly and is responsible for reviewing, monitoring, drafting, and revising the Integrated Prevention and Care Plan.

HRSA Ryan White Part B funding was used to contract with the University of Oklahoma Educational Training, Evaluation, Assessment & Measurement (OU E-TEAM) to conduct and evaluate a needs assessment of Oklahomans living with HIV, affected by, or at high risk for HIV. The E-TEAM reviewed the 2017 Oklahoma SCSN and worked with the SHHRS Integrated Prevention and Care Planning Committee to develop a client survey. The OHHPC was instrumental in the distribution of the survey to individuals in facilities and community-based organizations in the metro areas and communities in rural areas. As the OHHPC is comprised of various individuals and groups including people living with HIV (PLWH), the group was the best avenue to get information out about the survey. The survey was also advertised to RW funded organizations, local and county health departments, and other stakeholders across the state.

Engagement of People Living with HIV

The engagement of PLWH in the planning council and in the planning and development of the integrated plan was and is a priority. The SHHRS consistently looks for opportunities to recruit and involve the persons most affected by HIV in activities and decisions impacting the population. However, this continues to be a challenge due in part to the heavy stigma and political climate surrounding HIV and LGBTQ issues in Oklahoma. Despite these challenges, input was received from PLWH during the planning and development stages of the plan and PLWH will be an integral part of the implementation, monitoring, evaluation and improvement as Oklahoma moves forward over the next five years. As part of the OHHPC, PWLH were able to give input on priority populations, plan highlights, review and editing of the plan, suggesting changes of all areas of the plan. As part of the OHHPC, PLWH were involved in setting the priorities of the plan, as well as its goals and objectives.

Communication and collaboration with Ryan White HIV/AIDS Program Part C and D recipients occur on regular and ongoing basis. Not only are Part C and D recipients voting members of the OHHPC but sub-recipients of Part B funding as well. These providers consistently play an integral role in priority setting and development of goals/objectives not just during development of the Integrated Plan but also in every day decisions related to best care for Ryan White clients. They will continue to be involved at a high level from implementation to improvement of the plan over the next five years.

The OHHPC reviewed and provided recommendations on plan goals and priorities, based on the results of the needs assessment. OHHPC advised of changes to be made to the written plan, as well to issue concurrence with reservations for the draft final plan. The final completed plan will be sent to the OHHPC for review via email with final approval expected at the next OHHPC meeting in January 2023. Recommendations were collected and effected with a letter of concurrence with reservations signed by the Chair.

Cluster Detection and Response Planning

The OHHPC is divided into several sub-committees in line with the EHE pillars to better streamline efforts towards each pillar's goals being achieved. The OHHPC Cluster Detection and Response Committee consists of 14 individuals. The committee discusses and advises on ethical and effective statewide cluster

response plan, as well as meet to discuss response efforts as needed. This committee and the OHHPC provided concurrence with the final Cluster and Outbreak Detection and Response (CDR) Plan and has reviewed and provided revisions to the plan as necessary.

Community engagement activities for the CDR committee are overseen by the Administrative Program Managers of each area of SHHRS: Surveillance and Analysis, Prevention, and Ryan White Care. In the fall of 2021, a survey was distributed via Qualtrics to the OHHPC. Members were encouraged to share this survey with their networks. The survey elicited feedback on the SHHRS CDR Plan, gaps in available services for HIV prevention and treatment in Oklahoma, and additional stakeholder recommendations for collaborations and methods to improve CDR efforts. The survey was designed by the SHHRS Integrated Prevention and Care Planning Committee. Findings will be incorporated into future CDR plan revisions.

Priority Populations Identified

The following priority populations were identified out of Oklahoma's planning and community engagement process, using HIV surveillance data and the 2022 needs assessment. These priority populations were used to create goals and activities for Oklahoma's 2022-2026 HIV Integrated Prevention and Care Plan:

Disproportionately Affected Populations

1. Black populations
2. Hispanic populations
3. Men who have sex with men (MSM)

Individuals with HIV Negative or Unknown Status

1. HIV testing awareness in heterosexual females under the age of 50, with average or higher income
2. HIV prevention awareness, including PrEP, PEP, and condom distribution program

Individuals Living With HIV

1. Immediate support and linkage to care at time of diagnosis
2. Emergency financial assistance
3. Housing assistance

Section III. Contributing Data Sets & Assessments

Data Sharing and Use

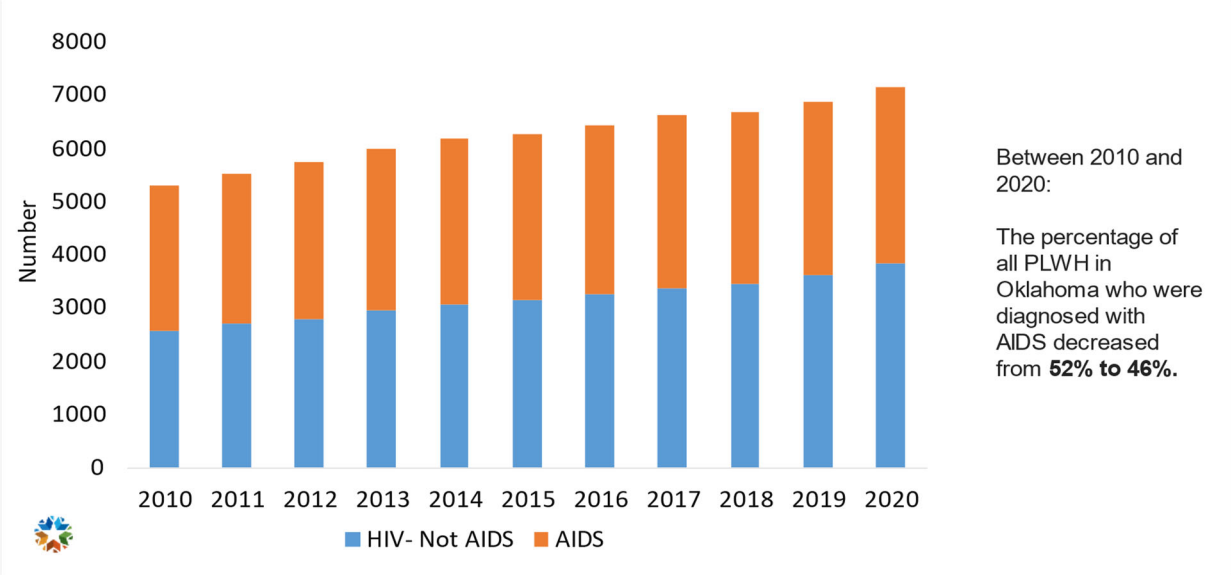
The Sexual Health and Harm Reduction Service (SHHRS) data and surveillance system is designed for all HIV/STI Prevention, Care, and Surveillance data to be shared inherently. Data used for analysis comes from a variety of databases:

- **Enhanced HIV/AIDS Reporting System (eHARS)** contains the majority of detailed HIV surveillance data for the residents of Oklahoma. Data is received from statewide mandatory reporting by all Oklahoma health care providers and laboratories, and is cross-matched with Oklahoma Vital Statistics data, as well as the National Death Index and Social Security Death Master File.
- **REDCap** contains client clinical data, including PEP and PrEP data for clients seen and treated by Advance Practice Registered Nurses (APRNs) in the SHHRS Rapid Start program.
- **CAREWare** contains Ryan White HIV/AIDS Program Part B and EHE clinical data from Ryan White sub-recipient contractors.
- **Public Health Investigation and Disease Detection of Oklahoma (PHIDDO)** includes ADAP application/eligibility and HIV counseling and testing (CTR) data entered by Ryan White sub-recipient contractors, as well as case report data from statewide mandatory reporting by all Oklahoma health care providers and laboratories for all reportable STIs.

Epidemiologic Snapshot of Oklahoma

Oklahoma has a state population of 3,980,783 as of 2020. At the end of December 2020, an estimated 7,158 people were living with HIV/AIDS in Oklahoma at a rate of 179.8 per 100,000 population. Of those, 46.4% (3,324) had been diagnosed with AIDS.

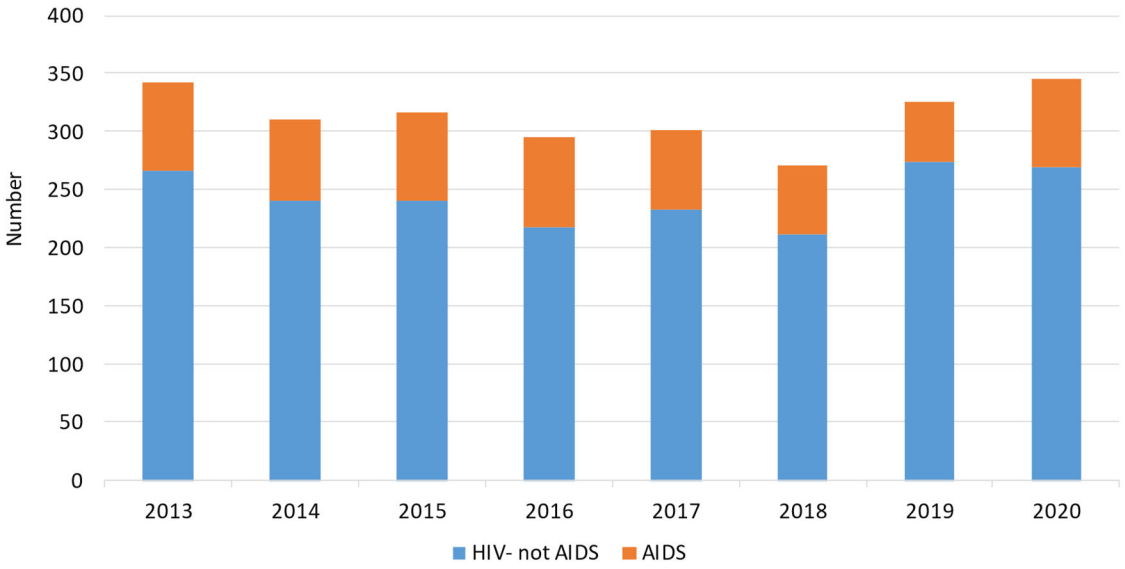
Figure A1. Number of PLWH in Oklahoma, by Year and AIDS Status, 2010-2020



In 2020, 345 individuals were newly diagnosed with HIV in Oklahoma at a rate of 8.7 cases per 100,000 population. 21.5% of those newly diagnosed with HIV in Oklahoma were classified as late testers, or those diagnosed with AIDS within three months of their HIV diagnosis.

NEWLY DIAGNOSED HIV CASES

Figure A2. Number of People With Newly Diagnosed HIV by Year of Diagnosis and AIDS Status, Oklahoma, 2013-2020



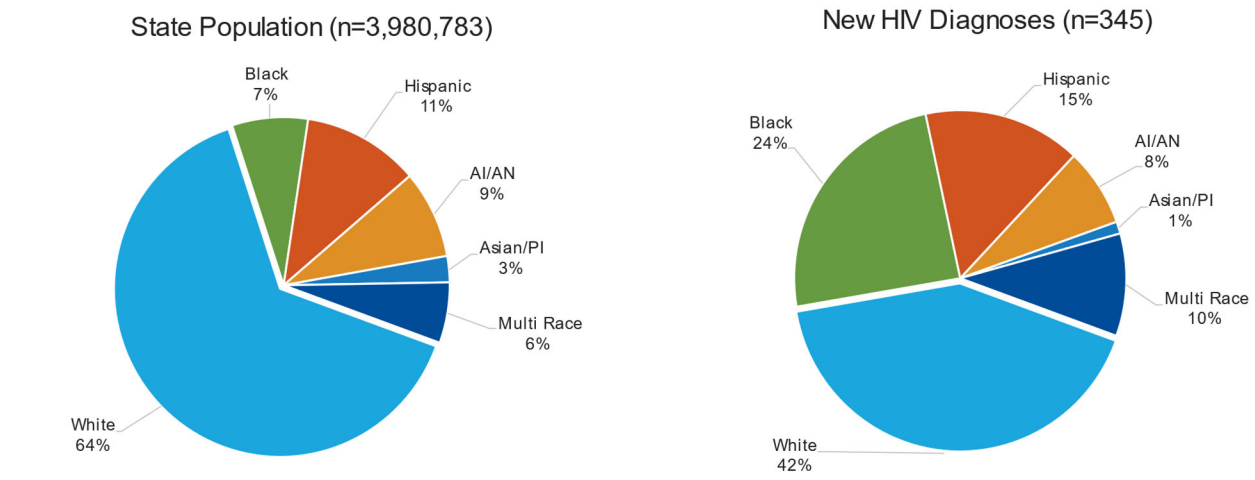
By Race

Of the 345 new HIV cases in 2020:

- 24.3% (84) were Black, non-Hispanic
- 9.9% (34) were Multi race, non-Hispanic
- 15.4% (53) were Hispanic, all races
- 7.5% (26) were American Indian/Alaska Native, non-Hispanic
- 41.7% (144) were White, non-Hispanic
- 1.2% (4) were Asian/Pacific Islander, non-Hispanic

Despite comprising only 7% of the state population, Blacks made up 24% of the new HIV diagnoses, and Hispanics comprise 11% of the state population while making up 15% of the new HIV diagnoses in 2020. Blacks had the highest rate of newly diagnosed HIV cases in 2020 (28.5 cases per 100,000 population) among all the racial and ethnic groups in Oklahoma. This rate was 3.3 times higher than state rate (8.7 cases per 100,000) and 5.1 times higher than the rate for Whites (5.6 cases per 100,000). Multi race had the second highest rate of newly diagnosed cases (14.7 cases per 100,000). Hispanics (11.7 cases per 100,000) had the third highest rate, followed by American Indian/Alaska Natives (7.7 cases per 100,000). The rate among Asian/Pacific Islanders was 4.0 cases per 100,000.

Figure A3. Distribution of the State Population and New HIV Diagnoses, by Race/Ethnicity, Oklahoma, 2020



By Sex

Males accounted for 86.1% (297) of the newly diagnosed cases and females accounted for 13.9% (48). The 2020 HIV rate among males (15.0 cases per 100,000) was 7.5 times higher than the rate among females (2.4 cases per 100,000). Among males, Whites (126; 42.4%) accounted for the highest number of cases, followed by Blacks (69; 23.2%) and Hispanics (47; 15.8%). However, Black males (46.7 cases per 100,000) had the highest rate among males and White males (10.0 cases per 100,000) had the lowest rate. Among females, Whites (18; 37.5%) accounted for the highest number of cases, followed closely by Blacks (15; 31.3%). Black females (10.2 cases per 100,000) had the highest rate among females and White females (1.4 cases per 100,000) had the lowest rate.

By Age

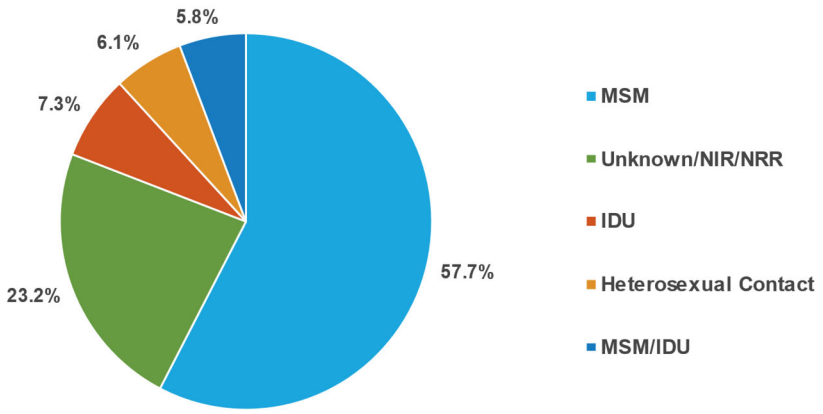
The 20 – 29 years age group had the highest number of newly diagnosed HIV cases in 2020 (123; 35.7%) as well as the highest rate (22.9 cases per 100,000). The 30 – 39 years age group had the second highest number of cases (105; 30.4%) and the second highest rate (19.3 cases per 100,000) among the age groups. The 40 – 49 years age group accounted for 14.8% (51) of the cases, followed by the 50 – 59 years age (36; 10.4%). Teenagers aged 13 – 19 years accounted for 3.8% (13) of the new cases in 2020 and 4.6% (16) of the cases were aged 60 years and over.

By Mode of Transmission

Of the 2020 newly diagnosed HIV cases:

- 57.7% (199) were men who have sex with men (MSM)
- 23.2% (80) were unknown/other
- 7.3% (25) were injection drug use (IDU)
- 6.1% (21) were heterosexual contact, known risk
- 5.8% (20) were MSM/IDU

Figure A4. Distribution of Exposure Among People With Newly Diagnosed HIV, Oklahoma, 2020 (N=345)

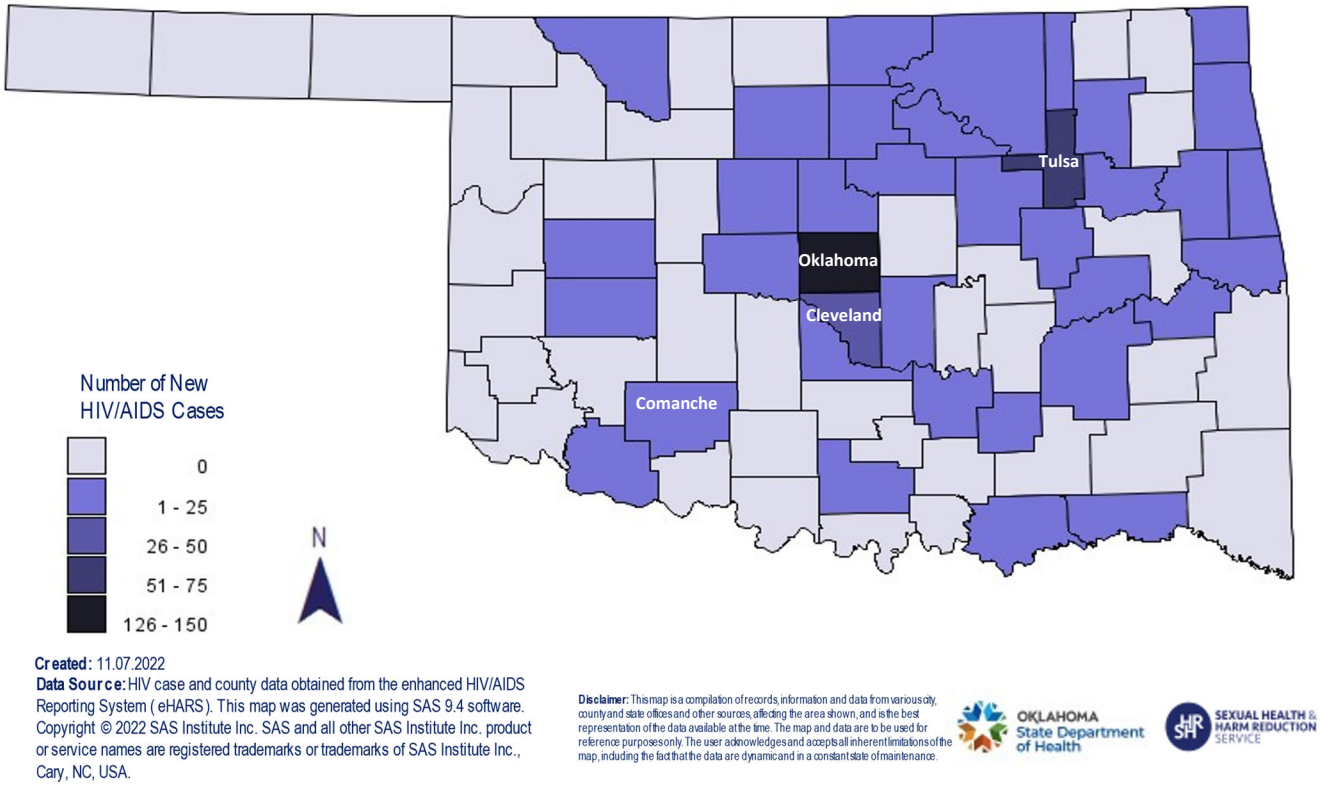


By Geography

Four counties in Oklahoma accounted for over 75% of the 2020 newly diagnosed HIV cases: Oklahoma (142; 41.2%), Tulsa (75; 21.7%), Cleveland (33; 9.6%), and Comanche (17; 4.9%). The rate in Oklahoma County was 17.8 cases per 100,000 and the highest rate among the four counties. Despite having fewer cases, Comanche County (13.9 cases per 100,000) had a higher rate of newly diagnosed HIV cases than Tulsa County (11.2 cases per 100,000) and Cleveland County (11.1 cases per 100,000).

The Oklahoma City metropolitan statistical area (MSA) accounted for 53.9% (186) of the 2020 newly diagnosed HIV cases in Oklahoma. The Oklahoma City MSA had a rate of 13.0 cases per 100,000, which was the second highest newly diagnosed HIV rate among the MSAs. Approximately 25% of the new HIV cases were diagnosed in the Tulsa MSA (87; 25.2%). The HIV rate in the Tulsa MSA was 8.6 cases per 100,000, which was the third highest rate among the MSAs. The Lawton MSA accounted for 4.9% (17) of the newly diagnosed cases with a rate of 13.4 cases per 100,000, the highest rate among the MSAs. In 2020, 15.9% (55) of the new HIV cases were diagnosed in counties that were not part of one of these three MSAs.

Figure A5. New HIV/AIDS Cases by County, Oklahoma 2020



LIVING HIV/AIDS CASES

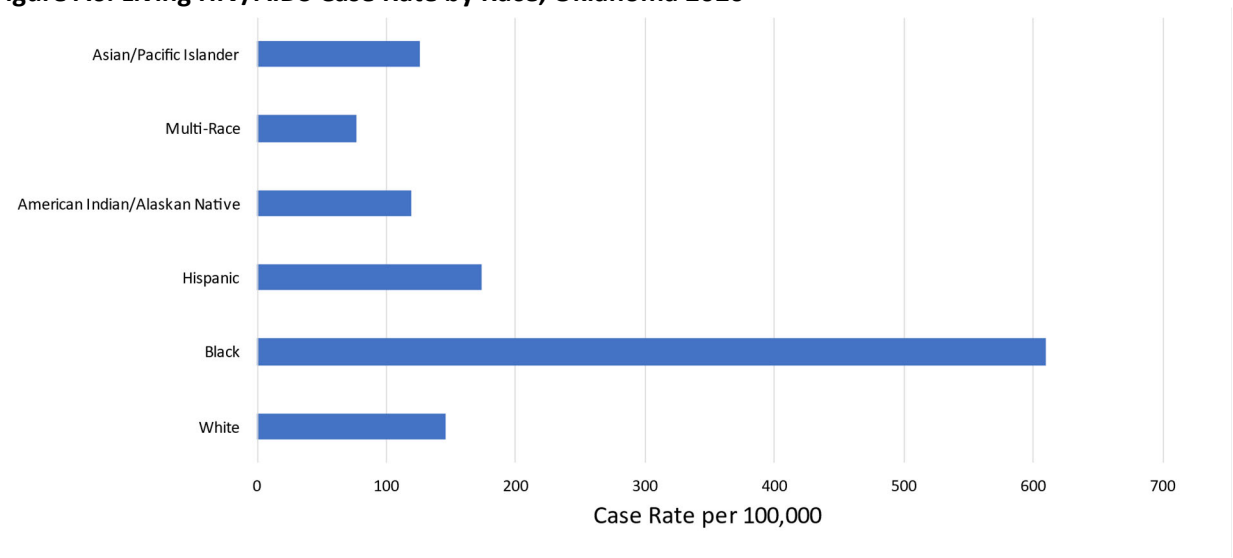
By Race

Of the 7,158 persons living with HIV/AIDS at the end of 2020:

- 51.0% (3,651) were White
- 24.7% (1,767) were Black
- 11.5% (821) were Hispanic
- 5.5% (396) were American Indian/Alaska Native
- 5.5% (393) were Multi race
- 1.8% (125) were Asian/Pacific Islander
- 0.1% (5) were Unknown/Other

At the end of 2020, Blacks had the highest rate of living HIV/AIDS cases (609.4 cases per 100,000) among the race/ethnic groups in Oklahoma. Hispanics (174.0 cases per 100,000) had the second highest rate, followed by Whites (145.2 cases per 100,000). The rate among the rate among Asian/Pacific Islanders was 125.6 per 100,000, and the rate among American Indians/Alaska Natives was 119.0 cases per 100,000. Multi race had the lowest rate of persons living with HIV/AIDS (77.3 cases per 100,000) in Oklahoma. Blacks are disproportionately affected by HIV/AIDS in Oklahoma, as the rate for Blacks living with HIV/AIDS was 3.4 times higher than the state rate (179.8 cases per 100,000) and 4.2 times higher than the rate of Whites living with HIV/AIDS in Oklahoma.

Figure A6. Living HIV/AIDS Case Rate by Race, Oklahoma 2020



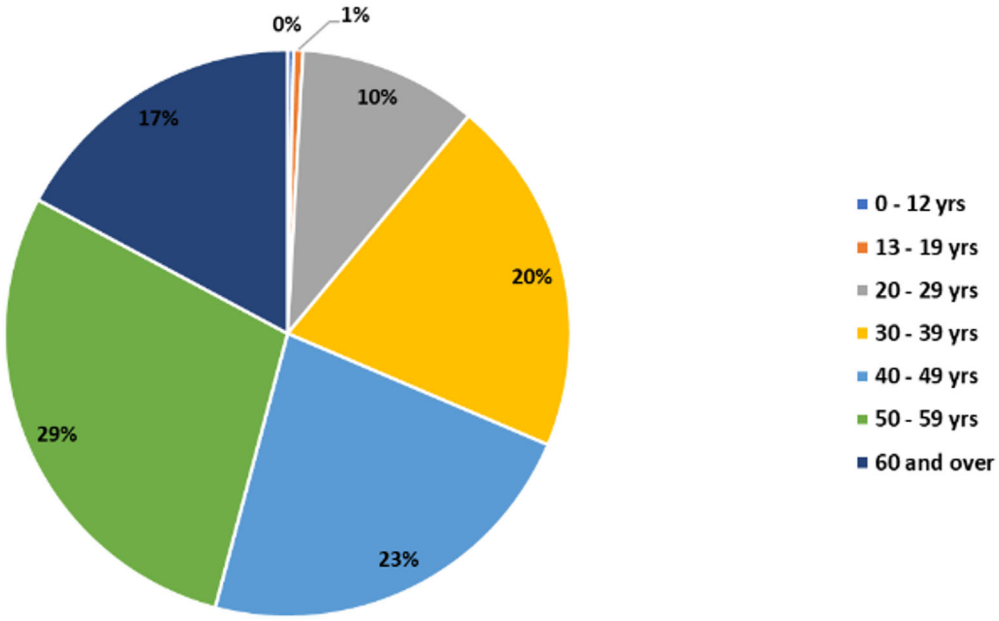
By Sex

Males accounted for 82.1% (5,878) of the HIV/AIDS cases living in Oklahoma, while females only accounted for 17.9% (1,280). The rate of males (296.2 cases per 100,000 population) living with HIV/AIDS in Oklahoma was 4.6 times higher than the rate of females (63.9 cases per 100,000 population).

By Age

By current age group, the 50 – 59 years age group (2,054; 28.7%) has the highest burden of living HIV/AIDS cases in Oklahoma, followed by the 40 – 49 years age group (1,625; 22.7%). The 30 – 39 years age group (1,457; 20.4%) accounted for the third highest number of cases. Age group 60 and over (1230) accounted for 17.2% and the 20 – 29 years age group (730) accounted for 10.2%. Teenagers (38; 0.5% and children 12 years and under (24; 0.3%) combined accounted for less than 1% of the living HIV/AIDS cases.

Figure A7. Living HIV/AIDS Cases by Age Group, Oklahoma 2020



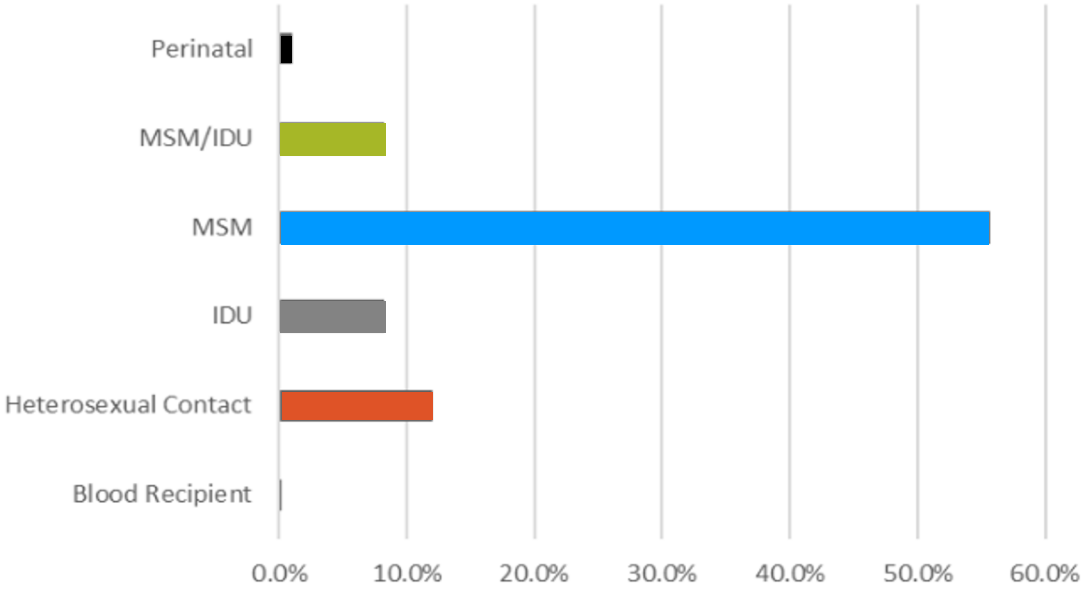
By Mode of Transmission

Of the 7,158 HIV/AIDS cases living in Oklahoma:

- 55.7% (3,985) were men who have sex with men (MSM)
- 14.6% (1,044) were no reported risk or no identified risk
- 12.0% (859) were heterosexual contact
- 8.3% (591) were injection drug use (IDU)
- 8.2% (590) were MSM and IDU
- 1.0% (70) were perinatal
- 0.2% (19) were blood recipients

Among males, MSM was the most commonly reported risk factor accounting for 67.8% (3,985) of the cases. MSM/IDU was the second most common risk factor among males accounting for 10.0% (590), followed by IDU (346; 5.9%). Among females, heterosexual contact (576; 45.0%) was the most commonly reported risk factor, followed by IDU (245; 19.1%).

Figure A8. Living HIV/AIDS Cases by Risk, Oklahoma 2020



By Geography

Approximately 70% of the living HIV/AIDS cases reside in four counties: Oklahoma (2,608; 36.4%), Tulsa (1,830; 25.6%), Cleveland (335; 4.7%), and Comanche (248; 3.5%). Oklahoma County had the highest rate of cases living with HIV/AIDS (327.5 cases per 100,000). Tulsa County had the second highest rate of cases living with HIV/AIDS cases (273.4 cases per 100,000).

The Oklahoma City MSA accounted for 45.6% (3,262) of the living HIV/AIDS cases. The Tulsa MSA accounted for 30.4% (2,175) of the living cases, and the Lawton MSA accounted for 3.5% (251) of the living HIV/AIDS cases. Approximately 20% (1,470; 20.5%) of the living HIV/AIDS cases resided in counties outside of these MSAs in Oklahoma.

Figure A9. Living HIV/AIDS Cases by County, Oklahoma 2020

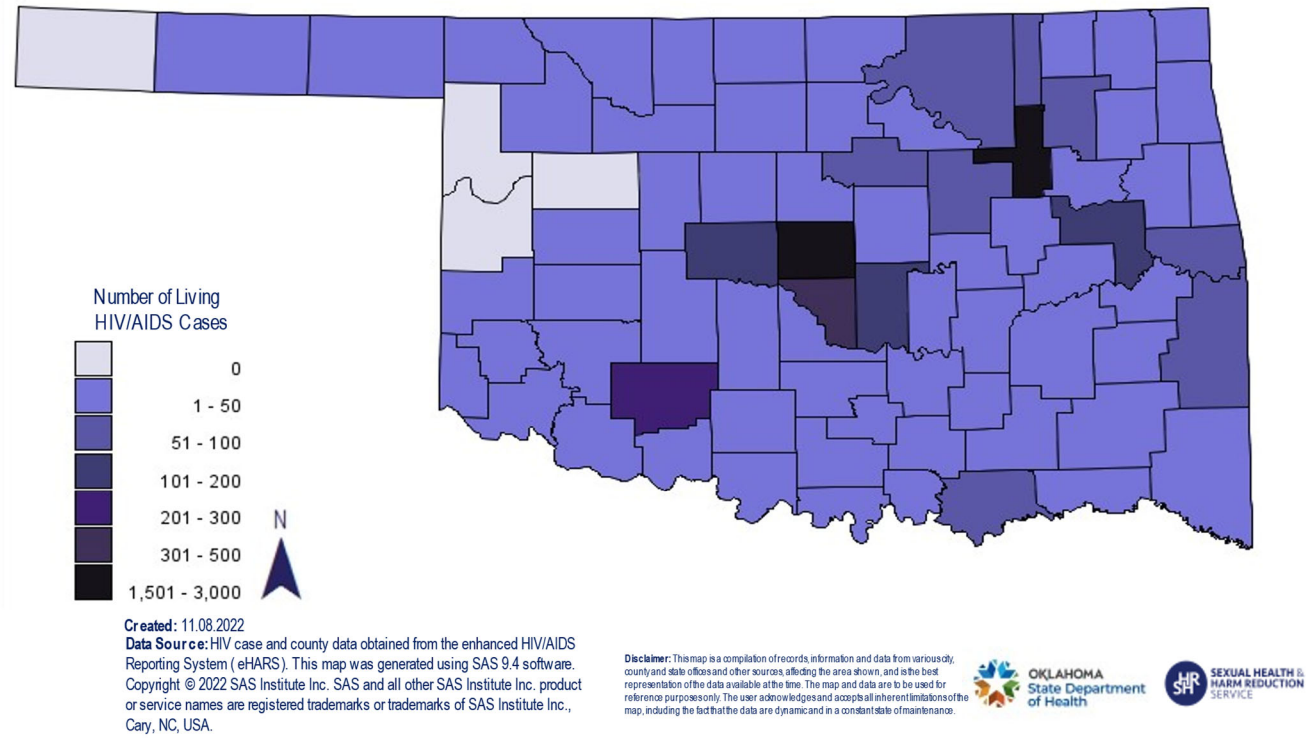


Table A1. Newly Diagnosed HIV Cases and Living HIV/AIDS Cases, Oklahoma 2020

	Newly Diagnosed HIV Cases		Living HIV/AIDS Cases	
	Number	Percent	Number	Percent
Race/Ethnicity				
Hispanic-All Races	53	15.4%	821	11.5%
American Indian/Alaska Native	26	7.5%	396	5.5%
Asian/Pacific Islander	4	1.2%	125	1.8%
Black	84	24.4%	1,767	24.6%
Multi race	34	9.9%	393	5.5%
White	144	41.7%	3,651	51.0%
Unknown/Other	0	0%	5	0.1%
Sex				
Male	297	86.1%	5,878	82.1%
Female	48	13.9%	1,280	17.9%
Age				
0 – 12 years	1	0.3%	24	0.3%
13 – 19 years	13	3.8%	38	0.5%
20 – 29 years	123	35.7%	730	10.2%
30 – 39 years	105	30.4%	1,457	20.4%
40 – 49 years	51	14.8%	1,625	22.7%
50 – 59 years	36	10.4%	2,054	28.7%
60 years and Over	16	4.6%	1,230	17.2%
Risk				
Blood Recipient	0	0%	19	0.3%
Heterosexual Contact	21	6.1%	859	12.0%
IDU	25	7.3%	591	8.3%
MSM	199	57.7%	3,985	55.7%
MSM/IDU	20	5.8%	590	8.2%
Perinatal	0	0%	70	1.0%
No Identified/Reported Risk	80	23.2%	1,044	14.6%
MSAs				
Oklahoma City	186	53.9%	3,262	45.6%
Tulsa	87	25.2%	2,175	30.4%
Lawton	17	4.9%	251	3.5%
Non-MSA	55	15.9%	1,470	20.5%
Total	**345**	**100%**	**7,158**	**100%**

Individuals with Undiagnosed HIV

The CD4 Model V4.1 SAS program was used to analyze the 2020 Oklahoma eHARS person-based dataset to determine the estimated number of individuals with HIV who have not yet been diagnosed. The estimated number of Oklahoma residents aged 13 years and older living with undiagnosed HIV infection in 2020 was 1,500 (95% CI: 800, 2300) with 87% (1300) being male (95% CI: 620, 1900). Of the males, 77% (1000) are estimated to fall in the transmission category of male-to-male sexual contact (95% CI: 450, 1600). Whites are estimated to have the highest percentage undiagnosed at 41% (95% CI: 120, 1100), followed by Blacks at 23% (95% CI: 10, 660) and Hispanics at 19% (95% CI: 0, 580). The age groups 25 – 34 years and 35 – 44 years had the highest percentage of estimated undiagnosed HIV at 43% (95% CI: 280, 990) and 25% (95% CI: 100, 650) respectively.

Table A2. Persons Living with Undiagnosed HIV Infection in Oklahoma, 2020

	Number	95% Confidence Interval	
Sex at Birth			
Male	1,300	620	1,900
Female	240	0	530
Age at Infection			
13 – 24	180	0	370
25 – 34	640	280	990
35 – 44	380	100	650
45 – 54	190	0	420
≥ 55	150	0	420
Race/Ethnicity			
American Indian/Alaska Native	140	0	350
Asian	30	0	110
Black/African American	340	10	660
Hispanic/Latinx	290	0	580
Native Hawaiian/Pacific Islander	0	0	30
White	610	120	1,100
Multi race	110	0	280
Transmission Category			
MSM	1,000	450	1,600
IDU	170	0	420
MSM/IDU	130	0	350
Heterosexual Contact	220	0	530
Total	**1,500**	**800**	**2,300**

HIV Clusters Identified in Oklahoma

Oklahoma routinely conducts HIV cluster time-space analyses at the county level to identify non-molecular clusters of concern. Currently Oklahoma has open cluster investigations in two counties. The first cluster was initially identified in October 2020 in a rural Oklahoma county. All identified members were male, with two-thirds reporting male to male sexual contact and one-third reporting injection drug use. Fifty percent had AIDS at diagnosis. Unfortunately, due to COVID-19, our response capacity was limited in 2020 and 2021. Several clients were also not interviewed because of severe injuries or death. Identifying risk networks has also been challenging due to the number of anonymous partners reported.

Public Health Detailers visited several clinics in this county to discuss the increase in new HIV diagnoses and provide education on HIV testing and the importance of linkage to care. Because we were unable to interview all members of the cluster and test all partners, we continue to monitor this cluster closely.

The second cluster was identified in July 2021 in a rural county. All identified cluster members were male and reported male to male sexual contact. One-third had AIDS at diagnosis. Due to the high number of anonymous partners reported, identifying risk networks for testing and linkage to PrEP was difficult. Our Public Health Detailers visited several clinics in this county to discuss the increase in new HIV diagnoses and provide education on HIV testing and the importance of linkage to care. We continue to monitor this county to ensure all cases are linked to care and achieve viral suppression, and ensure efforts are exhausted to contact and test named partners.

HIV Care Continuum 2020

Using 2020 surveillance data, a diagnosed-based HIV Care Continuum was created for Oklahoma. A diagnosed-based approach shows each step of the continuum as a percentage of the number of persons living with HIV, who have been diagnosed as opposed to a prevalence-based approach in which each step is the percentage of the total number of persons living with HIV (diagnosed and undiagnosed infection). Oklahoma chose the diagnosis-based continuum because this is the most accurate data available and this approach is the most beneficial for infection service delivery planning. As diagnosed persons are made known to the health department, they are the persons that can be most effectively targeted for interventions to help link and retain in care.

The 2020 Oklahoma HIV Care Continuum includes the four recommended steps for a diagnosis-based approach. The first step is *linkage to care* which is defined as those who received an HIV diagnosis in the calendar year of measure who have also had one or more documented CD4 or viral load tests within 30 days of diagnosis. This step has a different denominator than the other three steps of the continuum, and therefore, cannot be directly compared to the other three steps in the care continuum. The second step is *receipt of care* which is defined as the percentage of persons with diagnosed HIV who had at least one CD4 or Viral Load test within the calendar year of measure. The third step in the care continuum is *retained in care* which is defined as the percentage of persons with diagnosed HIV who had two or more CD4 or viral load tests performed at least three months apart. *Viral suppression* is the fourth step in the care continuum, and it is defined as the percentage of persons with diagnosed HIV who had a viral load test result of less than 200 copies/mL at the most recent viral load test during the measurement year.

Of the 345 HIV cases diagnosed in Oklahoma in 2020, 78.8% (272) were linked to care within thirty days of diagnosis. Of the 7,158 persons living with HIV in Oklahoma at the end of 2020, 66.9% (4,789) received care, 43.6% (3,124) were retained in care, and 55.3% (3,955) were virally suppressed.

Disparities in the percentage of newly diagnosed persons linked to care existed by race/ethnicity. Asian/Pacific Islanders (100%) had the highest percentage of persons linked to care; however, this group also accounted for the smallest number of new HIV cases in 2020. Multi race (82.4%) had the second highest percentage of linked to care, followed by Hispanics (81.1%) and Whites (78.5%). Blacks (77.4%) and American Indian/Alaska Natives (73.1%) had the lowest percentage of cases linked to care. Males and females had similar percentages of cases linked to care, 78.8% and 79.2% respectively. Cases classified as no identified risk/no reported risk (NIR/NRR) (83.8%) had the highest percentage of cases linked to care followed by heterosexual contact (81.0%) and MSM (80.4%). MSM/IDU (70.0%) and IDU (56.0%) had the lowest percentage of cases linked to care within thirty days.

Disparities in the percentage of persons living with HIV who received care were observed among racial/ethnic groups in 2020. Asian/Pacific Islanders had the highest percentage of cases receiving care (80.0%). Multi race (73.0%) had the second highest percentage followed by American Indians/Alaska

Natives (70.2%) and Whites (69.9%). Blacks and Hispanics had the lowest percentage of those receiving care, 62.2% and 57.5% respectively. Those with an unknown or other race had a percentage of 40.0% receiving care; however, this should be interpreted with caution as this group had the lowest number of cases (5). 67.6% of males received care, while 64.0% of females received care. Small variations were seen across risk groups for receipt of care. MSM had the highest percentage of cases who received care (71.0%), followed closely by MSM/IDU (69.2%) and perinatal (68.6%). Heterosexual contact and blood recipient had similar percentages of those receiving care, 63.7% and 63.2% respectively. IDU and those with no identified risk had the lowest percentages of those receiving care, 61.6% and 55.5% respectively.

Asian/Pacific Islanders had the highest percentage of those retained in care (59.2%) followed by Multi race (45.3%), Whites (45.0%), and American Indians/Alaska Natives (45.0%). Hispanics (41.3%) and Blacks (40.3%) have the lowest percentages of those retained in care. Males had 44.2% retained in care while females had 41.2%. Among risk factors, those with the highest retention in care had reported risk factors of perinatal (47.1%), MSM/IDU (46.8%), and MSM (46.1%) followed by heterosexual contact (43.4%). IDU and NIR/NRR factors had lower percentages of those retained in care, 39.6% and 35.0% respectively. Blood recipients (31.6%) had the lowest percentage of those retained in care.

Disparities also existed in viral suppression by race/ethnicity. Asian/Pacific Islanders contained the highest percentage of those virally suppressed (75.2%) followed by Whites (58.7%), Multi race (57.3%), and American Indian/Alaska Natives (56.1%). Hispanics and Blacks had the lowest percentage of those virally suppressed, 49.5% and 48.9% respectively. Males were 55.8% virally suppressed, while females were 52.8% virally suppressed. Among risk factors, MSM (59.6%) had the highest percentage of those virally suppressed followed closely by perinatal (57.1%), heterosexual contact (53.7%), MSM/IDU (52.9%), and blood recipients (52.6%). IDU and those with NIR/NRR contained the lowest percentage of those virally suppressed, 49.6% and 44.4% respectively.

Figure A10. Oklahoma HIV Care Continuum, 2020

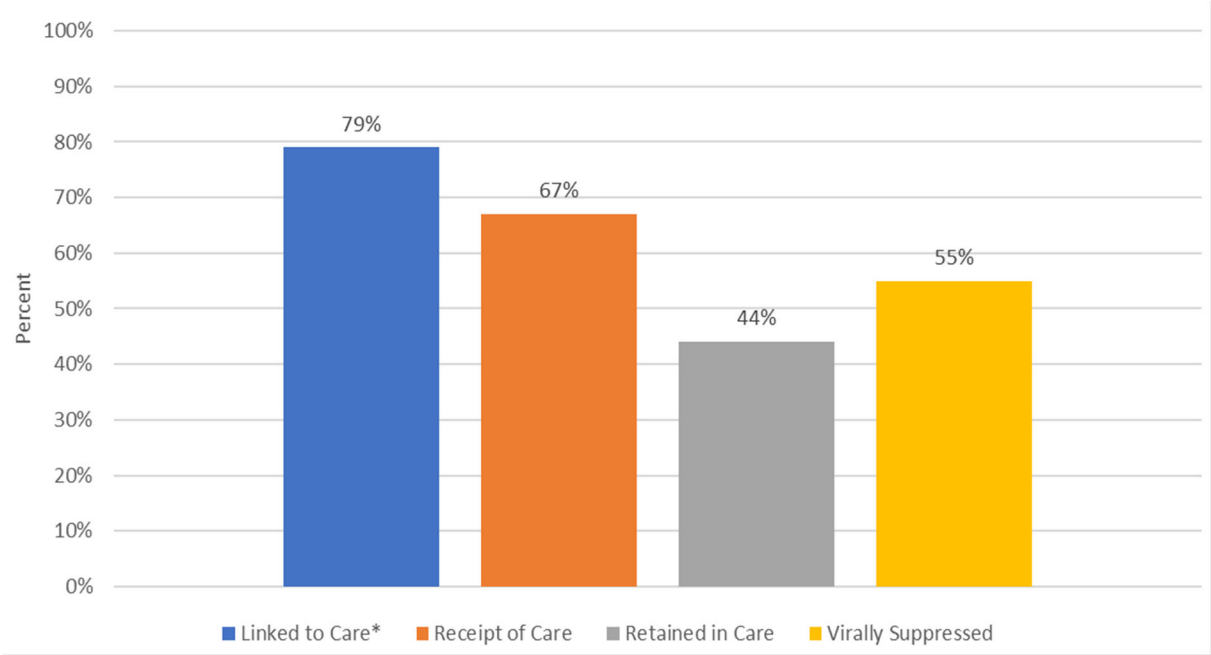


Figure A11. Diagnosis-Based HIV Care Continuum, by Race/Ethnicity, Oklahoma 2020

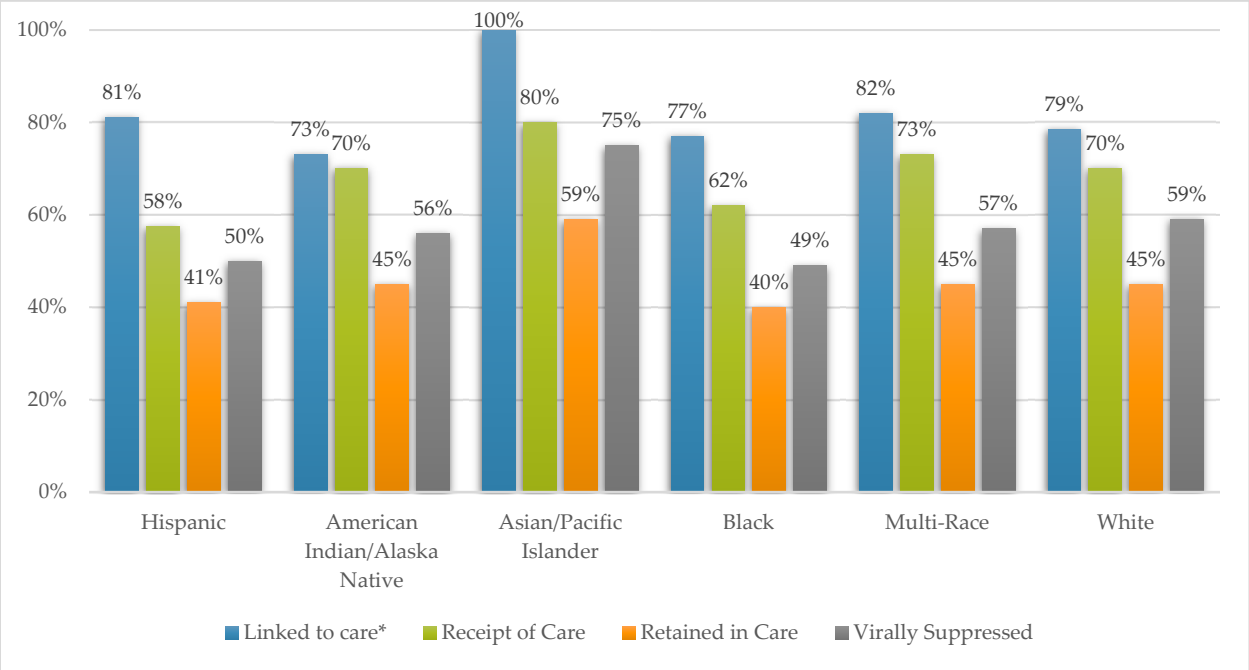


Figure A12. Diagnosis-Based HIV Care Continuum by Sex, Oklahoma 2020

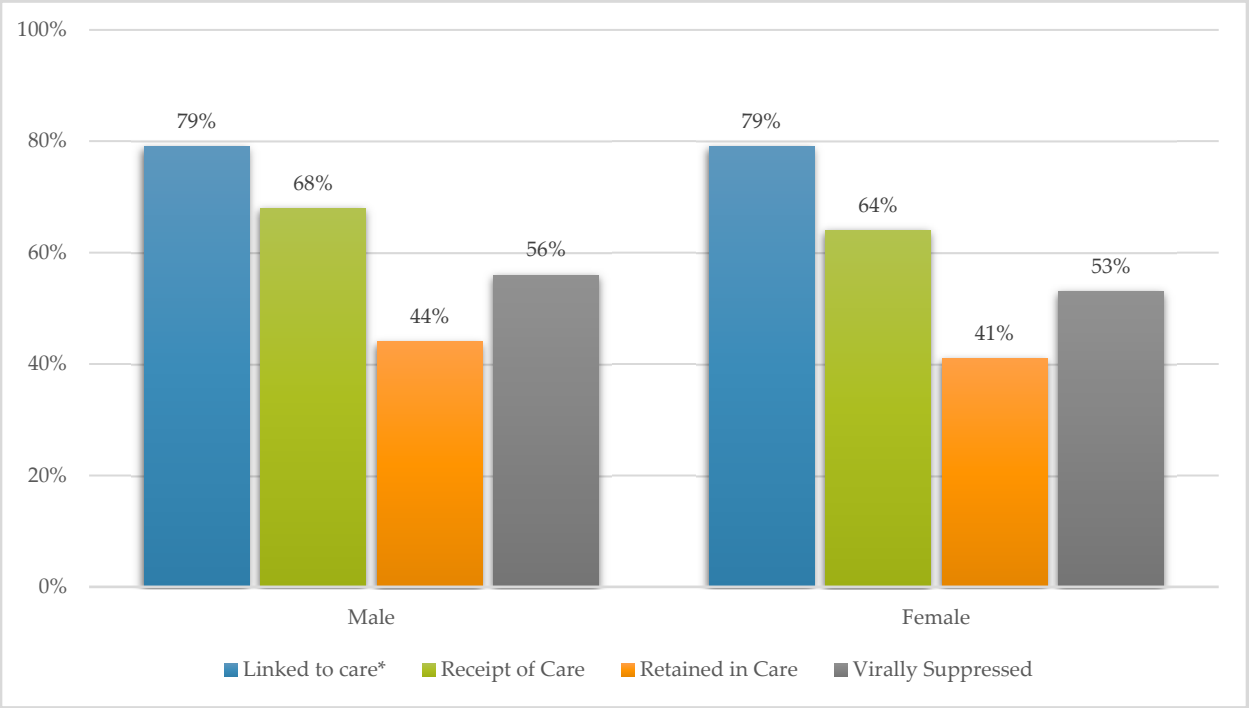
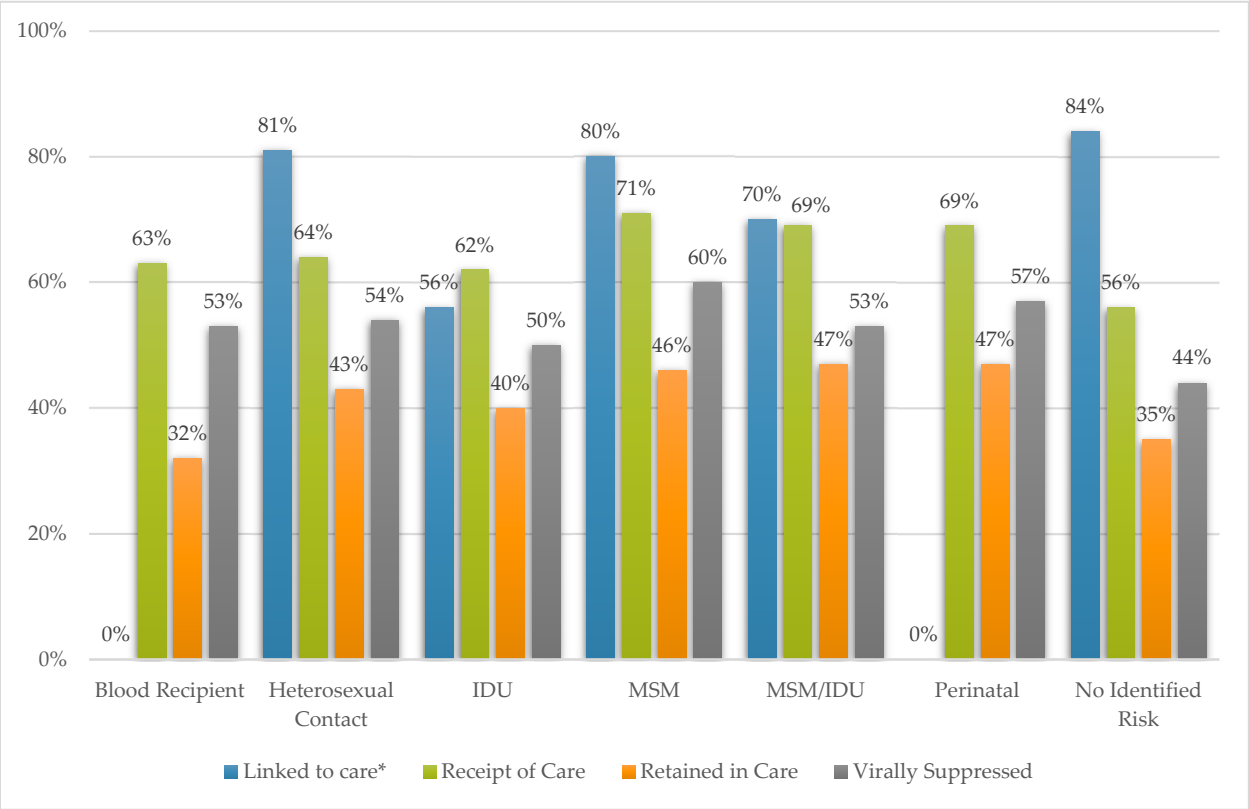


Figure A13. Diagnosis-Based HIV Care Continuum by Risk, Oklahoma 2020



*Note: *Linked to care* measures the percentage of people *newly diagnosed* with HIV; therefore, it is calculated differently and cannot be directly compared to other steps within the care continuum.

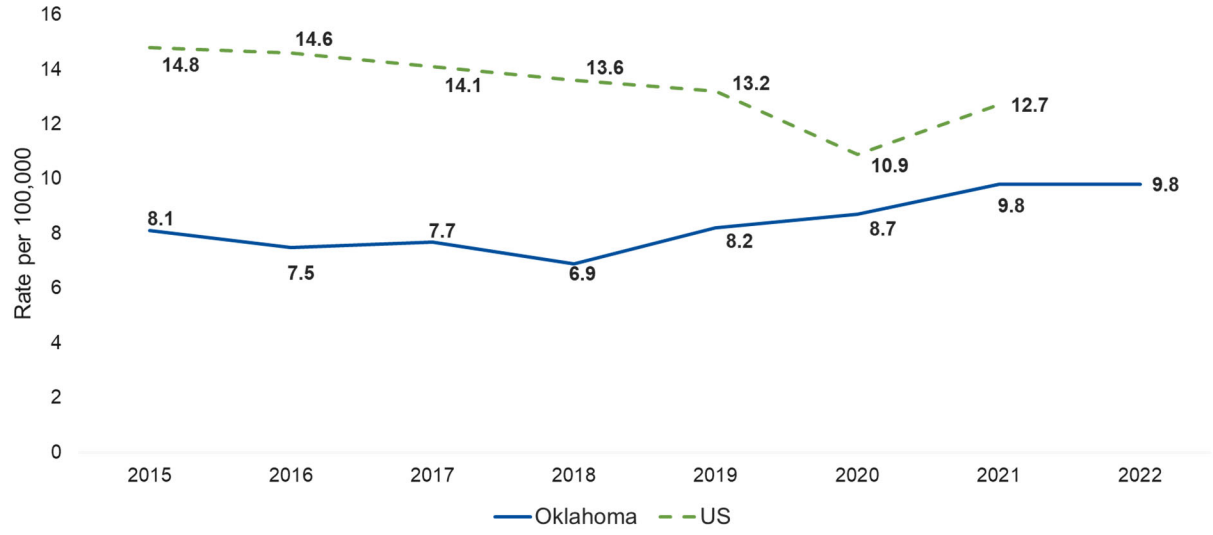
Addendum to Epidemiologic Snapshot of Oklahoma

NEWLY DIAGNOSED HIV CASES

Oklahoma has a state population of 4,019,800 as of 2022. At the end of December 2022, an estimated 7,684 people were living with HIV/AIDS in Oklahoma at a rate of 191.2 per 100,000 population. Of those, 44.3% (3,402) had been diagnosed with AIDS.

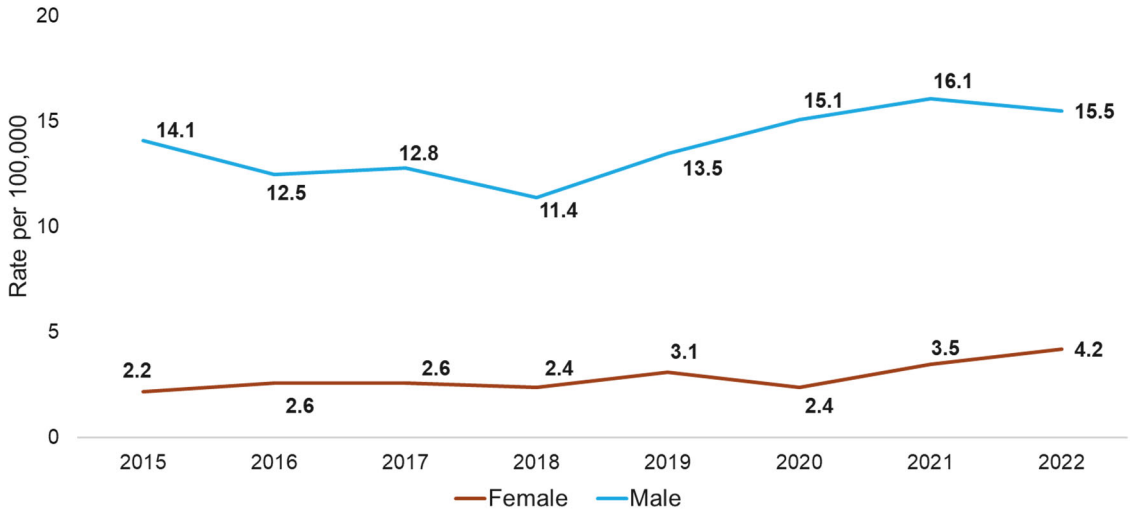
In 2022, 395 individuals were newly diagnosed with HIV in Oklahoma at a rate of 9.8 cases per 100,000 population, which was less than the U.S. rate of 12.7 per 100,0000. 21.3% of those newly diagnosed with HIV in Oklahoma were classified as late testers, or those diagnosed with AIDS within three months of their HIV diagnosis.

Figure A.14 Rates of New HIV Diagnoses among people ≥13 years, U.S. and Oklahoma 2015-2022



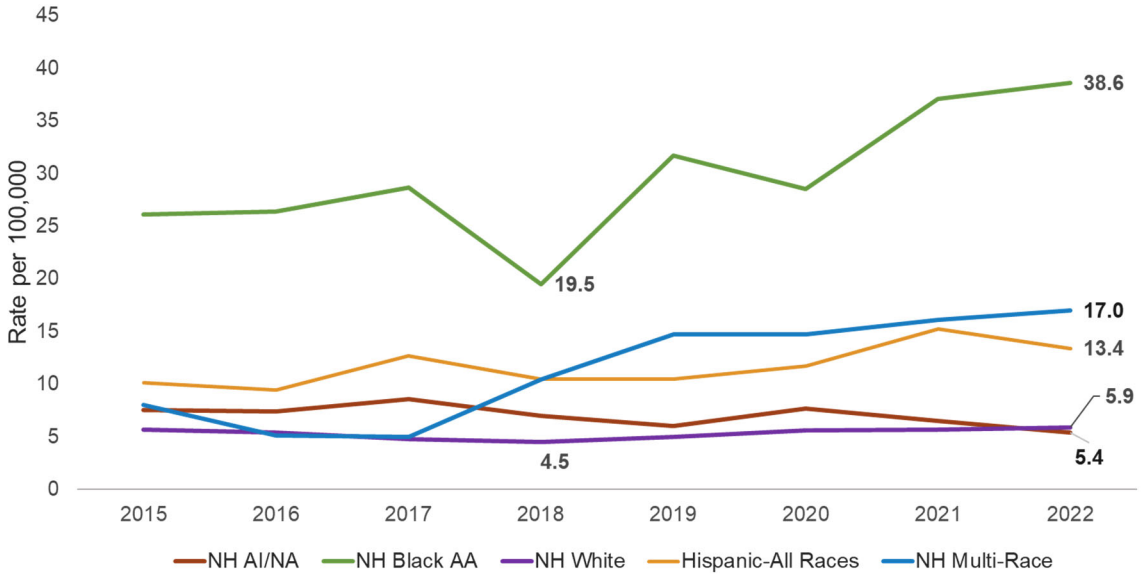
The rate of new HIV diagnoses in Oklahoma has increased steadily over time with a 45.8% increase from 2018 to 2022, and while the U.S. experienced a decrease in HIV diagnoses in 2020, Oklahoma observed a slight overall increase in new HIV diagnoses (Figure A.14).

Figure A.15 Rates of New HIV Diagnoses among people ≥13 years by Sex at Birth, Oklahoma 2015-2022



In 2022, males accounted for 78% (310) of the newly diagnosed cases and females accounted for 22% (85) (Figure A.15). Over time, the rate of new HIV diagnoses in Oklahoma has increased for both males and females with a 38.6% increase from 2018 to 2022 for males and a 77.1% increase for females. In 2020, a slight decrease by 22.6% from 2019 among females was observed, however males continued to increase by 12.5 %.

Figure A.16 Rates of New HIV Diagnoses among people ≥13 years by Race/Ethnicity, Oklahoma 2015-2022



Data notes: NH- Non- Hispanic, AI/AN- American Indian/Alaska Native, AA-African American.
Rates not shown for Non-Hispanic Asian/Pacific Islander due to small numbers.

In 2022, diagnosed new HIV infections for Blacks was 38.6 per 100,000 (the highest group rate) and for AI/AN was 5.4 per 100,000 (the lowest group rate) (Figure A.16). The difference in diagnosed HIV is 33.2 per 100,000. Thus, for every 100,000 Blacks with diagnosed HIV, 33.2 diagnoses would be prevented if Blacks had the same health experience as AI/AN. This compares to a relative risk (relative disparity) for Blacks receiving HIV diagnosis at a rate that is 7.1 times the rate of AI/AN.

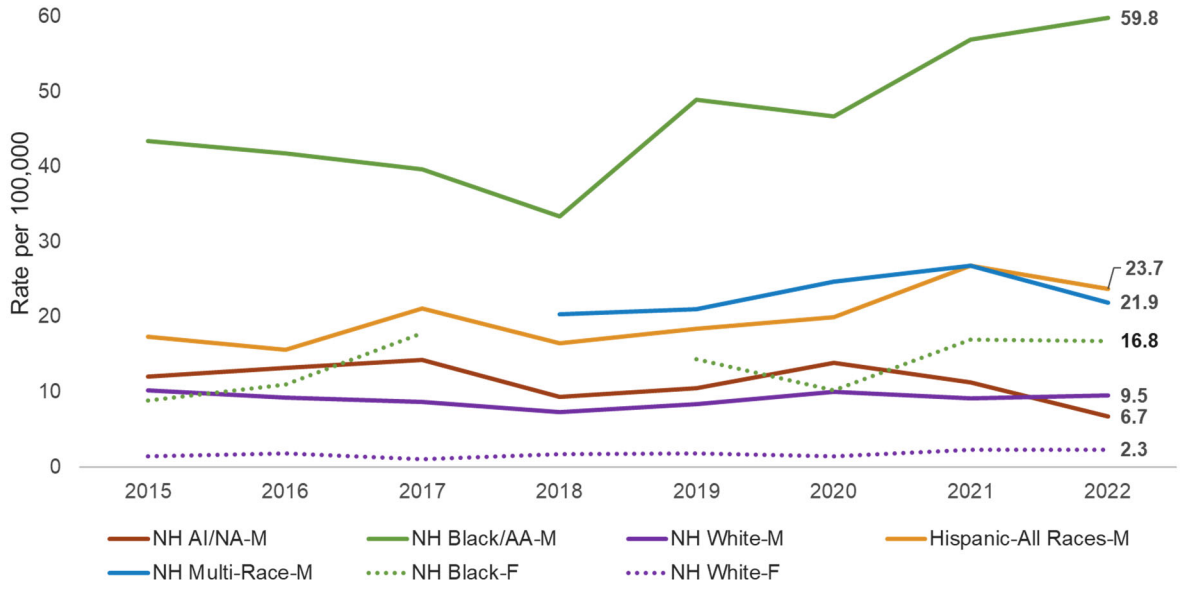
The change in maximal rate ratio was 2.8, which means the disparity between the highest group rate and the lowest group rate increased from 2018 to 2022 by 2.8 on a relative scale.

Among Oklahoma males, in 2022, diagnosed new HIV infections for Black males was 59.8 per 100,000 (the highest group rate) and for AI/AN males was 6.7 per 100,000 (the lowest group rate) (**Figure A.17**). The difference in diagnosed HIV (absolute difference) is 53.1 per 100,000. Thus, for every 100,000 Black male with diagnosed HIV, 53.1 diagnoses would be prevented if Black male had the same health experience as AI/AN male.

This compares to a relative risk (relative disparity) for Black males receiving HIV diagnosis at a rate that is 8.9 times the rate of AI/NA males (i.e., for every HIV diagnosis among AI/NA males, 8.9 diagnoses occur among Black males).

The change in maximal rate ratio was 4.4, which means the disparity from 2018 to 2022 has increased by 4.4 on a relative scale.

Figure A.17 Rates of New HIV Diagnoses among people ≥13 years by Race/Ethnicity and Sex Assigned at Birth, Oklahoma 2015-2022

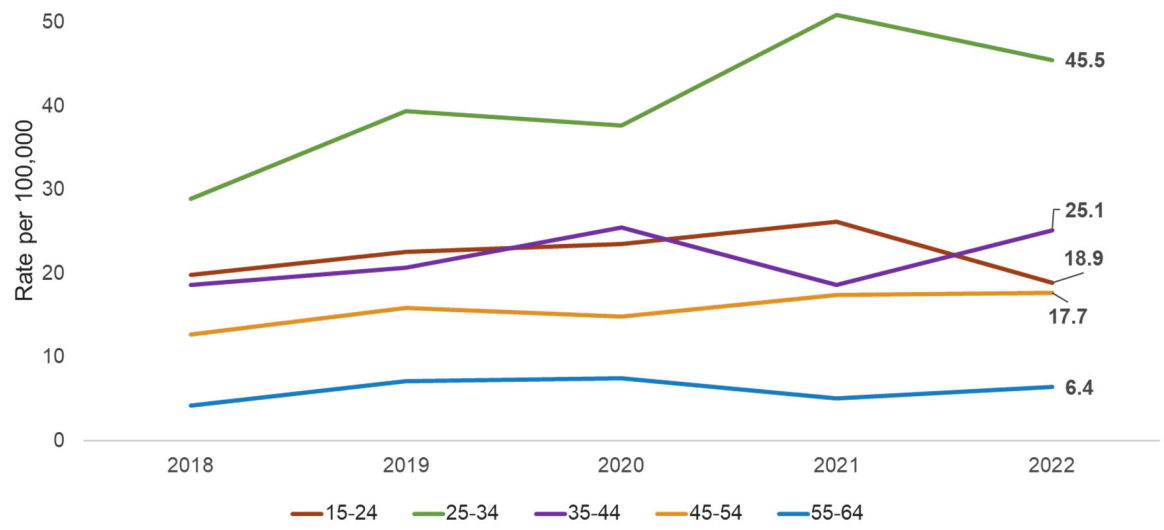


Data notes: NH- Non- Hispanic, AI/AN- American Indian/Alaska Native, AA-African American. M- Male, F-Female. Rates not shown for cell counts below 12 due to rate instability.

Among females, in 2022, diagnosed HIV infections for Black females was 16.8 per 100,000 (the highest group rate) and for white was 2.3 per 100,000 (the lowest group rate) (Figure A.17). The difference in diagnosed HIV (absolute difference) is 14.5 per 100,000. Thus, for every 100,000 Black females with diagnosed HIV, 14.5 diagnoses would be prevented if Black females had the same health experience as white females. This compares to a relative risk (relative disparity) for Black females receiving HIV diagnosis at a rate that is 7.3 times the rate of white females (i.e., for every HIV diagnosis among white females, 7.3 diagnoses occur among Black persons).

In 2022, among new HIV diagnoses, persons aged 25-44 accounted for 62.3% among new HIV diagnoses. Among newly HIV diagnosed males, the highest rate was observed among the 25–34 age group (45.5 per 100,000), while the lowest was among the 55-64 age group (6.4 per 100,000) (Figure A.18). We do observe a decrease among 15-24 age group from 2021 (N=77) to 2022 (N=57) by 26.0%, and an increase among 35-44 age group from 2021 (N=49) to 2022 (N=67) by 36.7%.

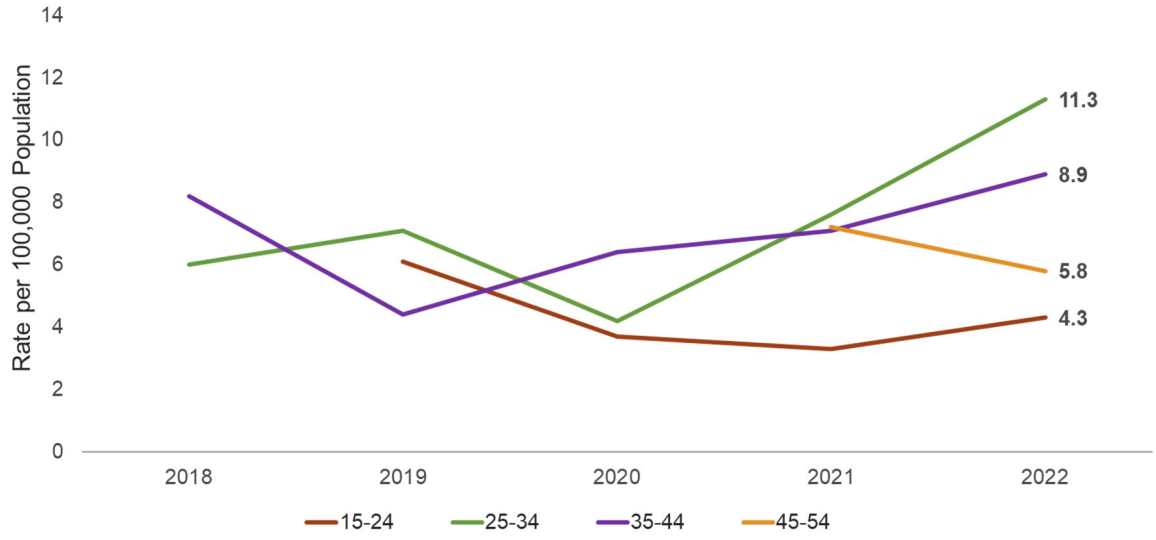
Figure A.18 Rates of New HIV Diagnoses among Males ≥13 years by Age Group, Oklahoma 2018-2022



Data notes: Rates not shown for ages below 15 or above 65 and up due to small numbers.

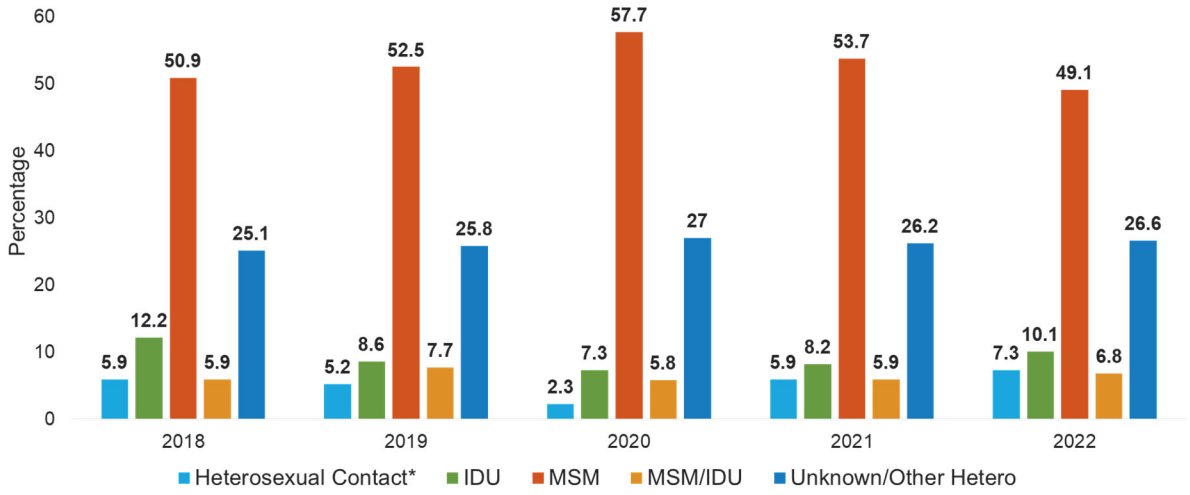
Among newly HIV diagnosed females, the highest rate was observed among the 25–34 age group (11.3 per 100,000) (Figure A.19). We do observe a decrease among 15-24 age group from 2021 to 2022 by 17.5%, and an increase among 35-44 age group by 34.3%.

Figure A.19 Rates of New HIV Diagnoses among Females ≥13 years by Age Group, Oklahoma 2018-2022



As described previously, the highest percentage reported mode of transmission among newly HIV diagnosed has been MSM and has been the highest for the last five years (Figure A.20). In 2022, there was a slight decrease in the MSM mode of transmission, however, still accounts for about half of newly HIV diagnosed. The mode of transmission has been somewhat consistent thru the years with a slight increase observed for the IDU and, IDU and MSM as mode of transmission from 2021.

Figure A.20 Distribution of Exposure Among Adults and Adolescents Aged 13 and Older With Newly Diagnosed HIV, Oklahoma 2018-2022

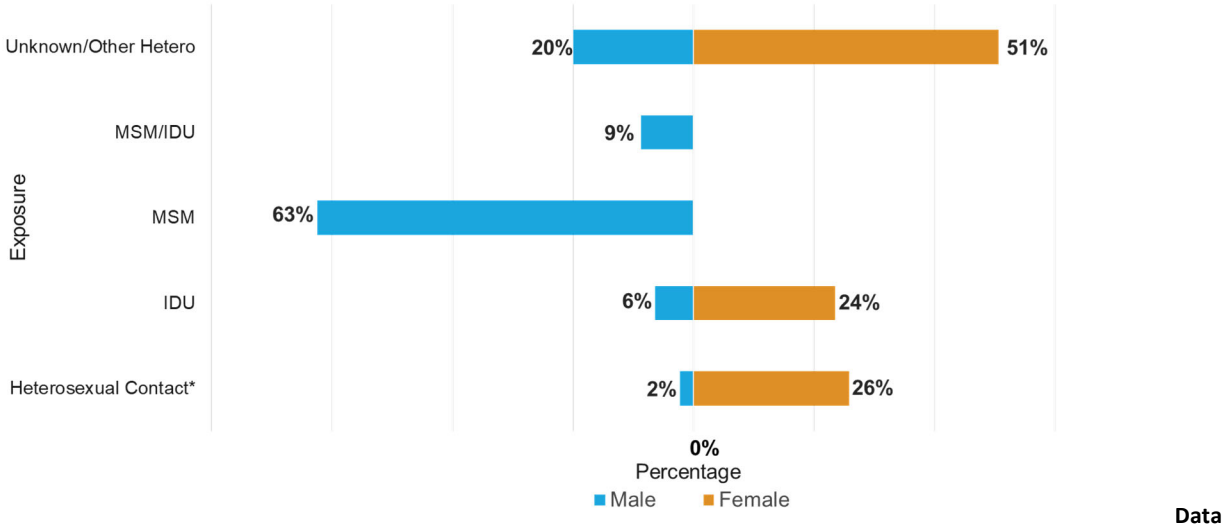


Data Notes: IDU- Injection Drug Use, MSM- Male to male sexual.

*Heterosexual contact with a person known to have HIV or known to be at high risk for HIV (e.g., MSM or person who injects drugs).

In 2022, among females the highest percentage for mode of transmission reported was either unknown or sex with a man without known risk for HIV (Figure A21). Thereafter, reported mode of transmission was sex with a person known to be at high risk for HIV (26%) and IDU (24%). Among males in 2022, 20% were unknown or sex with a woman with unknown risk for HIV, followed by IDU and MSM (9%), IDU only (6%) and 2% was sex with a woman known to be at high risk for HIV.

Figure A.21 Distribution of Exposure Among Adults and Adolescents Aged 13 and Older With Newly Diagnosed HIV by Sex Assigned at Birth, Oklahoma 2022



Notes: IDU- Injection Drug Use, MSM- Male to male sexual.
*Heterosexual contact with a person known to have HIV or known to be at high risk for HIV (e.g., MSM or person who injects drugs).

Oklahoma Social Determinants of Health Profile

The Oklahoma HIV surveillance data has highlighted differences in HIV burden and the trends of that burden for sex assigned at birth, race/ethnicity, and transmission category. However Social Determinants of Health (SDOH) contribute to these disparities and it's important to understand how things SDOH affects the health of the Oklahoma population. According to the 2018-2022 American Community Survey 5-year estimates, 13.8% of Oklahoma persons under 65 years old do not have health insurance, an 15.7% are persons in poverty among Oklahoma population. The median household income was $61,364 and 11.1% had less than high school diploma.

In Oklahoma, HIV infection was diagnosed for 347 adults (aged 18 years and older) whose residential address information was sufficient for geocoding to the census tract (or tract) level (Table A3.). These diagnoses represent approximately 87.8% of all diagnoses of HIV infection in 2022 among adults in these areas. The overall rate of diagnoses of HIV infection was 11.5.

POVERTY LEVEL

In 2022, Oklahoma adults with the highest HIV diagnosis rate of 19.1 per 100,000 population also live in census tracts with the highest level of poverty (i.e., lowest level of wealth; where 17% or more of the residents lived below the federal poverty level).

If those in the highest poverty/lowest wealth tracts lived in the lowest poverty/highest wealth tracts, then 13 cases would have been prevented (absolute disparity). The highest poverty/lowest wealth rate was 3 times the lowest poverty/highest wealth rate (relative disparity).

Education Level

In 2022, Oklahoma adults with the highest HIV diagnosis rate of 20.1 per 100,000 population also live in census tracts with the lowest level of education (where 17% or more of the residents had less than a high school diploma). Education plays an important role in preventing HIV; increased education reduces the social and economic circumstances that may put someone at increased risk for HIV.

If those in the lowest education tracts lived in the highest education tracts, then 12 cases would have been prevented (absolute disparity). The lowest education rate was 2 times the highest education rate (relative disparity).

Table A3. Diagnoses of HIV Infection among Adults (>18) and Selected Social Determinants of Health, Oklahoma 2022

	Number	Population	Rate
Below federal poverty level (%)			
< 6	33	560,399	5.9
6-<10	44	605,121	7.3
10-<17	103	981,589	10.5
17+	167	872,944	19.1
Less than high school diploma (%)			
<5	41	497,039	8.2
5-<9	67	755,957	8.9
9-<16	111	1,130,204	9.8
16+	128	636,853	20.1
Median household income (U.S. $)			
<49,000	167	815,554	20.5
49,000-<66,000	106	978,921	10.8
66,000-<90,000	46	727,039	6.3
90,000+	28	498,539	5.6
Without health insurance (%)			
<4	15	164,791	9.1
4-<8	23	357,657	6.4
8-<14	58	857,593	6.8
14+	251	1,640,012	15.3
Income Inequality (Gini index) (%)			
<37	77	652,145	11.8
37-<41	83	732,301	11.3
41-<46	103	950,514	10.8
46+	84	685,093	12.3
Total	**347**	**3,020,053**	**11.5**

Notes: 2018-2022 American Community Survey 5-year estimates. Rates are per 100,000 population. Row entries indicate categories based on census tracts; data reflect the census tract of the person's residential address at the time they received an HIV diagnosis.

Median Household Income

In 2022, Oklahoma adults with the highest HIV diagnosis rate of 20.5 per 100,000 population also live in census tracts with the lowest median household income (where the median household income was less than $49,000 a year). HIV leads to economic hardship and a decreased median household income may be related to lower probability of survival after an HIV diagnosis (absolute disparity).

If those in the lowest income tracts lived in the highest income tracts, then 15 cases would have been prevented. The lowest income rate was 4 times the highest income rate (relative disparity).

Health Insurance Coverage

In 2022, Oklahoma adults with the highest HIV diagnosis rate of 15.3 per 100,000 population also live in census tracts with the lowest health insurance or health coverage plan (where 14% or more of the residents did not have health insurance coverage). Health insurance coverage is associated with improved access to health services and better health outcomes.

If those in the lowest insurance coverage tracts lived in the highest insurance coverage tracts, then 6 cases would have been prevented. The lowest insurance coverage rate was 2 times the highest insurance coverage rate.

Income Inequality (Gini Index)

In 2022, Oklahoma adults with the highest HIV diagnosis rate of 12.3 per 100,000 population also live in census tracts with the highest income inequality (where income inequality was 46% or more). The Gini index is a measure of the distribution of income across a population. A higher Gini index indicates a greater inequality.

If those in the highest income inequality tracts lived in the lowest income inequality tracts, then 1 case would have been prevented. The highest income inequality rate was 1 times the lowest income inequality rate.

HIV Prevention, Care and Treatment Resource Inventory

SHHRS has the following funding sources: CDC STD PCHD (PS19-1901), CDC Integrated HIV Prevention and Surveillance (PS18-1802), CDC EHE (PS20-2010), CDC Integrated Hepatitis Surveillance and Prevention (PS21-2103), HRSA Ryan White Part B (X07), and HRSA Ryan White EHE (UT8). Other leveraged public and private funding sources include: HRSA Bureau of Health Primary Care, Indian Health Service, Medicaid.

The robust services available through public and private funding throughout the state of Oklahoma for people at-risk for or living with HIV provide access to quality health care. Expanded Medicaid has allowed for additional service provision in that some persons with HIV who may not have accessed Ryan White assistance due to the stigma and fear of exposure have felt more comfortable accessing Medicaid. The real challenge to full access for people is the lack of medical providers and availability of services, especially in rural Oklahoma. Expanded utilization of telehealth initiated during the COVID-19 pandemic and lessons learned from that will serve to enhance access to care moving forward.

The following HIV prevention, care and treatment inventory was completed by the Integrated Prevention and Care Planning Committee, with review and input from the OHHPC. Strengths and gaps identified in the prior EHE planning process were updated to include information identified in the 2022 Oklahoma Needs Assessment.

Substance Use Prevention and Treatment

SHHRS has developed a very strong relationship with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to help them establish harm reduction programs, so that individuals living with substance use disorder have the resources they need. This provides SHHRS access to numerous substance use facilities across the state. Harm Reduction programs are required to register with the Oklahoma State Department of Health and provide quarterly reporting to the state. Ryan White clients can access treatment at these facilities through the insurance assistance program.

HIV Prevention Organizations: Free HIV & STI Testing Sites (CDC-funded and other funding sources)*

Oklahoma State Department of Health - County Health Departments
Prevention services, testing, outreach and education
Visit https://oklahoma.gov/health/locations/countymap.html | Select the appropriate county to find a location near you.

Diversity Center of OK, Inc.
Prevention services, treatment, testing, outreach and education
2242 NW 39th St., Oklahoma City, OK 73112 | (405) 601-7686 | diversitycenterofoklahoma.org

Diversity Family Health
Prevention services, treatment, testing, outreach and education
1211 N Shartel Ave., Ste. 606, Oklahoma City, OK 73103 | (405) 848-0026 | diversityfamilyhealth.com

Equality Health Group Foundation
Prevention services, treatment, testing, outreach, mobile screening and education
4301 NW 63rd Street, Suite 9, Oklahoma City, OK 73116 | (405) 761-2762 | https://www.ehg.health/

Expressions Community Center* (Hablamos Español) (CDC Funding)
Prevention services, testing, outreach and education

Priority Population served: Hispanic/Latino, LGBTQ++
2245 NW 39th St. Oklahoma City, OK 73112 | (405) 521-0897 | Eccokc.org

Guiding Right, Inc. * (CDC Funding)
www.guidingright.org
Prevention services, treatment, testing, outreach, mobile screening and education
Priority population served: Black, Hispanic/Latino
1420 NE 23rd St., Oklahoma City, OK 73111 | (405) 733-0771
4619 S Harvard Ave. Suite 104, Tulsa, OK 74135 | (918) 986-8400

Healing Hands Health Care Services
Prevention services, treatment, testing, outreach, and education
411 NW 11th St. Oklahoma City, OK 73103 | (405) 272-0476 | www.communityhealthok.org
(provides services for homeless clients only)

Health Outreach Prevention Education, Inc. (H.O.P.E) * (Hablamos Español) (CDC Funding)
Prevention services, treatment, testing, outreach, mobile screening and education
Priority population served: PWUD, All persons
3540 E 31St Street, Suite 3, Tulsa, OK 74135 | (918) 749-8378 | https://hopetesting.org/

Latino Community Development Center (LCDA) * (Hablamos Español) (CDC Funding)
Prevention services, testing, outreach, and education
Priority population served: Hispanic/Latino
420 SW 10th St, OKC 73109 | (405) 236-0701 | Lcdaokc.com

New Hope Wellness Center * (Hablamos Español) (CDC Funding)
Prevention services, treatment, testing, outreach, and education
Priority population served: Black, Hispanic/Latino
2809 NW 31st St., Oklahoma City, OK 73112 | (405) 730-0771 | www.nhwellnesscenter.org

OKC County Health Department (OCCHD)
occhd.org
Prevention services, treatment, testing, outreach, mobile screening and education
6728 S Hudson Ave. Oklahoma City, OK 73139 | (405) 419-4119
2700 NE 63rd Street, Oklahoma City, OK 73111 | (405) 419-4200
4330 NW 10th Street, Oklahoma City, OK 73107 | (405) 419-4150

Red Rock Behavioral Health Services * (CDC Funding)
Prevention services, testing, outreach, SUC treatment (in-patient, out-patient) and education
Priority population: PWUD, LGBTQ++, youth
4400 N Lincoln Blvd. Oklahoma City, OK 73105 | (405) 424-7711 or 877-339-3330 | red-rock.com

Variety Care Teen Clinic
Prevention services, testing, outreach, and education
Visit Locations | Variety Care (http://www.varietycare.org) to find a testing location nearest you
(405) 632-6688 | http://www.varietycare.org/teen-clinic.html

Mary Mahoney Memorial Health Center

Prevention services, treatment, testing, outreach, and education
12716 NE 36th St., Spencer, OK 73084 | (405) 769-3301 | www.communityhealthok.org

Planned Parenthood Great Plains
Prevention services, treatment, testing, and education
www.plannedparenthood.org
3431 S Boulevard, Suite 108, Edmond, OK 73013 | (405) 348-9904
619 NW 23rd Street, Oklahoma City, OK 73103 | (405) 528-2157
1007 S Peoria Ave., Tulsa, OK 74120 | (918) 858-4661

Revan Health
Prevention services, treatment, testing, and education
5601 NW 72nd Street, Suite 142, Warr Acres, OK 73132 | (405) 896-7975 | www.revanhealth.com

Tulsa County Health Department (TCCHD)
Prevention services, treatment, testing, outreach, mobile screening and education
Visit HIV/AIDS Testing | Tulsa Health Department (www.tulsa-health.org) to find a testing location nearest you, or call (918) 582-9355

Tulsa CARES * (CDC Funding)
Prevention services, treatment, testing, outreach, mobile screening and education
www.tulsacares.org | 3712 East 11th Street, Tulsa, OK 74112-3952 | (918) 834-4194

Variety Care
Prevention services, treatment, testing, outreach, mobile screening and education
Visit Locations | Variety Care (http://www.varietycare.org/you) to find a testing location nearest you
(405) 632-6688

Community Care by Trust Women
Prevention services, treatment, testing, outreach, low barrier buprenorphine treatment, harm reduction services, gender affirming care and education
1240 SW 44th St. Oklahoma City, OK 73109 | (405) 429-7940 | www.trustwomen.org

HRSA Ryan White Part B Funded HIV Care and Treatment Locations

*(*IHS facilities: must have a CDIB card from a federally recognized Tribe for services.)*

Guiding Right - New Hope Wellness Center (Hablamos Español) (HRSA EHE funding, priority populations Black and Hispanic)
Medical Case Management and Outpatient Ambulatory Health Care
2809 NW 31st St., Oklahoma City, OK 73112 | (405) 730-0771 | www.nhwellnesscenter.org

Oklahoma Department of Human Services – AIDS Coordination and Information Services (DHS-ACIS) (Hablamos Español) (HRSA Ryan White Part B Funding)
Social Services Case Management
444 S. Houston, Tulsa, OK | (918) 230-0940 or (918) 378-7008
940 NE 13th St., Ste 2100, Oklahoma City, OK | (405) 271-271-5816

Oklahoma State University Internal Medicine Specialty Services (HRSA Ryan White Part B Funding)
Medical Case Management, Outpatient Ambulatory Health Care, Dental Care, Mental Health Services, and Transportation Assistance
717 S. Houston Ave., Ste 300, Tulsa, OK | (918) 382-5058 or (800) 586-0754

RAIN Oklahoma (HRSA Ryan White Part B and EHE funding)
Social Services Case Management, Dental Services, Transportation Assistance, Nutrition Services
3800 N. Classen Blvd., Ste 200, Oklahoma City, OK | (405) 232-2437 or (800) 285-2273
1103 SW C Ave. #4, Lawton, OK | (580) 353-7900 or (800) 285-2273

Tulsa CARES (Hablamos Español) (HRSA Ryan White Part B Funding)
Social Services Case Management, Mental Health Services, and Transportation Assistance
3712 E. 11th St., Tulsa, OK | (918) 834-4194 or (800) 474-4872

University of Oklahoma Health Sciences Center (HRSA Ryan White Part B Funding)
Medical Case Management, Outpatient Ambulatory Health Care, Dental Services, and Mental Health Services
711 Stanton L. Young Blvd #430, Oklahoma City, OK | (405) 271-6434

PrEP Providers

*(*IHS facilities: must have a CDIB card from a federally recognized Tribe for services.)*

Caring Hands Healthcare Centers | McAlester, OK (918) 426-2442

Cherokee Nation*
Vinita (918) 256-4800; Jay (918) 253-1700; WW Hastings Indian Hospital, Tahlequah (918) 458-3100

Clifford Wlodaver, MD | Midwest City (405) 737-3100

Community Care by Trust Women | Oklahoma City (405) 429-7940 | www.trustwomen.org

Council Oak Comprehensive Health (Muscogee Creek Nation)* | Coweta (918) 233-9550

Coweta Medical Group | Coweta (918) 486-7425 | Visit facebook.com/PREPClinicOK/ for clinic dates.

Deng Family Medicine Center | Midwest City (405) 737-3278

Diversity Family Health | diversityfamilyhealth.com | Oklahoma City (405) 848-0026; Ardmore (405) 848-0026

Equality Health Group Foundation | Oklahoma City (405) 761-2762

Fulcrum Clinic | fulcrum-clinic.com | Oklahoma City; (405) 546-7888

Gamble Family Medical Practice | Tulsa (918) 442-2236

Guiding Right, Inc. | guidingright.org **|** Oklahoma City (405) 733-0771 or (405) 601-7686; Tulsa; (918) 986-8400

Healing Hands Health Care Services | communityhealthok.org | Oklahoma City (405) 272-0476

Health, Outreach, Prevention, Education, Inc. (HOPE) | hopetesting.org | Tulsa (918) 749-8378

Indian Health Services (IHS)*

- Anadarko Indian Health Center| (405) 247-7900
- Carnegie Indian Health Center | (580) 654-1100
- Claremore Indian Hospital | (918) 342-6200
- El Reno Indian Health Center | (405) 295-1500
- Lawton Indian Hospital | (580) 354-5000
- Pawnee Indian Health Center | (918) 762-2517
- Watonga Indian Health Center | (580) 623-4991
- Wewoka Indian Health Center | (405) 257-6282

Infectious Diseases Consultants of OKC | Oklahoma City (405) 644-6464

Mary Mahoney Memorial Health Center | communityhealthok.org | Spencer (405) 769-3301

Meridian Medical Center | meridianmedcenter.com | Oklahoma City (405) 601-3330

New Hope Wellness Center | nhwellnesscenter.org | Oklahoma City (405) 730-0771

OKEQ Health Clinic | okeq.org | 621 East 4th St. Tulsa, OK 74120 | (918) 938-6537

Oklahoma City Indian Clinic* | Oklahoma City (405) 948-4900

OSDH Rapid Start | email RapidStart@health.ok.gov or call (405) 426-8400

OSU Physicians Specialty Services Clinic | Tulsa (918) 382-5058

OU Family Medicine | Oklahoma City (405) 271-4311; Tulsa (918) 619-4400 or 619-4600

OU Health Sciences Infectious Diseases Institute | Oklahoma City (405) 271-6434

OU Physicians Schusterman Center | Tulsa (918) 619-4400

OU Physicians South Memorial |Tulsa (918) 634-7600

OU Physicians Wayman Tisdale Specialty Health | Tulsa (918) 619-8700

Pallavi Agarwal, MD | Tulsa (918) 742-4900

Perry A. Klaassen Family Medical Center | communityhealthok.org | Oklahoma City (405) 419-9800

Planned Parenthood Great Plains | Oklahoma City (405) 528-2157; Edmond (405) 348-9904; Tulsa (918) 587-1101

Revan Health | revanhealth.com | Warr Acres (405) 896-7975

SSM St. Anthony Healthplex | ssmhealth.com | Oklahoma City (405) 252-3450

Tulsa CARES | tulsacares.org **|** (918) 834-4194 or (800) 474-4872

Utica Park Clinic | Tulsa (918) 574-0350

Variety Care | VarietyCare.org/you | Oklahoma City (405) 632-6688

Resource Inventory Strengths

- Increase in access to PrEP from non-physicians; free PrEP access
- Increase in community-based access; CBO ability to find clients
- Increase in state policy awareness around prevention
- County nurse sexual health education comprehension
- Condom distribution program
- Outreach events (testing/education)
- HIV Prevention CO-OP
- Oklahoma State University Infectious Disease Clinic (OSU) can treat quickly (usually within one week); OSU PrEP clinic
- OSDH and partner agencies are good at identifying client partners
- At-risk communities (LGBTQ, Black, Hispanic) are now interested in PrEP and self-advocating, due to media and commercials lowering stigma
- OSDH SHHRS Rapid Start Program
- OHHPC website and social media campaign
- Legislative support for Harm Reduction Programs
- Expanding opportunities for syringes/syringe service programs

- Public Health Detailers and provider education

Resource Inventory Gaps

- Difficulty getting information to rural communities
- Lack of funding for sexual health education/financial support
- Lack of provider education regarding PrEP and PEP; lack of prescribing providers
- Lack of LGBTQ affirming care
- Buy-in from religious organizations
- Lack of transportation to rural areas
- Lack of community knowledge, education, awareness
- Lack of access to care in rural communities
- Lack of care provision through FQHCs
- Lack of availability and understanding of PEP: need to consumer and provider level education on PEP, build network of PEP providers and pharmacies

2022 Oklahoma HIV Needs Assessment Survey

OSDH partnered with the OU E-TEAM to conduct an updated needs assessment to gather information about HIV prevention and treatment needs among Oklahoma citizens. This needs assessment survey collected data from Oklahoma citizens who were HIV-positive or living with AIDS and those who were HIV-negative but at high risk for contracting HIV. Questions were related to HIV testing, HIV prevention, HIV services and care, sexual activity, income and financial assistance, health insurance, general health care, substance use, internet access and telehealth, housing, and transportation.

To solicit survey responses, E-TEAM distributed flyers with a link and QR code for the online needs assessment survey to the 68 OSDH county health departments, the two independent county health departments (Tulsa Health Department and Oklahoma City County Health Department) and clinics that offer HIV testing and services. Additionally, E-TEAM worked with the Oklahoma Department of Mental Health Services and Substance Abuse Services (ODMHSAS) to distribute flyers to 88 community mental health centers across all Oklahoma Counties. E-TEAM also collaborated with Other Options, Inc., a non-profit food pantry focusing on the impact of HIV and AIDS, to include the survey flyers in their food distribution boxes. E-TEAM also distributed the flyer to the YWCA of Oklahoma City, health clinics at community colleges and universities around the state, Palmer Women's Residential facility, counseling centers, Comanche Nation WIC, *The Gayly*, and the VA Oklahoma City Healthcare System's Affirmative Care Clinic, endocrinology department, and infectious disease department.

Survey responses were collected between September and October of 2022. E-TEAM analyzed survey data and prepared this report. Survey findings are presented separately for individuals who indicated they were HIV-positive or living with AIDS and those who reported they were HIV-negative or did not know their HIV status. A summary and recommendations follow each section.

Respondents With HIV-Negative or Unknown Status

There were 159 respondents to the needs assessment survey who were HIV negative, and eight did not know their HIV status.

Demographics

County of Residence

Survey responses came from individuals living in 33 of Oklahoma's counties. The largest numbers of responses were from Oklahoma County (29%), Tulsa County (12%), and Cleveland County (10%; Table B1).

Table B1. Respondents' County of Residence (n = 139)

Beaver	1%	**Mayes**	2%
Beckham	1%	**Muskogee**	2%
Caddo	1%	**Nowata**	1%
Canadian	1%	**Oklahoma**	29%
Carter	1%	**Okmulgee**	1%
Cherokee	3%	**Osage**	2%
Choctaw	1%	**Payne**	6%
Cleveland	10%	**Pittsburg**	4%
Comanche	1%	**Pontotoc**	1%

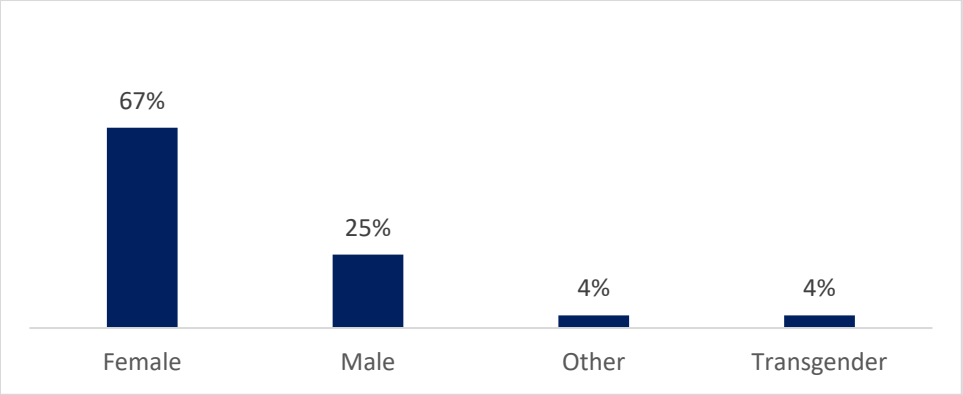
Craig	1%	**Pottawatomie**	1%
Creek	1%	**Roger Mills**	1%
Custer	1%	**Sequoyah**	1%
Garvin	1%	**Tulsa**	12%
Greer	1%	**Wagoner**	3%
Haskell	1%	**Washington**	1%
Jackson	2%	**Mayes**	2%
Kay	2%	**Muskogee**	2%
LeFlore	4%		

Note: Due to rounding, percentages may not add up to 100%.

GENDER

Most survey respondents (67%) were female. A quarter of the responses came from male respondents (Figure B1).

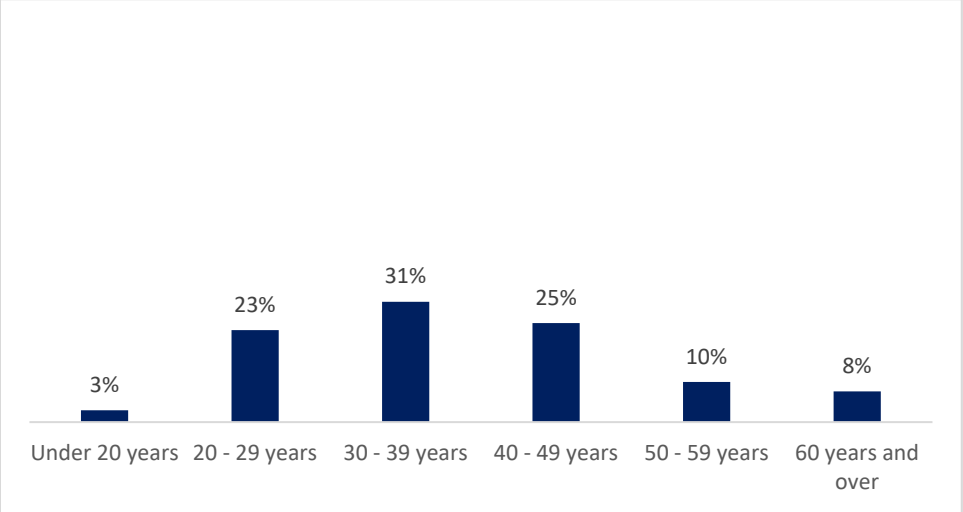
Figure B1. Respondents' Gender (n = 167)



AGE

Most respondents (79%) were between the ages of 20 and 49. Eighteen percent were 50 or older, and only 3% were under 20 years old (Figure B2).

Figure B2. Respondents' Age (n = 167)



Race/Ethnicity

Most respondents (84%) were White. Seventeen percent were American Indian/Alaska Native, and 10% were Black (Table B2).

Table B2. Respondents' Race/Ethnicity (n = 167)

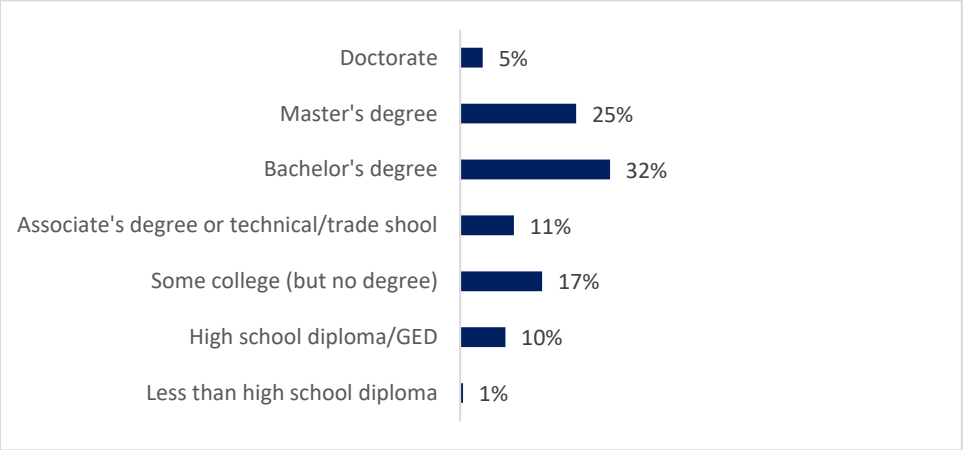
Black	**10%**
White	84%
Native Hawaiian/Pacific Islander	---
American Indian/Alaska Native	17%
Asian	2%
Hispanic/Latino(a)	4%
Other	2%

Note: Respondents could choose more than one option.

Education

More than half of the respondents (57%) had either a bachelor's or master's degree (Figure B3).

Figure B3. Respondents' Highest Level of Education (n = 167)



Note: Due to rounding, percentages may not add up to 100%.

Employment

Most respondents (72%) were employed full-time, and 10% were employed part-time (Table B3).

Table B3. Respondents' Employment Status (n = 167)

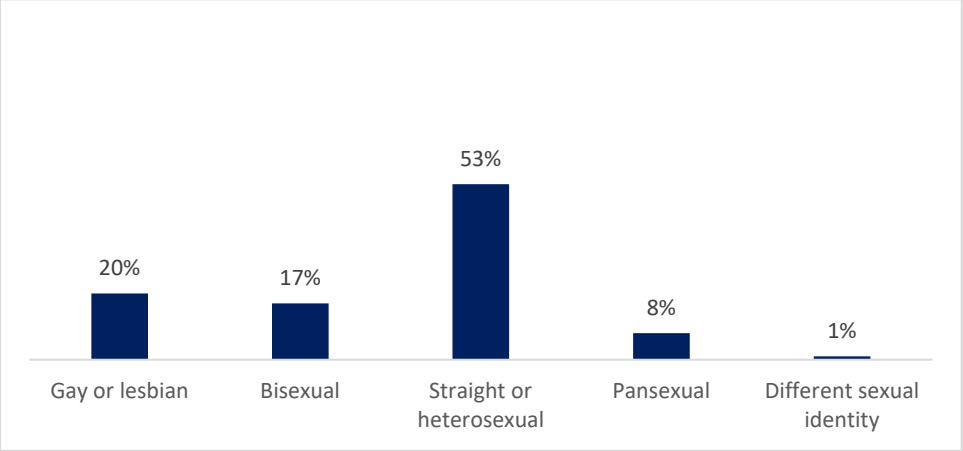
Employed full-time (35+ hours per week)	**72%**
Employed part-time	10%
Temporary or contract work	3%
Self-employed	7%
Unemployed, looking for work	3%
Unemployed, not looking for work	2%
Unemployed, disabled	2%
Unemployed, retired	5%
Other	4%

Note: Respondents could choose more than one option.

Sexual Orientation

More than half of the respondents (53%) were straight or heterosexual, 20% were gay or lesbian, and 17% were bisexual (Figure B4).

Figure B4. Respondents' Sexual Orientation (n = 166)



Note: Due to rounding, percentages may not add up to 100%.

HIV Testing

Seventy-five percent of respondents reported that they had been tested for HIV. Nineteen percent had never been tested, and 6% did not know if they had been tested (n = 167). Of those who had been tested (n = 125), 30% were last tested less than six months ago, 12% were tested 6-12 months ago, and 51% were tested over a year ago. Seven percent did not know when they were last tested for HIV.

Free testing (44%), at-home tests (44%), and healthcare providers' recommendations (41%) were the most common motivating factors for getting tested for HIV (Table B4). Respondents mentioned other motivators such as accessible testing locations, having a new partner, safe transportation to testing sites, more comfortable (less sterile) testing sites, and becoming sexually active. One respondent said they would be motivated to get tested if there were "messaging that reinforces that HIV testing is simply a part of clinical care, like testing for diabetes and high blood pressure."

Table B4. Motivating Factors for Respondents Getting Tested for HIV (n = 112)

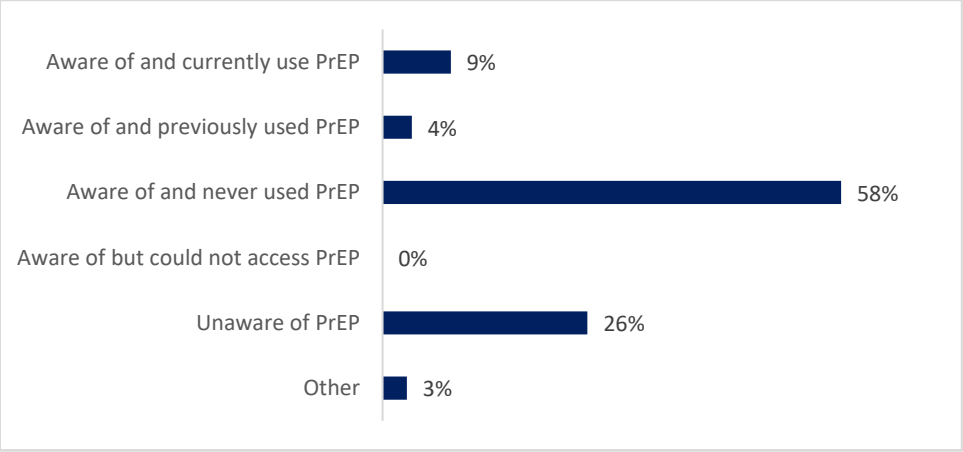
Free testing	**44%**
Incentives for testing	29%
Your healthcare provider's recommendation	41%
At-home tests	44%
Your friend or partner suggests testing	31%
A testing location where you can't be recognized	18%
Not having to use your health insurance	27%
Going to get tested with a trusted friend	13%
Ads or billboards about HIV testing	6%
Seeing social media posts about HIV testing	9%
Other	13%
Nothing can increase how often I am tested for HIV	17%

Note: Respondents could choose more than one option.

HIV Prevention

Most respondents were aware of and had never used pre-exposure prophylaxis (PrEP; 58%; Figure B5). No respondents answered that they were aware of but could not access PrEP. A few respondents explained that they did not feel they needed to use PrEP because they are HIV-negative, which indicates that they are possibly unaware of the purpose of PrEP.

Figure B5. Respondents' Awareness and Use of PrEP (n = 161)



Among those who were aware of PrEP but had never used it, the most commonly cited reasons for not using PrEP were fear of side effects (18%), not knowing where to start (15%), not being able to afford it (11%), and their provider saying it is unnecessary (11%). Sixty percent responded that there were other reasons for not using PrEP (Table B5). Most of these individuals stated that they do not need it or are not at high risk for HIV. Others were in a monogamous, long-term relationship or were not sexually active. Two respondents said they had a negative reaction to PrEP, two did not understand when and how to use it, one said they had not made the effort, and another said they did not have time to get the necessary prescription and negative HIV test.

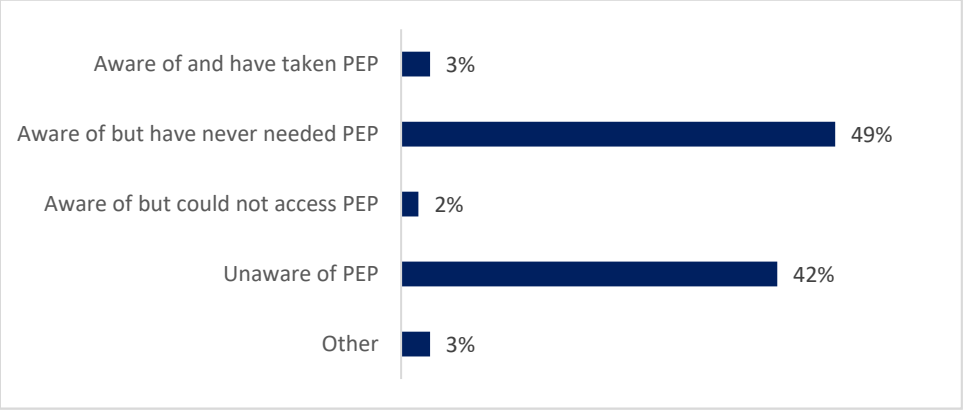
Table B5. Reasons Respondents Do Not Use PrEP (n = 91)

Do not know where to start	**15%**
Afraid to talk to my doctor	3%
Afraid to use my local pharmacy to fill PrEP prescription	3%
Afraid my partner would find out	1%
Cannot afford PrEP	11%
My provider said PrEP is unnecessary	11%
I am afraid of being negatively judged for taking PrEP	5%
I am afraid of potential side effects	18%
Other	60%

Note: Respondents could choose more than one option.

Nearly half of the respondents (49%) were aware of but had never needed post-exposure prophylaxis (PEP), and 42% were unaware of PEP (Figure B6). Those who were aware of but could not access PEP reported that they did not know where to go to access PEP. One respondent said their provider refused to prescribe PEP. Of those who did access PEP (n = 5), 40% accessed it in an emergency room, 40% in a clinic/health center, 20% from their family doctor, and 40% from other locations, including their work virtual provider (respondents could select more than one option).

Figure B6. Respondents' Awareness and Use of PEP (n = 153)



Note: Due to rounding, percentages may not add up to 100%.

Most respondents (81%) would most like to interact with HIV prevention staff who are easy to talk to and do not judge them. In addition, about half of respondents (51%) felt it is important that the staff member be a doctor, nurse, or other health care provider (Table B6). Other important characteristics were staff who are experienced providers, HIV advocates, providers who are not religious, "socially and emotionally aware" providers, and those who do not "have weird preconceptions about trans folks' sexual orientations and interests."

Table B6. Important Characteristics of HIV Prevention Staff (n = 136)

Same gender or sex	**32%**
Same sexual orientation	29%
Close to my age	29%
Same ethnic or racial background	20%
Easy to talk to/doesn't judge me	81%
Mental health counselor	40%
Doctor, nurse, or other health care provider	51%
Other	6%

Note: Respondents could choose more than one option.

According to respondents, doctors/nurses (64%) and health educators/outreach (61%) were the most effective sources of HIV prevention information. Other commonly reported sources included health departments (48%), HIV testing sites (47%), and HIV groups or programs (44%; Table B7).

Table B7. Most Effective Sources of HIV Prevention Information (n = 137)

Doctor or nurse	**64%**
Case manager	26%
Health educator or outreach	61%
HIV group or program	44%
HIV testing site	47%
Health department	48%
Media (e.g., TV, internet, radio)	36%
Brochure, billboard, or poster	19%
Peer navigator/peer advocate	31%
Friends or family	21%
Social media (e.g., Twitter, Facebook)	31%

Partner/significant other/spouse	15%
Mobile app	15%
Faith-based group	6%
Other	2%

Note: Respondents could choose more than one option.

The most commonly reported barriers to getting HIV prevention services were not knowing where to go for services (17%), providers making them uncomfortable and not understanding their issues (12%), and having too many things going on in their lives (11%). One respondent explained that a barrier for them is not having doctors they can trust and those who will not judge them for asking for testing. About half (49%) of respondents reported that they did not need services, and 24% said nothing gets in the way of them getting prevention services (Table B8).

Table B8. Barriers to Getting HIV Prevention Services (n = 136)

Don't know where to go	**17%**
Services are too far away	8%
Services are not offered in my community	7%
Services are not offered in places I hang out	7%
Providers make me uncomfortable or don't understand my issues	12%
Providers pressure me to do things I don't want to do	5%
Lack of childcare	4%
Not open during times I would go	9%
Services cost too much	9%
They only deal with HIV, and I need other services	6%
Not accessible for people with disabilities	<1%
No staff living with HIV	4%
Afraid they will turn me into police or immigration services	4%
Not provided in my language	---
Too many things going on in my life	11%
I don't need services	49%
I don't want any services	4%
Nothing gets in the way of my getting prevention services	24%
Other	4%

Note: Respondents could choose more than one option.

Sixty-two percent of respondents indicated that HIV prevention services should provide information about high-risk behaviors. Other HIV prevention services needed included assisting with accessing health care (58%), and addressing mental health (54%), financial issues (52%), and health matters (50%; Table B9). Respondents also mentioned several other ways in which HIV prevention service providers should assist them, including:

- promoting safe sex practices for females (e.g., female condoms, dental dams),
- providing education about HIV and prevention,
- helping destigmatize HIV and prevention,
- providing sterile syringes,
- providing transportation,
- providing services for free,
- providing mobile services in rural communities,
- placing vending machines and accessible services at county health departments,

- training staff at county health departments in gender-affirming care, with gender-affirming care as an expectation of the job),
- making PrEP accessible at county health departments, and
- making referrals for services the provider cannot address.

Table B9. Issues HIV Prevention Services Should Address (n = 131)

Issues related to substance use	**47%**
Health matters	50%
Financial issues	52%
Family and relationship issues	44%
Information related to high-risk behaviors	62%
Accessing health care	58%
Mental health-related issues	54%
Other	7%

Note: Respondents could choose more than one option.

Most respondents preferred to receive HIV prevention services at a medical facility or clinic (47%) or in their home, neighborhood, or community (28%; Table B10). Other places they preferred to receive services included at schools and colleges or at a trusted LGBTQ+ center.

Table B10. Preference for Accessing HIV Prevention Services (n = 135)

In my home, neighborhood, or community	**28%**
At my place of worship	<1%
On the street or in a public place	2%
In a medical facility or clinic	47%
At a substance use prevention/treatment center or mental health services center	7%
Through the internet	12%
Other	3%

Respondents reported that the services they need most are web-based information about HIV/AIDS (31%), places to get free condoms (34%), and HIV testing (24%). Those services were available to most respondents: 75% had access to web-based information about HIV/AIDS, 79% had access to free condoms, and 77% had access to HIV testing (Table B11).

Table B11. Respondents Who Answered 'Yes' to Questions About HIV Prevention Services

Service	Is this service available to you	Do you need this service	Do you use this service	Did the service meet your need
HIV testing	77% (102)	24% (99)	31% (100)	89% (38)
Individual counseling about safe sex, HIV testing, safe needle use, or preventing HIV transmission	67% (102)	15% (100)	13% (100)	72% (18)
HIV prevention support groups where you talk with others about HIV prevention	26% (101)	8% (98)	2% (98)	50% (4)
A forum or community meeting about HIV where you talk with others about HIV prevention	22% (101)	8% (99)	3% (98)	75% (4)
A hotline that provides information and answers questions about HIV	41% (101)	13% (99)	3% (97)	50% (4)

Educational group sessions where experts provide information about how to prevent the spread of HIV	27% (100)	12% (98)	6% (97)	60% (5)
Outreach work: workers in the community who provide people with information on HIV infection, HIV testing, and HIV prevention	51% (101)	17% (98)	13% (97)	100% (9)
A place where you can get bleach kits for cleaning used needles	12% (99)	2% (98)	1% (96)	50% (2)
A service that notifies the sex partners of people infected with HIV or STDs that they have been exposed	25% (100)	16% (97)	5% (97)	50% (6)
Sermons and events at churches, synagogues, mosques, or other places of worship that encourage safe sex and drug use behaviors	15% (99)	9% (97)	4% (97)	80% (5)
Web-based information about HIV or AIDS	75% (101)	31% (97)	22% (97)	91% (22)
A place where I can get free condoms	79% (100)	34% (97)	23% (96)	88% (26)
Television or radio messages about HIV or AIDS	50% (100)	20% (96)	13% (97)	83% (12)

Note: Numbers in parentheses represent the number of respondents for the question.

Respondents rated their agreement with several statements related to HIV. Some respondents' ratings indicated that they engage in high-risk sexual behaviors. For example, 30% agreed or strongly agreed that when they are high on drugs, they do not think much about the transmission of HIV to others (Table B12).

Table B12. Respondents Agreement with Statements Related to HIV

Statements	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I believe if my sex partner(s) are HIV positive, they will tell me (n = 88)	5%	16%	18%	24%	38%
It is the responsibility of the person I am having sex with to protect themselves from HIV infection (n = 89)	15%	26%	16%	19%	25%
When I have sex, I am usually high on alcohol and/or drugs (n = 79)	61%	24%	10%	5%	---
When I am high on drugs, I don't think much about transmission of HIV infection to others (n = 36)	25%	25%	19%	22%	8%
I know when my partner is infected with HIV (n = 60)	25%	27%	25%	13%	10%
I want to have kids, and condoms are a type of birth control (n = 56)	20%	9%	14%	30%	27%
Not using condoms or sharing needles is exciting – it tempts fate (n = 72)	71%	14%	4%	10%	1%
My partner insists on having sex with a condom (n = 59)	32%	24%	20%	12%	12%
I do not have sex with people who I know are infected with HIV, regardless of condom use (n = 62)	3%	13%	10%	23%	52%
I ask all my sexual partners their HIV status before I have sex with them (n = 65)	6%	20%	15%	26%	32%
I am in control of whether or not I use protection during sex (n = 81)	1%	4%	7%	28%	59%
I have made a commitment to myself to only have safe sex (n = 81)	5%	9%	14%	27%	46%

Substance use affects my ability to control whether we use condoms during sex (n = 51)	27%	22%	10%	27%	14%
I ask all my drug-using partners their HIV status before I share needles with them (n = 11)	---	27%	45%	18%	9%
I make the decision about whether or not to share needles (n = 10)	---	10%	30%	40%	20%

Note: Due to rounding, percentages may not add up to 100%.

Nearly all respondents reported that they believe they reduce their risk of contracting HIV by talking to their partner about sex (96%) and not sharing needles or other injection equipment (95%). Many others reported only having sex with HIV-negative people (90%), not shooting up (89%), using condoms (88%), and engaging in masturbation with their partner (83%; Table B13). Respondents also reduced their risk by asking for test results before sex and using lubricants to prevent tearing.

Table B13. Ways Respondents Believe They Reduced Their Risk of HIV (n = 139)

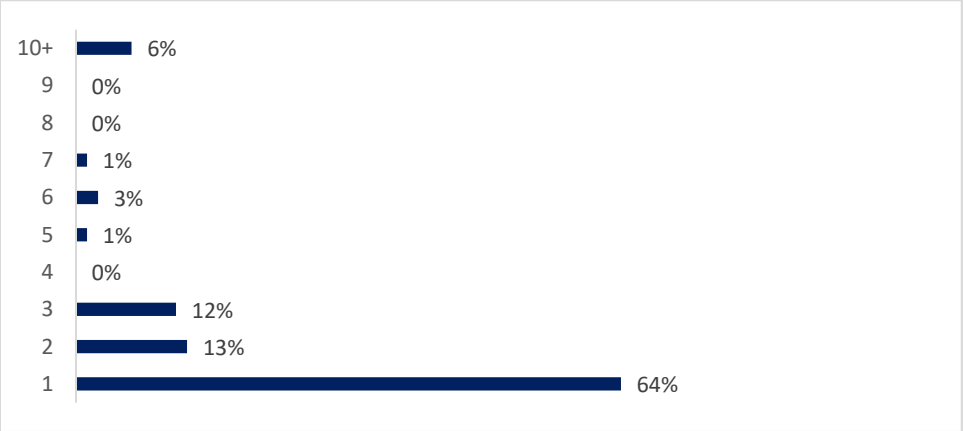
I use condoms (n = 72)	**88%**
I talk to my partner about sex (n = 77)	96%
I pull out before ejaculating (n = 37)	19%
My partner pulls out before ejaculating (n = 63)	22%
I only have oral sex (n = 73)	19%
I wash after having sex (n = 77)	47%
I am always the insertive partner (n = 50)	20%
I am always the receptive partner (n = 65)	35%
I engage in masturbation with my partner (n = 70)	83%
I have sex with just one partner (n = 78)	76%
I only have sex with HIV negative people (n = 67)	90%
I do not have sex (n = 69)	49%
I only have sex when sober (n = 65)	52%
I do not share needles or other injection equipment (n = 41)	95%
I do not shoot up (n = 56)	89%
I shoot up first (n = 21)	14%
I use bleach to clean needles, syringes, and works (n = 14)	43%
I wash needles and other works, but not with bleach (n = 14)	21%
Other (n = 5)	20%

Note: Respondents could choose more than one option.

Sexual Activity

Most respondents (64%) had only had one sex partner in the past 12 months. Few respondents had four or more sex partners (Figure B7).

Figure B7. Respondents' Number of Sex Partners in the Past 12 Months (n = 77)



Respondents primarily met their sex partners through friends (59%) and dating or hookup apps (46%; Table B14). Some respondents did not choose an option, stating that they were celibate or had a monogamous partner and were not looking for a sex partner.

Table B14. Locations Where Respondents Met Sex Partners (n = 61)

Internet	**34%**
Church/place of worship	3%
Social events	39%
Sex parties	8%
Friends	59%
School/classes	13%
Work	23%
Bars	26%
Bathhouses/adult bookstores	2%
Street cruising/parks/public places	2%
Dating or hookup apps	46%

Note: Respondents could choose more than one option.

In the past five years, most females (75%) reported they had sex with men, most males (69%) had sex with men, most transgender respondents (60%) had sex with both men and women, and other genders most often did not have sex with anyone (67%; Table B15).

Table B15. Gender of Respondents and the Sex of Their Partners in the Past Five Years (n = 90)

Gender of Respondent	Both men and women	Men	Women	No one
Female (n = 56)	11%	75%	5%	9%
Male (n = 26)	8%	69%	19%	4%
Transgender (n = 3)	33%	20%	20%	67%
Other (n = 5)	60%	20%	20%	---

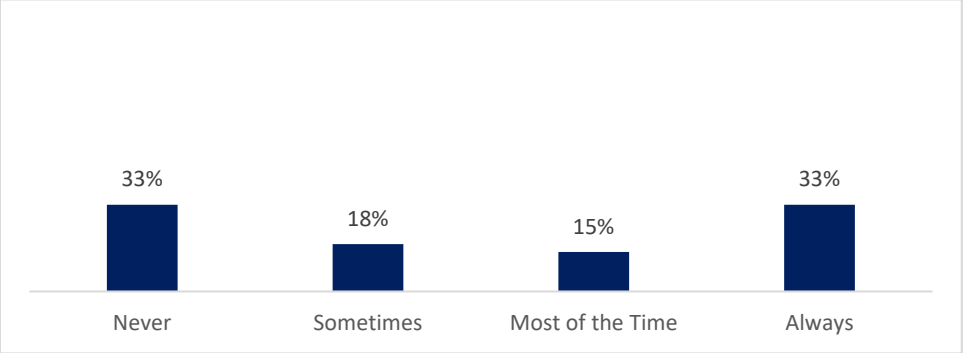
Thirty-four percent of respondents reported they had sex while high or drunk in the past 12 months, and about a quarter of respondents (26%) had anal, vaginal, or oral sex with a person without knowing their HIV status (Table B16).

Table B16. Respondents Who Answered 'Yes' to Statements About Their Sexual Activity in the Past 12 Months

I had unprotected anal, vaginal, or oral sex with someone living with HIV (n = 90)	**7%**
I had unprotected sex with someone at high risk for HIV (n = 89)	13%
I had unprotected sex with someone who uses intravenous drugs (n = 89)	2%
I had anal, vaginal, or oral sex with a person without knowing their HIV status (n = 89)	26%
I had sex while I was high or drunk (n = 89)	34%

Thirty-three percent of respondents never ask new sex partners about their HIV status, and 33% always ask (Figure B8).

Figure B8. How Often Respondents Ask New Sex Partners Their HIV Status (n = 87)



Note: Due to rounding, percentages may not add up to 100%.

Seventy percent of respondents had a regular sex partner at the time they completed the survey. Of those, 92% said their partner was HIV negative, 5% did not know their partner's HIV status, and 3% said their partner was HIV positive.

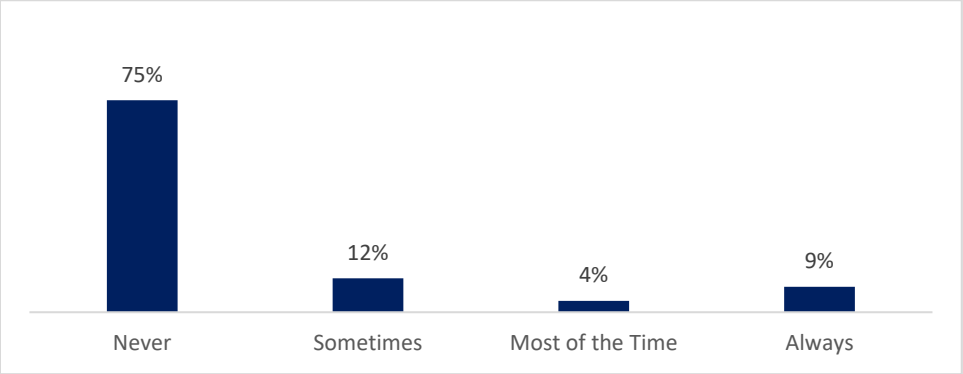
Most respondents with regular sex partners said they and their partner have agreed to always have safer sex outside the relationship (83%), and they have agreed to not use a condom during anal or vaginal sex (78%; Table B17).

Table B17. Respondents' Sexual Practices with Their Regular Partner

We never have anal or vaginal intercourse (n = 56)	**4%**
We agree not to use a condom during anal or vaginal sex (n = 55)	78%
We agree to always have safer sex outside the relationship (n = 23)	83%
We never talk about the type of sex we have outside our relationship (n = 26)	19%

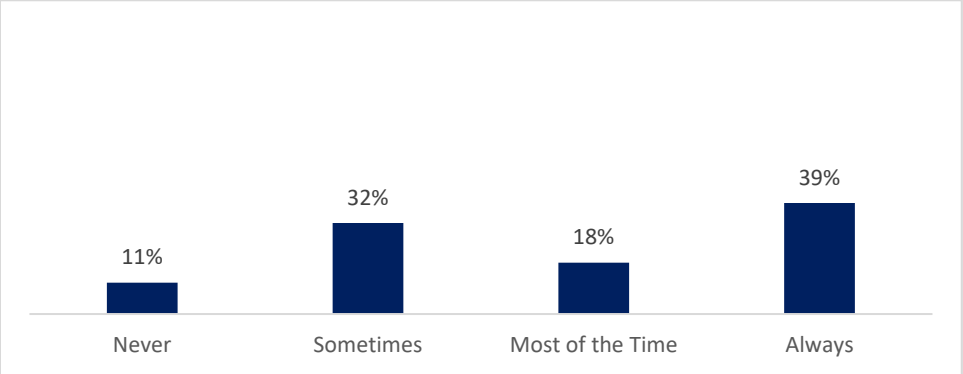
Seventy-five percent of respondents never use condoms with their regular partner, and 12% sometimes use them (Figure B9).

Figure B9. How Often Respondents Use Condoms with Their Regular Partner (n = 57)



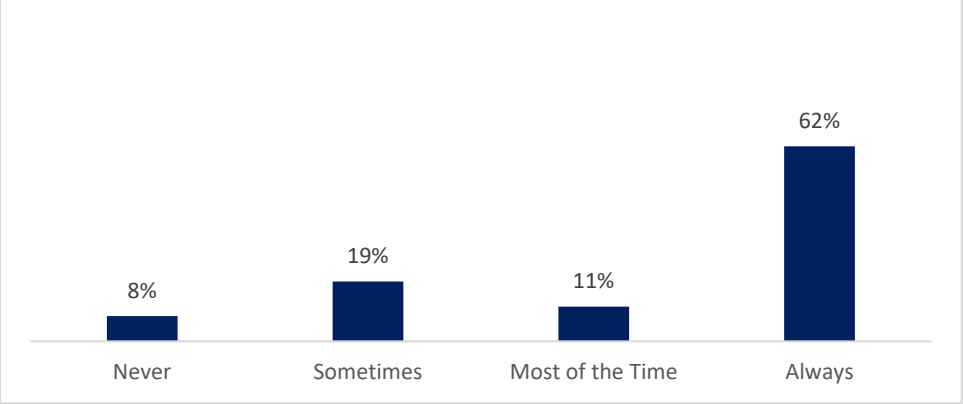
Thirty-nine percent of respondents always use condoms with their causal partners, and 18% use them most of the time (Figure B10).

Figure B10. How Often Respondents Use Condoms with Their Casual Partners (n = 44)



Most respondents (62%) always have access to condoms, and 11% have access to them most of the time (Figure B11).

Figure B11. How Often Respondents Have Access to Condoms (n = 90)



Half of the respondents did not regularly have access to condoms because they were unable to afford them. Forty-four percent did not regularly have them because of a lack of desirable condom types (Table B18).

Table B18. Respondents' Reasons for Not Regularly Having Access to Condoms (n = 18)

Unable to afford	**50%**
Discomfort/embarrassment accessing condoms	28%
Not sure where to get them	---
Lack of desirable condom types	44%
Fear of being seen accessing condoms	11%

Note: Respondents could choose more than one option.

The most common reason respondents did not use a condom in the past 12 months was that they were having sex with one of their regular partners (65%). Other reasons they did not use a condom were because they were in a monogamous relationship, only having oral sex, in a lesbian relationship, or trying to get pregnant (Table B19).

Table B19. Situations Where Respondents Did Not Use a Condom in the Past 12 Months (n = 62)

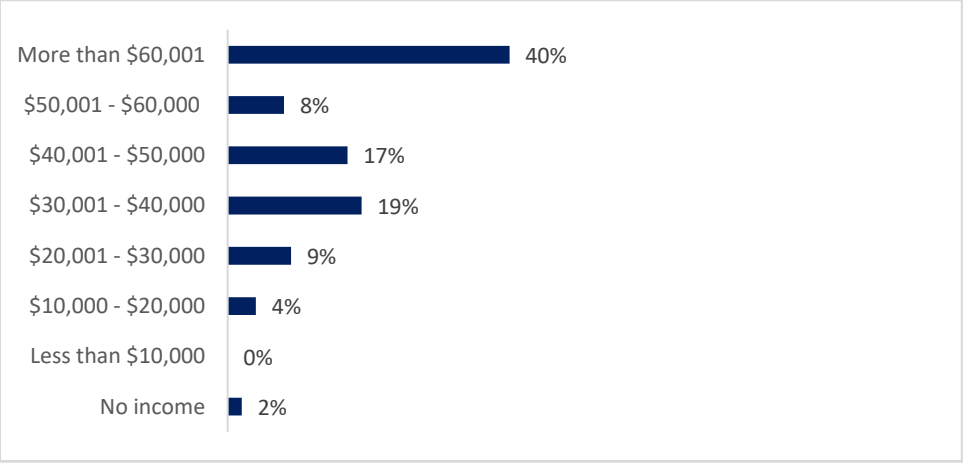
With one of my regular partners	**65%**
Caught in the moment	21%
Chose not to use a condom	29%
With someone I have had sex with before, without a condom	34%
With a new partner	15%
With an anonymous partner	6%
After using alcohol or drugs	10%
My partner or I was on birth control	26%
Didn't have a condom	2%
I am on PrEP	11%
My partner is on PrEP	15%
My partner did not look sick	5%
I didn't feel comfortable asking to use a condom	3%
Other	19%

Note: Respondents could choose more than one option.

Income & Financial Assistance

Forty percent of respondents had a combined household income of more than $60,001 for the past 12 months (Figure B12).

Figure B12. Respondents' Combined Total Household Income in the Past 12 Months (n = 89)



Note: Due to rounding, percentages may not add up to 100%.

Most respondents (69%) did not receive any financial benefits at the time they completed the survey. Eleven percent received Indian Health Services (Table B20). One person received SoonerCare.

Table B20. Respondents' Benefits Received (n = 87)

Veteran's Assistance (VA)	**3%**
Indian Health Services (IHS)	11%
Section 8 or Voucher Rental Assistance	---
Housing for People Living with AIDS (HOPWA)	---
SNAP (food stamps)	9%
Women, Infants, Children (WIC)	1%
Temporary Assistance to Needy Families (TANF)	---
Supplemental Security Income (SSI)	1%
Social Security Disability Income (SSDI)	3%
Social Security	3%
Worker's Compensation	---
Annuity/Life Insurance Payments	---
Retirement/Pension Benefits	6%
Long-Term Disability	1%
Other	1%
None of these	69%

Note: Respondents could choose more than one option.

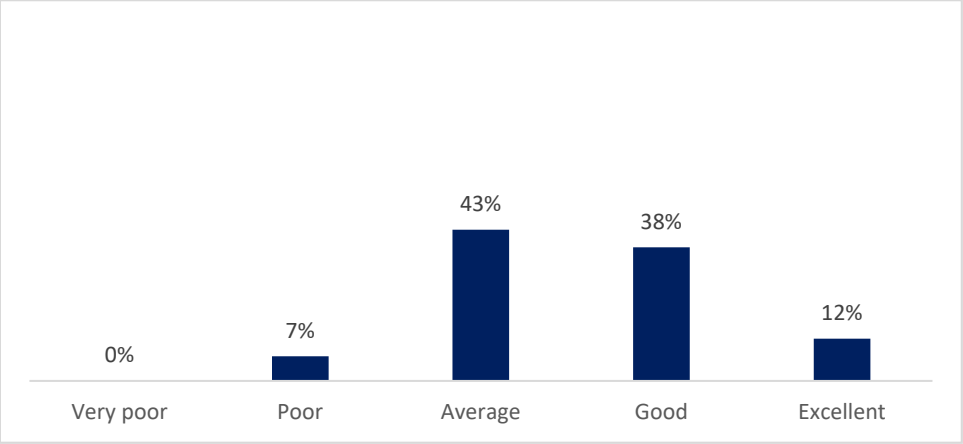
Seventy percent of respondents were never worried that their food might run out before they got money to buy more in the past 12 months. Nineteen percent were sometimes worried, and 11% were often worried (n = 89).

Fifty-nine percent of respondents never felt they could not afford to eat balanced meals in the past 12 months. Twenty-one percent sometimes felt they could not afford to eat balanced meals, and 20% often felt they could not afford to eat balanced meals (n = 90).

General Health Care

Most respondents rated their overall health as average (43%) or good (38%). No respondents rated their health as very poor (Figure B13).

Figure B13. Respondents' Ratings of Their Overall Health (n = 89)



Most respondents (65%) did not have a disability. Twenty percent had post-traumatic stress disorder (PTSD), and 17% had other disabilities (Table B21). Other disabilities mentioned included mental health disorders (e.g., depression, ADHD), rheumatoid arthritis, lupus, fibromyalgia, degenerative disk disease, psoriatic arthritis, type I & II diabetes, post-COVID heart and lung damage, and difficulty walking due to back injury.

Table B21. Respondents' Reported Disabilities (n = 83)

Do not have disabilities	**65%**
Wheelchair-bound or physically disabled (not correctable with eyeglasses)	2%
Blind/visually impaired	1%
Deaf/heard of hearing	4%
Developmental disability	5%
Post-traumatic stress disorder (PTSD)	20%
Other	17%

Note: Respondents could choose more than one option.

Sixty-eight percent of respondents reported having seen a dentist in the past 12 months (n = 90). Of those, 11% respondents had teeth pulled in the past 12 months (n = 56). Sixty-six percent of respondents have been treated for anxiety, and 59% have been treated for depression. Few respondents reported having one of the conditions listed but not being treated (Table B22).

Table B22. Respondents' Diagnosed and/or Treated Conditions

Condition	Have been treated for this condition	Have been diagnosed but not treated for this condition
Cardiac/health problems	9% (67)	--- (56)
High blood pressure	38% (68)	7% (54)
High cholesterol	18% (67)	7% (54)
Heart disease	7% (61)	--- (51)
Lung disease	5% (62)	--- (50)
Arthritis	16% (62)	4% (50)

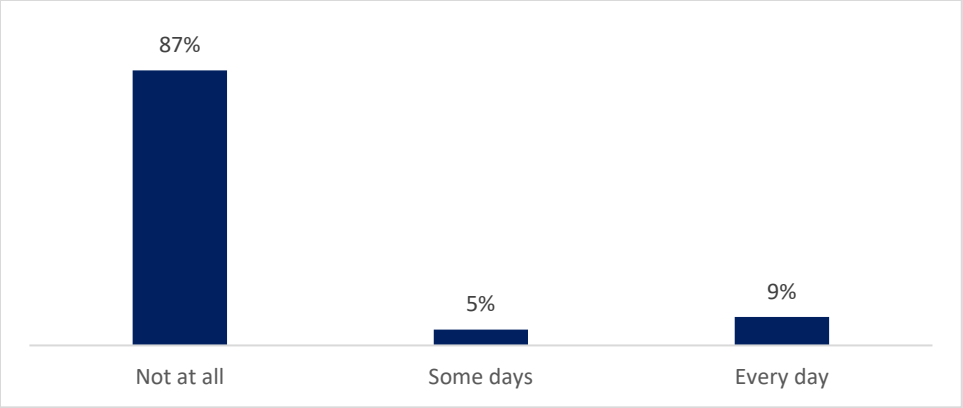
Asthma	26% (62)	2% (48)
Cancer	9% (58)	4% (46)
Diabetes	7% (61)	--- (48)
Pre-diabetes	5% (62)	4% (48)
Nerve (epilepsy, neuropathy)	3% (60)	--- (47)
Kidney disease	2% (62)	--- (47)
Cirrhosis/liver disease	2% (61)	--- (47)
Osteoporosis/bone loss	5% (61)	4% (49)
Anxiety	66% (70)	9% (47)
Depression	59% (71)	6% (48)
Other mental health condition	32% (63)	2% (46)
Substance dependency	6% (63)	--- (47)
Syphilis	6% (62)	2% (47)
Genital herpes	5% (62)	--- (47)
Gonorrhea	5% (62)	2% (47)
Chlamydia	13% (62)	2% (47)
Hepatitis A	2% (62)	--- (47)
Hepatitis B	--- (61)	--- (47)
Hepatitis C	--- (62)	--- (47)
Tuberculosis	2% (62)	--- (47)

Note: Numbers in parentheses represent the number of respondents for the question. Respondents could choose more than one disorder.

Substance Use

Most respondents (61%) had not smoked at least five packs of cigarettes in their lives. Thirty-eight percent had, and 1% did not know or were not sure if they had (n = 82). Eighty-seven percent of respondents did not smoke at the time they completed the survey (Figure B14). Smokers indicated how ready they were to quit smoking on a scale of 1 to 10, with 10 being 'very ready to quit.' The average readiness score was 7.63 (n = 8).

Figure B14. Respondents' Frequency of Smoking (n = 82)



Note: Due to rounding, percentages may not add up to 100%.

Most respondents (90%) had used alcohol in the past 12 months, and 56% had used marijuana (Table B23).

Table B23. Respondents' Substance Use in the Past 12 Months (n = 70)

Alcohol	**90%**
Marijuana	56%
Crack or cocaine	6%
Heroin	---
Meth	3%
Inhalants, hallucinogens, etc.	10%
Club/party drugs (ecstasy, ketamine, etc.)	3%
Prescription drugs (not prescribed)	1%
Pain medications (not prescribed)	6%
Other	1%

Note: Respondents could choose more than one option.

Two percent of respondents had injected drugs in the past 12 months (n = 81). One respondent who injected drugs reported that they always use new needles, sometimes backload while injecting drugs, never share needles, use needles cleaned with bleach, or share other works (e.g., cooker, cotton). The other respondent who injected drugs said they sometimes use needles cleaned with bleach but did not answer the other questions.

Sixty-five percent of respondents agreed or strongly agreed that they had access to harm-reduction programs, 56% agreed or strongly agreed that they were willing to visit or participate in harm-reduction programs, and 52% agreed or strongly agreed that there is a need for additional harm-reduction programs (Table B24).

Table B24. Respondents' Ratings of Statements Related to Harm-Reduction Programs (n = 75)

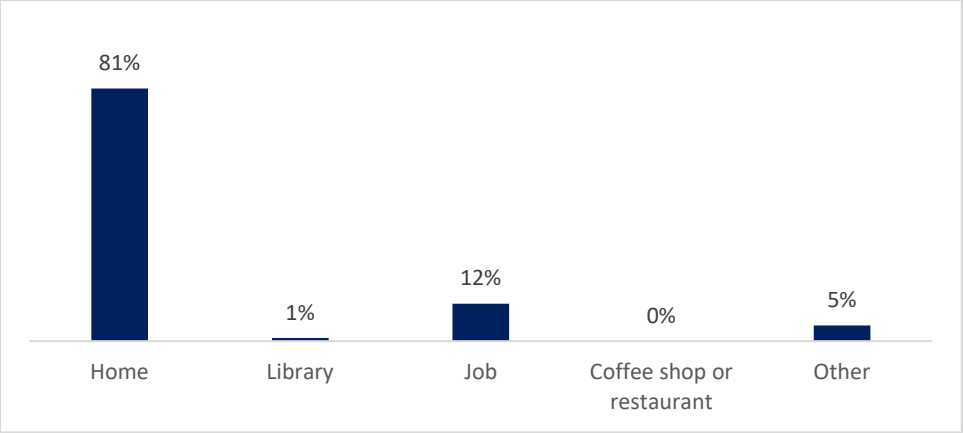
Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I currently have access to harm-reduction programs	3%	8%	24%	41%	24%
I am willing to visit or participate in harm-reduction programs	9%	5%	29%	37%	19%
There is a need for additional harm-reduction programs	3%	4%	21%	32%	40%

Note: Due to rounding, percentages may not add up to 100%.

Internet Access/Telehealth

Most respondents (81%) primarily access the internet from home, and 12% from their job (Figure B15). Respondents also access the internet through their phones.

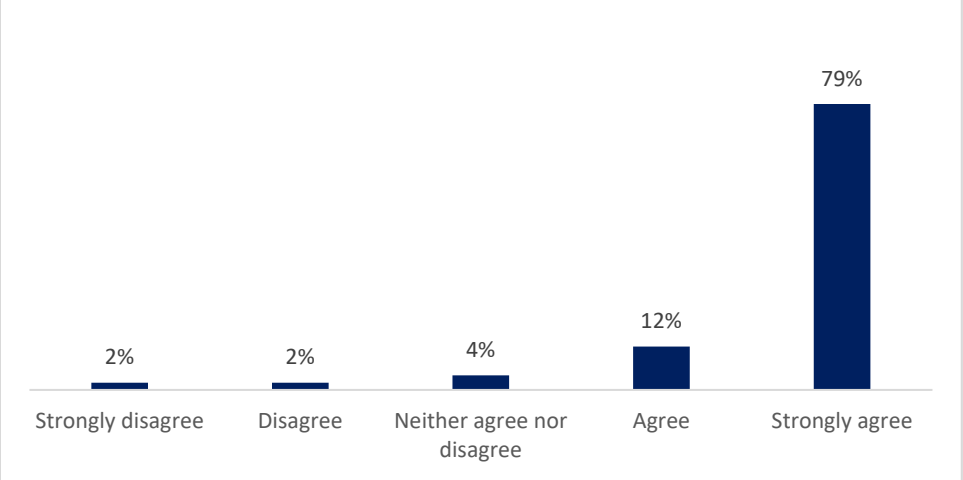
Figure B15. Location Respondents Primarily Access the Internet (n = 81)



Note: Due to rounding, percentages may not add up to 100%.

Nearly all respondents (91%) agreed or strongly agreed that they feel comfortable using a computer (Figure B16).

Figure B16. Respondents' Rating to the Question 'I Feel Comfortable Using a Computer' (n = 81)



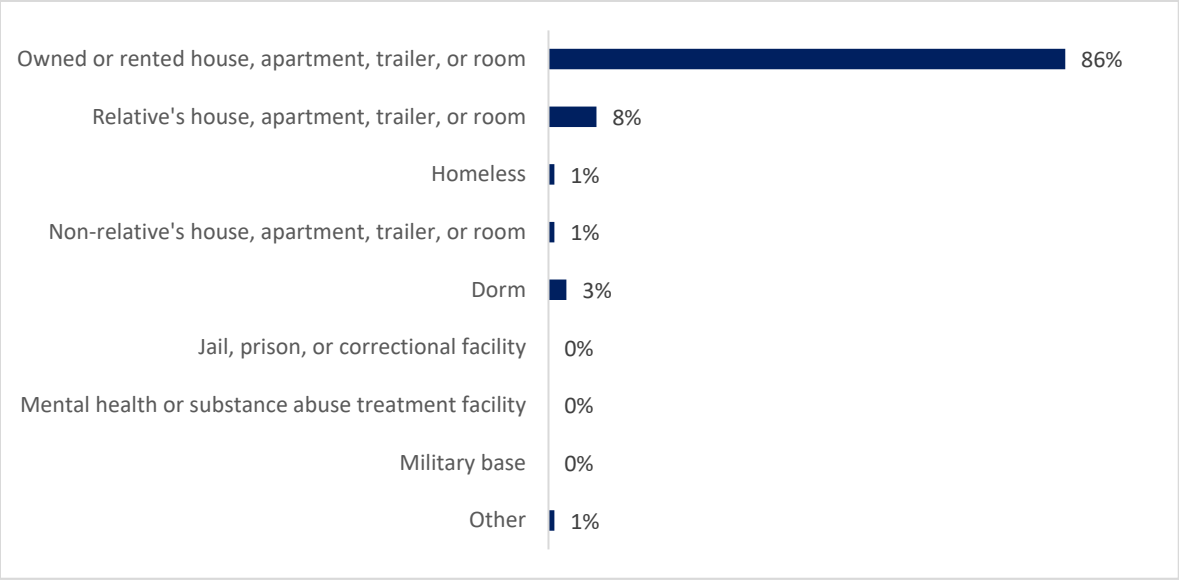
Note: Due to rounding, percentages may not add up to 100%.

Seventy-nine percent of respondents had used telehealth services, and 1% were unsure if they had (n = 80). Sixty-five percent would like to use telehealth services, and 15% were unsure (n = 80).

Housing

Most respondents (86%) lived in an owned or rented house, apartment, trailer, or room in the past 30 days (Figure B17). For those living in a house, apartment, trailer, or room, the average number of adults living in the household (including themselves) was 2.13, and the average number of children was 0.63 (n = 76). The average number of HIV-positive adults in the household was 1.25 (n = 4).

Figure B17. Respondents' Primary Living Situation in the Past 30 Days (n = 80)



Twenty-five percent of respondents reported worrying about or having trouble finding a place to live in the past 12 months (n = 80). The most common reasons for having trouble finding housing were not being able to afford it (75%) and not having enough money for a deposit (65%; Table B25).

Table B25. Respondents' Reasons for Having Trouble Finding Housing (n = 20)

Didn't have enough money for a deposit	65%
Could not find affordable housing	75%
No transportation to search for housing	10%
Credit issues	35%
Put on a waiting list	40%
Mental/physical disability	10%
Criminal record	5%
Didn't qualify for housing assistance	15%
Discrimination	15%
History of substance use	---
Other	10%

Note: Respondents could choose more than one option.

Eight percent of respondents reported having been homeless at some point during the past 12 months, and 1% had been in jail or prison during the past 12 months (n = 78). Of those with housing bills, 38% had difficulty paying rent, mortgage, or utility bills in the past 12 months (n = 76).

Summary and Recommendations for Respondents With HIV-Negative or Unknown Status

The 2022 HIV Needs Assessment Survey had 159 HIV-negative respondents and 8 respondents with an unknown HIV status. Most were females between the ages of 20-49, and most were employed full-time and had either a bachelor's or master's degree. Around half were heterosexual, and most had only one sex partner in the past 12 months. The majority had been tested for HIV.

Over half of these respondents were aware of but had never used PrEP because they were in a monogamous, long-term relationship or were not sexually active. A few respondents explained that they did not need to use PrEP because they were HIV-negative. Nearly half were aware of but had never needed PEP, and 42% were unaware of PEP. The confusion around the uses for PrEP and the high number of respondents who were unfamiliar with PEP indicates that more education about these treatments could benefit HIV-negative individuals and those at high risk for contracting the disease.

Respondents said that the most effective sources of HIV prevention information were doctors/nurses and health educators or outreach, so these sources would likely be useful places in which to focus HIV prevention education efforts. Some responded that they do not know where to go for HIV prevention services; investing in advertising for locations where people can access these services may help reduce this barrier. Respondents felt that HIV prevention services should address many issues, particularly information related to high-risk behaviors, assistance accessing health care, and services related to mental health, financial, and health issues. Survey respondents prefer to access services in a medical facility or clinic. This indicates that HIV prevention efforts should encompass all aspects of an individual's life and these services should be available at medical facilities.

Slightly more than half of the respondents reported using condoms with casual partners most or all the time; however, most respondents always had access to condoms. The most common reason for not having access to condoms was that respondents could not afford them, though few reported this.

Most respondents made more than $40,000 in the past year and did not receive any financial benefits. In addition, most never worried that their food might run out before they got money to buy more and could afford balanced meals.

No respondents rated their health as poor or very poor; most reported their health as average or good. Most did not have disabilities, and few reported having a medical condition for which they did not receive treatment. Anxiety and depression were the most commonly reported medical conditions for which they received treatment.

Most respondents were not smokers and did not use drugs other than marijuana. Almost all used alcohol in the past year. Very few had injected drugs in the past year. Most had access to harm-reduction programs, and over half were willing to participate in them.

Respondents primarily accessed the internet from home, and most felt comfortable using a computer. The majority had used telehealth services and would like to use these services.

Most respondents lived in an owned or rented house, apartment, trailer, or room in the past month, and only a quarter worried about or had trouble finding a place to live in the past year. The most common reasons for housing trouble were an inability to afford the housing or deposit. This indicates that providing housing assistance to this population would be beneficial.

Respondents Living With HIV

There were 54 respondents to the needs assessment survey who were HIV-positive or diagnosed with AIDS.

Demographics

County of Residence

Survey respondents lived in 10 of Oklahoma's counties, with most (60%) living in Oklahoma County (Table B26).

Table B26. Respondents' County of Residence (n = 45)

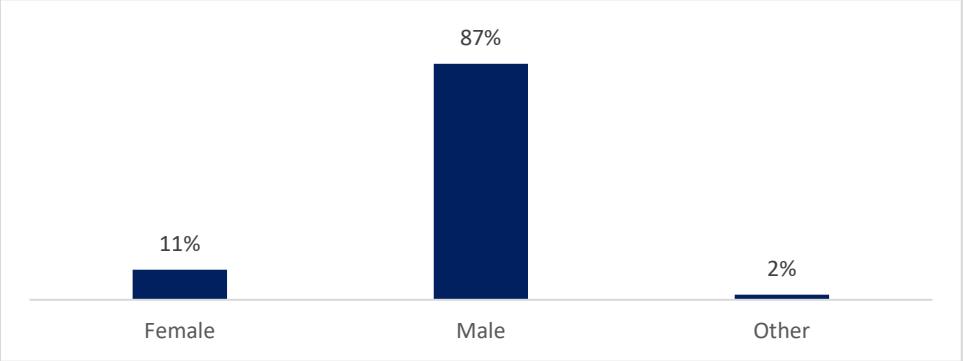
Canadian	**2%**
Carter	2%
Cleveland	7%
Comanche	2%
Kay	4%
LeFlore	2%
Lincoln	4%
Oklahoma	60%
Tulsa	13%
Wagoner	2%

Note: Due to rounding, percentages may not add up to 100%.

Gender

Most survey respondents (87%) were male. Eleven percent were female (Figure B19).

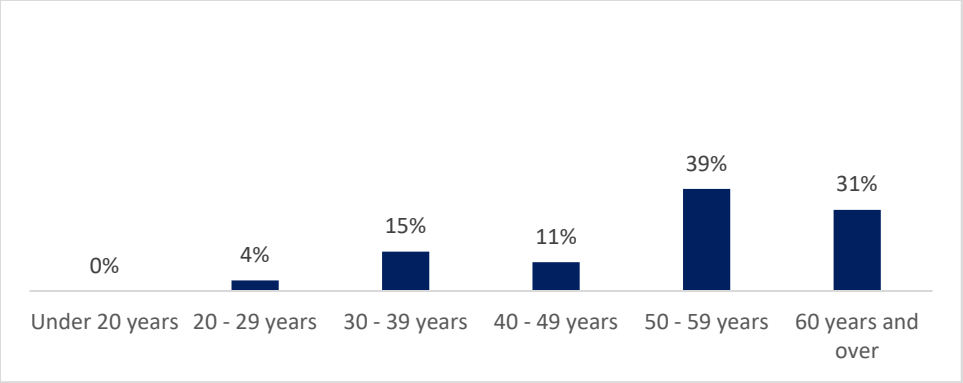
Figure B19. Respondents' Gender (n = 54)



Age

Seventy percent of respondents were 50 years old or older. Only 4% were 29 years or younger (Figure B20).

Figure B20. Respondents' Age (n = 54)



Note: Due to rounding, percentages may not add up to 100%.

Race/Ethnicity

Most respondents were White (70%). Twenty-two percent were Black, and 13% were American Indian/Alaska Native (Table B27).

Table B27. Respondents' Race/Ethnicity (n = 54)

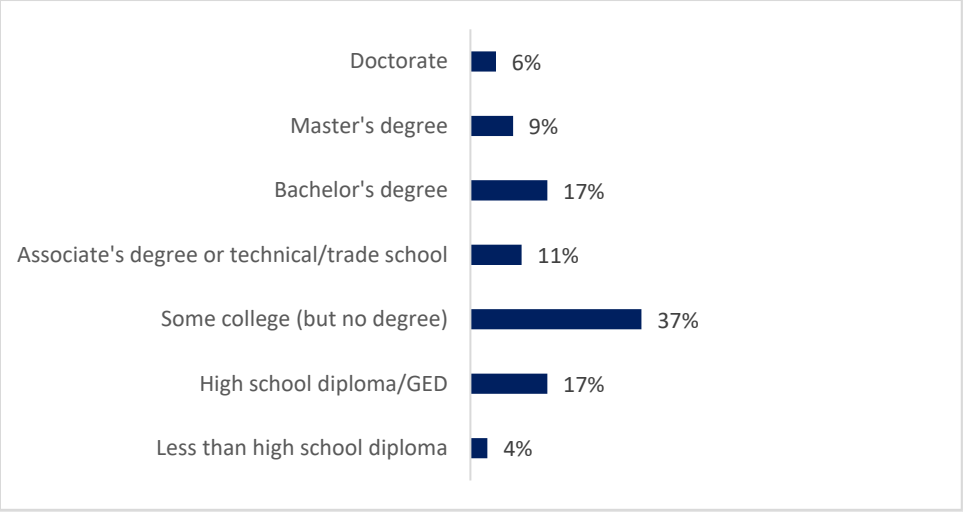
Black	**22%**
White	70%
Native Hawaiian/Pacific Islander	2%
American Indian/Alaska Native	13%
Asian	---
Hispanic/Latino(a)	9%
Other	2%

Note: Respondents could choose more than one option.

Education

Most respondents had less than a high school diploma (4%), a high school diploma/GED (17%), or some college but no degree (37%; Figure B21).

Figure B21. Respondents' Highest Level of Education (n = 54)



Note: Due to rounding, percentages may not add up to 100%.

Employment

Sixty percent of respondents were unemployed, and 33% were employed full-time (Table B28).

Table B28. Respondents' Employment Status (n = 54)

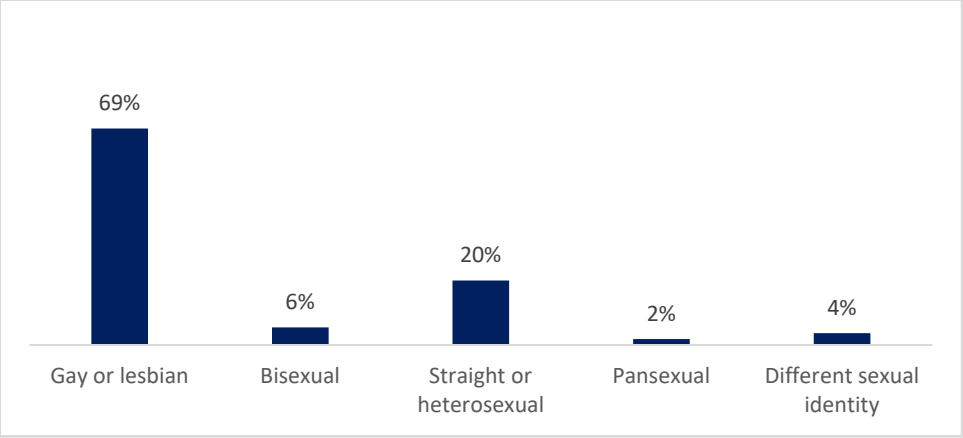
Employed full-time (35+ hours per week)	**33%**
Employed part-time	7%
Temporary or contract work	---
Self-employed	6%
Unemployed, looking for work	4%
Unemployed, not looking for work	4%
Unemployed, disabled	37%
Unemployed, retired	15%
Other	4%

Note: Respondents could choose more than one option.

Sexual Orientation

Eighty-nine percent of respondents reported their sexual orientation as gay/lesbian (69%) or straight/heterosexual (20%; Figure B22).

Figure B22. Respondents' Sexual Orientation (n = 54)

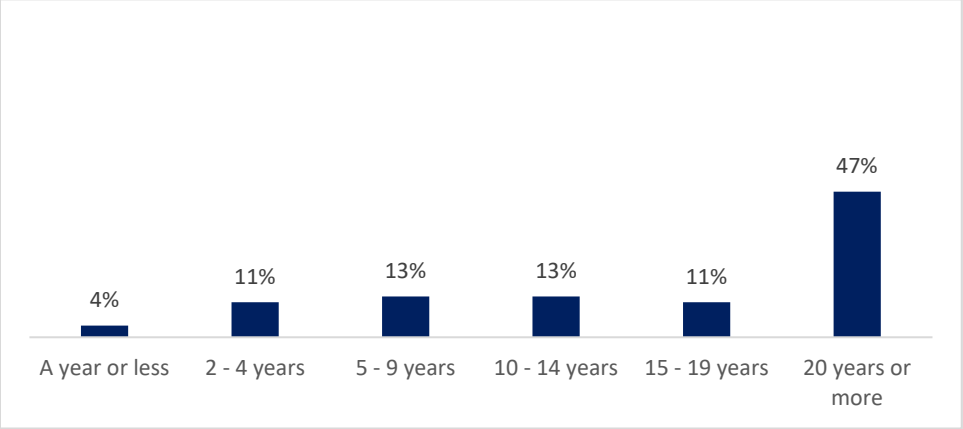


Note: Due to rounding, percentages may not add up to 100%.

HIV Diagnosis

None of the respondents reported being born with HIV. Eight percent reported that they had received blood products or a transfusion that was infected with HIV (n = 53). Most respondents reported they were diagnosed 20 or more years ago (Figure B23).

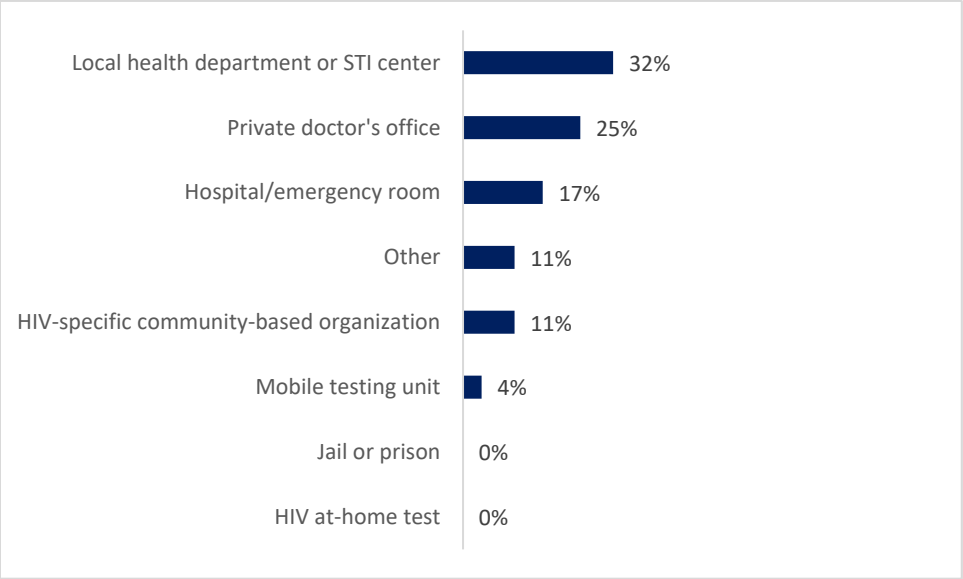
Figure B23. Number of Years Since Respondents Were Diagnosed with HIV (n = 53)



Note: Due to rounding, percentages may not add up to 100%.

Respondents most commonly reported learning of their HIV diagnosis at their local health department or STI center (32%; Figure B24). Other locations where they learned of their diagnosis included the Army or through blood donation, and one respondent reported they learned of their HIV diagnosis at a tuberculosis clinic.

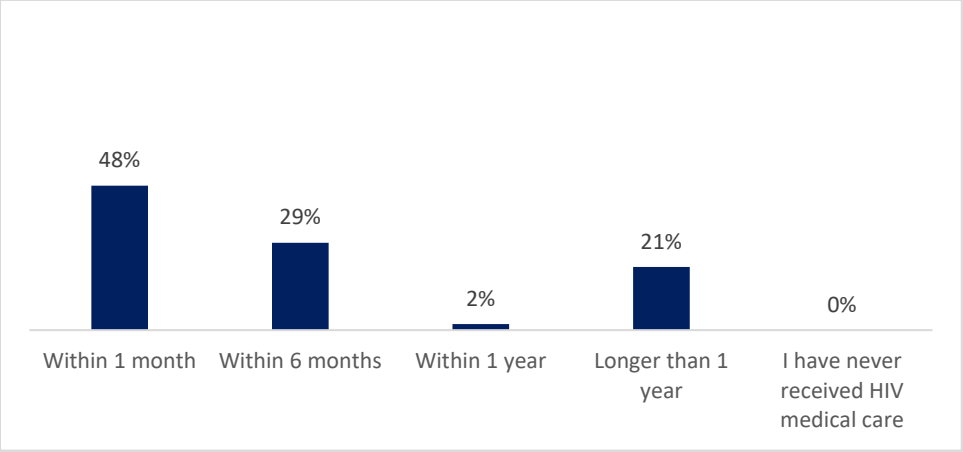
Figure B24. Location Where Respondents Learned of Their HIV Diagnosis (n = 53)



HIV Services and Care

Forty-eight percent of respondents reported receiving HIV medical care within one month of their diagnosis, and 29% received medical care within six months (Figure B25).

Figure B25. When Respondents Received HIV Medical Care After Diagnosis (n = 52)



Most respondents who did not receive HIV medical care for more than a year reported counseling about HIV (78%) and someone to guide them through the system (56%) as the resources that could have helped them receive medical care (Table B29).

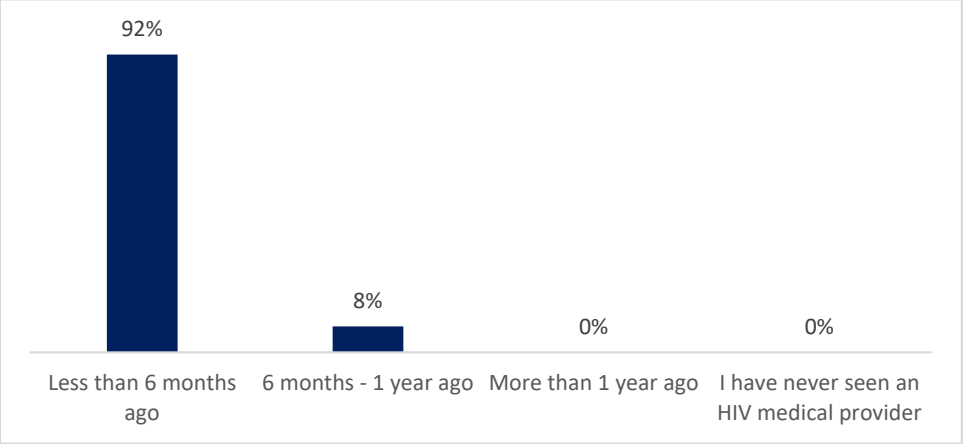
Table B29. Resources That May Have Helped Respondents Receive Medical Care Within One Year of Diagnosis (n = 9)

Talk/counseling about HIV when I was diagnosed	**78%**
Someone with HIV to help me	22%
Knowing more about problems I could have by not getting care	22%
Someone to guide me through the system	56%
A way to pay for medical care	11%
Reliable transportation to medical appointments	11%
Mental health/substance abuse treatment	---
More follow-up from staff after my diagnosis	22%

Note: Respondents could choose more than one option.

One hundred percent of respondents have seen an HIV provider within the past year (Figure B26).

Figure B26. When Respondents Last Saw an HIV Medical Provider (n = 51)



All respondents had at least one T-cell (CD4) test in the past 12 months (Figure B27), and 98% reported having at least one viral load test in the past 12 months (Figure B28).

Figure B27. Number of T-Cell (CD4) Tests in the Past 12 Months (n = 50)

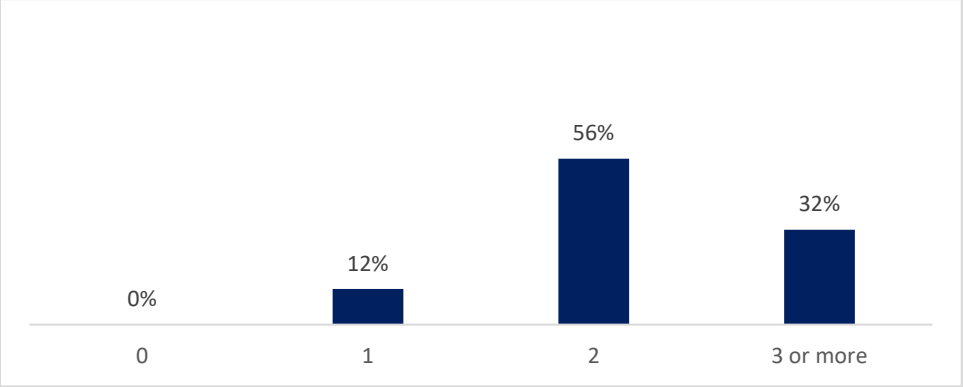
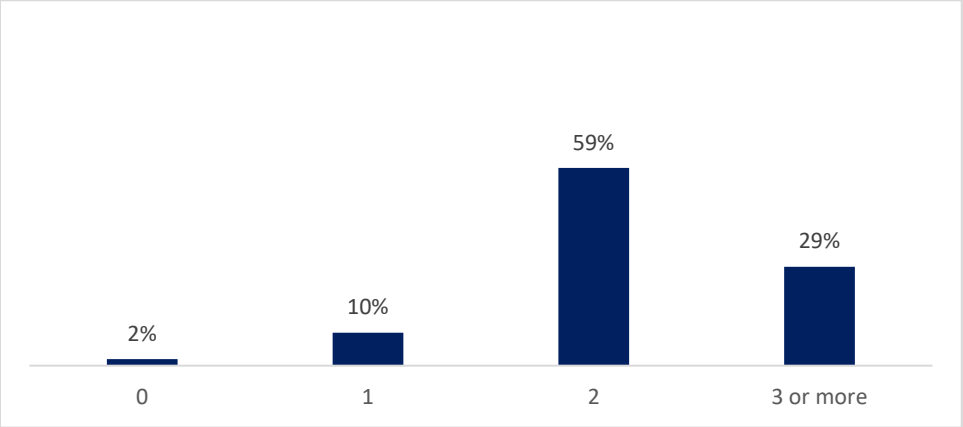


Figure B28. Number of Viral Load Tests in the Past 12 Months (n = 51)



The most common locations respondents received medical care were the OU Infectious Diseases Institute (55%) and private physician's office (35%; Table B30). For those who reported going to other locations, they specified that they went to Diversity Health and DLO.

Table B30. Where Respondents Received HIV Medical Care (n = 51)

OU Infectious Diseases Institute (OU IDI Clinic)	**55%**
OSU Center for Health Sciences (OSU IDI Clinic)	12%
Community health center/public health department	---
Private physician's office/clinic	35%
Hospital	2%
VA hospital/clinic	6%
Emergency room (ER)	---
Jail/prison	---
Free clinic	---
Indian Health Services (I)	2%
Currently not in care	---
Other	4%

Note: Respondents could choose more than one option.

At the time they completed the survey, all respondents who see an HIV medical provider were taking their HIV medication as prescribed (n = 51). Seventy-two percent reported they had not missed a dose in the past two weeks, and 28% reported missing a dose 1-2 times in the past two weeks (n = 50). Sixty-nine percent of those who had missed a dose forgot to take their medication (Table B31). Others missed medication because they were sick, stayed out late, or did not receive their medication in the mail on time.

Table B31. Reasons Respondents Missed HIV Medication Dose(s) in the Past Two Weeks (n = 13)

Don't have transportation to get my prescription filled	**---**
Could not afford my HIV medication	---
Wanted to avoid side effects	---
Didn't want to take them	8%
Mental health issues	---
Forgot to take them	69%
Too many medications to take	---
Felt too sick	8%

Drug use/addiction	---
Could not get to a doctor or clinic	---
HIV medical provider told me to stop taking them	---
Taking a break from medication	---
Felt healthy	---
Other	23%

Note: Respondents could choose more than one option.

Ninety percent of respondents received information about HIV from their doctor or nurse, and 63% received information from their case manager (Table B32).

Table B32. Where Respondents Receive Information About HIV (n = 51)

Doctor or nurse	**90%**
Case manager	63%
Health educator or outreach	20%
HIV group or program	22%
HIV testing site	16%
Health department	18%
Media	35%
Brochure, billboard, or poster	22%
Peer navigator/peer advocate	8%
Friends or family	8%
Social media	16%
Partner/significant other/spouse	12%
Mobile app	2%
Faith-based group	---
Other	4%

Note: Respondents could choose more than one option.

Most respondents (67%) reported case managers as the type of support system that helps them manage their HIV (Table B33). Other support systems mentioned included support from employers and the Homeless Alliance. Two respondents reported not getting support.

Table B33. Types of Support Systems That Help Respondents Manage HIV (n = 49)

Case manager	**67%**
Partners/spouse	37%
Friend/family	47%
Church	4%
Therapist	16%
Other	10%

Note: Respondents could choose more than one option.

Respondents identified emergency financial assistance (23%) and housing assistance (23%) as the services they most frequently needed but did not have access to in the past 12 months. In addition, 20% of respondents reported needing but not having access to dental care. Medication assistance (65%) was the most frequently used service in the past 12 months (Table B34).

Table B34. Respondents' Needed or Accessed Services in the Past 12 Months

Service	Used this service in the past 12 months	Needed but did not have access to this service in the past 12 months	Did not need this service in the last 12 months
Outpatient medical care (n = 45)	58%	2%	38%
Medication assistance (n = 43)	65%	2%	33%
Health insurance assistance (n = 43)	63%	7%	30%
Home health (n = 41)	12%	---	88%
Dental care (n = 45)	40%	20%	40%
Inpatient services (n = 42)	17%	---	83%
Medical case management (n = 42)	52%	5%	43%
Non-medical case management (n = 41)	24%	2%	73%
HIV medication adherence (n = 42)	26%	2%	71%
Transportation to medical appointments (n = 43)	12%	7%	81%
Mental health services (n = 45)	38%	13%	49%
Substance abuse services (n = 43)	5%	---	95%
Nutritional counseling (n = 43)	14%	12%	74%
Food bank/pantry (n = 43)	37%	16%	47%
Physical rehabilitation (n = 43)	7%	12%	81%
Employment services (n = 43)	5%	2%	93%
Childcare (n = 43)	---	2%	98%
Child welfare (n = 43)	---	---	100%
Day/respite care for adults (n = 43)	---	---	100%
Emergency financial assistance (n = 43)	9%	23%	67%
Housing assistance (n = 43)	16%	23%	60%
Legal assistance (n = 44)	2%	11%	86%
Buddy/companion (n = 43)	---	14%	86%
Client advocacy (n = 41)	---	10%	90%
Support groups (n = 43)	14%	12%	74%
Health education (n = 43)	7%	7%	86%
HIV prevention for positives/risk reduction (n = 42)	5%	2%	93%
HIV counseling, testing, and referral (n = 42)	17%	---	83%
Other (n = 27)	---	---	100%

Note: Due to rounding, percentages may not add up to 100%.

Sexual Activity

Forty-two percent of respondents had only had one sex partner in the past 12 months. Sixteen percent reported three partners, 5% reported four, 5% reported seven, and 32% reported ten or more partners in the past 12 months (n = 19).

Respondents primarily met their sex partners through dating or hookup apps (38%), social events (33%), or the internet (33%). Some respondents did not choose an option, stating that they were celibate or had a monogamous partner and were not looking for a sex partner.
(Table B35).

Table B35. Locations Where Respondents Met Sex Partners (n = 21)

Internet	**33%**
Church/place of worship	---
Social events	33%
Sex parties	10%
Friends	29%
School/classes	---
Work	---
Bars	10%
Bathhouses/adult bookstores	19%
Street cruising/parks/public places	5%
Dating or hookup apps	38%

Note: Respondents could choose more than one option.

In the past five years, most males (65%) reported they had sex with men, and half of the females did not have sex with anyone (Table B36).

Table B36. Gender of Respondents and the Sex of Their Partners in the Past Five Years

Gender of Respondent	Both men and women	Men	Women	No one
Female (n = 4)	25%	25%	---	50%
Male (n = 34)	3%	65%	---	32%
Transgender (n = 0)	---	---	---	---
Other (n = 1)	---	100%	---	---

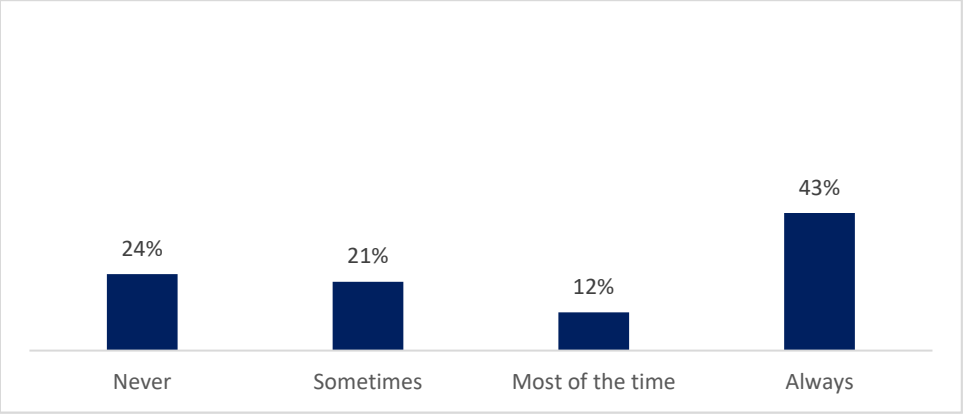
Thirty-eight percent of respondents had unprotected anal, vaginal, or oral sex with someone who was HIV-positive in the past 12 months, and about a quarter of respondents (27%) had anal, vaginal, or oral sex with someone without knowing their HIV status (Table B37).

Table B37. Respondents Who Answered 'Yes' to Statements About Their Sexual Activity in the Past 12 Months

I had unprotected anal, vaginal, or oral sex with someone living with HIV (n = 37)	**38%**
I had unprotected sex with someone at high risk for HIV (n = 38)	24%
I had unprotected sex with someone who uses intravenous drugs (n = 35)	9%
I had anal, vaginal, or oral sex with a person without knowing their HIV status (n = 37)	27%
I had sex while I was high or drunk (n = 36)	8%

Forty-three percent of respondents always ask new sex partners about their HIV status, and 24% never ask (Figure B29).

Figure B29. How Often Respondents Ask New Sex Partners Their HIV Status (n = 42)



Seventy percent of respondents had a regular sex partner at the time they completed the survey (n = 47). Of those, 55% said their partner was HIV positive, 41% said their partner was HIV negative, and 5% were unsure of their partner's status.

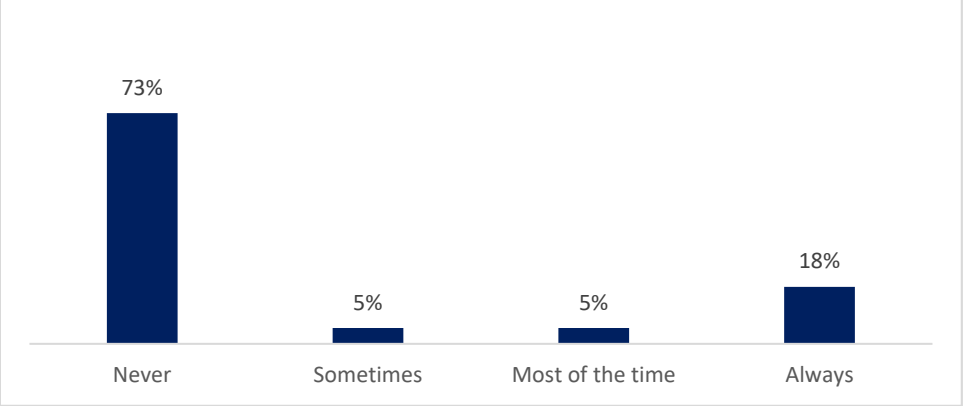
Most respondents (60%) with regular sex partners said they and their partner have agreed not to use a condom during anal or vaginal sex, and 53% agreed to always have safer sex outside the relationship (Table B38).

Table B38. Respondents' Sexual Practices with Their Regular Partner

We never have anal or vaginal intercourse (n = 19)	**11%**
We agree not to use a condom during anal or vaginal sex (n = 20)	60%
We agree to always have safer sex outside the relationship (n = 15)	53%
We never talk about the type of sex we have outside our relationship (n = 12)	17%

Seventy-three percent of respondents never use condoms with their regular partner, and 18% always use them (Figure B30).

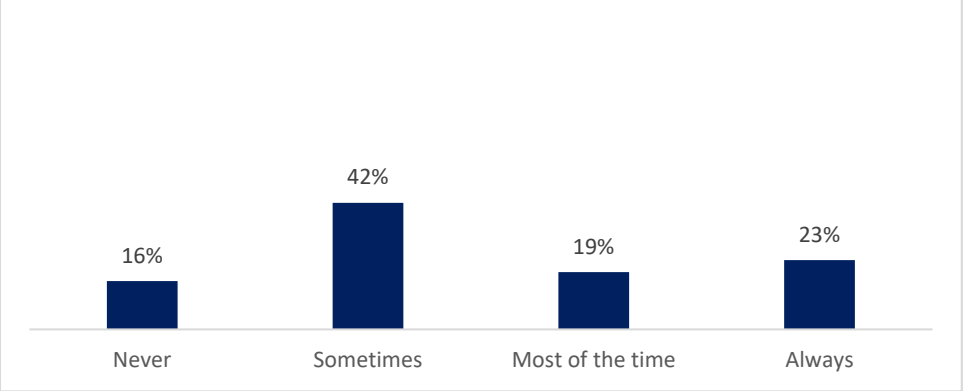
Figure B30. How Often Respondents Use Condoms with Their Regular Partner (n = 22)



Note: Due to rounding, percentages may not add up to 100%.

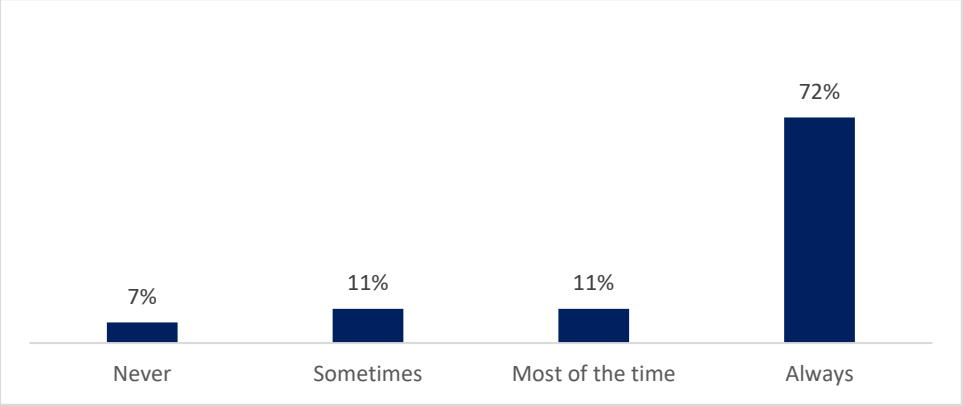
Forty-two percent of respondents sometimes use condoms with their causal partners, and 23% always do (Figure B31).

Figure B31. How Often Respondents Use Condoms with Their Casual Partners (n = 31)



Most respondents (72%) always have access to condoms, and 11% have access to them most of the time (Figure B32).

Figure B32. How Often Respondents Have Access to Condoms (n = 46)



Note: Due to rounding, percentages may not add up to 100%.

Most respondents (83%) did not regularly have access to condoms because they were uncomfortable or embarrassed about accessing them. Thirty-three percent were not sure where to get them (Table B39).

Table B39. Respondents' Reasons for Not Regularly Having Access to Condoms (n = 6)

Unable to afford	**17%**
Discomfort/embarrassment accessing condoms	83%
Not sure where to get them	33%
Lack of desirable condom types	17%
Fear of being seen accessing condoms	---

Note: Respondents could choose more than one option.

The most common reason respondents did not use a condom in the past 12 months was that they were having sex with one of their regular partners (68%). Another reason they did not use a condom was that they had no sex partners in the past 12 months (Table B40).

Table B40. Situations Where Respondents Did Not Use a Condom in the Past 12 Months (n = 31)

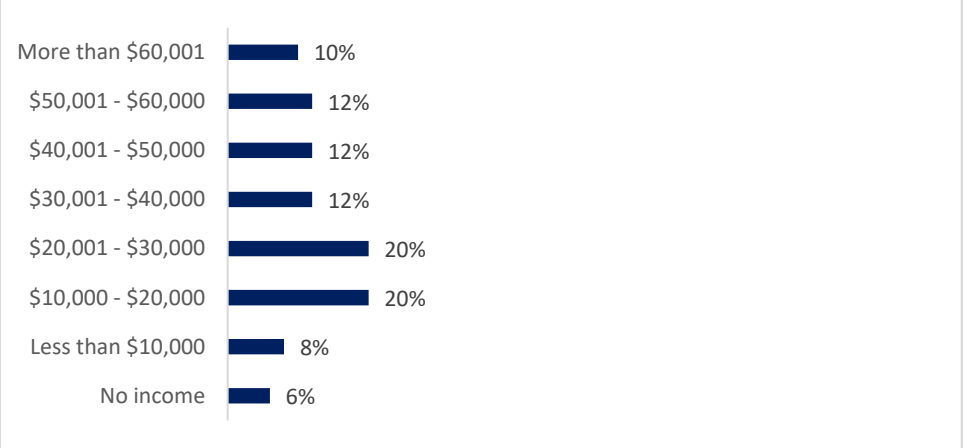
With one of my regular partners	**68%**
Caught in the moment	29%
Chose not to use a condom	23%
With someone I have had sex with before, without a condom	32%
With a new partner	16%
With an anonymous partner	23%
After using alcohol or drugs	6%
My partner or I was on birth control	--
Didn't have a condom	16%
I am on PrEP	--
My partner is on PrEP	16%
My partner did not look sick	6%
I didn't feel comfortable asking to use a condom	3%
Other	13%

Note: Respondents could choose more than one option.

Income and Financial Assistance

Forty percent of respondents reported earning between $10,000 and $30,000 in the past 12 months. (Figure B33).

Figure B33. Respondents' Combined Total Household Income in the Past 12 Months (n = 50)



Thirty-four percent of respondents did not receive any financial benefits at the time they completed the survey. Thirty-two percent received Social Security Disability Income (Table B41).

Table B41. Respondents' Benefits Received (n = 47)

Veteran's Assistance (VA)	**6%**
Indian Health Services (I)	4%
Section 8 or Voucher Rental Assistance	4%
Housing for People Living with AIDS (HOPWA)	4%
SNAP (food stamps)	26%
Women, Infants, Children (WIC)	---
Temporary Assistance to Needy Families (TANF)	---
Supplemental Security Income (SSI)	6%

Social Security Disability Income (SSDI)	32%
Social Security	15%
Worker's Compensation	---
Annuity/Life Insurance Payments	---
Retirement/Pension Benefits	2%
Long-Term Disability	6%
Other	---
None of these	34%

Note: Respondents could choose more than one option.

Sixty-one percent of respondents were never worried that their food might run out before they got money to buy more in the past 12 months. Twenty-two percent were sometimes worried, and 16% were often worried (n = 49).

Fifty-six percent of respondents never felt they could not afford to eat balanced meals in the past 12 months. Twenty-six percent sometimes felt they could not afford to eat balanced meals, and 18% often felt they could not afford to eat balanced meals (n = 50).

Health Insurance

To pay for HIV care, respondents most frequently reported using the Oklahoma HIV Drug Assistance Program (43%) and insurance through their employer (29%). All respondents reported some type of insurance or assistance (Table B42).

Table B42. How Respondents Pay for HIV Care (n = 49)

Insurance through work	**29%**
COBRA	2%
Insurance not through work (Marketplace)	10%
Insure Oklahoma	6%
Medicare D	22%
Oklahoma HIV Drug Assistance Program (HDAP)	43%
Indian Health Service (IHS)	2%
Other prescription assistance program	12%
Compassionate care program	---
VA hospital/clinic	6%
Medicaid (SoonerCare)	24%
Don't have insurance or assistance with HIV expenses	---

Note: Respondents could choose more than one option.

Fifty-seven percent of respondents reported no problems with their health insurance or assistance in the past 12 months. Twenty percent had difficulty paying bills from doctor visits or labs (Table B43). One respondent said they were dropped from their insurance in the past year.

Table B43. Respondents' Problems with Health Insurance or Assistance in the Past 12 Months (n = 44)

Have not experienced problems with health insurance or assistance	**57%**
Paying premiums and/or co-payments	18%
Accessing doctors in my care network	9%
Getting certain medications/filling prescriptions	7%
Paying bills from doctor visits or labs	20%
Paying bills from hospitalization	14%

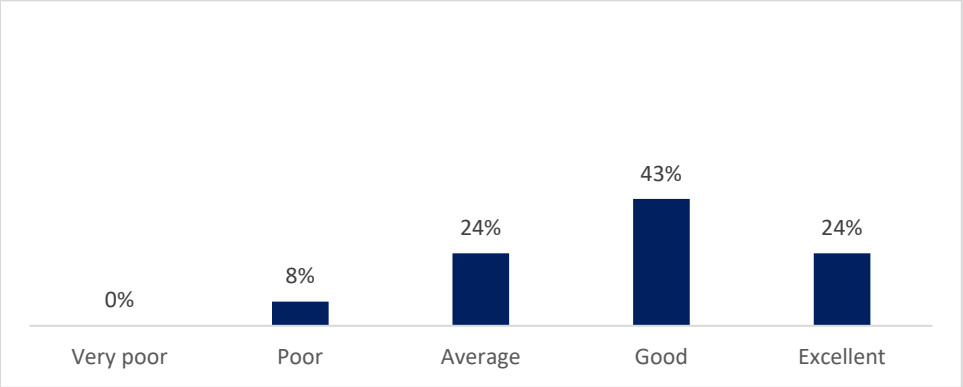
Making appointments with specialists	9%
Other	5%

Note: Respondents could choose more than one option.

General Health Care

Most respondents rated their overall health as good (43%) or excellent (24%). No respondents rated their health as very poor (Figure B34).

Figure B34. Respondents' Ratings of Their Overall Health (n = 49)



Note: Due to rounding, percentages may not add up to 100%.

Forty-nine percent of respondents did not have a disability, and 20% had post-traumatic stress disorder (PTSD; Table B44). Other disabilities mentioned included end-stage renal failure, heart failure, cancer, bipolar disorder, panic disorder, and anxiety disorder.

Table B44. Respondents' Reported Disabilities (n = 41)

Do not have disabilities	**49%**
Wheelchair-bound or physically disabled (not correctable with eyeglasses)	10%
Blind/visually impaired	2%
Deaf/heard of hearing	2%
Developmental disability	2%
Post-traumatic stress disorder (PTSD)	20%
Other	17%

Note: Respondents could choose more than one option.

Fifty-nine percent of respondents reported having seen a dentist in the past 12 months (n = 49). Of those, 22% of respondents had teeth pulled in the past 12 months (n = 27).

Eighty-one percent of respondents had been treated for high blood pressure, 77% had been treated for depression, and 62% had been treated for anxiety. Forty-five percent of respondents had been diagnosed with arthritis but not treated (Table B45).

Table B45. Respondents' Diagnosed and/or Treated Conditions

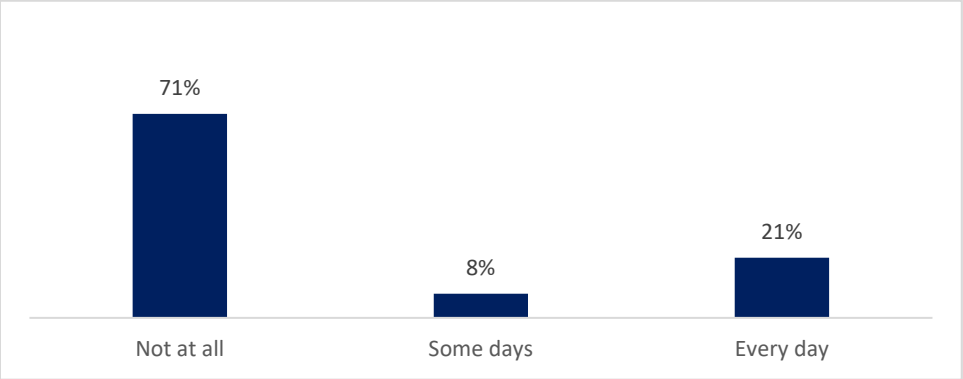
Condition	Have been treated for this condition	Have been diagnosed but not treated for this condition
Cardiac/health problems	32% (25)	--- (11)
High blood pressure	81% (31)	22% (9)
High cholesterol	37% (27)	11% (9)
Heart disease	26% (23)	--- (9)
Lung disease	19% (21)	--- (9)
Arthritis	24% (17)	45% (11)
Asthma	22% (18)	--- (9)
Cancer	26% (19)	--- (8)
Diabetes	45% (22)	13% (8)
Pre-diabetes	26% (19)	11% (9)
Nerve (epilepsy, neuropathy)	38% (21)	--- (8)
Kidney disease	24% (21)	13% (8)
Cirrhosis/liver disease	6% (17)	--- (8)
Osteoporosis/bone loss	7% (15)	20% (10)
Anxiety	62% (21)	25% (8)
Depression	77% (22)	38% (8)
Other mental health condition	38% (16)	25% (8)
Substance dependency	18% (17)	--- (8)
Syphilis	42% (19)	13% (8)
Genital herpes	12% (17)	--- (8)
Gonorrhea	26% (19)	--- (8)
Chlamydia	17% (18)	11% (9)
Hepatitis A	6% (17)	--- (8)
Hepatitis B	--- (16)	--- (8)
Hepatitis C	24% (17)	--- (8)
Tuberculosis	6% (16)	--- (8)

Note: Numbers in parentheses represent the number of respondents for the question. Respondents could choose more than one disorder.

Substance Use

Sixty percent of respondents had smoked at least five packs of cigarettes in their lives (n = 48). Twenty-nine percent reported that they currently smoke some or every day (Figure B35). Smokers indicated how ready they were to quit smoking on a scale of 1 to 10, with 10 being 'very ready to quit.' The average readiness score was 5.25 (n = 12).

Figure B35. Respondents' Frequency of Smoking (n = 48)



Most respondents (84%) had used alcohol in the past 12 months, and 50% had used marijuana (Table B46).

Table B46. Respondents' Substance Use in the Past 12 Months (n = 38)

Alcohol	**84%**
Marijuana	50%
Crack or cocaine	3%
Heroin	---
Meth	3%
Inhalants, hallucinogens, etc.	5%
Club/party drugs (ecstasy, ketamine, etc.)	---
Prescription drugs (not prescribed)	---
Pain medications (not prescribed)	---
Other	5%

Note: Respondents could choose more than one option.

Four percent of respondents had injected drugs in the past 12 months (n = 48). One hundred percent of respondents who reported injecting drugs indicated that they never share needles (n = 2).

Forty-eight percent of respondents agreed or strongly agreed that they had access to harm-reduction programs, 28% agreed or strongly agreed that they were willing to visit or participate in harm-reduction programs, and 37% agreed or strongly agreed that there is need for additional harm-reduction programs (Table B47).

Table B47. Respondents' Ratings of Statements Related to Harm-Reduction Programs (n = 42)

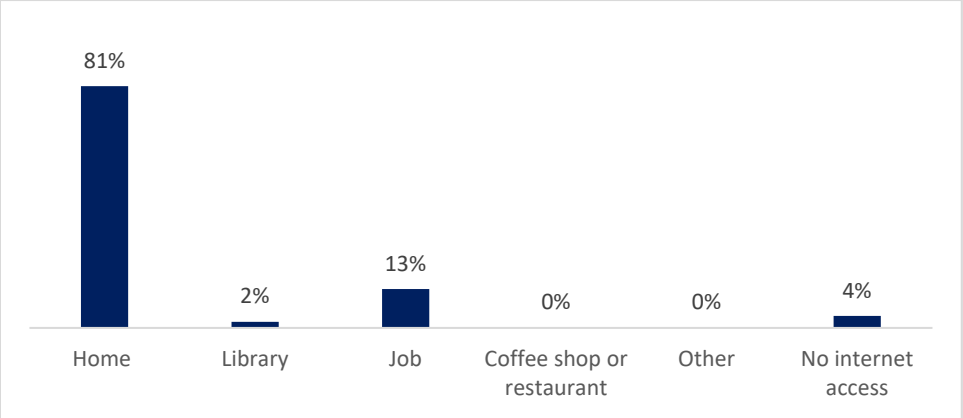
Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I currently have access to harm-reduction programs	12%	5%	36%	36%	12%
I am willing to visit or participate in harm-reduction programs	10%	10%	52%	26%	2%
There is a need for additional harm-reduction programs*	10%	10%	44%	22%	15%

*Note: Due to rounding, percentages may not add up to 100%. *n = 41*

Internet Access/Telehealth

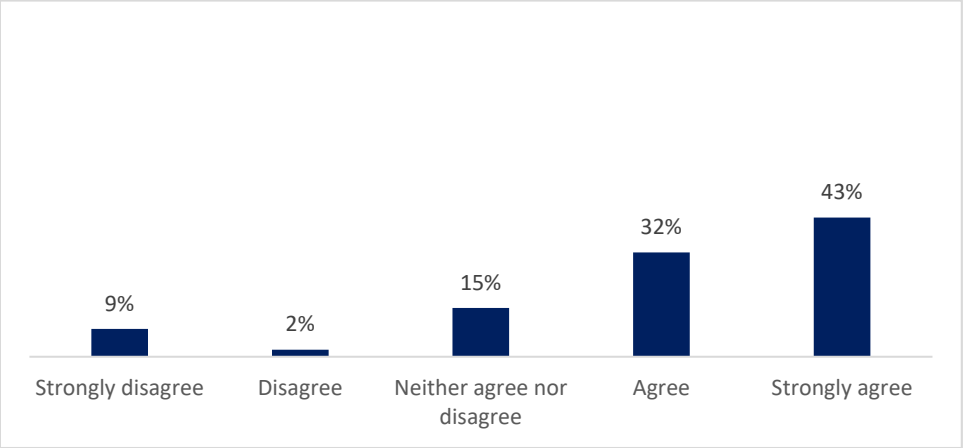
Most respondents (81%) primarily access the internet from home, and 13% from their job (Figure B36).

Figure B36. Location Respondents Primarily Access the Internet (n = 47)



Seventy-five percent of respondents agreed or strongly agreed that they feel comfortable using a computer (Figure B37).

Figure B37. Respondents' Rating to the Question 'I Feel Comfortable Using a Computer' (n = 47)



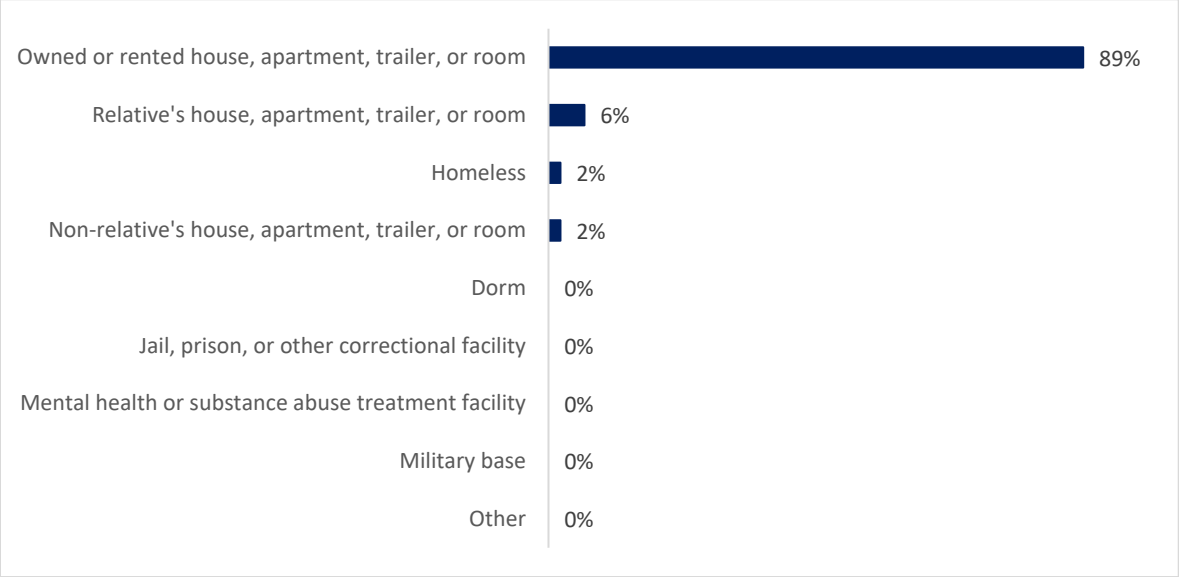
Note: Due to rounding, percentages may not add up to 100%.

Sixty-four percent of respondents had used telehealth services (n = 47), and 40% reported they would like to use telehealth services (n = 47).

Housing

Most respondents (89%) lived in an owned or rented house, apartment, trailer, or room in the past 30 days (Figure B38). For those living in a house, apartment, trailer, or room, the average number of adults living in the household (including themselves) was 1.70 (n = 46), and the average number of children was 0.29 (n = 43). The average number of HIV-positive adults in the household was 1.29 (n = 44).

Figure B38. Respondents' Primary Living Situation in the Past 30 Days (n = 47)



Note: Due to rounding, percentages may not add up to 100%.

Fifteen percent of respondents reported worrying about or having trouble finding a place to live in the past 12 months (n = 47). The most common reasons for having trouble finding housing were not being able to afford it (71%) and not having enough money for a deposit (57%; Table B48).

Table B48. Respondents' Reasons for Having Trouble Finding Housing (n = 7)

Didn't have enough money for a deposit	**57%**
Could not find affordable housing	71%
No transportation to search for housing	---
Credit issues	43%
Put on a waiting list	---
Mental/physical disability	14%
Criminal record	---
Didn't qualify for housing assistance	14%
Discrimination	---
History of substance use	---
Other	---

Note: Respondents could choose more than one option.

Two percent of respondents reported having been homeless at some point during the past 12 months, and none had been in jail or prison during the past 12 months (n = 47).

Of those with housing bills, 30% had difficulty paying rent, mortgage, or utility bills in the past 12 months (n = 47).

Transportation

Eighty-seven percent of respondents reported driving themselves to their medical appointments (Table B49). Other methods of transportation included the GRI Ride Program or riding a bike.

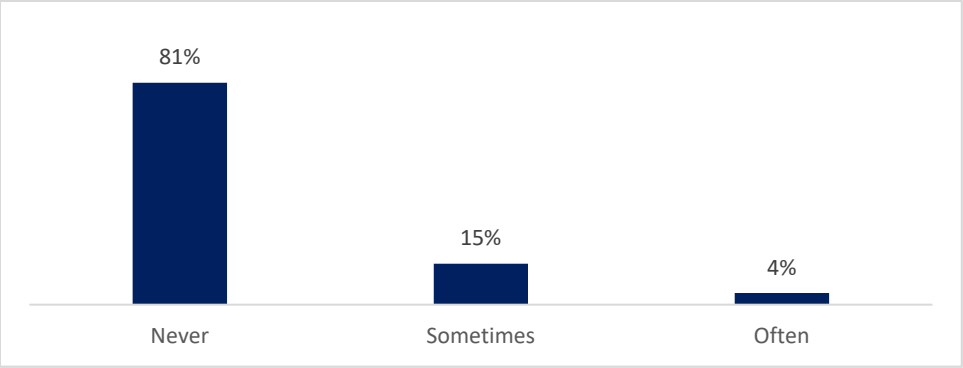
Table B49. How Respondents Get to Medical Appointments (n = 47)

I drive myself	**87%**
Friend/family	28%
Taxi	---
Uber/Lyft	6%
Shuttle/van service	2%
Other	4%

Note: Respondents could choose more than one option.

Nineteen percent of respondents sometimes or often had problems with transportation to their medical appointments in the past 12 months (Figure B39).

Figure B39. Frequency of Problems with Transportation to Medical Appointments (n = 47)



Summary and Recommendations for Respondents Living With HIV

The 2022 HIV Needs Assessment Survey had 54 HIV or AIDS-positive respondents. Most were males between 50-59, and most were unemployed (disabled) and had some college but no degree. Most were gay or lesbian, and 42% had only one sex partner in the past 12 months.

Almost half of the respondents received HIV medical care within a month of their diagnosis. Those who did not receive care for more than a year after their diagnosis felt talking about HIV when they were diagnosed and having someone to guide them through the system may have helped them receive medical care sooner. Ensuring that those diagnosed with HIV have support from the time they learn of their diagnosis is important and may help them get treatment earlier.

All respondents had seen an HIV medical provider, and over half received their HIV medical care at the OU Infectious Diseases Institute. All had received at least one T-cell test, and nearly all had received at least one viral load test in the past year. All respondents who saw an HIV medical provider reported taking their HIV medication as prescribed, with most reporting they had not missed a dose in the past two weeks. Of those who did miss a dose, most reported it was due to forgetting to take their HIV medication. Respondents said that they received information about HIV from their doctor and case manager, and case managers were the ones who primarily helped respondents manage their HIV.

Respondents identified emergency financial assistance and housing assistance as the services they most frequently needed but did not have access to in the past 12 months. In addition, almost a quarter of respondents reported having difficulty paying bills from doctor visits or labs. Most who had trouble finding a place to live in the past 12 months reported this was due to an inability to find affordable housing. Additionally, a little more than half made less than $30,000 in the past year. In general, all of this suggests that respondents have unmet financial needs that, if not addressed, could impact their ability to manage their HIV.

Less than half of respondents reported using condoms most or all the time with casual partners, though most always had access to them. The most common reason for not having access to condoms was that respondents could not afford them, though this number was low.

Overall, over half of respondents reported being in good or excellent health. The most frequently reported conditions respondents were treated for were high blood pressure, depression, and anxiety. The most frequently diagnosed but untreated condition was arthritis.

Over half of the respondents reported drinking alcohol, and half reported cannabis use. About half of the respondents reported having access to harm-reduction programs, and about a quarter were willing to participate in them.

Most respondents accessed the internet from home, and most felt comfortable using a computer. Most had used telehealth services, but less than half would like to use these services.

Conclusion

Most of the 221 respondents to the 2022 HIV Needs Assessment Survey were HIV-negative. Most HIV-negative respondents and those who were unsure of their HIV status were females under 50 who were employed full-time, educated, heterosexual, and had a good income. Those who were HIV-positive were mostly older males who were unemployed and disabled, had some college but no degree, were gay, and had a low income. Both groups indicated that HIV prevention and treatment services should include many aspects of their lives, including assistance with financial issues, housing, and healthcare. Responses also revealed that education around PrEP and PEP may be useful, and that HIV-positive individuals should receive immediate support following their diagnosis. Focusing efforts in these areas would likely improve HIV prevention and treatment services in Oklahoma.

Key Priorities

After review of the needs assessment, the Oklahoma Integrated Prevention and Care Planning Committee determined that the needs assessment was not reflective of persons living with HIV or highly vulnerable to acquiring HIV in Oklahoma. For this reason, Oklahoma will re-conduct the needs assessment in 2024. Key priorities for the Oklahoma Integrated Prevention and Care Plan will remain consistent with the four pillars of EHE:

1. Diagnose all people with HIV as early as possible.
2. Treat people with HIV rapidly and effectively to reach sustained viral suppression.
3. Prevent new HIV transmissions by using proven interventions.
4. Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them.

Section IV. Situational Analysis

Pillar 1: Diagnose

Pillar 1 (Diagnose) Strengths in Oklahoma

SHHRS Public Health Detailer (PHD) Program

The PHDs meet with providers throughout Oklahoma to share information about routine opt out HIV screening, treatment, PrEP usage and referral to our rapid ART program (Rapidstart). After a discussion about the previously mentioned topics, each provider is given a toolkit that contains resources for implementing HIV screening. The toolkit also contains resources for patients about screening, prevention and treatment services.

The provider is visited in-person two more times to provide additional resources and answer any questions or concerns that may have arisen from the previous visits. During the visits, the following educational topics are covered (or information is left behind): implementing routine/opt-out HIV testing; understanding the 4th generation HIV testing algorithm; mandatory reporting guidelines for HIV/STIs; referral process to the SHHRS Rapid Start program; information on PrEP for individuals highly vulnerable to contracting HIV; information about training and technical assistance, including the South Central AIDS Education and Training Center and the OSU Extension for Community Healthcare Outcomes (ECHO) program, (a bi-weekly, virtual, guided-practice teaching for clinicians regarding HIV assessment, testing, and treatment, and comorbid conditions); SHHRS condom distribution program; taking a sexual health history; partner services information; and other STI topics.

PHDs also offer general guidance around billing for HIV services and incorporating HIV screening into a system's electronic medical record. These interactions ensure that health care providers and staff are aware of EHE efforts and best practices for providing HIV and sexual health services. Fostering relationships with providers all across the state helps to strengthen public and private investments in EHE by leveraging resources to screen and provide HIV services to all Oklahomans, especially in rural parts of the state.

Network of Community-Based Organizations (CBOs)

Oklahoma has a small, but very active network of long-standing community-based organizations focused on providing HIV testing and prevention education to target specific communities (Black, Hispanic, LGBTQ+). These organizations have increased their HIV screening activities in response to the Statewide EHE plan. These organizations work closely together and are very knowledgeable about the communities they serve and represent, which makes them very successful in locating individuals who may need testing. Contracted CBOs support in-reach and out-reach testing for those at higher risk and encourage enrollment in the SHHRS PrEP program. They also provide routine testing for those experiencing homelessness and individuals living with addiction.

County Health Departments and Sexual Health Education

County health department nurses continue to participate in STI Academy to learn routine assessment of sexual health history and other topics related to STI. Awareness of the importance of HIV and STI assessment and testing continues to grow. Nurses have been conducting more thorough assessments on clients presenting to county health departments for issues that may be related to HIV and STIs. STI

Academy occurs about 6 times per year and can only accommodate about 15 nurses at once. Oklahoma is researching additional resources to get more CHD nurses the training they need in this area.

SHHRS HIV Self-Test Program Pilot

The SHHRS HIV Self-Test program pilot has been very successful. Over 700 self-test kits were requested in the first half of 2022, with more than 50% of requesters being women under the age of 50. Individuals were able to order tests through the OHHPC website. These orders were fulfilled by SHHRS staff and sent through U.S. mail in discrete packaging.

Future plans are to support fulfillment of the HIV self-test program through community-based organizations in the next year. CBOs are better equipped with the physical space to store the inventory of test kits, as well as adequate staff to quickly fill orders and follow up with clients for confirmatory testing.

SHHRS will also continue to partner with Turnkey Health, which provides medical services to individuals in county jails, to supply these self-test kits for use in routine opt-out HIV screening for high-risk detainees upon intake.

HIV Counseling and Testing Outreach Activities

SHHRS is involved in outreach and education events year-round across the state to bring awareness to HIV prevention and testing. SHHRS has created an outreach committee with the intention of ensuring that SHHRS is present and making an impact at community events, bars, and anywhere that allows. This has been very impactful, particularly in the promotion of our programs such as the HIV self-testing program and the condom distribution program. LGBTQ+ Pride events are very well participated in by SHHRS staff in all counties that host events.

Pillar 1 (Diagnose) Challenges in Oklahoma

High Rural Burden of HIV

Getting information to rural communities is often difficult. Many individuals in these communities do not have access to the internet, so targeted advertising of HIV testing messaging and geofencing is difficult to achieve.

Stigma Surrounding HIV

There is still a great deal of stigma in Oklahoma surrounding HIV and sexual health issues, often compounded by stigma related to addiction, mental health, homelessness or any other individual struggle that places someone on the outside of social acceptance. This stigma is reflected in the political climate and legislation in Oklahoma that impacts HIV prevention program activities, such as prohibition of syringe service programs, which could significantly reduce IDU HIV transmission. Other legislation in Oklahoma results in the criminalization of HIV.

Stigma is also reflected in a lack of buy-in from OSDH senior leadership. SHHRS experiences push back on innovative program ideas and social media messaging, often facing heightened scrutiny and intense approval processes, and having to repeatedly justify programs, contracts, and activities needed to fulfill CDC and HRSA grant requirements.

Stigma is a barrier to HIV education and awareness for health care providers. HIV screening is not seen as a priority; therefore, routine opt-out screening is not a common practice. Many individuals avoid

getting tested because the denial of knowing their status in some ways allows them to avoid this stigma. Oklahoma is one of 12 southern states considered as "the Bible Belt." A lack of buy-in from the faith community and religious organizations brings stigma full circle.

Pillar 2: Treat

Pillar 2 (Treat) Strengths in Oklahoma

OSDH SHHRS Rapid Start/PrEP Program

The SHHRS Rapid Start program has been very successful. SHHRS clinicians are able to see clients across the state within 7-15 days of initial positive HIV test result and start them on anti-retroviral therapy immediately. The clients formerly had to wait until they could get an appointment with either OSU or OU infectious disease clinics. They are now able to get a 30-day supply of ART medication through the rapid start program soon after diagnosis, while they wait to get into the infectious disease clinics at either OSU, OU, or the new EHE Clinic at New Hope Wellness. The Rapid Start program provided ART to over 130 newly identified clients since the program began in July of 2020. The Public Health Detailers have been instrumental in directing referrals from health care providers throughout the state to this program. PHDs ensure providers all across the state are aware of Rapid Start services, eligibility, and the referral process. Rapid Start materials, including a brochure, OKHAN-Alert, and referral form, are included as part of the detailing toolkits.

Federally Qualified Health Centers (FQHC)

Since the launch of EHE, Federally Qualified Health Centers have been receiving funding for HIV testing. Oklahoma has 10 FQHCs with Bureau of Primary Health Care EHE funding and two additional facilities are expected to apply this year. The Oklahoma Primary Care Association has been instrumental in this recruiting process. Each of the 10 facilities is focused on increasing testing and therefore diagnosis, as well as increasing PrEP services to people in need. Variety Care and Community Health Centers of Oklahoma have several locations throughout the state that provide both testing and treatment to individuals living with HIV.

South Central AIDS Education and Training Center (SCAETC)

The SCAETC central office is located in Albuquerque New Mexico and serves a 5-state region including Oklahoma. The Oklahoma local partner site is housed at the University of Oklahoma Health Sciences Center. The SCAETC provides training/education and technical assistance to health care professionals and organizations with the goal of building capacity and confidence to provide HIV-related services. The SCAETC provides services to professionals and facilities throughout the state. Beginning in 2020, with Oklahoma EHE priority jurisdiction designation, much of this training has been focused on HIV testing and prevention services. The SCAETC has provided support ranging from ECHO-type instruction to comprehensive training and technical assistance curricula to all ten FQHCs currently funded through the EHE Bureau of Primary Health Care Primary Care HIV Prevention grant.

New Ryan White EHE Clinic Targeting Black and Latino Populations

Oklahoma has recently awarded a contract to an additional Ryan White clinic, New Hope Wellness Clinic, using HRSA EHE funding. This clinic provides ambulatory health and medical case management services, targeting the priority populations of Black and Latino communities. The parent agency, Guiding Right, Inc., has had a long-standing presence in Oklahoma City and Tulsa, providing HIV prevention and other services to underserved communities. As a result, this clinic has been very successful in reaching the target

population, as evidenced by their performance outcomes. This is the only HIV clinic funded by Ryan White other than the two university IDI clinics in Oklahoma.

Wait Time at Infectious Disease Clinics in Oklahoma

Client wait time for treatment at the University of Oklahoma IDI clinic in Oklahoma City has drastically improved over the past 2 years, from two to three months, to 30-45 days, currently. This Part B and C clinic links patients to care by getting baseline lab work and medical case management as appropriate prior to the first appointment with phone follow-up as needed. This clinic also routinely has pharmacy residents training in clinic, as well as infectious disease fellows to expand their capacity to care for people with HIV.

The OSU Internal Medicine Specialty Service clinic's objective is to reduce wait time and/or wait list for all patients seeking HIV treatment. Newly diagnosed patients obtain treatment within 14 days of diagnosis. The OSU-IMSS clinic has 38 Internal Medicine Internist/Residents that provide primary and HIV treatment for patients in Northeastern Oklahoma. If a newly diagnosed individual cannot be seen by an Internist/Resident within 14 days, this individual must be seen by the Attending Provider. Having additional medical personnel onsite improves adherence and retention within the clinic (Physician Assistant; pharmacist; pharmacy students; clinical case managers; clinical nurse case manager; therapist and peer advocate). The Part B and C clinic links individuals to care by getting baseline lab work, seen by a clinical case manager, therapist and peer advocate, as appropriate, prior to the first medical appointment with telephone follow-up as needed.

OSU Extension for Community Healthcare Outcomes (ECHO) Program

Oklahoma State University IDI clinic provides bi-weekly ECHO learning sessions focused on assessing and implementing HIV care in primary care settings. Project ECHO is a revolutionary guided-practice model that reduces health disparities in under-served and remote areas through innovative tele-mentoring. ECHO uses a hub-and-spoke knowledge-sharing approach where expert teams lead virtual clinics, amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities.

Oklahoma HIV Drug Assistance Program (HDAP/ADAP)

Oklahoma's ADAP program has consistently had a very generous eligibility threshold of 400% of the Federal Poverty Level. This allows individuals with income even higher than the state's average household income to qualify for health insurance premiums, copays, and medications paid at 100%. This greatly eliminates the financial barriers so that clients can maintain their HIV treatment and care and achieve viral suppression.

Oklahoma HIV and Hepatitis Planning Committee (OHHPC) Website

SHHRS has contracted with COX Media to develop and maintain a website for the OHHPC: www.endinghivoklahoma.org. This website includes comprehensive information about HIV/STI prevention and care in a format that is more visually engaging for consumers and offers more user-friendly navigation than the SHHRS page provided on the OSDH website. The website includes a symptom guide for each STI, an electronic order form for condoms, educational videos and information, HIV testing center locations, and a contact request form.

This website allows SHHRS to provide updated HIV/STI information much faster than could be done through OSDH, as well as the ability to select imaging that reflects the target populations we need to

attract. The OHHPC website will also be used by clients and stakeholders to access Oklahoma's EHE plan, Integrated Prevention and Care Plan, Ryan White Quality Management Plan, and policies.

HIV Prevention and Care Social Media Campaign

SHHRS has contracted with COX Media to fund a social media campaign for widespread HIV care and prevention messaging. The campaign includes:

- Search engine marketing to promote the OHHPC website on Google and Bing.
- Mobile geofencing surrounding locations such as HIV test centers and known hangouts for target populations (Black, Hispanic, and MSM).
- Ryan White Program advertisements (English and Spanish) placed on streaming TV apps (PlutoTV, Samsung TV Plus, LG Channels, etc.) as well as game and other apps (Wordscapes, Paint by Number, Spider Solitaire, America's Best Pics, etc.)
- Social media posts (Facebook, YouTube, etc.) addressing HIV testing and treatment, using/ordering condoms, staying in care/viral suppression (U=U), and PrEP.
- Educational and informational videos filmed with Oklahoma service providers (2-10 min each) on various topics (the importance of dental care, mental health, HDAP program, case management, outreach, normalizing HIV testing, transgender stories, Rapid Start/PrEP, etc.)
- Imaging targeting Black/African Americans, Hispanic/Latinos, transgender persons, MSM, Native Americans, and heterosexual women.

Positive Peers Smartphone Application

Oklahoma has recently contracted with MetroHealth in Ohio to purchase four administrative accounts for the Positive Peers smartphone application. This mobile application was developed through a HRSA SPNS project for youth 13-34 years old living with HIV. Features include: medication and appointment reminders, viral load and CD4 tracking, easy to understand HIV health education information, local community resources, social networking and private chat with peers in their designated age group, and private chat with the four designated SHHRS employee administrators. This program has been found to assist younger users in sustaining viral suppression.

Pillar 2 (Treat) Challenges in Oklahoma

Lack of Cultural Diversity in Care Providers

Oklahoma has historically had a lack of cultural diversity in health care providers, especially in the area of HIV treatment and care. Consumers have voiced the importance of having a health care provider who looks like them and understands their culture. SHHRS continues to search for ways to partner with Black, Latino, and LGBTQ+ affirming organizations to provide care in non-traditional health care settings to reach these target groups.

HIV Health Care Provider Shortages

Oklahoma is designated as having a health care provider shortage and medically underserved areas. Very few health care providers are willing to bid on Ryan White care contracts because of intense reporting requirements and lack of capacity. In addition, Oklahoma has historically had very few health care providers willing to treat HIV.

High Rural Burden of HIV

Individuals living with HIV in rural areas may have to travel up to two hours to receive care, which is for the most part, located in the larger metro areas of Oklahoma. Oklahoma's public transportation system meets minimal needs in the metro areas, but does not provide service to rural areas. This is an ongoing

barrier for individuals lacking transportation resources. Oklahoma was able to fund additional transportation with EHE money; however, there continues to be a shortage of drivers at ride share companies. In addition to the transportation barrier, these communities often do not have access to the internet, making targeted advertising of HIV care messaging and geofencing difficult.

Stigma Surrounding HIV

Stigma is a barrier to HIV education and awareness for Oklahoma health care providers as well as Oklahoma citizens. This discourages some individuals living with HIV from accessing treatment and staying in care.

Pillar 3: Prevent

Pillar 3 (Prevent) Strengths in Oklahoma

PrEP Uptake

PrEP referrals to the SHHRS Rapid Start program have increased. The Rapid Start program received 117 referrals for PrEP in its first year and received 187 referrals in the second year. We expect this program to continue to grow in year 3, as the program gains exposure through social media, the Public Health Detailer program, and word of mouth.

Interest in PrEP has grown in at-risk communities (MSM, Black, and Hispanic) likely due to targeted social media and commercials that are working to create awareness and lower stigma. Individuals who are highly vulnerable to contracting HIV are feeling more empowered to advocate for themselves and are asking for PrEP. Oklahoma has seen an increase in access to PrEP, mainly in community-based organizations that use advance practice nurses to prescribe PrEP.

HIV Prevention Co-Op Activities

SHHRS is part of an outreach group called the Oklahoma HIV Prevention Co-Op. This group is comprised of various HIV service organizations that meet weekly to assemble condom and lubricant kits. Each organization alternates the task of distributing these kits to bars, clubs, and other venues around the NW 39th Street enclave in Oklahoma City, a prominent LGBTQ+ district known as “The Strip” or “The Gayborhood.”

Increased Awareness of Oklahoma Legislation Impacting Sexual Health

SHHRS routinely investigates and tracks legislative policies related to sexual health and provides updates to the OHHPC planning group, so that members can advocate for or against these policies. One example is Oklahoma Senate Bill 511: *Controlled dangerous substances; authorizing certain entities to engage in harm-reduction services; providing for registration and reporting. Emergency*. Before this bill was written, SHHRS staff along with OHHPC members worked to get information to the legislators writing the bill. This was very instrumental in influencing the language used in the bill, as well as the overall concurrence, and eventual passing of the bill. This bill legalized harm reduction programs for the first time in the state. SHHRS has also been working towards decriminalization of HIV laws within the state.

Oklahoma HIV and Hepatitis Planning Committee (OHHPC) Website

SHHRS has contracted with COX Media to develop and maintain a website for the OHHPC: www.endinghivoklahoma.org. This website includes comprehensive information about HIV/STI prevention and care in a format that is more visually engaging for consumers and offers more user-friendly navigation than the SHHRS page provided on the OSDH website. The website includes a symptom guide

for each STI, an electronic order form for condoms, educational videos and information, HIV testing center locations, and a contact request form.

This website allows SHHRS to provide updated HIV/STI information much faster than could be done through OSDH, as well as the ability to select imaging that reflects the target populations we need to attract. The OHHPC website will also be used by clients and stakeholders to access Oklahoma's EHE plan, Integrated Prevention and Care Plan, Ryan White Quality Management Plan, and policies.

Condom Distribution Program

The SHHRS condom distribution program has been very successful. This program allows individuals to order condoms online via the OHHPC website. SHHRS prevention staff fulfill these orders, sending them the individual through the U.S. mail in discrete packaging. In 2020, this program began amidst the COVID-19 pandemic, and a total of 1,420 condoms were distributed to individuals across Oklahoma. In 2021, this number increased to 2,360 condoms. By only the third quarter of 2022, over 24,500 condoms had been distributed to individuals across the state, well surpassing the combined total for 2020 and 2021.

In addition to individual requests, organizations can order condoms via email or through the OHHPC website. Organizations receive condoms, lubricant, and condom dispensers upon request. In 2019, a total of 123,680 condoms were distributed to organizations, and in 2020, a total of 120,120 condoms were distributed. In 2021, a total of 342,266 condoms were distributed to organizations across Oklahoma. Data collected in the third quarter of 2022 shows that the total amount of condoms distributed thus far in 2022 total 471,368 and counting—far more than the total for previous years.

The SHHRS condom distribution program is promoted by the distribution of handbills at outreach and other events and through Public Health Detailer visits, as well as through clickable ads placed on websites and YouTube, via Cox media. Advertising promotes not only this program but safer sex practices, prevention messages focused on Ending the HIV Epidemic, and HIV treatment and care.

HIV Prevention and Care Social Media Campaign

SHHRS has contracted with COX Media to fund a social media campaign for widespread HIV care and prevention messaging. The campaign includes:

- Search engine marketing to promote the OHHPC website on Google and Bing.
- Mobile geofencing surrounding locations such as HIV test centers and known hangouts for target populations (Black, Hispanic, and MSM).
- Ryan White Program advertisements (English and Spanish) placed on streaming TV apps (PlutoTV, Samsung TV Plus, LG Channels, etc.) as well as game and other apps (Wordscapes, Paint by Number, Spider Solitaire, America's Best Pics, etc.)
- Social media posts (Facebook, YouTube, etc.) addressing HIV testing and treatment, using/ordering condoms, staying in care/viral suppression (U=U), and PrEP.
- Educational and informational videos filmed with Oklahoma service providers (2-10 min each) on various topics (the importance of dental care, mental health, HDAP program, case management, outreach, normalizing HIV testing, transgender stories, Rapid Start/PrEP, etc.)
- Imaging targeting Black/African Americans, Hispanic/Latinos, transgender persons, MSM, Native Americans, and heterosexual women.

Oklahoma HIV Drug Assistance Program (HDAP/ADAP)
Oklahoma's ADAP program has consistently had a very generous eligibility threshold of 400% of the Federal Poverty Level. This allows individuals with income even higher than the state's average household income to qualify. This program pays for anti-retroviral medications at 100%, which prevents the transmission of HIV for those who are able to achieve viral suppression.

New Partnership With OKC Homeless Alliance, Healthy Housing/HOPWA Program
SHHRS has recently developed a new partnership with the OKC Homeless Alliance, as homelessness is frequently a barrier to retention in care. The Homeless Alliance receives the largest portion of HOPWA funding in Oklahoma City, but has not historically been connected to SHHRS. HOPWA case managers are now included in HIV interagency meetings. SHHRS now provides tailored training and guidance to these case managers for various topics needed or requested, and conducts monthly on-site HIV, syphilis, and HCV testing.

SHHRS Public Health Detailer Program (PHD)
The Public Health Detailers meet with providers throughout Oklahoma to share information about routine opt out HIV screening, treatment, PrEP usage and referral to our rapid ART program (Rapid Start). Providers who are receptive to managing PrEP for their patients are provided information and resources on PrEP prescribing. Experienced and/or trained PrEP providers are given the opportunity to have their clinic listed on our statewide PrEP and PEP provider list.

A toolkit is provided that includes guidelines and best practices for using PrEP to improve their patients' health outcomes and materials for educating patients. Additional resources are provided to ensure clinicians have access to training, clinical consultation, and technical assistance to support their learning and service delivery. The provider is visited in-person two more times to provide additional resources and answer any questions or concerns that may have arisen from the previous visits. During the visits, information and resources are tailored to the needs of the provider and meant to empower providers to implement routine HIV screening and preventive services.

These interactions ensure that health care providers and staff are aware of EHE efforts and best practices for providing HIV and sexual health services. Fostering relationships with providers all across the state helps to strengthen public and private investments in EHE by leveraging resources to screen and provide HIV services to all Oklahomans, especially in rural parts of the state.

Pillar 3 (Prevent) Challenges in Oklahoma

High Rural Burden of HIV
Getting information to rural communities is a challenge. Many individuals in these communities do not have access to the internet, so targeted advertising of HIV prevention messaging and geofencing is difficult to achieve. Oklahoma continues to work with the social media contractor to find for solutions to this problem.

Post Exposure Prophylaxis (PEP)
Providers and pharmacists lack education on assessment for PEP treatment. Access to PEP is limited. There are no in-state patient assistance programs for PEP in Oklahoma.

Stigma Surrounding HIV
Stigma is a barrier to HIV education and awareness for health care providers. HIV screening is not seen as a priority; therefore, routine opt-out screening is not a common practice. Many individuals avoid

getting tested because the denial of knowing their status in some ways allows them to avoid this stigma. Oklahoma is one of 12 southern states considered as "the Bible Belt." A lack of buy-in from the faith community and religious organizations brings stigma full circle.

Pillar 4: Respond

Pillar 4 (Respond) Strengths in Oklahoma

SHHRS Integrated Surveillance Team

Oklahoma has a very skilled Surveillance and Analysis team with excellent employee retention and cross training. Prevention and Care data is housed in the same area, and is readily available to all Surveillance staff for cross matching without the barrier of a data request process.

Disease Intervention Specialists

Oklahoma has a relatively large number of very knowledgeable Disease Intervention Specialists (DIS) located throughout the state, with a specific team dedicated to HIV. The DIS are highly skilled at locating clients to provide testing, treatment, and partner notification services, quickly mitigating any potential outbreaks, even in rural areas. Oklahoma has recently received additional state funding to hire supplemental DIS staff to meet the anticipated increase in clients due to EHE efforts. Oklahoma will soon have over 40 DIS to cover the state, including a new position dedicated to outbreak management.

Cluster Detection and Response

SHHRS Surveillance conducts time space analyses routinely to identify non-molecular clusters. An internal team meets to discuss any potential clusters identified. The OHHPC Cluster Detection and Response Committee was formed as a subcommittee of the OHHPC. A statewide laboratory assessment is being conducted to evaluate the completeness of HIV laboratory reporting, especially with regard to nucleotide sequences.

Pillar 4 (Respond) Challenges in Oklahoma

Cluster Detection and Response

Molecular cluster detection has not been started. Nucleotide sequences have not been routinely received by SHHRS. However, in the fall of 2022, changes were made to the disease reporting statute to specifically include "HIV nucleotide sequences" as reportable. In addition, Oklahoma is planning to hire a staff person dedicated to conducting these activities.

Section V. Goals & Objectives for 2022-2026

Pillar 1: Diagnose

Goal 1: By December 31st, 2026, increase knowledge of HIV status in people living with HIV to 90%.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase routine HIV testing in primary care facilities, women's health services/prenatal service providers, and acute care facilities, by providing provider education and awareness through the Public Health Detailer program.
2. Increase public awareness campaigns focused on getting tested and treated to reach Hispanic, Black, MSM populations, and heterosexual women under the age of 50 with average or higher income, through a geofenced Cox Media social media campaign.

Key Partners: county health departments, community-based organizations, OK Primary Care Association, FQHCs, correctional facilities, sexual health clinics, women's health services/prenatal services providers, hospitals, Cox Media, tribal/IHS facilities

Funding Resources: CDC EHE funding, HRSA RW EHE funding, State STD funding

Outcomes: Number of newly identified persons with HIV; Number of undiagnosed HIV cases.

Monitoring Data Source: eHARS

Expected Impact on Status Neutral Approach: Increase the number of people who know their HIV status to 90%.

Pillar 2: Treat

Goal 2a: By December 31st, 2026, engage 90% of new HIV diagnoses in ongoing HIV care and treatment within 30 days of diagnosis.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase linkage to care activities in Hispanic, Black, and MSM populations, by implementing a Linkage to Care Case Management program designed for individuals who are newly diagnosed or have fallen out of care.
2. Increase public awareness campaigns focused on getting tested and treated to reach Hispanic, Black, and MSM populations, through a geofenced Cox Media social media campaign.

Key Partners: OK Primary Care Association, FQHCs, SCAETC, contracted HIV care providers, medical care providers, community-based organizations, COX Media

Funding Resources: HRSA RW Part B funding, HRSA RW EHE Funding

Outcomes: Number of individuals newly diagnosed and linked to HIV care within 30 days.

Monitoring Data Source: Careware, eHARS

Expected Impact on the HIV Care Continuum: Increase the number of people receiving ART to 90% which should in turn improve viral suppression rates in targeted populations to 90%

Goal 2b: By December 31st, 2026, re-engage 90% people who are identified as not in HIV care.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase linkage to care and support activities in Hispanic, Black, and MSM populations re-engaged in care, by implementing a Linkage to Care Case Management program designed for individuals who are newly diagnosed or have fallen out of care.
2. Increase housing, emergency financial assistance, and transportation needs assessment and referral activities, by implementing a Linkage to Care Case Management program designed for individuals who are newly diagnosed or have fallen out of care.
3. Increase public awareness campaigns focused on staying in care (U=U) to reach Hispanic, Black, and MSM populations, through a geofenced Cox Media social media campaign.

Key Partners: OK Primary Care Association, FQHCs, contracted HIV care providers, medical care providers, community-based organizations, COX Media

Funding Resources: HRSA RW Part B Funding, HRSA RW EHE Funding

Outcomes: Number of persons with HIV identified as not in care who are re-engaged in care.

Monitoring Data Source: Careware, eHARS

Expected Impact on the HIV Care Continuum: Increase the number of people receiving ART to 90% which should in turn improve viral suppression rates in targeted populations to 90%

Goal 2c: By December 31st, 2026, increase retention in care for HIV to 90%.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase linkage to care and support activities for newly diagnosed individuals in Hispanic, Black, and MSM populations, by implementing a Linkage to Care Case Management program designed for individuals who are newly diagnosed or have fallen out of care.
2. Increase housing, emergency financial assistance, and transportation needs assessment and referral activities, by implementing a Linkage to Care Case Management program designed for individuals who are newly diagnosed or have fallen out of care.
3. Increase public awareness campaigns focused on staying in care (U=U) to reach Hispanic, Black, and MSM populations, through a geofenced Cox Media social media campaign.

Key Partners: OK Primary Care Association, FQHCs, contracted HIV care providers, medical care providers, community-based organizations, MetroHealth, COX media

Funding Resources: HRSA RW Part B funding, HRSA RW EHE Funding

Outcomes: Number of persons with HIV with at least two viral load or CD4 counts at least 3 months apart.

Monitoring Data Source: Careware, eHARS

Expected Impact on the HIV Care Continuum: Increase the number of people retained in care to 90%.

Pillar 3: Prevent

Goal 3a: By December 31st, 2026, increase capacity and implementation of PrEP and PEP programs in the state.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase access to PrEP and PEP, by creating increasing awareness of PrEP and PEP training offered by the South Central AETC, by increasing the number of providers seen through the Public Health Detailer program by 90%.
2. Increase access to PrEP and PEP, by increasing the number of providers trained to prescribe PrEP

and PEP by 90%, through trainings provided by the South Central AETC and other avenues.
3. Increase number of patients prescribed PrEP through the SHHRS Rapid Start program by 90%, by increasing awareness of PrEP services offered by SHHRS, through the geofenced Cox Media social media campaign and OHHPC website.
4. Increase number of patients maintained in PrEP care through the SHHRS Rapid Start program by 90%, through intentional follow up, counseling, risk reduction conversations, and monthly re-screening of clients currently on PrEP.
5. Increase public awareness of HIV Prevention, including Ready Set PrEP, PEP, and condom distribution in Hispanic, Black, MSM populations, and heterosexual women under 50 with average or higher income, through a geofenced Cox Media social media campaign and OHHPC website.

Key Partners: SCAETC, Community based organizations, OHHPC, OK Primary Care Association, FQHCs, sexual health clinics, women's health services/prenatal services providers, hospitals, Primary Care Association, COX Media
Funding Resources: CDC EHE funding, HRSA RW EHE funding
Outcomes: Number of providers seen through the public detailer program; number of patients prescribed PrEP through the SHHRS Rapid Start program; number of patients maintained in PrEP care through the SHHRS Rapid Start program.
Monitoring Data Source: REDCap, Careware, eHARS, Public Health Detailer data, SC AETC data
Expected Impact on Status Neutral Approach: Increase by 90% number of providers seen by the public health detailer program; Increase by 90% the number of providers trained to prescribe PrEP and PEP; Increase by 90% the number of patients prescribed PrEP by the SHHRS Rapid Start program; Increase by 90% the number of patients maintained in PrEP care through the SHHRS Rapid Start program.

Goal 3b: By December 31st, 2026, increase condom distribution by 50%.

Target Date: December 31, 2026
Key Activities and Strategies:

1. Increase number of condoms requested and distributed by increasing public awareness of the SHHRS condom distribution program, through the Cox Media social media campaign and the OHHPC website.
2. Increase public awareness of HIV Prevention services, including Ready Set PrEP, PEP, and condom distribution in Hispanic, Black, MSM populations, and heterosexual women under 50 with average or higher income, through a geofenced Cox Media social media campaign and the OHHPC website.
3. Increase participation in outreach and education events where safer sex kits are distributed through partnerships with local county health departments, community-based organizations and other entities.

Key Partners: Community-based organizations, OK Primary Care Association, FQHCs, OHHPC, condom manufacturers, COX Media, community partners
Funding Resources: CDC EHE funding, CDC HIV Prevention and Surveillance funding, RW HRSA EHE funding
Outcomes (reported annually, monitored quarterly): Number of condoms distributed
Monitoring Data Source: Condom distribution database
Expected Impact on Status Neutral Approach: Decrease number of heterosexual and MSM transmission cases by 25%.

Goal 3c: By December 31st, 2026, increase number of registered harm reduction sites in the state by 50%.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase number of registered harm reduction services, by utilizing the Public Health Detailer program to increase awareness of the Harm Reduction Training Program offered by SHHRS Prevention Services.
2. Increase number of statewide harm reduction trainings performed by the Harm Reduction coordinator to increase awareness and education surrounding harm reduction and programs within the state.
3. Collaborate with OSDH Injury Prevention Services and Oklahoma Department of Mental Health and Substance Abuse Services to share information and ensure that efforts are not duplicated but built upon, working together to support harm reduction sites and efforts throughout the state.

Key Partners: Community based organizations, OK Primary Care Association, FQHCs, OHHPC, harm reduction sites, ODMHSAS, OSDH Injury Prevention Service, ASTHO

Funding Resources: CDC EHE funding, CDC HIV Prevention and Surveillance funding

Outcomes (reported annually, monitored quarterly): Number of sites trained to provide harm reduction services

Monitoring Data Source: REDCap, eHARS, Careware

Expected Impact on Status Neutral Approach: Decrease number of IDU transmission cases by 25%.

Pillar 4: Respond

Goal 4: By December 31st, 2026, increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks.

Target Date: December 31, 2026

Key Activities and Strategies:

1. Increase involvement of health department staff, community members, and community organizations in response planning, implementation, and evaluation by developing an OHHPC Cluster Detection and Response Committee.
2. Develop and implement a comprehensive HIV Cluster and Outbreak Detection and Response Plan.
3. Develop a Cluster and Outbreak Detection and Response Team comprised of Disease Intervention and epidemiological staff.

Key Partners: OHHPC Cluster Detection and Response Committee, county health departments, community-based organizations, HIV care providers, OK Primary Care Association FQHCs, hospitals, social services providers, people living with HIV

Funding Resources: CDC HIV Prevention and Surveillance funding, State STD funding

Outcomes (reported annually, monitored quarterly): Establishment of strengthened cluster and outbreak detection and response plan; number of cluster alerts; number of cluster investigations opened, and lessons learned; incorporation of strategies from Diagnose, Treat, and Prevent pillars into responses to clusters.

Monitoring Data Source: Local protocols and reports

Expected Impact on Status Neutral Approach: Increase the number of people in networks affected by rapid transmission who know their HIV diagnosis, are linked to medical care, and are virally suppressed, or who are engaged in appropriate prevention services.

Section VI. Integrated Planning Implementation, Monitoring & Jurisdictional Follow Up

Introduction

The SHHRS is a fully integrated service consisting of STD, HIV, and Viral Hepatitis, which includes: SHHRS Prevention, Intervention Division, Care Delivery Division (Ryan White/HIV Drug Assistance Program (HDAP)/Hepatitis), and the SHHRS Surveillance and Analysis Division. The SHHR Service employees include many diverse educational and experience backgrounds including, but not limited to epidemiologists, biostatisticians, statisticians, nurses, health educators, insurance specialists, statistical research specialists, field surveillance specialists and disease intervention specialists. Having a fully integrated service of related programs allows for program collaboration and service integration across federally funded cooperative agreements and state-supported projects. From this group of staff, the integrated plan committee was selected consisting of individuals from all four divisions: Care Delivery, Prevention, Intervention, and Surveillance and Analysis.

Just like Oklahoma's Ending the HIV Epidemic plan, a review of the integrated HIV prevention and care plan will occur twice a month, by pillar. This review will be followed by a vote to adopt changes, updates and revisions to the plan by the OHHPC. Continuous monitoring and evaluation will occur as the OHHPC is divided into sub-committees based on the pillars of EHE. These groups are also responsible for identifying successes and challenges with the implementation of plan activities and strategies as well as brainstorming possible solutions.

Implementation

Work towards EHE and goals in this integrated plan has already begun. Continued targeted measures and services are being provided to serve the most at-risk populations that must be reached in order to ensure the success of not only the integrated plan and SCSN but the EHE plan.

Coordination of partners will continue through the OHHPC and communications resulting from the meetings and websites will be distributed widely. Conversations with TA providers at the national level and federal funding partners will provide input into the implementation process with information regarding changes/increases in funding and new potential recipients.

Reviews of the plan and status updates will be provided at OHHPC meetings and will help drive changes in service delivery or priorities based on data analysis and outcomes. New partners will be identified using information from federal funding sites in regard to expanded funding, for example, to FQHCs or other HIV service entities. Requests for collaboration on funding applications is another tool to be used for identification of new partners. Public Health detailers do and will continue to provide a great mechanism for communication and know what is occurring across the state with health providers with respect to the prevention and care integrated plan. Not only do they gather information, but they also disseminate priority information as needed to those health providers.

Monitoring

Progress toward the integrated plan goals and objectives will be monitored by the Integrated Prevention and Care Planning Committee. This committee is comprised of staff from three areas of SHHRS: Prevention, Ryan White Care, and Surveillance. This committee will continue to meet monthly to review data and discuss the implementation of any changes requested by the OHHPC planning group, or as indicated by outcome data. This committee will be responsible for updating the plan and providing updates to the OHHPC at bi-monthly meetings.

Any SHHRS staff member responsible for overseeing a CDC or HRSA grant is a member of the Integrated Prevention and Care Planning committee. This helps to ensure that collaboration takes place between different funding streams, and that the most updated information is consistently available for use in all plans in the appropriate timelines, while minimizing duplication of effort.

Following any update to the Oklahoma Integrated HIV Prevention and Care Plan, there will be a review and approval process performed by the OHHPC. Voting members of the council will vote to approve, modify or disapprove suggested updates or changes to the plan. This process will also allow for the OHHPC to review the goals and pillar strategies, making sure that activities being performed by various organizations are still in line with accomplishing the outlined goals and objectives of the plan. The OHHPC is divided into sub-committees based on the pillars. These sub-committees are responsible for the reviewing and monitoring of their portions outlined within the plan, providing updates and feedback on progress and need for changes.

Evaluation

Due to CDC definitions, *linkage to care* and *retention in care* data will be evaluated annually; all other performance measure data will be evaluated quarterly. All data will be reported annually to HRSA and CDC through required reporting mechanisms. Progress will be reported to stakeholders through presentations at bi-monthly OHHPC meetings twice a year. The performance measures used to evaluate progress on Integrated Prevention and Care Plan goals and objectives are shown in the table below (Table C1).

Table C1. Evaluation Plan for Oklahoma 2022-2026

Performance Measures		Evaluation Method	Data Source	Responsible Person
Pillar 1: Diagnose	**New HIV Cases**	The number of newly diagnosed HIV cases within the calendar year of measure in Oklahoma.	eHARS, Careware	HIV Surveillance Manager
	Knowledge of HIV Status	The percentage of the total number of individuals living with HIV, undiagnosed divided by total of diagnosed and undiagnosed, in the calendar year of measure in Oklahoma.		
Pillar 2: Treat	**Linkage to Care***	The number of newly diagnosed HIV cases within the calendar year of measure in Oklahoma who have one or more documented CD4 or viral load tests within 30 days of diagnosis.	eHARS, Careware	Ryan White Data Manager
	Viral Suppression	The number of persons living with HIV in Oklahoma in the calendar year of measure who have a viral load of less than 200 copies/mL.		

	Re-engagement in Care	The number of persons living with HIV in Oklahoma who had previously been determined to be out of care who receive a CD4 or viral load test within the calendar year of measure.		
	Retention in Care*	The number of persons living with HIV in Oklahoma with at least two viral load or CD4 tests at least three months apart within the calendar year of measure.		
Pillar 3: Prevent	**PrEP/PEP Providers**	The number of providers seen through the public detailer program in Oklahoma within the calendar year of measure.	PHD Program Data	Public Health Detailers
		The number of providers trained to prescribe PrEP/PEP through the South Central AETC.	SC AETC Data	
	SHHRS Rapid Start PrEP	The percent change of those prescribed PrEP in the calendar year of measure through the SHHRS Rapid Start Program compared to the previous year's count.	REDCap	Ryan White Data Manager
		The number of patients maintained in PrEP care through the SHHRS Rapid Start program.		
	Condom Distribution	The percent change of condoms distributed in the calendar year of measure compared to the previous year's count of condom distribution in Oklahoma.	Condom Database	HIV Surveillance Manager
	Decrease in Heterosexual Transmissions	The percent change in the number of newly diagnosed HIV cases in the calendar year of measure with a risk of 'heterosexual contact' compared to the previous year in Oklahoma.	eHARS	
	Decrease in MSM Transmissions	The percent change in the number of newly diagnosed HIV cases in the calendar year of measure with a risk of 'MSM' compared to the previous year in Oklahoma.	eHARS	
	Registered Harm Reduction Sites	The number of registered harm reduction sites in Oklahoma within the calendar year of measure.	REDCap	
	Decrease in IDU Transmission Cases	The percent change in the number of newly diagnosed HIV cases in the calendar year of measure with a risk of 'IDU' compared to the previous year in Oklahoma.	eHARS, REDCap	
Pillar 4: Respond	**Cluster Detection**	The number of cluster alerts and cluster investigations opened in Oklahoma within the calendar year of measure.	Cluster Detection & Response Data	HIV Surveillance Manager
	Cluster Response	The number of HIV cluster responses in Oklahoma within the calendar year of measure.		

**Note: Due to CDC definition, performance measure is calculated annually.*

Improvement

Oklahoma will use the quarterly data analysis to make revisions and improvements to the HIV Integrated Prevention and Care Plan. Stakeholders will be informed of progress on the plan through presentations at bi-monthly OHHPC meetings twice a year and the Ryan White Quality Management Committee, which plans to implement Consumer Advisory Groups in 2023. Committee members, including people living with HIV, will be provided opportunities to request changes to the plan. The Integrated Prevention and

Care Plan committee will discuss these changes and any others needed, based on data analysis, during monthly meetings. Plan revisions will be made by the Integrated Prevention and Care Plan committee and presented to the OHHPC for voting and adoption. Voting on the revisions to the plan will occur twice a year.

Reporting and Dissemination

The Oklahoma HIV Integrated Prevention and Care Plan will be published and updated annually on the OHHPC website at www.endinghivoklahoma.org, as is the Oklahoma EHE Plan. Stakeholders will be informed of progress on the implementation, monitoring, evaluation, and improvement made to the plan through presentations at bi-monthly OHHPC meetings, as well as Consumer Advisory Groups formed through the Ryan White Quality Management Committee.

Updates to Other Strategic Plans

Portions of the Oklahoma Ending the HIV Epidemic plan were used to inform the Integrated HIV Prevention and Care Plan for Oklahoma. This plan is one that was reviewed by the OHHPC and is consistently revised and updated. As activities are completed, it is updated by the Prevention Programs Manager and presented to the OHHPC to review and vote on changes during meetings. This review and approval of changes process for the Oklahoma EHE plan occurs at least once a year. The plan is housed on the OHHPC website, www.endinghivoklahoma.org. Information utilized in this plan was also gathered from Oklahoma's previous Integrated Prevention and Care plan. This plan was used to compare needs assessment to determine plan structure as well as alignment and continuation of activities.

Oklahoma always reviews both plans side by side to make sure that they align and that the activities of both are being addressed. The OHHPC reviewed the EHE plan and alongside the Integrated plan during the August 2023 OHHPC meeting within their breakout groups which are according to the EHE pillars. The following challenges and successes were identified based on on-going or completed efforts.

Respond Pillar

Successes

- Dedicated staff persons hired for reporting and surveillance
- Being able to identify clusters allows for more outreach in affected areas
- Increase testing across the state

Challenges

- HIV surveillance team is small
- Cluster detection response relies on many teams (communication errors might occur)
- Knowing whether nucleotide testing actually being reported or done
- Steep HIV criminalization laws in Oklahoma

Diagnose Pillar

Successes

- Increased harm reduction activities across the state
- Messaging, education, screening and testing are reaching the rural areas better
- Increased testing while in prenatal care and during pregnancy

Challenges

- Challenges in defining what rural is versus non-rural areas in Oklahoma outside the MSAs
- Difficulties getting into or reaching isolated communities

Treat Pillar

Successes

- Peer-mentoring program created for newly diagnosed patients with HIV
- Increased number of case managers and outreach case managers
- AETC and OSU ECHO for provider education on the treatment of HIV
- OHHP website creation
- Increased number of ART-prescribing providers by 25% by 2022

Challenges

- Delays in the implementation of linkage to care case management program for individuals that have fallen out of care.

Prevent Pillar

Successes

- Established condom distribution program
- Provider education through public health detailing program, AETC and OSU ECHO programs
- Legalization of SB 511 for harm reduction programs to operate in Oklahoma

Challenges

- Stigma surrounding HIV prevention messaging

Section VII. Integrated Planning Council Letter of Concurrence

OKLAHOMA
State Department
of Health

January 30, 2023

Dear George Fistonich and Mary “Angie” Allen,

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

The OHHPC has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The OHHPC concurs that the Oklahoma Integrated HIV Prevention and Care Plan and Statewide Coordinated Statement of Need submission fulfills the requirements put forth by the CDC’s Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The OHHPC participated in the planning and development process of the Oklahoma EHE plan in 2020 as well as this current Integrated Plan. The OHHPC members have reviewed and approved the Needs Assessment and provided active feedback during the preparation process. The OHHPC met on January 30, 2023, for a final review and concurrence by vote.

The signatures below confirm the concurrence of the planning body with the Oklahoma Integrated HIV Prevention and Care Plan.

donald Rose jr. (Oct 26, 2023 10:42 CDT)

Donald Rose Jr.
OHHPC Community Co-Chair

Atonbara Sowemimo
OHHPC OSDH Co-Chair

Health.Ok.gov