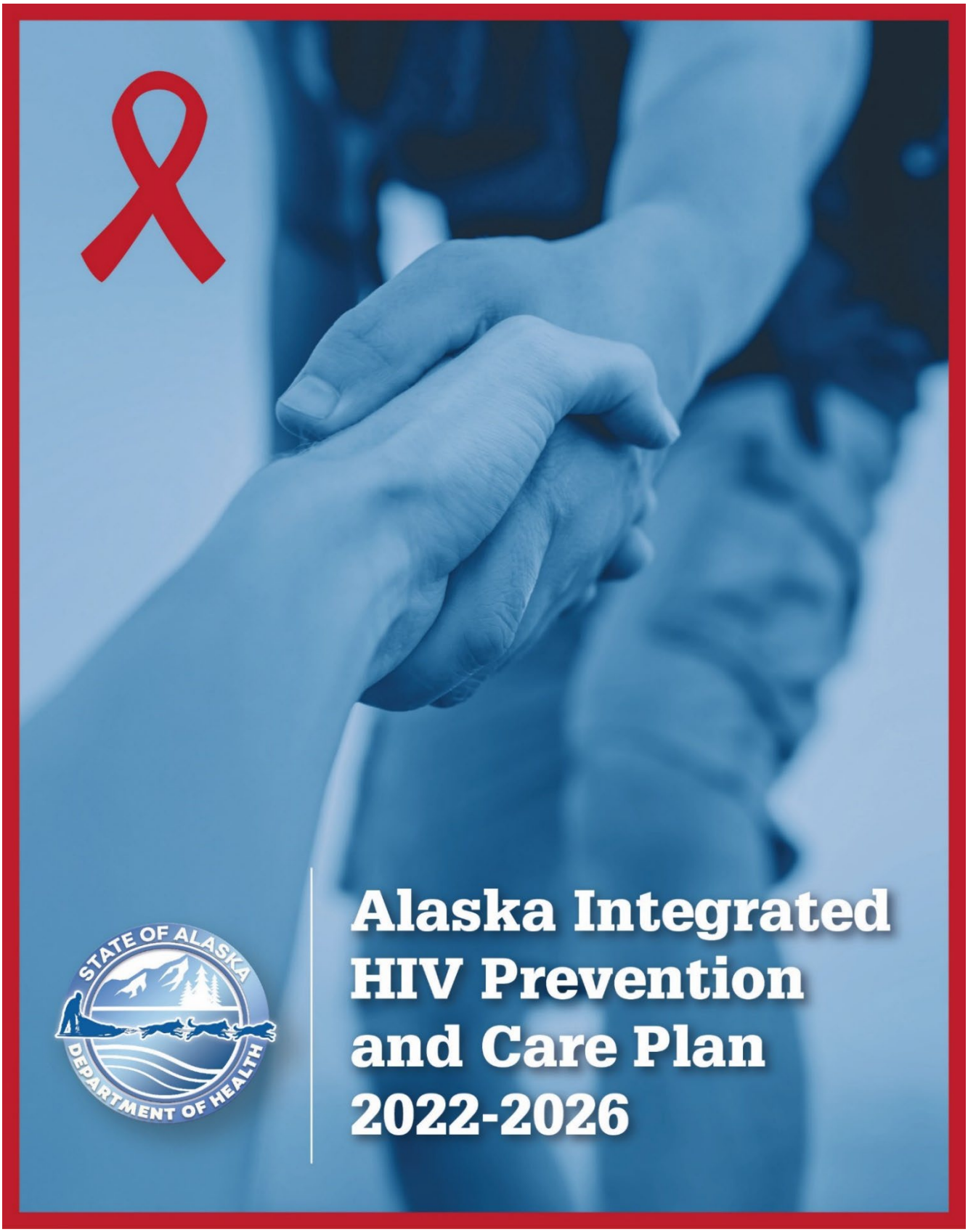

Alaska Integrated HIV Prevention and Care Plan, 2022-2026

Contributors

The Alaska Integrated HIV Prevention and Care Plan is the product of many dedicated individuals working together to improve the quality of prevention, early intervention, and treatment for persons at risk or living with HIV in the region. We would like to acknowledge the Alaska HIV/STD Program Staff who assisted in the development of the 2022-2026 Integrated HIV Prevention and Care Plan.

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In addition to the HIV/STD Program Staff, we would like to thank the following community partners who generously participated in the development of this plan.

Jennifer Arnold, ANTHC
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Matthew Feist, OASH
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Finally, we would like to extend a particular thanks to all the community members, consumers, people living with HIV, and partner agency staff who participated in the needs assessments, responded to survey requests, provided feedback on the Integrated Planning process, all of who are the backbone of ensuring that HIV prevention and care services continue to meet the needs of Alaskans. Thank you for your time and support.

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Abbreviations

ACF	Administration for Children and Families (SAMHSA)
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AI/AN	American Indian / Alaska Native
AIHAG	Alaska Integrated HIV Advisory Group
ANHC	Anchorage Neighborhood Health Center
ANMC	Alaska Native Medical Center
ANPLWH	Alaska Native Persons Living with HIV
ANTHC	Alaska Native Tribal Health Consortium
APRN	Advance Practice Registered Nurses
ATHS	Alaska Tribal Health System
BJA	Bureau of Justice Assistance
CAI	Chief Andrew Isaac Health Center
CBA	Capacity Building Assistance
CDC	Centers for Disease Control and Prevention
CDC PCHD	PS19-1901 Strengthening STD Prevention and Control for Health Departments
CDRP	Cluster Detection and Response Plan
DIS	Disease Intervention Specialist
DIS WF Sup	Disease Intervention Specialist Workforce Supplement
DMI	Data Modernization Initiative
DOH	Alaska Department of Health
DOJ	Department of Justice
ECHO	Extension for Community Healthcare Outcomes
EHE	Ending the HIV Epidemic
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FASAP	Four A's Syringe Access Program
Four As	Alaska AIDS Assistance Association
FQHC	Federally Qualified Health Center
HAWG	Hepatitis Advisory Working Group
HCV	Hepatitis C Virus
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HNY	Healthy Native Youth
HNY PRT	Healthy Native Youth Project Red Talon
HOPWA	Housing Opportunities for People with AIDS

HPPG	Alaska HIV Prevention Planning Group
IAA	Interior AIDS Association
IDMG	Infectious Disease Management Group
IDU	Injection Drug Use
ID	Infectious Disease
IHS	Indian Health Services
IHSEPI	IHS Epidemiology Program for American Indian/Alaska Native Tribes and Urban Indian Communities
IVDU	Intravenous Drug Use
L2C	Linkage to Care
LDHP	Liver Disease and Hepatitis Program
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, Plus…
MAT	Medication-Assisted Treatment
Mat-Su	Matanuska-Susitna Valley
MCM	Medical Case Management
MOA	Municipality of Anchorage
MSM	Men Who Have Sex With Men
MWAETC	Mountain West AIDS Education and Training Center
NBS	National Electronic Disease Surveillance System
NE	Northern Exchange
OASH	Office of the Assistant Secretary for Health
ONDCP	Office of National Drug Control Policy
OSMAP	Alaska's Office of Substance Misuse and Prevention
OTS	Opioid Treatment Services
OUD	Opioid Dependence
PCP	Primary Care Provider
PEP	Post-Exposure Prophylaxis
PHC	Alaska's Public Health Center
PIO	Alaska’s Public Information Office
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
PREP	Alaska Personal Responsibility Education Program
PWID	Persons Who Inject Drugs
PWIS	Persons Who Inject Substances
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services

SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCF	Southcentral Foundation
SCSN	Statewide Coordinated Statement of Need
SDH	Social Determinants of Health
SOA	State of Alaska
SOE	Section of Epidemiology
SOPHN	Section of Public Health Nursing
SSPs	Syringe Service Programs
STD	Sexually Transmitted Disease(s)
TB	Tuberculosis
YKHC	Yukon-Kuskokwim Health Corporation

Section I: Executive Summary of Integrated Plan and Statewide Coordinated Statement of Need

The Alaska Department of Health Division of Public Health presents the 2022-2026 Integrated HIV Prevention and Care Plan, which responds to the integrated planning guidance issued by both the Centers for Disease Control and Prevention and the Health Resources and Services Administration. This document serves as the joint jurisdictional plan for the State of Alaska, which is a Ryan White Part B recipient.

Since the previous Statewide Coordinated Statement of Needs (SCSN) and the development of the 2017-2022 Integrated Care Plan, the Alaska Department of Health has made strides towards the goals of primary prevention, early identification of HIV, linkage to care, and supporting high quality health care services resulting in viral suppression.

In 2020, the Ryan White Program provided core medical and supportive services to 289 persons living with HIV across the state. The AIDS Drug Assistance Program (ADAP) program provided coordination of services and access to benefits and pharmacological support to 99 individuals.

In 2020, using CDC PS18-1802 funding, approximately 559 rapid HIV tests were conducted, resulting in 2 new HIV diagnoses. Of these 2 new HIV diagnoses, 100% were successfully linked to follow-up testing and medical care. Seventy-one persons were referred to a PrEP provider, and nearly 79,050 condoms were distributed in Alaska.

Still, in 2020, 30 persons were newly diagnosed with HIV in Alaska. Of the 30 cases, 43% were Alaska Native/American Indian, 30% were White, and 13% were Hispanic/Latino (all races). Of these new diagnoses, 57% were in persons 34 years or younger at the time of diagnosis. Due to great strides in providing statewide prevention services and increasing accessibility and availability of care, only 12% of all PLWH in Alaska have not been retained in medical care.

The HIV/STD Program views the process of conducting this SCSN and the subsequent development of an Integrated HIV Prevention and Care Plan as an important opportunity to assess and prioritize unmet needs and gaps in services. The HIV/STD Program is committed to finding innovative methods to prevent new cases of HIV in Alaska and to ensure that Alaskans living with HIV are able to access medical care and support services allowing them to experience better health and enhanced quality of life. Together with clinical and non-clinical community partners, the efforts are sure to succeed.

Approach

A collaborative process was used to develop the Integrated HIV Prevention and Care Plan. The process used to collect the data was developed by the HIV/STD Program Staff and the Alaska Integrated HIV Advisory Group (AIHAG). This advisory group consists of HIV/STD Program Staff, HIV care providers, HIV prevention staff, Ryan White Part B (RWPB) recipients, pharmacists, Tribal Health partners, HIV consumers, and others. This group was created to ensure consumer input that was representative of Alaskans. Opportunities for input were provided to consumers receiving services from RW Part B as well as key stakeholders. Community partners provided information regarding current HIV prevention and care services and input on additional needed services. In addition to seeking input from persons familiar with current HIV service delivery system, we also attempted to gather information from:

- PLWH who know their HIV status;
- Persons at higher risk for HIV infection; and
- People experiencing HIV-related health disparities.

Community input was gathered in addition to data gathered by DOH HIV Surveillance to complete the Epidemiological Profile. Input consisted of information from consumer interviews, consumer surveys, and AIHAG listening sessions. Input was received from voices who are present in both urban and rural areas of the state and from communities affected by HIV via an open-ended survey. Through all these processes, approximately 40 people provided invaluable feedback.

HIV prevention and care in Alaska is complex and multilayered, involving many stakeholders with a wide range of needs and perspectives. The Integrated Plan materialized by bringing these stakeholders together, and the work involved in achieving our goals will be undertaken in the same way.

Documents Submitted to Meet Requirements

While the 2017-2021 Integrated HIV Prevention and Care Plan served as a resource for developing the 2022-2027 Plan, an entirely new plan was developed to meet the requirements set forth by CDC and HRSA. Materials updated and developed for this plan include:

Documents Developed

- Epidemiological Snapshot
- Needs Assessment – Survey
- Needs Assessment – Interview Questions
- Situational Analysis
- Goals and Objectives
- Implementation, Monitoring, and Evaluation

Documents Updated

- Cluster Detection and Response
- Data Sharing Agreement
- HIV Prevention and Care Resource Inventory
- Priority Populations

A detailed list of required documents and sections can be found in Attachment 1.

Section II: Community Engagement and Planning Process

Jurisdiction Planning Process

Alaska began the integrated planning process by first evaluating the requirements of the plan, developing a timeline, assigning staff to various sections, and facilitating planning meetings. The needs assessment was one of the most difficult portions of the Integrated Plan as one had not been conducted since the previous plan in 2017. Therefore, a survey tool was developed early on in order to gather information from clients on HIV prevention and care services statewide. An AIHAG meeting was held in February 2022 to outline the requirements of the Integrated Plan, proposed activities, and allow members an opportunity for feedback on the survey tool. The needs assessment survey went live in March 2022 in both online and paper formats. Medical clinics and providers across the state were notified about the survey, paper copies of the survey and fliers with a QR code were distributed. Next the Resource Inventory was updated and emailed to community partners for review and updates. There were numerous internal staff meetings to develop the Situational Analysis, outline pillars, and establish Goals and Objectives. Additional AIHAG meetings were held in May, August, and November 2022 to discuss plan progress and obtain feedback. All AIHAG members had an opportunity to review a draft of the Integrated Plan prior to finalization and submission, see Section VII: Letter for Concurrence.

The following examples describe the input of PLWH, key stakeholders, and other community members during the integrated planning process over the past five years:

Alaska Integrated HIV Advisory Group (AIHAG): PLWH have always been invited and encouraged to attend AIHAG meetings. In prior years, the AIHAG group included multiple PLWH members however it has been challenging to retain their participation. PLWH were not compensated for their time at the meetings and meetings moved to a virtual platform after the COVID-19 pandemic began. To involve more PLWH in the AIHAG and development of the Integrated Plan, Alaska developed a flyer about the opportunities to participate as well as gift cards for participation. The flyer was posted at HIV Care sub-recipient agencies and distributed to clients via food boxes. The AIHAG has offered different levels of membership to accommodate anyone interested in participating. Members can apply to be a full voting member which includes some requirements for attendance, or they can sit on the group as an associate member which allowed for more flexibility in participation. Lastly, HIV/STD program staff reached out to community members who have shown interest in past HIV prevention or care activities and invited them to be involved in the AIHAG or additional workgroups. The members who participated in the AIHAG and work groups were active in providing feedback, opinions, and experiences during meetings and via email communication, and assisted in the development of surveys. These surveys included the HIV Prevention and Care Services survey, through which Alaska sought statewide feedback from impacted populations.

Public Hearings: Alaska conducts public hearings annually to ask for input on improving care and prevention strategies and other HIV activities throughout the state. The hearings are held in Anchorage and have a telephonic option for clients residing in other regions of the state so that PLWH and other community members are afforded the opportunity to have their voice heard. Unfortunately, there has been very little participation in the public hearings from the community over the past five years.

Individual and Small Group Engagement Sessions: There are many at-risk sub-populations and PLWH who are not represented adequately in traditional community engagement settings. Therefore, Alaska decided to conduct a focus group as another way to obtain feedback from consumers who utilize HIV prevention and care services. Unfortunately, despite HIV/STD program staff receiving RSVPs, no consumers were present at the scheduled focus group. Alternatively, the consumers who were interested in attending the group were able to participate in one-on-one interviews with HIV/STD program staff. Feedback from these participants was

incorporated into the current needs assessment and thus the formation of the specific strategies and activities needed to address identified needs, barriers, and gaps.

Needs Assessment Survey: The HIV/STD Program conducted an HIV Prevention and Care Services survey for persons utilizing those services. Recruitment of survey participants relied heavily on case manager outreach to current clients. The survey was distributed statewide through private providers, Public Health Nursing, medical clinics, village health clinics, and community service organizations. The survey was open for approximately 3 months; however, there was limited participation. Due to the low response of the survey, one-on-one interviews were conducted with consumers to better understand current care and treatment services within Alaska. These interviews were conducted by HIV staff and consisted of 10 questions that asked about stigma, case management, and personal struggles.

Goals and Objectives Planning Meetings:
The HIV/STD Program held weekly Goals and Objectives planning meetings to streamline the direction of the Integrated Plan's goals and objectives. These meetings were hosted in person with the option to attend virtually if desired. Invitations to join these meetings and participate in the development of the goals and objectives were advertised during two AIHAG meetings. Participation of these meetings were limited to HIV/STD Program Staff, with one meeting attended by a AIHAG member.

Entities Involved in Planning Process

The Alaska Integrated HIV Advisory Group (AIHAG) is the statewide planning body that advises the Alaska HIV/STD Program on the development, implementation, and evaluation of HIV prevention and care services. The goal of the community planning process is to ensure the provision of high-quality and effective HIV prevention, care, and treatment services to meet the current and future needs of persons at risk for HIV infection.

The HIV/STD Program has strong collaborations with the key stakeholders, many of whom conduct work in both HIV prevention and care. AIHAG is comprised of 30 to 35 members who are broadly representative of the affected communities and key stakeholders in Alaska. The AIHAG leadership is composed of a Community Co-Chair and a State Health Department Co-Chair. The representation in the group consists of persons from Part B and C HIV Care, state Hepatitis Coordinator, HIV Prevention and Care sub-recipients (including ADAP), private providers, consumers, community members, pharmacists, tribal health, Planned Parenthood, and other key stakeholders. The integrated planning group also consults with and invites numerous entities for technical advice when needed including HIV Primary Care physicians, HIV Surveillance staff, substance abuse treatment providers, Medicaid staff, mental health providers, Mountain West AIDS Education and Training Center, and Alaska STD program staff.

The AIHAG charter prioritizes a membership recruitment process which ensures representation from HIV prevention agencies, HIV care agencies, and the community. Members are invited to participate as full members or associate members, dependent on their ability to commit to participation in the AIHAG. Members who participate in the AIHAG and planning process are:

- Health Department Staff, including the HIV Prevention Coordinator, HIV Care Coordinator, HIV Surveillance Coordinator, Linkage to Care Coordinator, HIV/STD Program Coordinator, and Disease Intervention Staff
- Ryan White HIV/AIDS Programs (RWHAP): Part B sub-recipients at Alaskan AIDS Assistance Association (Four As) and Interior AIDS Association (IAA), Part C Clinicians and nurses from Anchorage Neighborhood Health Center (ANHC) and Alaska Native Tribal Health Consortium (ANTHC), and Part F recipients from ANTHC.

- HIV clinical care clinicians from private practice
- HIV clinical care clinician from tribal health entity
- Persons living with HIV
- HIV Prevention Sub-recipients including representatives from Municipality of Anchorage Health Department, ANTHC, IAA, and Four A's
- Representative from HOPWA
- STD clinics and programs including representatives from Planned Parenthood, Identity Inc., as well as other clinics listed above.
- Community health care center representatives including FQHCs are represented by ANHC staff
- Mental health providers represented by a clinician from Identity Inc.
- Tribal health representatives include a pharmacist from Southcentral Foundation and representatives from ANTHC

Due to the size and dynamics of Alaska's health and social service programs, full required representation in AIHAG was not achieved. Despite personalized invitations by HIV/STD program staff to individuals and organizations, representation from all required entities was not attained. The following representation was not present for any of the last four quarterly AIHAG meetings.

- Several non-elected community representatives
- Substance use treatment providers
- Hospital planning agencies and health care planning agencies
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility
- Representatives from state or local law enforcement and/or correctional facilities
- Medicaid/Medicare partners

Additionally, updates regarding the Integrated Plan are provided to the Anchorage STD/HIV Advisory Group which meets on a quarterly basis. Members of that group were provided with the opportunity to participate in the integrated planning process. Membership of that group consists of many of the entities listed above and has representatives from Department of Corrections, the military, and the Public Health Laboratory.

Role of the RWHAP Part A Planning Council/Planning Body

Not applicable, Alaska does not have a RWHAP Part A Planning Council.

Role of Planning Bodies and Other Entities

In 2015, the Alaska HIV Prevention Planning Group (HPPG) and HIV Care planning bodies formally merged to create the Alaska Integrated HIV Advisory Group (AIHAG). The purpose of the Advisory Group is to provide guidance and insight for HIV-related issues statewide, with a particular focus on creating, maintaining, implementing, and evaluating an integrated Alaska HIV Prevention & Care Plan which identifies service gaps and areas of greatest need for HIV prevention and care services.

Alaska does not have an EHE planning body. The AIHAG includes representatives from all sub-recipient entities, as well as key stakeholders who have an interest in HIV Prevention and Care. Due to Alaska's limited resources, all the same entities would be involved in any future EHE planning.

Collaboration with RWHAP Parts

Alaska receives federal funding for RWHAP Part B, C, and F. The AIHAG members provided the most input on the Integrated Plan requirements. Representatives from the Part B sub-recipients (Four A's and IAA), Part C entities

(ANTHC and ANHC), and Part F (AETC) participate in the AIHAG. All these members are provided an opportunity to give input on the Integrated Plan through quarterly meetings, focused workgroup meetings, and by reviewing the drafted plan. Alaska has only one Integrated Plan.

Engagement of People with HIV

The inclusion of PLWH is invaluable to the development of the Integrated Plan. In the formulation of this plan, HIV/STD program staff collaborated extensively with the AIHAG, agencies serving persons at increased risk for HIV, as well as PLWH, to create a plan representative of their needs. It has been challenging to obtain consistent involvement of PLWH in the AIHAG and integrated planning process. HIV/STD program staff has attempted to improve participation by increasing incentive amounts, so participants feel their time is fairly compensated for. Alaska aims to obtain feedback from PLWH throughout the next five years as activities are implemented and the plan is evaluated to ensure their input is included and their voices are represented.

Priorities

A full list of key priorities that arose during the integrated planning process can be found in the Needs Assessment. These priorities include, but are not limited to:

- Addressing stigma and cultural competency
- Access to PrEP and PEP
- Prevention, care, and treatment for substance users, including persons who inject drugs
- Comprehensive sexual health education for youth
- Addressing barriers to service in rural areas

Updates to Other Strategic Plans Used to Meet Requirements

The Integrated Plan is the only strategic plan for the state related to HIV Care and Prevention. Alaska updates the HIV Care Continuum on an annual basis and uses that data to evaluate engagement in HIV medical care and the rate of viral suppression. The HIV/STD Program conducts annual site visits to the sub-recipient agencies which includes meetings with consumers and stakeholders. Information obtained from the site visits are used to determine if changes are needed to the delivery of services. Additionally, HIV Care sub-recipient agencies conduct annual client satisfaction surveys which are used to evaluate the quality of services delivered and the needs of consumers.

Section III: Contributing Data Sets and Assessments

Data Sharing and Use

Data Policies

The Alaska HIV/STD Program is a fully integrated program. As such, there are no data policies that prohibit sharing of data between HIV Surveillance, HIV Care, and HIV Prevention staff for public health action or for preparation of the HIV Integrated Care Plan and HIV Care Continuum. The exception is that data collected by the HIV/STD Program to administer Ryan White funded programs and services are not available for HIV Surveillance case ascertainment activities or individual-level linkage to care activities. Rather, these data are used to monitor the fiscal processes and implementation of programs and services funded under Ryan White as well as by grantees and contractors.

Use of HIV surveillance data for public health action (i.e., partner services and linkage to care activities) is authorized by the State of Alaska HIV/STD Program Security and Confidentiality Policy and Procedure under the following data use statement:

> "Alaska supports an integrated HIV/STD Program, and staff duties often overlap across various grants. All HIV/STD Program staff must adhere to the above stated policy for the handling and storage of identified HIV/STD data, regardless of the use of that data. Identified HIV/STD data may be used internally for program implementation and reporting purposes but may not be released outside of the HIV/STD Program. Identified data used for conducting Partner Services and Linkage to Care investigations, ICCR and RIDR/CIDR activities, and for other programmatic reporting or analysis purposes are maintained pursuant to this policy."

Data for Decision Making

Both state level and national level population data were easily available as both are available to the public online. These data were used to provide an overview of state and national population characteristics. Due to the above referenced program integration and data use agreement, access to the required internal data sources utilized to prepare the plan was complete.

While Ryan White Care data is not available for the day-to-day implementation of linkage to care activities, this policy was not a barrier to preparation of the plan as Ryan White data was not needed to prepare the HIV Care Continuum. The continuum is produced annually by the HIV Surveillance Program using the reportable HIV case surveillance database, as it provides the most complete source of laboratory and demographic data for all reported persons living with HIV in Alaska. Data collected under Ryan White funded program activities are not used for the HIV Care Continuum because it is limited to those persons living with HIV that are receiving Ryan White services and does not include those who are not enrolled in a Ryan White funded service or program.

Epidemiologic Snapshot

The purpose of the Epidemiologic Profile is to describe the burden of HIV in Alaska, particularly in terms of the geographic, behavioral, and clinical characteristics of persons diagnosed with HIV, persons living with HIV, and persons at increased risk for HIV infection/acquisition. The data presented herein serve to inform prevention, care, and treatment efforts across the HIV care continuum.

When interpreting data in this section, it is important to consider that Alaska is a low incidence jurisdiction. Resultingly, interpretation of trends over time are challenging as there is insufficient data to support valid conclusions. Changes in percentages and rates should be interpreted with caution and some of the data may be statistically unreliable.

Moreover, data for 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Structure of the Profile

In order to appropriately summarize HIV in Alaska and highlight emerging trends, the Epidemiologic Profile will present data using a variety of timelines and populations. The subsequent four sections will present data on all reported cases as well as cases with a new diagnosis in Alaska. The profile will also include a section on persons living with HIV. The final section will present data on sexually transmitted diseases. Sections will include data by assigned sex at birth, age at time of diagnosis, race/ethnicity, transmission category, and region at diagnosis (cumulative cases only).

The four sections include:

A. **All Reported Cases of HIV, 1982 – 2020** – This section presents cumulative data for all cases of HIV reported to the Section of Epidemiology from January 1, 1982, through December 31, 2020. This section includes cases newly diagnosis in Alaska as well as cases of persons with a previous diagnosis out-of-state that received care in Alaska during this period.

B. **Cumulative, 1982 – 2020 and Recent, 2016 – 2020** – This section compares trends among persons newly diagnosed in Alaska from 1982 – 2020 to persons newly diagnosed in Alaska between 2016 – 2020. This section does not include data on cases diagnosed out-of-state.

C. **Persons Living With HIV, 2020** – This section presents data on all persons with HIV thought to be living in Alaska as of December 31, 2020 and will summarize the HIV Care Continuum during 2020. This section includes cases diagnosed in Alaska and out-of-state for persons not known to have died and for persons whose most recent available address was in Alaska as of December 31, 2020.

D. **Sexually Transmitted Diseases** – This section summarizes the burden of reportable STDs in Alaska (chlamydia, gonorrhea, and syphilis) with a brief discussion of co-infection.

HIV in Alaska – At A Glance

HIV in Alaska vs. US in 2019[†][12]

- In Alaska, the 2019 statewide incidence rate was 4.5/100,000 persons, while the national incidence rate was estimated to be 12.6/100,000 persons.
- Males (assigned sex at birth) represented 74% of persons newly diagnosed in Alaska, while all males represented 79% of persons newly diagnosed in the U.S.
- Male-to-male sexual contact (MSM), including MSM and IDU, was attributed to 56% of cases newly diagnosed in Alaska and approximately 70% in the U.S., while heterosexual contact was attributed to 22% of cases newly diagnosed in Alaska and 23% in the United States.
- In Alaska, 44% of cases newly diagnosed were White, 22% were Alaska Native/American Indian, 19% were Black/African American, and 15% were Hispanic/Latino. In the U.S. 25% of cases newly diagnosed were White, <1% were Alaska Native/American Indian, 42% were Black/African American, and 29% were Hispanic/Latino.

[†]*2019 data is used for this comparison as 2020 state and national data should be interpreted with caution due to the impact of the COVID-19 pandemic*

[1]*CDC.* Diagnoses of HIV Infection in the United States and Dependent Areas 2019: National Profile. Available at: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-32/content/national-profile.html

[2]CDC. HIV Surveillance Report: Estimated HIV Incidence and Prevalence in the United States, 2015–2019. Available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-26-1.pdf

HIV in Alaska[‡]

- An average of 32 Alaskan residents are newly diagnosed with HIV annually in Alaska.
- An average of 65 cases of HIV are reported to the Alaska Section of Epidemiology each year, including cases with an initial diagnosis in Alaska and those previously diagnosed out-of- state who relocated to and received care in Alaska.
- Among males (assigned sex at birth), male-to-male sexual contact (MSM) is the predominant risk factor, and among females (assigned sex at birth), heterosexual contact is the predominant risk factor.
- In 2019, 27 persons were newly diagnosed with HIV in Alaska.

[‡]*Based on previous 10 years of reportable HIV data (2010-2019)*

Section A: Summary of All Reported Cases of HIV – Alaska, 1982 – 2020

Section Highlights

- From January 1, 1982, through December 31, 2020, 2,026 cases of HIV infection were reported to the Alaska Section of Epidemiology.
    - Of those cases 1,294 (64%) had an initial diagnosis in Alaska, and 732 (36%) were previously diagnosed out-of-state but are known to have lived and received care in Alaska.
- 1,283 (63%) ever had a diagnosis of Stage3/AIDS.
- 704 (35%) are known to have died.
- 1,638 (81%) were assigned male sex at birth.
- Male-to-male sexual contact (MSM), including MSM and IDU, was attributed to 61% (n=1,227) of all reported cases, while heterosexual contact was attributed to 18% (n=372) of all reported cases.
- 1,031 (51%) of all reported cases were White; 399 (20%) were Alaska Native/American Indian; 286 (14%) were Black/African American.

Sex Assigned at Birth

Of the 2,026 cases of HIV reported in Alaska from 1982 through 2020, 1,638 (81%) cases were diagnosed in persons assigned male sex at birth and 388 (19%) cases were diagnosed in persons assigned female sex at birth. Of all reported cases, 1,294 (64%) were newly diagnosed with HIV in Alaska, with 1,016 (79%) cases diagnosed in persons assigned male sex at birth and 278 (21%) cases diagnosed in persons assigned female sex at birth (Table 1).

Males are over-represented in reported cases of persons newly diagnosed with HIV in Alaska. As of April 2020, the Alaska Department of Labor and Workforce Development (AKDOL) estimated the population of Alaska to be 733,391 persons, of whom 377,246 (51%) persons were male and 356,145 (49%) persons were female. While males represented an estimated 51% of the overall population in Alaska in 2020[1], persons assigned male sex at birth account for 79% (n=1,016) of the 1,294 HIV cases newly diagnosed in Alaska.

Since reporting began in 1982, fewer than 6 cases of HIV have been reported among known transgender persons and persons with additional gender identity. Classifying transgender persons and persons with additional gender identity in the surveillance system requires accurate collection of both sex assigned at birth and gender identity variables. Sex assigned at birth and gender identity data are collected from person's self-report, their diagnosing provider, and/or medical record review. Gender identity has been collected routinely since 2018. Therefore, it is anticipated that HIV cases among transgender persons are likely to be underrepresented in these data due to missing and inadequate gender identity information.

[1] State of Alaska, Department of Labor and Workforce Development, Statewide Population Estimates, 2020. Available at http://live.laborstats.alaska.gov/pop/. Accessed September 12, 2022.

Table 1. Summary of Reported Cases of HIV by Assigned Sex at Birth – Alaska, 1982-2020

	All Reported Cases N=2,026		Reported Cases First Diagnosed in Alaska n=1,294	
	Male*	Female*	Male*	Female*
HIV (non–AIDS)	584	159	343	114
HIV with AIDS	1,054	229	673	164
TOTAL #	1,638	388	1,016	278

*Assigned sex at birth

Age

Of the 2,026 cases of HIV reported in Alaska between 1982 and 2020, 1,335 (66%) persons were between the ages of 25 and 44 years old at initial diagnosis. Among the 1,335 persons aged 25-44 years old at initial diagnosis, 65% (n=841) were first diagnosed with HIV in Alaska (Table 2). The majority of cases in persons <14 years old at diagnosis were among non-U.S. born persons and were attributed to exposure at birth or through breastfeeding. Of persons <14 years old at initial diagnosis, one case is believed to be attributed to premastication of food.

Table 2. Summary of Reported Cases of HIV by Age at Diagnosis – Alaska, 1982-2020

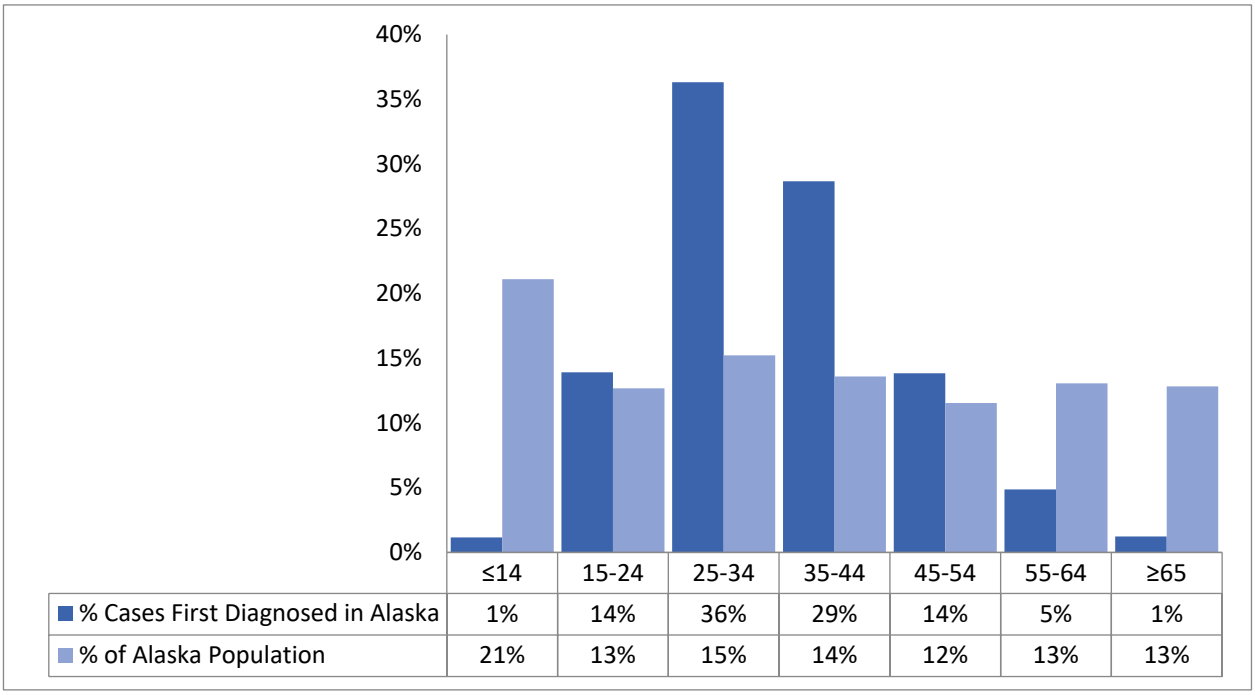
Age (Years)	All Reported Cases N=2,026		Reported Cases First Diagnosed in Alaska n=1,294	
	Male*	Female*	Male*	Female*
<14	12	14	8	7
15–24	274	71	136	44
25–34	634	133	373	97
35–44	470	98	303	68
45–54	180	51	136	43
55–64	54	18	47	16
≥65	14	3	13	3

*Assigned sex at birth

Persons aged 25-44 years are over-represented in the proportion of persons with an initial HIV diagnosis in Alaska, representing 65% of all diagnoses combined (Figure 1), but only 29% of the Alaska population.[2]

[2] State of Alaska, Department of Labor and Workforce Development, Statewide Population Estimates, 2020. Available at http://live.laborstats.alaska.gov/pop/. Accessed September 12, 2022.

Figure 1. Percentage of Reported HIV Cases with an Initial Diagnosis in Alaska, by Age at Diagnosis (1982-2020) and Percentage of the Alaska Population by Age (April 2020)[3]



	≤14	15-24	25-34	35-44	45-54	55-64	≥65
% Cases First Diagnosed in Alaska	1%	14%	36%	29%	14%	5%	1%
% of Alaska Population	21%	13%	15%	14%	12%	13%	13%

Race and Ethnicity

In Alaska, HIV cases have been reported among persons from all racial and ethnic groups (Table 3).

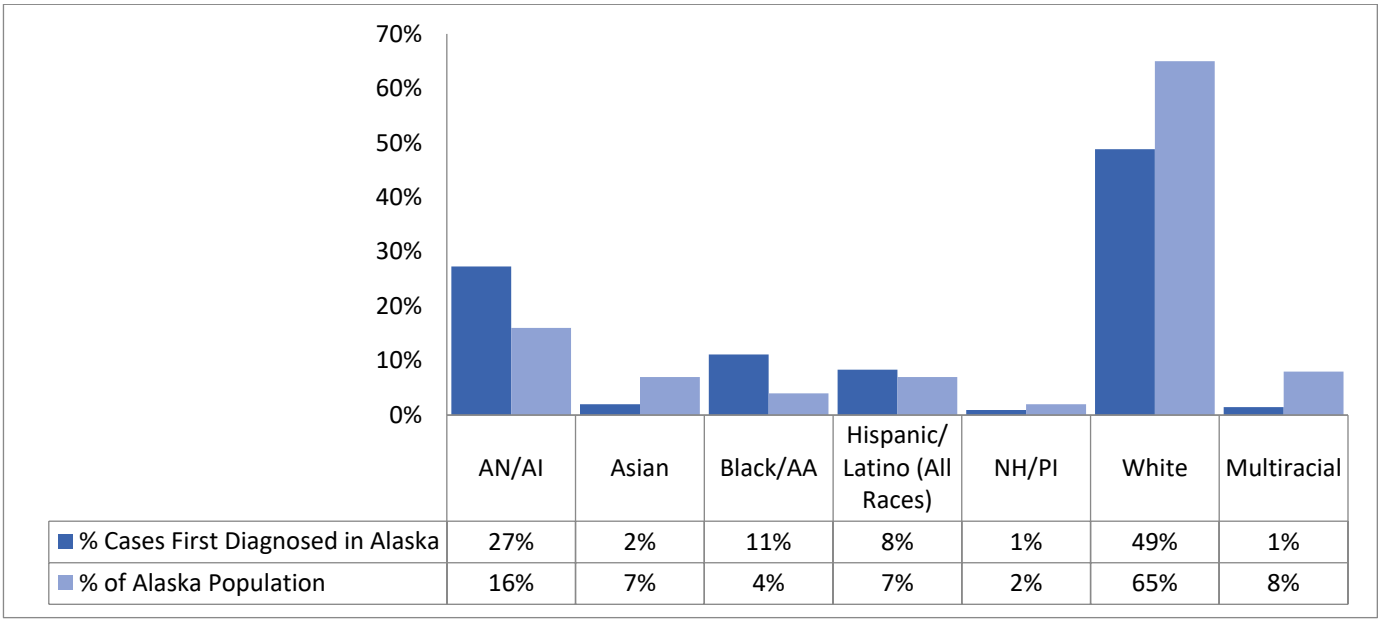
Table 3. Summary of Reported Cases of HIV by Race and Ethnicity – Alaska, 1982-2020

	All Reported Cases N=2,026		Reported Cases First Diagnosed in Alaska n=1,294	
	Male*	Female*	Male*	Female*
Alaska Native/American Indian (AN/AI)	273	126	232	121
Asian	30	19	14	12
Black/African American (Black/AA)	221	65	110	34
Hispanic/Latino (All Races)	163	36	87	21
Native Hawaiian/ Pacific Islander (NH/PI)	11	3	10	2
White	901	130	548	84
Multiracial	39	9	15	4

*Assigned sex at birth

[3] State of Alaska, Department of Labor and Workforce Development, Statewide Population Estimates, 2020. Available at http://live.laborstats.alaska.gov/pop/. Accessed September 12, 2022.

The highest proportion of HIV cases first diagnosed in Alaska are among White persons (49%; n=632). However, AN/AI persons (27%; n=353) and Black/African American (11%; n=144) persons are over-represented in HIV cases first diagnosed in Alaska. While AN/AI persons represented an estimated 16% of the Alaska population in 2020, 27% of reported cases first diagnosed in Alaska were among AN/AI persons. Similarly, while Black/African American persons represented an estimated 4% of the Alaska population in 2020, 11% of reported cases first diagnosed in Alaska were among Black/African American persons (Figure 2).



	AN/AI	Asian	Black/AA	Hispanic/ Latino (All Races)	NH/PI	White	Multiracial
% Cases First Diagnosed in Alaska	27%	2%	11%	8%	1%	49%	1%
% of Alaska Population	16%	7%	4%	7%	2%	65%	8%

Figure 2. Percentage of Reported Cases of HIV with an Initial Diagnosis in Alaska by Race/Ethnicity (1982-2020) and Percentage of Alaska Population by Race and Hispanic Origin (April 2020)[4]

Transmission Category

Transmission categories are documented in the HIV surveillance system through elicitation of behavioral and health histories of persons with HIV. Behaviors and health histories are elicited by health care providers and through interviews conducted by health department disease intervention specialists (DIS). Exposure categories are designed to classify behaviors and risks attributed to HIV transmission. Exposure categories do not classify current gender identity or sexual identity. The HIV surveillance system accounts for sex at birth in transmission category assignment; therefore, the attributed risk for transgender persons living with HIV may be an incomplete classification. Transmission categories among reported cases of HIV in Alaska include:

- Male*-to-male sexual contact (MSM);
- Injection drug use (IDU);
- Male*-to-male sexual contact and injection drug use (MSM/IDU);
- Heterosexual contact with a person with documented HIV infection, and/or heterosexual contact with a person who injects drugs, and/or heterosexual contact with a bisexual male (HTC);
- Perinatal HIV infection, when a person living with HIV transmits HIV to the infant in gestation, childbirth, or breastfeeding (perinatal); and

[4] State of Alaska, Department of Labor and Workforce Development, Statewide Race and Hispanic Origin, 2020. Available at http://live.laborstats.alaska.gov/pop/. Accessed September 12, 2022.

- Other/Not Specified, includes hemophilia and blood transfusion, as well as risk factor not reported (NRR) or not identified (NIR). No Identified Risk (NIR), when no known risk factor was identified or calculated. No Risk Reported (NRR), when a person did not report any potential attributed risk behavior.

*Assigned male sex at birth

Exposure categories are weighted within the HIV surveillance system according to the probability of HIV transmission; categories are system-assigned. Persons with more than one reported category are classified (system-assigned) in the exposure category most likely to have resulted in HIV transmission.

In Alaska, the most frequently reported transmission category is male-to-male sexual contact for all reported cases as well as persons first diagnosed in Alaska (Table 4).

Table 4. Summary of Reported Cases of HIV by Transmission Category – Alaska, 1982-2020

	All Reported Cases N=2,026		Reported Cases First Diagnosed in Alaska n=1,294	
	Male*	Female*	Male*	Female*
MSM	1,056	-	650	-
IDU	144	79	95	51
MSM/IDU	171	-	79	-
HTC	105	267	75	199
Perinatal	7	13	4	6
Other/Not Specified	155	29	113	22

*Assigned sex at birth

Due to the proportion of cases attributed to male-to-male sexual contact (MSM), it is imperative to review transmission categories by sex assigned at birth. Among all reported cases, the most common transmission category for persons assigned male sex at birth is MSM (Figure 3), whereas for persons assigned female sex at birth, the most common is heterosexual contact (Figure 4).

Figure 3. Cumulative Reported Cases of HIV in Persons Assigned Male Sex at Birth by Transmission Category, Alaska – 1982-2020

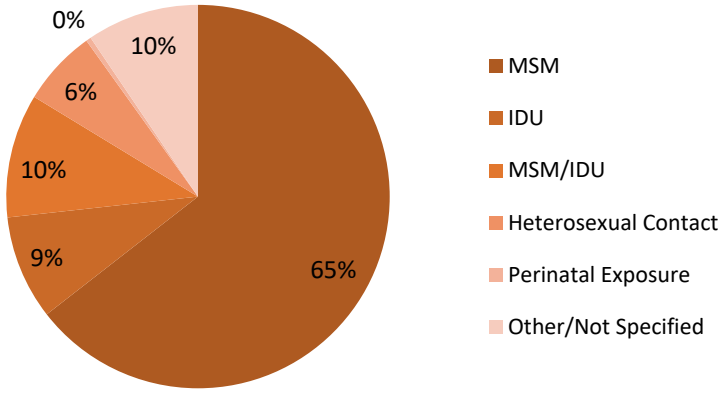
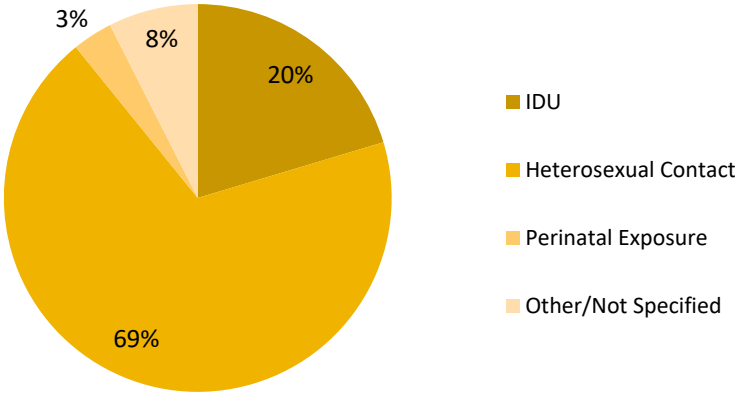


Figure 4. Cumulative Reported Cases of HIV in Persons Assigned Female Sex at Birth by Transmission Category, Alaska – 1982-2020



Geographic Region of Residence

Since 1982, HIV cases have been reported to the Alaska Section of Epidemiology from all regions of Alaska as well as from out-of-state/country (Table 5).

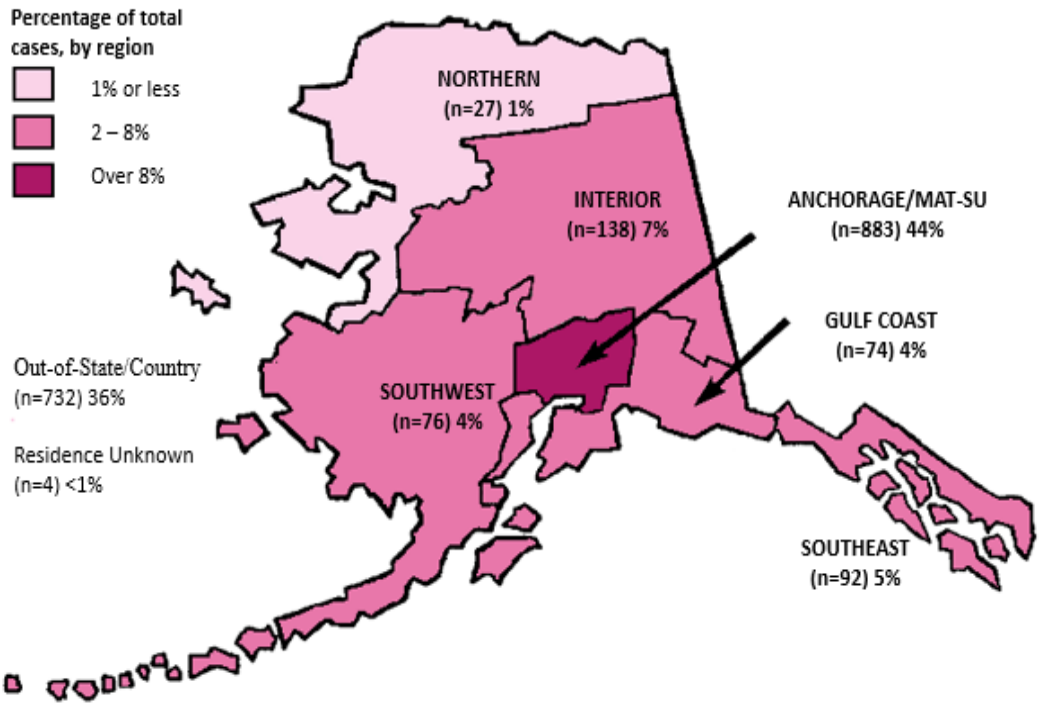
Table 5. Summary of Reported Cases of HIV by Residence at Diagnosis, Alaska – 1982-2020

Region	All Reported Cases N=2,026		Reported Cases First Diagnosed in Alaska n=1,294	
	Male*	Female*	Male*	Female*
Anchorage/ Mat–Su	713	170	713	170
Gulf Coast	58	16	58	16
Interior	103	35	103	35
Northern	18	9	18	9
Southeast	65	27	65	27
Southwest	56	20	56	20
Out of State/ Country	622	110	-	-
Alaska Unspecified	3	1	3	1

*Assigned sex at birth

The majority of persons newly diagnosed with HIV in Alaska were residing in the Anchorage/Matanuska-Susitna (Mat-Su) region at diagnosis, the most populous region within Alaska. Residence of diagnosis is verified through multiple methods; these methods include medical record review, diagnosing physician reports, and patient interviews conducted by DIS. Residence at diagnosis for persons with initial diagnosis in Alaska are only reported by economic region, as opposed to boroughs and census areas, to protect the confidentiality of persons with HIV in regions with low population (Figure 5). It is important to note that residence at diagnosis is not necessarily the region where HIV exposure occurred. Residence at diagnosis may also likely not be the region where a person newly diagnosed with HIV currently resides or accesses care services.

Figure 5. Cumulative HIV Cases First Diagnosed in Alaska by Economic Region at Diagnosis, Alaska – 1982-2020



Section B: HIV in Alaska – Cumulative, 1982-2015 and Recent, 2016-2020

Section Highlights

- Of the 2,026 cases of HIV infection were reported to the Alaska Section of Epidemiology, 1,294 (64%) had an initial diagnosis in Alaska.
- This section compares trends among persons newly diagnosed in Alaska cumulatively from 1982-2015 (n=1,148) to persons newly diagnosed in Alaska more recently, 2016-2020 (n=146). This comparison demonstrates:
    - Sustained majority of new diagnoses among persons assigned male sex at birth
    - Increases in cases in persons younger than 34 years old and persons aged 55-64 years old
    - Increases in cases in persons assigned female sex older than 45 years of age
    - Increases in cases among Alaska Native/American Indian people
    - Male* -to-male sexual contact continues to be attributed to the majority of cases

*Assigned sex at birth

Sex Assigned at Birth

Cumulatively from 1982-2015, 78% (n=901) of HIV cases diagnosed in Alaska were among persons assigned male sex at birth and 22% (n=247) were among persons assigned female sex at birth. Among persons diagnosed with HIV in Alaska between 2016-2020, 79% (n=115) were among persons assigned male sex at birth and 21% (n=31) were among persons assigned female sex at birth (Table 6).

Since reporting began in 1982, fewer than 6 cases of HIV have been reported among known transgender persons and persons with additional gender identity. Classifying transgender persons and persons with additional gender identity in the surveillance system requires accurate collection of both sex assigned at birth and gender identity variables. Sex assigned at birth and gender identity data are collected from person's self-report, their diagnosing provider, and/or medical record review. Gender identity has been collected routinely since 2018. Therefore, it is anticipated that HIV cases among transgender persons are likely to be underrepresented in these data due to missing and inadequate gender identity information.

Table 6. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,294) by Gender – Cumulative, 1982-2015 and Recent, 2016-2020

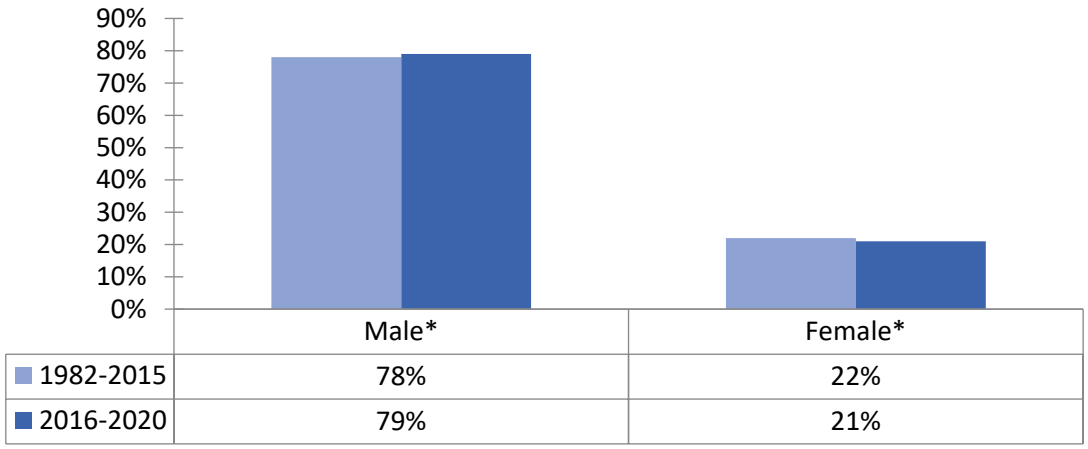
	Cumulative through 2015 (n=1,148)		2016 (n=38)		2017 (n=29)		2018 (n=22)		2019 (n=27)		2020** (n=30)	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
Female*	247	(22)	8	(21)	8	(28)	3	(14)	7	(26)	5	(17)
Male*	901	(78)	30	(79)	21	(72)	19	(86)	20	(74)	25	(83)

*Assigned sex at birth

**COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Among cumulative cases of HIV diagnosed in Alaska from 1982-2015 as well as cases of HIV diagnosed in Alaska between 2016-2020, the majority of cases were among persons assigned male sex at birth (Figure 6).

Figure 6. Percentage of Newly Diagnosed Cases of HIV in Alaska by Sex – Cumulative, 1982-2020 and Recent, 2016-2020



*Assigned sex at birth

Age

Cumulatively from 1982-2015, the majority of HIV cases newly diagnosed in Alaska were among persons aged 25-34 (36%; n=409) and persons aged 35-44 (30%; n=343). Among persons newly diagnosed with HIV in Alaska between 2016-2020, the majority of cases were diagnosed among persons aged 15-24 years (21%; n=31) and persons aged 25-34 years (41%; n=60) (Table 7).

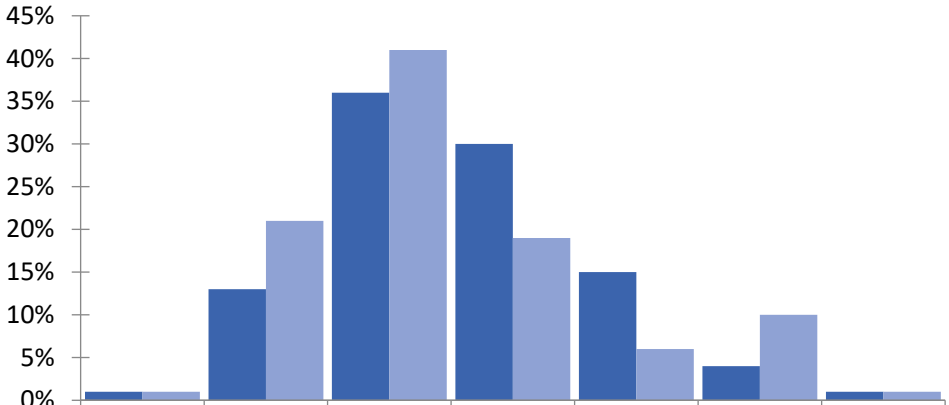
Table 7. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,294) by Age – Cumulative, 1982-2015 and Recent, 2016-2020

	Cumulative through 2015 (n=1,148)		2016 (n=38)		2017 (n=29)		2018 (n=22)		2019 (n=27)		2020* (n=30)	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
<14	14	(1)	0	-	0	-	0	-	0	-	1	(3)
15–24	150	(13)	5	(13)	9	(31)	5	(23)	6	(22)	6	(20)
25–34	409	(36)	17	(45)	11	(38)	9	(41)	13	(48)	10	(33)
35–44	343	(30)	8	(21)	4	(14)	3	(14)	4	(15)	9	(30)
45–54	170	(15)	2	(5)	2	(7)	3	(14)	1	(4)	1	(3)
55–64	48	(4)	4	(11)	3	(10)	2	(9)	3	(11)	3	(10)
≥65	14	(1)	2	(5)	0	-	0	-	0	-	0	-

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Comparing age at HIV diagnosis during 1982-2015 to age at HIV diagnosis during 2016-2020, persons aged 25-34 years continue to account for the largest proportion of new diagnoses in Alaska (Figure 7). Additionally, the average age range among persons with new HIV diagnosis is less distributed across the lifespan, with decreases in new diagnosis among persons aged 35-44 years and 45-54 years (Figure 7).

Figure 7. Percentage of Newly Diagnosed Cases of HIV in Alaska by Age at Diagnosis – Cumulative, 1982-2015 and Recent, 2016-2020

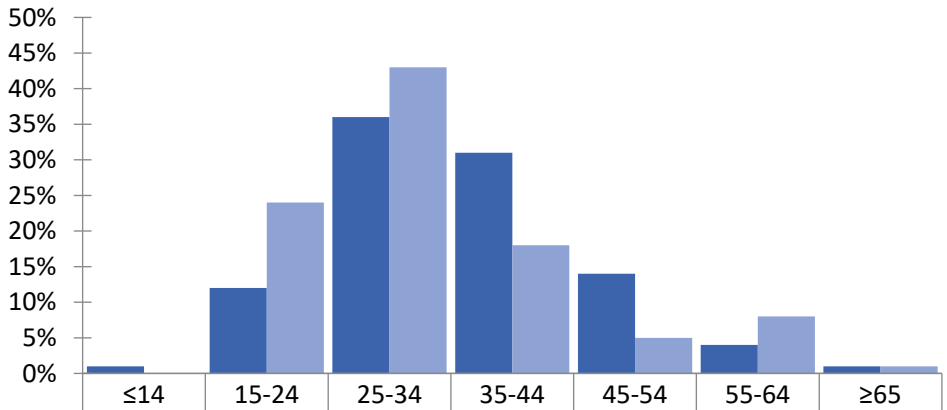


	≤14	15-24	25-34	35-44	45-54	55-64	≥65
1982-2015	1%	13%	36%	30%	15%	4%	1%
2016-2020	1%	21%	41%	19%	6%	10%	1%

Comparing age at HIV diagnosis during 1982-2015 to age at HIV diagnosis during 2016-2020 among persons assigned male sex at birth, persons aged 25-34 years continue to account for the largest proportion of new diagnoses among persons assigned male sex at birth in Alaska (Figure 8). Moreover, the distribution of cases

across the lifespan for males (assigned sex at birth) is consistent with the distribution seen among all persons newly diagnosed in Alaska (Figure 7).

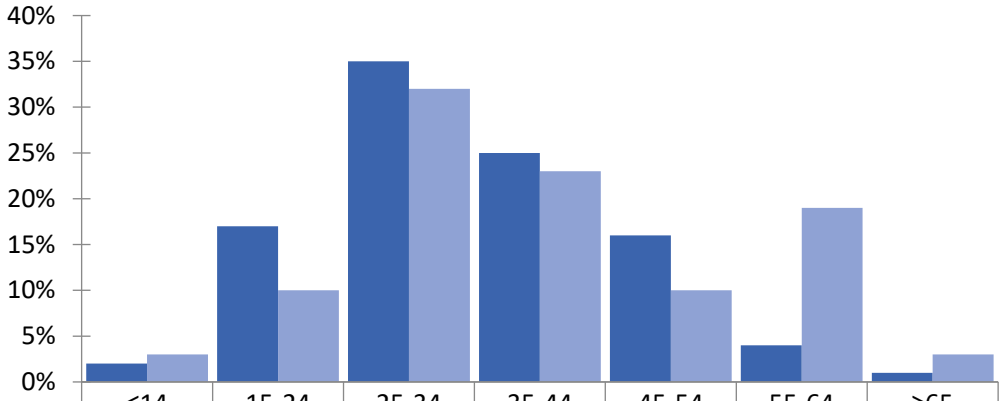
Figure 8. Percentage of Newly Diagnosed Cases of HIV in Alaska Among Persons Assigned Male Sex at Birth by Age at Diagnosis – Cumulative, 1982-2015 and Recent, 2016-2020



	≤14	15-24	25-34	35-44	45-54	55-64	≥65
1982-2015	1%	12%	36%	31%	14%	4%	1%
2016-2020	0%	24%	43%	18%	5%	8%	1%

Comparing age at HIV diagnosis during 1982-2015 to age at HIV diagnosis during 2016-2020 among persons assigned female sex at birth, persons aged 25-34 years continue to account for the largest proportion of new diagnoses among persons assigned female sex at birth in Alaska (Figure 9). Comparing age at HIV diagnosis during 1982-2015 to age at HIV diagnosis during 2016-2020 among persons assigned female sex at birth, there was a notable increase in new diagnoses among persons older than 55 years old (Figure 9).

Figure 9. Percentage of Newly Diagnosed Cases of HIV in Alaska Among Persons Assigned Female Sex at Birth by Age at Diagnosis – Cumulative, 1982-2015 and Recent, 2016-2020



	≤14	15-24	25-34	35-44	45-54	55-64	≥65
1982-2015	2%	17%	35%	25%	16%	4%	1%
2016-2020	3%	10%	32%	23%	10%	19%	3%

Race and Ethnicity

Cumulatively from 1982-2015, the majority of HIV cases newly diagnosed in Alaska were among persons with reported race/ethnicity of White (51%; n=586) and Alaska Native/American Indian (26%; n=296) (Table 11). During 2016-2020, the majority of HIV cases newly diagnosed in Alaska were also among persons with reported race/ethnicity of White (32%; n=46) and Alaska Native/American Indian (39%; n=57) (Table 11, Figure 10).

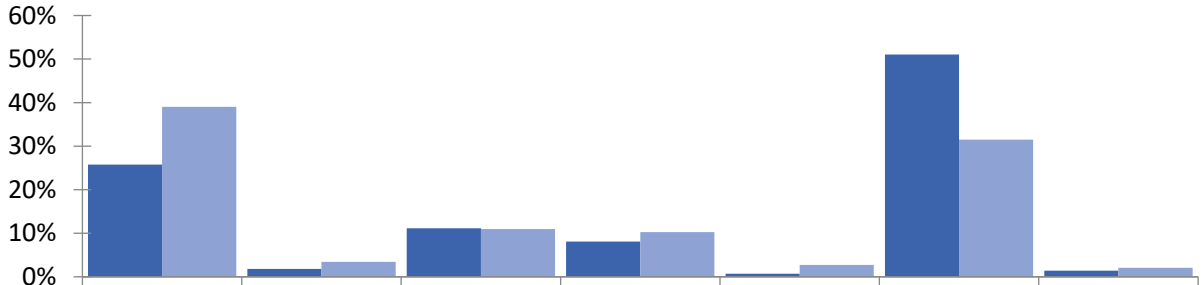
Table 8. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,294) by Race and Ethnicity – Cumulative, 1982-2015 and Recent, 2016-2020

	Cumulative through 2015 (n=1,148)		2016 (n=38)		2017 (n=29)		2018 (n=22)		2019 (n=27)		2020* (n=30)	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
AN/AI	296	(26)	17	(45)	13	(45)	8	(36)	6	(22)	13	(43)
Asian	21	(2)	4	(11)	0	-	0	-	0	-	1	(3)
Black/AA	128	(11)	5	(13)	4	(14)	1	(5)	5	(19)	1	(3)
Hispanic/Latino (All Races)	93	(8)	3	(8)	3	(10)	1	(5)	4	(15)	4	(13)
NH/PI	8	(1)	0	-	0	-	2	(9)	0	-	2	(7)
White	586	(51)	9	(24)	9	(31)	7	(32)	12	(44)	9	(30)
Multiracial	16	(1)	0	-	0	-	3	(14)	0	-	0	-

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Comparing reported race/ethnicity during 1982-2015 to race/ethnicity during 2016-2020, there is a notable increase in persons newly diagnosed with reported race/ethnicity of Alaska Native/American Indian (Figure 10). It is anticipated that some increase in case detection may be a result of increased accessibility and availability of HIV screening within the Alaska Tribal Health system. Comparing reported race/ethnicity during 1982-2015 to race/ethnicity during 2016-2020, there is a notable decrease in persons newly diagnosed with reported race/ethnicity of White (Figure 10).

Figure 10. Percentage of Newly Diagnosed Cases of HIV in Alaska by Race/Ethnicity Category – Cumulative, 1982-2015 and Recent, 2016-2020



	AN/AI	Asian	Black/AA	Hispanic/Latino (All Races)	NH/PI	White	Multiracial
1982-2015	26%	2%	11%	8%	1%	51%	1%
2016-2020	39%	3%	11%	10%	3%	32%	2%

Transmission Category

Male-to-male sexual contact was attributed to the largest proportion of cases newly diagnosed in Alaska among persons aged 13 years and older at diagnosis during 1982-2015 (50%; n=568) and 2016-2020 (57%; n=82) (Table 9).

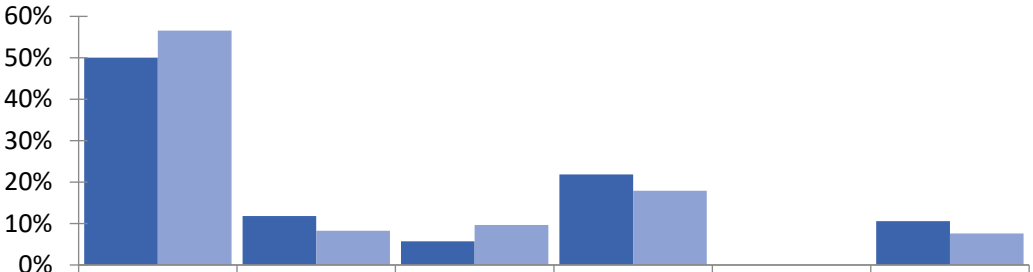
Table 9. Summary of Reported Cases of HIV Diagnosed in Alaska (N=1,280) by Transmission Category Among Persons Aged 13 and Older at Diagnosis – Cumulative, 1982-2015 and Recent, 2016-2020

	Cumulative through 2015 (n=1,135)		2016 (n=38)		2017 (n=29)		2018 (n=22)		2019 (n=27)		2020* (n=29)	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
MSM	568	(50)	25	(66)	16	(55)	12	(55)	14	(52)	15	(52)
IDU	134	(12)	1	(3)	3	(10)	2	(9)	3	(11)	3	(10)
MSM/IDU	65	(6)	2	(5)	2	(7)	5	(23)	1	(4)	4	(14)
HTC	248	(22)	8	(21)	7	(24)	2	(9)	6	(22)	3	(10)
Perinatal	0	-	0	-	0	-	0	-	0	-	0	-
Other/Not Specified	120	(11)	2	(5)	1	(3)	1	(5)	3	(11)	4	(14)

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Comparing HIV transmission category trends among persons newly diagnosed in Alaska cumulatively during 1982-2015 to persons newly diagnosed with HIV in Alaska during 2016-2020, there are no notable changes in attributed risk (Figure 11).

Figure 11. Percentage of Newly Diagnosed Cases of HIV in Alaska by Transmission Category Among Persons Aged 13 and Older at Diagnosis – Cumulative, 1982-2015 and Recent, 2016-2020



	MSM	IDU	MSM/IDU	HTC	Perinatal	Other/Not Specified
1982-2015	50%	12%	6%	22%	0%	11%
2016-2020	57%	8%	10%	18%	0%	8%

Section C: Characteristics of People Living with HIV in Alaska and the HIV Care Continuum, 2020

Section Highlights

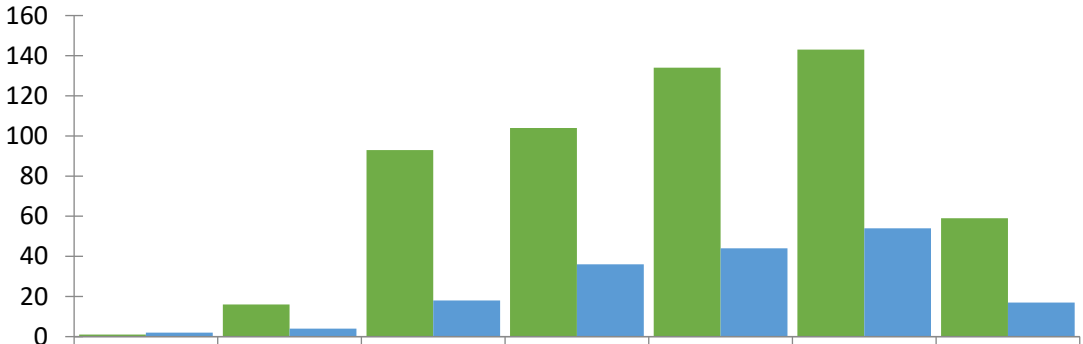
- As of December 31, 2020, an estimated 725 persons living with HIV (PLWH) were residing in Alaska.
- As of December 31, 2020, the majority (76%; n=550) of PLWH in Alaska were assigned male sex at birth; of the 550 PLWH assigned male sex at birth, the majority (50%; n=277) are between the ages of 45 and 64 years old.
- Of the 733 PLWH living in Alaska during 2020, 643 (88%) were engaged in HIV medical care (defined as having received at least one CD4 or HIV viral load (VL) laboratory test in 2020).*
- Of the 643 PLWH engaged in HIV medical care in Alaska during 2020, 582 (91%) have laboratory test results indicating viral suppression (defined as a viral load equal to or less than 200 copies/mL).*
- Approximately 79% of the PLWH in Alaska during 2020 were virally suppressed (Figure 15).*

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

Of the 725 persons living with HIV (PLWH) believed to be alive and residing in Alaska as of December 31, 2020, 76% (n=550) were assigned male sex at birth and 24% (n=175) were assigned female sex at birth. Fewer than 4 PLWH whose current gender identity is known to be transgender or an additional gender identity were believed to be alive and residing in Alaska as of December 31, 2020.

Of the 550 PLWH assigned male sex at birth believed to be alive and residing in Alaska as of December 31, 2020, the majority (50%; n=277) were between the ages of 45 and 64 years (Figure 12).

Figure 12. Persons Living with HIV in Alaska by Age at End of Year and Assigned Sex at Birth – As of December 31, 2020 (N=725)



	≤14	15-24	25-34	35-44	45-54	55-64	≥65
Male*	1	16	93	104	134	143	59
Female*	2	4	18	36	44	54	17

*Assigned sex at birth

White persons assigned male sex at birth (n=235) and Alaska Native/American Indian persons assigned male sex at birth (n=139) accounted for the largest proportion of persons living with HIV in Alaska as of December 31, 2020 (Table 10).

Table 10. Persons Living with HIV in Alaska by Race/Ethnicity and Sex at Birth – As of December 31, 2020 (N=725)

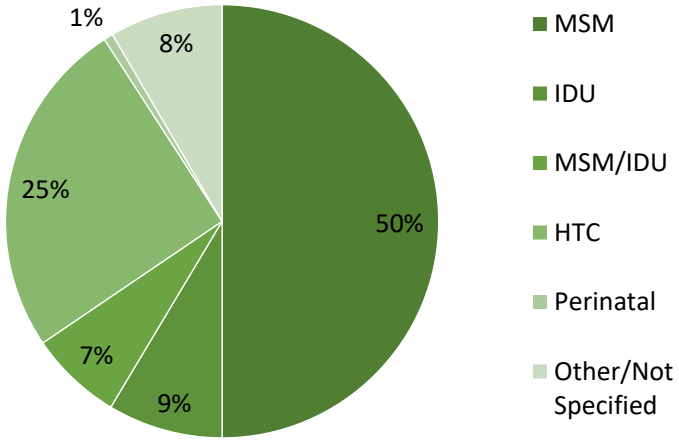
	Male* # (%)	Female* # (%)	Total # (%)
AN/AI	139 (25)	67 (38)	206 (28)
Asian	21 (4)	9 (5)	30 (4)
Black/African American	76 (14)	29 (17)	105 (14)
Hispanic/Latino (All Races)	53 (10)	22 (13)	75 (10)
Native Hawaiian/ Pacific Islander	3 (1)	1 (1)	4 (1)
White	235 (43)	41 (23)	276 (38)
Multiracial	23 (4)	6 (3)	29 (4)

*Assigned sex at birth

Male-to-male sexual contact was attributed to the majority (50%; n=361) of cases in persons aged 13 years and older living with HIV in Alaska as of December 31, 2020 (Figure 13). Heterosexual contact was attributed to 25% (n=183) of cases in persons aged 13 years and older living with HIV in Alaska as of December 31, 2020 (Figure 13). Male-to-male sexual contact and injection drug use was attributed to 7% (n=50) of cases in persons aged 13 years and older living with HIV in Alaska as of December 31, 2020 (Figure 13). Injection drug use was attributed

to 9% (n=62) of cases in persons aged 13 years and older living with HIV in Alaska as of December 31, 2020 (Figure 13).

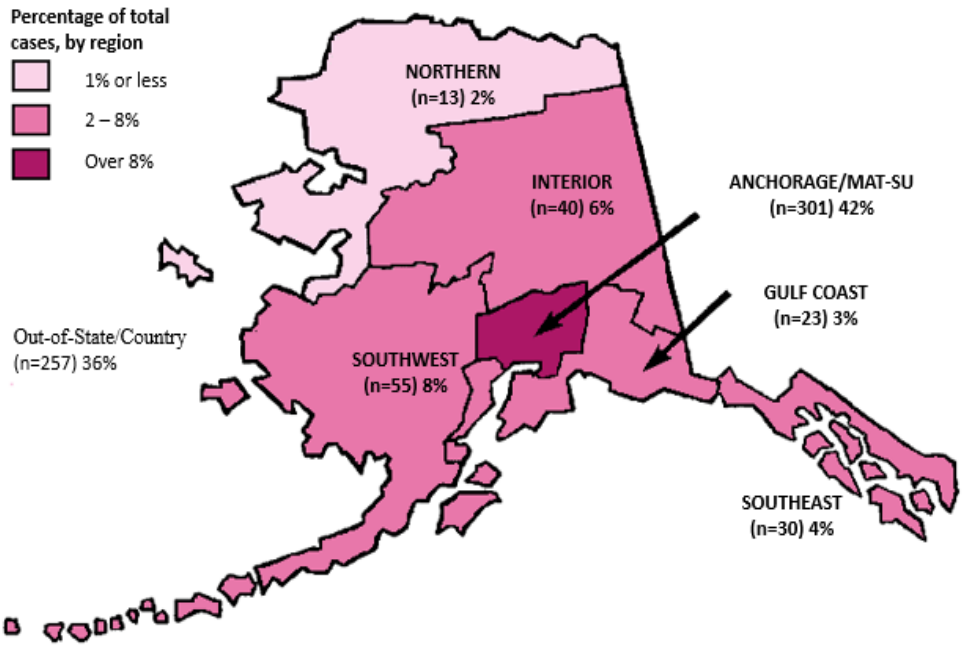
Figure 13. Persons Aged 13 Years and Older Living with HIV in Alaska by Transmission Category – As of December 31, 2020 (N=722)



The majority (42%; n=301) of persons living with HIV in Alaska as of December 31, 2020, reported residence in the Anchorage/Matanuska-Susitna (Mat-Su) region at diagnosis (Figure 14). Residence of diagnosis is verified through multiple methods; these methods include medical record review, diagnosing physician reports, and patient interviews conducted by DIS. Residence at diagnosis for persons with initial diagnosis in Alaska are only reported by economic region, as opposed to boroughs and census areas, to protect the confidentiality of persons with HIV in regions with low population (Figure14).

It is important to note that residence at diagnosis is not necessarily the region where HIV exposure occurred. Residence at diagnosis may also not reflect a person's current residence within Alaska. For example, 36% (n=257) persons living with HIV in Alaska as of December 31, 2020, have a residence at diagnosis outside of Alaska. These persons' current residence may be anywhere in Alaska. Moreover, persons with reported residence in one region of Alaska may have subsequently moved to another economic region.

Figure 14. Persons Living with HIV by Economic Region at Initial Diagnosis, Alaska — As of December 31, 2020 (N=719)



HIV Continuum of Care

Ensuring that persons living with HIV receive safe and comprehensive medical care is an effective intervention in preventing disease progression and reducing HIV transmission. The HIV Continuum of Care model outlines the sequential steps of HIV care engagement, from initial diagnosis through treatment. The primary stages of the Care Continuum are:

1. HIV diagnosed,
2. Linked to HIV Care,
3. Retained in HIV Care, and
4. Viral Suppression.

HIV surveillance data collected by the Alaska Section of Epidemiology (SOE) are used to monitor linkage and retention in care for persons living with HIV in Alaska. Of the 2,026 persons ever reported to SOE, only 719 were believed to be alive and still residing in Alaska as of December 31, 2020.

Of the 733 persons living with HIV in Alaska during 2020, 643 (88%) were known to be linked to HIV care and 582 (79%) were known to be virally suppressed as of December 31, 2020 (Figure 15).

HIV Care Continuum Indicator Definitions

HIV-Diagnosed: The total number of persons ever reported with HIV (with or without AIDS) to the Alaska Section of Epidemiology (SOE). This number includes persons living with HIV who were diagnosed in Alaska and who were previously diagnosed with HIV and subsequently relocated to Alaska.

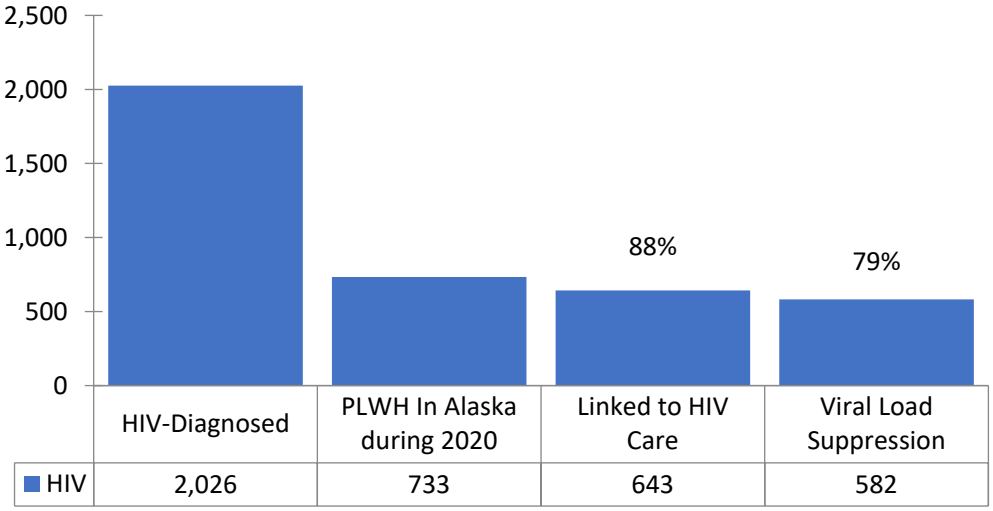
PLWH in Alaska: The total number of reported persons believed to be alive and living in Alaska during 2020 (as of December 31, 2020). This number includes persons living with HIV who were diagnosed in Alaska and who were previously diagnosed with HIV and subsequently relocated to Alaska.

Linked to HIV Care: The total number of persons diagnosed with HIV that had one or more documented CD4 or HIV viral load labs in the 12 months preceding this analysis, between January 1, 2020 and December 31, 2020. As SOE is unable to track medical visits for all persons living with HIV in the state, the receipt of CD4 or HIV viral load lab is used as a proxy to determine linkage with a medical provider.

Viral Load Suppression: The total number of persons whose most recent HIV viral load in the 12 months preceding this analysis, between January 1, 2020 and December 31, 2020, was considered undetectable; defined as an HIV viral load equal to or less than 200 copies/mL. As SOE is unable to track medical visits for all persons living with HIV in the state, viral load suppression is used as a proxy to determine care retention with a medical provider.

Due to COVID-19 restrictions, Alaska experienced significant closures and reductions in capacity across medical facilities, outpatient laboratories, mental health service providers, and substance use treatment facilities. Although many HIV care providers quickly transitioned to offering telemedicine appointments, disparities in access to cells phones, high-speed internet, and other technologies needed to utilize telemedicine systems meant that more vulnerable patients encountered significant barriers to accessing care and support services. Many HIV care providers utilizing telemedicine technologies also recommended that their stable patients delay receiving labs for monitoring HIV infection, including HIV viral load and CD4 labs, until COVID-19 case numbers were better controlled. This guidance/recommendation greatly increased the number of patients who appeared on the surveillance-generated not-in-care (NIC) list, even though these patients were actively engaging with their HIV medical provider. Moreover, it is anticipated that this guidance/recommendation also impacted the HIV Care Continuum (Figure 15) as both Linked to HIV Care and Viral Load Suppression indicators rely on documented and reported lab results. It is anticipated that the HIV Care Continuum (Figure 15) underrepresents the number of persons living with HIV in Alaska and linked to HIV care as well as viral suppression among persons living with HIV in Alaska.

Figure 15. HIV Care Continuum, Alaska – As of December 31, 2020* (N=733)



*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, prevention, and care-related services.

In Alaska, linkage and retention services are provided to persons living with HIV by health department staff, medical providers, patient navigators, and case management agencies. Persons newly diagnosed with HIV receive support through care initiation, including assistance in accessing long-term case management services. Persons known to be living with HIV who are not believed to be accessing medical care also receive support in re-engagement with medical care and supportive services.

Data to Care (D2C) surveillance activities were implemented quarterly in 2020 to identify persons known to be living with HIV who did not have a CD4 or HIV viral load lab reported to SOE in the 12-months preceding the quarterly analysis. Of the 287 PLWH reviewed for HIV care engagement status, 19 persons were identified to be living in Alaska and not in HIV medical care; PLWH who have previously repeatedly refused services were not included in these data. All 19 (100%) persons identified as not-in-care were offered re-engagement services and 17 (89%) accepted services.

Characteristics of persons known to be living with HIV in Alaska and not in HIV care are not available.

Section D: Sexually Transmitted Diseases – Alaska, 2016-2020

Section Highlights

- Since 2010, Alaska has had the highest reported chlamydia rate in the United States (U.S.). In 2020, Alaska had a chlamydia case rate of 696 cases per 100,000 persons, compared to the U.S. rate of 481 cases per 100,000 persons.*
    - In 2020, compared to previous years, there were notable decreases in reported chlamydia infections in Alaska and the U.S. In 2020, the number of reported cases of chlamydia decreased by approximately 13% in the United States.[1] These reductions are attributed to reduced screening as well as reduced surveillance and response activities across jurisdictions. [1]
- In 2020, Alaska had a gonorrhea case rate of 271 cases per 100,000 persons, compared to the national rate of 201 cases per 100,000 persons.*
- In 2020, Alaska had a syphilis case rate of 49 cases per 100,000 persons, compared to the national rate of 41 cases per 100,000 persons.*
    - Eight congenital syphilis cases were identified in Alaska in 2020.

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to STI testing, prevention, and care-related services.

[1]CDC. Impact of COVID-19 on STDs. Available at: https://www.cdc.gov/std/statistics/2020/impact.htm

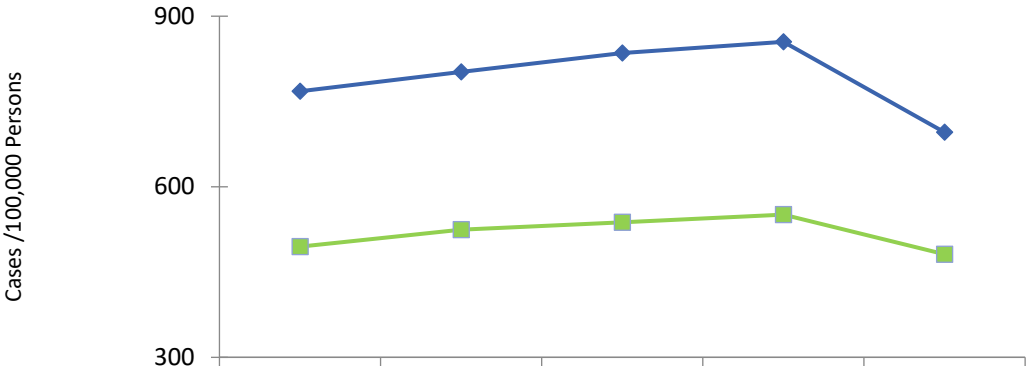
Chlamydia

In 2020, 5,087 cases of chlamydia were reported to Alaska, yielding a 2020 statewide incidence rate of approximately 697.9 cases per 100,000 persons.[5] Due to program priority, minimal disease investigation was conducted for chlamydia. No disease investigation was conducted for chlamydia cases among PLWH who were virally suppressed and in care. Therefore, co-infection investigations among PLWH were not created. Resultingly, the data quality for reported chlamydia cases among all PLWH is poor due to reporting limitations within the surveillance system.

Of the 30 newly diagnosed cases of HIV in Alaska in 2020, 6 (20%) cases were co-infected with chlamydia and 2 (6.7%) cases were co-infected with chlamydia and gonorrhea.[6]

Since 2010, Alaska has had the highest reported chlamydia rate in the United States. In 2020, Alaska had a chlamydia case rate of 696 cases per 100,000 persons, compared to the national rate of 481 cases per 100,000 persons (Figure 16).

Figure 16. Chlamydia Infection Rates, by Year — Alaska and the United States, 2016-2020[7]



	2016	2017	2018	2019	2020*
Alaska Rate	768	802.1	835.2	854.9	695.8
U.S. Rate	494.7	524.6	537.5	551	481.3

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to STI testing, prevention, and care-related services.

[5] Alaska SOE. 2020 Annual (January-December) Infectious Disease Report. Available at: https://health.alaska.gov/dph/Epi/hivstd/Pages/hivdata.aspx

[6] Alaska SOE. HIV Update – 2020. (Pending approval)

[7] CDC. Chlamydia — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at https://www.cdc.gov/std/statistics/2020/tables/3.htm

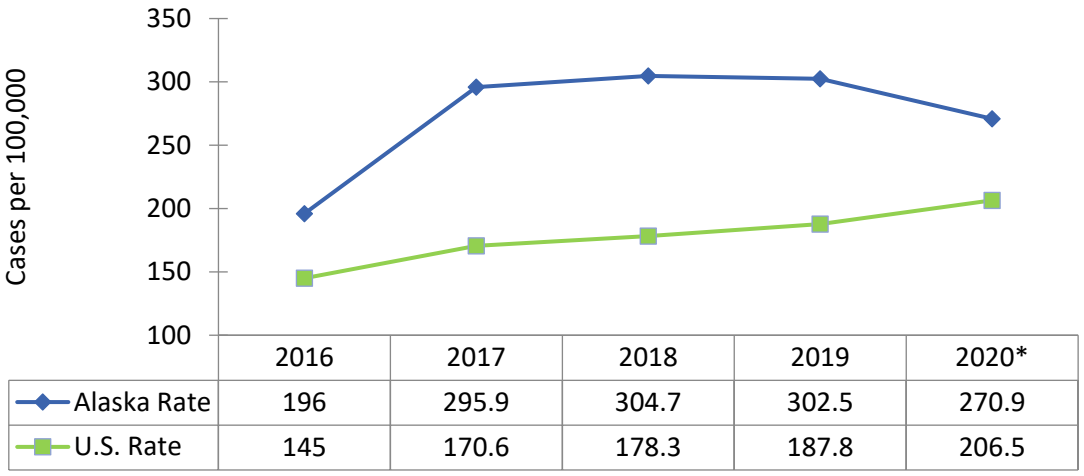
Gonorrhea

In 2020, 1,981 cases of gonorrhea were reported in Alaska, yielding a 2020 statewide incidence rate of approximately 271.8 cases per 100,000 persons.[5] Due to program priority, minimal disease investigation was conducted for gonorrhea. No disease investigation was conducted for gonorrhea cases among PLWH who were virally suppressed and in care. Therefore, co-infection investigations among PLWH were not created. Resultingly, the data quality for reported gonorrhea cases among all PLWH is poor due to reporting limitations within the surveillance system.

Of the 30 newly diagnosed cases of HIV in Alaska in 2020, 2 (6.7%) cases were co-infected with gonorrhea and 2 (6.7%) cases were co-infected with gonorrhea and chlamydia.[6]

In 2020, Alaska had a gonorrhea case rate of 271 cases per 100,000 persons, compared to the national rate of 201 cases per 100,000 persons (Figure 17).

Figure 17. Gonorrhea Infection Rates, by Year — Alaska and the United States, 2016-2020[8]



	2016	2017	2018	2019	2020*
Alaska Rate	196	295.9	304.7	302.5	270.9
U.S. Rate	145	170.6	178.3	187.8	206.5

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to STI testing, prevention, and care-related services.

[8] CDC. Gonorrhea — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at https://www.cdc.gov/std/statistics/2020/tables/8.htm

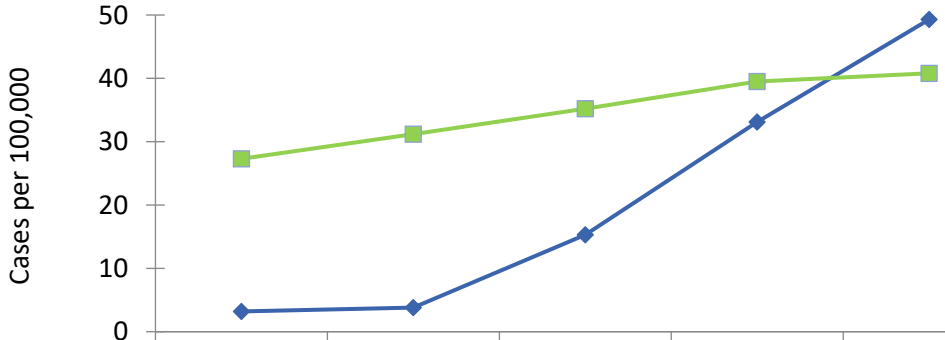
Syphilis

In 2020, 361 cases of syphilis (all stages) were reported to SOE, representing a 49% increase over 2019 (n=242).[9] The 2020 SOE syphilis data was published with incorrect co-infection data and has yet to be formally corrected. The current SOE report states that of the 361 syphilis cases, 4 (1%) cases were co-infected with HIV, and 17 (5%) were co-infected with HIV and chlamydia or gonorrhea.[10]

The following (corrected) data is pending approval. Of the 361 cases of syphilis (all stages) reported to SOE in 2020, 18 (5%) cases were among persons living with HIV (PLWH).[6] Of the 18 syphilis cases with HIV co-infection, 6 (33.3%) syphilis cases were in persons newly diagnosed with HIV. Of the 6 syphilis cases with concurrent newly diagnosed HIV infection, 1 (16.7%) case was also co-infected with chlamydia and 1 (16.7%) case was also co-infected with chlamydia and gonorrhea.[6]

In 2020, Alaska had a syphilis case rate of 49 cases per 100,000 persons, compared to the national rate of 41 cases per 100,000 persons (Figure 18).

Figure 18. Syphilis Infection Rates, by Year — Alaska and the United States, 2016-2020[11]



	2016	2017	2018	2019	2020*
Alaska Rate	3.2	3.8	15.3	33.1	49.3
U.S. Rate	27.3	31.2	35.2	39.5	40.8

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to STI testing, prevention, and care-related services.

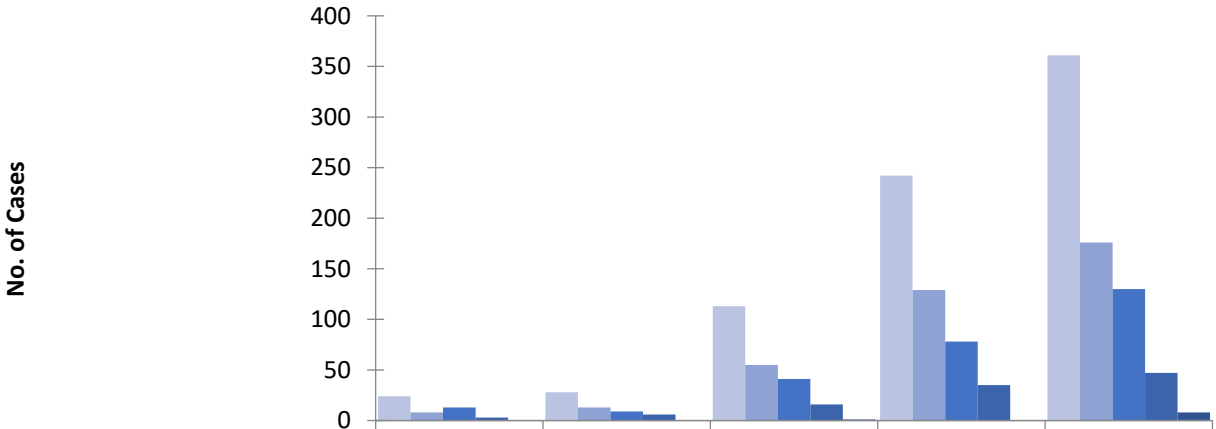
[9] Alaska SOE. 2019 Annual (January-December) Infectious Disease Report. Available at: http://www.epi.alaska.gov/bulletins/docs/b2021_09.pdf

[10] Alaska SOE. Syphilis Outbreak Update – 2020. Available at: https://health.alaska.gov/dph/Epi/hivstd/Pages/hivdata.aspx

[11] CDC. Total Syphilis — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/12.htm

In 2020, Alaska observed case increases across all stages of syphilis infection (Figure 19). Most notably, 8 congenital syphilis cases were identified in Alaska in 2020 (Figure 19).

Figure 19. Cases of Syphilis Infection by Stage and Year – Alaska, 2016-2020[12,13,14,15,16]



	2016	2017	2018	2019	2020*
Total Cases	24	28	113	242	361
Primary and Secondary	8	13	55	129	176
Early Non-Primary/Non-Secondary	13	9	41	78	130
Late and Unknown Duration	3	6	16	35	47
Congenital	0	0	1	0	8

*COVID-19 Pandemic – Data should be interpreted with caution due to the impact of the COVID-19 pandemic on access to STI testing, prevention, and care-related services.

[12] CDC. Total Syphilis — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/12.htm
[13] CDC. Primary and Secondary Syphilis — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/14.htm
[14] CDC. Early Non-Primary Non-Secondary Syphilis — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States and Territories, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/18.htm
[15] CDC. Unknown Duration or Late Syphilis* — Reported Cases and Rates of Reported Cases by State/Territory and Region in Alphabetical Order, United States, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/19.htm
[16] CDC. Congenital Syphilis — Reported Cases and Rates of Reported Cases by Year of Birth, by State/Territory* and Region in Alphabetical Order, United States, 2016-2020. Available at: https://www.cdc.gov/std/statistics/2020/tables/21.htm

Additional Information

Persons interested in learning more about sexually transmitted infections and hepatitis C virus in Alaska, including disease surveillance data by region and demographic breakdown, may visit the Alaska SOE Epidemiology Bulletin Index at: https://health.alaska.gov/dph/Epi/Pages/bulletins/default.aspx. Bulletins are listed by disease category or by date of publication.

Persons interested in learning more about the impact of COVID-19 on HIV can find additional information at: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/index.html.

Persons interested in learning more about the impact of COVID-19 on STDs can find additional information at: https://www.cdc.gov/std/statistics/2020/impact.htm.

HIV Prevention, Care, and Treatment Resource Inventory

The following inventory describes the financial and human resources which directly impact HIV prevention and care services in Alaska. These include Federal and State-funded programs that address HIV prevention, care, and treatment services, including funding that may impact steps along the HIV Care Continuum, such as substance use prevention and treatment. Funded agencies closely collaborate to ensure smooth delivery of services and coordination of services between funding sources. Because of the limited pool of agencies that offer HIV prevention and care services in Alaska, it is relatively easy for agencies to communicate and ensure comprehensive continuity of services to clients.

Approaches and Partnerships

The HIV prevention and care inventory was compiled by Alaska's HIV/STD Program staff. Agencies listed in previous inventories were asked to update their program descriptions and provide additional information on new services. The inventory was completed with ease due the limited number of service providers and collaboration between HIV/STD Program staff and partner agencies, which are routinely kept up to date through advisory meetings, when a new organization comes into play, or a pre-existing agency receives funding for a new program. Newly identified staff, organizations, and programs were invited and encouraged to participate in not only the inventory but in quarterly advisory groups to stay up to date on state-wide programs and services.

As discussed throughout this plan, the HIV/STD Program has strong partnerships and collaboration with key stakeholders. Alaska agencies have made significant progress in improving the outcomes along the HIV Care Continuum in recent years and are committed to improving outcomes for all.

Inventory List

State of Alaska Division of Public Health – Section of Epidemiology, HIV/STD Program

Program Name: STD Prevention

Funding Source: Centers for Disease Control and Prevention (CDC)

Funding Amount (most recent years): $1.36 million from CDC Prevention and Control for Health Departments and DIS Workforce Supplement

Program Description: The Alaska HIV/STD Program receives CDC funds to conduct STD control activities. Program functions include STD surveillance and data management, disease investigation, outbreak response activities, partner services, health education and risk reduction, program evaluation, and training and professional development. Additionally, funds are awarded to the Municipality of Anchorage Reproductive Health Clinic to support STD clinical prevention services for uninsured and underinsured persons.

Priority Populations: Women of Reproductive Age, Homeless/Unstably Housed, Substance Use/Misuse

Support Services Available: HIV Prevention and Diagnosis, Linked to Care, Harm Reduction

Program Name: PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments

Funding Source: CDC

Most Recent Year's Funding Amount: $299,819.00

Program Description: Alaska's HIV Prevention funds are allocated to the core program components required by the CDC: HIV testing, diagnoses, linkage to care, and risk-reduction interventions. Four agencies (Alaskan AIDS Assistance Association, Alaska Native Tribal Health Consortium, Interior AIDS Association, and the Municipality of Anchorage) receive sub-awards totally $264,000 (2018) to implement testing, condom distribution, or prevention with positives activities in their service area. Additional information on sub-recipient organizations, including grant amounts and offered services, are included by the organization below. Alaska uses the remaining funding to support HIV/STD partner services, provide sub-award grant oversight, and offer statewide technical assistance and education associated with HIV prevention and testing.

Populations Served: Direct patient services not provided.

Support Services Available: HIV Prevention and Diagnosis

Program Name: HIV Care Ryan White Part B State/Territories Formula and AIDS Drug Assistance Program (ADAP) Formula Grant

Funding Source: Health Resources and Services Administration (HSRA)

Most Recent Year's Funding Amount: $1,058,133.00

Program Description: Alaska's Part B funds are allocated to two sub-recipients (Alaskan AIDS Assistance Association and Interior AIDS Association) for statewide HIV care services and one pharmacy contract (Bernie's Pharmacy). Most of these funds are used to provide case management to maximize resources and the number of PLWH who enter and stay in care. Funds are prioritized based on need and are also used to purchase outpatient medical care, oral health care, mental health services, substance use services, food bank, housing support, and transportation to medical care. Funds are also used to support the statewide ADAP program.

Populations Served: Direct patient services not provided.

Support Services Available: HIV Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Care Ryan White Part B Supplemental Grant

Funding Source: Health Resources and Services Administration (HSRA)

Most Recent Year's Funding Amount: $123,768.00

Program Description: Funds support the Linkage to Care (L2C) program within the state HIV/STD program, which connects HIV positive clients to medical care. The program provides short-term intensive support to engage newly diagnosed or out of care persons in medical care and treatment. L2C helps identify a health care provider, connects with social service organizations that can provide long-term case management, and provides assistance identifying financial resources to help pay for HIV-related medical care.

Populations Served: PLWH, high-risk persons

Support Services Available: HIV Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

State of Alaska Division of Public Health – Section of Epidemiology, Infectious Disease Program

Program Name: Hepatitis Prevention Program

Funding Source: CDC Grant PS21-2103 Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments

Funding Amount (most recent years): FY22 $315,000 This amount includes personnel costs, contract with Inductive Health for Hepatitis surveillance projects, a small amount for training/travel and supplies.

Program Description: The Alaska Hepatitis Prevention Program coordinates the state's public health activities related to viral hepatitis. The Section of Epidemiology (SOE) is responsible for hepatitis surveillance, vaccination programs, infectious disease outbreak response, prevention, and integration activities. In addition, local public health centers throughout the state

have responsibilities for assessment, vaccination, education, and response in their communities.

Priority Populations: Persons born between 1945-1965, people of any age who use or have used injection drugs, people experiencing homelessness or housing insecurity, people born in countries with high prevalence of HBV, household and sexual contacts of HBV infected people, pregnant women and infants born to hepatitis infected mothers.

Support Services Available: Linkage to Care

State of Alaska Division of Public Health – Section of Public Health Nursing

Program Name: Public Health Nursing Centers

Funding Source: State of Alaska

Program Description: State public health nursing provides services at 19 public health centers (PHCs) across the state, and itinerant services to more than 250 communities. In addition, the Section of Public Health Nursing provides state grant assistance for public health nursing services in the Municipality of Anchorage, Northwest Arctic/Maniilaq (Kotzebue), and the North Slope Borough (Barrow). PHCs are located in Anchorage (contract with the Municipality of Anchorage, Department of Health and Human Services), Bethel, Craig, Delta Junction, Dillingham, Fairbanks, Homer, Juneau, Kenai, Ketchikan, Kodiak, Kotzebue (contract with Maniilaq), Wasilla, Barrow (contract with North Slope Borough), Nome, Petersburg, Sitka, Tok, and Valdez. Public health nurses provide HIV counseling and testing, STD diagnosis and treatment, and HIV/STD partner services. Other services include immunizations, family planning, pregnancy testing, prenatal monitoring, postpartum home visits, senior clinics, chronic disease services, well-child exams, Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), outreach, screening, and referral, clinics for special needs children, Women, Infants, and Children (WIC) and Infant Learning Program (ILP) referrals, school screenings, audiograms, tuberculosis screening, epidemiological investigations, parenting education, health education, community assessment, and participation in community partnerships in response to public health concerns. Fees are assessed for all clinic visits utilizing a sliding fee scale. However, no one is denied service due to an inability to pay.

Populations Served: Low-income, uninsured/underinsured, rural, adolescent, adult, high-risk.

Support Services Available: HIV Prevention and Diagnosis, Linked to Care, Retained in Care

State of Alaska Division of Public Health – Section of Women's, Children's, and Family Health

Program Name: Adolescent and Young Adult Health Services

Funding Source: Maternal and Child Health Services Block Grant

Most Recent Year's Funding Amount: $6,000

Program Description: A professional services contract with the City and Borough of Juneau is administered to provide reproductive and related preventive health services to students attending high schools in the Juneau-Douglas School District. Services are provided at the 4 high school-based health centers by advance practice registered nurses (APRNs) and include: comprehensive clinical family planning and reproductive health services, initial and annual medical and social history, preventive health examinations, health risk assessment, risk

reduction counseling, lab testing as indicated, diagnosis and treatment of minor primary care needs including minor gynecological abnormalities, referral and follow-up, STI testing and treatment or referral, and screening and referral to a primary care medical home.

Populations Served: All students attending Juneau Douglas School District High Schools (including the alternative high school).

Support Services Available: HIV Prevention and Diagnosis

Program Name: Comprehensive Family Planning and Related Preventive Health Services

Funding Source: Title X Family Planning Services Grant

Most Recent Year's Funding Amount: $100,000

Program Description: One clinical service site under this grant provides low-cost, confidential services that include (but are not limited to): annual well visits, clinical breast examinations, Pap smear screening, screening, testing, and treatment for sexually transmitted infections, and counseling and provision of, or referral for permanent contraception services (sterilization). The clinical service site also provides access to the full range of current, FDA-approved contraceptive methods and supplies to their family planning clients. In addition to clinical services, the site provides counseling and education on reproductive and preventive health topics, including abstinence education, sexually transmitted infections/Human Immunodeficiency Virus (STI/HIV). Funds from Title X Family Planning Grant are being used by grant recipients to support HIV prevention services such as PrEP and nPEP services.

Populations Served: Low-income, uninsured/underinsured, individuals at high-risk.

Support Services Available: HIV Prevention and Diagnosis

Program Name: Teen and Unintended Pregnancy Prevention Program

Funding Source: Division of Public Assistance- Alaska Temporary Assistance Program

Most Recent Year's Funding Amount: $170,000

Program Description: This program provides comprehensive sexual health and relationship education to youth ages 10-25 in Anchorage and Homer using curricula that meets the 2021 Future of Sex Education Standards aiming to promote sexual wellness and reduce interpersonal violence, teen pregnancy, STDs, and HIV.

Populations Served: Youth ages 10-25

Support Services Available: HIV/STD, Education, Prevention and Diagnosis through the Reproductive Health Clinic and Kachemak Bay Family Planning Services.

Program Name: Personal Responsibility Education Program

Funding Source: Family Youth Services Bureau

Most Recent Year's Funding Amount: $250,000

Program Description: The State Personal Responsibility Education Program (PREP) grant is awarded by the Family Youth Services Bureau to educate young people on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV. The program targets youth ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates or come from racial or ethnic minority groups. The Alaska PREP project supports the training, distribution, and technical assistance of the Fourth R Health curriculum and the Healthy Relationships Plus Program curriculum to schools and community agencies across the state of Alaska.

Populations Served: 10-19 years

Support Services Available: HIV/STD Prevention Education

State of Alaska Division of Behavioral Health

Program Name: Comprehensive Behavioral Health Treatment Program

Funding Source: Alaska Division of Behavioral Health

Most Recent Years Funding Amount: n/a

Program Description: This program awards community grants to support integrated treatment across the spectrum of behavioral health services. Funded programs are statewide and serve all ages. Priority target populations eligible for grant-funded mental health treatment include clients needing psychiatric emergency services, adults with serious mental illness, youth with serious emotional disturbance, and clients with co-occurring substance use disorders. Priority target populations eligible for grant-funded substance use disorder treatment include pregnant injection drug users, pregnant females, injection drug users, females with dependent children, persons, and families whose presenting problem is the addiction to, dependency on, or chronic disabling use/abuse of alcohol and other drugs, and clients with co-occurring mental health disorders. Funded substance use disorder treatment programs are required to have staff trained in, and all clients provided with, hepatitis, TB, HIV, and Fetal Alcohol Spectrum Disorder risk assessment, education, early intervention, and risk reduction counseling. The program also funds two opioid treatment programs providing medication-assisted treatment (Methadone maintenance): the Narcotic Drug Treatment Center in Anchorage and Project Special Delivery in Fairbanks,

Priority Populations: High-risk, uninsured/underinsured, Substance Using

Support Services Available: HIV Prevention and Diagnosis, Substance Use Referral and Treatment

State of Alaska Office of Substance Misuse and Addition Prevention (OSMAP)

Program Name: Varies

Funding Source[s]: SAMHSA, HRSA, ACF, ONDCP, DOJ, US Dept. of Labor, BJA

Most Recent Year's Funding Amount: Unknown

Program Description: The Alaska Office of Substance Misuse and Addiction Prevention, established in July 2017, uses a public health approach to prevent and reduce substance use disorders, prevent harms caused by substance use, and support community-based activities across Alaska. Services protect the life, health, and safety of Alaskans, and focus largely on strengthening the essential public health infrastructure, services, systems, and partnerships across the state. Current activities are focused on opioid and marijuana misuse and addiction prevention, data, and evaluation, including program and systems changes to mitigate harms.

Priority Populations: All populations

Support Services Available: Substance Use Referral and Treatment, Harm Reduction

Alaska Native Tribal Health Consortium – HIV/STD Prevention Program

Program Name: iKnowMine (www.iKnowMine.org)

Funding Source: Variety of funding sources contribute to providing education, materials, and resources on the iKnowMine platform.

Most Recent Year's Funding Amount: Variety of funding sources contribute to providing education, materials, and resources on the iKnowMine platform.

Program Description: *iKnowMine* is a youth wellness website that promotes healthy relationships and lifestyles to Alaska Native youth. The website contains information on topics ranging from sexual health to mental, physical, and emotional health as well as information about substance misuse prevention. Visitors to the website also have the opportunity to ask questions and engage with peers and *iKnowMine* staff through a variety of social media outlets. Through its website, the *iKnowMine* program provides condoms, STD testing kits, and other harm reduction supplies, including Opioid Overdose Response Kits, fentanyl testing strips, safe medicine disposal bags and substance misuse prevention resources, free of charge to all Alaska residents.

Priority Populations: Youth, Rural.

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction

Program Name: Healthy Native Youth Project Red Talon (HNY PRT)

Funding Source: Indian Health Services

Most Recent Year's Funding Amount: $100,000

Program Description: The HNY PRT's project aim is to work collaboratively to advance the EHE agenda for AI/AN communities. The partners will provide outreach, education, and technical assistance in their regions to disseminate best practices for long-standing and critically emerging issues for improved HIV prevention for increased risk AI/AN (including MSM, young adults, IDUs, and transgender individuals), leveraging the Healthy Native Youth, We R Native, and iKnowMine resources.

Priority Populations: Youth, Rural

Support Services Available: HIV Prevention and Diagnosis

Program Name: Administration for Children and Families, Tribal Personal Responsibility Education Program (PREP)

Funding Source: Administration for Children and Families, Family and Youth Services Bureau

Most Recent Year's Funding Amount: $468,198

Program Description: The Tribal PREP Program's aim is to implement a culturally relevant, comprehensive, and medically accurate sexual health and wellness education program for youth. Priority populations are youth aged 10-19 years old, and pregnant and/or parenting youth up to 21 years old. The program is implemented in two phases. Phase one (Year 1) consists of a needs assessment to gather qualitative information to assist in identifying current sexual health education activities occurring in the following five regions of Alaska: Yukon-Kuskokwim, Norton Sound, Northwest Arctic, Arctic Slope, and Bristol Bay. Phase two (Years 2-5) involves the implementation and evaluation of a comprehensive and culturally relevant sexual health and wellness education program at up to three program implementation sites.

Priority Populations: Youth, Rural

Support Services Available: HIV Prevention and Diagnosis

Program Name: Indian Health Service Epidemiology Program for American Indian/Alaska Native Tribes and Urban Indian Communities (IHSEPI)

Funding Source: Indian Health Services

Most Recent Year's Funding Amount: $100,000

Program Description: The ANTHC IHSEPI program's aim is to increase coordination and collaboration opportunities for HIV prevention. Year one will consist of activities such as participating in local, regional, and national committees, conferences and workgroups that address public health priorities in HIV/STD primary and

secondary prevention activities. Years two through five of the project will focus on supporting regional capacity for planning, implementation, technical assistance, and evaluation activities for HIV prevention programming needs.

Priority Populations: Youth, rural

Support Services Available: HIV Prevention and Diagnosis

Program Name: 2021-2022 Harm Reduction Safer Injection Kit project

Funding Source: Healthy Alaskan Natives Foundation (HANF)

Most Recent Year's Funding Amount: $30,286.18

Program Description: The Harm Reduction Safer Injection Kit one-year project allows people who inject substances (PWIS) to order safer injection supplies through the iKnowMine.org website, free of charge with shipping included. These kits are made available to Alaskan-based mailing addresses only and intended to lower the risk of HIV and HCV by providing safer injection supplies. These kits are intended for people who inject substances, as well as Tribal organizations and non-profits in Alaska that provide services to people who inject substances.

Priority Populations: PLWH, Youth, Rural.

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction

Program Name: Alaska Stigma Index Project

Funding Source: Indian Health Service

Funding Amount (most recent years): $162,845

Program Description:

The project aims are to: 1. Understand how stigma and discrimination are experienced by ANPLWH in Alaska by administering the standardized survey/questionnaire known as the Global People Living with HIV (GNP+) Stigma Index. The collected data will also provide insights into HIV testing, access to HIV medical care, behavioral health services and engagement in care. 2. Ascertain provider perceptions of ANPLWH and misconception and gaps in understanding by surveying health facility staff and providers, and 3. Develop recommendations based on the Stigma Index findings to improve the diagnosis, linkage to- and engagement in care as well as access to- and utilization of support services. These recommendations will be disseminated to key stakeholders in the Alaska Tribal Health System (ATHS).

Priority Populations: Alaska Native People Living with HIV (ANPLWH)

Support Services Available: HIV Prevention and Diagnosis, Linked to Care, Retained in Care

<u>Alaska Native Tribal Health Consortium - Early Intervention Services HIV Clinical Services</u>

Program Name: I Want the Kit

Funding Source: Various

Most Recent Year's Funding Amount: $25,000

Program Description: *I Want the Kit* allows Alaskans ages 14 and older to order self-collected STD (gonorrhea, Chlamydia, and trichomonas) specimen kits free of charge through a partnership with Johns Hopkins University. Persons who submit specimens are contacted regarding their test results. Those who test positive are linked to care. The *I Want the Kit* program is particularly targeted towards rural areas of the state where access to services may be limited.

Priority Populations: Youth, Rural.

Support Services Available: HIV Prevention and Diagnosis

Program Name: HIV Care Ryan White Part C

Funding Source: HRSA

Most Recent Year's Funding Amount: n/a

Program Description: ANTHC receives Part C funds to provide outpatient early intervention services for PLWHA statewide, working with and through Statewide Native Health Corporations. ANTHC serves Alaska Natives and all Alaskans outside Anchorage. The Part C Early Intervention Services (EIS) clinical team works on the campus of the Alaska Native Medical Center; program hub sites are in Anchorage, Sitka, Juneau, Bethel, and Fairbanks. In addition, the ANTHC clinical team provides medical consultation across the state. Part C EIS regional (or Hub) site coordinators provide medical and non-medical case management and coordination of primary care services to clients living in rural areas. ANTHC providers are particularly vital for clients in the Interior region of the state (Fairbanks area), as they are the source of direct care for many clients in that area. Part C also coordinates the consumer advisory group that focuses on all Part C activities for quality improvement and program development. These activities have led to support services to assist with travel costs and core services that can provide oral and medication prescription services.

Priority Populations: PWLH, rural.

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Care Ryan White Part B- Patient Navigator

Funding Source: Program Income

Most Recent Year's Funding Amount: Up to $116,988

ANTHC receives Ryan White Part B program income funding to employ a patient navigator. The role of the patient navigator is to provide intensive medical case management to individuals at high risk of falling out of medical care to help them problem solve barriers to care, assist with referrals, and arrange medical transportation.

Priority Populations: PLWH, rural

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Care Ryan White Part F

Funding Source: HRSA

Most Recent Year's Funding Amount: n/a

The Alaska AETC markets and recruits Alaskan providers for the University of Washington's MWAETC's HIV preceptorships, education, clinical consultations, clinical support tools, speakers, and technical assistance. ANTHC also receives Part F funds for a specialized Minority AIDS Initiative component focusing on capacity development for HIV response in targeted Alaska Native communities. As of 2016, ANTHC is funded to work with a site for a potential Practice Transformation Project, also funded under Part F.

Priority Populations: PLWH, minorities.

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Prevention and Education

Funding Source: CDC PS18-1802 HIV Prevention Funds, through Alaska HIV/STD Program

Most Recent Year's Funding Amount: n/a

Program Description: ANTHC receives CDC HIV Prevention grant funds through a sub-grant from the State of Alaska HIV/STD Program to implement prevention with positives programming among clients who receive HIV care through their Early Intervention Services program. Activities include additional case management for engagement and retention in HIV care, medication adherence systems, and prevention counseling and HIV testing for sexual and injection partners.

Alaska Native Tribal Health Consortium – Liver Disease and Hepatitis Program

Funding Source: Various

Funding Amount (most recent years): n/a

Program Description: The ANTHC Liver Disease and Hepatitis Program (LDHP) provides hepatitis C treatment and Hepatitis B management care to AN/AI persons throughout the state of Alaska and to non-AN/AI persons living in rural areas who receive their healthcare through the regional tribal health organization (THO). The LDHP collaborate with local health teams to increase the prevention, screening, diagnosing, and management/treatment rates and of this population.

Priority Populations: AN/AI, rural communities, PWID.

Support Services Available: HIV prevention and Diagnosis, Linked to Care, Harm Reduction

Alaska Native Tribal Health Consortium – Substance Misuse Prevention

Funding Source: Consortium funds/ federal and non-profit organizations-grant funds (e.g., SAMHSA, IHS and Office of Violence Against Women)

Most Recent Year's Funding Amount: n/a

Program Description: The Substance Misuse Prevention Program works in collaboration with Tribes and Tribal Health organizations to prevent substance misuse and dependence in communities we serve and encourage enhancement of healthy, supportive community environments. Program strategies include supporting evidence-based practices, encouraging assessment and evaluation, and funding support of local level efforts to promote substance misuse prevention and resiliency. Some specific efforts that the Substance Misuse Prevention Program supports, includes harm reduction programs and practices, safe storage and disposal of prescription medications, overdose prevention and education, destigmatizing recovery, and other public health interventions.

Priority Populations: Alaska Native/ American Indian people, rural Alaskan communities, PWID

Support Services Available: Harm Reduction, Substance Use Referral and Treatment, Recovery Services, Technical Assistance for Rural Communities and Tribal Health Organizations

Alaska AIDS Assistance Association (Four As)

Program Name: HIV Ryan White Part B

Funding Source: HSRA RW HIV Care funds, through the Alaska HIV/STD Program

Most Recent Year's Funding Amount: $1,263,485

Program Description: Four A's, according to local needs and resources, defines priorities for use of Part B funds under the direction of the State HIV Care grants guidance. The bulk of funds are directed towards medical case management (MCM) and the AIDS Drug Assistance Program (ADAP). These services are available statewide and assists clients with access to medical and social services, HIV-related medications, and health insurance. Any funds remaining are used to purchase core medical services, followed by support services for persons with HIV infection and support services for affected family members.

Priority Populations: PLWH, uninsured/underinsured, low-income

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed.

Program Name: Four A's Syringe Access Program – Anchorage, Matanuska-Susitna Valley, and Juneau

Funding Source: MSHF, Juneau Community Foundation, various funding streams

Most Recent Year's Funding Amount: $180,567

Program Description: Four A's Syringe Access Program (FASAP) provides persons who inject drugs (PWID) with access to new and sterile syringes, safe injection equipment, and a place to safely dispose of used syringes. Along with syringes, clients are offered cookers and cottons, a sharps container, tourniquets, and alcohol swabs. Services are provided on a drop-in basis and all clients are offered safe injection education, NARCAN and overdose education, Fentanyl test strips, free rapid HIV and Hepatitis C (HCV) testing, condoms, and referrals to treatment facilities or services as appropriate.

Priority Populations: High-risk, PWID

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction, Linked to Care

Program Name: Four A's Office – Juneau

Funding Source: Pride Foundation, Juneau Community Foundation

Most Recent Year's Funding Amount: $45,000

Program Description: Four A's Juneau Office offers HIV education and outreach services with a focus on the LGBTQ+ community. Services include rapid HIV testing to walk-in clients and persons who inject drugs, HIV 101 risk reduction presentations at Lemon Creek Correction Center, Gastineau Human Services, and Rainforest Recovery Center, and condom distribution to community bars.

Priority Populations: Low-income, High-risk, PLWH, PWID, High-risk, Unhoused, Uninsured/Underinsured

Support Services Available: HIV Prevention and Diagnosis, Linked to Care, Harm Reduction

Program Name: Housing Opportunities for People with AIDS (HOPWA) – Southeast

Funding Source: U.S. Department of Housing and Urban Development

Most Recent Year's Funding Amount: $153,109

Program Description: The focus of funds is to assist persons living with HIV (PLWH) to maintain stable housing through tenant-based rental assistance, housing placement assistance, short-term rent, utility, and mortgage assistance. Funds can also support HIV case management and supportive services including nutrition, transportation, and substance abuse treatment.

Priority Populations: Low-income, High-risk, PLWH, PWID, High-risk, Unhoused, Uninsured/Underinsured

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Prevention and Education

Funding Source: CDC PS18-1802 HIV Prevention Funds, through the Alaska HIV/STD Program

Most Recent Year's Funding Amount: $95,000

Program Description: Funds support rapid HIV and HCV testing in non-clinical settings and the statewide distribution of condoms.

Priority Populations: High-risk, low-income, uninsured/underinsured, PWID.

Support Services Available: HIV Prevention and Diagnosis

Anchorage Neighborhood Health Center

Program Name: ANHC Ryan White Program

Funding Source: Ryan White Part C: Early Intervention Services for PLWH

Most Recent Year's Funding Amount: $319,913 (5/1/22-4/30/25)

Program Description: ANHC provides HIV testing, risk counseling, PrEP (Pre-Exposure Prophylaxis)/PEP (Post-Exposure Prophylaxis) Services, and ongoing care for persons living with HIV. The Ryan White HIV/AIDS Program provides funding to support a comprehensive system of care for people living with HIV. ANHC receives funding under the Ryan White Part C program to provide primary care services to people living with HIV who are uninsured or underinsured. Currently, seven providers at our Health Center specialize in HIV primary care. Care coordinators, patient navigators, and nursing staff connect HIV clients with a wide range of additional services (patient advocacy, medical transportation, linguistic services) to assist in removing barriers to their healthcare journey. Core services provided include outpatient medical care (including lab, radiology, and pharmacy), medical case management, behavioral health services, and dental care.

Priority Populations: High-risk, PLWH, Low-income, Uninsured/Underinsured.

Support Services Available: HIV Prevention and Diagnosis, Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Program Name: HIV Care Ryan White Part B- Patient Navigator

Funding Source: Program Income

Most Recent Year's Funding Amount: Up to $147,222

ANHC receives Ryan White Part B program income funding to employ patient navigators. The role of the patient navigators is to provide intensive medical case management to individuals at high risk of falling out of medical care to help them problem solve barriers to care, assist with referrals, and arrange medical transportation.

Priority Populations: PLWH, rural

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Bernie's Pharmacy

Program Name: HIV Care Ryan White ADAP

Funding Source: HRSA RW HIV Care funds, through the Alaska HIV/STD Program

Funding Amount (most recent years): $88,000

Program Description: Bernie's Pharmacy is a community retail pharmacy contracted by the Alaska ADAP program to order, dispense, and ship (when necessary) prescribed medications for PLWH who are enrolled in ADAP. Bernie's Pharmacy also answers questions for clients about medications, coordinates with the Alaska AIDS Assistance Association's and Interior AIDS Association's ADAP case managers, advises prescribing providers, and provides monthly client data.

Priority Populations: PLWH, low income, uninsured/underinsured

Support Services Available: Retained in Care, Prescribed Antiretroviral Therapy, Virally Suppressed

Interior AIDS Association

Program Name: HIV Care Ryan White Part B

Funding Source: HRSA RW HIV Care Funds, through Alaska HIV/STD Program

Most Recent Year's Funding Amount: $95,000

Program Description: Program priorities and use of Part B funds are used under the direction of the State HIV Care grants guidance. The bulk of funds is directed towards medical case management (MCM). MCM services are directly provided by staff in grantee agencies. These services are available statewide and help clients get access to medical and social services, HIV-related medications, and health insurance. Any funds remaining are used to purchase core medical services, followed by support services for persons with HIV infection and support services for affected family members.

Priority Populations: PLWH, Uninsured/Underinsured, Low-income

Support Services Available: Linked to Care, Retained in Care, Prescribed Antiretroviral Therapy, Viral Suppression

Program Name: Northern Exchange

Funding Source: Program Income from IMAT and donations support Syringe Services.

Most Recent Year's Funding Amount: $10,000

Program Description: Northern Exchange (NE) has been offering syringe exchange services in Fairbanks since 1989. Multiple secondary exchangers distribute syringes and supplies both in town and in more remote areas. Syringes are accepted for disposal and picked up on-site by a medical waste company. NE supports secondary exchanges, where clients pick up safer injection supplies for others who can't or won't come into the exchange. Outreach workers provide a range of support during each contact, including risk assessment and safer-injection education. NE offers syringes based on need, appropriate disposal containers, safety kits that include a syringe, water, antibiotic cream, alcohol wipes, cottons, cooker, and a condom, and referrals as needed. Rapid HIV testing is offered by IAA to exchangers. In addition, HCV rapid testing is available. With the availability of the rapid HCV test, which is popular with exchangers, IAA has seen an increase in HIV testing of injection drug users who agree to do the tests simultaneously.

Priority Populations: PWID, High-risk, Low-income, Unhoused.

Support Services Available: Harm Reduction

Program Name: Housing Opportunities for People With AIDS (HOPWA)

Funding Source: HUD with AHFC (State) matching funds

Most Recent Year's Funding Amount: $225,000

Program Description: HOPWA funds provide for HIV Case Management and supportive services, including nutrition, transportation, and substance abuse treatment. The focus of funds is to assist PLWH to maintain stable housing through tenant-based rental assistance, housing placement assistance, short-term rental, utility, and mortgage assistance.

Priority Populations: PLWH, Low-income, Unhoused

Support Services Available: Linked to Care, Retained in Care

Program Name: HIV Prevention and Education

Funding Source: CDC PS18-1802 HIV Prevention Funds, through Alaska HIV/STD Program

Most Recent Year's Funding Amount: $67,990

Program Description: Funds support rapid HIV and HCV testing in non-clinical settings and the distribution of condoms.

Priority Populations: High-risk, Low-income, PWID, Unhoused, Incarcerated

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction, Substance Use Treatment

Program Name: Interior Medication Assisted Treatment

Funding Source: SAMSHA SAPT Block Grant funds through the State of Alaska and General funds and FNSB Matching grant

Most Recent Years Funding Amount: Total program funding $1,062,000.

Program Description: IMAT provides comprehensive Opioid Treatment Services (OTS) offering SBIRT, biopsychosocial assessment and referral, SUD treatment including individual and group counseling, case management, and outreach, medication assisted treatment which include methadone, buprenorphine and Vivitrol, and HIV testing. The process of screening and assessment provides an opportunity for problem identification, psychoeducation, and referrals related to the person's identified concerns resulting in increased quality of life. SUD treatment and medications for opioid use disorder are HIV prevention as people work on decreasing risky drug use behaviors such as use by injection and begin attending to important medical and life issues that increase positive health choices.

Priority Populations: People with OUD (priority admission for pregnant women/PWID/people w/children)

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction, Substance Use Treatment

Kachemak Bay Family Planning Clinic

Program Name: HIV/STD Prevention

Funding Source: Title X, Southern Peninsula Hospital Service Area Board, third party billing, Medicaid, community donations

Funding Amount: N/A

Program Description: Kachemak Bay Family Planning Clinic provides HIV/STD testing for men and women on the southern Kenai Peninsula. HIV testing is performed by either rapid HIV tests or serology through Alaska State Public Health Laboratory. Additional STD tests include Chlamydia and Gonorrhea, Syphilis, Herpes, and Hepatitis, many of which are rapid tests done on-site. Universal screening for HIV has been included at Annual Wellness Visits and HIV/STD testing is available on a walk-in basis. PrEP/PEP counseling and prescriptions are also available. KBFPC is a Title X agency. The income of all self-pay clients is assessed on a sliding scale that allows discounts for those with incomes up to 250% of federal poverty guidelines; however, no one is denied services due to inability to pay. KBFPC is an independent contractor with South Peninsula Hospital to meet its desire to

provide confidential testing and counseling for STDs outside the hospital facility. KBFPC participates in a collaborative community effort for opioid/heroin harm reduction and prevention; KBFPC provides outreach support currently focused on HIV/STD information, resources, and clinical input for project implementation. KBFPC also provides 7th through 12th-grade sexual health education, including HIV/STD information as part of the local school curriculum and has a peer health education program that covers HIV/STD in detail.

Priority Populations: High-risk, Low-income, Rural, Adolescents, PWID, Uninsured/Underinsured.

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction

Municipality of Anchorage Department of Health and Human Services

Program Name: HIV/AIDS Prevention

Funding Source: Award 601-281-22004; PS18-1802 HIV Prevention Funds, through the State of Alaska HIV/STD Program

Funding Amount (most recent year's): $106,470

Program Description: Funds support rapid HIV and HCV testing in non-clinical settings, harm reduction counseling, condom distribution, and treatment referral.

Priority Populations: High-risk, Low-income, Uninsured/Underinsured, Unhoused, PWID

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction

Program Name: Teen and Unintended Pregnancy Prevention

Funding Source: Award 601-285-22001

Funding Amount (most recent year's): $85,000

Program Description: Funds support sexual health education in the community with youth ages 10-24 to address teen pregnancy prevention with comprehensive medically accurate and evidence-informed sexual health education by strengthening protective factors based on knowledge, skills, beliefs, attitudes, and risk behaviors related to teen pregnancy, condom intentions, STI/HIV prevention, and personal safety and the autonomy to seek out resources and safe adults.

Priority Populations: High-risk, Low-income, Uninsured/Underinsured, Unhoused, PWID

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction

Program Name: Public Health Nursing

Funding Source: Award 601-289-22001

Funding Amount (most recent year's): $3,726,797

Program Description: Funds support rapid HIV and HCV testing in clinical setting, STI testing in clinical setting, harm reduction counseling, condom distribution, HIV treatment referral, STI treatment, and Narcan Kit distribution.

Priority Populations: High-risk, Low-income, Uninsured/Underinsured, Unhoused, PWID

Support Services Available: HIV Prevention and Diagnosis, Harm Reduction, Referral to Linked to Care

Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, Kentucky

Program Name: HIV/STD Prevention

Funding Source: Title X, Others

Most Recent Year's Funding Amount: n/a

Program Description: Planned Parenthood Great Northwest, Hawaii, Alaska, Indiana, Kentucky has four health centers in Alaska - Anchorage, Fairbanks, Juneau, and Soldotna. Each of these Alaska health centers provides HIV and STD testing, treatment, and risk reduction counseling as well as PrEP (Pre-Exposure Prophylaxis). The Alaska health centers provide these services to clients that are low-income and uninsured/underinsured at little to no cost.

Priority Populations: High-risk, Low-income, Uninsured/Underinsured

Support Services Available: HIV Prevention and Diagnosis

Megan's Place Homer Exchange

Funding Source: Variety of grants, including Alaska Mental Health Trust Fund (2017-18), Comer Family Foundation (2020-21), City of Homer Covid Grant (2021) and 100 Women Who Care Homer Branch (2022)

Funding Amount (most recent years): 100 Women Who Care: $14,000; City of Homer: $10,000, Comer Family Foundation: $5,000

Program Description: Homer Exchange, d.b.a. Megan's Place has been offering syringe exchange services in Homer since 2016. Syringes are accepted for disposal and picked up on-site by a medical waste company. Homer Exchange offers syringes based on needs, by providing clients with syringe safety kits that include syringes, sterile waters, sharps disposal containers, cookers, wound care supplies, fentanyl testing strips, safe smoking supplies, and naloxone during openings two evenings a month (first and third Tuesday). We also offer free rapid testing for Hepatitis C and HIV, administered by volunteer medical clinicians trained on the testing procedures and protocols. We also offer personal hygiene items including tampons and condoms. We provide information to all our participants about other resources in the community such as Hepatitis prevention and treatment, HIV prevention and treatment, substance use disorder counseling, treatment and peer support, and support groups. When funding allows, we provide gift cards to gas stations, grocery stores and general goods stores, as an incentive for in-person participation.

Priority Populations: IVDU, high-risk, persons without houses

Support Services Available: Harm Reduction

Other Public and Private Organizations

In addition to the agencies and funding sources listed above, Alaska has a network of public and private providers who provide HIV prevention or treatment services on an as-needed basis. While these agencies do not receive direct State or Federal funding to address HIV prevention, HIV care, STD prevention and treatment, or to specifically support PLWH, they may offer services such as routine screening for HIV and STD, prescription medications, substance use treatment services, services that support the homeless, youth education and support, emergency medical services, or other services for all Alaskans, which persons in any part of the HIV care continuum may access.

Strengths and Gaps

Throughout the assessment of available HIV services available in Alaska, stakeholders agreed that communication between agencies was a highlighted strength. Due to the limited resources available in Alaska, community partners can easily communicate and engage with each other to provide high-quality prevention and care services. Quarterly advisory meetings and Extension for Community Health Outcomes (ECHOs), which are a series of webinars hosted by community partners, have allowed for providers to strengthen relationships with

each other outside of care coordination and referrals. Additionally, due to the racial makeup of Alaskan residents, HIV care services are able prioritize under-served populations such as Alaska Natives through the Tribal Health Care System, LGBTQ+ through Identity Inc, PWID through IAA and Four As, and under-insured populations through ANHC.

HIV prevention services have been greatly disrupted due to the COVID-19 pandemic. Geographic and health equity disparities have increased due to limited access to care and services. Alaska is continuing to rebound from the pandemic with efforts to increase the capacity of services such as HIV testing, SSP access, PrEP prescriptions, and care as prevention in both rural and metropolitan areas.

Needs Assessment

Approach

The HIV prevention and care-associated needs assessments were conducted with two populations: community members and HIV prevention and care providers. Over the past several years, community partners conducted several HIV/STD-related community needs assessments; however, none were specific enough to be used in the Integrated Plan. The last needs assessment was conducted by the HIV/STD Program in 2017 during the preparation for the 2017-2022 Integrated HIV Prevention and Care Plan. Upon receiving guidance for this Integrated HIV Prevention and Care Plan, HIV/STD program staff immediately began developing a community-level needs assessment survey to better understand the situation from a community level. An online and paper survey tool was developed to capture client-level HIV/STD prevention and care services. Unfortunately, the number of responses were too low for analysis, which lead to the decision to conduct 1-on-1 interviews with HIV care consumers. In addition to the community-level needs assessment, the first-hand experiences of HIV prevention and care providers were collected to better understand the needs of HIV prevention and care consumers from a provider perspective. Additional details are described below.

Community Members – Survey

In 2022, community members accessing HIV/STD prevention, testing, and care services throughout the state were surveyed to assess HIV prevention needs for people who are not HIV-infected, or who did not know their current HIV status, and HIV care needs for the PLWH. The survey consisted of 53 questions (37 questions were addressed to all participants and 16 were addressed to participants living with HIV) and was estimated to take 25 minutes to complete. The survey was developed and tested by HIV/STD program staff and reviewed for accuracy and clarity by a sample of clinical service providers and AIHAG members. Surveys were promoted by HIV prevention and care staff at various health care facilities and participants were able to access the survey online via SurveyMonkey. HIV/STD program staff sent an initial email to community partners (n=60) across the state, inviting them to discuss the survey with their clients, hang flyers in clinic rooms and waiting areas, and post survey link on social media. The survey was open for a total of three months. An initial invitation email was sent out to community partners on March 21, 2022, followed up with a verbal invitation and reminder during the May 11, 2022, AIHAG meeting. HIV/STD program staff also distributed flyers to Anchorage-based clinics to assist with advertising. Due to COVID-19-related restrictions and limited community events, HIV/STD program staff were unable to promote surveys outside of healthcare facilities and community partner organizations.

A total of 5 responses to the community survey were collected. Since respondents were given the option of skipping any questions which they did not feel comfortable answering, the total number of respondents for each

question varied. Due to the low number of responses collected, quantitative data was not analyzed or reported. General responses to the survey were as follows:

- A majority of responses were from respondents aged 25-34 years
- Racial makeup was split between AI/AN and White
- No responses were marked as "Homosexual / Gay / Lesbian"
- All respondents reported having Health Insurance
- No respondents reported using a needle in inject meth, heroin, or any other drug in the past 12 months
- All respondents reported having been tested for HIV at least once in their lifetime
- "I don't know where to go to access services" was marked as a barrier for receiving HIV prevention services (testing, PrEP, PEP, SSPs, condoms, etc.)
- No respondents reported taking PrEP in the past 12 months
- No respondents reported ever testing positive for HIV

HIV Care Consumers – Interviews

In 2022, HIV care consumers who are currently accessing treatment and care resources and living in Anchorage were invited to participate in one-on-one interviews to assess the current climate surrounding HIV treatment and care services. A total of three interviews were conducted by HIV/STD program staff. Invitations to participate were sent out through HIV care providers (Four As and ANTHC EIS). These providers were asked to distribute a flyer and encourage their clients to attend. Each participant was provided with a $25 grocery store gift card and two one-day use bus passes as compensation for their time and expertise. The interviewer reviewed confidentiality and all participants provided verbal consent. The interview consisted of 10 questions related to HIV care services. Interviews were limited to one hour and were conversational in style, jumping from question to question depending on the participants' responses. Due to time constraints, some questions were omitted from interviews. Responses were written down by the interviewer to assist with qualitative review. Responses were anonymously analyzed with key takeaways reported below.

Key points discussed during the three individual interviews:

1. Greatest challenges in life included: access to food, education expenses, and non-HIV related medical care.
2. HIV stigma was perceived to be the highest at jails/prisons, rural communities, as well as community stigma by peers, and businesses located near/next to HIV-related service entities.
3. HIV diagnosis allowed for PLWH to become more aware and knowledgeable about other personal health issues.
4. Barriers to accessing HIV services included transportation, communication with case management, lack of available services since the COVID-19 pandemic, and high staff turnover.
5. The most positive aspect of accessing HIV services in Anchorage was easy access to treatment and care services.
6. Suggestions for improving HIV prevention services included: increased education around PrEP, HIV-related stigma (especially in rural communities), and an incentive for testing program.
7. Suggestions for Department of Health improvements included: Provide community education in the form of handouts/flyers, encourage, and assist with the development of a facility that provides "wrap around" services for PLWH such as housing, food, shelter, community center, resources, etc.., work with Community Health Aids to provide HIPAA privacy training, and facilitate HIV/STD/Sex Education in school aged children (specifically in rural communities).

HIV Prevention and Care Providers

From 2020-2022, conversations with HIV prevention and care providers were conducted during quarterly advisory meetings as well as during planning meetings to assess the current availability of HIV prevention and care in Alaska. The audience for these meetings included HIV/STD program staff, physicians, nurse practitioners, and non-clinical healthcare staff such as Directors, Case Managers, and Administration Staff. Discussion of first-hand experiences surrounding provided services and reported client experiences yielded the following information:

- HIV/STD testing can sometimes be overlooked in standard health care conducted through primary care providers.
- Providers who understand importance of and have the ability to prescribe PrEP, are limited across the state.
- Although the linkage to care rate is high, resources for care providers outside of Anchorage, Fairbanks, and Juneau are limited.
- Clients report limited access to safe, effective harm reduction interventions, such as SSPs.

Due to the extremely limited responses, HIV/STD program staff used historical program knowledge and stakeholder communication to determine community needs and drive goals and objectives. This information and data can be found in the Situational Analysis section and is also integrated into the Goals and Objectives.

Priorities

Key priorities assessed from the needs assessments methods were limited. Therefore, collaboration between HIV prevention and care providers assisted with developing the priorities addressed in this plan. Through quarterly advisory meetings, one-on-one phone calls, reviews of medical records, and discussions with clients during partner services, the following priorities were identified:

- Improve access to and increase availability of HIV care services for PLWH (i.e., transportation, food assistance, health insurance literacy).
- Develop collaborative initiatives in rural communities to reduce stigma surrounding HIV, STDs, and LGBTQ+ persons
- Increase HIV testing at clinical and non-clinical sites
- Increase access to care by increasing the number of rural providers who are trained in HIV care and prevention (i.e., PrEP, PEP, ARVs)
- Expand the number of health education and HIV prevention programs that specifically address the experiences of MSM and transgender persons in areas such as health literacy, condom negotiation, PrEP, and HIV treatment adherence.
- Increase awareness of and access to local SSP programs.

Additionally, the following barriers have been routinely noted by both HIV prevention and care providers and consumers:

- Lack of health insurance and ability to pay for health care related services
- Cultural differences emphasized during communication and care
- Stigma and racial/ethnic prejudice
- Syringe services and drug laws

- Expedited partner therapy utilization
- Funding for PrEP, PEP, and behavioral health
- COVID-19 related barriers (e.g., missed appointments, clinic closures, lack of available services, income, etc.)

Additional needs and barriers are identified in Section IV: Situational Analysis.

Actions Taken

The identified barriers have been known issues to the jurisdiction for several years. The HIV/STD Program and each community partner has taken steps to reduce barriers to their services and enhance services provided to best service their clients. Many partners have provided education resources (ECHOs, trainings, webinars, advisory meeting topics) to HIV prevention and care providers that address the barriers listed above, such as: stigma and bias awareness training, PrEP, PEP, COVID-19 and HIV, ARV adherence, as well as the newly emerging Monkeypox virus.

Section IV: Situational Analysis

Based on community engagement, the Integrated Plan planning process, and staff expertise, the following is a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. This analysis, in combination with the needs assessments and AIHAG input, helped drive the strategies of the Integrated Plan's Goals and Objectives.

Alaska's Social Determinants of Health Analysis

Social Determinant of Health are factors that drive or impact the health of a person [1]. Persons whose SDH needs are not adequately met can contribute to the probability of acquiring an infectious disease such as HIV, including limited access to healthcare and limited access to testing services and prevention services. Where a person physically lives (state, city, neighborhood, house, apartment, etc.) can be a factor in health outcomes due to environmental factors such as unsafe air, water, or extreme weather, all of which can contribute to the burden of disease [1]. A person's socioeconomic status plays a role in their health because a person's income is associated with levels of mortality [2]. For example, income determines whether and when a person seeks medical care, can determine the quality and accessibility of housing, work, education, and ultimately whether they are at risk of exposure to environmental toxins or poor air/water quality [2].

As related to HIV, SDH can create barriers to accessing HIV prevention and care [2]. SDH can lead to gaps in the stages of engagement in the HIV care continuum [3] [2]. "Housing First" is an evidence-based practice that is shown to improve health outcomes for PLWH who are unstably housed [4]. Having a history of incarceration is associated with disruption to the HIV care continuum, especially during the discharge/release process due to the potential of the individual being falling out of HIV care [4]. There are limited reentry supports in Alaska for persons re-entering society post incarceration which makes it difficult to access safe housing, work, quality food, and other community and individual supports. Lack of housing can result in poor health outcomes for PLWH because it is associated with barriers to care engagement such as the additional burden of stress caused by having to constantly seek out a place to live and sleep, reprioritizing social and health commitments, and lack of a mailing address for prescription medication mailing. These things, among others, can lead to fragmented care engagement among PLWH who are unhoused [4]. Some of the barriers faced in Alaska include housing

limitations and lack of housing supports, geographical isolation, travel, food insecurity, HIV-related stigma and inequity, and limited mental health counseling and substance misuse treatment options.

Supply of Primary Care Providers:

The University of Washington's Center for Health Workforce Studies stated that in 2021, Alaska had a total of 1,751 physicians providing some type of direct patient care [6]. Of those, 695 physicians provided primary care. 201 physicians were surgeons, 96 physicians were psychiatrists, and 759 physicians were listed as "other" [6]. Per the AAMC's Alaska Physician Workforce Profile released in 2021, there are 240 active physicians per 100,000, and 94 primary care providers per 100,000 in Alaska [7]. A needs assessment on primary care in 2021 reports 69.28% of physicians in Alaska practice in the Anchorage/Mat-Su regions followed by 10.12% in the Interior region which includes Fairbanks [8]. The Robert Graham Center reported in 2018 that approximately 5% of Alaska residents live in rural communities that are underserved "with more than 2,000 persons per PCP" [9].

Supply of Specialty Care (Infectious Disease) Providers

There are a limited number of infectious disease (ID) providers adequately trained in HIV care in Alaska. Most Alaska ID providers are in Anchorage; however, there are a few ID providers in Fairbanks and Juneau. Among available ID providers, some providers are not comfortable initiating treatment for persons newly diagnosed and/or managing treatment for persons with new/complicated Stage 3 infection (AIDS). Care accessibility is further compounded by new patient appointment availability, as many ID providers also have hospital rotations and/or provide other specialty care. Despite relative centralized HIV care in Anchorage, the Alaska Division of Public Health 2021 Primary Care Needs Assessment identified 46 medically underserved areas in Alaska, including Anchorage [8]. Anchorage has a Federally Qualified Health Center (FQHC) (Anchorage Neighborhood Health Center) that receives Ryan White Program funding.

Socioeconomic Factors

The 2021 Alaska Scorecard reports 22.1% of renter-occupied households exceed 50% of household income dedicated to housing. The rate of chronic homelessness is 44.6 per 100,000, which is an increase from 2019 data which had 31.6 people experiencing homelessness per 100,000 [5]. The cost of travel for PLWH who live in rural Alaska can be a barrier to accessing HIV care as travel expenses are usually the responsibility of the person in need of care (note: some medical travel is approved through Tribal Health benefits; Medicaid allows for some travel). Additionally, persons who spend more than thirty percent of their monthly income on rent and/or mortgage will end up reducing spending on other essential needs such as food, utilities, transportation, and medication [5].

Healthy Alaskans 2030 estimates that "approximately 18.9% of the population of Alaska (and 26.2% of those under 18 years) lives below 125% of the Federal Poverty Level" [1]. The 2021 Alaska Scorecard estimates that 82.9.% of Alaskans are living above 125% of the federal poverty line [1].

In 2018, the Anchorage Coalition to End Homelessness and the Alaska Coalition on Housing and Homelessness released a report containing data surrounding the unstably housed population in Alaska [11]. They counted all persons in emergency shelters, transitional housing, or unsheltered/camping and determined that there are 1,956 people who are unstably housed or unhoused in the state [11]. 1 out of every 5 persons experiencing homelessness are under the age of 18. The 2021 Alaska Scorecard indicates that Alaska has a chronic

homelessness rate of 44.6 per 100,000 [5]. “Chronic homelessness is defined as a homeless individual or head of household with a disability that meets the Department of Housing and Urban Development (HUD) definition of a disability who (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; (b) and in general have been homeless and living in one of these places continuously for at least 12 months or on at least four separate occasions in the last three years” [5]. Alaskans who experience chronic homelessness are among the most at-risk for adverse health conditions [5].

Substance Use

The 2021 Alaska Scorecard reports 15% of Alaskans were identified as needing, but not receiving treatment, at a specialty facility for substance use in the past year [5]. Alaska’s initial rate of alcohol-induced mortality was 13.1 per 100,000 [5]. However, the most current data for 2020 shows a rate of 24.2 per 100,000 [5]. Alaska has the 10th highest prevalence rate of adult binge-drinking in the United States, and in 2015, Alaska had the third highest rate of alcohol-attributed mortality [5]. SAMHSA published a Behavioral Health Barometer for Alaska which looks at mental health and substance use. From 2017-2019, the annual average percentage of heroin use in Alaska was 0.73% while the national average is 0.30% [10]. During the 2017-2019 period, the average prevalence of opioid use disorder in Alaska was 0.6% and illicit drug use disorder was 3.6% [10]. Alcohol use disorder during the same 2017 to 2019 timeframe averaged at 7.6%. Substance use disorder during 2017-2019 was at 10.2% [10].

Health Insurance

According to Alaska Scorecard 2021 and Healthy Alaskans 2030, a total of 12.6% of people living in Alaska did not have health insurance in 2020 [1] [5]. This does not account for the rates of under-insured persons who often need to access programs like ADAP or Gilead’s Advancing Access Program.

Transportation

Numerous challenges exist in providing medical and medication services to PLWH in Alaska. Alaska differs from other states due to its extreme climate, diverse geography, low population density, relatively young population, and high cost of living. A significant proportion of the state is only accessible by air travel, which is expensive and vulnerable to harsh weather conditions. Additionally, immediate specialized care availability is reduced in rural areas, requiring persons in need of specialized medical care to travel to regional or urban hub hospitals.

The geography and extreme weather of Alaska limits access to care and services. Around a quarter of the population in Alaska reside in geographically isolated areas. Alaska has around 200 villages/rural communities that are only accessible by boat, plane, or snowmachine; and extreme weather conditions have a direct impact on whether people in these areas can access healthcare or other needed services [1]. Alaska has a low population density compared to other states, but accounts for one fifth of the landmass of the United States [1].

Situational Analysis – Pillar One: Diagnose

Overview: Early diagnosis of all persons with HIV is imperative to reducing the transmission of HIV. From 2011 to 2020 the annual Alaska HIV diagnosis rate has remained consistent. From 2011 to 2020, a total of 286 HIV cases were diagnosed among persons living in Alaska. Of persons newly diagnosed with HIV during 2020, 10% were diagnosed with AIDS/Stage 3 at the time of initial diagnosis.

Racial disparities exist among Alaskans newly diagnosed with HIV. Across all reported cases, the highest There are higher percentages of new diagnoses among Alaska Native/American Indian people and Whites. Among persons newly diagnosed with HIV in Alaska in 2020, 43% were Alaska Native/American Indian, despite only accounting for 22% of the Alaska population in 2020 (combined AN/AI race). Due integrated and comprehensive care services within the Alaska Tribal Health system, Alaska Native/American Indian people are able to access HIV/STI testing and preventative care routinely. Due to the high level of care available to Alaska Native/American Indian people, State-driven testing and prevention efforts have been focused on other priority populations.

The HIV/STD Program financially supports in-person HIV counseling and testing activities in Anchorage, Juneau, Fairbanks, and state-wide at-home testing services. Sponsored non-clinical agencies offer rapid-HIV-1/2 antibody testing (OraQuick, Insti) and can provide results in minutes. Those with reactive results from an initial rapid test are then immediately tested for an HIV-1/2 antibody/antigen combination immunoassay or referred to a provider of their choice for additional testing and to be promptly linked to medical care. All reactive rapid-HIV tests are mandatory reported to the HIV/STD Program in order to assist with follow up testing, linkage to care, and partner services. All state sponsored testing sites offer confidential HIV testing free of cost by either appointment, walk-in, or at-home basis. Pre-test and post-test counseling are offered at all agencies.

Gaps – Limited Testing: Limited routine and universal HIV testing occurs in acute care, emergency care settings, outpatient medical encounters, and the criminal justice system which results in missed opportunities for new diagnosis. No emergency departments in Alaska are known to be participating in opt-out testing, despite CDC recommending routine opt-out HIV testing since 2006. Additionally, there is limited focused testing in communities with increased risk for HIV and other STDs outside of Anchorage, Juneau, and Fairbanks. The incarcerated population is among the most challenging to diagnose and treat for HIV due to limited outreach, jail/prison policies, and limited care providers. Incarcerated persons are most likely to benefit from HIV prevention interventions due to related HIV risk behaviors including high rates of substance dependence, however, HIV testing is not a mandatory or routine test for inmates entering jail or prison facilities in Alaska. While IAA and Four A's provide free community-based at-home HIV test kits, ANTHC's iKnowMine.org is the only agency in the state providing mail order, free at-home test kits at a state-wide level. Additional missed opportunities include pharmacies not being currently utilized for HIV testing.

Gaps – Limited LGBTQ+ Services: LGBTQ+ affirming physical health providers and care facilities are limited in Alaska. As of December 2022, there is one clinic that specializes in LGBTQ+ and/or gender affirming care in Anchorage. As of December 2022, there are seven facilities and 14 providers identified as providing inclusive health care for LGBTQ+ persons. The challenges of care unavailability and inaccessibility are further compounded by pervasive systemic issues, including conservative politics and stigma. While members of the LGBTQ+ community may access care at any healthcare facility, clients have reported experiences of judgement, stigma/bias, and unsafety due to their gender identity, sexual orientation, sex practices, and/or HIV status.

Challenges: Challenges in this area are multiple as evident by high rates of concurrent diagnosis for HIV and AIDS among MSM transmission, undetermined transmission, and new diagnosis in rural areas. There are limited funding sources and resources at the state level to coordinate and expand collaborations across healthcare settings. Compliance with non-mandated routine HIV testing from EDs, urgent cares, and primary care facilities can be difficult to obtain, even when a testing referral is provided. There is no existing collaboration with

pharmacies and other state programs outside of the Section of Nursing for HIV testing. Policy and funding continue to be a hinderance for HIV testing in the criminal justice system. Hard to reach populations, such as PWID and persons experiencing homelessness have unique barriers/challenges to implement outreach and testing.

Limited awareness and stigma continue to be a challenge. Verbal reports from PLWH and HIV case managers identify a presence of HIV stigma in various aspects that affect testing, treatment, linkage to care, and social services. One partner agency, ANTHC, is working on conducting an HIV Stigma Index to fully report on the sigma PLWH experience in their day-to-day life and through care services.

Needs (resources, infrastructure, service delivery): The following needs were identified: increased testing in both increased risk populations and in general populations based on universal screening guidelines; comprehensive list of urgent care facilities that can perform walk-in HIV testing; data to assess which providers, agencies, and organizations are already implementing routine HIV testing in acute, emergency, and outpatient settings; outreach materials for persons at increased risk for HIV identified in healthcare settings; referral process and protocols to connect persons who are HIV negative and identified with increased risk of HIV infection to PrEP; and culturally sensitive outreach materials.

Barriers: Several barriers have been identified in regard to HIV diagnosis in multiple healthcare settings. Providers are not routinely ordering HIV tests in acute, emergency, and outpatient settings; providers have not widely adopted routine HIV screening as part of medical care. When HIV testing is ordered, providers are either not ordering the full HIV testing algorithm, or do not know how to properly read test results and provide accurate diagnoses. Stigmatizing behavior or un/undertrained staff and lack of cultural competence has routinely been identified by persons as a barrier in some clinical settings.

Strengths: Alaska has several identified strengths in healthcare systems. Positive relationships exist between DOH and the Alaska Tribal Health System. There is a close relationship between HIV/STD program staff and community partners who are performing tests. DOH has a network of Public Health Nursing facilities located throughout various regions of the state that provide HIV screening to their community members. ANTHC's IKnowMine.org provides free of charge rapid HIV tests to any individual with an Alaska-based address.

Situational Analysis – Pillar Two: Treat

Overview: Alaska defines "in care" as the percentage of people living with HIV who have at least one HIV medical care visit within the preceding 12 months. "In care" is measured through receipts of care, such as attendance of HIV care appointments, VL/CD4 labs within a 12-month period, or timely pick-up of ART prescriptions. As of December 31, 2020, 19 persons were identified to be living in Alaska and not in HIV medical care.

Linkage to Care is critical to getting PLWH into care quickly and helping achieve viral suppression. Approximately 12% of persons believed to be living with HIV in Alaska as of December 31, 2020, were not engaged in medical care. Approximately 21% of persons believed to be living with HIV in Alaska as of December 31, 2020, did not have evidence of viral suppression.

Of the 30 people newly diagnosed with HIV in Alaska in 2020, 29 (97%) were eligible for linkage to care (L2C) services. The one person not eligible for linkage to care services is known to have died prior to receiving their HIV result. Despite the COVID-19 pandemic, all 29 (100%) people newly diagnosed with HIV were offered L2C support, including assistance in engaging with an HIV care provider, referral to HIV medical case management services, and assistance in accessing other essential services, if needed. Of the 29 people eligible for L2C, 29 (100%) completed an initial CD4 and viral load lab, and 26 (90%) received labs within 30 days of their HIV diagnosis. Twenty-four (24; 83%) people had at least one lab indicating viral suppression by April 2021.

Gaps – Rural areas: Rural Alaska has unique transportation and location challenges, and therefore difficult to provide HIV care. Alaska Native Tribal Health Consortium's EIS team hosts field clinics in several rural areas to meet the needs of PLWH who live there. EIS clinics have been conducted in areas such as Fairbanks, Bethel, Sitka, Dillingham, Ketchikan, and Juneau. Some PLWH who live in rural communities (Tribal Health beneficiaries and non-beneficiaries) do choose to receive care at regional hub locations (i.e., Bethel, Ketchikan, Kotzebue, etc.), however many of these clients are then faced with the barrier of confidentiality and health privacy as communities due to the close-knit community dynamics. Clients who are fearful their confidentially may be jeopardized are forced to receive care in Anchorage, Fairbanks, or Juneau. Traveling can cause disruptions in care appointments, labs, and medication. For many clients, the cost for travel is not covered as a medical expense and travel can be an expensive out of pocket cost.

Gaps – Transportation: Since the majority of HIV specialists practice in Anchorage, many PLWH must travel to receive specialty HIV care. Travel in Alaska can be challenging due to weather conditions and some people must use multiple modes of transportation to get to Anchorage such as snow machine, boat, and plane. Public transportation options in the larger cities are insufficient due to limited bus routes, long wait times, and long walks to get to some locations from the bus stop. The Linkage to Care Coordinator and medical staff spend time and resources arranging transportation and often HIV/STD program staff transport clients to appointments. Individuals frequently need assistance with airline travel, bus passes, ride share services, and fuel.

Challenges: There are multiple challenges related to treatment of HIV in Alaska. The two Community Based Organizations (CBOs) who provide core medical and support services to PLWH struggle with frequent staff turnover. This makes it difficult for PLWH to build a rapport with their case manager. Additionally, training new staff takes a significant bandwidth which can burden the agencies and can ultimately limit services received.

Another challenge is the limited number of medical providers and infectious disease doctors in Alaska. There are limited providers in rural Alaska, with most specialized providers located in the Anchorage area. Linking PLWH in remote areas to care presents unique challenges due to the vast geography, transportation, weather conditions for small-aircraft flights.

Needs (resources, infrastructure, service delivery): Several needs were identified to improve HIV treatment. There is a need for more transportation options for PLWH to attend medical appointments and lab testing. Those in rural areas would benefit from expanded telehealth options and more access to technology to be able to attend telehealth appointments. Additionally, there is a need for increased training and responsibility for Department of Health Disease Intervention Specialists in terms linkage to both HIV prevention and care services. An expanded DIS workforce would allow for more routine prevention education, partner services, and a potential influx in HIV care services.

Barriers: Alaska has a limited number of primary care providers, especially in rural areas. Even within larger cities, public transportation is limited, difficult to navigate, and costly. Patient confidentially has been expressed as a barrier when seeking healthcare. Rural villages are often small and tight knit, this causes clients to be reluctant to seek care at their local clinic. Oftentimes a family member or friend is employed by the clinic in some capacity and there is fear their HIV status will not be kept confidential. Across the state there are still persons who are reluctant to seek care due to fear of stigma and discrimination. Lastly, HIV care and treatment can be expensive, therefore, a lack of insurance or interruption in insurance can be a barrier for those who are not familiar the Ryan White and other financial and aid services.

Strengths: The current structure of HIV/STD Program encourages DIS to work with providers across the state allowing for the facilitation of partnerships with medical providers and program staff. Alaska also has great success in linking PWLH to care shortly after initial diagnosis. Of persons newly diagnosed with HIV in Alaska in 2020, 87% were linked to HIV medical care within 30 days of diagnosis. The RWHAP program is available to provide case management to any PLWH in the state who is interested in the service. The two sub-recipient agencies employ case management staff in Anchorage, Juneau, and Fairbanks. These areas are some of the most populated cities in Alaska which allows for in-person case management to a majority of the Ryan White (RW) Part B clients. Clients who reside in rural areas communicate with staff primarily by phone, email, and texting. Case managers and the ADAP Manager travel to remote communities such Sitka, Ketchikan, Homer, Kenai, Seward, and Wrangell on an annual basis to meet with clients in person.

In 2018, the State of Alaska assisted in the Data to Care Program Guidance project. The purpose of Data to Care activities is to identify people who are out of care, people who are in care but not virally suppressed, and identify pregnant women/exposed infants. The state of Alaska has the Linkage to Care program which started in 2012 and has incorporated Data to Care with the Linkage to Care Program to locate and connect people living with HIV to care and services.

Situational Analysis – Pillar Three: Prevent

Overview: Since 2018, drug overdose rates in Alaska have seen an upward trend. The national opioid epidemic has contributed to an increase in HIV and HCV cases and a need for increased prevention efforts. Among persons newly diagnosed with HIV in 2020, 10% of cases were attributed to injection drug use and 13% were attributed to male-to-male sexual contact and injection drug use. Goals to prevent new HIV transmission include pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), SSPs, condoms, and other harm reduction strategies.

PrEP continues to be most available and accessible in metropolitan areas, despite increased advocacy for state-wide usage. In 2021, SOA developed an internal process to ensure active PrEP referrals for persons identified through disease investigation activities. However, broader, and focused provider prevention efforts are necessary to improve the availability and accessibility of PrEP statewide.

DOH provides prevention outreach, partner services, and linkage to care services to ensure that those living with HIV know their status and have access to the most effective treatments, coordinated healthcare, transportation,

and social services. Community engagement and partner agency participation is important in reducing the transmission of HIV and reducing stigma associated with the disease.

Gaps – PrEP: Through patient interactions and referral attempts, it was found that there is a lack of prescribing PrEP for HIV prevention among primary care providers as well as a potential lack of general knowledge of PrEP in persons who are at risk for HIV. For clients who receive medical care outside of the Alaska Tribal Health System, there are a scarce number of providers available who are routinely prescribing PrEP to their clients, especially via telemedicine efforts. Beneficiaries of the Alaska Tribal Health System have access to PrEP services through ANTHC's EIS team as well as through telemedicine. However, non-beneficiary persons are limited to a handful of providers throughout the state, with most of them offering services in Anchorage. There is only one known provider offering telehealth services for PrEP. Newly developed PrEP materials need to be culturally appropriate and acceptable for persons at increased risk, especially for those in rural areas of the state.

Gaps—PEP: There are an insufficient number of providers who are knowledgeable of PEP and willing to prescribe it within a timely manner. Outside of the Alaska Tribal Health System, all PEP services are currently only administered though hospital emergency departments. The only known option for a non-tribal individual seeking PEP, is a local emergency department. There are currently no known urgent care facilities in the state that are prescribing PEP.

Gaps – SSP: Through community discussion and agency reporting, several gaps were identified in SSPs. SSPs are only located in high-density communities such as Anchorage, Mat-Su Valley, Fairbanks, Juneau, and the Kenai Peninsula. The only SSP service available in rural Alaska is through online ordering of Harm Reduction Kits from iKnowMine.org, however, as of June 27, 2022, funding for this service has lapsed and remaining kits are only available to Alaska residents with rural addresses. Additionally, due to state politics and funding, some SSPs have limitations on the services available and one-for-one exchanges, despite best practice recommendations and a nation-wide push for better harm reduction services.

Challenges: There are challenges for PrEP, PEP, and SSPs. The limited provider knowledge and awareness of PEP and PrEP coupled with the scarce number of providers willing to prescribe these prevention methods puts an amplified burden on persons who are already at increased risk of acquiring HIV. Funding for both PrEP and SSPs is limited. SSPs are locally driven, resulting in many variations in structure, services provided, and community support. PWID can be reluctant to access preventative services in SSPs due to time needed, location, loss of anonymity, or other barriers.

Needs (resources, infrastructure, service delivery): The following needs were identified: increased number of providers trained to prescribe PrEP; increased education for at-risk populations and providers on PrEP and where to access it; funding for a statewide PrEP coordinator; champions and local experts on PrEP; PrEP media campaign; and linkage to PrEP for persons that are identified as at-risk and test negative for HIV. Needs for SSPs include additional funding; advocating for policy change; and community education/awareness of SSP benefits.

Barriers: Despite best practice recommendations and due to community and political acceptance, barriers to SSPs include lack of support and funding and one-for-one exchange or the number of syringes that can exchanged at a given time. For PrEP, a lack of payment assistance options exists for uninsured and underinsured

persons. Due to the unique make-up of the state, Alaska needs more PrEP prescribing providers including those willing to prescribe using telehealth services. For both SSPs and PrEP, there can be a lack of cultural competency, lack of social support, and a lack of transportation.

Strengths: Alaska is unique as it has a very large health infrastructure support due to Tribal Health Services. Tribal Health EIS can provide routine in-person services to clients in rural areas as well as provide telehealth services and transportation services to Anchorage if necessary. Although Tribal Health Services can typically only be accessed by tribal beneficiaries, the services they provide allows for a community presence to assist with HIV prevention awareness and education.

Although limited, PrEP is being prescribed at higher rates in Anchorage and throughout the Alaska Tribal Health System. While there are no PrEP specific clinics located in the jurisdiction, there is an Infectious Disease Medical Group who provides HIV care and treatment as well as PrEP. The HIV/STD Program has ongoing PrEP marketing efforts directed towards providers as well as the general population. While still in its infancy, the HIV/STD Program is providing linkage to PrEP services to persons identified through HIV/STD disease investigation.

Condom distribution and access to free condoms is a great prevention strength throughout the state. Multiple organizations distribute and provide free condoms to bars, clubs, universities, and group housing facilities in urban areas (Anchorage, Juneau, Fairbanks). ANTHC provides and mails free condoms to persons and clinics with an Alaska address through their online sexual health website and store, iKnowMine.org.

Situational Analysis – Pillar Four: Respond

Overview: In 2019, the Centers for Disease Control and Prevention (CDC) provided new guidance to jurisdictions funded through PS18-1802 for use in developing an HIV Cluster and Outbreak Detection and Response Plan. HIV Cluster Detection and Response Plan utility and importance was first introduced to the Alaska Integrated HIV Prevention and Care Advisory Group (AIHAG) membership during the May 2019 all-member meeting. Stakeholders were provided information about the importance of HIV cluster and outbreak detection and response, as well as the utility of molecular sequence data in identifying priority HIV clusters. The Alaska HIV Cluster Detection and Response Plan was first submitted to the CDC on September 28, 2020. Surveillance staff continue to work to incorporate feedback and to further develop cluster detection and response processes.

Oversight and management of cluster detection and response activities are coordinated by leadership staff within the Alaska HIV/STD Program, including the HIV/STD Program Manager, the HIV Surveillance Coordinator, the HIV Prevention Coordinator, the STD Program Coordinator, and other staff as assigned. The HIV Surveillance Coordinator is the primary staff person coordinating cluster detection and response activities. Cluster investigations are initiated by the HIV Surveillance Coordinator through monthly review of time-space cluster surveillance data as well as analysis of molecular data using Secure HIV-TRACE.

In 2021, the first known molecular cluster was identified in Alaska.

Gaps – Available Sequence Data: Reporting of nucleotide sequence data via laboratory reporting was previously not required in Alaska. Therefore, the reporting regulations were required to be changed and amended to specifically mandate the reporting of nucleotide sequence data by laboratories; the final reporting regulation change became effective in December 2019.

Gaps – Report Delays: Alaska does not have an in-state laboratory that can process genotype testing, often resulting in delayed reporting of nucleotide sequences (approx. 2-4 weeks following collection).

Gaps – Reporting: Genotype testing has not been completed for all persons newly diagnosed in Alaska, resulting in incomplete nucleotide sequence data for analysis. Nucleotide sequence data is not reported for persons who complete genotype testing through military-affiliated hospitals and laboratories.

Gaps – PrEP: PrEP is most available and accessible in urban hubs, particularly in Anchorage. Additional details, regarding PrEP availability and accessibility, are discussed under Pillar Three.

Challenges: Cluster monitoring processes are still being developed in Alaska; strategic and comprehensive process development is time intensive. Through the investigation and reporting process of the first known molecular cluster in Alaska, the HIV/STD program gained essential firsthand experience in analyzing and monitoring clusters. The cluster reporting process provided an important opportunity to improve data collection standards as well as enhance Alaska's utilization of NBS (NEDSS Base System) to identify persons within risk networks as well as to accurately document testing, re-testing, and PrEP referrals. These standards are still being developed and implemented.

Within rural Alaskan communities, the stigma associated with HIV infection may be compounded by cultural and social tradition, further challenging acceptable community-based HIV education and prevention activities. Although increasing routine screening in rural areas is a key prevention effort, potential barriers to the success of this strategy may include lack of clinic utilization by the priority population as well as hypermobility by many community members. It is not unusual for residents of rural villages in Alaska to frequently move between the village, regional hubs, fish camps, seasonal employment locations, and urban hubs such as Anchorage and Fairbanks. CHA/Ps in the village may be aware of the need for HIV screening when community members access services at the village clinic. However, if a rural resident accesses services in another service area or at larger tribal health facilities, such as the Alaska Native Medical Center (ANMC) in Anchorage, the HIV screening alert will not be visible at those outside facilities.

Needs (resources, infrastructure, service delivery): The following needs were identified: standardization of case investigation activities within NBS; continued development of the cluster detection and response plan to incorporate new detection methods, partnerships, and response activities; development of communication plans to support cluster response activities.

Barriers: Several barriers to HIV cluster detection and response were identified. Firstly, HIV molecular cluster detection requires analyzable nucleotide sequence data. Care availability, acceptability, and accessibility concerns, as outlined in Pillar Two, may also impact cluster response in rural regions.

Strengths: As a low-incidence jurisdiction, Alaska can conduct time-space cluster analysis on an ongoing basis, as case reports are received. Time-space cluster analysis is conducted by the HIV Surveillance Coordinator, who is also the primary HIV DIS for the State.

There are numerous existing community engagement structures which can be leveraged for HIV cluster and outbreak response initiatives. These groups include the statewide Integrated Alaska HIV Prevention and Care Advisory Group (AIHAG), the HIV/STD Advisory Committee, and the HIV Care Coordination meeting. In addition, funded sub-recipients for HIV Prevention and Care meet regularly to coordinate activities and initiatives. These

groups foster routine engagement with priority populations across Alaska, including: People living with HIV, people representing priority populations for HIV prevention in Alaska, LGBTQ partners, HIV care providers, Ryan White Care Part B and C providers, Tribal Health partners, pharmacists, Federally Qualified Health Centers, U.S. Military (Army and Air Force), AIDS Service Organizations, local health departments, statewide Public Health Nursing, Planned Parenthood, overdose prevention and response staff, syringe service program staff, and Health and Human Services Region 10 staff.

Priority Populations

Alaska does not focus HIV prevention activities on specific groups, in accordance with recommendations outlined by the National HIV/AIDS Strategy (NHAS) and CDC. The Alaska HIV/STD Program is only able to fund (through CDC HIV Prevention) three jurisdictional areas for HIV prevention projects. Moreover, CDC directives largely determine the way in which prevention efforts are structured. Guided by the recommendations of NHAS and CDC, Alaska's prevention focus has been dedicated to increasing testing efforts, increasing condom distribution, promoting treatment as prevention, and advocating for policy development to assist with destigmatizing HIV. In Alaska, priority populations have been identified as gay, bisexual, and other men who have sex with men and transgender persons, persons who inject drugs, and heterosexual persons at increased risk. These populations have been prioritized by CDC prevention initiatives in the past and continue to be the focus of Linkage to Care and partner services activities. Finally, these populations have measurable and available testing and linkage to care data in Alaska.

Gay, Bisexual, and other Men Who Have Sex with Men (MSM) and Transgender Persons

In Alaska, HIV cases attributed to male-to-male sexual contact account for the largest proportion among both prevalent and incident cases. In 2020, more than 50% of cases were attributed to male-to-male sexual contact. Due to systemic stigma/bias and few safe, inclusive social spaces, LGBTQ+ persons may utilize online and mobile applications to meet sex partners. Any person utilizing online and mobile applications is at increased risk of HIV/STD infection due to the (frequent) anonymity of these platforms. Moreover, LGBTQ+ affirming physical health providers and care facilities are limited in Alaska. The challenges of care unavailability and inaccessibility are further compounded by pervasive systemic issues, including conservative politics and stigma. While members of the LGBTQ+ community may access care at any healthcare facility, clients have reported experiences of judgement, stigma/bias, and unsafety due to their gender identity, sexual orientation, sex practices, and/or HIV status. Resultingly, the Alaska HIV/STD Program will continue to prioritize HIV testing services in nonclinical and clinical settings for gay, bisexual, and other men who have sex with men and transgender persons. The program will also continue to conduct enhanced partner services and Linkage to Care activities for this priority population.

Persons Who Inject Drugs (PWID)

Among newly diagnosed HIV cases in 2020, 10% were attributed to injection drug use. Alaska is experiencing an increase in opioid dependency. In 2019, a needs assessment was completed among PWID in Alaska and results found that many former users of prescription opioids were switching to intravenous drug use, due to cost and accessibility. This needs assessment also identified that access to syringe services was a barrier in many Alaskan communities. Hepatitis C is the third most frequently reported infectious disease in Alaska; persons with new hepatitis C infection in Alaska often report needle-sharing.

Expanded efforts to engage PWID in prevention and care services is a goal and priority of the HIV/STD Program, including objectives to improve health outcomes and eliminate new HIV infections among PWID. Resultingly, the Alaska HIV/STD Program will continue to prioritize HIV testing services in nonclinical and clinical settings for persons who inject drugs. The program will also continue to conduct enhanced partner services and Linkage to Care activities for this priority population.

Heterosexual Persons at Increased Risk

Heterosexual contact is the third largest transmission category for HIV infection in Alaska. Among newly diagnosed persons in 2020, 10% of cases were attributed to heterosexual contact. Additional risk factors among this priority population include homelessness, mental health, and polysubstance misuse/abuse. Resultingly, the Alaska HIV/STD Program will continue to prioritize HIV testing services in nonclinical (including homeless and emergency shelters) and clinical settings for heterosexual persons at increased risk. The program will also continue to conduct enhanced partner services and Linkage to Care activities for this priority population.

Section V: Goals and Objectives

The Integrated HIV Prevention and Care Plan for Alaska is designed as a blueprint for achieving HIV prevention, care, and treatment goals in the state. Planning group members, HIV/STD program staff, and other key stakeholders all provided input on priorities and opportunities which they feel are important components of comprehensive HIV prevention and care services in Alaska. In addition, findings from the 2022 Needs Assessment and Situational Analysis helped drive the direction of the goals and objectives.

While the objectives and strategies of the *HIV Integrated Plan* are designed to be achievable by the end of the calendar year 2026, challenges and barriers to the successful implementation of the plan will be ongoing. For the HIV Prevention, lack of funding will continue to hamper efforts to implement robust, comprehensive programming statewide including PrEP, PEP, and SSPs. For HIV Care, barriers caused by high costs of care and real or perceived stigma may prevent persons living with HIV from linking and retaining in HIV care. For both HIV prevention and care, geographic distances, cultural differences, and lack of human resources may create challenges to successful implementation.

Despite the challenges and barriers listed above, Alaska's HIV prevention and care efforts are supported by a dedicated network of agencies, partners, stakeholders, and community members committed to addressing HIV in the state. The dedication and support of these groups and individuals are what make the goals and objectives outlined in the *HIV Integrated Plan* realistically and achievable over the next five years.

Due to limitations to client services as well as data collection, analyzing, and reporting heightened by the COVID-19 pandemic, many of the data to be used as baseline levels for the following Goals and Objectives are not obtainable and/or accurate. The HIV/STD Program hopes to develop methods to accurately measure Integrated Plan strategies, however, at this time some goals are not measurable.

PILLAR 1: DIAGNOSE			
Goal 1: Increase the number of Alaskans tested for HIV at least once in their lifetime.			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
1.1: By December 31, 2026, assess accessibility and availability of HIV prevention and testing services at Alaskan primary care facilities.	**1.1.1:** Increase the number of Alaskans between the ages of 14 and 65 years of age who know their HIV status.	**1.1.1a:** Survey Alaskan primary care providers to assess and evaluate current HIV screening practices by 2024. **1.1.1b:** Based on survey results, develop, and implement a plan to educate Alaskan primary care providers about new CDC and USPSTF HIV screening recommendations by 2026.	Populations: • Primary care providers • Alaskans between the ages of 14 and 65 years old • Community organizations Metrics: • Number of primary care facilities providing services, planning to provide services, and not providing services • Number of facilities/providers who attend trainings • Number of trainings completed
	1.1.2: Ensure Alaskan providers have access to culturally and clinically appropriate education to offer comprehensive HIV/STD prevention and testing services to all Alaskans.	**1.1.2a:** On an ongoing basis, offer HIV/STD education and updates for Alaskan providers, which will include taking a complete sexual/risk history, extragenital STD screening, and PrEP/PEP. **1.1.2b:** Work with Alaskan community organizations to provide HIV/STD clinical updates to ensure that culturally and clinically appropriate services are available and accessible to all Alaskans.	
1.2: By December 31, 2026, provide community outreach and education events to broaden the capacity of Alaskans to advocate for HIV testing with their medical provider.	**1.2.1**: Increase awareness and knowledge of HIV prevention and testing services among Alaskans.	**1.2.1a**: Offer biannual community outreach events to advocate for HIV prevention and testing. **1.2.1b:** Develop new promotional and marketing materials to educate and direct Alaskans to HIV prevention and testing services.	Populations: • Alaskans • HIV/STD service providers Metrics: • Number of new materials developed • Number of distribution platforms – links/sites • Number of media interactions

Goal 2: Increase provider knowledge of HIV prevention, testing, and treatment services			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
2.1: By December 31, 2026, provide community outreach and other education events to broaden the capacity of Alaskan providers to include routine HIV/STD/HCV services.	**2.1.1**: Increase provider awareness and knowledge of HIV/STD/HCV CDC screening recommendations.	**2.1.1a:** Offer quarterly events (e.g.., ECHOs, AIHAG, Advisory Meetings, HAWG, etc.) with Alaskan providers and community partners to provide updates and education.	Populations: • Alaskan Providers • Community Partners • Advisory Groups Metrics: • Number of events • Number of attendees • Number of entities represented
2.2: By December 31, 2026, increase the number of medical care providers educated about and willing to prescribe PrEP for HIV prevention.	**2.2.1:** Increase provider awareness and knowledge of HIV prevention services including PrEP, PEP, and status neutral care.	**2.2.1a:** Offer quarterly events (e.g.., ECHOs, AIHAG, Advisory Meetings, etc.) with Alaskan providers and community partners to provide updates and education. **2.2.1b:** Develop, write, and distribute materials to Alaskan providers and community partners with PrEP updates (e.g., new medications, patient assistance programs, updated guidelines, etc.) **2.2.1c:** Include PrEP in all existing HIV/STD trainings for clinical providers. **2.2.1d:** Maintain a state-wide PrEP prescriber list for community distribution.	Populations: • Alaskan Providers • Community Partners Metrics: • Number PrEP awareness and education activities conducted • Number of providers willing to prescribe PrEP • Number of materials created/distributed
Goal 3: Increase access to HIV prevention and testing services.			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**

3.1: By December 31, 2026, increase access to PrEP services for Alaskans.	**3.1.1:** Increase the number of Alaskans who are aware of PrEP for HIV prevention.	**3.1.1a:** Develop Alaskan-specific PrEP materials for consumers. **3.1.1b:** Maintain a state-wide PrEP prescriber list for community distribution. **3.1.1c:** Offer active PrEP referrals to all persons initiated through HIV/STD partner services investigations.	<u>Populations:</u> • Alaskans 12 and older • PrEP prescribers • HIV/STD program staff <u>Metrics:</u> • Number of providers willing to prescribe PrEP • Number of PrEP referrals initiated (from NBS) • Number of persons linked to PrEP provider via SOA referral
	3.1.2: Implement an internal PrEP referral process.	**3.1.2a:** Create an NBS investigation for persons inquiring about and requesting assistance with PrEP access. **3.1.2b:** Develop and maintain a PrEP referral form and utilize NBS to track PrEP referral outcomes.	
3.2 By December 31, 2026, increase the number of HIV tests offered to Alaska-identified priority populations.	**3.2.1:** Increase the number of HIV testing events at non-clinical locations.	**3.2.1a:** Partner with community organizations to provide HIV rapid testing.	<u>Populations:</u> • Alaska-identified priority populations • HIV/STD program staff • Community partners <u>Metrics:</u> • Number of non-clinical testing events • Number of gay, bisexual, and other MSM who receive enhanced partner services • Number of PWID who receive enhanced partner services • Number of persons with high-risk heterosexual contacts who receive enhanced partner services
	3.2.2: Bolster HIV/STD partner services efforts for gay, bisexual, and other MSM.	**3.2.2a:** Develop a protocol to enhance partner services to gay, bisexual, and other MSM who test positive for and/or are named as contacts to HIV and syphilis. **3.2.2b:** Using HIV/STD surveillance data, identify and initiate gay, bisexual, and other MSM, diagnosed with and/or named as contacts to HIV and syphilis, for enhanced partner services. **3.2.2c:** Deliver enhanced HIV/STD partner services to gay, bisexual, and other MSM.	
	3.2.3: Bolster HIV/STD partner services efforts for PWID.	**3.2.3a:** Develop a protocol to enhance partner services to PWID who test positive for and/or are named as contacts to HIV and syphilis.	

		3.2.3b: Using HIV/STD surveillance data, identify and initiate PWID, diagnosed with and/or named as contacts to HIV and syphilis, for enhanced partner services. **3.2.3c:** Deliver enhanced HIV/STD partner services to PWID.	
	3.2.4: Bolster HIV/STD partner services efforts for persons with high-risk heterosexual contact.	**3.2.4a:** Develop a protocol to enhance partner services for persons with high-risk heterosexual contact who test positive for and/or are named as contacts to HIV and syphilis. **3.2.4b:** Using HIV/STD surveillance data, identify and initiate enhanced partner services to persons with high-risk heterosexual contact, diagnosed with and/or named as contacts to HIV and syphilis. **3.2.4c:** Deliver enhanced HIV/STD partner services to persons with high-risk heterosexual contact.	
3.3: By December 31, 2026, increase the number of Alaskans who have access to harm reduction and safer injection services.	**3.3.1:** Increase access to needle and syringe exchange programs.	**3.3.1a:** Educate medical providers about the importance and availability of needle and syringe exchange services in Alaska. **3.3.1b:** Partner with OSMAP to identify potential SSP funding for community partners. **3.3.1c:** Promote community-based syringe service programs. **3.3.1d:** Distribute naloxone to community partners and individuals.	<u>Populations:</u> • People who inject drugs • Alaskan providers • Substance use/misuse treatment centers • Substance use/misuse advocacy groups • HCV treatment providers • Syringe service programs <u>Metrics:</u>

	3.3.2: Increase knowledge of HIV/HCV status among persons who inject drugs.	**3.3.2a:** Coordinate with local substance use/misuse advocacy groups to ensure access to HIV/HCV screening services is integrated into comprehensive substance use/misuse program activities. **3.3.2b:** Ensure that all syringe service programs in Alaska offer HIV/HCV screening services. **3.3.2c:** Educate HCV treatment providers about the importance of screening persons diagnosed with or receiving treatment for HIV/HCV.	• Number of SSPs operating in Alaska • Number of SSPs who offer HIV/HCV screening services • Number of HIV/HCV tests performed at SSPs
PILLAR 2: TREAT			
Goal 1: Increase Linkage to Care Services for Persons Living with HIV			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
1.1: By December 31, 2026, of the people newly diagnosed with HIV in Alaska each year, 80% are linked to HIV medical care within 30 days of their HIV diagnosis.	**1.1.1:** Offer all persons living with HIV in Alaska linkage to care services.	**1.1.1a:** Using HIV surveillance data, initiate linkage to care for all individuals newly diagnosed with HIV in Alaska. **1.1.1b:** Offer linkage to care services to all persons newly diagnosed with HIV in Alaska. **1.1.1c:** Offer linkage to care services to all previously reported persons living with HIV who are new to Alaska. **1.1.1d:** Ensure that all linkage to care activities are entered into NBS for monitoring and evaluation.	<u>Populations:</u> • Persons newly diagnosed with HIV in Alaska • Persons living with HIV in Alaska <u>Metrics:</u> • Proportion of persons living with HIV in Alaska engaged in medical care • Proportion of persons living with HIV in Alaska who are virally suppressed

	1.1.2: Offer all persons newly diagnosed with HIV in Alaska HIV partner services.	**1.1.2a:** Using HIV surveillance data, initiate partner services for all individuals newly diagnosed with HIV in Alaska. **1.1.2b:** Offer partner services and HIV testing to all named partners or contacts of persons newly diagnosed with HIV. **1.1.2c:** Ensure that all HIV partner service activities are entered into the Alaska NBS system for monitoring and evaluation.	
	1.1.3: Coordinate with HIV care providers to ensure quick and timely appointment access for persons newly diagnosed with HIV.	**1.1.3a:** Conduct monthly Care Coordination meetings between linkage to care, Ryan White Part B, and Ryan White Part C.	
1.2: By December 31, 2026, of the people living with HIV in Alaska, a minimum of 80% are engaged in HIV medical care and 70% have achieved viral suppression.	**1.2.1:** Develop an annual HIV care continuum for Alaska.	**1.2.1a:** Conduct routine surveillance activities including inter-state de-duplication and death-matching to ensure that data elements used for the HIV care continuum are current. **1.21b:** At least annually, conduct a review of the HIV care continuum to monitor progress towards engagement in HIV care and achievement of viral suppression.	<u>Populations:</u> • Persons living with HIV in Alaska <u>Metrics:</u> • Proportion of persons living with HIV in Alaska engaged in medical care • Proportion of persons living with HIV in Alaska who are virally suppressed
	1.2.2: Coordinate with Alaska HIV clinical care providers and medical case management sub-recipients to emphasize the importance of engagement and retention in HIV medical care.	**1.2.2a:** At least twice per year, educate HIV care and medical case management providers about the availability of linkage to care and retention services offered through the State HIV/STD Program. **1.2.2b:** At least twice per year, work with Alaskan HIV clinical care providers to identify, and if necessary, re-engage	

		PLWH in Alaska who have possibly been lost to care, including coordination and collaboration of re-engagement efforts between the HIV Surveillance program and HIV clinical care providers.	
Goal 2: Build capacity of public and private health care workforce			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
2.1: By December 31, 2026, increase workforce development to effectively identify and diagnose HIV, as well as to provide holistic care for people living with HIV.	**2.1.1**: Strengthen the medical case management program and referral networks.	**2.1.1a:** Implement a standardized medical case management training for community partners. **2.1.1b:** Work with regional AETC to provide continuing education and support services for community partners. **2.1.1c:** Utilize quarterly events (e.g.., ECHOs, AIHAG, Advisory Meetings, HAWG, etc.) to improve collaboration among community partners. **2.1.1d:** Continue to offer DOH sponsored, bi-yearly courses on the Fundamentals of HIV Prevention, Testing, and Counseling to Alaska health care providers.	Populations: • Community Partners • HIV/STD Program Staff • PLWH • AETC Metrics: • Number of training events • Number of community partner meetings • Number of providers and/or agencies offering HIV telemedicine • Number of Fundamentals of HIV Prevention, Testing, and Counseling courses offered
	2.1.2: Improve access to core medical and support services.	**2.1.2a:** Identify and develop relationships with community providers to support service delivery and accessibility. **2.1.2b:** Integrate telemedicine services into state-wide HIV resource manual. **2.1.2c:** Develop a community group to strategize on methods to improve care access in rural Alaska.	

	2.1.3: Strengthen quality of HIV care and treatment services.	**2.1.3a:** Develop culturally-appropriate referral process to prioritize client-centered care. **2.1.3b:** Offer quarterly events (e.g.., ECHOs, AIHAG, Advisory Meetings, HAWG, etc.) with Alaskan providers and community partners to provide updates and education.	
Goal 3: Reduce HIV-related disparities and health inequalities.			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
3.1: By December 31, 2026, reduce disparities in the rate of new diagnoses in the following groups: gay and bisexual and other MSM, Transgender persons, PWID, and Alaska Native people.	**3.1.1:** Engage communities with health disparities to affirm support for people living with HIV.	**3.1.1a:** Ensure quarterly events (e.g.., ECHOs, AIHAG, Advisory Meetings, HAWG, etc.) include representation of agencies and providers who serve communities experiencing health disparities. **3.1.1b:** Ensure that educational materials are inclusive and culturally competent.	<u>Populations:</u> • PLWH • Community Partners • Providers • IKnowMine.org (ANTHC) <u>Metrics:</u> • Number of new diagnoses among gay and bisexual and other MSM, transgender persons, PWID, and Alaska Native people • Number of entities represented at events/meetings • Number of IKnowMine.org website visits
	3.1.2: Fill gaps in HIV services to better meet the prevention and care needs of priority populations.	**3.1.2a:** Promote IKnowMine.org services. **3.1.2b:** Maintain a state-wide PrEP prescriber list for community distribution. **3.1.2c:** Maintain a state-wide HIV care provider list for community distribution, including telemedicine availability.	
	3.1.3: Integrate social determinants of health (SDH) into program planning, design, and implementation.	**3.1.3a:** Use SDH data to inform policy and program decisions. **3.1.3b:** Design holistic programs that alleviate health disparities.	
3.2: By December 31, 2026, reduce disparities in the rate of new diagnoses in rural Alaska regions.	**3.2.1:** Increase HIV prevention, care, and treatment service availability for persons living in rural Alaska.	**3.2.1a:** Promote IKnowMine.org services. **3.2.1b:** Maintain a state-wide PrEP prescriber list for community distribution.	<u>Populations:</u> • PLWH in Rural Alaska • SOPHN • Community Partners

		3.2.1c: Maintain a state-wide HIV care provider list for community distribution, including telemedicine availability. **3.2.1d:** Develop a community group to strategize on methods to improve care access in rural Alaska. **3.2.1e:** Partner with SOPHN to include HIV/STD screening during other health promotion activities in rural areas (e.g., TB outreach, vaccination clinics, and other primary care).	• Providers • IKnowMine.org (ANTHC) <u>Metrics:</u> • Number of IKnowMine.org website visits • Number of entities represented at events/meetings • Number of new diagnoses in rural Alaska • Number of screening events with SOPHN

PILLAR 3: PREVENT			
Goal 1: Increase Awareness of HIV			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
1.1: By December 31, 2026, increase condom distribution.	**1.1.1:** Increase the number of condoms distributed by community partners.	**1.1.1a:** Maintain condom distribution sites and events. **1.1.1b:** Identify and establish additional condom distribution sites and events	<u>Populations:</u> • Community partners/organizations • Distribution Sites • HIV/STD Program Staff <u>Metrics</u> • Number of condom distribution sites • Number of condoms distributed
1.2: By December 31, 2026, increase knowledge of HIV transmission and prevention strategies, and increase awareness of HIV	**1.2.1:** Utilize social marketing campaigns to: Increase knowledge of HIV transmission and prevention strategies; Build awareness of HIV risk factors; Encourage Alaskans to	**1.2.1a:** Develop and implement media campaigns (e.g., social media posts, dating app advertisements, bus wraps).	<u>Populations</u> • Community partners • IknowMine.org • HIV/STD Program Staff

prevention, care, and treatment services.	know their HIV status; Address HIV-related stigma.	**1.2.1b:** Promote existing community partner resources (i.e., IKnowMine.org)	• SOA PIO Staff • Social Media • SOPHN Metrics • Number of media campaigns • Number of IKnowMine.org website visits/clicks • Number of community outreach events • Number of outreach locations • Number of screening events with SOPHN
	1.2.2: Increase the number of community outreach and testing events.	**1.2.2a:** Re-establish previously existing (pre-COVID-19) outreach and testing events. **1.2.2b:** Identify and establish additional outreach and testing events. **1.2.2c:** Partner with SOPHN to include HIV/STD screening during other health promotion activities in rural areas (e.g., TB outreach, vaccination clinics, and other primary care).	
Goal 2: Expand and improve implementation of safe, effective HIV prevention interventions			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
2.1: By December 31, 2026, improve PEP availability and accessibility throughout Alaska.	**2.1.1:** Promote system-level change to include PEP in routine medical care.	**2.1.1a**: Encourage PEP protocol for emergency rooms and urgent care centers to assist providers in responding to potential HIV transmission related to sexual activity or IVDU. **2.1.1b:** Use the existing network of PrEP providers to create a supportive system to help clients obtain PEP, and access care or prevention services.	Populations: • Emergency rooms • Urgent care centers • PEP providers • HIV/STD Program Staff • PrEP Providers • SOA PIO Staff Metrics • Completed PrEP provider list • Number of providers willing to prescribe PEP • Number of PEP campaigns
	2.1.2: Promote community-level change to include PEP as an HIV prevention method.	**2.1.2a:** Create culturally appropriate PEP education and awareness campaign to help educate the community about PEP, including how and where to access it.	
2.2: By December 31, 2026, integrate harm reduction practices into standard medical care.	**2.2.1:** Advocate for increase in SSPs.	**2.2.1a:** Expand the number of harm reduction resources and syringe service centers throughout the state.	Populations: • Community Partners • HIV/STD Program staff

		2.2.1b: Identify funding sources for harm reduction materials.	• Law Enforcement • Substance Use Treatment Facilities <u>Metrics</u> • Harm reduction funding • Number of SSPs • Number of harm reduction resource centers • Number of meetings with law enforcement • Number of community education sessions
	2.2.2: Promote system-level incorporation of harm reduction practices across community organizations.	**2.2.2a:** Develop LGBTQ+ cultural humility in substance use/misuse treatment facilities and mental health care provider networks **2.2.2b:** Build public health/law enforcement partnerships to conduct regular harm reduction trainings and conversations with law enforcement entities.	
	2.2.3: Promote community-level integration of harm reduction practices across care networks	**2.2.3a:** Develop an educational campaign for the general public about harm reduction and access to SSPs.	
2.3: By December 31, 2026, develop a state-wide status neutral care model.	**2.3.1:** Increase awareness of HIV treatment as prevention.	**2.3.1a:** Collaborate with HIV care providers to encourage U=U as a biomedical intervention for HIV/AIDS. **2.3.1b:** Create culturally appropriate education and awareness campaign to empower clients to ask questions about U=U while also addressing barriers to U=U.	<u>Populations</u> • HIV care providers • HIV/STD Program staff • SOA PIO Team • PrEP Providers • Emergency rooms • Urgent Care centers • Telehealth providers • AETC • CBA partners <u>Metrics</u> • Number of meetings with HIV care providers • Number of U=U campaigns • Number of PrEP resources developed • Number of persons referred to PrEP provider during partner services
	2.3.2: Improve PrEP availability and accessibility throughout Alaska.	**2.3.2a:** Facilitate inclusive care practices in emergency departments, urgent care centers, and primary care settings that will ensure clinicians are discussing PrEP with clients. **2.3.2b:** Support TelePrEP services to expand access to PrEP for individuals who face barriers to in-person provider visits. **2.3.2c:** Create a culturally appropriate education and awareness PrEP	

		campaign regarding access, benefits, and cost. **2.3.2d:** Work with regional AETC and CBA partners to develop a continuing education module for providers on the PrEP process and how to prescribe. **2.3.2e:** Develop a PrEP referral and linkage to care process for all index patients and contacts identified through disease investigation.	• Number of community PrEP education events • Number of continuing education modules • Number of PrEP education modules • Number of PrEP linkage to care referrals • Number of contacts identified through disease investigation
Goal 3: Advance HIV-related communications to improve HIV messaging			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
3.1: By December 31, 2026, improve the quality of HIV-related messaging.	**3.1.1:** Identify HIV-related stigma in healthcare settings.	**3.1.1a:** Integrate ANTHC's Stigma Index findings/data into HIV prevention messaging (In 2021, ANTHC began administering a stigma index survey for ANPLWH and tribal health care providers). **3.1.1b:** Work with regional AETC and CBA partners to develop a continuing education module for prevention and care staff about HIV messaging.	<u>Populations</u> • ANPLWH • ANTHC • HIV/STD Program Staff • AETC • CBA <u>Metrics</u> • Number of providers who participate in stigma survey • Number of ANPLWH who participate in the stigma survey • Number of continuing education webinar attendees
3.2: By December 31, 2026, increase the number of HIV-related marketing and messaging.	**3.2.1:** Implement a state-wide HIV prevention media campaign.	**3.2.1a:** Create calendar of HIV/STD national- and state-wide events and days of importance for SOA Public Information Team campaign development. **3.2.1b:** Collaborate with HIV/STD Communications Advisory Board.	<u>Populations</u> • HIV/STD Staff • DOH PIT • ANTHC Public Information Office • HIV/STD Communications Advisory Board

		3.2.1c: Consult with CBA to develop new print materials. **3.2.1d:** Collaborate with state-wide community partners for print and digital materials.	• CBA • Community partners <u>Metrics</u> • Number of new HIV messaging materials • Number of surveillance reports published • Number of advisory meetings and community presentations • Number of cluster responses
	3.2.2: Disseminate HIV-related data to Alaskan healthcare providers and community partners	**3.2.2a:** Publish annual HIV surveillance report and slide deck. **3.2.2b:** Utilize advisory meetings and community presentations to discuss data updates. **3.2.2c:** Utilize cluster detection and response plan to alert and notify community partners of cluster and response activities.	

PILLAR 4: RESPOND			
Goal 1: Enhance the quality, accessibility, and uses of data			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
1.1: By December 31, 2026, increase the timeliness, completeness, and accuracy of data on persons living with and at-risk for HIV in Alaska.	**1.1.1:** Improve the accuracy and completeness of HIV surveillance data.	**1.1.1a:** Standardize programmatic use of surveillance data. **1.1.1b:** Conduct routine analysis of surveillance data to assess data quality and completeness. **1.1.1c:** Seek opportunities to integrate and improve system processes through modernization initiatives.	Populations • HIV/STD Program Staff • PLWH • STD index cases • Named contacts and associates to index cases • DMI technical advisors Metrics • Number of QA analyses performed • Number of CDC performance standards met
Goal 2: Strengthen HIV cluster detection			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**
2.1: By December 31, 2026, enhance DOH's ability to detect HIV clusters.	**2.1.1**: Utilize the cluster detection and response plan.	**2.1.1a:** Complete case ascertainment activities. **2.1.1b:** Ensure partner services surveillance database data points are accurate. **2.1.1c:** Continue to utilize HIV surveillance data to conduct monthly cluster analysis. **2.1.1d:** Annually review the CDRP to incorporate new detection methods, partnerships, and response activities.	Populations • HIV/STD Program Staff • PLWH • STD index cases • Named contacts and associates to index cases Metrics • Number of HIV clusters • Number of risk group members
Goal 3: Strengthen HIV cluster response			
Objectives	**Strategies**	**Activities**	**Populations & Metrics**

3.1: By December 31, 2026, enhance DOH's ability to respond to HIV clusters.	**3.1.1:** Utilize the cluster detection and response plan.	**3.1.1a:** Facilitate discussions with care providers (i.e., ANTHC EIS, PHC) on developing a feasible immediate cluster response in rural regions. **3.1.1b:** Develop communication plans to support cluster response activities. **3.1.1c:** Collaborate with internal and external partners to support efficient and effective cluster response activities. **3.1.1d:** Use the existing network of HIV prevention and care providers to create a supportive system to help clients access prevention and care services. **3.1.1e:** Continue to utilize the partner services surveillance database to document cluster response activities. **3.1.1f:** Complete CDC required cluster report forms. **3.1.1g:** Establish cluster response monitoring and evaluation processes to assess outcomes. **3.1.1h:** Annually review the CDRP to incorporate new detection methods, partnerships, and response activities.	<u>Populations</u> • HIV/STD Program Staff • PLWH • HIV prevention and care providers • STD index cases • Named contacts and associates to index cases <u>Metrics</u> • Number of HIV clusters • Number of risk group members • Number of cluster response activities • Duration of cluster response

Section VI: Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

Integrated Planning Implementation Approach

Strategies and activities identified in the Goals and Objectives section will drive new and ongoing Health Department activities. When the HIV/STD Program and/or community organizations apply for future funding opportunities, the HIV Integrated Plan will serve as a resource for determining needs and establishing new programs.

Implementation

The HIV/STD Program will immediately begin interlacing plan findings, goals and objectives, and monitoring into daily program practices. As grant cycles are renewed, solicitations will be altered to closely align with the developed goals, objectives, strategies, and activities. Community partners will be encouraged to adapt the Integrated Plan to best match their provided services. The 2023 AIHAG meetings will consist of presentations on various sections of the plan. This will allow for AIHAG members to review and understand plan details and to assist with facilitating action. Due to the close relationship with community partners, coordination and collaboration between agencies is easily achievable as all agencies routinely connect and support each other's programs.

Over the next five years, HIV/STD program staff will continuously recruit new members for AIHAG when there is staff turnover or when new key stakeholders are identified. Staff also plan to increase efforts to recruit PLWH for participation in the AIHAG or through an alternative group aimed to obtain feedback from consumers of HIV services. Alaska has recognized the need to adequately compensate PLWH for the time they provide in hopes their participation will continue.

The HIV/STD Program currently only receives funding for HIV prevention and care services via CDC and HRSA. However, the Health Department staff hope to utilize this plan and its goals and objectives to redirect HIV prevention and care services at a community and health department level.

Monitoring and Evaluation

The HIV Program will utilize direct email contact, as well as the Department of Health's website to update the AIHAG, HIV/STD program sub-recipients, prevention and care providers, and other stakeholders on the process of implementing the Integrated HIV Prevention and Care Plan, as well as to obtain and utilize feedback as part of the Integrated Plan's continuous quality improvement. PLWH and prevention consumers will receive updates via their care providers, case managers, the DOH website, and/or AIHAG meetings.

Responsibility

HIV Program Staff will continue to assume the lead responsibility for monitoring the Integrated Plan. A greater emphasis will be placed on quantifiable and qualitative data that demonstrates the outcomes for each activity outlined in the plan's Goals and Objectives. HIV program staff will report back to AIHAG on the progress associated with the various goals, objectives, and activities.

Tracking Worksheet

HIV Program Staff and AIHAG members will develop and implement a monitoring and evaluation benchmark tracking worksheet to track and monitor results for the plan's Goals and Objectives. This worksheet will include the level of detail needed to accurately monitor all aspects of the plan in a simple, easy-to-follow format. It will also include tracking of progress toward meeting the objectives outline in the Goals and Objectives.

Monitoring Process

Ongoing monitoring, input, and adjustment are critical to ensure the available HIV prevention and care resources in Alaska are maximized and the use of these resources are prioritized when changes to the system are needed. HIV Program Staff and AIHAG members will evaluate the plan's progress every six months, and modifications will be made as needed based on measures indicated in the plan. This monitoring process with help HIV program staff and all stakeholders reprioritize, adjust, or revise strategies in a timely manner to respond to the evolving needs or changing profile of HIV services.

Continuous Quality Improvement

If objectives need to be adjusted based on activities and other developments over the course of the plan's duration, HIV program staff and AIHAG members will develop and recommend changes to be submitted for consideration and incorporation. HIV program staff will identify reports that will allow the tracking of the measurable outcomes defined in the goals and objectives. In addition, stakeholders will collect ongoing provider and consumer feedback through surveys, focus groups, and/or interviews.

Additionally, HIV program staff will compile lessons learned from the process for the development of the next jurisdictional plan. Staff will survey partners on their readiness for ongoing engagement, their needs for continued involvement, and possible "best practices" for maintaining partner relationships throughout the implementation of the plan.

Annual Evaluation

At least annually, AIHAG will convene to review data, assess direction of stated objectives, provide explanation of outcomes, respond to monitoring questions, and report findings. AIHAG will continue to attempt to have representation of PLWH as part of the review committee.

HIV program staff has the primary responsibility for monitoring and evaluating the implementation of the Integrated HIV Prevention and Care Plan. HIV program staff will monitor the Integrated Plan throughout the five-year planning period in order to assess the progress toward meeting goals and objectives. HIV program staff will continue to utilize AIHAG to review monitoring data. Quantitative evaluation will include annual measurement of the plan's goals and objectives through HIV surveillance data, sub-recipient quarterly reports, HIV Care continuum annual updates, CAREWare reports, HRSA and CDC report data, as well as other data sources. Qualitative input will be obtained during AIHAG meetings, sub-recipient site visits, HIV/STD Advisory group meetings, HIV Provider group meetings, as well as through other discussions with State staff, consumers of the services, and key stakeholders.

Monitoring and Evaluation Guidelines

DIAGNOSE - Goal 1: Increase the number of Alaskans tested for HIV at least once in their lifetime.

Guiding Principle
All persons in Alaska should have access to confidential HIV testing regardless of age, cost, insurance, and other social determinates of health.

Monitoring Questions

- To what extent was success achieved in health care settings in promoting routine testing and integrating HIV screening into workflow?
- To what extent did non-clinical HIV testing services effectively prioritize communities with the greatest disease prevalence?
- To what extent did non-clinical testing services effectively prioritize communities with the greatest disease burden?
- To what extent were systems successfully established across prevention networks to engage persons about HIV screening?
- To what extent were educational opportunities presented to Alaskan providers to assist with the encouragement of HIV testing among their clients?

DIAGNOSE - Goal 2: Increase provider knowledge of HIV prevention, testing, and treatment services.

Guiding Principle
All health care providers in Alaska should have the capacity to incorporate HIV prevention and testing strategies into routine health care services.

Monitoring Questions

- What activities have been scheduled or executed that provide HIV screening education to health care providers?
- What activities have been scheduled or executed that provide PrEP education to health care providers?
- What is the status of the state-wide PrEP prescriber list?

DIAGNOSE - Goal 3: Increase access to HIV prevention and testing services.

Guiding Principle
In order to reduce new HIV infections, bolster HIV testing among priority populations, increase utilization of PrEP by high-risk negative persons, as well as broaden condom distribution among persons living with HIV and those at high-risk and access to sterile syringes for those who inject substances.

Monitoring Questions

- To what extent was new education material developed and utilized to promote testing and prevention services?
- To what extent was condom distribution expanded in the state?

- To what extent was access to syringe services for PWID achieved?
- To what extent was PrEP utilized by persons with increased risk?
- To what extent were PrEP referrals offered and conducted by HIV/STD Program Staff to persons during partner services?
- To what extent did non-clinical HIV testing expand in the state?
- What is the partner index of newly diagnosed persons in Alaska?

TREAT - Goal 1: Increase linkage to care services for PLWH.

Guiding Principle
All PLWH in Alaska should have access to, and be retained in culturally appropriate, coordinated HIV care and treatment.

Monitoring Questions
- To what extent did facilities providing routine testing successfully achieve linkage to care across prevention and care systems?
- To what extent was monitoring and surveillance data used to identify clients with unsuppressed viral load and/or insufficient engagement in HIV medical care?
- To what extent were systems established across prevention and care networks to engage PLWH who have struggled with consistent engagement in care?
- To what extent were systems established across prevention and care networks for re-engaging PLWH who have fallen out of care?
- To what extent was every newly diagnosed offered partner services?

TREAT - Goal 2: Build capacity of public and private health care workforce.

Guiding Principle
All PLWH in Alaska should have access to holistic care services.

Monitoring Questions
- To what extent have medical case managers improved their services for PLWH?
- What HIV care and case management educational sessions have been scheduled or executed by community partners?
- How often were DOH-sponsored HIV Fundamentals courses provided?

TREAT – Goal 3: Reduce HIV-related disparities and health inequalities.

Guiding Principle
All PLWH should have access to equitable, appropriate, and effective HIV care that is free of stigma and discrimination, regardless of their age, gender, sex, socio-economic status, race, sexual orientation, or gender identity.

Monitoring Questions

- To what extent were available data and existing research utilized in the identification of Alaska's populations experiencing HIV-related health disparities?
- To what extent did key stakeholders assist in identifying, developing, and implementing strategies to reduce HIV-related stigma and discrimination?
- To what extent were community-level approaches identified and implemented for reducing HIV infection in communities at increased risk?
- To what extent were rural Alaskan communities included in prevention and care services?
- To what extent were health outcome disparities reduced in priority populations?

PREVENT – Goal 1: Increase awareness of HIV.

Guiding Principles
All Alaskans should have access to state-wide HIV data.

Monitoring Questions
- To what extent was social media used to build awareness of HIV statistics, risk factors, and transmission, and prevention strategies?
- To what extent were community outreach events utilized to promote HIV education and screening?
- How have non-clinical HIV outreach and testing events evolved?

PREVENT – Goal 2: Expand and improve implementation of safe, effective HIV prevention and interventions.

Guiding Principle
All Alaskans should have access to comprehensive HIV services regardless of HIV status.

Monitoring Questions
- To what extent PEP been incorporated into non-emergency department medical services?
- To what extent ha emergency department PEP protocols been established or updated?
- To what extent have state-wide SSPs been improved?
- To what extent have harm reduction services been made available?
- Has a status-neutral care model been adapted by any health care facilities?
- To what extent have PrEP services been improved?
    - PrEP resources for providers and clients
    - TelePrEP
    - PrEP referral and linkage services provided during partner services

PREVENT – Goal 3: Advance HIV-related communication to improve HIV messaging.

Guiding Principle
In order to reach the highest number of Alaskans, HIV-related communications should be disseminated using high-quality information and current methods.

Monitoring Questions

- To what extent has stigma impacted HIV prevention and care services?
- To what extent were HIV prevention and care communications included in social media?
- To what extent were annual HIV reports distributed?
- To what extent were cluster detection and response activities conducted?

RESPOND – Goal 1: Enhance the quality, accessibility, and uses of data.

Guiding Principle

Alaska HIV data should be timely and accessible to key stakeholders in order to respond and adapt to changing HIV priorities.

Monitoring Questions

- To what extent has surveillance data been standardized?
- What were the findings of data quality assurance analyses?
- What data modernization initiatives have been incorporated?

RESPOND – Goal 2: Strengthen HIV cluster detection.

Guiding Principle

HIV data should be accurate and current in order to detect an HIV cluster.

Monitoring Questions

- To what extent was HIV surveillance data used to conduct cluster analysis?
- What additions were made to the cluster detection and response plan?

RESPOND – Goal 3: Strengthen HIV cluster response

Guiding Principle

HIV cluster detection findings should guide response activities.

Monitoring Questions

- To what extent were internal and external partners present in cluster response discussions?
- To what extent has a communication plan for cluster response activities been established?
- What additions were made to the cluster detection and response plan?

Monitoring and Evaluation Tracking Worksheet – Yearly Benchmarks for SMART Objectives

Goal and SMART Objective	Last Known Baseline	Benchmarks				
		2022	2023	2024	2025	2026
DIAGNOSE Goal 1: Increase the number of Alaskans tested for HIV at least once in their lifetime						

1.1 By December 2026, assess accessibility of HIV prevention and testing services at Alaskan primary care facilities						
1.2 By December 31, 2026, provide community outreach and education events to broaden the capacity of Alaskans to advocate for HIV testing with their medical provider						
DIAGNOSE Goal 2: Increase provider knowledge of HIV prevention, testing, and treatment services						
2.1 By December 31, 2026, provide community outreach and other education events to broaden the capacity of Alaskan providers to include routine testing						
2.2 By December 31, 2026, increase the number of medical care providers educated about and willing to prescribe PrEP for HIV prevention.						
DIAGNOSE Goal 3: Increase access to HIV prevention and testing services						
3.1 By December 31, 2026, increase access to PrEP services for Alaskans.						
3.2 By December 31, 2026, increase the number of HIV tests offered to Alaska-identified priority populations						
3.3 By December 31, 2026, increase the number of Alaskans who have access to harm reduction and safer injection services						
TREAT Goal 1: Increase linkage to care services for persons living with HIV						
1.1 By December 31, 2026, of the people newly diagnosed with HIV in Alaska each year, 90% are linked to HIV medical care within 90 days of their HIV diagnosis						
1.2 By December 31, 2026, of the people living with HIV in Alaska, a minimum of 80% are engaged in HIV medical care and 70% have achieved viral suppression.						
TREAT Goal 2: Build capacity of public and private health care workforce						
2.1 By December 31, 2026, increase workforce development to effectively identify, diagnose, and provide holistic care for people living with HIV.						
TREAT Goal 3: Reduce HIV-related health disparities and health inequalities						
3.1 By December 31, 2026, reduce disparities in the rate of new diagnoses in the following groups:						

gay and bisexual and other MSM, Transgender persons, PWID, and Alaska Native people.						
3.2 By December 31, 2026, reduce disparities in the rate of new diagnoses in rural Alaska regions.						
PREVENT Goal 1: Increase Awareness of HIV						
1.1 By December 31, 2026, increase condom distribution.						
1.2 By December 31, 2026, increase knowledge of HIV transmission and prevention strategies, and increase awareness of HIV prevention, care, and treatment services.						
PREVENT Goal 2: Expand and improve PEP availability and accessibility throughout Alaska						
2.1 By December 31, 2026, improve PEP availability and accessibility throughout Alaska.						
2.2 By December 31, 2026, integrate harm reduction practices into standard medical care.						
2.3 By December 31, 2026, develop a state-wide status neutral care model.						
PREVENT Goal 3: Advance HIV-related communications to improve HIV messaging						
3.1 By December 31, 2026, improve the quality of HIV-related messaging.						
3.2 By December 31, 2026, increase the number of HIV-related community messaging.						
RESPOND Goal 1: Enhance the quality, accessibility, and uses of data						
1.1: By December 31, 2026, increase the timeliness, completeness, and accuracy of data on persons living with and at-risk for HIV in Alaska.						
RESPOND Goal 2: Strengthen HIV cluster detection						
2.1: By December 31, 2026, enhance DOH's ability to detect HIV clusters.						
RESPOND Goal 3: Strengthen HIV cluster response						
3.1: By December 31, 2026, enhance DOH's ability to respond to HIV clusters.						
Due to quality of services used, projects performed, and data collected during 2020/COVID-19, the baseline data used to base SMART goals off is 20XX. Some data is unable to be projected due to…						

Improvement

HIV/STD Program Staff will take into consideration all key stakeholder feedback as it pertains to any section of the Integrated Plan. Due to the long-term nature of the plan, some improvement decisions will not be known. However, HIV/STD Program Staff will be prepared to conduct the following strategies to improve the any section of the plan.

- At the conclusion of each calendar year, HIV/STD Program Staff will present an EOY progress report to AIHAG members. Members will be asked to give verbal or written feedback on the

progress of the plan. Feedback obtained through these meetings will be used to update any section of the plan.

- While funding for HIV Program activities in DOH is already projected, the HIV/STD Program will encourage reallocation of services/funds of community partners to better emphasize key strategies outlined in the plan's Goals and Objectives.
- Throughout the monitoring process, HIV/STD program staff will be prepared to update proposed activities to align with changing services, funding, staffing, and policies.

Reporting and Dissemination

The Integrated HIV Prevention and Care Plan will be distributed state-wide via electronic download. The Integrated Plan will be available on the HIV/STD Program website. Upon completion, the HIV Integrated Plan will be distributed to AIHAG members and reviewed during advisory meetings to encourage wider distribution. All agencies that reported to the Resource Inventory will be sent a personalized email with the Integrated HIV Prevention and Care Plan attached.

Anticipated Challenges or Barriers in Implementing the Integrated Plan

There are anticipated challenges which may impact the execution of this plan. Some barriers may include client-level challenges while others are system- or organization-level challenges:

- Due to the size of Alaska and various healthcare systems, it may be difficult to implement strategies and initiate change in rural communities. Healthcare opportunities will always remain limited in rural areas of the state which will limit outreach opportunities and care facilitation.
- There is a need for enhanced public communication strategies—social medial, internet searches, websites, dating apps, etc. to expand access to information. The political agenda of the DOH, limits the type of content that can be created and posted using DOH resources.
- Continued need for housing, transportation, behavioral health, substance use treatment, and other ancillary services continue to arise as barriers for persons at increased risk for HIV and PLWH. The challenges faced by clients present complex needs may be costly to address.
- The growing substance use epidemic will be a challenge when it comes to implementing certain plan strategies. In Alaska, rates of IVDU related to HIV are low, outbreaks of HIV in other jurisdictions of the country believed to be linked to IVDU could serve as a roadmap on how substance use will affect future HIV rates in Alaska.
- Alaska-based HIV prevention and care service agencies tend to occasionally see high staff turnover due to various factors. Staff changes within the HIV/STD Program as well as partnering agencies may hinder or delay the execution of Integrated Plan components. The HIV/STD Program will remain committed to using this Plan as a roadmap for HIV prevention and care services throughout the state.

Updates to Other Strategic Plans Used to Meet Requirements

Alaska does not have any other strategic plans. The Integrated HIV Prevention and Care Plan is the only strategic plan for the state related to HIV Care and Prevention. Alaska updates the HIV Care Continuum on an annual basis and uses that data to evaluate engagement in HIV medical care. Alaska conducts annual site visits to sub-recipient agencies which can include meetings with consumers and stakeholders. Information obtained from site visits are used to determine if changes are needed in the delivery of services. Additionally, HIV Care sub-recipient agencies conduct annual client satisfaction

surveys which are used to evaluate the quality of services delivered and the needs of consumers. Stakeholder feedback is also sought during quarterly advisory group meetings.

Section VII: Letter of Concurrence

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

DIVISION OF PUBLIC HEALTH
Section of Epidemiology

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November 21, 2022

To Whom It Concerns:

The Alaska Integrated HIV Advisory Group (AIHAG) ***concurs*** with the included submission by the Alaska Division of Public Health, Section of Epidemiology, HIV/STD Program in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The AIHAG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it described how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV. The planning body ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS18-1802, the Ryan White HIV/AIDS Program legislation and the program guidance.

On November 9, 2022, the AIHAG membership met to review and provide feedback on the Integrated HIV Prevention and Care Plan. Membership was provided with a copy of the *Integrated HIV Prevention and Care Plan* along with the CDC and HRSA Guidance to the proposed Integrated Plan two weeks prior to the meeting. Membership was provided with the opportunity to ask Health Department staff questions about the proposed plan and provide feedback. All present and eligible members were provided the opportunity to vote on the Integrated Plan concurrently, and **the concurrence passed without reservations.**

The signatures below confirm the **concurrence** of the AIHAG with the Integrated HIV Prevention and Care Plan.

Lisa Davis
AIHAG Health Department Co-Chair

Anna Nelson
AIHAG Community Co-Chair

Alaska Integrated HIV Prevention and Care Plan Sources

[1] State of Alaska Department of Health and Social Services & Alaska Native Tribal Health Consortium, "Healthy Alaskans 2030," 2019. [Online]. Available: https://anthc.org/wp-content/uploads/2019/11/ha2030_state_health_assessment_finaloct21.pdf.

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[5] State of Alaska Department of Health and Social Services & Alaska Mental Health Trust Authority, "2021 Alaska scorecard: Key issues impacting Alaska mental healht trust beneficiaries," March 2022. [Online]. Available: https://health.alaska.gov/Commissioner/Documents/MetnalHealth/scorecard/AlaskaScorecard.pdf.

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[7] Association of American Medical Colleges, "AMA Physician Materfile," 31 December 2018. [Online]. Available: https://www.aamc.org/media/37841/download.

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[10] Substance Abuse and Mental Health Services Administration , "Behavioral health barometers: Alaska, Volume 6," https://www.samhsa.gov/data/sites/default/files/reports/rpt32818/Alaska-BH-Baromter_Volume6.pdf, 2020.

[11] Alaska Coalition on Housing and Homelessness & Anchorage Coalition to End Homelessness, "State of Alaska: Homelessneww population," Alaska Mental Health Trust, 2018.

Attachment 1: Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material		7	
a. Approach	New Material		7-8	
b. Documents Submitted to Meet Requirements	New Material		8	
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material		9-10	
a. Entities Involved in Process	New Material		10-11	
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material		11	
c. Role of Planning Bodies and Other Entities	New Material		11	
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material		11-12	
e. Engagement of People with HIV – SCSN Requirement	New Material		12	
f. Priorities	New Material		12	
g. Updates to Other Strategic Plans Used to Meet Requirements	New Material		12	
Section III: Contributing Data Sets and Assessments				

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
1. Data Sharing and Use	Existing Material	Alaska HIV/STD Security & Confidentiality Policy & Procedure 2021	12-13	
2. Epidemiologic Snapshot	New Material		13-41	
3. HIV Prevention Care and Treatment Resource Inventory	New Material		42-56	
a. Strengths and Gaps	New Material		56-57	
b. Approaches and Partnerships	New Material		42	
4. Needs Assessment	New Material		57-60	
a. Priorities	New Material		59	
b. Actions Taken	New Material		60	
c. Approach	New Material		57	
Section IV: Situational Analysis				
1. Situational Analysis	New Material		60-70	
a. Priority Populations	New and Existing Material	HRSA Alaska FY22 Part B Supplemental Application	70-71	
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material		71-86	
a. Updates to Other Strategic Plans used to Meet Requirements	New Material		11	No existing goals/objectives material to update
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				
1. 2022-2026 Integrated	New Material		87	

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Planning Implementation Approach				
a. Implementation	New Material		87	
b. Monitoring	New Material		87	
c. Evaluation	New Material		87-94	
d. Improvement	New Material		94-95	
e. Reporting and Dissemination	New Material		95	
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material		95-96	
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material		97	
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)				
3. RWHAP Part B Planning Body Chair or Representative				
4. Integrated Planning Body				
5. EHE Planning Body				