OKLAHOMA INTEGRATED HIV PREVENTION & CARE PLAN 2027 - 2031

With Statewide Coordinated Statement of Need

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

SEXUAL HEALTH & HARM REDUCTION SERVICE

OKLAHOMA State Department of Health

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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.

Income Inequality (Gini index): The Gini index measures income inequality, with a value ranging from 0 (perfect equality) to 1 (perfect inequality). It is calculated using the Lorenz curve, which plots the cumulative percentage of income against the cumulative number of recipients. A higher Gini index indicates greater income inequality, meaning that a smaller percentage of the population holds a larger share of the total income.

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

> **B.1.1. Oklahoma City MSA:** Principal City - Oklahoma City, includes - Canadian County, Cleveland County, Grady County, Lincoln County, Logan County, McClain County, and Oklahoma County.
>
> **B.1.2. Lawton MSA:** Principal City – Lawton, includes Comanche County and Cotton County
>
> **B.1.3. 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 500% of the Federal Poverty Level and have no other means to access case management or mental health services.

Non-Medical 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. Introduction

The HIV Integrated Prevention and Care Plan for Oklahoma builds on the last iteration of the Integrated Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) developed and implemented in 2022 ending in 2026. This last iteration of this plan 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 as risk of getting HIV. The integrated HIV prevention and care plan, including the SCSN from 2022, also articulated the existing and needed collaboration among people living with HIV (PLWH), service providers, funded program implementers, and other stakeholders (OSDH, Oklahoma HIV Integrated Prevention and Care Plan, 2022).

This new iteration of the 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 other national directives as new programs and directives arise.

From 2018 to 2022, it is estimated that HIV infections in the United States decreased by 12 percent because of the decrease in new HIV infections reported among people between the ages of 13 to 24. Additionally, viral suppression rates nationally for clients in the Ryan White HIV/AIDS Program (RWHAP) increased from 69.5 percent in 2010 to 90.6 percent in 2023. Oklahoma did see a different trend with a 14 percent decrease in the number of newly diagnosed HIV from 2023 to 2024. However, the number had been increasing since 2018, in which there was a 20.7 percent increase in the number of new HIV diagnosis from 2018 to 2024. Additionally, in 2017, 49 percent of those living with HIV in Oklahoma were virally suppressed, which increased to 66% in 2024. This is a 35% increase in viral suppression among those living with HIV in Oklahoma from 2017 to 2024.

Oklahoma's plan mirrors the guidance put forth by the Centers for Disease Control and Prevention (CDC) and the Health Resource Service Administration (HRSA) in February of 2025 utilizing the four pillars of the EHE as a frame of reference for activities and programming to be in line with national standards with priorities detailed in national HIV goals and implementation strategies outlined in the Ending the HIV Epidemic in the U.S. Initiative. Oklahoma's plan will address the four goals established in 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
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and collaborators

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).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Oklahoma operates as an integrated unit with its prevention and care program being under the same service area within the Oklahoma State Department of Health. This makes for easy collaboration and communication across areas and reduces the occurrence of duplication of efforts and help make good use of resources in planning and implementing activities.

Approach

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 2022. 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. Oklahoma is aligned with national efforts and strategies to end the HIV epidemic in the United States by 2030.

As outlined in the CDC and HRSA Guidance, the Integrated HIV Prevention and Care Plan 2027 – 2031 is designed to:

1. Coordinate HIV prevention and care activities by assessing resources and service delivery gaps and needs across HIV prevention and care systems to ensure the allocation of resources based on data (e.g., other payors, number of ADAP-eligible clients on health insurance coverage, in-depth analysis of needs assessment of people with HIV and people who can benefit from HIV prevention services or are vulnerable to HIV acquisition);
2. Address requirements for planning, community engagement, and coordination established by the RWHAP legislation as well as programmatic planning and community engagement requirements established by both HRSA and CDC through guidance;
3. Improve health outcomes along the HIV care continuum by using data to prioritize people and communities who have been disproportionately impacted by HIV where systems of care are not adequately addressing high HIV morbidity and/or lower overall viral suppression rates;
4. Promote a whole-person approach to improve the health of people with HIV and people who can benefit from prevention services;
5. Utilize other planning documents to meet Integrated Plan requirements by aligning submission requirements and dates across HIV prevention and care funding;
6. Advance health by ensuring that government programs promote effective delivery of services and engage people with lived experience in service delivery system design and implementation; and,
7. Leverage strategic partnerships to prioritize efforts, and focus resources and evidence informed interventions, to reach those who are diagnosed, but not engaged in care.

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 four-hour meetings on a quarterly 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. In 2023, OHHPC meetings occurred in January, April, August, and November, and switched back to in person meetings. This year was unique in that the OHHPC also hosted an EHE Community Engagement Session in collaboration with federal EHE partners in October and also hosted an appreciation event for its members in December. By vote of members, regular OHHPC meeting switched to bi-monthly for two hours instead of four-hour quarterly meetings beginning in 2024, including January, March, May, July, September, and November. The OHHPC also hosted its first Voting Membership Orientation in March of that year. For 2025, OHHPC voting members, elected to move back to bi-monthly meetings for four-hours, with two of those months designated specifically for subcommittee meetings. These meetings were held in February, April, June, August, October, and December, with Voting Membership Orientation in March. For 2026, voting members approved four four-hour hybrid quarterly meetings, with additional subcommittee meetings in between. The OHHPC meetings for 2026 will be hosted in February, May, August, and November, with Voting Member Orientation occurring in March.

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, including those disproportionately impacted by HIV.

Key Stakeholders in the OHHPC Integrated Planning Body:

- **ABBVIE:** provider education liaison with community-based organizations and state department of health on hepatitis prevention.
- **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.
- **AMPLIFY YOUTH HEALTH COLLECTIVE, TULSA:** Prevention and education organization in the Tulsa area focused on sexual health, healthy relationships and engaging the community to promote the health and well-being of youth.
- **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 (FQHC) providing primary health care and other health-related services in central Oklahoma on a sliding scale income basis.
- **COMMUNITY HEALTH CONNECTION:** FQHC serving northeast Oklahoma
- **DIVERSITY FAMILY HEALTH:** provides primary and comprehensive care services.

- **East central oklahoma family health center:** Rural FQHC focused on improving health care needs in the community. They serve Wetumka, Henryetta, Wewoka counties and also provide behavioral health services along with primary care. Provides outreach and education as well.
- **END HIV OKLAHOMA:** non-profit dedicated to ending the HIV epidemic in Oklahoma.
- **Equality Health:** 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.
- **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.
- **Fox Project Foundation:** works throughout Oklahoma's treatment centers providing education, testing and linkage to care services for HIV and hepatitis C by meeting people where they are physically in treatment centers and emotionally through shared lived experience to improve access to prevention services and linkage to care.
- **Gilead Sciences, Inc.:** biopharmaceutical company focusing on researching and developing antiviral drugs used in the treatment of HIV/AIDS, hepatitis B, hepatitis C, influenza.
- **Guiding Right, Inc./New Hope Wellness Clinic:** a community-based organization providing health care and supportive services to improve the quality-of-life among 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.
- **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.
- **Ideal Touch Healthcare, Inc.:** 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.
- **Legal Aid Services of Oklahoma:** non-profit, 501(c)(3) organization that provides civil legal assistance, as well as ACA insurance navigation to low-income persons throughout Oklahoma
- **Merck & Co.:** biopharmaceutical company focusing on researching and developing antiviral drugs used in the treatment of HIV/AIDS, hepatitis B, hepatitis C, influenza.
- **Muscogee Creek Nation:** assists tribal citizens with medical services, dental services.
- **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 Health Care Authority (OHCA):** statutory authority responsible for administering Oklahoma's Medicaid program, commonly known as SoonerCare.
- **Oklahoma City Indian Clinic:** assists tribal citizens with medical and social service needs in the Oklahoma City area.
- **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 the HRSA Ryan White Part B/EHE and CDC Prevention/EHE funding recipient for the state of Oklahoma.
- **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.
- **Onyx Health and Wellness:** community-based organization providing health care and supportive services to improve the quality of life among people living with HIV in Oklahoma. Receives HRSA Ryan White EHE funding.
- **Osage Nation:** federally recognized Native American tribal government.
- **Orasure Technologies Inc.:** provides education and training on rapid testing technologies.
- **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. Receives HRSA Ryan White EHE subrecipient funding through OSDH SHHRS.
- **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 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.
- **SHOTS:** a non-profit program for individuals dealing with substance use disorders.

- **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 Parts C, D, and F 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 six staff members from each area of SHHRS: SHHRS Director, Ryan White Care Programs Manager, HIV Prevention Programs Manager, Prevention and EHE Manager, Ryan White Data and Evaluation Manager, and HIV Surveillance Manager. This committee meets quarterly and is responsible for reviewing, monitoring, drafting, and revising the Integrated Prevention and Care Plan.

SHHRS Ryan White program utilized a practicum student to create and disseminate the Ryan White Needs Assessment. 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 PLWH, the group was a good source of information for the survey. The survey was also conducted among 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 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 and are members or the Ryan White statewide Clinical Quality Improvement Committee, 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 was sent to the OHHPC for review via email with final approval at the OHHPC meeting in June 2026. 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 (CDR) Subcommittee consists of 9 individuals with professionals from OSDH, local CBOs, and health care facilities. The purpose of the OHHPC CDR Subcommittee is to develop, review, distribute, and facilitate education on clear and accessible information to the public and service providers about HIV surveillance, CDR, and data privacy. By identifying and promoting the use of less stigmatized language related to HIV CDR as well as ensuring diverse representation and perspectives among active members, the

subcommittee will help ensure Oklahoma HIV CDR efforts are ethical, effective, sensitive, and culturally appropriate.

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. The OHHPC CDR subcommittee is currently developing an accessible and condensed HIV CDR action plan to ensure community partners and providers are fully aligned on our cluster outbreak and response procedures. This will also allow for strengthened coordination and transparency.

Section III. Contributing Data Sets & Assessments

Data Sharing and Use

The SHHRS data and surveillance system is designed for all HIV/STI Prevention, Care, and Surveillance data to be shared inherently, without the requirement of data sharing agreements. Data used for analysis comes from a variety of databases:

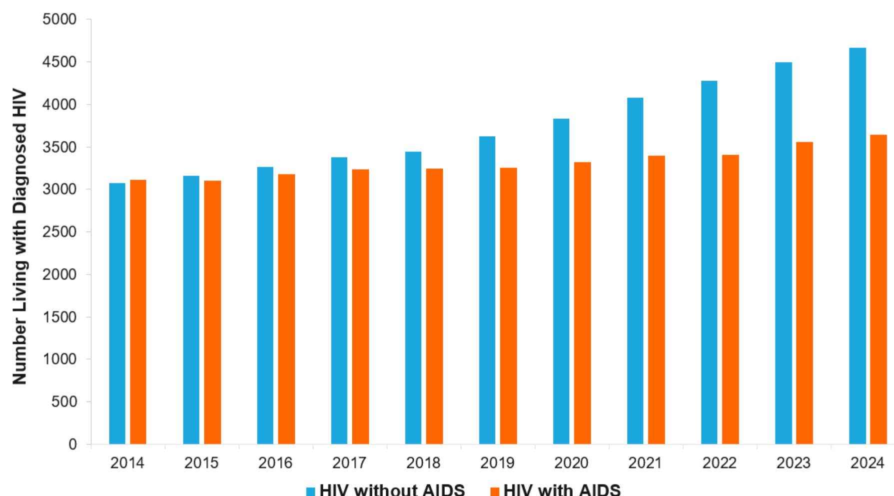
- **Enhanced HIV/AIDS Reporting System (eHARS)** contains the majority of detailed HIV surveillance data for the residents of Oklahoma. Data is received from statewide mandatory reporting by all Oklahoma health care providers and laboratories, and is cross-matched with Oklahoma Vital Statistics data, 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.
- **Provide Enterprise** contains Ryan White HIV/AIDS Program Part B and EHE eligibility and client level service data from Ryan White sub-recipient contractors in addition to ADAP application/eligibility data entered by Ryan White sub-recipient contractors.
- **Public Health Investigation and Disease Detection of Oklahoma (PHIDDO)** HIV counseling and testing (CTR) data entered as well as case report data from statewide mandatory reporting by all Oklahoma health care providers and laboratories for all reportable STIs.

A. Epidemiologic Snapshot of Oklahoma

Oklahoma has a state population of approximately 4,095,393 as of 2024. At the end of December 2024, an estimated 8,315 people were living with HIV/AIDS in Oklahoma at a rate of 203.0 per 100,000 population. Of those, 43.8% (3,645) were diagnosed with AIDS.

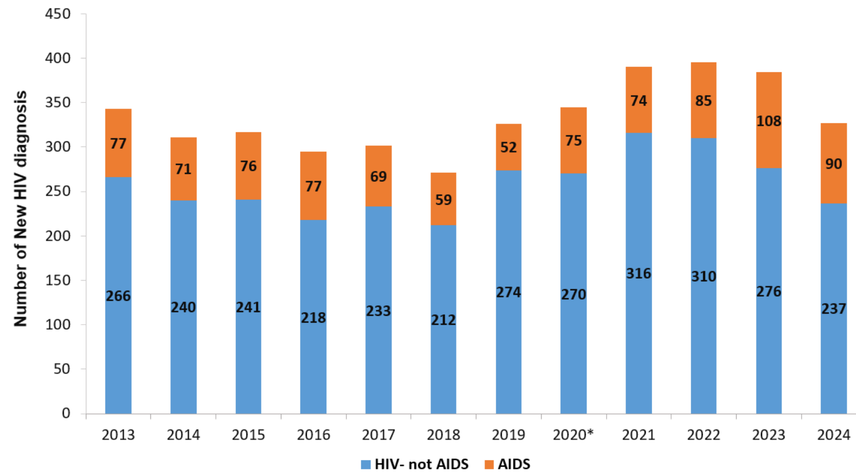
In 2024, 327 individuals were newly diagnosed with HIV in Oklahoma at a rate of 8.0 cases per 100,000 population. 26.6% of those newly diagnosed with HIV in Oklahoma were classified as late testers, or those diagnosed with AIDS within three months of their HIV diagnosis.

Figure A1. Number of PLWH in Oklahoma, by Year and AIDS Status, 2014-2024



Note: 2020 data should be interpreted with caution due to the impacts of the COVID-19 pandemic.

Figure A2. Number of People with Newly Diagnosed HIV by Year of Diagnosis and AIDS Status, Oklahoma, 2014-2024



*2020 data should be interpreted with caution due to the impacts of the COVID-19 pandemic.

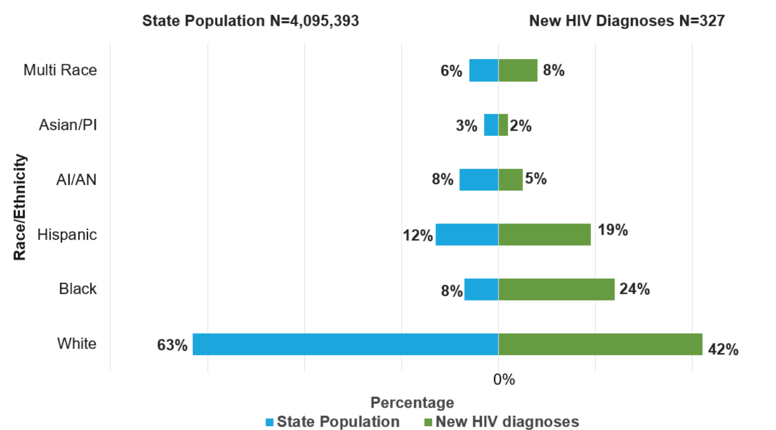
NEWLY DIAGNOSED HIV CASES

By Race

Despite comprising only 8% of the state population, Blacks made up 24.2% of the new HIV diagnoses, and Hispanics comprise 12% of the state population while making up 19.3% of the new HIV diagnoses in 2024.

Blacks had the highest rate of newly diagnosed HIV cases in 2024 (25.8 cases per 100,000 population) among all the racial and ethnic groups in Oklahoma. This rate was 3.2 times higher than state rate (8.0 cases per 100,000) and 4.8 times higher than the rate for Whites (5.4 cases per 100,000). Hispanic had the second highest rate of newly diagnosed cases (11.4 cases per 100,000). Multi-Race (10.0 cases per 100,000) had the third highest rate. (See Figure A3.)

Figure A3. Distribution of the State Population and New HIV Diagnoses, by Race/Ethnicity, Oklahoma, 2024



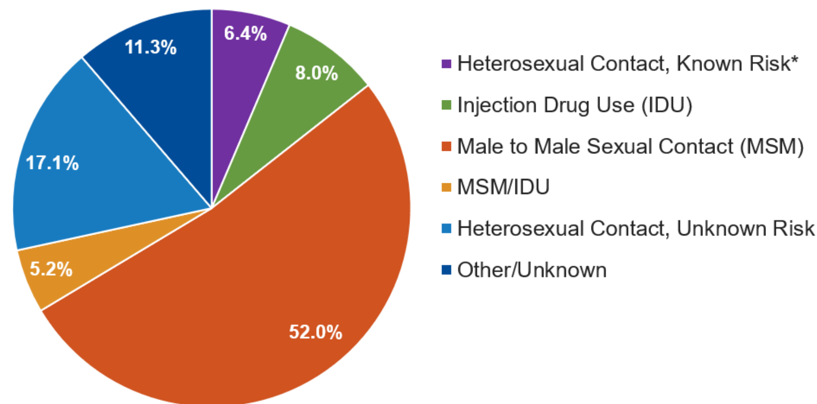
By Sex
Males accounted for 82.3% (269) of the newly diagnosed cases and females accounted for 17.7% (58). The 2024 HIV rate among males (13.2 cases per 100,000) was 4.7 times higher than the rate among females (2.8 cases per 100,000). Among men in 2024, diagnosed HIV infections for Blacks was 41.4 per 100,000 (the highest group rate) and for AI/NA was 6.7 per 100,000 (the lowest group rate). Among women in 2024, diagnosed HIV infections for Blacks was 9.9 per 100,000 (the highest group rate) and for white was 1.7 per 100,000 (the lowest group rate).

By Age
The 25 – 34 years age group had the highest number of newly diagnosed HIV cases in 2024 (124; 37.9%). The 35 – 44 years age group had the second highest number of cases (67; 20.5%), the 15 – 24 years age group accounted for 20.2% (66) of the cases, followed by the 45 – 54 years age (44; 13.5%) and 55 – 64 years age (23; 7.0%).

By Mode of Transmission
Of the 2024 newly diagnosed HIV cases:

- 52.0% (170) were men who have sex with men (MSM)
- 17.1% (56) were heterosexual contact, unknown risk
- 8.0% (26) were injection drug use (IDU)
- 6.4% (21) were heterosexual contact, known risk
- 5.2% (17) were MSM/IDU
- 11.3% (37) were other/unknown
-

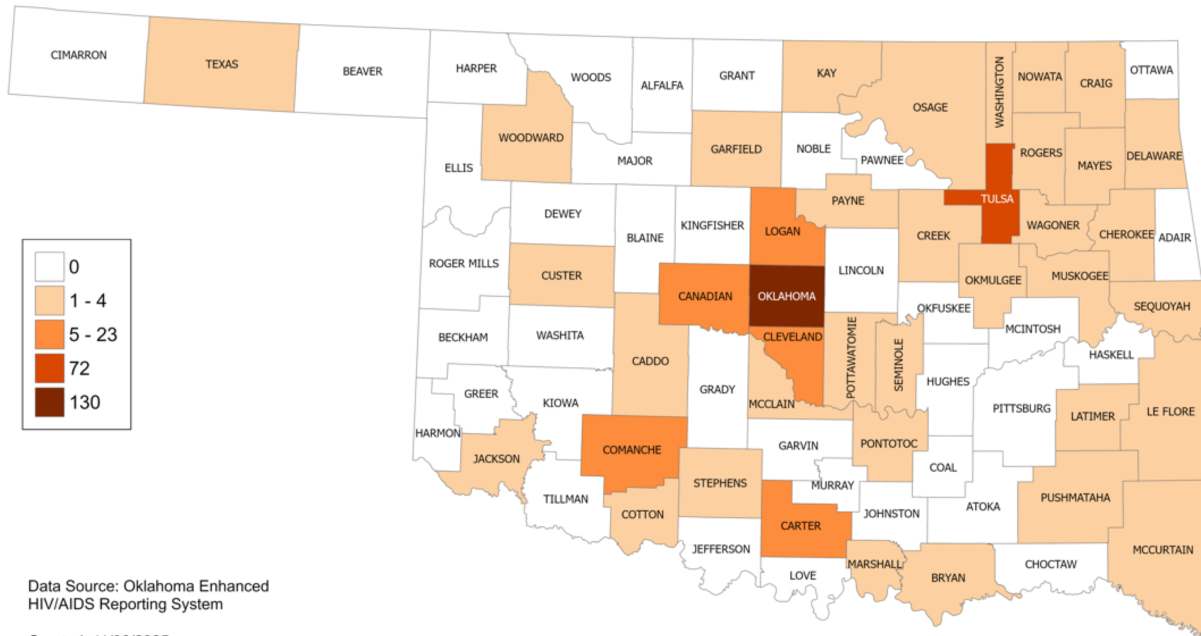
Figure A4. Distribution of Exposure Among People with Newly Diagnosed HIV, Oklahoma, 2024 (N=327)



*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)

By Geography
Four counties in Oklahoma accounted for 72.2% of the newly diagnosed HIV cases in 2024: Oklahoma (130; 39.8%), Tulsa (72; 22.0%), Cleveland (23; 7.0%), and Canadian (11; 3.4%).

Figure A5. New HIV/AIDS Cases by County, Oklahoma 2024



LIVING HIV/AIDS CASES

Overview

At the end of 2024, the rate of people living with diagnosed HIV among Oklahoma residents, was 203.0 per 100,000. This includes all people with HIV diagnosed that were alive at the end of 2024, regardless of AIDS status. Oklahoma has experienced a 16.2% increase in people living with HIV from 2020 to 2024.

By Race

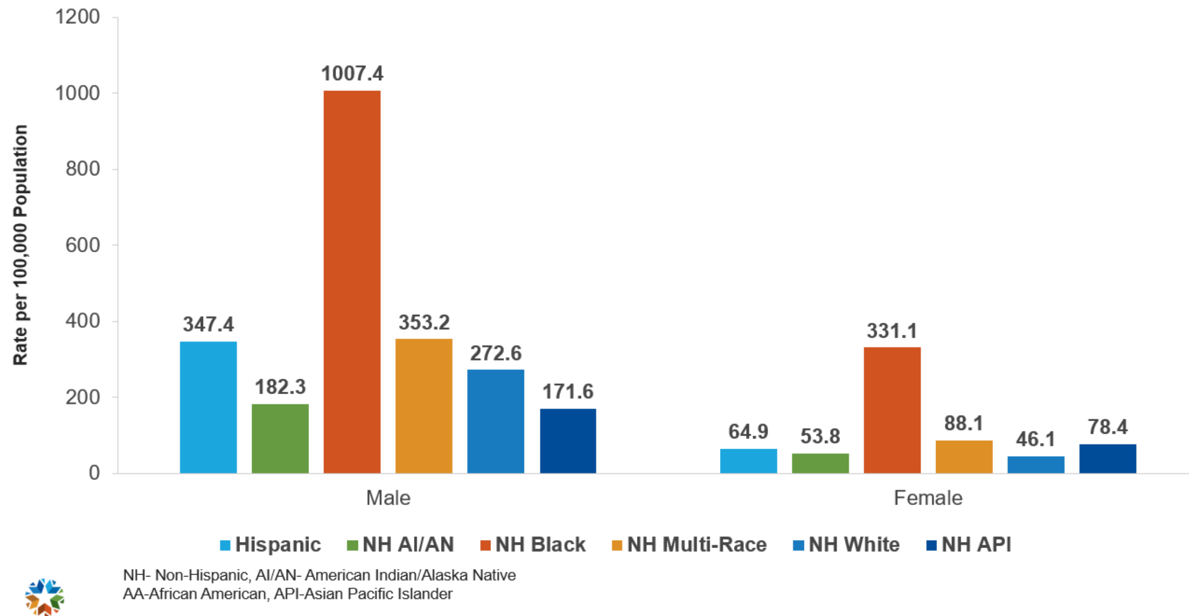
Of the 8,315 persons living with HIV/AIDS at the end of 2024:

- 48.2% (4,008) were NH White
- 24.7% (2,057) were NH Black
- 14.0% (1,166) were Hispanic
- 6.6% (547) were NH Multi race
- 4.7% (391) were NH American Indian/Alaska Native
- 1.8% (146) were NH Asian/Pacific Islander

Among the 8,315 people living with HIV at the end of 2024, 4,008 (48.2%) were Non-Hispanic (NH) White, 2,057 (24.7%) were NH Black, 1,166 (14.0%) were Hispanic, 547 (6.6%) were NH Multiple races, 391 (4.7%) were NH American Indian/Alaska Native (AI/AN), and 146 (1.8%) were NH Asian/Pacific Islander.

Non-Hispanic Black persons had the highest rate of people living with HIV (672.8/100,000) among the racial/ethnic groups in Oklahoma. The rate for NH Black people living with HIV was 3.3 times the rate for the entire state (203.0/100,000) and 4.3 times the rate of NH White people living with HIV in Oklahoma (158.0/100,000). Persons of NH Multiple races had the second highest rate of people living with HIV (218.6/100,000). The rate among NH Asian/Pacific Islander persons was 123.3/100,000. Non-Hispanic AI/AN persons had the lowest rate of 117.2/100,000.

Figure A6. Living HIV/AIDS Case Rate by Race, Oklahoma 2024



By Sex

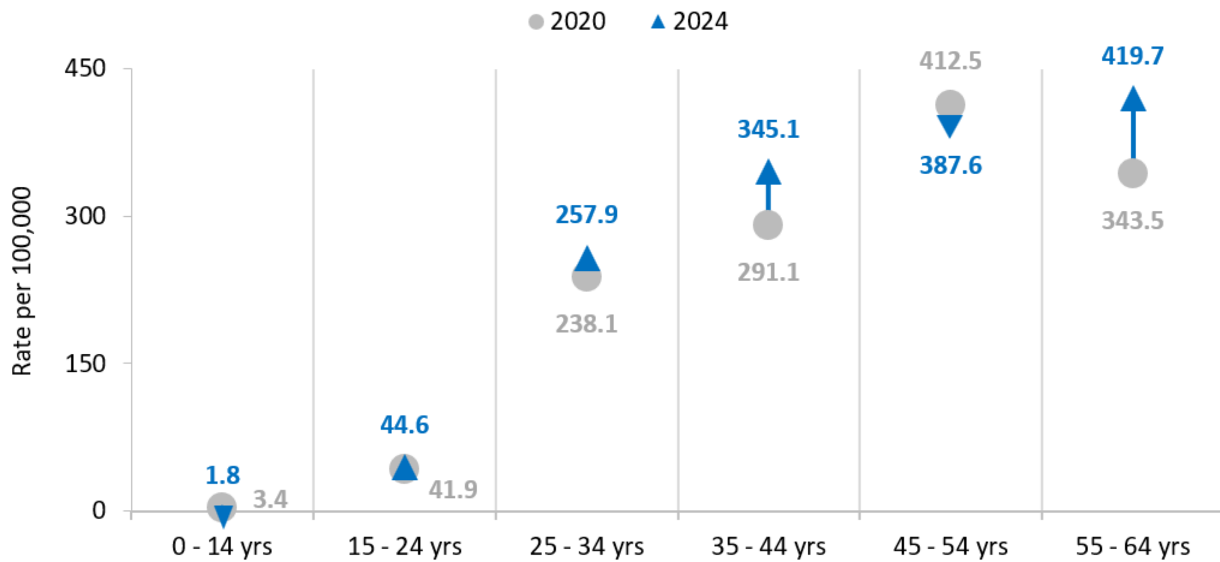
Of all people living with HIV in Oklahoma at the end of 2024, 6,799 (81.8%) were assigned male sex at birth. While there was an increase in the number of diagnoses compared to 2020, the distribution is similar (n=5,878, 82.1%).

Non-Hispanic White males had the highest number of people living with HIV at the end of 2024 (n=3,216, 41.1%), followed by NH Black males (n=1,556, 18.7%), Hispanic males (n=994, 12.0%), NH White females (n=592, 7.1%), and NH Black females (n=501, 6.0%). However, the highest rate among sex at birth were among NH Black males (1007.4 per 100,000 population), and NH Black females (331.1 per 100,000 population) (Figure A6).

By Age

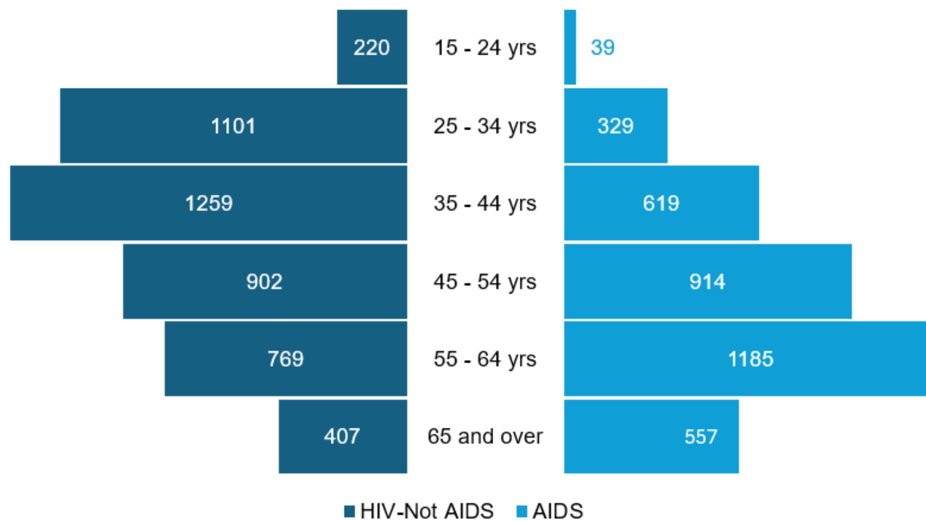
Persons aged 55-64 had the highest number of people living with HIV at the end of 2024 with 1,954 diagnoses. The rate of people living with HIV increased with age, peaking in persons aged 45-55 before decreasing. The highest rate of 419.7 per 100,000 population was observed among persons aged 55-64. Compared to 2020, the rate of people living with HIV has increased for all except persons aged 0-14 and 45-54 (Figure A7).

Figure A7: Rate of People Living with HIV, by Current Age, 2020 and 2024



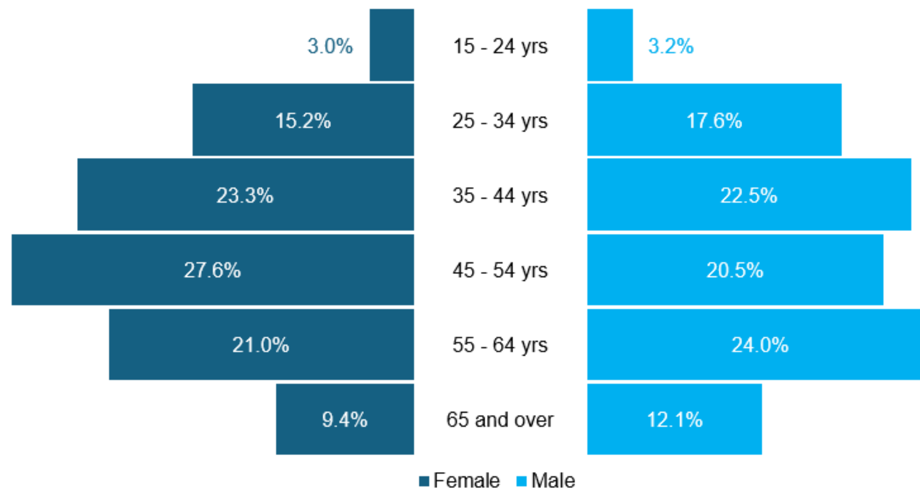
When stratified by AIDS status, we found an increasing trend across age groups in AIDS diagnoses among people living with HIV, showing a maximum in persons aged 55-64 (Figure A8). Persons aged 55-64 had the highest number of people living with AIDS at the end of 2024 with 1,185 (32.5%). The opposite effect is observed among people living with HIV-not AIDS. The group with the highest number of HIV-not AIDS diagnoses were persons aged 35-44 with 1,265 (27.1%).

Figure A8: Number of People Living with HIV by Current Age Group and AIDS Status, Oklahoma, 2024



At the end of 2024, persons aged 55-64 had the highest distribution of people living with HIV among males (n=1,634, 24.0%), however persons aged 45-54 had the highest distribution among females (n=419, 27.6%) (Figure A9).

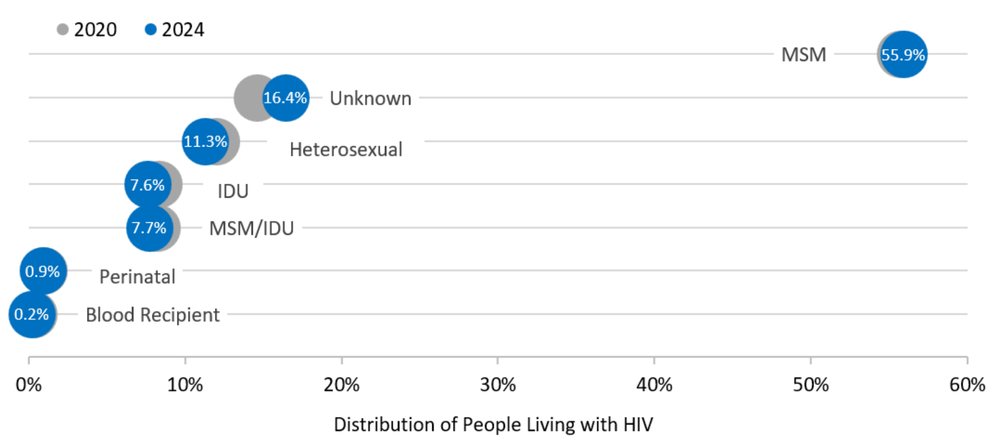
Figure A9: Distribution of People Living with HIV by Current Age and Sex at Birth, Oklahoma, 2024



By Mode of Transmission

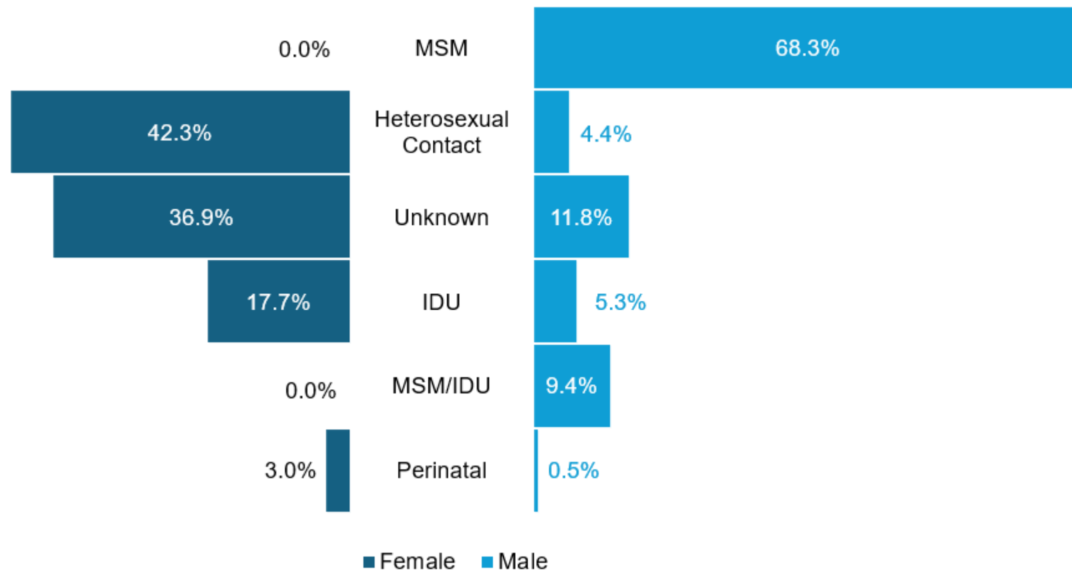
At the end of 2024, over half (n=4,647, 55.9%) of people living with HIV had an attributed risk factor of Male-to-Male Sexual Contact (MSM). Unknown (which includes heterosexual contact with someone of either unknown HIV status or HIV negative, and unknown risk for HIV) accounted for 1,364 (16.4%), while Heterosexual contact with a person known to have HIV or known to be a high risk for HIV represented 939 (11.3%). Injection drug use (IDU) and MSM/IDU had a similar distribution of 630 (7.6%) and 642 persons (7.7%) respectively. Compared to 2020, the distribution of Unknown modes of transmission have increased while the distribution of Heterosexual contact, IDU, and MSM/IDU have decreased (Figure A10).

Figure A10: Distribution of Mode of Transmission among PLWH, Oklahoma, 2020 and 2024



Among males, MSM transmission accounted over half (n=4,647, 68.3%) of people living with HIV at the end of 2024. Heterosexual contact with a person known to have HIV or known to be at high risk for HIV, Unknown, and IDU were more predominant among females (42.3%, 36.9%, 17.7%) compared to males (4.4%, 11.8%, 5.3%) (Figure A11).

Figure A11: Distribution of Mode of Transmission among People Living with HIV, Oklahoma, 2024

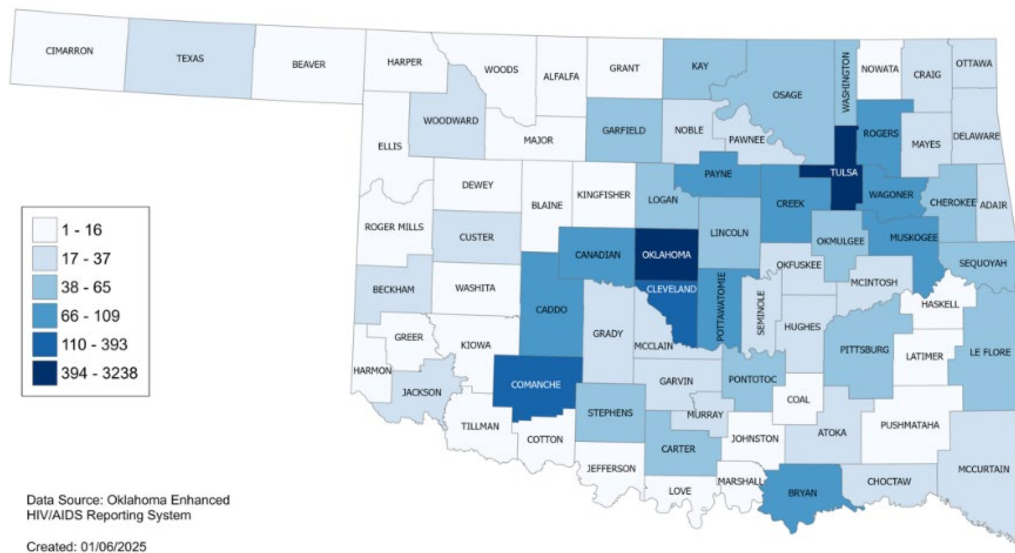


Among the 4,647 persons classified as MSM, the majority were NH White (n=2,360, 50.8%), followed by NH Black (n=1,027, 22.1%) and Hispanic (n=688, 14.8%).

By Geography

A majority of people living with HIV at the end of 2024 (n=5,949, 71.5%) resided in four counties in Oklahoma: 3,238 in Oklahoma (38.9%), 2,064 in Tulsa (24.8%), 393 in Cleveland (4.7%), and 254 in Comanche (3.1%) (Figure A12).

Figure A12: Number of People Living with Diagnosed HIV by Current County of Residence, Oklahoma, 2024



At the end of 2024, the highest distribution of PLWH resided in the Oklahoma City metropolitan statistical area (MSA) (n=3,912, 47.0%), followed by the Tulsa MSA (n=2,475, 29.8%) (Figure A13). At the end of 2024, 1,559 (18.7%) people living with HIV resided in counties that were not part of a MSA (Figure A13).

Figure A13: Distribution of the State Population and People Living with HIV, by Metropolitan Statistical Area, Oklahoma, 2024

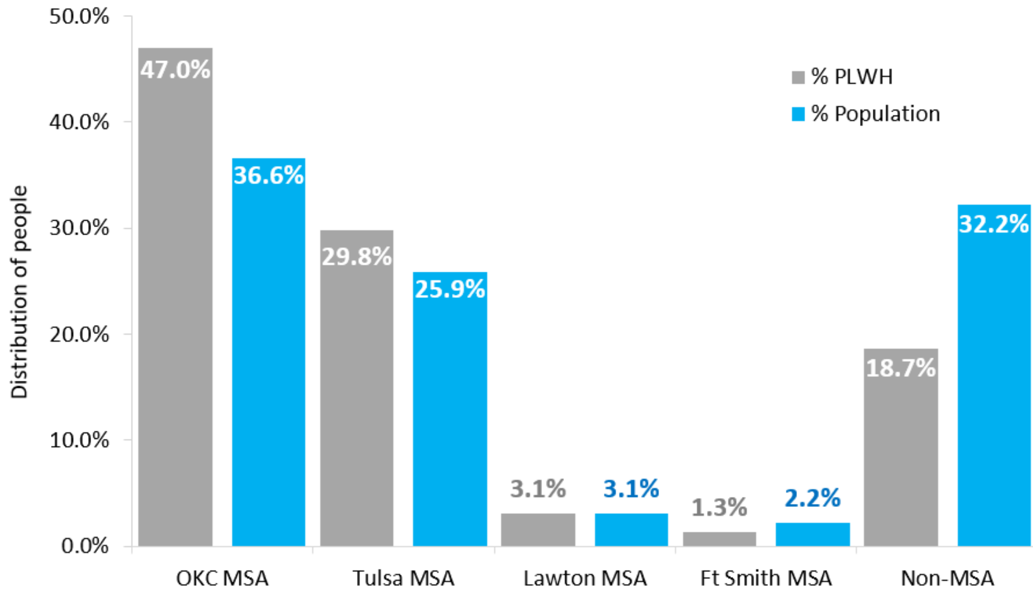


Table A1. Newly Diagnosed HIV Cases, Oklahoma 2024

Cases	HIV without AIDS[1]		HIV with AIDS[2]		Total Newly Diagnosed		
	Number	(%)[3]	Number	(%)[4]	Total	(%)[5]	Rate[6]
Total	237	72.5	90	27.5	327	--	8
Sex at Birth	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Female	43	74.1	15	25.9	58	17.7	2.8
Male	194	72.1	75	27.9	269	82.3	13.2
Age (in years)	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
15 – 24	58	87.9	8	12.1	66	15.6	11.4
25 – 34	88	71	36	29	124	15.6	22.4
35 – 44	48	71.6	19	28.4	67	34.6	12.3
45 – 54	29	65.9	15	34.1	44	23.7	9.4
55 – 64	*	*	*	*	*	*	*
65+	*	*	*	*	*	*	*
Race/Ethnicity	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
NH American Indian/Alaska Native	*	*	*	*	16	4.9	4.8
NH Asian/Pacific Islander	*	*	*	*	6	1.8	5.1
NH Black	58	73.4	21	26.6	79	24.2	25.8
Hispanic (All Races)	45	71.4	18	28.6	63	19.3	11.4
NH White	100	72.5	38	27.5	138	42.2	5.4
NH Multiple Races	18	72	7	28	25	7.7	10
Transmission Category[7]	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Male-to-Male Sexual Contact (MSM)[8]	132	77.7	38	22.3	170	52	--
Injection Drug Use (IDU)[8]	21	80.8	5	19.2	26	8.0	--
Heterosexual Contact, Known Risk[9]	14	66.7	7	33.3	21	6.4	--
MSM/IDU[10]	*	*	*	*	*	*	*
Unknown	*	*	*	*	*	*	*
Metropolitan Statistical Area (MSA)	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Fort Smith MSA	*	*	*	*	*	*	*
Lawton MSA	*	*	*	*	*	*	*
OKC MSA	120	70.2	51	29.8	171	52.3	11.4
Tulsa MSA	68	81.9	15	18.1	83	25.4	7.8
Non-MSA	40	69.0	18	31.0	58	17.7	4.4

Note: *Cell counts and calculations may have been suppressed due to small cell size (less than 5). percentages may not add up to 100% due to rounding; [1]people with HIV first diagnosed in 2024, who were not diagnosed with AIDS in 2024; [2]people with HIV first diagnosed in 2024, who were also diagnosed with AIDS in 2024; [3]percentage of HIV without AIDS diagnoses; [4]percentage of HIV with AIDS diagnoses; [5]percentage of all HIV diagnoses; [6]rate per 100,000 population, rates not available for transmission category; [7]each person is assigned one mode of exposure based on the CDC's hierarchy of risk, with the exception of those reporting both MSM and IDU;[8]does not include men who reported both MSM and IDU; [9]heterosexual contact with a person known to have or to be at high risk for HIV; [10]infections attributed to MSM and IDU (i.e., men who reported both risk factors).

Table A2. Living HIV/AIDS Cases, Oklahoma 2024

Cases	HIV without AIDS[1]		HIV with AIDS[2]		Total Living with HIV		
	Number	(%)[3]	Number	(%)[4]	Total	(%)[5]	Rate[6]
Total	4,670	56.2	3,645	43.8	8,315	--	203.0
Sex at Birth	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Female	911	60.1	605	39.9	1,516	18.2	
Male	3,759	55.3	3,040	44.7	6,799	81.8	
Current Age (in years)	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
15 – 24	220	84.9	39	15.1	259	3.1	44.6
25 – 34	1,101	77.0	329	23.0	1430	17.2	257.9
35 – 44	1,259	67.0	619	33.0	1878	22.6	345.1
45 – 54	902	49.7	914	50.3	1816	21.8	387.6
55 – 64	769	39.4	1,185	60.6	1954	23.5	419.7
65+	407	42.4	557	57.8	964	11.6	139.3
Race/Ethnicity	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
NH American Indian/Alaska Native	216	55.2	175	44.8	391	4.7	117.2
NH Asian/Pacific Islander	91	62.3	55	37.7	146	1.8	123.3
NH Black	1,192	57.9	865	42.1	2,057	24.7	672.8
Hispanic (All Races)	700	60.0	466	40.0	1,166	14.0	211.5
NH White	2,140	53.4	1,868	46.6	4,008	48.2	158.0
NH Multiple Races	331	60.5	216	39.5	547	6.6	218.6
Transmission Category[7]	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Male-to-Male Sexual Contact (MSM)[8]	2,600	56.0	2,047	44.0	4,647	55.9	--
Injection Drug Use (IDU)[8]	335	53.2	295	46.8	630	7.6	--
Heterosexual Contact, Known Risk[9]	500	53.2	439	46.8	939	11.3	--
MSM/IDU[10]	322	50.2	320	49.8	642	7.7	--
Perinatal[11]	*	*	*	*	76	0.9	--
Blood Recipient	*	*	*	*	17	0.2	--
Unknown	860	63.0	504	37.0	1,364	16.4	--
Metropolitan Statistical Area (MSA)	**Number**	**(%)**	**Number**	**(%)**	**Total**	**(%)**	**Rate**
Fort Smith MSA	48	45.3	57	44.7	105	1.3	
Lawton MSA	164	63.4	95	36.6	259	3.1	
OKC MSA	2.202	56.2	1,710	43.8	3,912	47.0	
Tulsa MSA	1.390	56.5	1.085	43.5	2,475	29.8	
Non-MSA	866	55.5	698	44.5	1,564	18.8	

Note: *Cell counts and calculations may have been suppressed due to small cell size (less than 5). percentages may not add up to 100% due to rounding; [1]people living with diagnosed HIV who were not diagnosed with AIDS; [2]people living with diagnosed HIV who were also diagnosed with AIDS; [3]percentage of HIV without AIDS diagnoses; [4]percentage of HIV with AIDS diagnoses; [5]percentage of all HIV diagnoses; [6]rate per 100,000 population, rates not available for transmission category; [7]each person is assigned one mode of exposure based on the CDC's hierarchy of risk, with the exception of those reporting both MSM and IDU;[8]does not include men who reported both MSM and IDU; [9]heterosexual contact with a person known to have or to be at high risk for HIV; [10]infections attributed to MSM and IDU (i.e., men who reported both risk factors); [11]Perinatal transmission of HIV (also called mother-to-child transmission of HIV) is when HIV is passed from a person with HIV to their child during pregnancy, childbirth (also called labor and delivery), or breastfeeding (through breast milk).

Table A3. Persons Living with Undiagnosed HIV Infection in Oklahoma, 2022

	Number[1]	95% Confidence Interval	
Sex at Birth			
Male	1,700	840	2,500
Female	330	30	640
Age at Infection			
13 – 24	230	0	460
25 – 34	840	400	1,300
35 – 44	510	90	930
45 – 54	270	0	550
55 – 64	120	0	350
≥ 65	40	0	220
Race/Ethnicity			
American Indian/Alaska Native	110	0	330
Asian	30	0	110
Black/African American	510	140	880
Hispanic/Latino[2]	470	60	890
Native Hawaiian/Pacific Islander	0	0	20
White	670	120	1,200
Multi race	210	0	510
Transmission Category[3]			
MSM	1,300	650	1,900
IDU	300	0	770
MSM/IDU	150	0	460
Heterosexual Contact[4]	290	0	580
Total	2,000	1,100	2,900

Notes: *2022 is the latest version of CDC SAS CD4 model program; [1]Estimates derived by using HIV surveillance and CD4 data for persons aged ≥13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤1,000 to reflect model uncertainty. Subgroups may not add to the total column due to rounding. [2]Hispanics/Latinos persons can be of any race. [3]data by transmission category has been statistically adjusted to account for missing transmission category. Rates are not calculated by transmission category due to lack of population data from the U.S. Census. [4]Heterosexual contact with a person known to have, or with a risk factor for, HIV infection.

HIV Clusters Identified in Oklahoma

Currently Oklahoma has four open cluster investigations, two are time-space and two are molecular. The first cluster was identified in February 2025 within a county that shares a border with one of the most populous counties in the state. Most identified members were male, and reported MSM contact. Members were predominantly in the younger age group (20-29), all of whom were diagnosed at a hospital or a community-based organization. The Intervention team conducted case reviews of members in the cluster to assess viral suppression and determine if any required linkage to care. This county was prioritized for Public Health Detailing where several clinics were visited to discuss the increase in new HIV diagnoses and provide education on HIV testing. A visit to a local college took place two weeks prior to identifying the cluster. The county is currently under continued monitoring for new diagnoses.

A second time-space cluster identified in April 2025 is related to a syphilis outbreak within the same county. Individuals in this cluster were diagnosed with HIV from 2024 to present, resided in western Oklahoma county at diagnosis, subject to housing instability, substance use (specifically methamphetamine, fentanyl, some IDU), and trading of sex for drugs. A joint meeting with Intervention

and Surveillance takes place weekly to discuss newly diagnosed HIV cases meeting the case definition. The Intervention team identify contacts, performing screening for syphilis and HIV, and linking people to care.

A molecular cluster was identified in January 2025. The cluster, not geographically restricted, includes four Oklahoma counties. When identified, all cluster members were male, half were non-Hispanic White, one-quarter were Hispanic, and a majority reported MSM contact. Nearly all the sex partners reported by newly diagnosed members were anonymous and a majority reported meeting through apps. Most were virally suppressed, all were interviewed, and partners had been identified and contacted. The Intervention team prioritized case reviews of members who were not virally suppressed, to ensure linkage to care. Prioritized response activities included outreach events, linkage to care, and Public Health Detailing.

A second molecular cluster was identified in August 2025. Cluster members resided in the same county at diagnoses, a majority reported MSM contact and nearly half identified as Hispanic. Over half are virally suppressed and all individuals were interviewed prior to detection. Since all individuals in the cluster have been interviewed and in care, response activities predominantly consist of weekly monitoring.

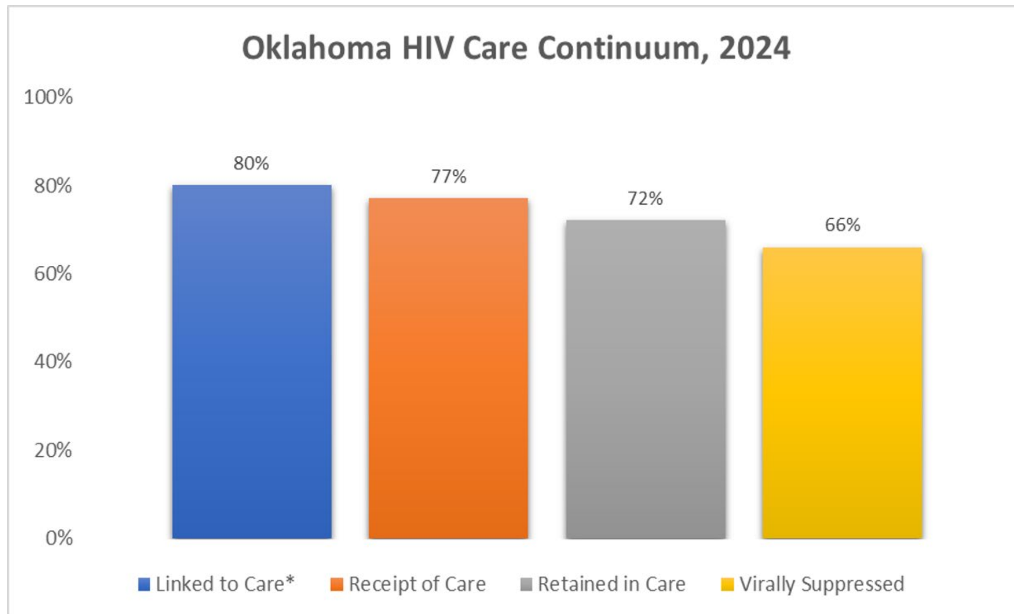
HIV Care Continuum 2024

Using 2024 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 PLWH, who have been diagnosed as opposed to a prevalence-based approach in which each step is the percentage of the total number of PLWH (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 2024 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.

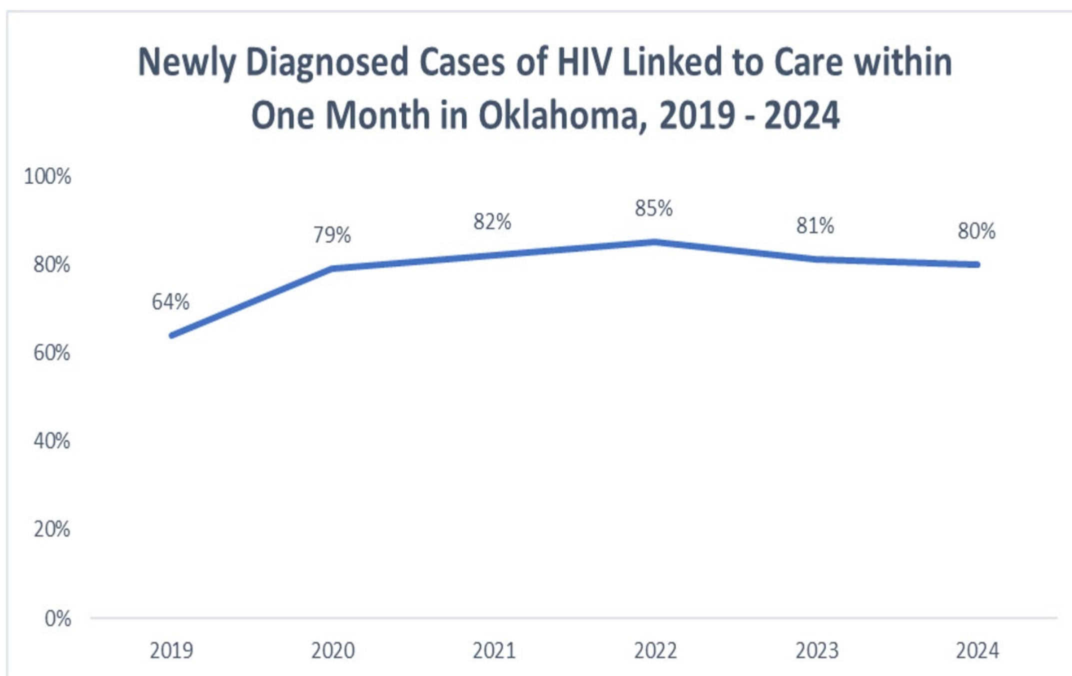
Of the 327 HIV cases diagnosed in Oklahoma in 2024, 80.4% (263) were linked to care within thirty days of diagnosis. Of the 8,315 persons living with HIV in Oklahoma at the end of 2024, 77.1% (6,411) received care, 72.4% (6,024) were retained in care, and 66.2% (5,503) were virally suppressed.

Figure A14. Oklahoma HIV Care Continuum, 2024



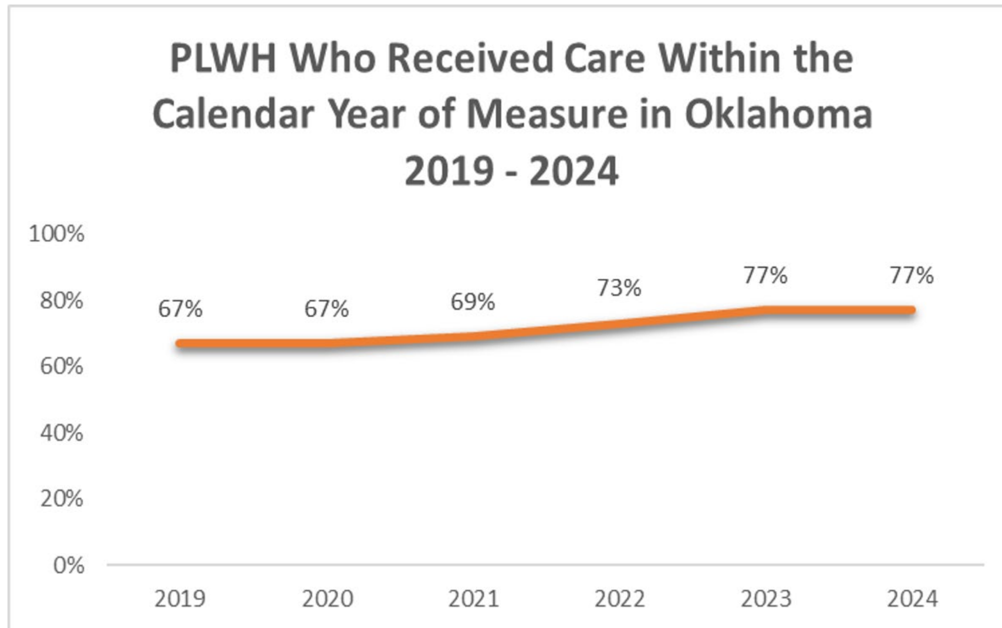
Newly diagnosed cases linked to care within 30 days increased from 2019 to 2024. The proportion of clients newly diagnosed with HIV in Oklahoma who were linked to care within one month of diagnosis increased significantly by 15 percentage points from 2019 (64%) to 2024 (80%). The Chi-square test showed a significant difference in the proportion of clients with the outcome between 2019 and 2024 ($X^2(1)=21.7$, $p<0.0001$).

Figure A15. Newly Diagnosed Cases of HIV Linked to Care Within One Month in Oklahoma, 2019-2024



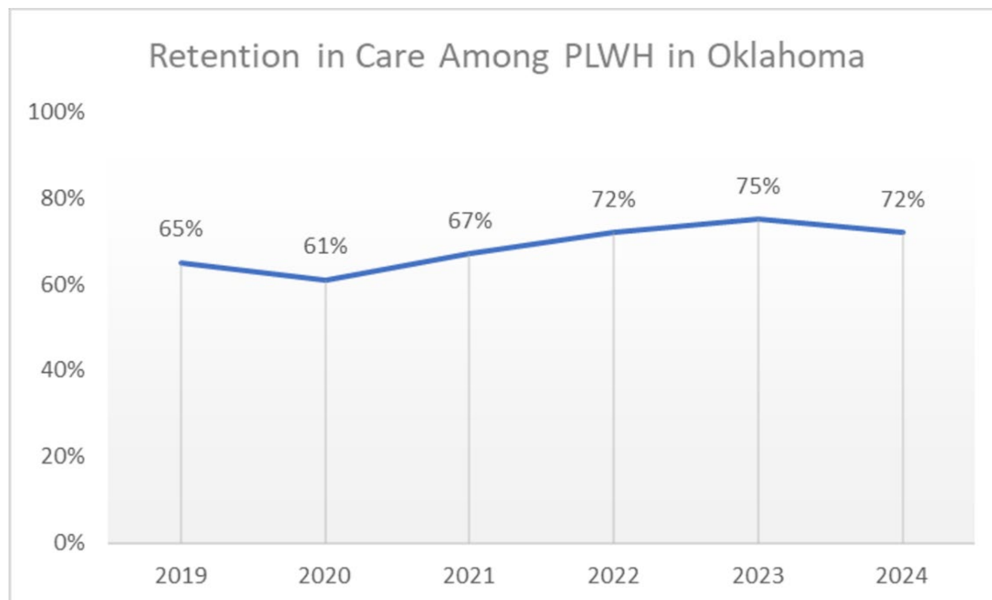
The proportion of PLWH who received care increased from 2019 to 2024. The odds of PLWH in Oklahoma and receiving care was 1.5633 times higher in 2024 than in 2019, (p<0.0001, CI: 1.5008, 1.6257).

Figure A16. PLWH Who Received Care Within the Calendar Year of Measure in Oklahoma, 2019-2024



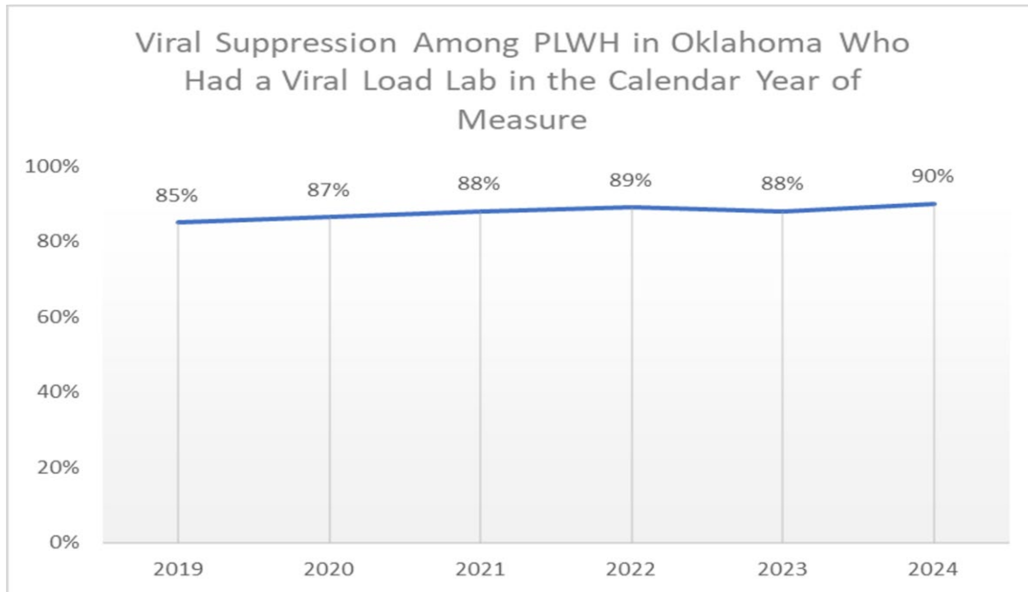
Retention in care of PLWH increased from 2019 to 2024. The odds of PLWH in Oklahoma who are retained in care is 1.393 times in 2024 than in 2019, (p<0.0001, CI: 1.294, 1.499).

Figure A17. Retention in Care Among PLWH in Oklahoma



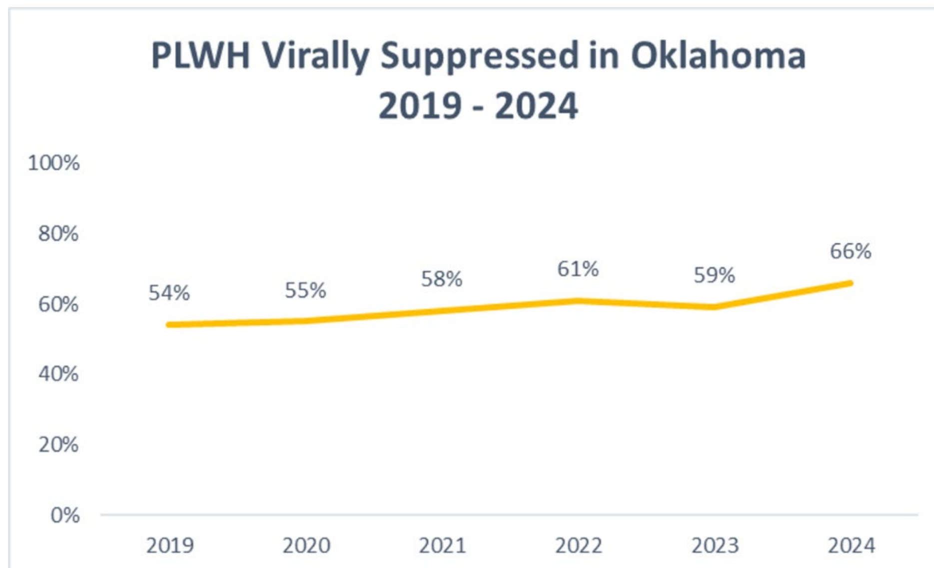
Among those living with HIV who had a viral load lab drawn during the calendar year of measure, there was an increase in viral suppression from 2019 to 2024. The odds of a PLWH in Oklahoma who had a viral load lab in the calendar year of measure being virally suppressed was 1.621 times higher in 2024 than in 2019, ($p<0.0001$, CI: 1.438, 1.827).

Figure A18. Viral Suppression Among PLWH in Oklahoma Who Had a VL in the Calendar Year



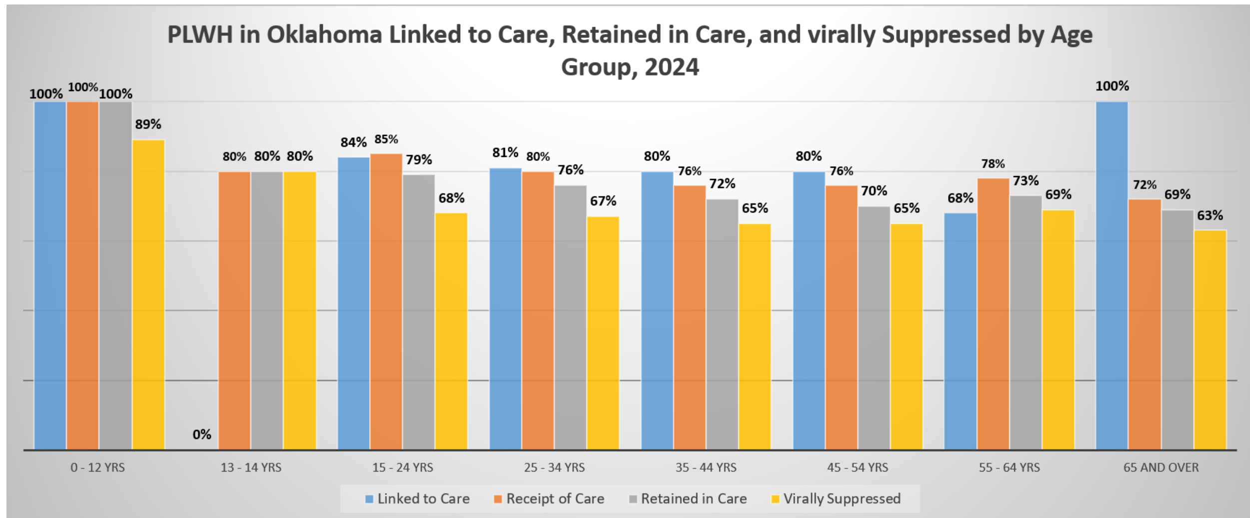
When evaluating those who did not have a viral load lab in the calendar year of measure, those individuals are categorized as not virally suppressed. Though this causes the viral suppression rate to appear lower than those virally suppressed among those who received labs, there was a significant increase in viral suppression from 2019 to 2024. The odds of a PLWH in Oklahoma being virally suppressed were 1.611 times higher in 2024 than in 2019, ($p<0.0001$, CI: 1.503, 1.728).

Figure A19. PLWH Virally Suppressed in Oklahoma, 2019-2024



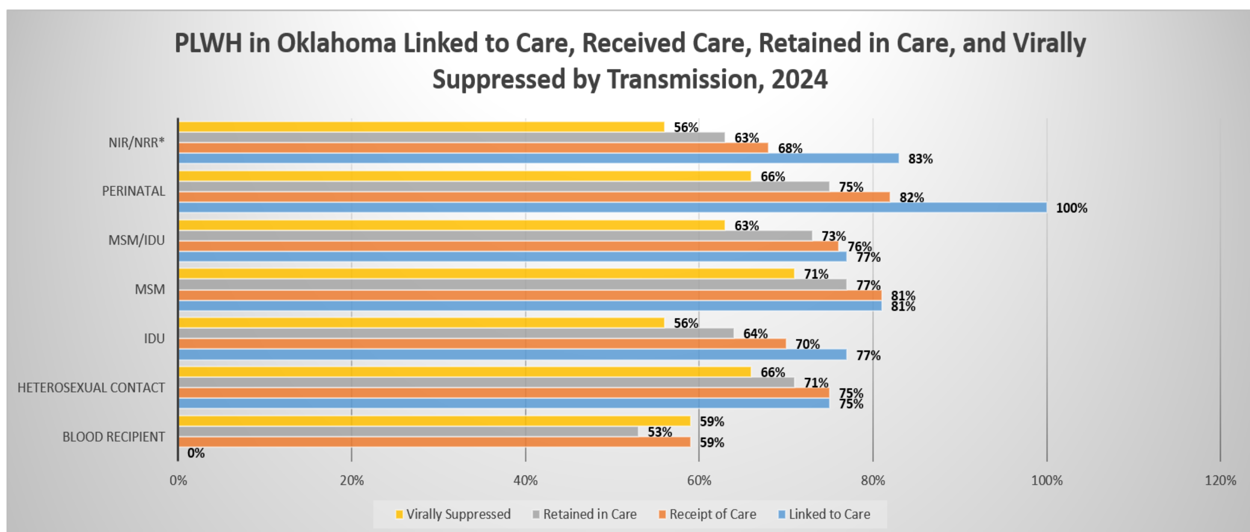
There was a significant association between age groups and being in care in 2024 ($X^2(7)=21.63$, $p<0.029$). The proportion of individuals in care differed significantly across age groups. There was also a significant association between age groups and viral suppression in 2024 ($X^2(7)=21.63$, $p<0.0029$). The proportion of individuals virally suppressed differed significantly across age groups.

Figure A20. PLWH in Oklahoma Linked to Care, Retained in Care, and Virally Suppressed by Age, 2024



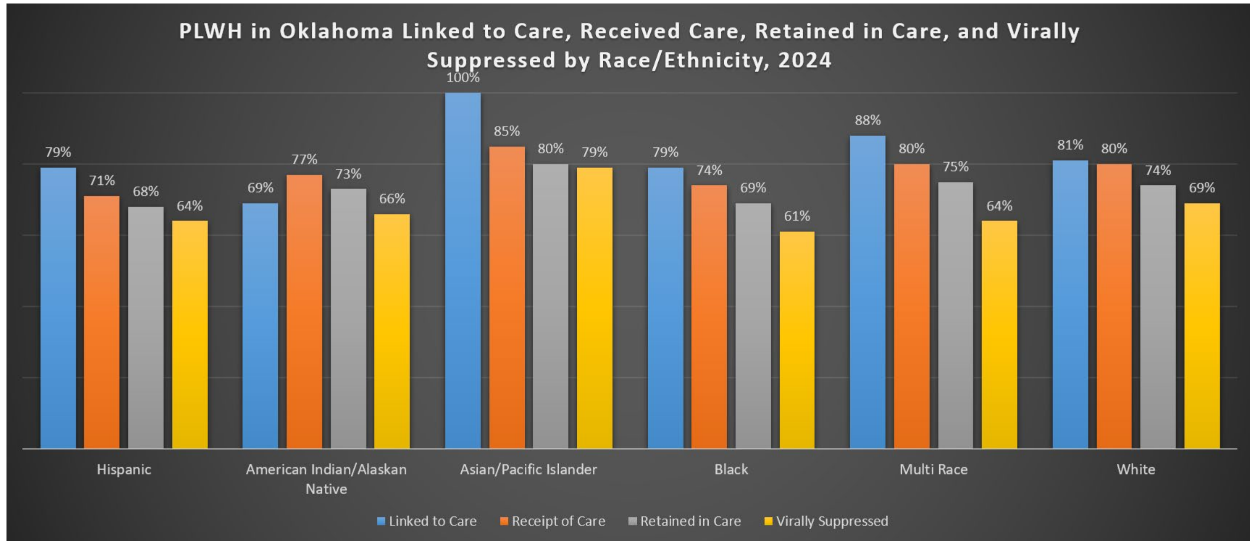
There was a significant association between transmission groups and being in care in 2024, ($X^2(6)=141.00$, $p<0.0001$). The proportion of individuals in care differed significantly across transmission groups. There was a significant association between transmission groups and viral suppression in 2024 ($X^2(6)=139.37$, $p<0.0001$). The proportion of individuals virally suppressed differed significantly across transmission groups.

Figure A21.PLWH in Oklahoma Linked to Care, Received Care, Retained in Care, and Virally Suppressed by Transmission, 2024



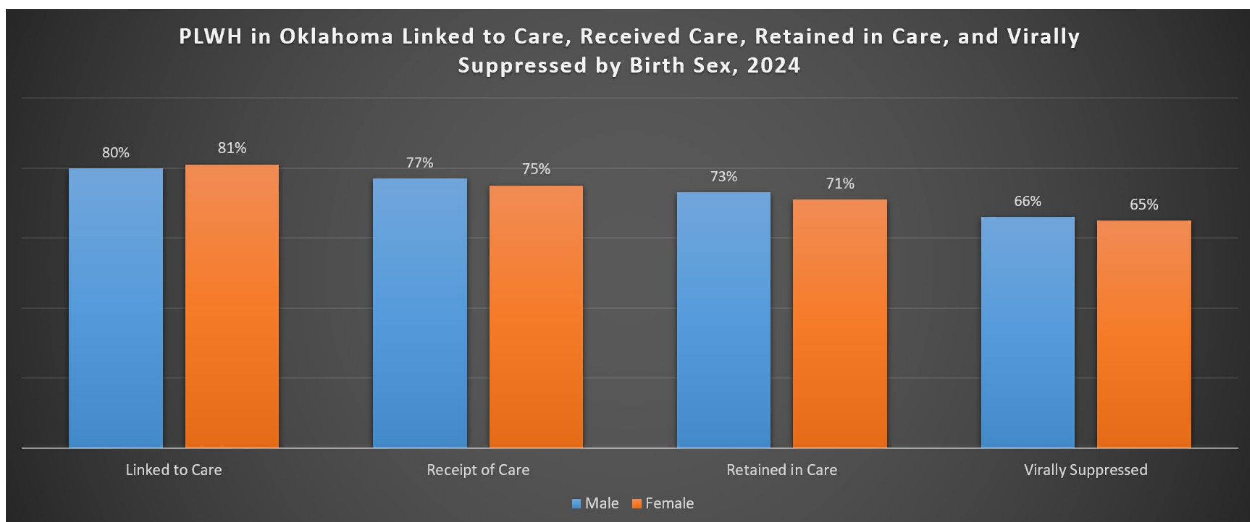
There was a significant association between race and being in care in 2024 ($X^2(5)=54.38$, $p<0.0001$). The proportion of individuals in care differed significantly across racial groups. There was a significant association between race and viral suppression in 2024 ($X^2(5)$ 56.81, $p<0.0001$). The proportion of individuals virally suppressed differed significantly across racial groups.

Figure A22. PLWH in Oklahoma Linked to Care, Received Care, Retained in Care, and Virally Suppressed by Race/Ethnicity, 2024



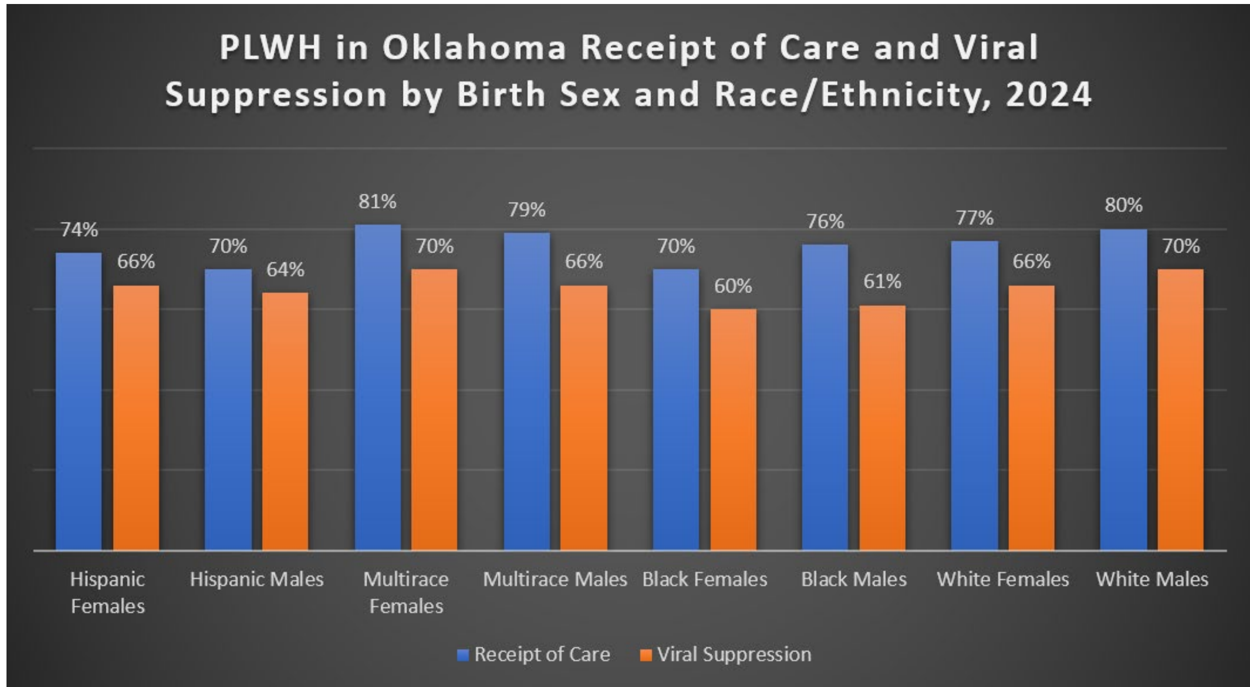
A Fisher's Exact Test indicated that birth sex and care status were significantly associated (p=0.0026). This suggests that the proportion of individuals in care in 2024 differed significantly by birth sex. A Fisher's Exact Test indicated that birth sex and viral suppression were not significantly associated (p=0.2191). This suggests that the proportion of individuals virally suppressed in 2024 did not differ significantly by birth sex.

Figure A23. PLWH in Oklahoma Linked to Care, Received Care, Retained in Care, and Virally Suppressed by Birth Sex, 2024



There was a significant association between race and birth sex and being in care in 2024 ($X^2(7)=62.50$, $p<0.0001$). The proportion of individuals in care differed significantly across race and birth sex groups. There was a significant association between race and birth sex and viral suppression in 2024 ($X^2(7)=48.98$, $p<0.0001$). The proportion of individuals virally suppressed differed significantly across race and birth sex groups. Hispanic males and black females had the lowest proportion of those receiving care (70%), while again black females (60%) and black males (61%) had the lowest proportion of those virally suppressed.

Figure A24. PLWH in Oklahoma Receipt of Care and Viral Suppression by Birth Sex and Race/Ethnicity, 2024



Oklahoma Social Drivers 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 Drivers of Health (SDOH) contribute to these disparities and it's important to understand how things SDOH affect the health of the Oklahoma population. According to the 2020-2024 American Community Survey 5-year estimates, 12.9% civilian non-institutionalized Oklahoma persons do not have health insurance, and 14.9% Oklahoma persons 18 years old and over live below poverty level. The median household income was $65,039 and 10.6% had less than high school diploma.

In Oklahoma, HIV infection was diagnosed for 282 adults (aged 18 years and older) whose residential address information was sufficient for geocoding to the census tract level (Table A3.). These diagnoses represent approximately 86.2% of all diagnoses of HIV infection in 2024 among adults. The overall rate of diagnoses of HIV infection was 9.2 per 100,000 population.

Poverty Level
In 2024, Oklahoma adults with the highest HIV diagnosis rate of 15.5 per 100,000 population lived 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 11 cases would have been prevented (absolute disparity). The highest poverty/lowest wealth rate was 3.7 times the lowest poverty/highest wealth rate (relative disparity).

Education Level
In 2024, Oklahoma adults with the highest HIV diagnosis rate of 14.3 per 100,000 population also live in census tracts with the lowest level of education (where 16% 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 6 cases would have been prevented (absolute disparity). The lowest education rate was 1.8 times the highest education rate (relative disparity).

Table A4. Diagnoses of HIV Infection among Adults (>18) and Selected Social Determinants of Health, Oklahoma 2024

	Number	Population	Rate
Below federal poverty level (%)			
< 6	21	505,286	4.2
6-<10	43	573,325	7.5
10-<17	80	1,093,154	7.3
17+	138	891,988	15.5
Less than high school diploma (%)			
<5	45	561,629	8.0
5-<9	65	793,845	8.2
9-<16	92	1,147,881	8.0
16+	80	560,398	14.3
Median household income (U.S. $)			
<49,000	104	639,816	16.3
49,000-<66,000	83	988,184	8.4
66,000-<90,000	67	824,682	8.1
90,000+	28	611,071	4.6
Without health insurance (%)			
<4	7	131,513	5.3
4-<8	30	535,614	5.6
8-<14	88	980,554	9.0
14+	157	1,416,072	11.1
Income Inequality (Gini index) (%)			
<37	53	567,720	9.3
37-<41	65	773,786	8.4
41-<46	105	1,032,483	10.2
46+	59	689,764	8.6
Total	**282**	**3,063,753**	**9.2**

Notes: 2020-2024 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 2024, Oklahoma adults with the highest HIV diagnosis rate of 16.3 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 12 cases would have been prevented. The lowest income rate was 3.5 times the highest income rate (relative disparity).

Health Insurance Coverage

In 2024, Oklahoma adults with the highest HIV diagnosis rate of 11.1 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 2.1 times the highest insurance coverage rate.

Income Inequality (Gini Index)
In 2024, Oklahoma adults with the highest HIV diagnosis rate of 10.2 per 100,000 population also live in census tracts with the higher income inequality (where income inequality was 41%-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 2 case would have been prevented. The highest income inequality rate was 1.2 times the lowest income inequality rate.

B. HIV Prevention, Care and Treatment Resource Inventory

SHHRS has the following funding sources: CDC STD PCHD (PS19-1901), CDC High Impact HIV Prevention and Surveillance Grant for Health Departments (PS24-0047), 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 2026 Oklahoma Care Needs Assessment.

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.

Caring Hands Healthcare Centers
Free testing
McAlester: 918-426-2442

Diversity Family Health
Prevention services, treatment, testing, outreach and education
1211 N Shartel Ave., Ste. 300, Oklahoma City, OK 73103 | (405) 848-0026 | diversityfamilyhealth.com

Equality Health Group Foundation * (CDC Funding)
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/

Red Rock Behavioral Health Services – Expressions Community Center* (Hablamos Español) (CDC Funding)
Prevention services, testing, outreach and education
Priority Population served: Hispanic/Latino
4420 N Lincoln Blvd, OKC 73105 | (405) 521-0897 |

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
4720 E 51st St, Tulsa, OK 74135 | (918) 749-8378 | https://hopetesting.org/

Ideal Touch Healthcare * (CDC Funding)
Prevention services, treatment, testing, outreach, education
Priority population served: rural populations
915 E Owen K Garriott Rd, Enid OK 73701 | 580-302-9101 | https://idealtouchhealthcare.com

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) (HRSA and CDC Funding)
Prevention services, treatment, testing, outreach, and education
Priority population served: Black, Hispanic/Latino, MSM
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

OKC Indian Clinic
Free testing
309 S Ann Arbor Ave, Oklahoma City, OK 73182
405-419-4900 *CDIB required

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

Variety Care- Sequoyah
Prevention services, testing, outreach, and education
Visit Locations | Variety Care (http://www.varietycare.org) to find a testing location nearest you
(405) 632-6688
Teen Clinic text line: 405-882-3598

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

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

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)
Medical Case Management, Outpatient Ambulatory Health Care, and Peer Navigation
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)
Non-Medical 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 and C 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

Onyx Health and Wellness (HRSA Ryan White EHE Funding)
Outpatient Ambulatory Health Services, Medical Case Management, Emergency Financial Assistance/Housing, Mental Health, and Peer Navigation
6520 E Reno Ave, Midwest City, OK 73110 | (405) 455-3008 | https://onyxhealthwellness.com/
Priority population served: Black, Hispanic/Latino, MSM

RAIN Oklahoma (HRSA Ryan White Part B and EHE funding)
Non-Medical 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)
Outpatient Ambulatory Health Services, Non-Medical 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 and C 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

HIV 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

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
- 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
- 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

C. 2026 Oklahoma HIV Care Needs Assessment Survey

OSDH SHHRS designed and conducted a cross-sectional, anonymous needs assessment to evaluate barriers to HIV care, health literacy, and unmet service needs among adults living with HIV in Oklahoma. The survey was administered electronically using REDCap. The target population includes adults aged 18 years or older who self-identify as HIV-positive, currently reside in Oklahoma, and are either currently engaged in HIV care or have fallen out of care. A non-experimental, descriptive cross-sectional design was used.

Data was collected through a self-administered, online questionnaire distributed through community-based and public health HIV service networks. Participation was voluntary and anonymous. Convenience sampling was utilized to recruit participants. Recruitment occurred through partnerships with key stakeholders in the OHHPC integrated planning body: RAIN Oklahoma, Tulsa CARES, Other Options Food Pantry, OSU, OUHSC, Onyx Health and Wellness, New Hope Health and Wellness, and the Department of Human Services.

The survey was hosted in REDCap and accessed primarily through a QR code and direct survey link. Participants were first asked to complete eligibility screening questions to confirm they were 18 years or older, HIV positive, and a resident of Oklahoma. Eligible participants would then proceed to the main survey using the REDCap survey queue logic. No personally identifiable information was collected. Survey responses were stored securely within REDCap and accessed only by approved project personnel. The data collected was exported into SAS for analysis.

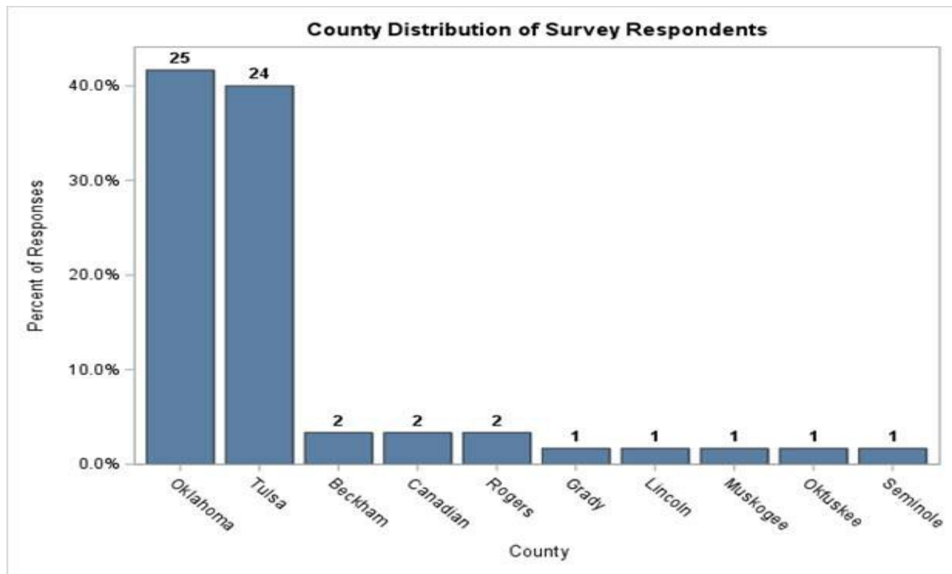
Participation was voluntary, and informed consent information was provided electronically prior to survey initiation via consent text. Because the survey was anonymous and minimal risk, participants were allowed to discontinue participation at any time without penalty.

A total of 96 total survey responses were submitted, 64 met inclusion criteria by completing the qualifying questions and consenting at the start of the survey. Among the 64 who met inclusion criteria, 62 completed the English version and 2 completed the Spanish version.

County Distribution

Percentages are based on respondents who provided an answer to this item (n=60). Most respondents lived in the Oklahoma and Tulsa County (82%), while others lived in Beckham, Canadian, Rogers, Grady, Lincoln, Muskogee, Okfuskee, and Seminole (Figure C1).

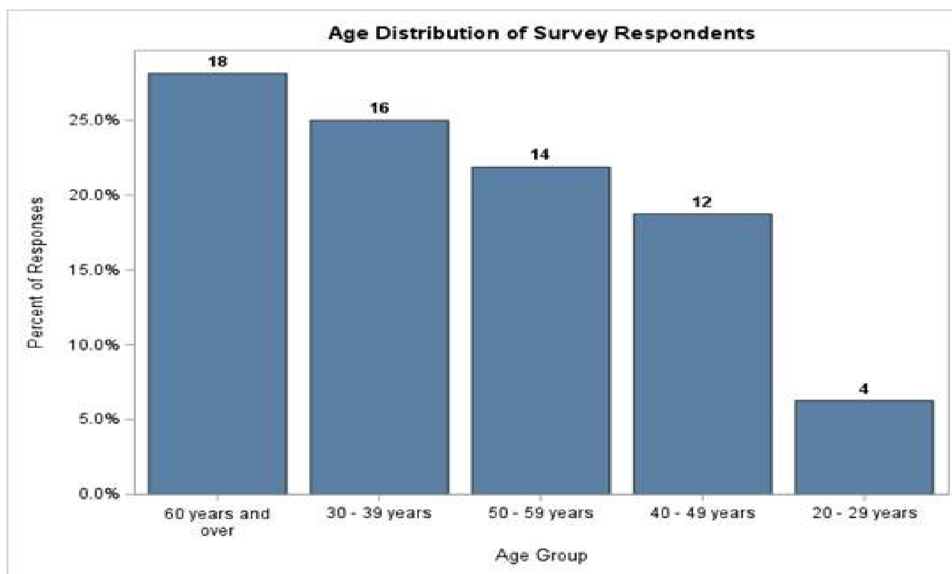
Figure C1. County Distribution of Survey Respondents



Age Group

Among all respondents (N=64), the age distribution shows that the largest proportion fell within the 60 years and over age group (28.1%, n=18), followed by 30 - 39 years (25%, n=16). Smaller proportions were observed among respondents aged 50 - 59 years (21.9%, n=14) (Figure C2).

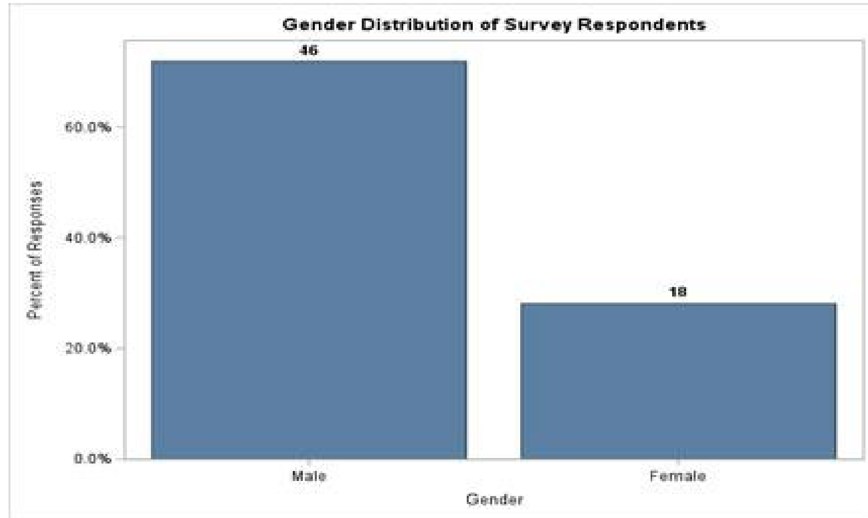
Figure C2. Age Distribution of Survey Respondents



Gender

Among all respondents (N=64), most identified as male (71.9%, n=46), followed by female (28.1%, n=18) (Figure C3). No respondents identified as "other".

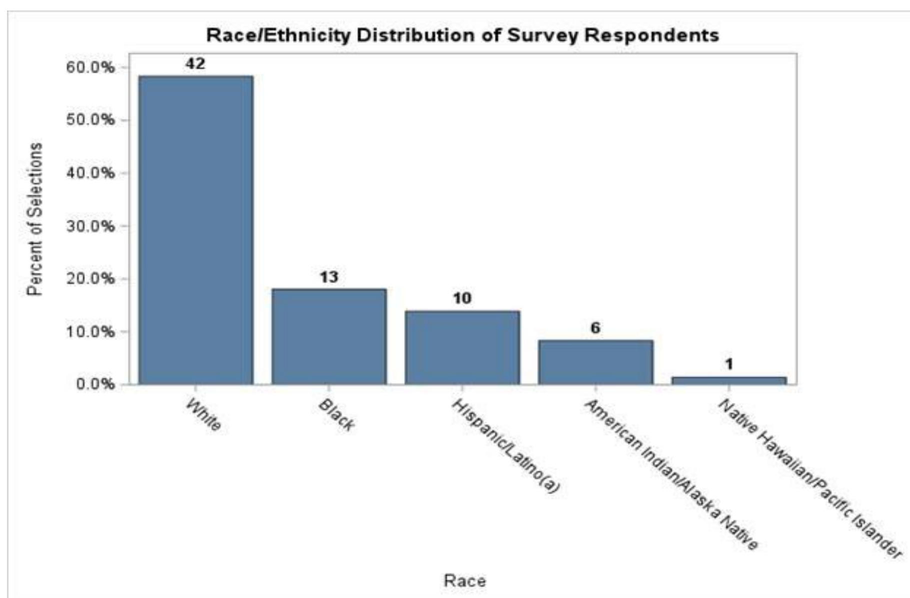
Figure C3. Gender Distribution of Survey Respondents



Race/Ethnicity

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. Among reported racial and ethnic identities, the most frequently selected category was white (65.6% of selections, n=42), followed by Black (20.3%, n=13). Hispanic/Latino(a) accounted for 15.6% (n=10) of the respondents. Other categories, including American Indian/Alaskan Native, and native Hawaiian were selected less frequently (Figure C4).

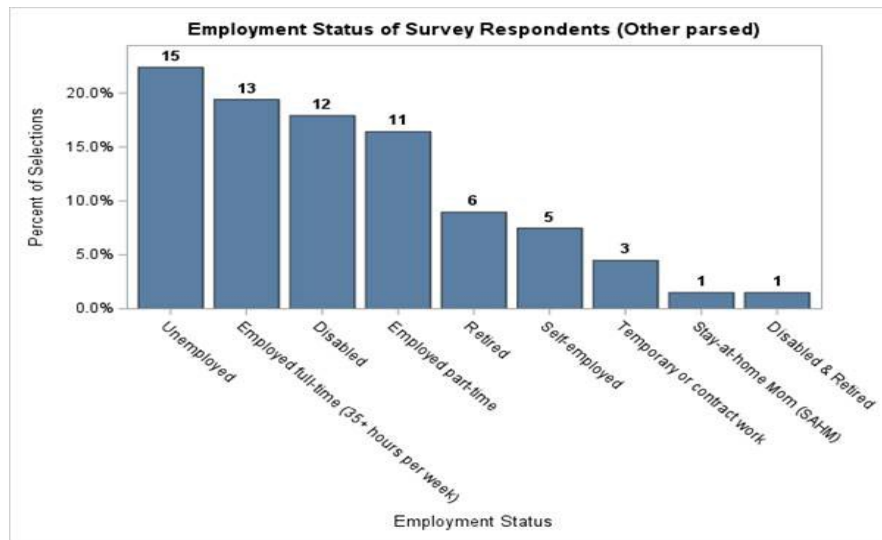
Figure C4. Race/Ethnicity Distribution of Survey Respondents



Employment Status

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. The most commonly reported employment status was Unemployed (23.4% of selections, n=15), followed by Employed full-time (35+ hours per week) (20.3%, n=13). Additional categories such as Disabled were reported less frequently (Figure C5).

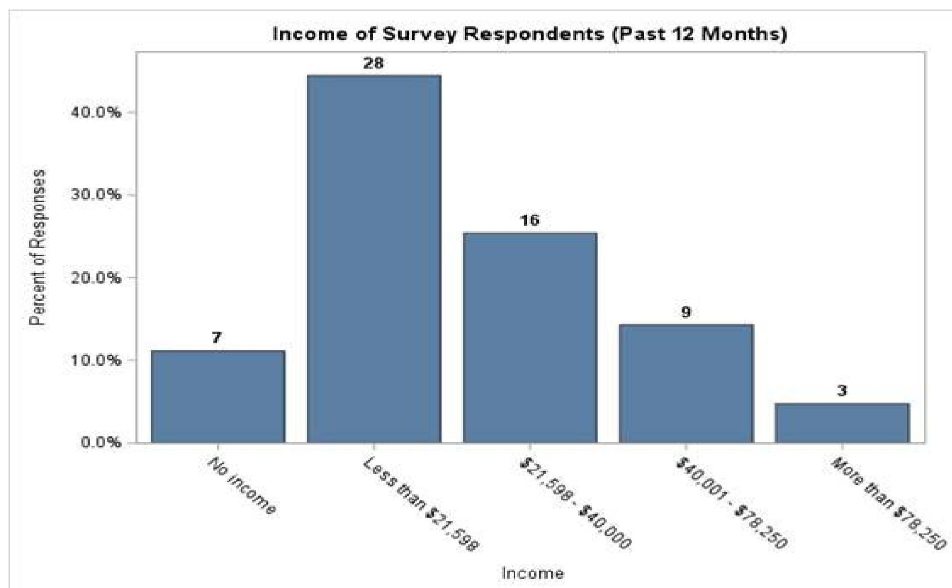
Figure C5. Employment Status of Survey Respondents



Income

Percentages are based on respondents who provided an answer to this item (n=63). A majority of respondents reported an annual income of Less than $21,598 (44.4%, n=28), followed by $21,598 - $40,000 (25.4%, n=16). Notably, 11.1% (n=7) reported no income (Figure C6).

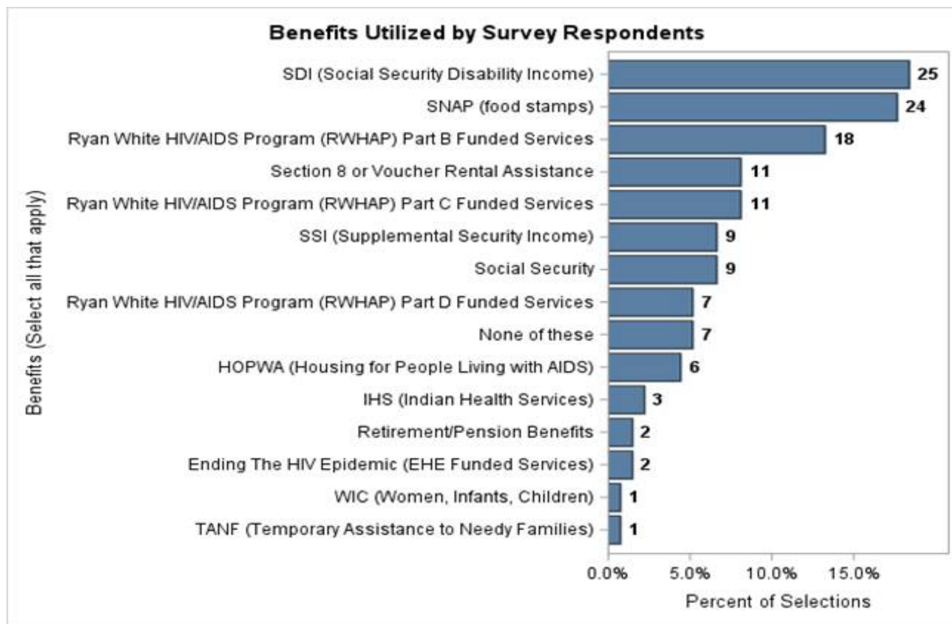
Figure C6. Income of Survey Respondents



Benefits Distribution

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. The most frequently utilized benefits were SDI (Social Security Disability Income) (39% of selections, n=25) and SNAP (food stamps) (37.5%, n=24). Other benefits, such as Ryan White HIV/AIDS Program (RWHAP) Part B Funded Services, were reported less frequently (Figure C7).

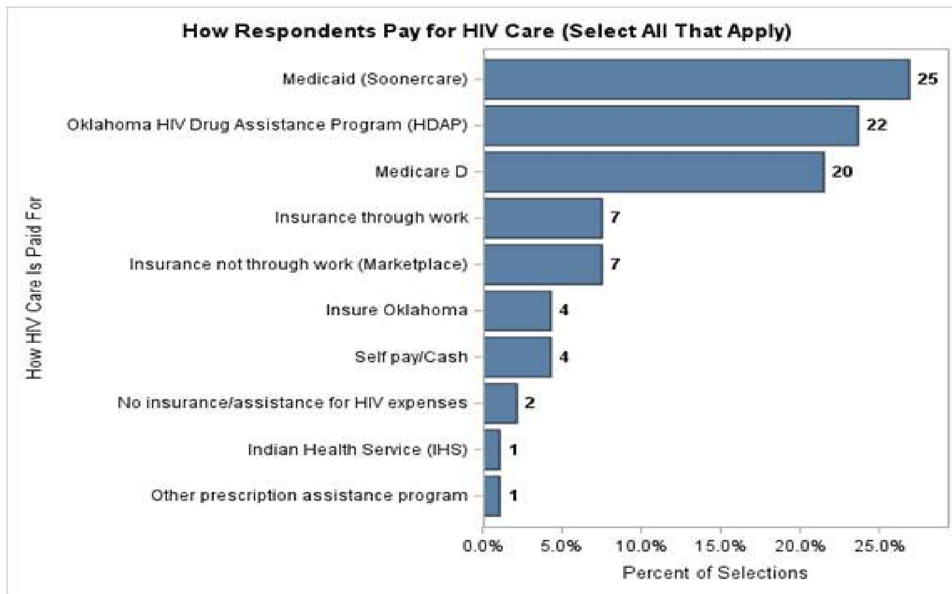
Figure C7. Benefits Utilized by Survey Respondents



HIV Care Pay Sources

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. The primary reported payment sources for HIV care included Medicaid (Soonercare) (39.1% of selections, n=25) and Oklahoma HIV Drug Assistance Program (HDAP) (34.4%, n=22). A smaller proportion relied on Medicare D (Figure C8).

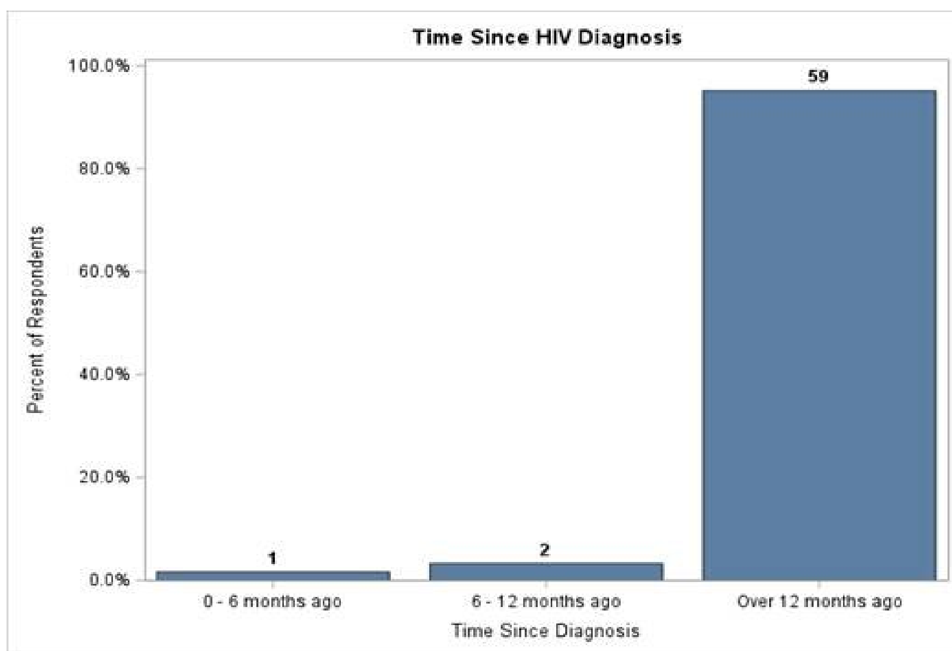
Figure C8. How Respondents Pay for HIV Care



Time Since HIV Diagnosis

Percentages are based on respondents who provided an answer to this item (n=62). Most respondents reported being diagnosed Over 12 months ago (95.2%, n=59), followed by those diagnosed 6 - 12 months ago (3.2%, n=2) (Figure C9).

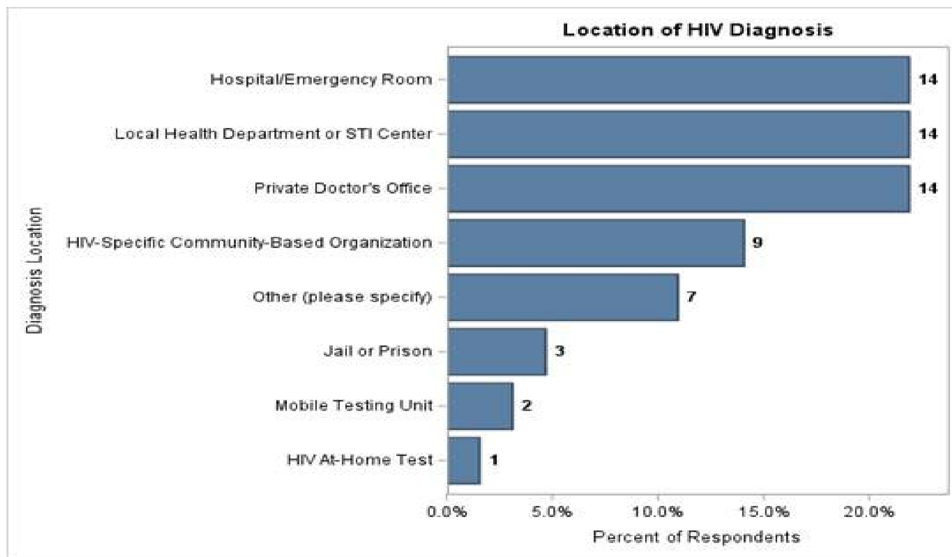
Figure C9. Time Since HIV Diagnosis



Location of HIV Diagnosis

Among all respondents (N=64), the most common location of diagnosis was tied with Hospital/Emergency Rooms, Local Health Department or STI Center, and HIV At-Home Test’s all at (21.9%, n=14), followed by HIV-Specific Community-Based Organization (14.1%, n=9). Fewer respondents reported diagnosis in labs, jails, and mobile testing unit settings (Figure C10).

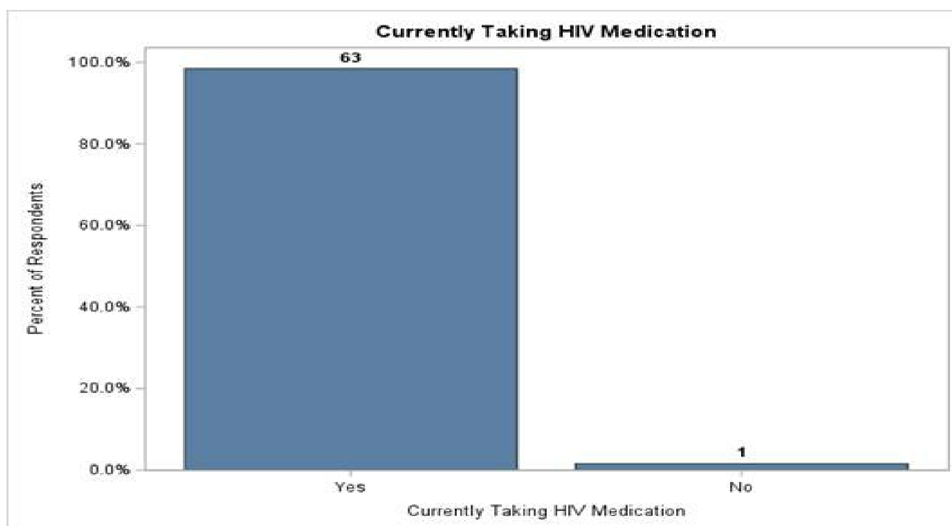
Figure C10. Location of HIV Diagnosis



Currently Taking HIV Medication

Among all respondents (N=64), A majority reported “yes” (98.4%, n=63), indicating that most participants are currently engaged in HIV treatment. However, 1.6% (n=1) reported “no” (Figure C11).

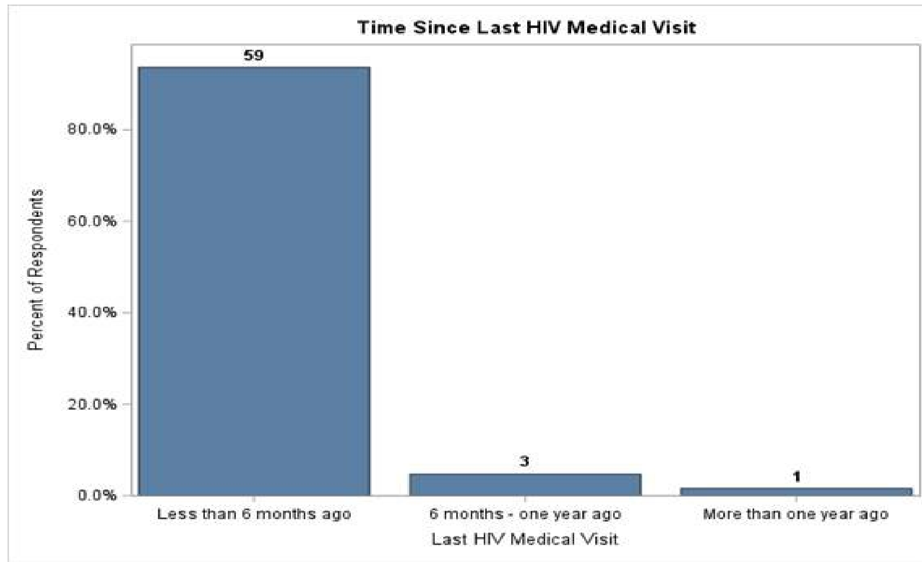
Figure C11. Currently Taking HIV Medication



Time Since Last HIV Medical Visit

Percentages are based on respondents who provided an answer to this item (n=63). Most respondents reported their last HIV-related medical visit occurred Less than 6 months ago (93.7%, n=59), while a smaller proportion indicated 6 months - one year ago (4.8%, n=3) (Figure C12).

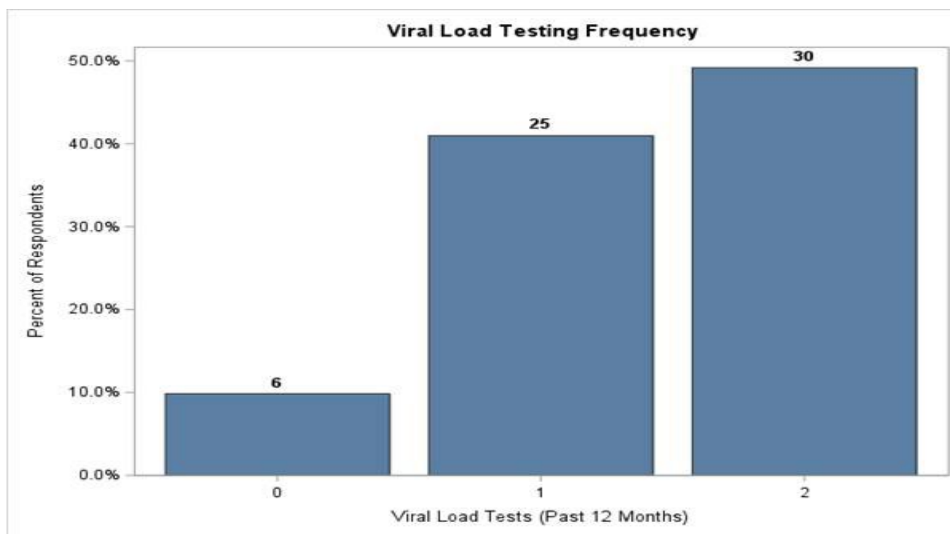
Figure C12. Time Since Last HIV Medical Visit



Viral Load Tests in Past Year

Percentages are based on respondents who provided an answer to this item (n=61). The most common testing frequency was two times in the past year (49.2%, n=30), followed by "once" (41%, n=25). A smaller group reported no testing (Figure C13).

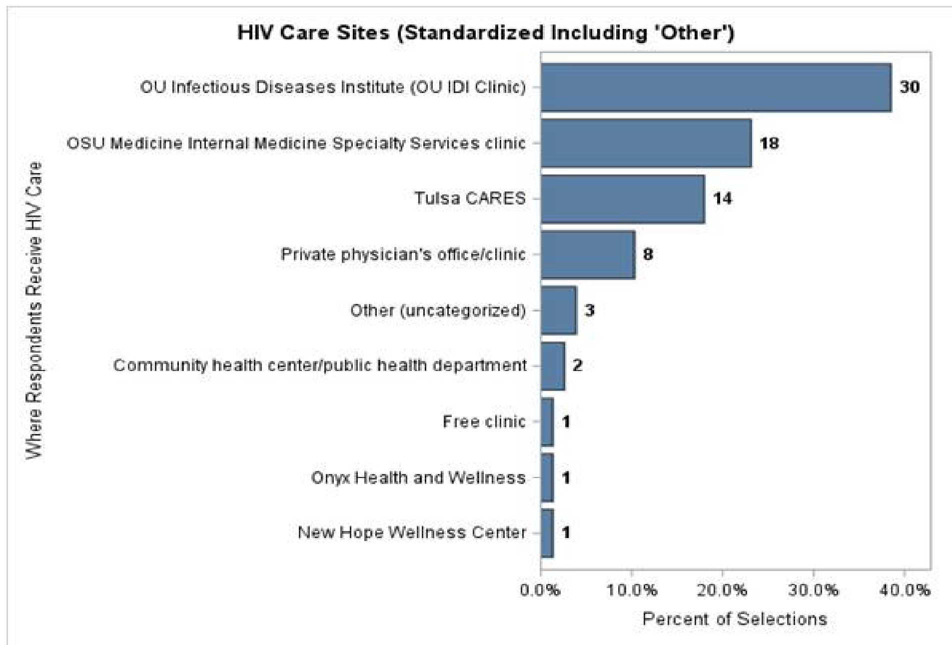
Figure C13. Viral Load Tests in Past Year



HIV Care Sites – Including Parsed "Other" Text

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. Respondents most commonly received care at OU Infectious Diseases Institute (OU IDI Clinic) (46.9% of selections, n=30), followed by OSU Medicine Internal Medicine Specialty Services clinic (28.1%, n=18). Fewer respondents reported receiving care at places like Tulsa CARES, and private physician's office/clinics (Figure C14).

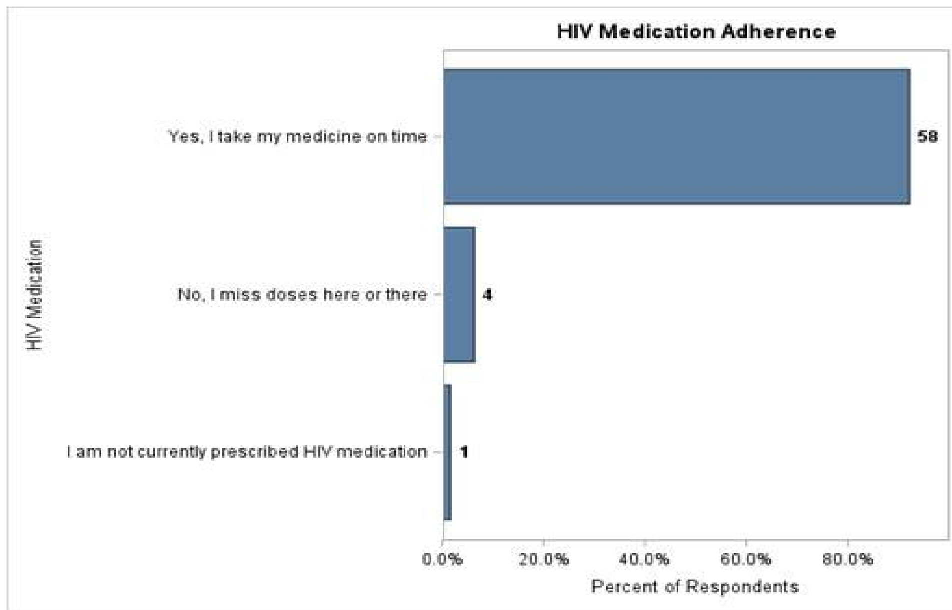
Figure C14. HIV Care Sites



HIV Medication Adherence

Percentages are based on respondents who provided an answer to this item (n=63). Most respondents reported "Yes, I take my medicine on time" (92.1%, n=58), indicating generally high adherence. 6.3% (n=4) reported "No, I miss doses here or there" (Figure C15).

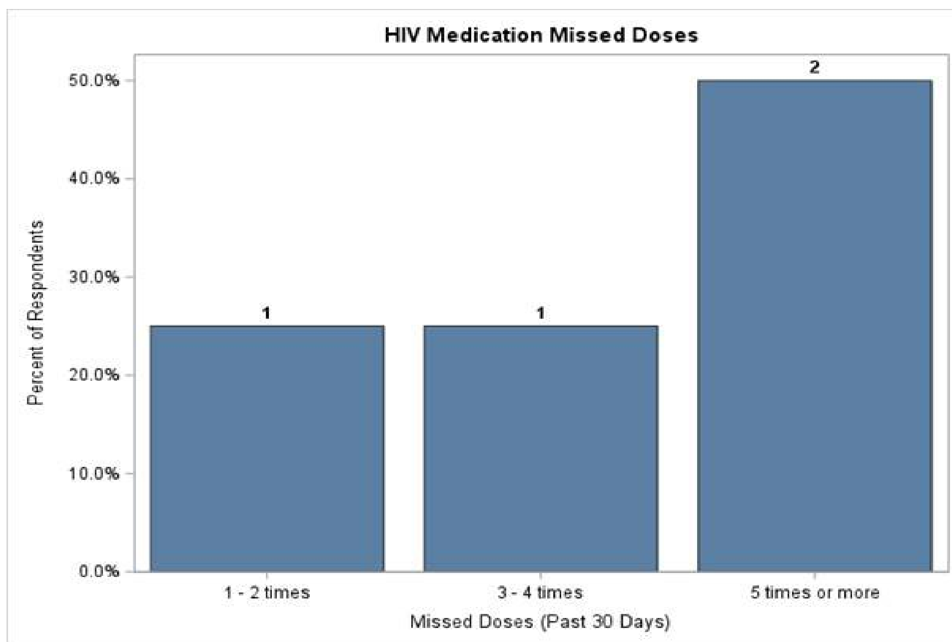
Figure C15. HIV Medication Adherence



Missed Medication Doses

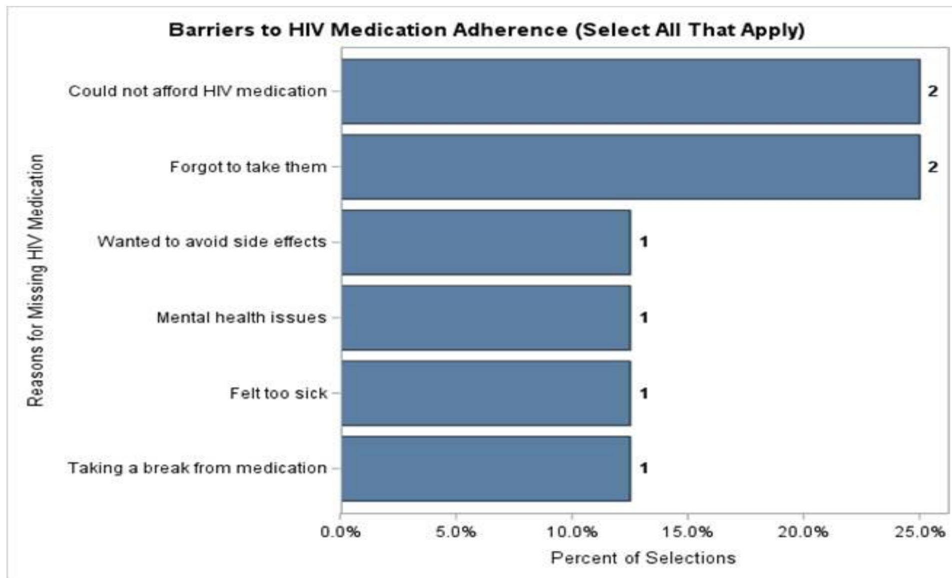
Participants were asked, “In the last two weeks, how often have you missed a dose of any HIV medications?” Only four respondents answered this question (n=4). As shown in Figure C16, responses were distributed across multiple categories, including reports of missing several doses, indicating varying levels of nonadherence within this small subset. No respondents selected or specified “other” as a response.

Figure C16. HIV Medication Missed Doses



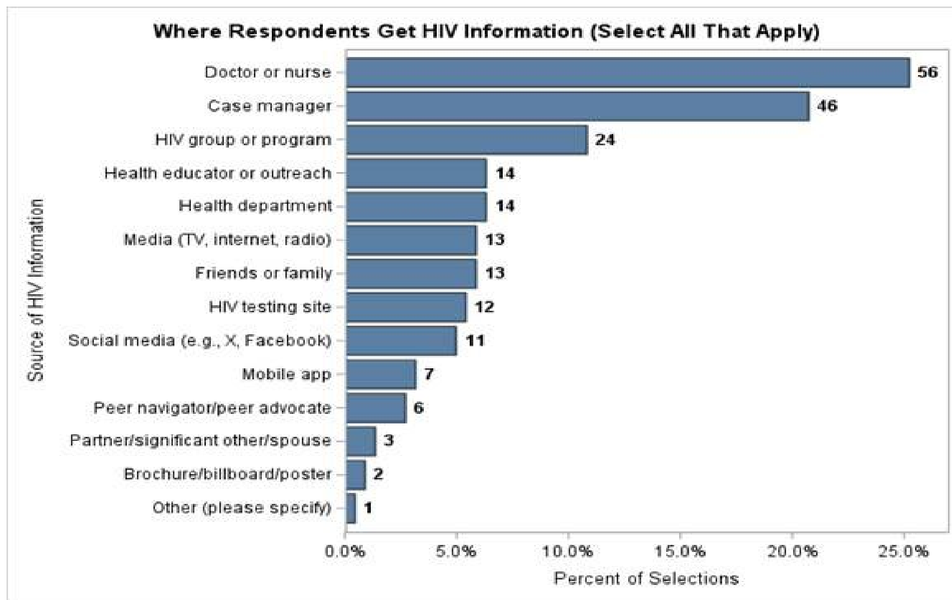
Barriers to HIV Medication Adherence
Percentages are based on respondents who provided an answer to this item (n=8). The most frequently reported reasons for missed doses were “Could not afford HIV medication” and “Forgot to take them” (25% of respondents, n=2). Additional reasons, including “Wanted to avoid side effects,” “Mental health issues,” “Felt too sick,” and “Taking a break from medication”, were less commonly reported (each 25%, n=1) (Figure C17).

Figure C17. Barriers to HIV Medication Adherence



Where Respondents Get HIV Information
Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. Respondents most commonly reported obtaining HIV-related information from doctors or nurses (87.5% of selections, n=56), followed by case managers (71.9%, n=46). Other sources were less frequently utilized (Figure C18).

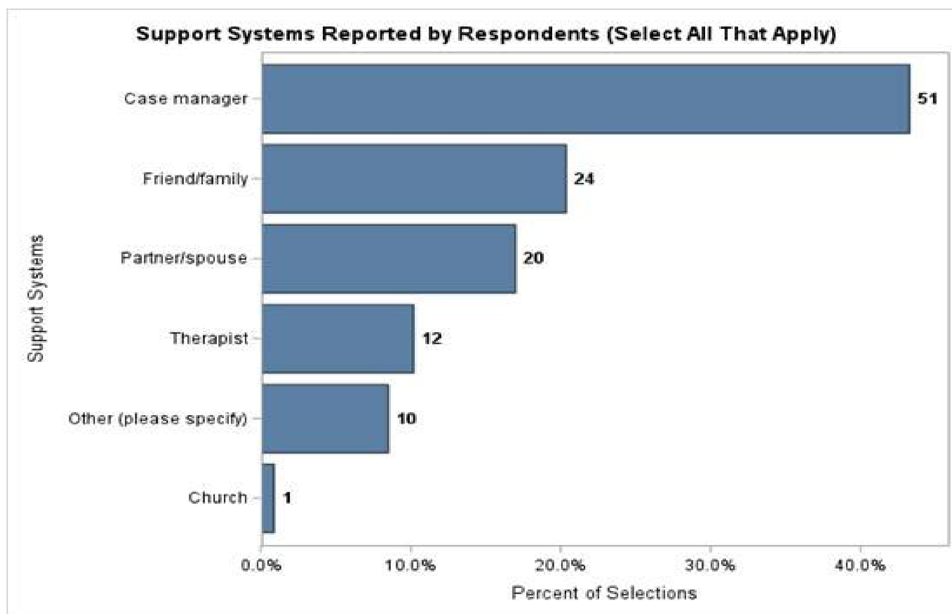
Figure C18. Where Respondents Get HIV Information



Support Systems

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. The most frequently reported sources of support were Case manager (80% of selections, n=51) and friend/family (37.5%, n=24). Some respondents reported limited or no support (Figure C19).

Figure C19. Support Systems Reported by Respondents



Service Use, Need, and Unmet Need (Past 12 Months)
Across services, utilization varied substantially. Services such as dental care, food pantry, medical assistance, and outpatient medical care showed high levels of use, while others demonstrated notable unmet need, particularly dental, emergency financial assistance, and housing assistance.

Services such as dental care, emergency financial assistance, housing assistance, and legal assistance showed higher levels of need without perceived access. Some services were also commonly reported as not needed and were left blank on the table (Table C1).

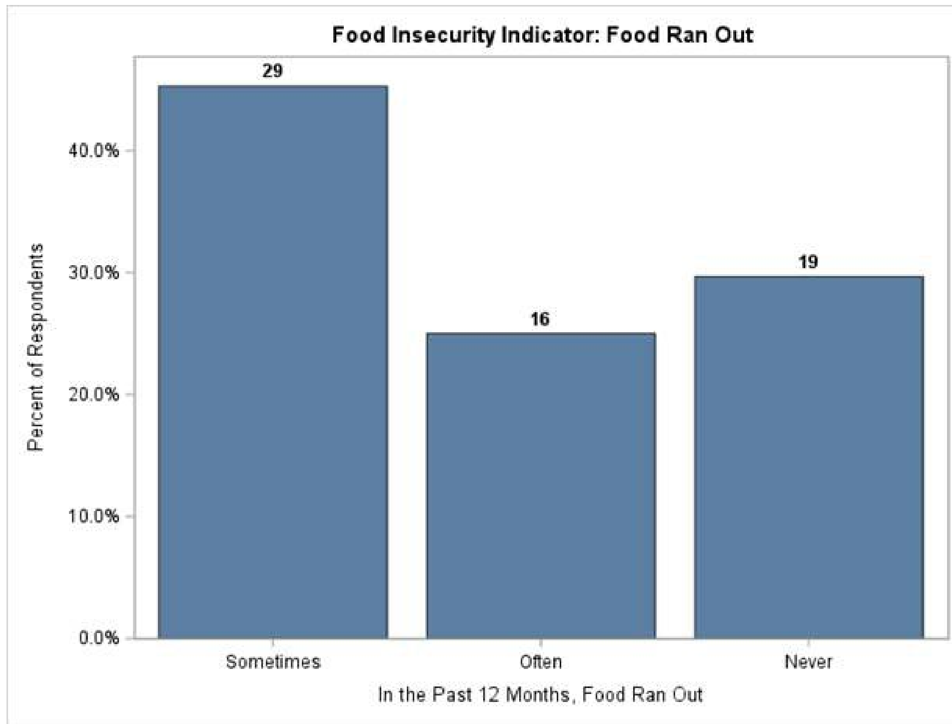
Table C1. Service Use, Need, and Unmet Need

Service Use, Need, and Unmet Need (Past 12 Months)			
Service	Used in Last 12 Months n (%)	Needed But No Access n (%)	Did Not Need n (%)
Childcare	0 (0%)	2 (4.2%)	46 (95.8%)
Child welfare	1 (2.0%)	1 (2.0%)	47 (95.9%)
Client advocacy	4 (8.0%)	7 (14.0%)	39 (78.0%)
Day/respite care for adults	0 (0%)	1 (2.0%)	49 (98.0%)
Dental care	30 (50.0%)	13 (21.7%)	17 (28.3%)
Emergency financial assistance	7 (14.0%)	11 (22.0%)	32 (64.0%)
Employment services	2 (3.9%)	4 (7.8%)	45 (88.2%)
Food bank/pantry	48 (80.0%)	3 (5.0%)	9 (15.0%)
HIV counseling, testing, and referral	12 (23.1%)	3 (5.8%)	37 (71.2%)
HIV medication adherence	18 (34.6%)	6 (11.5%)	28 (53.8%)
HIV prevention for positives/risk reduction	5 (10.0%)	4 (8.0%)	41 (82.0%)
Health education	7 (14.0%)	3 (6.0%)	40 (80.0%)
Home health	6 (12.0%)	4 (8.0%)	40 (80.0%)
Housing assistance	12 (23.1%)	11 (21.2%)	29 (55.8%)
Inpatient services	12 (23.5%)	1 (2.0%)	38 (74.5%)
Legal assistance	6 (12.0%)	9 (18.0%)	35 (70.0%)
Medical case management	25 (46.3%)	4 (7.4%)	25 (46.3%)
Medication assistance	37 (63.8%)	4 (6.9%)	17 (29.3%)
Mental health services	20 (35.1%)	6 (10.5%)	31 (54.4%)
Non-medical case management	18 (34.6%)	2 (3.8%)	32 (61.5%)
Nutritional counseling	12 (23.5%)	6 (11.8%)	33 (64.7%)
Outpatient medical care	38 (63.3%)	4 (6.7%)	18 (30.0%)
Physical rehabilitation	10 (19.6%)	5 (9.8%)	36 (70.6%)
Substance abuse services	4 (7.7%)	3 (5.8%)	45 (86.5%)
Support groups	9 (17.6%)	8 (15.7%)	34 (66.7%)
Transportation to medical appointments	17 (31.5%)	5 (9.3%)	32 (59.3%)

Food Insecurity

Among all respondents (N=64), when asked “in the past 12 months, were you ever worried that your food might run out before you got money to buy more?”, A substantial proportion reported “sometimes” (45.3%, n=29). Conversely, 30% (n=19) reported never (Figure C20).

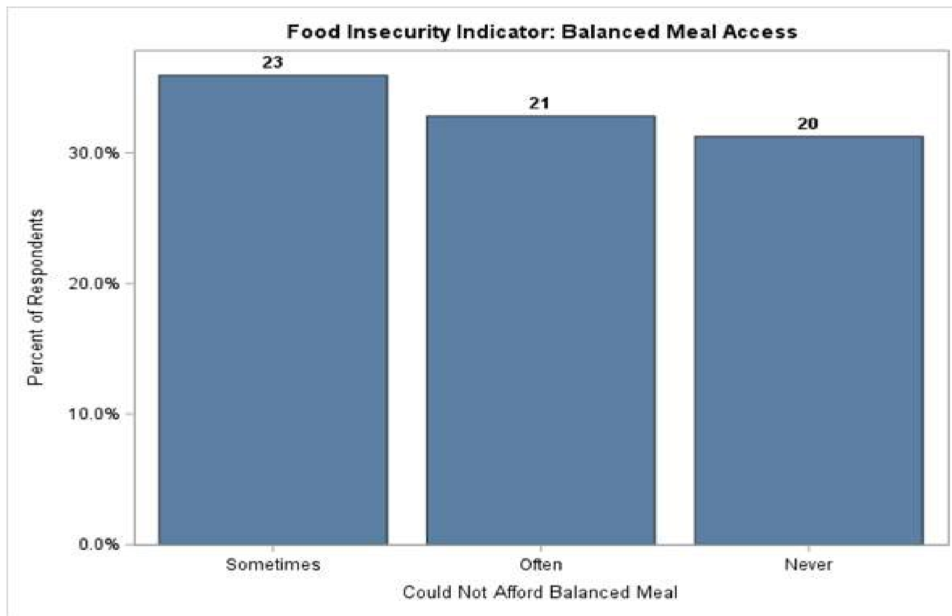
Figure C20. Food Insecurity Indicator: Food Ran Out



Food Insecurity Indicator: Balanced Meal Access

Among all respondents (N=64), when asked “in the past 12 months, did you ever feel that you could not afford to eat balanced meals?” a majority reported “sometimes” (36%, n=23) indicating limited access to nutritionally adequate meals, while (31.3%, n=20) individuals indicated “never” having access to balanced meals. (Figure C21).

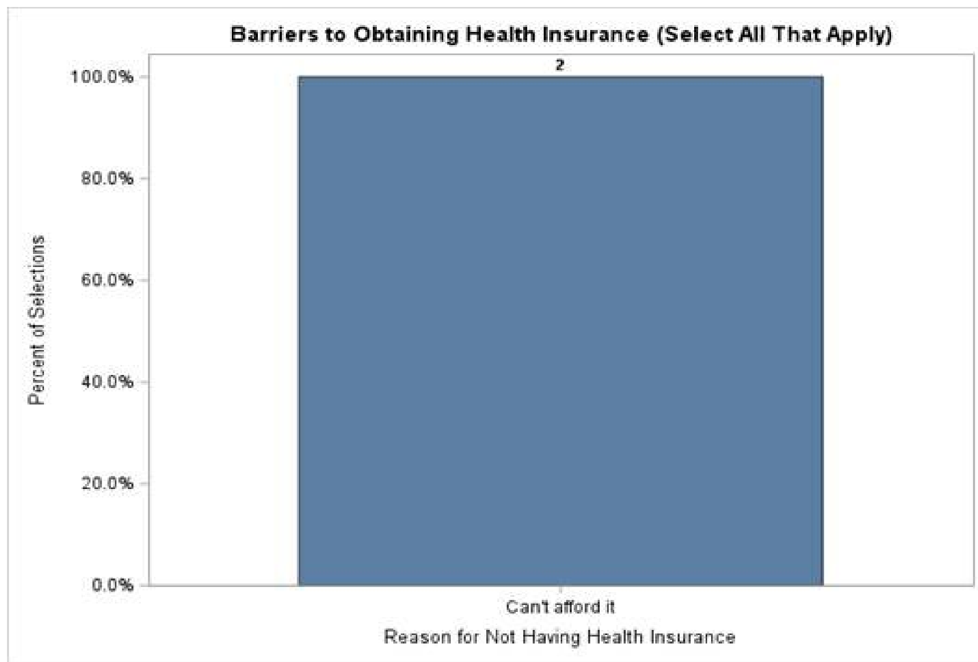
Figure C21. Food Insecurity Indicator: Balanced Meal Access



Barriers to Obtaining Health Insurance

Percentages are based on respondents who provided an answer to this item (N=2). The only barrier reported to obtaining health insurance was "can't afford it" (100% of selections, n=2. (Figure C22).

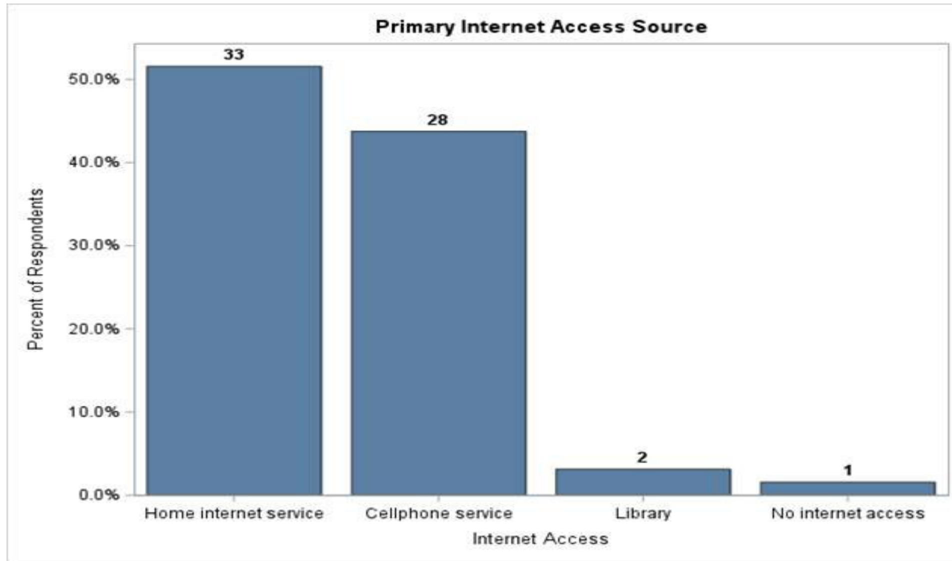
Figure C22. Barriers to Obtaining Health Insurance



Primary Internet Access Source

Among all respondents (N=64), a majority reported accessing the internet via home internet services (51.6%, n=33), followed by cellphone service (43.8%, n=28). A smaller proportion reported limited or no access (Figure C23).

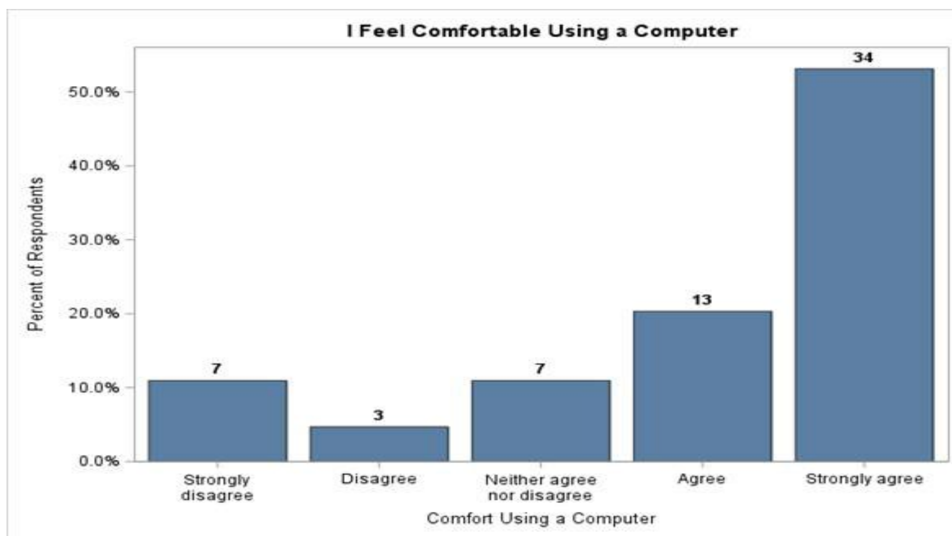
Figure C23. Primary Internet Access Source



Computer Comfort

Among all respondents (N=64), a majority reported that they "strongly agreed" with the statement "I feel comfortable using a computer" (53.1%, n=34). The next highest proportion was "agree" with 20.3% (n=13) (Figure C24).

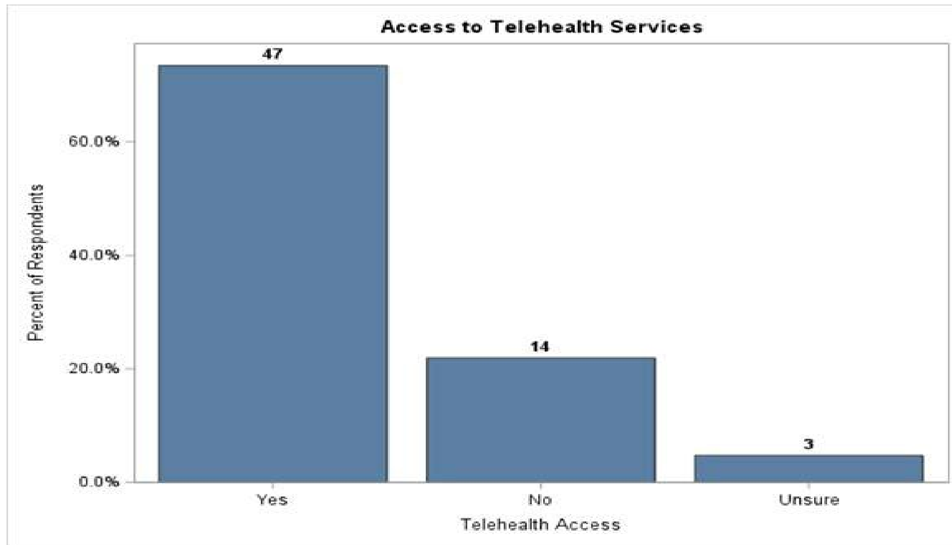
Figure C24. Computer Comfort



Telehealth Services

Among all respondents (N=64), Most reported "Yes" to the question of do they have access to telehealth (73.4%, n=47), while 22% (n=14) reported "No" (Figure C25).

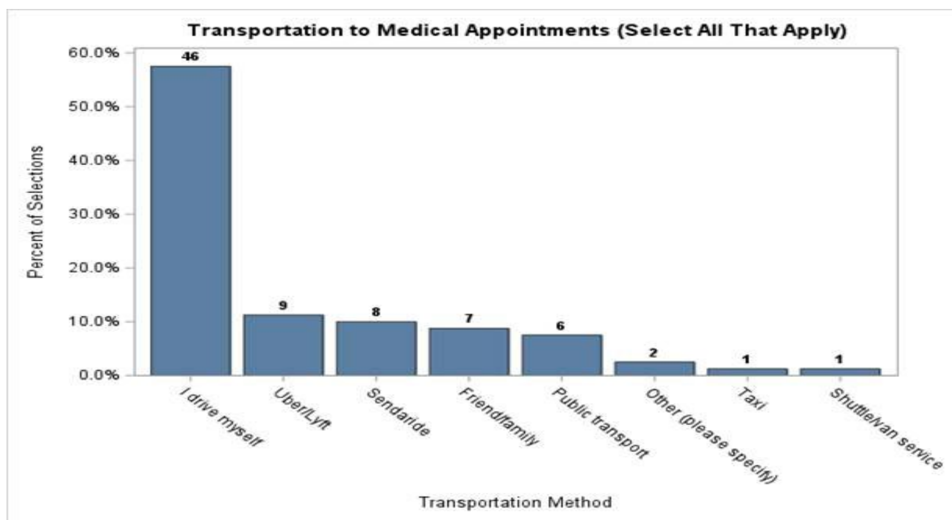
Figure C25. Access to Telehealth Services



Transportation to Medical Appointments

Percentages are based on the total number of respondents (N=64); responses were not mutually exclusive. The most commonly reported transportation methods were driving themselves (73.4% of selections, n=47). Rideshare services like Sendaride, uber/Lyft, and public transportation were the next most commonly used (Figure C26).

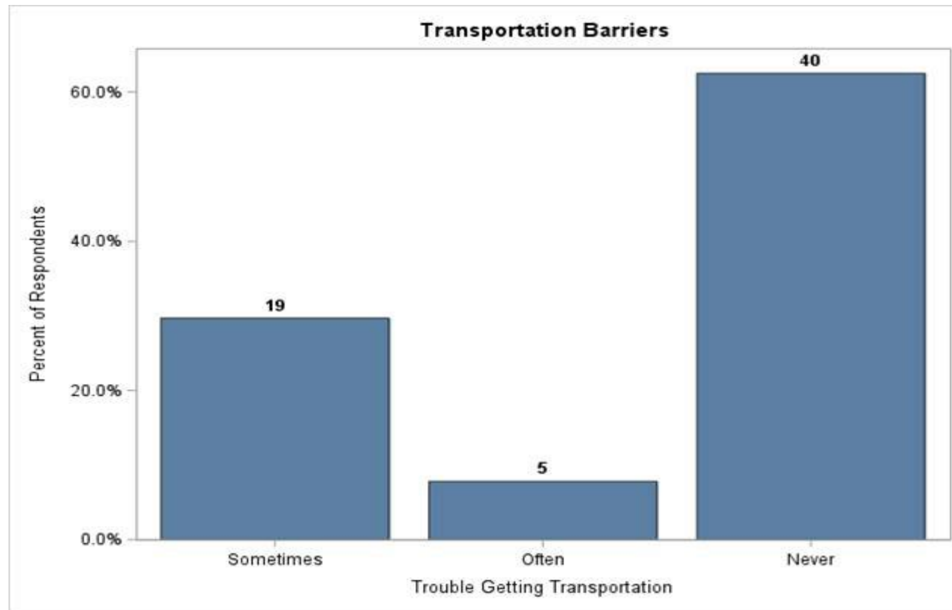
Figure C26. Transportation to Medical Appointments



Transportation Barriers

Among all participants (N=64), a proportion of respondents reported “Never” when asked if they had difficulty obtaining transportation (62.5%, n=40), while 29.7% (n=19) reported “sometimes” (Figure C27).

Figure C27. Transportation Barriers



Limitations

Convenience sampling may have limited generalizability of the HIV population as those found for the survey were typically at food pantries, or HIV care sites may not accurately represent PLWH who are reluctant or not connected to HIV care. Self-reported data may have led to participants inaccurately reporting their information related to medication adherence, healthcare utilization, housing stability, or other sensitive topics. Individuals without reliable internet services, smartphones, or digital literacy may have been under-represented because the survey was distributed online through REDCap. Selection bias may have occurred because recruitment was primarily conducted through HIV care providers, outreach staff and community organizations. Individuals already connected to services may have different experiences compared to those completely disengaged with care. Participants may have difficulty accurately recalling past experiences, healthcare interactions, or barriers encountered over time resulting in recall bias. Participants who voluntarily completed the survey may have stronger opinions, greater healthcare engagement, or higher motivation than nonparticipants resulting in volunteer bias.

Key Priorities

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 PHD meets with providers throughout Oklahoma to share information about routine opt out HIV screening, treatment, PrEP usage and referral to our Rapid Start/PrEP Program. After a discussion, 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 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 HIV prevention; information about training and technical assistance, including the South Central AIDS Education and Training Center and the AETC Extension for Community Healthcare Outcomes (ECHO) program, (a 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.

The PHD also offers 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. 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 SHHRS 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 4 times per year and can only accommodate about 15 nurses at once. Oklahoma also offers education opportunities upon request to clinical and non-clinical staff in various hospital and community health systems across the state.

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. SHHRS Disease Intervention Specialists (DIS) are also very involved in testing and outreach across the state, particularly in communities that would ordinarily no access a healthcare system for testing. DIS have done consistent testing efforts at places such as the Homeless Alliance, Second Chamces Thrift Store among other efforts. DIS have fostered relationships with several partners in communities that they serve and often work with such partners to execute comprehensive testing events using a syndemic approach.

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 advertising of HIV testing messaging and geofencing is difficult to achieve.

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 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 7-14 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 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, New Hope Health and Wellness, Onyx Health and Wellness or Tulsa Cares. The Rapid Start program provided ART to over 363 newly identified clients since the program began in July of 2020. The Public Health Detailing program has been instrumental in directing referrals from health care providers throughout the state to this program. The PHD ensures that providers 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 (FQHC) have been receiving funding for HIV testing. FQHCs across the state are 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. Most of their training has been focused on HIV testing and prevention services, including several partnerships with OSDH SHHRS on education events. 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. SCAETC also hosts several preceptorship opportunities for providers across the state interested in HIV prevention and care efforts. SCAETC also hosts the HIV ECHO to cover topics relating to HIV diagnosis and care as well as other syndemic topics. This is provider focused and providers are able to present any cases that they might need a second opinion or help navigating in real time.

New Ryan White EHE Clinics
Oklahoma has recently awarded contracts to two additional Ryan White clinics, Onyx Health and Wellness Clinic and Tulsa Cares, using HRSA Ryan White Part B and EHE funding. These clinics provide ambulatory health and medical case management services. Tulsa Cares has previously been funded to provide case management and social services support. Tulsa Cares is also funded by prevention through CDC EHE funds for prevention, testing, education and social support services. These clinics have been very successful in reaching people as evidenced by their performance outcomes. These two clinics join New Hope Wellness as community-based clinic systems for HIV care services 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 years. 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 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.

OU AETC Extension for Community Healthcare Outcomes (ECHO) Program
OU SCAETC provides 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 underserved 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. The current maximum is 500% 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 GHOST to revamp 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, PrEP information including sites that offer PrEP and PEP, HIV Care providers locations, OHHPC information, a contact request form among others.

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 is appropriate. 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.
The OHHPC website can be updated in real time and provides information to members of the public in a manner that is easily accessible and understandable.

Positive Peers Smartphone Application
Oklahoma has 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.

Ryan White Care Multimedia Campaign
The Oklahoma Ryan White Program contracted with Robot House to develop a multimedia campaign: Ryan Can Help. The campaign consists of the following:

- **Bus shelters and benches** - 22 locations in Oklahoma City and 11 locations in Tulsa
- **Digital advertising** - strategically targeted to gay male audiences using a combination of:
  - Geofencing around gay nightclubs and key nightlife districts
  - Higher impression delivery during weekends
  - Behavioral targeting including search history, male dating platforms, and relevant health-related content
- **Outdoor advertising** – rural billboard locations:
  - Altus, OK
  - Broken Bow, OK
  - Enid, OK

  - Lawton, OK
  - Sulphur, OK
- **Over the Top (OTT) video** - OTT video runs statewide with increased weight in identified high-performing "hotspot" counties and zip codes. Video delivery is further refined through demographic targeting, with a focus on Black and Hispanic male audiences.
- **Print advertising** - print placements appear in the Gayly Oklahoman, providing direct access to an established and trusted LGBTQ+ readership within the state.
- **Programmatic advertising** - animated programmatic placements deliver statewide reach across high-traffic lifestyle environments including bars, clubs, gas stations, and dispensaries, ensuring consistent exposure within social and leisure settings.
- **Radio and Spotify advertising** - all commercial radio placements run exclusively on Spanish-language stations in the Oklahoma City and Tulsa markets to effectively reach Hispanic audiences. Streaming audio placements run on both Spanish-language and English language Spotify inventory, allowing the campaign to reach users across music, lifestyle, and podcast listening environments.
- **Reddit Advertising** - sponsored Reddit posts are placed within relevant subreddits centered on gay male communities, drag culture, and LGBTQ+ popular culture to ensure contextual relevance and authentic audience engagement.
- **Social Media Advertising** - paid social campaigns utilize a mix of demographic targeting and lookalike audiences to expand reach while maintaining alignment with core audience characteristics.

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 culturally-sensitive organizations to provide care in non-traditional health care settings to reach individuals.

HIV Health Care Provider Shortages

Oklahoma is designated as a health care provider shortage area with 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 advertising of HIV to specific 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

SHHRS Rapid Start program continues to receive referrals from across the state. Interest in PrEP has grown in communities likely due to social media and commercials that are working to create awareness and lower stigma and increased funding and medication options. Oklahoma has seen an increase in access to PrEP, mainly in community-based organizations that use advanced practice nurses or physicians to prescribe PrEP.

PrEP Supplemental Activities

Oklahoma was awarded $2M as a PS24-0047 supplement to create programs to improve PrEP and PEP services in the state. This funded was one-time funding with an allowance of use for two years. Through this funding, Oklahoma was able to do the following:

- Creation of PrEP Access Plan for Oklahoma
- Creation of PrEP hotlines for easy access to and navigation for PrEP services
- Expand PrEP navigation services through community-based organizations to ensure warm handoffs from testing to care
- Creation and distribution of media campaigns to reduce stigma and encourage use of PrEP

- Develop and distribute culturally and linguistically appropriate educational materials tailored to priority populations
- Strengthen partnerships with pharmacies to support same-day PrEP initiation and medication access
- Enhance data collection and reporting systems to track PrEP referrals, uptake, and retention in care
- Conduct targeted outreach in high-incidence zip codes identified through surveillance data
- Expand transportation assistance programs to reduce barriers to attending PrEP-related appointments
- Collaborate with community organizations to provide training for stakeholders who interact with at risk populations
- Conduct training for providers and SANE on PrEP
- Develop and maintain a directory of providers that is accessible for the public
- Creation of a Provider Toolkit for PrEP and PEP medications
- Requisition and evaluation of PrEP uptake data from Oklahoma Health Care Authority

PrEP Center for Excellence – PrEP Access Programs

Oklahoma currently has two contracts for the PrEP Centers for Excellence through Guiding Right, Inc, Oklahoma and Health Outreach Prevention and Education (HOPE Testing) in Tulsa. Through these entities, Oklahoma will be able to have PrEP navigators as well as secure hotlines for individuals to get rapid connection to PrEP and PEP navigation. Persons will also be able to be linked to rapid PrEP and PEP medication through structures in place for telehealth visits and starter pack medications all in the same day. Oklahoma also funded these entities to provide copay support for clients that are insured or underinsured and might need assistance with any copays that they might have.

PrEP Navigation

Guiding Right, Tulsa and Southern Plains Tribal Health Board have been funded to provide PrEP navigation services. Southern Plains Tribal Health Board has established a “Text to PrEP” program to enable connection to the PrEP navigation who follows up via call with the client and links them to the nearest PrEP provider.

PrEP Campaign

Oklahoma has completed a statewide PrEP campaign facilitated by the OSDH Office of Communications through a company called Robot House. The campaign’s slogan was “Life Takes PrEP” and included placements on bus benches and also outdoor advertising. An educational landing page was created: Life Takes Prep. Placements were in Oklahoma City, Tulsa, Lawton, and Ardmore.

In addition to the OSDH Office of Communications Campaigns, Oklahoma also awarded Media and Communications contracts to Guiding Right Oklahoma City, Southern Plains Tribal Health Board, and HOPE, Tulsa. These entities are working with various companies to design campaigns on PrEP using traditional media outlets as well as radio and social media. OSDH SHHRS will approve all proofs before they are to be published.

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.

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.

Oklahoma HIV and Hepatitis Planning Committee (OHHPC) Website

SHHRS has contracted with GHOST 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. 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. 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 and lubricants 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. In 2025, 55,300 condoms were distributed to individuals across Oklahoma.

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 and in 2025, a total of 537.120 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 cards at outreach and other events and through Public Health Detailer visits, as well as through clickable ads placed on websites and YouTube when Cox Media was being utilized. Advertising promotes not only this program but safer sex practices, prevention messages focused on Ending the HIV Epidemic, and HIV treatment and care.

Figure IV: 1 - Condoms Distributed to Facilities in Oklahoma by Year, 2020 – Quarter 1, 2026

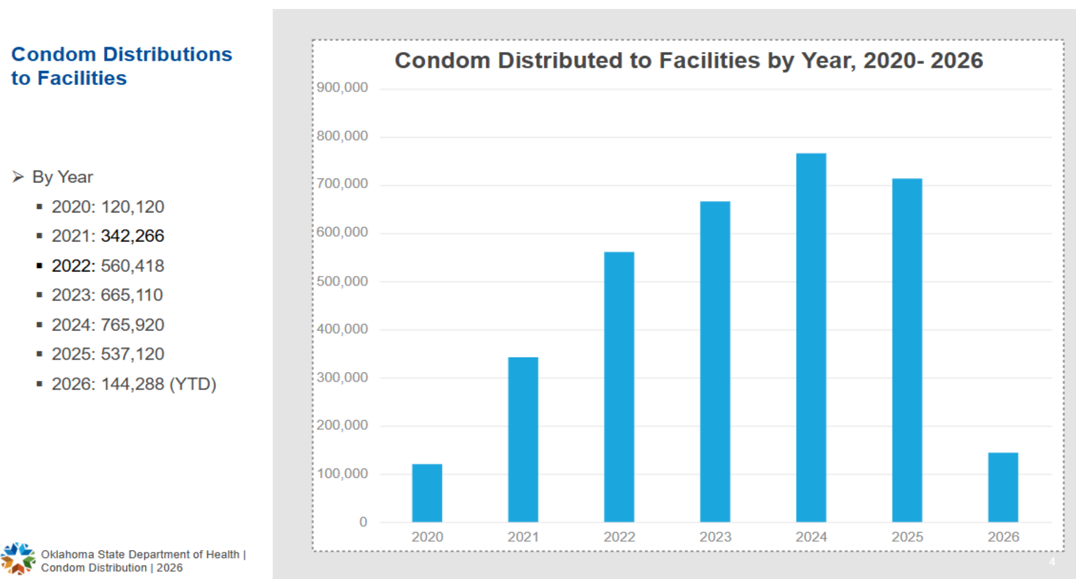
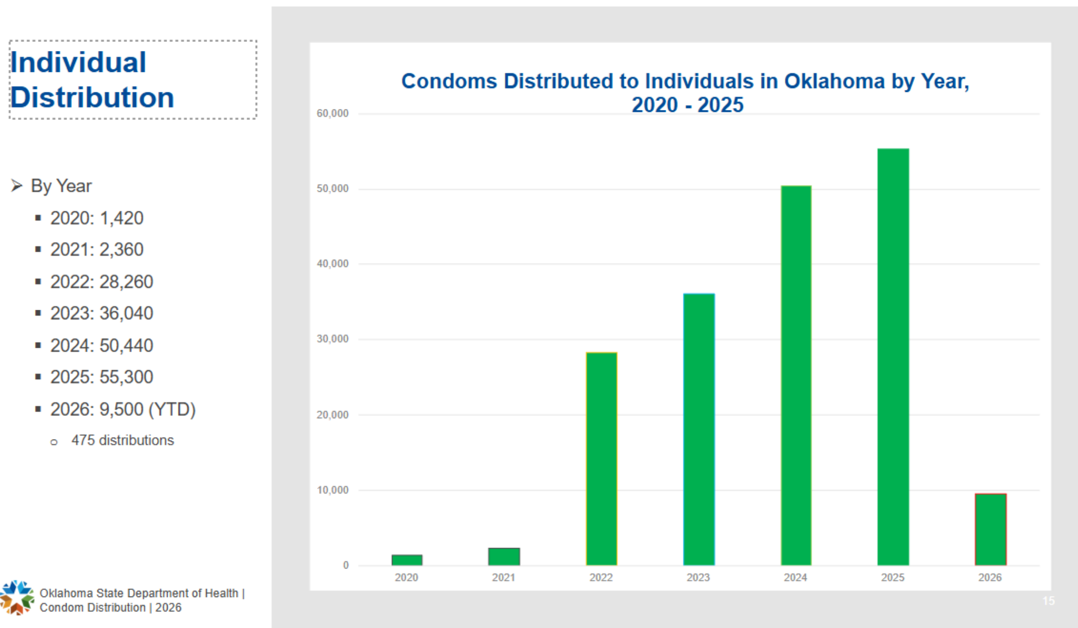


Figure IV: 2 – Condoms Distributed to Individuals in Oklahoma by Year, 2020 – Quarter 1, 2025



Oklahoma HIV Drug Assistance Program (HDAP/ADAP)

Oklahoma's ADAP program has consistently had a very generous eligibility threshold of 500% of the Federal Poverty Level. This allows individuals with income 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.

Partnerships with OKC Homeless Alliance, Healthy Housing/HOPWA Program, Second Chances Thrift Store

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 Disease Intervention Specialists (DIS) are also very involved in testing and outreach across the state, particularly in communities that would ordinarily no access a healthcare system for testing. DIS have done consistent testing efforts at places such as the Homeless Alliance, Second Chances Thrift Store among other efforts. DIS have fostered relationships with several partners in communities that they serve and often work with such partners to execute comprehensive testing events using a syndemic approach.

Partnerships with Tribal Entities

DIS partnerships with tribal entities play a critical role in responding to and controlling syphilis, HIV and hepatitis C across Oklahoma. Addressing these diseases requires a coordinated public health effort that brings together state, local, tribal, and community partners to expand prevention, testing, treatment, and disease intervention services. Partnerships with Southern Plains Tribal Health Board, Oklahoma City Indian Clinic, and Tribal DIS staff from the Choctaw Nation and Chickasaw Nation have strengthened response efforts by increasing access to screening and treatment services within affected communities. These collaborative efforts helped expand testing initiatives, improved linkage to care, supported partner

services, and interrupted ongoing transmission, ultimately contributing to more effective control of these conditions and ensuring improved public health outcomes for the communities that we serve.

SHHRS Public Health Detailer Program (PHD)
The Public Health Detailer meets 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 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. Oklahoma continues to seek solutions to this problem.

Post Exposure Prophylaxis (PEP)
Providers and pharmacists lack education on assessment for PEP treatment. Access to PEP is limited particularly on the weekends and after hours. 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 and molecular analyses routinely to identify clusters. Required reporting of HIV genotype sequence testing was effective beginning November 2023, which assisted in conducting molecular sequencing as more individuals had an available genotype test for molecular cluster analysis. A monthly meeting between Intervention, Surveillance, and Prevention takes place to review time-space and molecular clusters with the goal of assigning a level of concern, determining if any response activities are needed, and providing updates in ongoing response activities. The OHHPC Cluster Detection and Response Committee was formed as a subcommittee of the OHHPC. A primary goal of the OHHPC CRD Subcommittee is to reduce the stigma surrounding cluster detection, particularly molecular cluster detection as well as working to refine our communications related to HIV CDR.

Pillar 4 (Respond) Challenges in Oklahoma

Cluster Detection and Response

A major challenge with Cluster Detection and Response associated with molecular cluster detection is genotype test reporting timeliness. Batch reporting consisting of multiple months of labs takes place with one lab who regularly reports genotype data. Communication between labs and the SHHRS Laboratory Assessment Coordinator has assisted in improving the timeliness of reporting.

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 (CDR) Subcommittee consists of 9 individuals from OSDH, local CBOs, and health care facilities. The purpose of the OHHPC CDR Subcommittee is to develop, review, distribute, and facilitate education on clear and accessible information to the public and service providers about HIV surveillance, CDR, and data privacy. By identifying and promoting the use of less stigmatized language related to HIV CDR as well as ensuring diverse representation and perspectives among active members, the subcommittee will help ensure Oklahoma HIV CDR efforts are ethical, effective, sensitive, and culturally appropriate.

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. The OHHPC CDR subcommittee is currently developing an accessible and condensed HIV CDR action plan to ensure community partners and providers are fully aligned on our cluster outbreak and response procedures. This will also allow for strengthened coordination and transparency.

Section V. Goals & Objectives for 2027-2031

Epidemiologic data identifies three priority populations that experience a higher burden of HIV in Oklahoma. These communities are also less likely to be engaged in medical care, and/or are more likely to live in medically underserved areas:

- Gay, bisexual, and other men who have sex with men (MSM)
- Black or African American communities
- Hispanic communities

Oklahoma's Integrated HIV Prevention and Care Plan addresses the needs of these disproportionately impacted communities by directing prevention and care resources to the populations at highest risk, improving access to testing and medical care, reducing social and structural barriers, and engaging affected communities in planning and decision-making. These strategies aim to decrease new infections, improve health outcomes for people living with HIV, and reduce disparities across the state.

Pillar 1: Diagnose

Goal 1: Diagnose all people with HIV as early as possible.

Objective: By December 31st, 2030, increase the number of HIV tests conducted by 25%

Target Date: December 31, 2030

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. Plan and develop a wide dissemination of self-testing kits through contracted community-based organizations, DIS and other partner agencies to improve access to HIV testing.
3. Create a systematic process for the development and implementation of Memorandums of Understanding (MOUs) with 2 additional organizations to do HIV rapid Point of Care testing in the community at no cost to clients.
4. Increase public awareness campaigns with messaging that encourage testing and knowing your status through traditional and social media platforms.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

Key Partners: county health departments, community-based organizations, FQHCs, correctional facilities, sexual health clinics, women's health services/prenatal services providers, hospitals, tribal/IHS facilities.

Performance Measures:

- Number of HIV tests distributed
- Number of newly identified persons with HIV

Progress towards national HIV goals: Increase the number of people who know their HIV diagnosis by

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

Monitoring Data Source: eHARS

Pillar 2: Treat

Goal 1a: Engage new HIV diagnosis in ongoing HIV care and treatment within 30 days of diagnosis.

Objective: By December 31st, 2030, engage 90% of new HIV diagnoses in ongoing HIV care and treatment within 30 days of diagnosis.

Target Date: December 31, 2030

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.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

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

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

Progress towards national HIV goals: Increase in the number of newly diagnosed persons linked to HIV care within 30 days by 25%.

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

Monitoring Data Source: Careware, eHARS

Goal 1b: Increased re-engagement in HIV care for person who are not in care or who have fallen out of care.

Objective: By December 31st, 2030, 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.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC recipient

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

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

Progress towards national HIV goals: Improve viral suppression rates to 90% for people diagnosed.

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

Monitoring Data Source: Careware, eHARS, Provide

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

Goal 1c: Increase in retention of people in HIV care.

Objective: By December 31st, 2030, 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.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient

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

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

Progress towards national HIV goals: Increase in the number of individuals diagnosed and retained in care to 90%.

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

Monitoring Data Source: Careware, eHARS, Provide

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

Pillar 3: Prevent

Goal 1a: Prevent new HIV transmissions by implementing PrEP and PEP programs

Objective: By December 31st, 2030, increase capacity and implementation of PrEP and PEP programs in the state.

Target Date: December 31, 2030

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

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC Recipient

Key Partners: Community-based organizations, people and communities disproportionately impacted by HIV, FQHCs, STI/sexually transmitted disease clinics, hospitals, private providers, social service providers, primary care providers, OHHPC, SCAETC

Performance Measures: 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.

Progress towards national HIV goals: 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.

Funding Resources: CDC EHE funding, HRSA RW EHE funding

Monitoring Data Source: REDCap, Careware, eHARS, Public Health Detailer data, SC AETC data

Goal 1b: Prevent transmission of HIV through condoms distribution program

Objective: By December 31st, 2026, increase condom distribution by 50%.

Target Date: December 31, 2030

Key Activities and Strategies:

1. Increase number of condoms requested and distributed by increasing public awareness of the SHHRS condom distribution program, through social media campaigns, outreach and the OHHPC website.
2. Increase public awareness of HIV Prevention services, including condom distribution in Oklahoma

through the OHHPC website, campaigns through OSDH Office of Communications and communication campaigns with partner CBOs.

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.

Responsible Parties: RWHAP Part A recipient, RWHAP Part B recipient, EHE recipient, CDC Recipient
Key Partners: Community-based organizations, people and communities disproportionately impacted by HIV, FQHCs, STI/sexually transmitted disease clinics, hospitals, private providers, social service providers, primary care providers, OHHPC
Performance Measures: Number of condoms distributed to individuals and facilities
Progress towards national HIV goals: Decrease HIV transmission by 25%.
Funding Resources: CDC EHE funding, CDC HIV Prevention and Surveillance funding, RW HRSA EHE funding
Monitoring Data Source: Condom distribution database

Pillar 4: Respond

Goal 1: Respond quickly to potential HIV clusters and/outbreaks.

Objective: By December 31st, 2030, 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.

Responsible Parties: CDC Recipient

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

Performance Measures: 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.

Progress towards national HIV goals: 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

Disproportionately Impacted Communities: Communities disproportionately impacted by HIV benefit from this goal

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

Monitoring Data Source: Local protocols and reports

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 Division, Intervention Division, Ryan White Care 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.

A review of the integrated HIV prevention and care plan will occur quarterly. 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 measures and services are being provided in order to ensure the success of the integrated plan and SCSN and 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. The public health detailer 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 reviewing and monitoring 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 quarterly 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 D1).

Table D1. Evaluation Plan for Oklahoma 2027-2030

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, Provide Enterprise	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, Provide Enterprise	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 Detailer

		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. The number of patients maintained in PrEP care through the SHHRS Rapid Start program.	REDCap	Ryan White Data Manager
	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	HCV 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	
	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 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 PLWH, 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 quarterly 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.

The OHHPC reviewed the EHE plan alongside the Integrated plan during the August 2023 OHHPC meeting within their breakout groups which are according to the EHE pillars.

Challenges and Successes

The following challenges and successes were identified based on on-going or completed efforts.

Pillar 1: Diagnose

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

Pillar 2: Treat

Successes

- Peer-mentoring program created for newly diagnosed patients with HIV
- Increased number of case managers and outreach case managers
- AETC 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.

Pillar 3: Prevent

Successes

- Established condom distribution program
- Provider education through public health detailing program, AETC

Challenges

- Stigma surrounding HIV prevention messaging

Oklahoma consistently reviews both the Integrated plan and the Ending the HIV Epidemic Plan to make sure that they align and that the activities of both are being addressed.

Pillar 4: Respond

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)
- Delayed and incomplete nucleotide lab reporting
- Steep HIV criminalization laws in Oklahoma

Section VII. Integrated Planning Council Letter of Concurrence

June 22, 2026

Dear Kim Brown 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 Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

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 people and communities and geographical areas with high rates of HIV. The OHHPC concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The 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 virtually on July 22, 2026, 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.

Sincerely,

Ryan Ochsner
Ryan Ochsner (Jun 24, 2026 12:49:38 CDT)
Ryan Ochsner
Community Co-Chair
Oklahoma HIV and Hepatitis Planning Council

Maria Mancebo
Maria Mancebo (Jun 24, 2026 12:06:57 CDT)
Maria Mancebo
OSDH Co-Chair
Oklahoma HIV and Hepatitis Planning Council

https://endinghivoklahoma.org/